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November 1982

Vol. 3 No. 2

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Through the fire



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EDITOR

James Dunn

ASSOCIATE EDITOR
BUSINESS MANAGER

Robbyn Grant

ADVERTISING AND CIRCULATION

Rhonda Sussman

EDITORIAL COLLECTIVE

Don Weitz

Mel Starkman

Connie Neil

James Dunn

Robbyn Grant

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Contributors to Phoenix Rising:

Gerald Green, Sally Zinman,

Ruth Bartlett, Robert Newton,

Raymond Mitchell, Bud Osborn

Jenny Miller, Bob Harria,

Quinn the Eskimo,

Eldon Garnet, Christian Clark,

Alf Jackson

Cover Photo by Phillip Hoffman

contents

Features

Housing — Not Warehousing	7
Boarding Houses Are Not the Answer	10
A Patient-Run Residence	13
Some Facts About Group Homes	17
Housing Alternatives	18
Emergency Accommodation	20
This is the Law in B.C.	37

Regular Features

Profile — Margaret Gibson	22
—B.A.S.H.	24
Cruel and Usual	25
Phoenix Pharmacy — Tardive Dyskinesia	28
What's Happening	30
Frame By Frame — Titicut Follies	33
The Bookworm Turns	34

On Our Own

More Conference News	38
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What community support?

EDITORIAL

When we decided in 1977 to start ON OUR OWN, there was no self-help group run exclusively by and for ex-psychiatric patients. At first, we wanted to do a number of things. We wanted to get together with other lonely and stigmatized people — especially people recently released from psychiatric institutions — who had also been victimized by the “mental health” system. We wanted to have our own place where people with emotional problems could come for mutual support, acceptance, understanding and friendship; where people could meet and respect each other’s needs and rights — including the *right not to be labeled*; where we could start sharing some of our painful “mental patient” experiences and start learning how to control our own lives, instead of allowing professionals to control us. We’re well on the road to achieving these objectives.

However, as we look around us in Toronto, we find there are only three or four drop-ins where patients and ex-patients feel welcome; very few meaningful job training programs or job opportunities; very little affordable housing; and no community-based, ex-patient controlled crisis centres for people with heavy emotional problems. We also find that people with psychiatric histories are still being denied equal job opportunities or fired for trivial or arbitrary reasons.

Over one thousand poor ex-patients are being dumped and ghettoized in disgraceful boarding homes in Parkdale. Some communities or cities (such as North York) don’t want us living in group homes in their neighbourhood — they fear they’ll catch our “mental illness” or we’ll lower their precious property values. We find people — including some of our own members — who have just been released from Queen Street or the Clarke walking the streets aimlessly, bombed out of their bodies and minds from prescribed massive doses of tranquilizers and antidepressants, flat broke, with nowhere to go. One of our members was released from Queen Street about two years ago in the dead of winter with no shoes or money. Other recently released members have been forced to sleep outside during the winter — a few almost froze to death. And there are thousands of ex-patients who anxiously wait for their welfare cheques or “family benefits” allowances which are supposed to cover all their major living expenses for a month. (The cheques are routinely cut off once you’ve been admitted to a psychiatric institution.)

Then of course, we find that many psychiatrists, social workers and other “mental health” professionals are too busy to listen to our many *real* complaints and needs; too busy to help most of us get through the maddening bureaucratic maze of referral, delay and indifference; too busy to help us find a decent place to live, a job, or someone to talk to or a place where we can feel accepted and understood.

It is no wonder that the vast majority of our members and thousands of other ex-psychiatric patients feel that the professionals can’t or won’t help and that the community and government don’t give a damn about us. And it is no wonder that many of us feel we have no alternative but to go back to the psychiatric institution — sometimes three or four times a year — because of all this rejection and lack of community support. In a psychiatric institution, you can at least get three meals a day and a place to sleep with a roof over your head.

This “revolving door syndrome” can only result in further human pain and destruction. As deinstitutionalization becomes a reality, it is time to realize that emptying the institutions is not enough. To effect real change, the community must find ways to provide us with decent housing, jobs and support systems that will enable us to regain our autonomy and our strength.

IN OUR NEXT ISSUE

Schizophrenia: Exploding the Myth

Mental Health and Violence Against Women

A Mad People’s History of Madness



write on

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

I thank you for past copies of Phoenix Rising. I have however, decided to discontinue your publication. I understand the need for exposing what is going on in the hospitals, etc. to psychiatric patients. To the public who need educating this is a must. However, to those of us who have lived through such hell it is living through it again and again and again. This makes your publication negative. There are few success stories and very little about what is going on in the community when we try to leave hospital and be independent. This too is important. It is so bad that over 60% return to the hospital because of the rejection in every area of the city. It is particularly bad in smaller communities because we have few if any alternatives to the Psychiatric Department. No-one wants us. Why not write about these abuses? There are no directives that would help us when we get into the community published. This could help encourage people to go ahead and not continually mull over the horrors of psychiatric care which they have endured.

I have enjoyed the editorials about Patients' Rights and Government's lack of acceptance of the Psychiatric Patient's needs. These are educational and we need education in the field of psychiatry not to mention patients shoved out in the community to fend for themselves with no followup.

I do hope future issues will include more of this material and not just endless editorials on the horrors of psychiatric care in hospital, drugs, sexual abuse, etc. I don't want to relive it. Once around is enough and too much. A balance of other material would help a lot of people.

Barbara Brown
Peterborough, Ont.

★ ★ ★ ★

There has been a lot of talk lately about the plight of the mentally ill and as far as I can see, that's all that has happened — talk. Concern looks good in newspaper articles but this does not do much to help those who are incarcerated in mental institutions or are barely surviving in some of those fire traps called half-way houses.

It's time for action now — not ten years from now. In my opinion Canada is at the stone age level as far as care of the mentally ill is concerned. The deaths at Queen Street, due to incompetence, during the the past two years are a classic example of how medieval mental health care is in Canada.

Another good example is the overload of LGWs at St. Thomas where open wards are filled and there are no beds available for those who are expecting to get loosened warrants this year.

LGWs are treated worse than the most dangerous criminals in any penal system in the world. At least in a penitentiary, you have some idea when you are going to be released, whereas under the LGW system you are constantly kept in the dark. A prime example is that the Review Board met here at St. Thomas on May 17 and here it is July 24 and we still don't know the results of our boards. In my opinion this does not create better mental health. Instead, it creates bitterness and hatred towards those who control the strings.

Being an LGW makes one feel like a puppet on a string. It is a very dehumanizing experience and, contrary to some beliefs, is no picnic. Constantly you have to worry about being appropriate, for if you speak your mind too much you could be seen as a radical or as mentally ill and in drastic need of medication or more intensive therapy.

The LGW system is in dire need of changes because there are just too many inconsistencies in it. Not only LGWs, but also involuntary patients have a rough time under the Mental Health Act. In my opinion many of these people are kept too long and in some cases because they don't agree with the treatment they are receiving.

I feel that there are positive aspects of the therapy programs in some of these hospitals, but these are usually undermined by keeping the patients longer than they need to be kept, thus in some cases causing them to revert right back to the way they were when they first arrived.

There has been a lot said about what the Nazis did to the Jews and what is being done in these so-called hospitals is not much different.

G.L. Genereaux,
St. Thomas, Ontario.

★ ★ ★ ★

As the founder of an organization to protect consumers and provide accountability in psychotherapy, National Committee For Preventing Psychotherapy Abuse, I was particularly interested in Bonnie Burstow's article (Vol. 3, No. 1). I could not agree more with most of her twenty points as to what can be done to improve the psychological lot of the working class. Certainly no rational, concerned person would dispute the correcting of over-reliance on drugs (perhaps her term is a euphemism for the virtually universal use of drugs on clients in institutional settings), discontinuance of electroshock, the use of therapeutic ombudspersons and the financing of community-based alternatives.

Nevertheless, I am concerned with the lack of clarity in many of Ms. Burstow's remarks. It is difficult to tell whether this is intentional or represents a subconscious condescence towards clients and in particular towards the working class. The latter is part of the thinking process shared by the great majority of psychology professionals. Illustrating this lack of clarity is Ms. Burstow's reference to using ombudsmen. There is an omission as to whether such a person would have a meaningful position of authority in overseeing the accountability of professionals. A second omission occurs where she refers to, "the lower classes be centrally involved in planning and instituting these and related measures." Is there a reason why Ms. Burstow omits the idea of control by consumers? A third point of omission or

confused thinking is her number eight point. "Therapists assume more responsibility for informing clients of their rights and encouraging clients to protest against any treatment they feel violates those rights and/or is insensitive to them." I assume "therapist" in this situation refers to the succeeding psychology professional, rather than the psychology professional violator since it is difficult to believe that most abusive professionals would report their own criminal (a better term than misconduct) action.

I assume that Ms. Burstow is aware that the limited studies on abuse complaints filed by a psychology professional on behalf of his or her client involving blatant abuse such as sexual abuse by a prior therapist shows an affirmative response in the order of one percent. Our own preliminary study on behalf of consumers parallels this dismal record of ethics by the profession.

One final item, although seemingly incidental, bothers me. When Ms. Burstow refers to a Victorian doctor speaking about psychology for the working class who turns out to be none other than Dr. Sigmund Freud, I have difficulty understanding why it is that she is telling us this. Is her purpose to suggest that Sigmund Freud was a compassionate or early friend of the working class? If so, I suggest that she do a little more reading of Freud and the history of psychology. The following are examples of the lack of compassion by Freud of the working class: "Any one who tries to deal by psychotherapeutic means with a neurosis in a poor person usually makes the discovery that what is really required of him in such a case is a very different, material kind of therapy — the sort of healing which according to tradition, Emperor Joseph II used to dispense." Freud, *Therapy and*

Technique; Roazen in *Freud and His Followers* refers to Freud's class overtones where the Victorian doctor uses terms such as "good-for-nothings" in describing dealing clinically with what he considered the filth of human life. Another revealing passage of Freud's, again from *Therapy and Technique*, "It is gratifying that precisely the most valuable and most highly developed persons are best suited for these curative measures; and one may also safely claim that in cases where analytic psychotherapy can achieve but little, any other therapy would certainly not have been able to effect anything."

As an individual deeply concerned with the protection of therapy con-

sumers, the following quotation by Freud, a clear case of professional misconduct, is particularly offensive: "I know" Freud wrote, "the objections there are to making use of patients' reports, and I will therefore expressly state that my informant is a trustworthy person, well capable of forming a judgement . . . I make use of his communication without asking his consent, since I cannot allow that a psychoanalytic technique has any right to claim the protection of medical discretion." (Freud, *History of The Psychoanalytic Movement*). Where the protection of Freud's interests were at stake, the interests of the client were to be violated. This is by no means the only example of Freud's ethics. Perhaps the most blatant violation of professional responsibility was Freud's failure to blow the whistle publicly on the many analysts that sexually violated their 'patients.' Among others, these include, Ferenczi, Jung, Reich, Reik, Stekel and Tausk. Even Ernest Jones, Freud's official biographer, was actually imprisoned for a night, having been accused of indecent behavior to two small children during a speech test he conducted although the magistrate eventually dismissed the case. Following another comparable incident, Jones had to resign his position.

The only other reason that I can think of that Ms. Burstow may have used the Freud reference is one that is frequently used by professionals. It is used in the same manner as quoting the Bible. Freud's quotes are used as the 'omega', and it pivots the professional into the upmanship position of a sage. I cannot help but believe that this approach is intellectually dishonest and demeaning of the unsuspecting consumer/reader.

I truly hope that somehow my criticism of Ms. Burstow is not too harsh, that my deductions are largely in error. Nevertheless, I feel Ms. Burstow owes the Phoenix Rising readers some explanations. Perhaps the acid test of Ms. Burstow's intentions is for her to state how many of her own clients were sexually abused by prior therapists and to inform us of what individual action was initiated by her. Bill Cliadakis, founder NCPPA New York, N.Y.



During the next couple of years I expect there will be a lot of emphasis on 'normalizing' all types of disabled persons. I think the word 'normalization'

is bad terminology. All one has to do is to look at normal persons and see how many problems they have: how depressed, lonely, angry and hurt normal people are. Are people who have become inventors, movie stars, or politicians normal? (e.g., Einstein, Alexander Graham Bell, Ford, Martin Luther King.) Presidents, prime ministers, etc.? Were these normal people?

When one uses the term 'normal' one cannot confine the term to disabled people, or any other minority groups. Why are there so many normal people in mental institutions today with nervous breakdowns? Isn't it due to financial pressures, family pressures, etc.? Why are the professionals trying to get disabled people into that rat race?

What we really are looking for is to create "an environment that will develop each person's potential to its maximum capacity."

A normal person is a person who worries about what other people say about him and therefore he does nothing about a problem. Normal people see no solutions, hear no solutions, and feel no solutions to problems. Our educational system does everything possible to 'normalize' children's and young students' goals and squelch their imagination. Christianity teaches that we should become "new and different people," and "Be ye not conformed to this world but be ye transformed by every word that proceedeth out of thy mouth." The churches have been followers, not leaders, in this area.

Every person is unique and has special talents. Disabled persons are unique and have many talents. A small number of disabled persons have "vibrant personalities" but most are victimized by "scowling personalities" who are miserable themselves and enjoy making everyone else miserable. People must recognize their uniqueness. They must have respect for themselves and for other people who are different because of many unforeseen causes and choices, and get to know each other.

Normal persons are very frightened persons. They are frightened of themselves and of people who are different, or who have different ideas. So why should we, as disabled people, try and degrade ourselves even more by becoming 'normal'? Why not try and change the world little by little to make society see and meet our needs; and therefore, by helping us, they help themselves. Normal people need a purpose for living, and we need people to help us.

Please write your comments on this to:

John C. Kellerman,
25 Henry Lane Terrace, Apt. 575,
Toronto, Ontario M5A 4B6.



movement news

Alliance for the Liberation of Mental Patients

I felt that this year's conference was the best I had experienced since my first in 1976, which was in Boston. There were a number of significant steps taken forward in terms of movement ideology and analysis. One of these was the development of a comprehensive feminist attack upon and analysis of the psychiatrization of the women's community—i.e., the prevalence of "mental health" professionals in rape crisis centers and battered women's shelters, and the acceptance of psychiatric and medical model jargon in describing and defining women's experience and expression of emotional distress. An incisive statement analyzing the functions served by "feminist" therapy/psychology as seen from a feminist ex-inmate perspective is currently being finalized by conference women; it promises to be one of the most definitive and timely anti-psychiatry documents to date, and deals with issues of class as well as women's self-determination *vis-a-vis* psychiatry. It should be an important tool in building further bridges between the anti-psychiatry and women's movements.

Then there was the socialist study group. I was impressed and a little surprised by the relatively large turnout for the workshop. I also believe that the current interest in socialist-marxist approaches to things reflects the changing times and the deteriorating economic-political situation in the U.S.

Last, but certainly not least, there was the APA demonstration, followed by the Sheraton sit-in later that evening and the subsequent police action. We're really beginning to get our act together in terms of political theatre and media relations. For the first time ever, we demonstrated in front of national press that the ability of psychiatry to carry out its activities uncontested relies *not* on the power of reason, persuasion, or proven merit, but on the power of the state to violently suppress dissent. In

other words, as will become more and more apparent in the coming period, psychiatry and capitalism go hand-in-glove.

Why did our public actions work so well this year? With the larger noon-time demonstration, I think that the two major factors of success were: 1) the entire scenario of former "mental patients" confronting shrinks at their own convention is a "natural" for a colourful news event; and 2) our own militancy and resourcefulness in making creative use of what we had available—in this case, signs, chants, and street theatre. We made it clear that we were angry, but also displayed a sense of humour which contrasted to the formality and uptightness of the APA clones. Our human side came across splendidly, as did the seriousness of our message. The "official" demonstration set the stage for what was to follow, which would serve to dispell any lingering notions in the public mind of capriciousness or frivolity on our part.

"So what did you accomplish by all of that?" (I'm hearing voices.) Well, here are a few examples:

1. We finally outmaneuvered the APA publicity and security machines, serving notice on the shrinks that we know how to play mind games too. For a brief but intense moment we cut through the liberal camouflage of psychiatry and directly exposed its repressive nature. Shrinks were confronted with the sight of us being dragged away in the name of their own "security;" even "humanists" were forced to recognize the violence underlying their social power. We caught them off guard—when they thought we were being pacified by their patronization—and they reacted by panicking with all of Canada as their audience.
2. We effectively created a "charged" situation in which the shrinks' reactions served to clearly reveal some of their contemptuous attitudes towards their "patients." For example, the Toronto *Globe and Mail* reported that some of the shrinks looked "embarrassed", but that "others laughed at the patients." But the prizewinning quote came from the Toronto *Star*, to which a (naturally) unidentified shrink said,



“This demonstration only served to show that a lot of these people are still very ill and in need of treatment.” With gems like these coming from the other side, there’s very little we need to add! All of this, of course, helps to make the shrinks appear in the eyes of the public as the clowns and imposters that they really are, as opposed to their official propaganda image as concerned, knowledgeable and helpful professionals.

3. On an internal level, in addition to escalating our militancy and effectiveness in terms of direct action, we confirmed our continued and growing willingness to fight and face retaliation for our beliefs and principles. This kind of self-affirmation is vital to both our political and spiritual growth and contributes to providing those who take part with a renewed sense of solidarity and commitment.

It was the first arrest for many,

and for most others it was the most violent. Although there were no serious injuries, the spectacle of our sisters and brothers being dragged away by cops is itself very upsetting. But we held on to each other—before, during and after our arrests. The spirit in the jail was very high. The cops, with one or two asshole exceptions, were unable to maintain their stoic professionalism and gruffness. Even they had their consciousness raised—by the time we were done being “processed” they knew to refer to us as “former psychiatric inmates” and not to ask us whether or not we were “better” or “normal” now.

The press coverage was some of the best that I’ve ever seen in the (so-called) straight media. We made Canadian national news, which I didn’t have a chance to see. I did read a number of accounts in the *Toronto Star* and also the *Globe and Mail*, however, and was impressed with both the quantity and quality of the coverage. We were quoted

as saying that psychiatry is TORTURE, for example. Pretty strong stuff—usually we wouldn’t be able to get away with a quote like that without a host of rebuttal quotes from psychiatric “experts” to make us look “paranoid.” Also, in the *Globe and Mail*, the APA’s medical director was quoted as saying that he had “sympathy” for some of our concerns, but felt that the sit-in was an “inappropriate forum.” Following the quote, it was noted that when we staged our larger, “peaceful” demonstrator earlier (“peaceful” apparently meaning that we weren’t assaulted), only about 30 shrinks bothered to check it out—but that 200 of them had crowded into the lobby of the Sheraton to watch us get dragged away! So—we’re *definitely* starting to get more effective in terms of theatre, publicity, and media utilization. Self-congratulations are in order for all of us!

Bob Harris,
ALMP,
Philadelphia, PA.

Vermont Liberation Organization

It is mentioned in our last report that we became part of the Mental Health Support Group project, which has turned out to be a total fiasco and has taught us not to have anything to do with Mental Health Associations. One thing that did come out of it, however, is that the executive director of the mental health association here recommended us to Haymarket Peoples’ Fund, for grant funding, and we have got a \$2,500 grant from them to pay for our organizational expenses over the next year. The first thing we have done is to incorporate a non-profit, tax-free organization which we are calling the Vermont Liberation Organization. We have a great deal of grass roots support in this State and, being that Vermont is the way it is, we feel we have to really concern ourselves with the liberation of the entire community. We will work towards this end through our work in abolishing the psychiatric system and liberating Vermont from psychiatry.

Also in the last report, I mentioned that we’d helped to spring some people from the state institution and to some extent that was not successful in that either we did not have the support they needed or the situation was too desperate for any of us to be able to do much. To that end, it became apparent that we needed some sort of an extensive alternative to the present psychiatric system. So I began talking to people in Burlington about starting a drop-in

center there.

Burlington recently elected a socialist mayor through an organization called the Citizens’ Party and also recently this Spring elected a number of Citizens’ Party candidates to the Board of Aldermen. One of the people elected is a person named Rick Musty, who also is the Chairman of the Psychology Department at the University of Vermont and a psycho-pharmacologist who is vehemently anti-drug. He has been interested for quite some time now in starting detox centers, viewing psychotropic drug problems as a massive drug problem, like street drugs and alcohol. So we have made contact with the University of Vermont and they are helping us to get the drop-in center started in Burlington.

At the same time we have been in contact with an organization called Galaxy Protection Service in Montpelier and have been attending pot luck dinners there on Wednesday nights. They have been quite accommodating to ex-psychiatric inmates in terms of inviting them to dinner and to live there in Montpelier. Now they pretty much seem to be developing in the direction of becoming a full time residential facility for ex-psychiatric inmates, particularly those who are now being incarcerated under the plan of the Department of Mental Health to reduce the population of the state institution from 240 to 140 people over the next year. We have also made contact with

the Division of Alcohol and Drug Abuse in the State and learned that its director, Rufus Chaffee, is a person who is against psychotropic drugs, and also is quite interested in having a public information campaign (radio, television and newspaper) to inform the public of the effects and side effects of psychotropic drugs. So we will probably be doing that on a statewide level over this next year. Also, he is interested in funding the detox centers in conjunction with the University of Vermont and the Department of Mental Health.

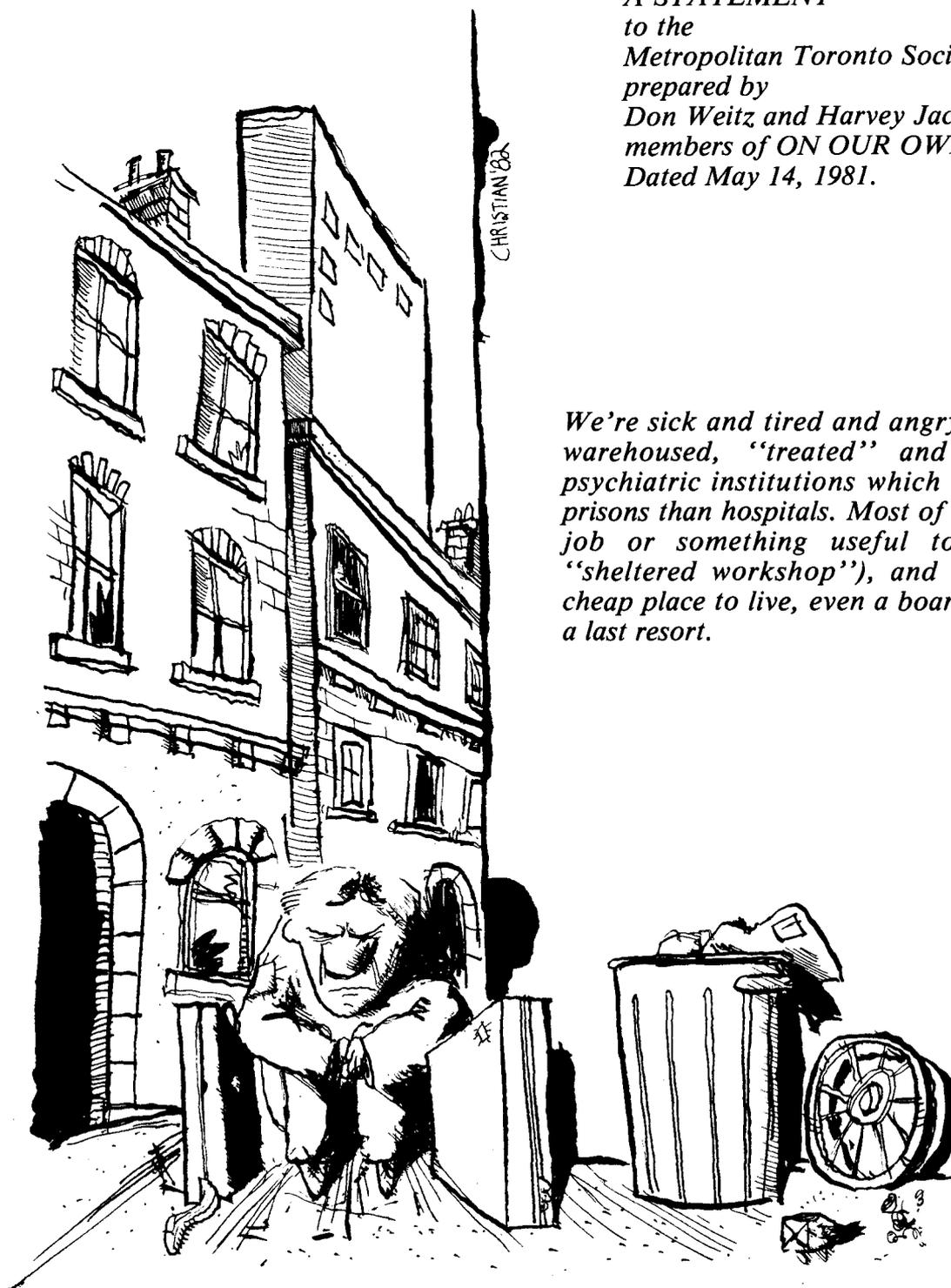
Finally, the Department of Mental Health has contracted to pay for our meetings on the telecommunications bridge, which is a statewide conference phone system which allows us to have hour-long meetings on Saturdays, from 10 to 11, from locations all around the state. The next thing that we hope to get into is monthly meetings on interactive television, which is a 2-way teleconferencing system through Vermont and New Hampshire. In Vermont we are very much used to direct participation and direct democracy. Vermont town meetings this spring voted to ban all nuclear weapons and hopefully we will be able to have a town meeting using two-way TV, which would be for those of us who live in the town called Psychiatric Oppression.

Quinn the Eskimo.

Housing — not warehousing

*A STATEMENT
to the
Metropolitan Toronto Social Services
prepared by
Don Weitz and Harvey Jackson,
members of ON OUR OWN.
Dated May 14, 1981.*

We're sick and tired and angry about being warehoused, "treated" and recycled in psychiatric institutions which are more like prisons than hospitals. Most of us just need a job or something useful to do (not a "sheltered workshop"), and a decent and cheap place to live, even a boarding house as a last resort.



This is why we support recommendation no. 2 in your "Final Report on Adult Residential Facilities", which calls for regular and thorough inspections and licensing of boarding homes by Toronto. If there were such inspections and power to license, we're sure many boarding homes would be closed, because they're unclean and overcrowded, and violate a number of other basic health and building standards. A lot of others would be forced to clean up their act to stay open. We'd also like to point out that all too many boarding home operators treat the residents as children or as a bunch of incompetents—a situation almost identical to the psychiatric ward where staff infantilize, patronize, humiliate and exploit patients. Boarding homes have become the community's back wards for people labeled "chronic" or "difficult to house." The boarding home operator is now the community's BIG NURSE.

Instead of more or better boarding homes, there should be many more co-op houses and apartments in which the residents control the day-to-day running of *their* house, share in all necessary chores, and make and enforce house rules and other policy decisions. We feel that's one major way in which ex-patients and other troubled, lonely people can become more independent, productive and self-respecting and can learn to stay out of institutions.

Resident-controlled houses (such as those run by the Mental Patients Association in Vancouver and HouseLink in Toronto) should also help to reduce admissions and readmissions to psychiatric institutions. In 1974, MPA (an organization similar to ON OUR OWN) conducted a survey which compared readmission rates of over 100 members living in its five houses with those of psychiatric in-patients. Within a nine-month period, only 10% of MPA residents were readmitted, but at least 60% of the inpatients were readmitted.

The Committee's recommendations no. 6 and no. 8 call for 100 more beds, and for social assistance, including financial aid for ex-patients. It is now over a year since these recommendations were made, yet the Ontario Government still has not acted on them. In its response to the recommen-

My name is Lornie. The boarding house where I live is cruel. I shouldn't have to live there. None of us should have to live there. We should each have our own apartment. Or else we could share apartments. Right now I get \$318 a month for disability, but my rent is \$260 and I have to share my room. The landlord isn't a bad guy, but he charges way too much. That only leaves me \$58 a month and I give about \$20 of that to my friend Fred because they won't give him anything. The rest I spend mostly on cigarettes or coffee. I'm always hungry because they never give me enough to eat. Most of the time they have us so doped up we don't know what we're doing. It's not right what they're doing to us.

dations in the "Final Report," the provincial government had the arrogance and/or ignorance to claim that no additional beds are needed or will be approved in Metro. (*Ed. Note: Since that time, the Ministry of Health has approved funding for 57 more beds.*) Furthermore, it claimed that "only a minority of the patients discharged from psychiatric facilities

"Being a single parent, I was living at the boarding house with Julia, and that was really hard. I was lucky I could work there and save some money to get out. If I worked, it was deducted off my rent. That was the only way for me. You can't save money on welfare. It's just like a never ending circle. I had lice. Julia had lice. We finally got out and now we're ok. I was lucky to be in a boarding house that accepted a child. They don't want children; they have enough problems. Anyone else would have lost their child. The child would have been placed in a foster home, and the mother would have been told, "When you find a place and you're more settled you can have your child back." But how can you get out of this kind of milieu? There's no way to get out of it."

(Diane Capponi)

require these types of assistance."

Only a minority? The April, 1981 research report, *Aftercare in Metropolitan Toronto*, shows that almost a quarter of seven hundred patients followed up for six months after discharge needed immediate housing. We believe the 22% figure is underestimated—30% to 40% would be more accurate and believable. For example, in one research institution studied (presumably the Clarke), housing needs were identified by staff for 35% of the patients; the figure was 27% in the public psychiatric institution (Queen Street.) However, staff rarely bothered to refer needy patients for housing—housing referrals never exceeded 15%.

We also wish to point out that the patients in greatest need of housing, financial and job assistance are the ones in public psychiatric institutions such as Queen Street. The *Aftercare* study also shows, for example, that there are proportionately more unskilled and unemployed people (54%), and people with less than Grade 9 education (42%), in Queen Street than in the other three institutions studied.

This result and others simply confirm what we already know: that there is a definite *class bias in institutional psychiatry*. The poor patients get dumped, ignored and generally abused in public institutions, while the middle and upper class patients get admitted to and more humanely treated in private institutions and psychiatric wards of prestigious general hospitals, as well as private psychiatrists' offices.

Assuming there are roughly 7000 psychiatric patients discharged every six months in Metro Toronto (according to the *Aftercare* study), at least 4000 ex-patients are in immediate

need of housing each year in Metro! And the provincial government simply dismisses these 4000 people as a "minority." So much for the government's concern about housing needs of recently released psychiatric patients.

Recommendation no. 10 in the "Final Report" of the Committee is preventive; it's one which we also strongly support. It calls for *direct admission* to "approved homes" instead of psychiatric institutions. ON OUR OWN has consistently advocated doing whatever is necessary to keep people out of psychiatric institutions. Frankly, we consider these institutions *health hazards*. From our own bitter experience and those we've shared with hundreds of other ex-patients, we know that people are more psychologically damaged (sometimes permanently) after hospitalization than they were when admitted to psychiatric institutions. So if we can prevent psychiatric institutionalization, we can prevent serious damage to people's bodies and minds. And we can remove the need for "deinstitutionalizing" people.

However, to keep people in crisis out of psychiatric institutions means we must make available a much larger number and greater variety of community alternatives. Specifically, we must have many more low-cost resident-controlled houses and co-ops; apartments and flats (MPA and House-Link are two useful models); many more drop-ins with long hours; and some 24-hour crisis centres and crisis "hot lines" predominantly staffed and run by ex-psychiatric patients, with on-call medical backup for emergencies. These community resources should also be strategically located throughout Metro, so that a person should be able to get to a drop-in or crisis centre within fifteen or twenty minutes. Accessibility is essential. To establish such community resources for people going through a personal or emotional crisis, there must be much greater public education about the need, and a *total commitment* on the part of ex-patients, health professionals, the government and the public to prevent admissions to psychiatric institutions. We must begin thinking COMMUNITY — not institutions. We must work together.

As a result of keeping troubled people in the community, health costs will be dramatically reduced. It now costs Ontario taxpayers over \$150 (perhaps \$200) to keep one person locked up and "treated" one day in a public psychiatric institution. In sharp contrast, it costs only \$40 to \$50 a day to maintain one person in a community co-op, group home or half-way house! Imagine the savings in health costs if we could prevent 10,000 psychiatric admissions each year in Metro. Assuming that the average institutional stay is two weeks, that means a saving of roughly fourteen million dollars in only one year!

Unfortunately, no city or provincial government is seriously committed to preventive, community-based health care for people in crisis. For 1980-81, according to the *After-care* study, the Government of Ontario is spending roughly 340 million dollars on maintaining psychiatric institutions, but only 14.3 million dollars on "community based psychiatric programs" (p. 68). In other words, the provincial government is spending 24 times as much on warehousing and recycling psychiatric patients as it is on preventing institutional "treatment" in the first place.

And let us also remember that the average yearly readmission rate for public psychiatric institutions in Ontario is

60% to 65%, a gross indication of the failure of institutional psychiatry. From a cost-benefit perspective, psychiatric institutionalization is extremely wasteful, expensive and inefficient. From a medical perspective, it's ineffective or anti-therapeutic. From a moral perspective, it's unethical. From a legal standpoint, it's unjust. And from the patient's perspective, it's harmful, degrading and often life-threatening.

Thousands of psychiatric patients and ex-patients in Toronto are sick and tired of being treated like second class citizens or worse by well-meaning, do-gooding "mental health" professionals, government officials and the public. We're sick and tired of being told again and again that people are only doing things such as getting us "treated" or committed "for our own benefit."

"Most of the boarding houses are enormously large. If you're on welfare, you're allowed two, three, four, five to a room. Most of the places don't have a dresser. Generally, you get one blanket which is kind of threadbare. And it gets cold in those houses, 'cause they're old and the heat doesn't rise in the winter. The bathroom is shared by nine or ten people. There is a central dining room with institutional-type tables and chairs. There's usually a poor, frightened lady working in the kitchen. Breakfast is cereal, toast, sometimes jam or peanut butter and tea. Lunch is a sandwich, soup, tea. Supper is hot, with lots of starch — heavy on the potatoes, heavy on the spaghetti, heavier on the rice. Medication makes you very hungry, especially the younger men. They can't appease their hunger on what they get. They wolf it down, go back in line and try again. Sometimes, there's seconds; sometimes there's not. Sometimes there's a TV room, two couches; sometimes it's a little more elaborate — three couches. A lot of places don't have proper smoke detectors and fire extinguishers. People get up and go for breakfast, which starts at 6:30 or 7:00 A.M., go back to bed, get up at lunch, nap 'til supper, and then they play cards or watch TV until they go to bed."

"They can now discharge who they want to discharge from hospital, because they know there's this bed and three meals a day. The person's not going to embarrass the shit out of them by dying on the street. When somebody's that's not too well tries to leave a boarding house and get a room somewhere, they begin to starve to death, and to get crazier and dirtier. And at the point where they're dying, they get admitted to hospital. I've seen it happen over and over again."

"Emotionally and personally, there's no dignity; there's no sense of being human. It's a very paternalistic atmosphere. I sometimes think that the people in boarding houses play up to that, because when you're institutionalized, authority is all. Somebody once said that oppressed people forget to look at who's oppressing them. They bitch at each other so much, they tear each other down."

"Some people get very comfortable in the boarding houses, which is frightening. Some people get angry, which is more reassuring, but frightening for you because you don't feel very good. How can you feel very good? You feel the world has really written you off. You know it in everybody's face when they look at you, or don't. And you know it when people are walking by and staring at your house."

(Pat Capponi)

Boarding Houses are not the Answer

an interview with Diane Capponi

By ROBBYN GRANT

I've travelled a lot and I've seen a lot of terrible conditions, but I've never seen anything like the boarding houses in Toronto. I've never seen a person be treated on such an inhumane level and live in such filth and degradation as I have here. All Canadians should be ashamed of how these people are forced to live.

In the ordinary boarding house you have maybe one staff person for 60-70 people. If the house is suitable to hold 20 people, it may hold 60. If you're lucky you get a pillow. You never get a private room. There are lice everywhere and people with the most bizarre behavior, medicated up to their eyebrows. Inside it's very dark, very depressing, and in the winter time, very cold. The meals served there usually consist of starch — bread, potatoes, spaghetti. There is no access to a phone, no access to a laundromat.

You don't even see your cheques. Mostly, everybody in the boarding house is on some kind of public assistance, and their cheque goes directly to the operator of the house. The balance is maybe \$20 a month and is supposed to cover all their needs — bus fare, laundry, soap, tobacco, etc. The rent people pay depends on their income. If they are on full disability they receive \$365 a month. That means that they pay \$285 a month room and board. They're the lucky ones. If you are on welfare, as most are (since people having problems with their mental health are not considered disabled), in Toronto you receive \$226 a month, and \$210 to \$218 is taken for room and board. If you get an increase in your welfare cheque, your rent goes up.

How can you get yourself out of this situation when your clothing is usually from the Sally Ann or from some other person's fourth or fifth hand down? Often you are so heavily medicated that you don't even care what you look like. Half the time these people won't even get dressed. They won't even get off their bed. There is no staff to motivate them because the owners can't afford it.

There are no controls by the city. I can think of two boarding houses operating right now that are not licensed. They have been suspended, but the city is so worried that if these places go out of business there won't be any place to put people coming out of the hospital. That's why the city doesn't step in to close them down.

There are arsonists living in these houses, sex offenders and dangerous criminals; people who have committed crimes repeatedly, who will commit them again, and who are putting everyone in the houses in jeopardy. It's so impossible. If you're not afraid of the guy next to you, you're afraid of the guy upstairs, or the guy down the hall. Or you're afraid of the staff member who isn't always impartial. You're afraid for your own life. You wonder if you're going to get your cheque so that maybe for a week you have enough money to get your tobacco. What are the meals going to be like? Are you going to be able to digest them? Half the time the fire safety equipment isn't operating; security in the house is nil. Lice is a constant problem. It's always like that. You are faced with these basic survival problems every day, and you're not going to get out of it.

You might feel relatively good in an institution. It's clean, you get three good meals a day, and there are so called "normal" people to talk to. A lot of people from boarding houses look forward to going back to the institutions. They get to walk around and meet people to talk to. When they are in a boarding house they stay in their room. They go to the TV room if there is one. The only people they see are the more active ones in the house that are out of their rooms. You usually don't get much of a chance to talk to the staff person. Usually the one staff member is on duty all the time and is just too busy handing out medication (even though half these people are not qualified to give out medication) and just making sure things are under control. If there are any problems they contact the hospital or a local satellite.

More than likely you are going to end up back at Queen Street, not because of the problems that originally put you into Queen Street, but because of the problems that you have to face in a boarding house. It's just a terrifying horror story. You have enough to deal with just entering society again. I was only in the hospital for a little while, but it's so foreign coming out. You need pressure taken off of you — not put on you.

Most people in boarding houses are totally alone, isolated. If you have children, by the time you are in an institution for a period of time, Children's Aid has usually stepped in and taken them from you. If you are lucky, you've had family who will help you, but most people's family abandon them once they go in institutions. I was really lucky. I had my sister Pat, to keep my daughter for me and she was a major influence for me getting out of Queen Street. If I had lost my daughter like most people do, I wouldn't have had a reason to continue working towards changing. Let's face it — you get comfortable in the sick role.

I don't think I would have made it if I had come out to face the usual boarding house situation. I came out and Pat was working in a boarding house. She was a supervisor there, and she made special arrangements to get me a special area in the basement away from everybody. I worked there part-time, so I was treated a little bit better. I got second helpings of food. I

patient. I wasn't half as medicated. I wasn't half as sick when I went in either, so when I came out I wasn't as sick. I had more going for me, more potential to make something of myself. If Children's Aid had seen the boarding house, there is no way they would have given me my daughter back.

I was in the hospital for 2 months and the boarding house for 4 months, but for me it seemed like a year. I was always surrounded by the same thing. You look around you and you can never get out of it. There is no foot hold. It's not as if you can go and take a bus somewhere for help. They have satellites in the area like Archway where they have therapists to help you out, but they are assigned maybe 40 patients each. Usually you only get attention if there is a problem (other than that you are heavily medicated) and the side effects from medication make you stick out like a sore thumb in any crowd. Plus the life style you are living makes you stick out. It makes you so that you really don't have the impetus to do anything else anyway. It makes you almost content with what you've got.

In Ontario they have decided that getting the people out and into the community is better than institutionalizing them, so they open their doors when they consider that treatment in hospital is over. There is no gradual process of letting people out. If they slowly integrated people into the community, and provided more treatment for the people once outside, the rate of returns to the hospital would be much less. People being discharged from hospital need to be made more aware of community services. They need more support systems on the outside. They need to have more life skills taught to them. They need less medication and the level gradually reduced. They need to be helped to look less bizarre, but none of these things are provided. They are just pushed out and told, "Okay, do it." If they took you individually and helped you financially; if they could find a group home setting, some kind of graduation to your own apartment, some kind of motivation, you could get out. You could be motivated by seeing that some-

one else who has done it. These people look at Queen Street now as a hotel. And if you do a survey at Queen Street, you'll find that 90% of the people have been in and out repeatedly. Now that really tells you something about what is happening, when people think of a mental institution as a nice place to go.

You can't belittle the landlords all the time and say it's all their fault, because there are some landlords with good intentions. But what can they do on \$7-\$8 a day? How could they possibly give adequate care? Some landlords do take advantage. They don't treat the people very well and they might accept any Joe who comes in off the street. They don't have any kind of security. Most of them can't afford any kind of security, but some of them do try to screen the people coming in.

Queen Street has a list of homes which they call recommended. Now if these homes are full, Queen Street will resort to a place like this. They have to put the guy somewhere. If there was proper housing, this wouldn't happen. If the licensing rules were tougher, the city could say: "OK, you're closed down, get everyone out of there and put them somewhere else." Then this kind of thing wouldn't happen.

But with the typical person coming out of Queen Street with a dry mouth, with a tic in his lip, and his arm flying, if he goes to a room the landlady is going to look at him and say 'no way.' Half the people coming out of Queen Street can't fend for themselves. They can't cook. They need a boarding house setting or group home setting where they can learn some basic life skills. A lot of professionals at Queen Street define the boarding house settings as group homes, and that is such a joke. I know what a boarding house is, and I know what a group home is, and there is such a difference. That's the whole housing problem — there is just no where to put these people. Nobody thinks it's that bad, but if that was what I had to look forward to, I'd probably stay in the institution as long as I could. I wouldn't want to come out to that. I wouldn't want to live in that.

For anybody coming out of the institution, housing and after-care is the most crucial part of treatment. If there is any potential for change, it is dependent upon what happens to you when you come out. That is the area where most people get most damaged, even more so than the institution. In Ontario there is no such thing as after-care. There is really no such thing as adequate housing provided for people just coming out of the hospital. There are flop houses that are a lot nicer than the boarding houses here.



The Ontario Welfare Council brief for the Committee of Social Planning Councils, April 1981, entitled "Community Based Services: The Need for a Planned Approach (The Case of Adult Residential Facilities)."

The brief deals with adult residential care facilities for groups at risk — mentally "ill", elderly, mentally retarded and physically disabled, children and youth, victims of physical abuse, ex-offenders and individuals with addictions — and the results of the Ontario government's policy of de-institutionalization.

It points to the lack of promised legislation and funding for this plan. In Metro Toronto only 200 community beds have been created in ten years. "When lakeshore Psychiatric Hospital closed in 1980, only one half of the \$2.6 million reportedly saved was redirected into new community programs . . . and only a tiny fraction went for housing." Pg. 8.

There is no adequate planning, clear responsibility or co-ordinated approach to funding for a coherent caring system. The need for systematic planning is obscured by current necessary crisis management.

At risk groups (described above) are placed in jeopardy. There is increasing resentment and frustration among service

providers, municipal authorities and citizens ill-prepared to face these crises. Finally, high re-admission rates indicate questionable cost effectiveness of present deinstitutionalized approaches.

Zoning by-laws by municipalities can block community based facilities. In the case of Metro Toronto, who acted responsibly in opening all neighbourhoods to group homes, the province ordered Metro to reconsider that decision, thus undermining responsible political action.

After-care planning and monitoring is lacking and these individuals get "lost" in the community.

Recommended action to the Province is that they provide a continuum of care for adults in need, and information to the public through briefs by providers, self-help groups and municipalities. Other action to include community placement and follow-up; legislation on licensing, standards and jurisdiction; and prevention of restrictive zoning for community based facilities.

My first experience with dehospitalization home placement was a disaster, as was my second and last. After the second experience I was considered incorrigible, and they were unwilling to recommend me to any other placements.

The first boarding house was owned and managed by an elderly couple who were trying to supplement their retirement income by accepting referrals from the hospital. There were two of us in the house, myself and another man in his early twenties who was retarded and had been living in the house for almost a year. Our shared living accommodation was in the basement, where we slept and ate our meals. Money was provided by social services for room and board with a small allowance given to us for our own personal expenses. My room-mate had arranged his bed and living space in a hole in the basement wall over which he had hung a blanket. Inside the hollowed-out space was his bed, a small night table, and a portable radio; the floor was bare dirt, and the room was damp and musty. I slept in the larger common room of the basement on a couch. Most of the time he spent alone in his room listening to the radio or reading comic books. Meals were served three times a day and consisted of cold, lumpy porridge with powdered milk for breakfast, Kraft Dinner and Koolaid for lunch, and boiled white rice with the occasional hot dog for supper. On Sundays extra meat or leftovers would be served, but otherwise the menu never varied.

The washroom was in the main part of the house which was upstairs, and when the owners were out or the house was locked, it was unavailable. Bathing and washing up were restricted, and the rest of the house was off limits. Since the monthly personal allowance was small (about thirty dollars) most outside activities, including transportation or movies, were out of the question. I used the money to try and supplement my diet while my room-mate used his for comics and chocolate bars. When there was an argument between him and the owners, he would be locked out of the house and would spend the time wandering the neigh-

borhood, missing his meals until the owners returned or decided to let him in. I remained for three weeks before complaining to the worker at social services. A city inspector was sent to investigate, and found the basement part of the house unsuitable for human occupation and we were relocated. I was sent to a group home and was warned that this was to be my last chance.

It housed between twenty-five to thirty ex-psychiatric inmates with anywhere from four to eight in a room. All of the people had severe emotional and mental problems. The first day I was there, one of the residents told me that I had been sent to spy on him, that I was part of the conspiracy to kill him, and that he knew for a fact that they were putting poison in his food. Bearing in mind that this was to be my last chance, I decided to try and make a go of it. Though I was given a key to the house, there was a curfew, and everyone was to be in the house by ten o'clock. Any meals missed were forfeited, and my schedule had to conform to the routine of the house. I was not interested in upsetting the regimen of the house and was willing to miss an occasional meal for my personal freedom; if I was away and couldn't or didn't want to return by five for supper, then I was willing to go hungry. They didn't see it that way.

I had trouble accepting that a grown man should be in by ten o'clock. I missed the curfew every night I was there. They also seemed suspicious when I didn't have any medication to declare. The medication was kept in a locked cupboard and dispensed to the people in the house. After the third night they complained about me to the hospital, and I was out. The system was infallible and (according to them) I just didn't fit. In the three days I was there, I witnessed fights between other members of the house as well as swapping and dealings in street and prescription drugs. Both of these houses were sponsored and used by social services, a government agency. Both of them were, in my opinion, inadequate and unsuited for the services which they were intended to provide.

(Name withheld)

A Patient-Run Residence

By SALLY ZINMAN

"We demand the right to be involved in decision-making at all levels of the institution, including decisions about the making of hospital rules, the hiring and firing of staff, and the way in which money is used. We demand that mental patients make up 50% of any government body." One of the demands of the participants in the North American Conference on Human Rights and Psychiatric Oppression, May 30, 1976.

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We began to conceive of a client-run residence, a non-professional, user-controlled house. We formulated the goals. The client-run house would be an alternative to the living environment of the mental health system. It would recognize and support emotional pain WITHOUT the attached conditions of the mental health system: without the mandatory psychiatric labels and drugs; without the arbitrary and restrictive structuring of our lives, such as fixed bedtimes, required reporting (and permission for) whereabouts, forced business during the day; without the intolerance of variable and different behavior, the forced adherence to narrow "norms" of behavior. The house would provide as free an adult living environment as the neighbours next door. Self-determination and group self-management would replace externally imposed controls; autonomy would replace authoritativeness. The service would be completely voluntary, with the kind of help (or no help) being determined by the resident. Group structure would be collective, a non-hierarchical, horizontal relationship of equals. This allows each resident to exercise control over the service and thus not abdicate to another control over his/her life. Therapeutically, the relationship is the strengthening movement of two people reaching across, not reaching down and reaching up. In the latter, one of the partners, overtly or covertly, is better than the other, healthy as opposed to pathological, defective as opposed to non-defective. This relationship erodes the confidence, the empowerment, of the patient; and this erosion more than offsets any gains made in "therapy." Politically, no one person has power over another person.

No one person is in the position to coerce another. No person has the authority to make decisions for another or in any way control another's life. As regards the mechanisms of psychiatric control, no one person has the power to commit (the ultimate mechanism of control), diagnose and label, or write records about, another.

IMPLEMENTATION

We were ready to implement our ideas. We secured a promise from a local mental health center for the capital, a loan for first, last, and security at the time we rented the house. We had people waiting to live there. In the three years we had existed, especially in the year since we had opened an office, we had developed a strong constituency, many of whom expressed a desire to live in the client-run house. We had the money and the people. We could not find a house; no one would rent to us. Not only were we mental patients, but unsupervised mental patients, without staff. Instead of rewarding us for our desire for self-management, we were additionally feared and avoided. It took us months of constant looking to find someone who would rent to us, a real estate agent with investment property, not an individual home owner. The house was too small and old for comfort, even delapidated, but within our price range, based on what we estimated an individual resident could afford. The area was zoned commercial, our house one of the few remaining remnants of the area's bygone residential days. It was isolated; the only neighbours were to the rear of us, with a major highway on one side and a shop-

ping center and empty lot on the other two sides. It was in unincorporated county area, though convenient to a ten minute county bus ride downtown (which, however, leaves in 1-1/4 hour intervals). We bought two very cheap beds. The rest of the furniture was either donated or loaned, some from our new landlord. Household furnishings, such as bathware, bedware, kitchenware, were sent in a stream of care packages from a very giving ex-patient in Miami. The month was mid-September, 1981; we had begun our search the first of June.

At the end of September we all met at the Mental Patients' Rights Association offices—the first residents of the house and all other interested members of Mental Patients' Rights Association (some of whom later became house residents). We devised what we called *Procedures and Rules and Regulations* for the house. These forms were just working tools to orient ourselves in this house venture; they were not just open to change, but were created to be changed with changing needs and developing problems. We were not imposing programs on the future, for the future had to be free to create its own forms.

We projected the individual rent at \$100.00 including utilities, based on an occupancy rate of three permanent persons. Although the house holds four persons, each with his/her own room, our plan was to leave one space open for emergency or transient use. We even made provisions for a three-day gratis stay at the house. Although there was anxiety that we would not keep the house full enough to maintain the rent, this proved to be unwarranted. We have had a minimum of 3-1/2 persons

per month since the inception. With the exception of \$100.00 and the repayment of the original loan from MPRA's general funds, the house has been completely self-sufficient, including repairs. We formulated the criteria to become a resident: He/she be a past psychiatric inmate; he/she be a past/present out-mate (out-patient) on an involuntary basis; he/she be in a severe emotional state that would most likely end in placement in a mental health facility were it not for the client-run house. These criteria remain unchanged. We determined procedures for admittance. The prospective resident, by initially contacting Mental Patients' Rights Association, would meet the current residents of the house who would make the admittance decision. We also projected a very complicated eviction process, with several house meetings, an impartial mediator at one of them, and even a hearing before the general MPRA membership if desired. Both procedures of admittance and eviction have changed. Upon initial acceptance, there is now a two week trial period in the house so that such an important decision on either side, the newcomer and the current residents, can be made with maximum information. One resident can veto the newcomer, even before the two weeks are over, though he/she must be able to substantiate the reason to the other residents. In practice, the eviction process has been simplified to two formal meetings which are attended by an outside member of MPRA, an initial meeting in which the resident is warned by the other residents of his/her disturbing behaviour and the consequences and, if the behaviour is not changed, a final meeting in which the resident is given one week to leave. Without realizing it we repeated a standard mental health system practice; we planned for weekly house meetings. Because this was so arbitrary and so reminiscent of the mental health system, the meetings never occurred. After six months of no meetings at all, the need clarified for another change — mandatory house meetings when there was a need to be determined by the residents.

The house rules created at that end of September meeting have also changed with time and experience. They were few and basic. No violence towards others or toward property. No illegal drugs. Violations of these rules would mean suspension or possible eviction, depending on the will of the other residents and the severity of the infraction. We have responded

harshly to violence against others, one resident who attacked another being evicted on the spot. We have reacted less strongly to property damage, settling for monetary accountability for the damage instead of expulsion. For our legal protection we expanded no illegal drugs to no illegal property, due to the unforeseen behaviour of some of our residents. We have added no theft, requiring compensation of a kind to be agreed on by the parties involved or expulsion. One resident has left because of stealing.

Most of these changes in house administration were due to an overall house process of structuring, a reclaiming of order for ourselves. None of the residents was willing or able to deal with the issue of controls. All of us had learned a healthy disrespect for controls. In our lives, controls had always been arbitrary, heavy-handed, and coercive — always imposed on us by others. The idea of internal controls was too novel to grasp. We needed to take that giant and difficult step to self-authority which is absolutely necessary in a free environment with no external controls or enforcers. At this point we were not ready. But the strong communal feeling was able to defer the encroaching chaos.

Eventually all the first residents, the friends and MPRA members, had gone. Strangers came, strangers to each other and to MPRA. They had neither a communal feeling with each other nor MPRA and the house. In addition, there was always the problem of transitory people. These people were always less committed. The growing disorganization mushroomed into a major house crisis which was inevitable. One of our residents had been quietly, by herself, using illegal drugs. No one would confront the issue; they looked the other way. The group would not accept the responsibility of house management; they would not accept the burden of enforcement. Two new residents moved in, and soon the three of them were using very heavy drugs which required large sums of money. Rents began not to be paid. The house was becoming a drug pad, and the three were the majority. Without precedent, MPRA called a meeting of all MPRA members and house residents including the three. Equally without precedent, the three were summarily kicked out of the house.

Having experienced chaos, we were no longer frightened of order. We had learned that total anarchy meant ineffectualness and even oppressiveness.

"Doing your own thing" ended with no one being able to do his own thing, with no freedom for anyone. We needed some kind of social consensus or contract and a commitment to enforce it. We began to see authority could be self-authority, order, internal and organic.

This need for order and dislike of chaos led, fortunately for only a short time, to an outside coordinator. The house wanted someone else to enforce the organization they were bringing into being. This petered out even before the particular grouping of residents changed.

Aside from this brief foray into a benevolent dictatorship, the movement of the house has been toward an increasing degree of self-management. This has been expressed in informal agreements and social contracts among the residents. For example: a monthly distribution of house chores; commitment to keep the common rooms clean; cut-off and on hours of T.V., radio, and excessive noises; and a multitude of tentative agreements among residents about current house matters. This has also been the *raison d'être* for most of the formal *Procedure* changes such as the \$5.00 maintenance fee (which eliminates the fights over who got the toilet paper last), the discontinuation of the three day gratis stay (which, although equally due to economics, eliminated a large proportion of the transitory people), and the two week trial period with the right to veto a newcomer before the two weeks are over (which gives the current residents more control over the kind of behaviour tolerated in the house). Most important among the changes are the mandatory house meetings whenever any resident perceives the need. A self-governing house needs a time set aside for the decision-making process. Moreover, we have learned that communication is essential to a free society creating its own forms. Self-assertiveness, communicating what you want, is the only way a resident can have representation in the creating process. The resultant decision making, confronting controversial issues and finding a common ground of agreement, builds the needed communal feeling of belonging together and to the house.

EVALUATION

We have been most successful in providing an alternative to the mental health system, a free adult living environment which recognizes and supports emotional pain. For those who have wanted it, it has provided a

total alternative, keeping them out of the mental health system altogether. However, at least half of our residents have chosen not to break completely from the mental health system. They have chosen instead to utilize some aspect of the system's out-patient services — most often, case management and/or medication.

Due to a working relationship with our catchment area's mental health center, our residents can avoid in-patient stays. When they are remanded to the Center's care, emergency committed or otherwise, the Center will release them, if they choose, to our house and custody. When they choose to stay in the Center, we retain power over what happens to them, participating their rehabilitation plan and assisting their release when they choose to leave.

The goal of providing an alternative is constantly being compromised by the goal of self-determination. Choice is what the house is about; it is our highest priority.

We have been least successful in creating a non-hierarchical, egalitarian group structure. Instead of using our group to free ourselves from oppressive patterns, we have recreated them in our relationships. This is not surprising, as we have experienced an even more hierarchical, leader-oriented society than the average non-patient citizen — a staff/patient, sane/insane, competent/incompetent society. Moreover, our energies have been consumed with getting our lives and heads together, with little left over for political innovation. The coordinator, though not a resident, is now a guiding presence in the house. She is house

mother, case manager, rent collector, provider of transportation (when public transportation is not available), garbage collector, and repairperson. Each resident relates more to her for support than to each other. Clearly, in the recreated pattern she is staff; the residents are the patients. She is the "strong one;" they are the "weak ones." She is, however, an ex-patient and therefore a living model that a patient can be the "strong one." Perhaps this is the point on which the old hierarchical patterns of relating will break down.

In fact, distinctions are beginning to fuse, roles beginning to merge. Support is becoming more shared; house governing is separate from the coordinator. She is learning to do less and the residents to ask for less. The problem is constantly examined.

Summary and Recommendations

Level II: Daily supervision	
Modified Co-operative.	10 beds
Supervised Apartments.	50 beds
Level III: Weekly Supervision	
Co-operative Residence)	35 beds
Satellite Apartments)
Level IV: On-call Supervision	
Independent Apartments	50 beds
TOTAL:.....	270 beds

RECOMMENDATION II — That a mandated agency be established which would be:

- a) Responsible for the following functions:
 - a provision of enrichment services to boarding homes and hostels
 - liaison with boarding homes and hostels
 - provision of necessary support services to former consumers of mental health services who gain admittance to public housing
 - operation of a centralized intake service for community residential placements
- b) Managed by a body which includes consumers, community groups and those directly responsible for the delivery of mental health services.

RECOMMENDATION III — That a 24-hour crisis team be established immediately to respond to the mental health crisis needs of residents of boarding and lodging homes and hostels; that a community-based crisis

facility (minimum of 5 beds) be established in 1982 for those who cannot be placed in a residential setting.

RECOMMENDATION IV — That one body at the municipal level be responsible for licensing and inspection of physical standards in boarding homes in each borough and city; that quality of care standards be developed by Metropolitan Toronto, local Boards of Health and members of the Supportive Housing Coalition.

RECOMMENDATION V — That the Government fund the short-term proposal of the Supportive Housing Coalition for 60 transitional beds, a community-based room finding service and administrative support.

RECOMMENDATION VI — That the Government of Ontario establish a permanent committee on supportive housing for consumers of mental health services; that this committee be composed of senior representatives from the Ministries of Health, Housing and Community and Social Services and that it report to the Secretariat of Social Development; that the committee have as its mandate the resolution of intergovernmental and inter-ministerial differences in policies and funding practices.

RECOMMENDATION VII — That the Municipality of Metropolitan Toronto form a permanent committee of senior advisors from the regional and local governments to develop an integrated system of services delivery; and that local representatives of the Inter-ministerial Committee be included in such a committee.

The Supportive Housing Coalition has released its blueprint entitled "Community Housing for Consumers of Mental Health Services in Metropolitan Toronto". The following is a brief summary of the blueprint, which can be obtained from PARC at 1499B Queen St. W. in Toronto.

Part One of the blueprint describes and analyzes the housing problems for consumers of mental health services in Metropolitan Toronto. Two hundred and two (202) beds have been lost within one year from a system which has never had an adequate number of supportive housing beds. The system is characterized by its custodial nature, lack of an accessible range of alternatives and problems in administration.

RECOMMENDATION I — That immediate steps be taken to fund proposals submitted for 270 beds in community housing. These beds will provide the alternatives necessary to meet the varying needs of consumers.

Transitional (Transitional houses have a maximum allowable length of stay.)

- Level I:
24-hour supervision... 25 beds
- Level II:
Daily supervision..... 30 beds

Long-Term (Long-term houses allow for an unlimited length of stay.)

- Level I:
24-hour supervision
High Support Facility.. 30 beds
High Support Co-operative
Co-operative..... 40 beds

**THE HOUSING GAP:
DEFICIENCIES IN APPROPRIATE HOUSING
FOR
EX-PSYCHIATRIC PATIENTS**

**JOINT STUDY FOR THE
CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH
AND
THE SUPPORTIVE HOUSING COALITION
MAY, 1982
SYNOPSIS OF FINDINGS**

1. DOES THE LACK OF SUPPORTIVE ACCOMMODATION DELAY THE DISCHARGE OF PSYCHIATRIC PATIENTS FROM PSYCHIATRIC FACILITIES?

Yes. There is a consensus of opinion among hospital staff involved in discharge planning that problems in securing supportive accommodation in the community result in delays in patient discharge. At the Clarke Institute of Psychiatry, 31% of the discharges during the survey period had been delayed due to placement problems, and at Queen Street Mental Health Centre, 26% of the discharges had been delayed because of difficulties in finding appropriate housing in the community.

2. WHAT PERCENTAGE OF PSYCHIATRIC PATIENTS BEING DISCHARGED REQUIRE A HOUSING PLACEMENT WITH SOME LEVEL OF SUPPORT?

More than half, 53%, of the patients discharged from the Queen Street Mental Health Centre during the survey time period were assessed as requiring 24-hour supervision.

At the Clarke Institute of Psychiatry, 62% of the patients considered for discharge during our survey were judged to be in need of support or supervision on a 24-hour or daily basis.

3. WHAT IS THE CURRENT EXPERIENCE OF SPECIALIZED SERVICES SET UP TO FIND HOUSING FOR EX-PSYCHIATRIC PATIENTS?

In the first three months of its operation, the Assessment and Referral Unit at Queen Street Mental Health Centre completed the processing of 62 cases. Of these 62 cases, 50% were assessed as requiring a housing placement with 24-hour supervision or support. Eleven patients with this requirement either remained in Queen Street Mental Health Centre because no housing placement could be found, or were placed unsuccessfully and returned to the Centre.

In the first 2 months of operation at the WoodGreen Community Centre, 25% of the 123 requests for help to the house-finder service came from ex-psychiatric patients. One worker's caseload included 9 ex-psychiatric patients who had been looking for housing for several weeks, one of whom had been looking for over a month.

4. IN WHAT SORT OF HOUSING ARE EX-PSYCHIATRIC PATIENTS CURRENTLY RESIDING?

Information from Queen Street Mental Health Centre showed that although 18% of the discharged patients were going to live with family, 11% were going to live on their own in a rented room, 7% were going to live in a boarding house, and 7% did not know where they would go. No housing information was available for 32% of the ex-patients.

At the Clarke Institute, 28% of the discharged patients

planned to live with family, but 24% intended to stay on their own in a rented room.

Data from general welfare assistance staff indicated that 42% of their "psychiatric" clients were living alone in a rented room, while 29% were in a boarding house situation.

5. HOW MANY EX-PSYCHIATRIC PATIENTS ARE CURRENTLY HOMELESS OR WITHOUT ADEQUATE HOUSING?

The survey of all the hostels in Metro Toronto found 249 people (17% of total adults) with a known or probable psychiatric history staying in the hostels on Tuesday, April 6th, 1982. In addition, a subgroup of the psychiatric population that is denied admission to the hostels was identified. Sixty-eight percent of the 366 names on the "barred lists" and 67% of the 256 names on the "caution alerts" appear on these lists for psychiatric reasons.

The five community programs reported that from 28% to 60% of their clients were experiencing problems finding suitable accommodation.

6. DOES THE LEVEL OF INCOME AVAILABLE TO EX-PSYCHIATRIC PATIENTS AFFECT THEIR ABILITY TO FIND SUITABLE HOUSING?

Yes. Well over half the patients discharged at the two psychiatric facilities surveyed during the research relied on welfare as their source of income. For this group, the ability to find suitable housing is severely restricted. The cheapest rented room costs more than half the monthly allowance, and the least expensive boarding house consumes almost the full amount.

7. HOW HEAVY IS THE DEMAND FOR THE AVAILABLE SUPPORTIVE HOUSING?

There is increased demand for the 133 beds offered by the alternative community housing operations. Referrals and inquiries are generally up, and those operations which keep waiting lists currently report 59 people awaiting accommodation. Residents are staying in these programs longer, and the time spent on waiting lists is increasing.

8. DO HOUSING PROBLEMS CONTRIBUTE TO RE-ADMISSION TO A PSYCHIATRIC FACILITY?

It was difficult to arrive at a definitive measure of the influence of the housing problem on actual admission, however, there was consensus among hospital staff interviewed that housing problems did play a part in causing ex-psychiatric patients to seek readmission. As well, the operators of the community programs repeatedly stressed the relationship between difficulties in finding adequate housing and readmission to hospital.

Some Facts About Group Homes and Boarding & Lodging Homes

+ p. 32

The following information has been prepared by the Supportive Housing Coalition, a metro-wide broad based coalition of mental health care professionals and agencies, interested community people and consumers of mental health services. The information comes out of the work and research of the Coalition, as well as the work and research of the experts in the field of mental health care.

1. A 1982 study undertaken jointly by the City of Toronto, Department of Public Health and the Supportive Housing Coalition found that the total discharges from Queen Street Mental Health Centre and the Clarke Institute from April 1, 1980 to March 31, 1981 were 3,761 and 1,241 respectively. These figures do not represent the total number of people discharged but rather strictly discharges. Therefore, many discharges represent people being discharged more than once.

2. Both institutions reported that over half of the people who were ready to be discharged from hospital required a housing placement with some level of support and further that the inability to find appropriate housing in the community has often resulted in delaying discharge from hospital.

3. The cost per person per day of being in hospital is \$150.00 - \$175.00 depending on the hospital. A high support group home costs in the range of \$45.00 - \$65.00 per person per day. Intermediate care facilities cost in the range of \$26.00 - \$40.00 per person per day. Low support care facilities cost in the range of \$14.00 - \$25.00 per person per day.

4. In the 1982 joint study, evidence was given that the extremely inadequate environment that ex-patients are often forced to live in can lead to a deterioration in mental health and often leads ex-patients to *seek* readmission to hospital.

5. The vast majority of people who enter psychiatric hospitals do so volun-

tarily, in order to *seek* treatment. Seeking psychiatric treatment in a hospital bears little difference to the person who can afford to see a psychiatrist privately in conjunction with home care. The difference is that the hospitalized person is usually unable to afford private treatment. The person receiving private treatment can be suffering from the same illness as the person in hospital.

6. Group homes are subject to greater control, evaluation and regulation than are boarding and lodging homes. Boarding and lodging homes are only subject to municipal housing standards bylaws. These bylaws deal with only the basic standard in fire, safety, health and some physical standards such as parking spaces, etc. In addition to the housing standards bylaws, group homes must satisfy any existing municipal group home bylaws. Since 1978 the total number of group homes that has been opened is 15, which are spread throughout the city. Everyone is well aware of the fact that there is the possibility and have in fact been "renegade" group homes. However, when this does happen, the fact that there is a well-defined group home bylaw in the City of Toronto, plus the controls put in place by the provincial government, insures that there are avenues of pressure that can close down those facilities. This is not the case with ill-run boarding and lodging homes, and rooming houses where the bylaws are either not enforceable or not sufficient at this point in time to apply the same pressure to have them closed.

7. The programming provided in group homes is designed to meet the special needs of the residents so that they can be reintegrated into society. These programs are administered and staffed by people specifically trained and experienced in the mental health field. Boarding and lodging homes are not under any obligation to provide programming for residents or to hire staff experienced in helping people with special needs. In fact, there is one

classification of boarding home that does not even require there be anyone in charge residing in the home.

8. Group homes do not decrease property values. Property values are material values directly related to current market conditions and physical make up and conditions of a property. The only time that the people who live in a neighborhood affect property values is when they fail to maintain their property in good condition. Since their inception, group homes have been under scrutiny of neighbors and the government. Their continued functioning depends on their being good neighbors. For this reason they are obligated to maintain the highest possible physical standards of their property. If there are any other problems or concerns that neighbors have, group homes have a Board of Directors whose function is to govern the operation of the group home, and who are accessible to the community. They have a vested interest in resolving any concern. There has been a long history of situations where neighbors who have raised concerns with a group home Board of Directors and upon learning the function and operation of the home have become members of the Board themselves.

9. Group homes are not the problem in Parkdale and Ward II. The problem is the great number of licensed and unlicensed boarding & lodging homes and rooming houses. Were there the same kinds of provisions and controls in legislation that regulated boarding & lodging homes and rooming houses as there are for group homes, then our problems of over concentrations of people with special needs in one area plus the poor quality of those forms of housing would be alleviated.

10. The Group Home bylaw as it exists in the City of Toronto (if & until there are any changes made to it) is the only one of its kind in that it does not make distinctions of "type/kind and Distribution". For example, it does not say that only group homes for the mentally retarded or adolescents are allowed, or that there could only be a certain number of each kind congregated in one area. There is a distance requirement that states that any group home must be at least 800 feet (that is a radius of 800 feet) from any other group home. Finally, the bylaw states that when there will be 6-10 residents in the group home that it is allowed "as-of-right" in any residential area. This is an important human right because the group home can situate in the neighborhood like any other resident, and does not have to announce or okay their moving in with the neighbors.

Housing Alternatives

HOUSELINK

By CONNIE NEIL

Housing in Toronto is a major problem for ex-psychiatric inmates. But there is one ray of hope and stability presented by the non-profit organization known as Houselink Community Homes.

Twelve small households of three to six persons with psychiatric histories are scattered throughout Metro Toronto (two in Scarborough, one in North York, nine in the City of Toronto) housing 54 persons in mixed cooperatives.

Cooperative living is not for everyone, and at the initial interview after referral, Research and Referral Officer Jo Ferris-Davies looks for a commitment to this living style. Applicants are seldom turned down, but may decide it is not for them at this interview. "Of approximately six interviews a week, only one would not follow through," Jo Ferris-Davies estimated.

"The rents vary from \$115 to \$155 monthly," she said, "and if a person has no *basic* commitment to wanting to live with other people, to support others, but is just looking for cheap rent, that person would not go on the waiting list."

Presently the waiting list is about a month for women and four to six months for men. When an opening is available, several applicants are sent to that cooperative to view it and talk to the people who currently live there. They choose the person they feel best fits their household.

The emphasis is on living independently. Everyone has a private bedroom, and there are a few sensible house rules and bi-weekly house meetings with a volunteer facilitator from Houselink to identify and solve any problems. One measure of their success in achieving independence is shown by the two co-ops that have reached an agreement with Houselink in the last 18 months to become completely autonomous.

Linda, who is also a member of On Our Own, has lived at Houselink for the past two years. Originally her co-op was on Bathurst Street, but when that owner was renovating, the co-op nucleus moved to a Houselink-owned home on Bartlett Street.

"I went from hospital to Regeneration House, which is supervised by live-in staff. It was while I was there that I heard about Houselink, and it seemed the next logical step from supervised living to living in a co-op. Originally I thought of this as a step to living on my own. But I'm realizing that co-op living is in itself an end. For now I'm quite happy with the situation I'm in. There's much more onus on the people within the co-op to give support to each other and take responsibility for their actions," said Linda.

"Certainly there are day-to-day problems, but only once was there a big problem. One guy was beating up on another. And finally after a particularly big fight, Houselink stepped in and asked him to leave," she explained.

Of the 54 living in Houselink Community Homes, about one-third are working and the other two-thirds either receive welfare or attend school. Peer pressure and mutual support helps them become more involved with their community. When they hear someone in their own home talking about a new job, they feel maybe they can do it too.

The new office location at 509 Bloor Street West, above the Renaissance Cafe, is also their drop-in centre which is open 9 to 5 weekdays and from 4 p.m. onwards on weekends. Here members hold monthly meetings, drop in for conversation, chess, bridge or to meet new people.

All members are encouraged to participate in the various activities—the hiring committees, social and recreation committee, public education, planning, research and fund raising committees—and they form at least one-third of the fourteen member Board of Directors.

Source: Community Resources Consultants of Toronto. "Profile Of Mental Health Housing Resources — 1982."

NOTE: The following types of housing for former psychiatric inmates are all community-based; their chief characteristics include a supportive/rehabilitative environment and life skills counselling which stress independent living.

METRO TORONTO

1. CHAI-TIKVAH

Address: Bathurst/Finch area.

Contact: Laurence Siegel.

Phone: (416) 665-0812.

Type facility: Co-op, daily supervision, no live-in staff.

Capacity: 3.

Length stay: No maximum.

Sex residents: Males only.

Age: ?

Staff: 1 executive director, 1 home supervisor, 1 night staff.

Program: No details available, access to drop-in, not restricted to Jewish community.

Cost: \$250/mo. — incl. rent for single room & food (kosher).

2. COMMUNITY INN CO-OPERATIVE

Address: St. Clair & Caledonia.

Contact: Helen Schumacher.

Phone: (416) 789-2969.

Type facility: Co-op, weekly supervision, staff on call for support.

Capacity: 9.

Length stay: Indefinite.

Sex residents: M & F.

Age: 18+.

Staff: 1 co-ordinator.

Program: Individual or group therapy/counselling, life skills, educational-recreational, shared household tasks, house meetings.

Cost: Rent - \$153/mo., food - \$80.

3. HERMAN HOUSE

Address: 77 Madison Avenue.
 Contact: Beatrika Rach.
 Phone: (416) 535-8501, ext. 147.
 Type facility: Co-op. daily supervision,
 no live-in staff.
 Capacity: 10.
 Length stay: 6-18 mos.
 Sex residents: Females only.
 Age: 30+.
 Staff: 4 co-ordinators, 1 social
 worker.

Program: Individual or group coun-
 selling, life skills training, shared
 household tasks, house meetings.
 Cost: Single room (rent & food) -
 \$250/mo.; shared room - \$220.

4. HOUSELINK COMMUNITY HOMES, INC.

Address: 509 Bloor St. W. (Bloor/
 Spadina)

Contact: Jo Ferris-Davies.
 Phone: (416) 968-0242.
 Type facility: Co-op, weekly super-
 vision, on-call staff.
 Capacity: 50.
 Length stay: Indefinite.
 Sex residents: M & F.
 Age: 18+.

Staff: 1 Exec. Dir., 1 Soc-Rec Co-
 ord., 1 Vol. Co-ord, 1 Referral &
 Resch. Co-ord, 1 Sec.

Program: Weekly house meetings,
 shared household tasks.
 Cost: Rent - \$125-150/mo.

5. MADISON AVENUE RESIDENCE

Address: 80 Madison Ave. (Bloor/
 Spadina).
 Contact: Dianne Denning.
 Phone: (416) 535-8501, ext. 552/562.
 Type facility: Co-op, daily staff super-
 vision, no live-in staff.

Capacity: 12.
 Length stay: Indefinite.
 Sex residents: M & F.

Age: 18+.
 Staff: 2 house advisors, 1 part-time
 co-ordinator.

Program: Weekly house meetings,
 shared household tasks, communal
 evening meals.

Cost: Rent - \$130/mo.; Food - \$14/wk.

6. PALMERSTON HOUSE

87 Spadina Road (Bloor/Spadina)

Contact: Krys Wlodarczyk.
 Phone: (416) 923-4580.
 Type facility: Co-op apt. - daily super-
 vision, no live-in staff.
 Capacity: 5.

Length stay: Varied according to
 needs; reviewed every 6 mos.

Sex residents: M & F.
 Age: 18+.

Staff: 1 co-ordinator.

Program: Individual or group therapy/
 counselling, life skills training,
 educational-recreational programs,
 shared household tasks, house
 meetings.

Cost: Rent & food: \$200/mo.

7. REGENERATION HOUSE

Address: 236 Annette Street (High Park
 area).

Contact: Jacqueline Schwan.
 Phone: (416) 766-1988.
 Type facility: Daily staff super-
 vision, no live-in staff.
 Capacity: 13.

Length stay: Max. 2 yrs.

Sex residents: M & F.

Age: 18+.

Staff: 1 director, 2 houseworkers.

Program: Individual or group coun-
 selling, life skills, training, social-rec
 activities, weekly house meetings,
 shared household tasks, weekend
 communal meals.

Cost: Sliding scale based on resi-
 dent's income.

8. SCARBOROUGH HOUSING PROJECT

Address: Scarborough area.

Contact: Joyce Killin.
 Phone: (416) 789-7957 or 968-0242.
 Type facility: Co-op, weekly super-
 vision, staff on call.
 Capacity: 7.

Length stay: Indefinite.

Sex residents: M & F.

Age: 18+.

Staff: 1 co-ordinator, shared with
 another modified co-op.

Program: Weekly house meetings,
 shared household tasks, planned re-
 creational programs, drop-in centre at
 Houselink (509 Bloor St. W., 2nd fl.)

Cost: Rent - \$125-\$150/mo.

9. THE SALVATION ARMY DUFFERIN RESIDENCE

Address: 248 Dufferin Street (Dufferin/
 King).

Contact: Lorna Grey.
 Phone: (416) 531-3523.
 Type facility: 24 hr. staff super-
 vision & live-in staff; also daily
 supervision, no live-in staff.
 Capacity: 23.

Length stay: Max. 1 yr.

Sex residents: M & F.

Age: 18+.

Staff: Program director, 2 coun-
 sellors, 1 resident counsellor, 1 con-
 sulting psychiatrist, 8 support staff.
 Program: Individual or group coun-
 selling, educational-rec programs,
 life skills training.

Cost: varied according to resident's
 income. *Note:* Residents not eligible
 for welfare, other financial assis-
 tance must be arranged.

10. TORONTO EAST GENERAL HALFWAY HOUSE

Address: Queen & Greenwood.

Contact: Lionel Belman.
 Phone: (416) 461-8272, etc. 1211.
 Type facility: Daily staff supervision,
 no live-in staff.
 Capacity: 8.

Length stay: No information available.

Sex residents: M & F.

Age: 18+.

Staff: 2 mental health workers.

Program: Weekly house meetings,
 shared household tasks, monthly
 goal setting & revision, individual
 & group meetings, activity evening in-
 community, discharge planning.

Cost: Rent & food - about \$190/mo.

11. ALTERNATIVE HOUSING PROGRAM — PEEL

Address: Cooksville (Junction of Hwy
 5 & Hwy 10).

Contact: Sharron McGill.

Phone: (416) 270-4573.

Type facility: Co-op, weekly staff
 supervision, no live-in staff.

Capacity: 10.

Length stay: 8-12.

Sex residents: M & F.

Age: 18+.

Staff: 1 co-ordinator, 1 life skills
 training worker.

Program: Life skills training, social
 -rec programs, shared household
 tasks, house meetings.

Cost: Rent - \$120/mo.; food - \$20/wk.

12. CO-OPERATIVE HOUSING PROGRAM — MENTAL HEALTH DURHAM

Address: City of Oshawa.

Contact: Peggy Ridgway.

Phone: (416) 728-9931.

Type facility: Co-op, weekly staff
 supervision, no live-in staff.

Capacity: 13.

Length stay: Short-term for 2 yrs. - 5
 beds. Long-term for indefinite stay
 - 8 beds.

Sex residents: M & F.

Age: 18+.

Staff: 1 co-ordinator.

Program: Life skills training, weekly
 house meetings, shared household
 tasks.

Cost: Rent for shared room - \$106/mo.

-rent for single room - \$125/mo.; food
 - about \$15/wk.

13. GRACE HOUSE

Address: 12 Old Mill Road, Oakville,
 Ont.

Contact: Barbara Rockwell.

Phone: (416) 844-4772.

Type facility: 24 hr. staff super-
 vision, live-in staff, high staff/
 resident ratio.

Capacity: 10.

Length stay: Max. 2 yrs.

Sex residents: M & F.

Age: 18+.

Staff: 1 director, 1 co-ordinator,
 4 residential counsellors.

Program: Individual or group counsel-
 ling, shared household tasks, house
 meetings, recreational programs.

Cost: Rent - \$160/mo. *Note:* Residents
 not eligible for welfare, other financial
 assistance must be arranged.

Emergency Accommodation for Men**City Shelter**

349 George Street 960-9240
Owned and operated by the City of Toronto. Check-in time 4:00 p.m. Out by 10:00 a.m. the following day. *Must be able to pay \$3.00 per night.* No maximum length of stay. Capacity 37, soon to be substantially increased.

Fred Victor Mission

147 Queen St. East 364-8228
Names taken at 4:00 p.m. for 6:00 p.m. check-in. Out by 8:00 a.m. the following day. (9:00 a.m. on Sunday). \$2.00 if able to pay. No maximum length of stay. Capacity 120.

Good Shepherd Refuge

411 Queen Street East 869-3619
Check-in time by 7:00 p.m. out by 6:00 a.m. following day. Hostel service available only Monday through Friday. Free. Capacity 30.

Overnight Drop-In Centre

All Saints Church Community Centre
315 Dundas Street East 368-8179
Overnight sleep accommodation on mats for men (as well as women in separate quarters). Check-in 10:30 p.m. and out by 7:00 a.m. the following day. Available 7 days per week Oct. 31 to April 30. Free. No maximum length of stay. Total capacity 126.

Overnight Drop-In Centre

430 Broadview Avenue
Funded by Cityhome (Toronto) managed by Dixon Hall. Overnight sleep accommodation on mats for men. Check-in 10:00 p.m. and out by 7:00 a.m. following day. Available 7 days a week to April 17, 1982. Free. Capacity 60.

Salvation Army Men's Residence

135 Sherbourne Street 366-2733
For men age 18 and over. Check-in between 9:30 a.m. and 3:30 p.m. Out by 7:00 a.m. the following day. \$2.50 per night if you can pay. Capacity 410.

Single Men's Residence

319-335 George Street
Metro Toronto Dept. of Community Services. Operates Seaton House and the Single Men's Hostel Unit. Must go through Intake Unit at 319 George St., 964-7323, 7:00 a.m. to 4:00 p.m. Telephone referral is advised. After hours call 367-8600. Total capacity 480.

Toronto Community Hostel

191 Spadina Road 925-4431
9:00 a.m. to 4:00 p.m. Limited accommodation for single men. Available only by referral from primary worker. Check-in time 5:30 to midnight. Maximum stay up to 5 days. Free. Capacity 17.

Y.M.C.A. Stop-Over

Apply to 40 College St. 921-5179 Ext. 29
For males age 16 to 29. Maximum stay is 7 days in every 2 month period. 50¢ per night includes 2 meals and support services. Capacity 70.

Emergency

Emergency/Crisis Accommodation for Women**Anduhyaun**

106 Spadina Road 920-1492
Women (with children), special service to native women. 6 week maximum stay. Shared household chores, life skills, recreational programs. Midnight curfew. Meals. Free, but \$40 per week to those who have income. Capacity 14.

Interval House

596 Huron St. 924-1491
Women (with children), priority to battered women. 24 hour admission. 6 week maximum stay. Individual counselling. Meals. Free. Capacity 22.

Nellies Hostel

275A Broadview Ave. 461-1084
Women (with children) age 16 and over. 24 hour admission Monday to Friday. Weekday check-in after 4:00 p.m. if possible. Midnight curfew. Must be out of house 10:00 a.m. to 4:00 p.m., Monday to Friday. 2 week maximum stay. Meals. Shared household chores. \$1/day if you can pay. Capacity 29.

Over-Night Drop-In

All Saints Church Community Centre
315 Dundas St. East 368-8179
Overnight sleep accommodation on mats for women (as well as men in separate quarters). Check-in 10:30 p.m. and out by 7:00 a.m. following day. Available 7 days per week, Oct. 31 to April 30. Free. Capacity 126.

Salvation Army Evangeline Residence

2809 Dundas Street West 762-9626
Emergency shelter for women age 16-60. 24 hour admission. 11:30 p.m. curfew (weekday), 12:30 p.m. curfew (weekend). Shared household chores. Meals. Free, but \$8/day for those who have income. 2 week maximum stay. Capacity 40.

Stop 86 (Y.W.C.A.)

85 Madison Avenue 922-3271
For women age 16-25. 24 hour admission, phone first. Must be out of the house every day from 9:00 a.m. to 4:00 p.m. 12:00 a.m. curfew (Sunday - Thursday), 1:30 a.m. curfew (Friday - Saturday). 6 week maximum stay. 2 meals/day, shared household chores. \$1/day. Capacity 25.

Streethaven

87 Pembroke Street 967-6060
Women age 16 and over. 24 hour admission. Check-in after 3:00 p.m. Must be out of the house every day from 10:00 a.m. to 3:00 p.m. Meals. Open dinner. 2 week maximum stay. Free. Capacity 10.

Toronto Community Hostel

191 Spadina Road 925-4431
Primarily serves women (with children) age 16 and over. Check-in time 5:30 to 6:00 p.m. Phoning first is advised. Hostel is closed between 9:00 a.m. to 5:30 p.m. Curfew. Maximum stay 5 days. Meals. Free. Capacity 17.

Women's Habitat of Etobicoke

149 Stanley Avenue 252-5829
Serves Western Metro Toronto. First priority to battered women with children. 24 hour admission, 7 days a week. Phone first. Length of stay 4-6 weeks. Shared household chores, meals. Range of support services, i.e. counselling, information, referral. Sliding scale fee to those with financial resources. Capacity 22.

Women In Transition

143 Spadina Road 967-5227
Women with children. 24 hour admission. Phone first. 12:00 a.m. curfew (weekday), 1:00 a.m. curfew (weekend). Meals. Shared household chores. Counselling. 6 week maximum stay (extension possible). Free. Capacity 18.

Emergency Accommodation for Families**Family Residence, Metro Toronto**

Dept. of Community Services
674 Dundas Street W. 363-5227
First priority is to women with children and single women. Couples and men as part of family are accommodated if space allows. 24 hour admission, 7 days a week. Phone first for intake inquiry. Maximum stay varies from 1 to 2-6 weeks depending on circumstances. No fee. Capacity approximately 100.

Toronto Community Hostel

191 Spadina Road 925-4431
Serves couples and women with children. Check-in time 5:30 - 6:00 p.m. Phoning ahead is advised. Hostel is closed between 9:30 a.m. to 5:30 p.m. Curfew. Maximum stay is 5 days. Meals. Free. Capacity 17.

Other Emergency Accommodation**Transition House**

162 Madison Avenue 925-4531
Serves men and women age 16 and over

Accommodation

who may require short-term supportive housing as an interim step. Shared accommodation and household chores. Length of stay up to 2 months. Must be out of house from 9:00 a.m. to 4:00 p.m. Professional referral required and worker involvement mandatory during resident's stay. Priority given to participating agencies. No fee at present, may change April 1, 1982. Capacity 17.

Room Registry Services

It has become increasingly difficult for agencies to maintain an adequate level of service as the number of requests has far exceeded the limited number of listings that are available. Recently Parkdale Information Centre closed its registry service and others are looking closely at their ability to remain viable.

Bloor-Bathurst Information Centre

835 Bloor St. W. (at Shaw) 531-4613
Mon. - Thurs. - 10:00 a.m. to 7:30 p.m.
Friday - 10:00 a.m. to 5:00 p.m.
(Closed between 12:00 - 1:00 p.m.)
List rooms, flats and apartments located primarily between Dupont and College, Avenue Road and Ossington.
Note: Very limited listings at present.

Jewish Information Service

491 Lawrence Ave. W. Ste. 503 789-7279
Mon. - Thurs. - 9:30 a.m. to 4:30 p.m.
Friday - 9:30 a.m. to 4:00 p.m.
Provides a housing registry for the Jewish community. List rooms, basement apartments and shared accommodation located primarily between Eglinton and Steeles at Bathurst Street. Some are located downtown or in Willowdale.

Nellie's - Woodgreen

Woodgreen Community Centre
835 Queen St. E.
Contact: Shirley, Norma or Pat
461-1168 - Ext. 146
Hours: 10:00 a.m. - 4:00 p.m., Mon.-Fri.
Help find housing for ex-psychiatric inmates anywhere in City of Toronto.

Open Door Room Registry

All Saints Church
315 Dundas St. E. 366-4319 or 366-2664
Mon. - Fri. - 9:00 a.m. to 3:30 p.m.
List rooms, flats and apartments in the area between St. Clair, Lakefront, High Park and Victoria Park. Call first for application interview. Very limited listings at present.

Ryerson Rooms Registry

Jorgenson Hall - 50 Gould St. 595-5296
Lists rooms, flats and apartments for the use of Ryerson students but is open to the public during the summer months, June to August. Prices range from moderate to high but occasional listings are inexpensive.

University of Toronto Housing Service

49 George Street 978-2542
Mon. - Fri. - 7:30 a.m. - 5:00 p.m.
Walk-in service. Main listings are in High Park, the Annex and the Beaches. Service is for U. of T. students only during July to September but open to the general public October to June.

Y.M.C.A. Action Service Contact Centre

185 - 5th Street, Etobicoke 255-5322
Mon. - Fri. - 9:00 a.m. - 5:00 p.m.
Walk-in service. Provide information regarding apartment buildings in southern Etobicoke.



Eldon Garnet



profiles

Outside The Butterfly Ward

By ROBBYN GRANT

Margaret Gibson is a writer living in Toronto with her son, Aaron, who is nine years old. She is the author of two books of short stories, Consider Her Condition, and The Butterfly Ward. She was the scriptwriter for the film, Outrageous, which was based on her short story, Making It.

Another story — Ada — was adapted for television by Quebec filmmaker Claude Jutra. Margaret Gibson is the winner of the first City of Toronto Book Award.

I had four crack-ups in two years. That's been within the last three years. In the hospital I didn't know how to spell anymore. My doctor got them to bring me a typewriter and I would write every day. I couldn't spell a simple word like 'row.' I was spelling 'roar.' The first year was spent just working that back up. That was really scary because I thought: 'I can't write anymore. That's it. This is the crack-up to end them all. I won't write anymore. I can't.' Finally in the past six months it has all been coming back to me — the white heat of writing and all that.

I think it was the hard times that brought on my illness. The place I lived in just before I went to the hospital had rats and roaches. And I got ripped off from *Outrageous*. I don't even like to talk about it too much because I get really angry, and then I get depressed and upset because we (Aaron and I) went through hell financially. One month I just took to bed, and I couldn't get out. It was oncoming for years. You know, you see something by your shoulder, but you don't know how to hit it away. I was at least seven months in bed not eating and not sleeping. I'd be pacing all night, and then I'd get into bed and not sleep. Aaron did the cooking. The place was awful. It was a basement flat. One night a rat ran across Aaron's foot. Roaches. Everything. The despair was tremendous. And I thought: 'How can I work here? I can't work anymore. I can't think anymore.' One day when a friend phoned me I became unconscious and Aaron took the phone out of my hand and hung it up. You see,

Aaron really has had to grow up fast. That's why we're staying here. This is a nice flat. It has sun, air, light, and I feel alive again.

The drugs weren't doing anything but anesthetizing me. I used to talk like a drunk person. I started on drugs when I was fifteen. I had to be brought down from everything else I was on, which included Nozinin, Placidil, Cogentin, Valium and one other which I can't remember. Then I started taking Dalmane, a sleeping pill at night, six Haldol during the night and four during the day.

Nozinin is a powerful pill. It rendered me a chemical lobotomy one year when I was living in a slum, with my son, after I had left my ex-husband. Aaron was about two or three. It was the first place we had moved to. We couldn't afford much else. I stopped all medication for a year, and I went crazy. I had awful hallucinations in which Aaron would be involved, too. During one hallucination we were literally running outside along the streets, and I was screaming. I was in my nylon stockings and a skirt and blouse with no sleeves. I'd remembered to put Aaron's boots on. This was in the winter with snow and ice.

"Maybe when I'm sixty I'll be able to write happy endings, but right now I have to write what's there."

I heard the planes strafing. It was World War II. I have a lot of hallucinations that deal with World War

II. I know how I got that. My father gave me his war. We were in occupied France. We were going to be killed, and I kept looking for the underground. I kept going up driveways to people's houses and then turning back, thinking: 'No, no, they're the enemy, really.' Finally there was this one house that seemed safe, so I knocked on the door. The woman who answered must have been very good and very kind. I must

"I think it was the hard times that brought on my illness. The place I lived in before I went into the hospital had rats and roaches. And I got ripped off from Outrageous."

have looked half dead with this little boy beside me just wearing boots in the dead of winter, and she let us in. I don't remember what happened after that. It's all a blank. In that sense the reality is only the hallucination. The reality is the dream.

I was off all drugs for a year, and I got back on Nozinin and took one tablet. They are 25 mg. apiece. I was at my parent's house for dinner with my son. I took one tablet and my mother called me into the kitchen for dinner. I started to drink some tea and then waves and waves of darkness came and I fell right off the chair. My parents were convinced I'd taken a suicidal dose of pills, and they dragged me all around the house. They got a doctor to come, and he counted all my pills and said: 'No, she's only taken one.' That was the second time that had happened in my life with Nozinin.

I'm still taking medication but a lot less than I used to take. It's the smallest amount I've taken since I began taking medication at fifteen. What I'm taking now is four Haldol at night, three during the day and my anti-seizure capsules. I have to take that. I'm an

epileptic. There's no way I would give that up because Aaron has seen those seizures, and it's not fair to him. He's nine and very independent and mature, but he had to grow up too damn fast. I want to allow him what remains of his childhood now that I'm feeling better.

When I went into Toronto General, I said I wouldn't come unless I could bring my son. So they let me have a crib. Aaron was four. They were cold, very cold. I wasn't pleased with that. I didn't stay very long. I don't like behavior psychiatry, and I had a behaviorist at that point. But I was relating to Aaron fine at that time.

The fourth time I was hospitalized the doctor spoke to Aaron and asked him: Which would be harder on you — for your mother to stay at home right now or for your mother to come into the hospital for a week just to undergo some therapy?, Aaron said: "For my mother to stay at home would be harder on her."

"I heard the planes strafing. It was World War II. I have a lot of hallucinations that deal with World War II. I know how I got that. My father gave me his war."

I hope I have always encouraged Aaron to tell me what he feels; if he's afraid, if he's angry, happy, sad, depressed. I hope that I do, because I didn't have that when I was a kid. I wasn't an ordinary kid either. It's awful. I didn't talk. I couldn't walk like other kids, either. For years, I walked back and forth. I didn't walk downstairs; I slid down. When I was four I kept trying to kill myself. I threw myself in front of cars and trucks. The higher I went in school the worse things became. I know I wasn't thinking rationally anymore. I had reached the point where I didn't understand things any longer. I threw a desk at a teacher once, and I told her to get off my goddamn back. I don't know why I did that.

When I was fifteen I tried to kill myself. I don't know how serious the attempt was. I started to cut up my arms with razors and glass. That was when I went to the first hospital. I never went back to school after that. I have only grade ten English, but I read an enormous amount. Many people are self-educated, and anyone who has the want and the need can do it. I really believe that.

As a child everything hurt. It hurt to be alive. A harsh word could kill. I still feel that way. I have to hang on to the

"As a child everything hurt. It hurt to be alive. A harsh word could kill. I still feel that way."

sensitivity to the pain, but at the same time it's not terribly enjoyable. Except that the writing is coming so well again it's now enjoyable. I wouldn't say I write because of the pain, but I just get driven to the typewriter. I can't explain it. It's a physical pain to write. I feel it in my arms. It's cathartic.

I hope my illness is not something which I have to live with. I don't accept things easily. I feel I have more control than I ever did. Sometimes it can be very pleasant, you know. I don't want to give it all up. Some hallucinations are quite pleasant. One night I thought I had some wonderful music on, and then I thought: 'Just a minute, I didn't turn the radio on.' I laid back in bed and listened to the music. I think it's important to my creativity.

I started to write when I was four. But, you know, I used to write happy stories of the way I wanted life to be. It was like a little journal which I would keep every day. But I wouldn't let anyone look at it. People still tell me: 'Margaret, the next book you do, have a happy ending.' It's not that I don't

appreciate happy things — I do. My son is a celebration, but I would find it really difficult to write a happy ending. At this point in my life. Maybe when I'm sixty I'll be able to write a happy ending, but right now I have to write what's there.

When Aaron was born I didn't love him right away because he was a new person. I had to get used to him just the way he was getting used to me. I was a new person to him except for the fact that he'd been in my stomach. When Aaron was about one I looked at him and I thought: 'I like you, kid.' When he was about one and a half I looked at him and I thought, 'I love you, kid.' He became so much, I never expected so much from one child. When I was growing up, I was totally alone. There was no-one who could help me. I don't feel that way anymore because of Aaron. We nearly starved and he's very brave about that. We're like a team, we really are. I lift him up sometimes and carry him, and then he lifts me and carries me. I pack up the typewriter and the kid (it used to be the cat, but she died) and hit the road again. He's a celebration. What more can I say?

One day I asked him how he would answer if anyone ever asked him about his years of poverty with his mother, Margaret Gibson, and he said, 'They were fun.'

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Shiatsu, also called acupressure, is an Oriental technique for relieving stress, tension and related health problems.

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It is a completely drugless technique and has no ill side effects. Shiatsu has been used with success to help people break their addiction to tranquilizers by working with the person's doctor to gradually reduce the dosage. Treatments usually last 1 hour, with an average price of \$25.

Bytown Association For Self-Help

By CONNIE NEIL

Another self-help group has emerged and is called BASH (Bytown Association for Self Help).

Coordinators Marjorie Arsenault and Atalanta Babchishin hold meetings in borrowed quarters at the Ottawa South Community Centre every second Monday. "Our meetings have been getting larger each time," said Babchishin, who estimates present attendance at about 40.

The idea to form a group came when Sue Potter of the Ottawa Parks and Recreation Department found that many ex-psychiatric inmates were showing up at a generalized drop-in centre run by that department. She and Ann Louise Prescott travelled to On Our Own in Toronto last autumn to see how it was organized.

"They got a few social workers together and invited us to meet with them. After a few meetings, they dropped into the background and Atalanta took over chairing the meetings," said Arsenault. "I mostly act as Secretary."

Since regular meetings began in February, 1982, much of the time was spent gearing up to a weekend seminar entitled "A Matter of Urgency" in early June. The seminar was well attended and organized. From On Our Own, Coreen Gilligan and myself were invited as keynote speakers and participated in a panel discussion with a local psychiatrist on medication, and workshops on housing, recreation and employment. The meeting following this seminar passed a resolution to limit attendance and voting to the psychiatricized only.

"We've got a lot of good publicity," said Babchishin. "One day after a radio interview where I mentioned that housing was a problem, I got a call from the Daybreak organization offering us a house."

"There are five people living there now," said Arsenault, "and room for two more, all with a private room."

This is Daybreak's first house. Originally planned as generalized low-cost housing, Babchishin's radio appeal gave them the idea to offer it to ex-psychiatric inmates. Rental is set at \$160 monthly and a BASH house coordinator handles day-to-day running, with Daybreak taking responsibility for maintenance and repairs.

"We are also working on participating in another housing project called Daily Co-op. Originally they hadn't thought of including ex-psychiatric inmates. I got angry when I heard that and called them up. So that's something in the future plans," said Babchishin.

The two coordinators met at Causeway, a government-funded rehabilitation work program with two phases: 1) programs to get the psychiatricized back into the work force; and 2) a sheltered work centre for the chronically or permanently disabled. Arsenault is a member of the board of directors of Causeway.

In addition Babchishin sits on the Ottawa Disabled Citizens' Advisory Board, the Causeway Coalition (which is involved in patients' rights and employment opportunities), and the city-wide After-Care Information for the psychiatricized. "A lot of these committees never had a psychiatric component before," said Arsenault, "but that's changing now."

Their work with BASH was a natural out-cropping from these other community involvements. In mid-August they visited Toronto to talk with people at PARC (Parkdale Activity and Recreation Centre) and On Our Own to help them set up BASH.

"Sometimes I feel at a loss because I've never done anything quite like this. I'm a little uncomfortable because they seem to look up to us, and I feel that I just want to be one of them," said Babchishin. "Some members are coming forward and taking responsibility in areas they are interested in," she added. "There is a political action group and a search committee for a drop-in centre location. We've applied for grants for the drop-in centre and a paid coordinator."

"We're concentrating on incorporating and getting the drop-in centre. That is what the members want. When we have that and can discover the skills of our members, more of it will come together," said Babchishin.

In the interim, you can contact Marjorie Arsenault at (613) 526-0287 or Atalanta Babchishin at (613) 728-3993 or write BASH c/o 725 Melbourne Street, Apt. 6, Ottawa, Ontario K2A 1X4.

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CRUEL AND USUAL

Mistrial declared in shock treatment death case

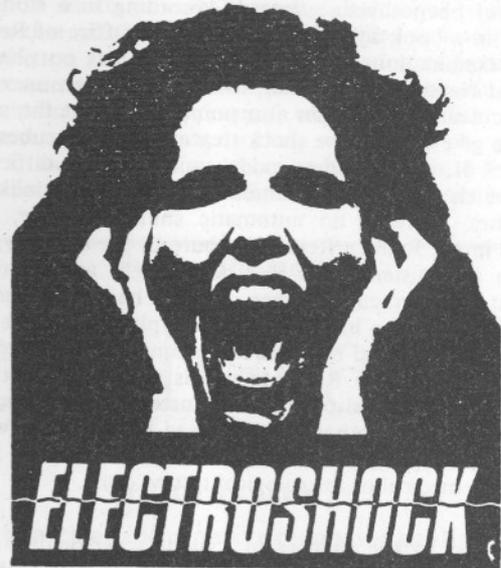
BY JENNY MILLER

On December 22, 1975, a 17-year-old black woman named Lynette Miller died from a cardiac arrest at Napa State Hospital in California. Until her first psychiatric incarceration, 13-1/2 months earlier, she had been an exceptionally capable, talented, and outgoing high school student, with no history of medical problems. In August of 1981, Lynette's mother, Selena Miller, won a default judgment of up to 7.8 million dollars in a wrongful death suit against Gladman Hospital. Gladman, located in Oakland, was the site of Lynette's first incarceration, where she had received electroshock treatment and massive doses of phenothiazine drugs. A jury trial to determine the exact amount of damages was held the week beginning July 6, 1982. Since it was a default hearing, Gladman Hospital was not permitted to present testimony. On July 12, after several days of testimony by witnesses for the plaintiff, Judge Barber declared a mistrial, based on what he termed his own bias, his suspicion that the witnesses "lacked candor," and his lack of medical expertise with which to evaluate the testimony.

During the trial, Selena Miller, who is currently employed as a bus driver, spoke about the nightmarish series of events which began in November of 1974, when she was notified by school authorities that Lynette was ill with nausea and stomach pains. Selena took Lynette to a doctor who diagnosed the problem as stress from overwork, and suggested that Lynette take the rest of the week off from school. At the suggestion of one of the teachers, Selena also took Lynette to see a psychiatrist, who failed to find any serious problems, but who prescribed Mellaril, "to calm her nerves." Mellaril is a powerful phenothiazine drug which has a long list of unpleasant "side-effects," including muscle cramping, impaired speech, thought, and movement, uncontrolled twitching, and hallucinations. The next day, Lynette told her mother that her arm hurt and she couldn't move it. Not having been informed of any possible adverse effects of the drug, Selena assumed it was a symptom of illness, and arranged for Lynette's grandmother to accompany her to the family doctor, while Selena went to work. During her visit to the doctor's office, Lynette reportedly had an hallucination and tried to jump out the window. The doctor immediately had her committed to Gladman Hospital, where she was again given large doses of phenothiazines.

Selena described the changes that came over Lynette after she was admitted to Gladman: "The second day I saw her she could hardly walk. I called her name. She looked right at me and didn't respond. I shouted, 'I don't know what the hell you've done, but my daughter doesn't know me!' I ate lunch with her at the hospital. She'd been feeding herself since she was a year old. All of a sudden she couldn't feed herself. It was four o'clock when the doctor appeared. He

said drugs were necessary to prevent her from escaping because she couldn't run on drugs. The doctor said the reason she couldn't talk was due to the drugs. He didn't mention any long-term effects. Lynette had always excelled in English and was a good student in French and Spanish. Now all she could say was 'Yes' or 'I don't know.' She couldn't control her movements, was constantly jerking." After two weeks Selena removed Lynette from the hospital against the doctor's advice. Intimidated by the doctor's warning that without the drugs Lynette would be harmful to herself and others, Selena continued to give her the huge prescribed doses of Thorazine and Stelazine. After a few days at home, Lynette started to go outside and run. Her mother described her running "like someone with infantile paralysis." Selena brought her back to Gladman because she was afraid she would get hurt running in that state. "The doctor said the condition of taking her back was no interference at all from me. Dr. Sklar said electroshock therapy was what Lynette needed to 'snap her back to reality.' He said it was her only hope. He referred to it as a 'treatment' — I took it to mean a one-time thing. He didn't tell me until they were through that it was a series of thirteen treatments. Dr. Sklar notified me that they'd done everything they could, and I brought Lynette home. She was



**IS A CRIME
AGAINST HUMANITY**

quieter, then she started passing out. She would just fall to the floor. She tried to help out. She would only be able to wash one or two dishes. She couldn't straighten the bed. She never went back to school. She never combed her hair again. She never brushed her teeth again. She couldn't remember her classmates — some she'd seen every day — we'd lived there 5 or 6 years."

While Lynette was at Gladman, she was visited by Reverend Thompson of the Berkeley Mount Zion Baptist Church, who had been her minister since she was 7 years old, and was a close friend of the family. Reverend Thompson testified that Lynette had been a leader in her Sunday school, and from an early age had been one of the small group selected to teach the other children. In some cases, Lynette was teaching children older than herself. She had been very gifted musically, and often sang solo in the church choir. When he visited her in Gladman Hospital, he found Lynette tied to the bed in four-point restraints (hands and feet). She told him the staff was going to electrocute her with some kind of machine because she had tried to escape. After her release, he testified that she seemed to be in a "zombie-ized" state, which was very different from her former manner. She told him, "They're after me. They're going to get me."

Also testifying at the trial was psychiatrist David Richman. He stated that in his medical opinion, the death was a result of electro-shock and drug treatments. He pointed out that the amount of phenothiazines that Gladman was giving her, at one point in excess of 3,000 mg. of Thorazine-equivalents, was much more than the maximum "safe" recommended dose of 800 mg. of Thorazine-equivalents. Richman testified that according to the neuropathology autopsy done, the extensive brain damage that Lynette showed was consistent with studies showing electro-shock and drug-induced brain damage. Sudden death due to cardiac arrest is a well-known effect of phenothiazine drugs. (According to a study mentioned in a book by the State Assembly Office of Research, in an examination of 218 deaths of patients on phenothiazines at Napa State Hospital, there were sixteen unexplained cardiac deaths.) Richman also pointed out that the machine used to give Lynette the shock treatments, the Reuben Reiter Modack II, is the crudest model, and the most difficult one with which to regulate the amount of electricity. Unlike other machines, there is no automatic shut-off device, despite claims in the Reuben Reiter brochure to the contrary, so the person administering the electricity might assume that the current had been cut off when in fact it had not. In addition, it is difficult for a human being to apply the current for the fraction of a second required in a manually-controlled machine like the Reuben Reiter (which is not to say that even a fraction of a second of electrical current is beneficial to the human brain). Another point stressed by Richman, was that at no time during Lynette's incarceration was any kind of adequate medical or neurological testing done.

Alarmed by the changes in Lynette's personality and behavior after the shock and drug treatments, her mother kept looking for a doctor or institution that would be able to "bring her back." After one or two more psychiatric admissions, Lynette was sent to Napa State Hospital against Selena's strenuous objections. After 72 hours, Lynette's family was granted permission to visit her at Napa. Here is how Selena describes this visit. "We went into a huge room. I've never seen so many people in one room in my life except at a convention. I didn't see Lyn. It's policy at Walnut Creek Hospital and Gladman to deny food as punishment. She was

30 lbs. underweight. When she was in the hospital she was afraid to speak. We asked for a writ of habeus corpus to get Lyn out. Dr. Rohr said he would bring Lyn out to see us. She was walking very slowly, wearing the same clothes she wore four days ago. Hair uncombed. She started screaming, 'Mommy! Mommy! Mommy!' We all sat down with her for two hours. I said let's sing some songs. She said OK—then can we go home? I didn't say anything since I didn't want to tell her the truth. She couldn't remember words to songs she had sung all her life, like 'Jingle Bells.' We left—she tried to leave with us. Dr. Rohr said he was going to extend the 72-hour hold. Two days later Dr. Rohr called and said Lyn had had a cardiac arrest. I got there in 30 minutes. We sat there waiting for at least an hour. The doctor said, 'I'm sorry Mrs. Miller. Lyn is dead.' After I got through screaming and crying, I said, 'You killed her. You broke her heart.'

One thing that came through clearly in all the testimony about Lynette was her strong spirit and will to resist injustice. Some observers felt that it was this refusal to submit that led to the ever-increasing levels of "treatment," and finally her death. After the mistrial was declared, the attorneys for Selena Miller, Deborah and Paul Halvonik, indicated that the case would not be dropped. It is interesting to note that after the default judgment against them last August, Gladman Hospital called a halt to the administering of shock treatment. The psychiatrist who administered shock to Lynette, Dr. Martin Rubenstein, is still practising his trade at Herrick Hospital in Berkeley, the scene of several recent demonstrations against shock.



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Pat and I

By BUD OSBORN

It worked well for the North American power and wealth elite when Pat and I played the roles assigned to us, roles designed to pit us against one another, roles produced by the patriarchal-capitalist-psychiatric triangle of isolation and torture. Pat and I were mother and son. Now, we are beautiful friends. We have taken our blood-lineage away from the crazy-making institutions.

We have broken free, free in our relationship with each other, after first being broken: broken in mental hospitals, broken in medical hospitals, broken in jails, broken by psychiatric nazis, so badly beaten we were convinced the terrific problems we were experiencing in our lives were each other's fault, each other's sole responsibility.

We became alcoholics, addicts, both of us attempted suicide and became emotionally demolished mental patients in terrorist-wards, wanting desperately to be of real help to one another and not knowing how, believing the sadistic shrinks telling us that we, not themselves, were each other's oppressor.

Such bullshit! But how long it has taken for her and I to learn that! How much misery we've endured! How much pain we've helplessly inflicted upon one another and upon others equally important to us!

Once, when I was in severe depression over "my" inability to adjust to a world of genocidal horror, disturbed about not being able to adapt unthinkingly to a culture of incredible physical and emotional violence, Pat suggested I commit myself to a mental hospital where perhaps I could resolve "my" problems.

It was a nightmarish experience. It was all I could do to prevent myself from exploding blindly every moment, against the locked ward, forced labour, heavy sedation, cruel psychiatrists, the tremendous suffering of the patients that not only went unrelieved but was greatly exacerbated by the place itself and its abusive, thieving attendants.

And yet, when Pat visited me each day, as I saw her approach in the ward, I felt rage growing until I'd actually accuse her, bitterly, saying: "Why have *you* done this to me?"

I'd obviously learned my cultural lessons well, focusing my anger upon one of the only people who truly cared for me. Despite the omnipresent evidence of vicious institutional oppression, my sight, my vision of reality belonged to the doctors.

A few years ago Pat found the role of docile, battered wife to be too much to endure, and instead of understanding her desire to get out of the situation as indicative of health, blamed herself for "her" failure to conform to oedipalized brutalization, and so allowed the paranoia-shrinks to experi-

ment upon her with devastating addictive psychotropic drugs, until her very life depended upon her breaking free in some way.

She made an amazing schizo-flight which lasted months, which ripped the facade off everyday life, exploded the pretensions, conformities, the everyday production of oppression that goes on relentlessly. She was wondrous.

But I knew that she would have to pay a heavy price; that society, policed especially by the mental health industry, would exact retribution for her liberation-beyond-limits, and finally she was incarcerated in the very same hospital to which I'd been admitted a few years previously.

At one point during her struggle I not only encouraged her to commit herself, but attempted to do it for her. I didn't know what else to do. I felt helpless, with a desperate caring I could not put into action.

When I visited her she demanded I take her out of there, out of the filth-cells. Of course she did; any lucid person would want out of there as quickly as possible. But I could do nothing. The police had committed her and I knew of no alternatives. So she blamed me for her situation and finally I knew the anguish, the deep soul-pain, the trepidation and guilt she felt when once she visited me.

So far we've both survived, both emerged from shackles of self-destructive accusation into free zones of openness and relatedness, into relationships of nurturance and support, simply through the arduous process of reclaiming our own experience, learning that the cultural institutions altogether, and the psychiatric-greed-machines specifically, are our enemies; that our real health depends upon our communication with one another, with all oppressed people, and that to realize our deepest personal desires, we must do what we can, each day, collectively, to make happen mutual aid and understanding, to create radically liberating alternatives to the institutions that maim us from birth, funnelling us into psych wards, ghettos, skidrows and prisons, isolating us from each other because what threatens the power and wealth elite most is the withdrawal of our energy, of our lives, from their institutions. And when we do that, we dissolve the power they wield over our minds and bodies as we learn to live, as much as possible, in our respective situations—on our own.

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The Tardive Dyskinesia Epidemic

by Don Weitz

The many "side effects" of the major tranquilizers or "anti-psychotic" drugs have already reached alarming epidemic proportions. The most serious and widespread "side effect" is Tardive Dyskinesia (T.D.), a neurological disorder of the central nervous system, which is caused by many of the major tranquilizers such as Thorazine (chlorpromazine), Stelazine, Mellaril, Moditen or Modicate (Prolixin in the U.S.) and Haldol. T.D. is a definite sign of brain damage; it is generally permanent and irreversible. Without exaggeration, it is safe to assume that hundreds of thousands of people in North America are currently suffering from it.

Tardive means "late appearing", dyskinesia means "abnormal muscular movement." T.D. is actually a well-defined cluster of symptoms, a syndrome which was first identified and described in the late 1950s and early 1960s shortly after Thorazine and similar phenothiazine-type drugs were introduced in the psychiatric institutions. Dr. George Crane was one of the first physicians in the United States to sound the alarm about T.D. However, the medical-psychiatric profession generally ignored or minimized the existence of T.D. until seven or eight years ago.

T.D. is a grotesque and disfiguring disorder. Its most common distinguishing features consist of involuntary movements focussed upon the face, particularly the mouth. In T.D.'s severe or advanced stages, the whole body is contorted and wracked by a host of uncontrollable tremors, spasms, cramps

and ticks, most of which are very painful. Consider this description of T.D.:

The symptoms . . . include slow, rhythmic and involuntary movements of the face and limbs; cheek-puffing; lip-smacking or lip-pursing; chomping of the tongue or repeated tongue thrusts in a "fly-catcher" movement; occasional stiffening of the neck and arms, difficulty in swallowing or speaking; in severe cases, rotation of the ankles or toes, or wrist and finger movements . . .⁴

Life-threatening respiratory problems such as "grunting" and persistent vomiting or "retching" have also been reported as indications of T.D.; however, as yet there have been no reports of deaths directly linked to T.D.⁵ People burdened with these bizarre and frightening symptoms are understandably supersensitive and extremely vulnerable to being shunned or socially ostracized.

Since T.D. is a definite indication of brain damage, this means that the disorder is permanent (destroyed brain cells are destroyed forever), unless it is detected in its earliest stage *and* all drugs, particularly the major tranquilizers or "neuroleptics", are totally discontinued.^{3, 7} The American Psychiatric Association has minimized the seriousness of T.D. by claiming: ". . . an alarmist view is unwarranted, especially since many cases are detected early and improve spontaneously."⁶ But, many other investigators are justifiably alarmed.^{3, 5, 7, 8, 9} Recently, two psychiatric investigators admitted that T.D. is "a significant public health problem."¹⁰

Although the onset of T.D. varies, most investigators agree that the symptoms usually appear within six months to two years after the start of treatment with phenothiazine drugs. T.D. is also known to appear within the first six months of "treatment," and in some cases within the first three weeks of continuous drug use. Frequently, T.D. makes its first appearance when the drug is temporarily or completely withdrawn; up to 40% of people who have never had T.D. can suddenly develop the disorder within a few days or a week after the drug(s) is stopped.⁹

T.D.'s symptoms are usually distinguished from similar involuntary or parkinsonian movements by their stubborn persistence after the drug(s) is withdrawn.

People at greatest risk of developing T.D. are: the elderly ("chronic" or "psychogeriatric" patients), children and others who've been taking high dosages of one or more of the major tranquilizers for months or years.

The prevalence of T.D. among drug-treated patients or psychiatric inmates is roughly 20% to 40%, but in some inmate populations the rate has been as high as 50% or higher, particularly in old people. In two studies of "schizophrenic" out-patients, 43% to 44% of the patients examined (randomly) showed definite symptoms of T.D.^{11, 12} A number of other studies of out-patient populations show the T.D. rate to be "closer to 50%."¹⁰ Children as young as six or seven have also developed T.D.! In one study involving eleven young children (7-12 years old), all of whom were given major tranquilizers (e.g., Thorazine, Stelazine or Mellaril) at various dosages for a period of six months to three years, 5 or 45% developed "withdrawal emergent symptoms." This early form of T.D. occurred within three weeks after the drugs were completely withdrawn.¹³

Unfortunately, there is no cure for T.D. Although various drugs have been used to "control" or minimize T.D., they only suppress or *mask* the symptoms and give temporary relief. Furthermore, commonly used "anti-parkinsonian" drugs such as Cogentin and Artane only aggravate the disorder. Despite the fact that T.D. is often hidden and does not become evident until the drugging has totally stopped, many psychiatrists continue to prescribe these brain-damaging, "anti-psychotic" drugs in the naive belief that they will control the symptoms. The fact is that continued drugging only aggravates T.D. or causes more brain damage.

Nobody knows exactly how such drug-caused brain damage is produced in the brain. There are many theories. "The most accepted theory is that these drugs damage the dopamine receptors and make them overly sensitive to do-

pamine, thus causing abnormal movements."⁸ Dopamine is a natural brain chemical, a "neurotransmitter," which is "necessary for normal muscle movements." Apparently, the major tranquilizers block or interfere with the normal functioning or sensitivity of this chemical.

If you are presently taking or have recently stopped taking any major tranquilizer(s), you should be aware of these risks of developing T.D.:

1. The longer you continuously take such drugs without any break ("drug holiday").
2. The higher the dose you get. a. For adults, more than 400 mg. of Thorazine a day, or its equivalent in other such drugs on a regular basis, is much more risky. b. More than 150 mg. of Thorazine a day, on a continual basis, in those over 55, is very risky.
3. More than 75 mg. of Thorazine a day in those over 65 is risky.
3. If you have suffered bad muscle reactions to these drugs (drug-induced parkinsonism, muscle cramps, i.e., dystonic reactions, abnormal muscle movements; i.e., acute dyskinesias), then you are also at higher risk of eventually developing T.D.
4. Women appear to be more susceptible to T.D. than men.
5. If you have any other kind of brain damage or neurological problem. This may also include prior electroshock (ECT), —but this is still unclear.
6. If you have been taking "anti-parkinsonian" drugs like Artane, Cogentin, etc., these drugs appear to increase the risk of getting T.D.
7. Long-acting injections of Prolixin (in Canada, Moditen or Modicate); i.e., Prolixin Enanthate or Prolixin Decanoate, also appear to be more likely to create T.D.⁷

Of course, the best cure is *prevention*. This simply means not becoming addicted to or dependent upon any psychiatric drugs, especially the major tranquilizers, for any length of time. Even two or three months of continual or daily drug use may be too long and risky. If you and your doctor believe you must take the drug(s), then only take it for the shortest possible time and at the lowest dosage. Then, completely and gradually stop taking the drug(s)—to prevent or minimize serious withdrawal reactions—under the care and supervision of your doctor. The "cold turkey" method can be very dangerous.

A final note on medical ethics and responsibility. For many years, the medical profession and drug industry covered up the bad news about T.D.:

... it was first recognized in the early sixties, but psychiatric power

potentates/drug dictators ignored it for as long as they could. Not until 1972, when legal action was taken against the drug companies on behalf of a "patient" with T.D. did the system publicly admit to the existence of the condition... In April of 1973 a special editorial finally appeared in *Archives of General Psychiatry* which spilled the beans so to speak and laid out the present psychiatric-party line about Tardive Dyskinesia. Note that this article appeared almost fifteen years after T.D. was first recognized, and six to eight years after it became obvious what T.D. was all about. It's about time that *all* the truth came out, about this very serious result of anti-psychotic drug use.¹⁴

Most (perhaps all) drug companies which manufacture the major tranquilizers now include a "package insert" about T.D. and other "side effects." However, very few, if any, drug users and potential drug users know about or can understand the technically-worded inserts. Besides, the vast majority of doctors don't bother informing their patients about T.D. as well as other serious effects of psychiatric drugs. It's time they did, so that people can decide whether they want to play Russian Roulette with brain-damaging psychiatric drugs.

NOTE: The editorial collective of Phoenix Rising considers Tardive Dyskinesia a serious HEALTH HAZARD and urges all physicians who prescribe major tranquilizers to inform their patients of this fact.

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what's happening

Ombudsman blows whistle on staff brutality.

Within the past two years, Alberta has suffered a rash of incidents involving staff abuse of patients (see *Phoenix Rising*, VOL. 1, nos. 1 and 2, vol. 2, nos. 2 and 3). The latest scandal to rock Alberta's "mental health" system has recently been exposed in a "Special Report of the Ombudsman," a 75-page study released in July by Ombudsman Randall Ivany. This report documents numerous staff abuses of psychiatric inmates which occurred on Ward 8/2 of the Edmonton Hospital, a 500-bed psychiatric institution similar to Toronto's Queen Street Mental Health Centre.

In July of 1981, a staff member alleged that another staff had abused an inmate; that quickly led to internal investigations by the Department of Social Services and Mental Health, which revealed many other abuses. When it became apparent that the Department had bungled its own investigations, Bob Bogle, Minister of the Department, requested Ombudsman Ivany to conduct his own investigation. However, the Department and the RCMP interfered or threatened to interfere with Ivany's investigation shortly after it began.

After nine months of study and roughly "300 interviews with professional, clerical and support staff," these are some of the findings in the "Special Report":

- Thirty-five staff were alleged to have physically and/or verbally abused many inmates on Ward 8/2.

- Nine staff were immediately fired and four suspended; twenty-two were ordered to be "counselled" (reprimanded), but only four were actually reprimanded.

- Fired and suspended staff included one male head nurse, four male and two female nurses, two male and four female aides.

- Ivany found evidence to support the firing of only five staff but recommended that a number of other staff be either transferred to other wards or institutions, or demoted to positions without contact with inmates.

- No criminal charges were laid against any staff.

The alleged staff abuses included these acts:

... slapping patients' heads and faces, kicking or kneeling patients in the groin, throwing coffee and water in the faces of patients, kicking a patient and then dragging him along the floor, twisting the arms of patients, throwing patients to the floor, slamming a table into a patient's stomach, and stepping on a patient's head . . . calling them (patients) "idiots" and "fools" . . . telling one patient that his wife was going to be involved in a sexual encounter with another man. (29 allegations against a female aide, p. 20-21).

... pulling a patient's whiskers out with a pair of tweezers, spanking a patient, kneeling another patient in the groin and twisting his arm, standing on a patient while

slapping his buttocks, putting a patient in a headlock and pushing a patient into a wall . . . verbal abuses including threats to kill patients, calling patients names and encouraging one patient to assault another patient. (15 "findings of inappropriate conduct" against one male nurse, p. 22)

... ripped the clothes off a patient and kicked the patient, struck the face of one patient, and used unnecessary roughness in cleaning a patient's ears, resulting in pain to the patient . . . swore at and about patients, told one patient his wife was a streetwalker, and another that his wife was having sexual encounters with another man, and yet another that his wife was a prostitute. (12 "findings of inappropriate conduct" against one female aide, p. 22-23).

In addition, there are allegations of some staff failing to report known or suspected staff abuses (one nurse waited nine days to report an incident) and allegations of three staff involved in assaulting an inmate on a bus — one "pulled the patient's hair, struck him."

In attempting to explain these abuses, Ombudsman Ivany lists six reasons:

1. "Desensitization . . . Staff become so desensitized that they could no longer recognize abuse."

2. Ward 8/2 became the hospital's dumping ground for its "most aggressive . . . overly difficult or overly bothersome patients."

3. Staff were unable to handle inmates' aggression and had "no meaningful supervision."

4. Staff doctors were unaware of these abuses (*hard to believe*).

5. There was "no physical evidence of the abuses" (*also hard to believe*).

6. Inmates were generally unable (*or too afraid*) "to speak out for themselves."

Among Ivany's twenty-four recommendations, five are very critical of the Department's investigative procedures; one urges that Personnel Director John Cels be disciplined for disobeying an order of the Assistant Deputy Minister (which temporarily obstructed the investigation); eight deal with disciplinary measures against a number of staff; and nine relate to various structural changes within the Department and hospital, including improved staffing, training and supervision of staff, as well as prompt and detailed reporting of any abuses.

In addition, Ivany urges the Department to adopt the definition of "patient abuse" together with specific guidelines for reporting abuses as proposed by the Manager of Employee Relations three years ago. The Department had previously rejected it. (*To the best of our knowledge, no province has adopted a definition of "patient abuse" or inmates' rights in its mental health legislation*). Ivany further proposes the establishment of a "Patient Abuse Committee" consisting of hospital staff. Significantly, it excludes psychiatric inmates or ex-inmates.

It's still too early to tell if this investigation and report of the Ombudsman will result in fewer staff abuses of inmates of Ward 8/2. Since no staff were charged with criminal of-

fences, we seriously doubt that it will. There is reason to assume that such abuses have occurred on other wards of the Edmonton Hospital, although Ivany denies this. There is also reason to assume that physical and verbal abuses of psychiatric inmates are still occurring, not only in Alberta, but all over the world.

NOTE: Copies of the "Special Report of the Ombudsman. Ministerial Order. Re: Alberta Hospital Edmonton" may be obtained by writing to: Robert S. Wyatt, Executive Assistant to the Ombudsman, Office of the Ombudsman, 1630 Phipps-McKinnon Building, 10020-101 A Avenue, Edmonton, Alberta, T5J 3G2.

Electroshock To Be Abolished In Berkeley?

The controversial psychiatric "treatment" called electroshock (ECT) may soon be outlawed in Berkeley, California. A recent citizen-initiated referendum, which makes the administration of shock treatment a "misdemeanor" punishable by imprisonment up to 6 months and/or a fine of \$500, will be on the voter's ballot in the city's November election. A petition with at least 1400 signatures was required to place it on the ballot — 2500 signatures were collected within only a few weeks.

The Coalition To Stop Electroshock, which includes NAPA (Network Against Psychiatric Assault) and many other anti-psychiatry groups, succeeded in mobilizing considerable citizen opposition to shock. Ted Chabisinski and Leonard Roy Frank, both former psychiatric inmates and shock survivors, have been struggling for seven or eight years to ban shock throughout California. Chabisinski was only six years old when he was forcibly shocked in New York's notorious Bellevue Hospital. He was probably the youngest person in the United States to get electroshocked. In the early 1960s, Frank was also forcibly "treated" with 40 insulin coma shock and 40 electroshock treatments in a private psychiatric institution in California. He survived, but with severe loss of memory — two years of his life were permanently "wiped out."

In 1980 in California, "more than 14,000 electroshock treatments were administered to 2,703 patients in 73 hospitals and doctor's offices." In that same year, 467 electroshock treatments were given to 68 psychiatric inmates in Herrick Hospital, "the sole Berkeley facility where electroshock treatment is administered to severely depressed patients."

Perhaps the citizens of Berkeley (including Mayor Eugene Newport, and three city councillors who support the ban) will vote to abolish electroshock this November. If they do, Berkeley will be the first city in the United States, or in the world, to make electroshock illegal. To allow citizens to vote on a so-called "medical" or psychiatric issue is itself "a victory, a victory for the Movement," says Frank.

U.S. Sells Shock Sticks To South Africa

Electric cattle prods or "riot sticks" have been exported by the United States Government to the Union of South Africa. According to a recent news report in Toronto's *Globe and Mail* last month, "a license for the \$200,000 sale was issued on April 26. . . ." of this year. Undoubtedly, these electric riot sticks will be used by police for "crowd control," to repress black dissidents protesting South Africa's racist and oppressive regime.

Some U.S. congressmen and government officials are already trying to make excuses by claiming that the sale was just an "honest mistake." Some mistake! Is the continued use of electroshock on psychiatric inmates, which always causes brain damage, just an "honest mistake" too?

Stigmatization leads to victimization

On April 7, 1982, a Parkdale youth was convicted of raping and assaulting a woman who was 5 months pregnant, *because he assumed her to be an ex-psychiatric patient.*

The young woman lived in a boarding house for ex-psychiatric patients, though she herself was not an ex-psychiatric patient. Crown attorney, Glen Orr told the court that Clifton Carl Ramsay, 19, chose an occupant of that specific building for his crime because it was inhabited by former residents of the Queen Street Mental Health Center, and he thought that because of her psychiatric background there would be little chance of his being convicted.

Ramsay lived across the street from the King Street West boarding house, and knew a lot of the tenants and the routine of the house. He had also been in the house three or four times prior to this attack, and had been arrested and released. The people he had attacked were ex-psychiatric patients who were heavily medicated and these people don't give really substantially incriminating evidence, or often, by the time of trial, the witnesses or the victims are in hospital. His name was pinned up in the supervisor's office after police were called when he attacked another woman in the house with a knife just a week prior to the rape.

At first the police were going to go for a simple assault charge because of the fact that the victim lived in a boarding house for ex-psychiatric patients, there were no witnesses, and according to police, they get about fifteen rape cases a month, only one of which goes through.

But this time he chose the wrong victim. She had been placed in the boarding house by her case worker. She was not medicated, was not an ex-psychiatric patient and was able to give testimony. For three full days, only two weeks after delivering her baby by caesarean birth, she took the stand.

According to Diane Capponi, the sole supervisor of the boarding house occupied by 62 residents, Ramsay was able to enter the victim's room easily by forcing open the hook and eye latch which substituted as a lock on her door, which was old and ill-fitted to its frame. (It is telling that the food in the boarding house was locked up, and there was a lock on the kitchen door.) The lock on the front door of the house had been broken for three weeks. Landlords did not replace it for another week after the rape.

Capponi further said that if the house had had the proper locks and security, and if it had been staffed by a night person instead of having one person on duty for 24 hours, this incident, and ones like it, could have been avoided.

Perhaps the saddest aspect of this case is the fact that the police considered it a milestone that Ramsay was convicted and sentenced to 3-1/2 years, and that those involved on the victim's behalf feel grateful.

The most horrifying aspect of the case is that in 3-1/2 years — maybe sooner — the same rapist will be released from prison, most likely unchanged (given the prison system's inability to affect any positive or substantial human change) except for being a little angrier and a little more hardened.

High Park fights Group Homes

The residents of High Park in Toronto's Ward 2 are "mad as hell." They don't want group homes or other alternative housing for ex-psychiatric inmates (or ex-prisoners) in their community. Apparently, the residents don't care about the fact that group homes are legal anywhere in the city, thanks to the "as of right" legislation which Metro Council passed in April of 1981.

Last summer was especially rife with tension, largely because of the loud and angry protests waged by some High Park residents against the establishment of one particular group home. The home is being planned and managed by the John Howard Society, a social agency which helps prisoners and ex-prisoners. It will house ten "mildly retarded" or "mentally handicapped" ex-prisoners and will have 24-hour staff supervision. Resident protest became particularly strident last July 24 when roughly 300 Archie Bunker-type people showed up at a rally. Ward 2 right-wing aldermen Ben Grys and Chris Korwin-Kuczynski, as well as Liberal MPP Tony Ruprecht and Conservative Yuri Shymko, were on hand to fuel the residents' fire. Shymko claimed the residents weren't really bigots when he complained: "What makes me sick is that this community and people like me who support it (the group home) are depicted as being bigoted."

However, residential bigotry is claimed to be justified, according to a pamphlet drafted and distributed by the High Park Concerned Citizens Committee. The front page of the pamphlet reads: "We're mad as hell. We won't take it any more. Stop 114 Indian Road. And any additional half-way house." Other statements, expressed as rhetorical questions, reveal residents' fears and myths about the dangerousness of ex-inmates and their threat to property values: "Will your children be safe now?" "Would you feel safe having your child play outside, or near such a half-way house?" "Are you tired of being harassed in our streets?" "Will the value of your property go down?" "Would you buy a house next door?" "Will our neighbourhood go down the drain?" The Ontario Human Rights Commission is presently investigating a complaint by two ex-psychiatric inmates who claim that the High Park pamphlet is not only inflammatory, but discriminates against "handicapped" people.

Curtis McQuire, spokesman for the High Park Concerned Citizens Committee, claims the residents aren't really against group homes—they just don't want any more of them in their community. He told the *Toronto Star*: "We have nothing against group homes. We've just done more than our share." The facts prove otherwise. Ward 2 has 12 group homes (134 residents); however, Ward 5 has 18 homes (181 residents), Ward 6 has 9 homes (163 residents), and Ward 7 has 12 homes (171 residents).

The High Park residents are still protesting. On August 26, about 400 packed the City Council Chamber to voice their complaints and fears, supported of course by aldermen Grys and Korwin-Kuczynski. However, on September 9, 400 group home supporters (chiefly informed residents from other downtown wards, community workers and about 10 or 12 ex-psychiatric inmates from ON OUR OWN and Parkdale Activity and Recreation Centre) loudly supported City Council's

reaffirmation of the group home by-law, which passed by an overwhelming majority vote.

So far, only the City of Toronto has passed an "as of right" legislation which legally allows group homes in any ward or community of the city. All the other boroughs have been stonewalling the by-law. For example, North York Mayor Mel Lastman has already appealed the group home by-law to the Municipal Board of Ontario. And the High Park committee is still obstructing the establishment of the group home on Indian Road by asking City Council to set up a special committee to investigate the "problems and merits" of group homes and other residential facilities in Ward 2.

What's needed, of course, is decisive action by the provincial government—approval and enforcement of Metro's group home by-law passed almost one and a half years ago, so that "deinstitutionalization" will become a reality instead of the farce or token effort which it is now.

NOTE: People wishing to express their views or opinions about group homes should write letters to their ward aldermen, Mr. Paul Godfrey, Chairman of Metropolitan Toronto Council, and/or Mr. Frank Drea, Minister of Community and Social Services.



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The Institution as Illusion

By JAMES DUNN

In 1966, Frederick Wiseman spent about six months filming the inmates, staff and daily activities at the Bridgewater State Hospital (for the criminally insane) in Massachusetts. When the finished film was previewed the following year at Bridgewater, the staff and administrators at the hospital were so angry that they sought and gained an injunction which prohibited the film from being shown anywhere in the State of Massachusetts.

The administrators had every right to be scared after seeing the film, which was titled *Titicut Follies*. The film, a stark, grainy, black and white documentary, carefully dissects the everyday brutality, the repressive control mechanisms and the ultimate denial of human dignity that an institution such as Bridgewater fosters.

The title specifically refers to a vaudeville show (jokes, skits, song and dance numbers) that the inmates and staff present annually. But in a larger sense, *Titicut Follies* exposes the institution itself as being nothing more than an elaborate costume drama staged for the outside world — a facade designed to convince so-called “normal” society that its misfits and malcontents are being “taken care of.” This metaphor of the institution as a piece of vaudeville theatre (complete with poorly concocted illusions) is constantly reinforced by the strict role-playing demanded of the inmates, who are seen as “bad” children who must be converted into “good” children.

Upon their arrival at the institution, the inmates are stripped of their clothing and thereby robbed of their former identity (the “bad” boy). Then they are interviewed by a very bored psychiatrist playing the role of the benevolent, understanding father who informs his children that they are very “sick.” Placed in solitary cells, the inmates are verbally and physically goaded, reprimanded and humiliated by

the guards, who act the parts of the tough, strict, disciplinary fathers in this drama. When one inmate (Jim) is taken for a shave, he is grilled mercilessly by the guards for having such an untidy cell. Again and again the guards taunt him and force him to repeat his promise to keep his room tidier in the future. At this point in the film, Wiseman forces us to partake of the guards’ brutality by using the camera as an aggressive weapon which invades Jim’s privacy and robs him of his human dignity (just as the guards do). In a particularly powerful scene, Jim stomps naked around his cell, his hands covering his genitals, glaring at the camera with a face contorted in pain. The audience is not only a witness to his pain, but a participant in his oppression. Wiseman’s strategy here is simple — since institutions are public, the public must take responsibility for what happens in those institutions. He is forcing us to look at something we “normally” choose to ignore.

As is the case in all of Wiseman’s films (*High School, Hospital, Juvenile Court*, etc.), *Titicut Follies* reinforces the notion of the institution as an inhumane, stone edifice that makes pretences of what is commonly known as family. And so despite the fact that many of the inmates are much more intelligent and feeling than their captors, they are never allowed to express themselves on an adult to adult basis. The administrators of the hospital, secure in their parental status, exude a facade of wisdom and kindness as they decide that the most “responsible” act they could perform would be to provide more medication for their “disturbed” children.

This is most evident in the case of Vladimir, an excitable, intelligent man whose only crime seems to be that he feels too much and too strongly. Despite his articulate, impassioned plea that his medication is causing him

harm, the administrators and social workers label him a “paranoid schizophrenic” and decide to “help” him by giving him a higher dose of tranquilizers. This same pattern of “helping” is seen with many of the other inmates. One man says he has been incarcerated for his “anti-American” views in regards to the Vietnam conflict. Another has invented his own language in order to protect himself from the oppressiveness of the language of his captors. And yet another inmate dies mysteriously after being brutally forced through nasal tubes because he refused to eat.

The “mother-figures” in the institution are adequately played by the nurses, who provide “nourishment” (medication), and by the members of the women’s auxiliary, who provide “caring” (condescending babying) for the inmates. This “caring” is shown in the birthday party sequence in which the inmates, one by one, are coerced and manipulated into playing “pin the paper on the bullseye,” a variation on a well-known children’s game.

In the end, we see that there is not even any attempt made at “helping” the inmates. The staff are only interested in making them conform to social controls. In this sense, *Titicut Follies* is not so much about the evils of Bridgewater State Hospital as it is about the evils of any institution that tries to set itself up as an enforcer of “normality.” By making the inmates dance the same steps and sing the same songs as everyone else, the authorities think they have finally taught their “bad children” to behave.

***There is no Canadian distributor for *Titicut Follies*. Canadian Filmmakers Distribution Centre, which distributes all of Wiseman’s other films, has not been allowed to distribute the film due to lawsuits launched against the film in the U.S. A copy of the film is owned by the Ryerson Media Library in Toronto.



the Book worm turns

Decarceration, by Andrew Scull. New Jersey: Prentice-Hall (1977).

Reviewed by Mel Starkman

Many Americans pride themselves that the "disease" of socialism has never reached their shores. Andrew Scull's *Decarceration*, a valuable neo-Marxist analysis, argues in part that a form of socialism *has* been practised in North America. We would call this form Asylum Socialism, meaning that state-run institutions like psychiatric hospitals and prisons operate uneconomically under bureaucratic procedures and to the detriment of the inmates who are supposedly there for rehabilitation. Democratic socialists argue that in a perfect world, freedom and responsibility would promote social wealth, not on the backs of the poor and the disadvantaged, but for the benefit of all. Meanwhile, according to Scull, welfare capitalism still functions for the accumulation of wealth, thereby discounting the individual health of large segments of the population.

Decarceration is a radical critique of the new panacea — deinstitutionalization and community "care" — for dealing with "problem" populations that in the past have been kept in institutions. In the last twenty years, these institutions have lost credibility, proving to be both unrehabilitative and cost-inefficient. Scull argues that economic, and not humanitarian, considerations have brought about the move to close institutions.

The book is divided into three sections with the introductory section comprising four chapters that try to make sense out of the past and present attempts to define the "problem" populations. In the various phases of the modern era, Scull shows how social control mechanisms contingent on economic considerations determine the patterns of treatment for "deviants" such as the "mad", the "bad", people with handicaps and the "undeserving" poor.

The fourth chapter, "The Demise of the Asylum: Decarcerating the Mad",

looks at developments in England and the United States that explode several myths including "the cult of curability" and the moral rhetoric of those with vested interests in the still lingering institutions. Careerism of administrators and non-portability of the skills of the unionized continue to block change. Many American states have been

"... abandoning or postponing hospital closures in the wake of organized resistance from employee unions — opposition which can prove politically troublesome not least because it often relies on the technique of creating "moral panics" in the surrounding communities to which patients are released." (73)

The second part of the book is of particular interest to ex-inmates with its focus on the "technological fix" of psychoactive drugs. As Wade Hudson indicated in his testimony reported in *Madness Network News* (Winter 81/82 issue) the institutions were being emptied before the appearance of "miracle" drugs. The logic of some psychiatrists and their bedmates that drugs facilitated the closures cannot withstand the test of factual analysis. The asylum is passing for economic reasons, according to Scull and others. Meanwhile psychiatry has continued to foster the myth of the benefits — individual, social and economic — to fortify their medical "figleaf". (79) The inability or unwillingness of most psychiatrists to be critical of drugs and the profit-orientation of drug companies is mute evidence that psychiatry does not belong in the ranks of acceptable pro-

fessions. Psychiatry has long played with chemicals to manage clients and this new/old wave will prove to be as harmful as the use of sodium bromide was in the 1920s. Scull quotes a source in 1925 justifying the use of this toxin for allowing

"... the conservation of energy of the nurses and other employees, which can subsequently be directed into productive fields of activity." (92)

Chapter six is a critique of social policy based on releasing patients such as the elderly into the hands of "moral" entrepreneurs whose operations are run for profit. Statistics are widely available indicating the higher death rates of the deinstitutionalized aged who are a dispensable commodity in our callous age. Scull's critique does not stop at the entrepreneurial profiteers. The attack on the asylums, like those of Goffman, are shown to have become popular because the timing was right and not because there were not many other earlier critics making the same points (but not listened to because Asylum Socialism fitted into the prevailing stage of capitalist enterprise). Our present stage of welfare statism requires a healthier general population, so the middle class is served first while the fixed capital costs of new institutions are resisted and the communities, most often poorer ones, bear the costs of the disabled deinstitutionalized.

The final two chapters are the summation of Scull's argument. They are powerful and insightful, indicating that the

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"... pattern of the socialization of loss and the privatization of profit, already well established in the military-industrial complex, is now imprinting itself on new areas of social existence." (150)

Scully's book is a critique without a vision, a welcome antidote to the prevailing rhetoric of community-based care. Scully uses a historical, sociological approach to make sense of what is happening in the present. It would be interesting to read something of Scully's that propounds a solution, but this is not the book he chose to do it in.



The Effects of Tranquilizers: Benzodiazepine Use in Canada, by R. Cooperstock and J. Hill, Ottawa: Health and Welfare Canada, 1982, 67 pp.

Reviewed by Don Weitz

Unfortunately, we live in a drug-oriented/drug pushing society which has programmed most of us to take tranquilizers and other psychiatric drugs as well as sleeping pills or "pain-killers" to get "instant relief," to get rid of virtually any kind of tension, pain or dis-ease. It's also unfortunate and scandalous that all too many doctors and the pharmaceutical industry — particularly the multinational drug companies—have been exploiting our human vulnerability to pain or suffering and making huge profits from our weaknesses. The price we're paying for such quick and temporary relief or tranquility is high, too high; serious or permanent medical complications, overdosing, addiction and sometimes death.

For many years, we've witnessed a national, if not international epidemic of "pill-popping." Millions of people in Canada and the U.S. have become hooked on Valium, Librium or other "miracle drug" tranquilizers (benzodiazepine is the chemical or generic name for the minor tranquilizers) after only a few weeks or months of use. Except for a few consumer-oriented books on drugs, most of us have received very little, if any, accurate and reliable information on these drugs from our doctors or hospitals.

So, this small fact-filled booklet on the minor tranquilizers by Ruth Cooperstock (researcher with Addiction Research Foundation in Toronto) and Jessica Hill (Project Director in Ontario for Health and Welfare's Health Promotion Directorate) is most timely and helps fill a big gap in our drug knowledge. Cooperstock is a widely recognized and respected authority on Valium and tranquilizer use by women (see her article on Valium in *Phoenix Rising*, vol. 1, no. 1, 1980).

The booklet, published with the blessing of Health and Welfare, is clearly, simply and tightly written; there's a minimum of technical-medical jargon which makes it easy for anyone to read and understand in one or two hours. The book is written for consumers as well as health professionals and researchers.

There are five key chapters: "Overview of Benzodiazepine Use;" "Appropriate Uses of Benzodiazepines;" "Undesirable Physiological and Psychosocial Consequences of Use;" "Factors Affecting Prescribing and Consumption;" and "Social meaning of Benzodiazepine Use." In the first chapter on drug use, the authors rightly single out some "high risk groups" such as women, the elderly and the institutionalized. The facts are upsetting. For example, we learn that roughly twice as many women as men are prescribed the tranquilizers. To me, this is a clear indication of sexism in the medical profession — a point only suggested or implied by these investigators. Old people also get drugged — twice as often as young people. Cooperstock and Hill are upfront in asserting that such overdrugging, particularly of the elderly, is a "means of behavioural control." Unfortunately, there is no discussion or evidence presented of the routine drugging of psychiatric inmates for the same purpose.

Although the authors mention the practice of polypharmacy (the prescribing of two or more drugs at a time), they are not as critical as they should be of this unethical medical practice, particularly when psychiatric and ex-inmates are the victims. However, the authors do present some research findings concerning the well-known drugging of people in mental retardation centres or institutions ("42 per cent") and the fact that Valium and other minor tranquilizers tend to release aggression or violent behaviour in prisoners (study on Millhaven).

Chapter 4 on the many documented "side effects" and health risks of the minor tranquilizers should come as no surprise to many of us, but it's still

worth reading. Even at "normal" or "therapeutic" doses, and after only a few months, these drugs can cause: dependency or addiction; severe withdrawal symptoms such as tremors, nausea, sleeplessness; and learning and memory impairments. Of course, when people mix a tranquilizer such as Valium with alcohol, a sleeping pill or barbiturate, they can overdose, develop seizures or die. The vast majority of overdoses and suicide attempts by drugs seen in emergency rooms involve these tranquilizers.

Cooperstock and Hill wisely warn the reader against long-term use of these drugs. They strongly recommend getting off any tranquilizer after two weeks or a maximum of 4 weeks, mainly because of the danger of dependence or addiction. I wonder if pill-pushing doctors will give that same warning to their patients. If they don't, they're being irresponsible and unethical.

I respect the authors' criticisms, although somewhat mildly expressed, of the medical model — the common myth that psychological or social problems of people are basically medical conditions or diseases which require medical treatment such as drugs. In this respect, the chapters on "Factors Affecting Prescribing and Consumption" and "Social Meaning of Benzodiazepine Use" are essential reading; they include some well-deserved criticism of drug peddling and misleading ads by the drug companies and the inadequate drug education of medical students.

At the end of the booklet, you'll find more helpful information: a list of all minor tranquilizers sold in Canada (about 12); a handy "glossary" or dictionary of many key medical-technical terms and a bibliography (144 references) for the student or researcher.

This booklet is *free* to doctors, other health professionals and researchers, and to some health-oriented consumer or self-help groups. My own personal opinion is that it should be free upon request to anybody; however, there's a limited supply of copies at present. So, if you wish to get a copy, write a letter to Health and Welfare and state what consumer or self-help group you belong to, and for what purpose(s) the booklet will be used. You just may get a free copy.

The address is:

Health Promotion Directorate
Health and Welfare Canada
Ottawa, Ont. K1A 1B4

Holiday of Darkness, A Psychologist's Personal Journey Out of His Depression, by Norman Endler, Toronto: John Wiley & Sons (1982). ✓

Reviewed by Connie Neil

Holiday of Darkness disturbs me. It has received major media coverage because psychologist Norman Endler, from personal experience, advocates ECT (electroconvulsive therapy) in his chapter titled "Living Better Electrically" as a benevolent, sure-fire cure for depression with no problematic side effects. Has the bad press of drug deaths and damaging irreversible "side effects" of drug therapy tempted psychiatrists to try to improve the image of ECT, a treatment they admit is a mystery to them? They try it: for some it works, but for many the results are horrendous.

Although Endler documents a case of preferential and most careful treatment for himself, the number of misdiagnoses, improper dosages of lithium prescribed (despite the fact he knows "the toxic and lethal level of lithium are close to its therapeutic level" (p. 126), side effect reactions and drug changes without proper time lapsed makes me wonder why Endler still "has faith in" his doctor and follows whatever treatment is prescribed. Endler was led down the garden path.

Once again, psychiatry erred. His problem was first diagnosed as depression. Various medications were prescribed which did not provide relief, yet caused "side effect" complications. Then Endler was persuaded to try ECT and was pronounced cured. But it was not just depression; it was manic depression. And the ECT "cure" shot him into the manic phase. It was at this point that lithium (at the wrong dosage) was prescribed.

Endler was lucky — nothing more. I'm glad for him and his family. But I hardly think his good luck is cause to advocate ECT for all depressives. It is only a symptomatic treatment that will supposedly allow withdrawn depressives to perk up enough to take an interest in psychotherapy, solving their own problems or choosing a drug compatible with their physical make-up when the depression is endogenous (genetic).

Poor Endler, inordinately pleased that his doctor addressed him as "doctor" and terrified of being hospitalized, had ECT on an out-patient basis. In fact, he was met at the elevator by his doctor, although he was not administering the treatment. During his second course of ECT following a

relapse after his ECT 'cure' (sandwiched in to accommodate Endler's travel plans), they consulted after treatments to decide whether he needed one or two more. (Could you imagine one of us suggesting when enough was enough?)

The insular picture Endler paints is tissue thin and in no way represents what happens to real people in the real world when they become depressed and seek aid. Of course, Endler has no way of knowing this, as he had no contact with others receiving ECT. The only detractors he quotes are creative writers — Hemingway and poet Sylvia Plath (both committed suicide after ECT) — and the fiction *One Flew Over The Cuckoo's Nest*, MUST reading. He could have used statistics available from the alternative press (Leonard Roy Frank's *The History of Shock Treatment* (1978); Dr. John Friedberg's *Shock Treatment Is Not Good For Your Brain* (1976); and Dr. Peter Breggin's *Electroshock: Its Brain Dabling Effects* (1981) on brain damage, permanent memory loss and death before setting out to prove there is no harm from ECT.

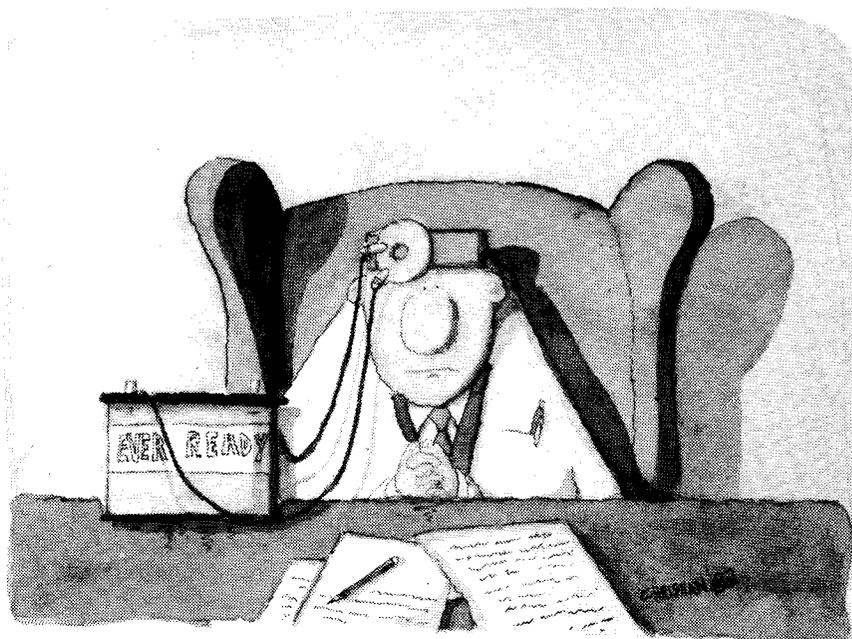
Endler claims they have improved ECT to eliminate those problems. That is little consolation to those already permanently damaged by ECT. Besides, in a recent ECT survivors workshop I discovered that the only difference in what I received 20 years ago and what

they do today is that mine was "bipolar" and now they prefer "unipolar" in an effort to by-pass the creative/language side of the brain. This sounds like good news. The bad news is they have to give you *twice as many* treatments and at a higher current to get the result they want.

I don't know why ECT damages some brains and not others — but neither do psychiatrists. Are you willing to take the chance that you or someone close to you will 'luck out' on the basis of one man's experience when many others have had the opposite, brain-damaging experience?

As a diary, I expect *Holiday of Darkness* might be of interest to his family and colleagues. But for an author with four previous books published, the personal testimony section is surprisingly boring, disjointed, stilted and without insight. And while the treatment sections may be informative for like-minded mental health professionals, for lay readers they are ploddingly unreadable in spots and show a serious lack of research to back up claims for treatment successes or failures.

I shudder to think of a person considering a way out of his/her depression being handed this book. Certain parts are of interest—like the drug side effects information. But the premise that ECT is *good* for you is dangerous when you consider the bad effects of ECT.



2 OUT OF 3 PSYCHIATRISTS RECOMMEND IT!!

This is the Law in B.C.

By GERALD GREEN

It is now the law in British Columbia that a person who has been admitted involuntarily to a mental institution and who has been described in a certificate signed by the Director of a Provincial mental institution as being incapable of managing his own affairs can bring legal proceedings in his own name and over the opposition of the person who is appointed to manage his affairs in an effort to get released from a mental institution. Under the British Columbia *Mental Health Act*, a person who has been certified for involuntary admission to a mental institution or a person whose involuntary admission has been applied for or a near relative of such a person or anyone who thinks that there isn't sufficient reason for that person to be put into a mental institution can petition the Supreme Court of British Columbia for an order that the person not be admitted to the mental institution or be discharged if he/she has already been admitted. Under a separate B.C. law called the *Patients Property Act*, the Director of a Provincial mental health facility can deprive a person of the power to manage his/her affairs by filling out a certificate stating that the person is incapable of managing his/her affairs. When a person is described in such a certificate as being incapable of managing his/her affairs, another person called a committee is appointed to act on behalf of the incapable person.

Within two years, two cases have reached the courts in which persons admitted involuntarily to mental institutions in British Columbia have sought orders in the Supreme Court of British Columbia that they be discharged from involuntary confinement. These cases were brought under the right of judicial review described in the previous paragraph (Section 27 of the *Mental Health Act*). There is no comparable section in the Ontario *Mental Health Act*.

For a long time there were no cases brought by involuntary mental patients or by others concerned with the situation of such patients even though the law contained a provision for judicial review of involuntary admissions to mental institutions. When we started to bring a large number of these cases, our experience was that, for whatever reasons, the patients on whose behalf they were brought would be released on leave or discharged from the institution without the case reaching the courtroom. It is only since 1980 that these cases have started to go to trial and that the Supreme Court has started to turn its mind to some of the issues in those cases.

We have presented legal argument in these cases on a number of issues including the following:

1. Should the Supreme Court in considering the legality of an involuntary admission to a mental institution apply the same test of who can be committed to a mental institution as the medical doctors who are given the power to certify people for involuntary admission must apply?
2. In a case of this sort does the involuntary patient have the burden of proving that he/she should not be in the institution or is the burden on the institution to prove that the patient should be confined there?
3. Does the case for continued detention of the patient or the case for an order that the patient be discharged have to be proved by proof beyond a reasonable doubt or is the standard of proof a lesser one than that?

A third matter has to do with the transfer of prisoners from Provincial jail facilities to mental institutions for involuntary treatment. There is a section of our *Mental Health Act* that says that a Provincial prisoner can be transferred to a mental institution by means of an Order-in-Council issued by the Provincial Cabinet; but a prisoner transferred under that section is not covered by a separate section of the *Men-*

tal Health Act which allows the Director of the mental institution to sign consent-to-treatment forms on behalf of involuntary patients. As a result, if a Provincial prisoner were to be transferred to a mental institution by means of an Order-in-Council he could not be given medical treatment without his consent. In order to get around this difficulty, the Provincial prison and mental health authorities could try to get Provincial prisoners into mental institutions not by means of an Order-in-Council but simply by issuing the prisoner a pass for the purpose of obtaining medical treatment and having two doctors certify the prisoner as an involuntary patient under the *Mental Health Act*. In this way, the prisoner could be given medical treatment without his consent after the transfer.

In the case of *Hilton v. Duffy* the B.C. Supreme Court decided that Provincial prisoners could only be removed to mental institutions by means of an Order-in-Council and were not subject to being civilly committed by being certified by two doctors under the *Mental Health Act*. It is important to note that this decision does not apply to transfers from Federal prisons to Provincial mental institutions. Those transfers are accomplished by means of a provision of the Criminal Code, and it is not clear to me whether or not a prisoner so transferred has a right to refuse medical treatment.

A fourth development in the law has to do with the transfer of involuntary mental patients who have been admitted to institutions under Provincial mental health legislation from one province to another. There is some doubt in my mind as to the legality of such transfers where the patient does not wish to be transferred. In a case that I brought several months ago, a person who had migrated from Saskatchewan to British Columbia and had been admitted involuntarily to a mental institution in British Columbia found out that his doctor planned to transfer him to an institution in Saskatchewan. He was not willing to go to that institution and he instructed me to apply to the British Columbia Supreme Court for an injunction to try to stop him from being transferred. The court granted a temporary injunction against the transfer without deciding whether or not there was authority to make the transfer so as to permit legal arguments to be presented on both sides of the issue. The British Columbia mental health authorities then dropped their plan to transfer the patient, so it was not necessary to proceed to a court hearing.

A fifth development has to do with the Review Panels (which are similar to the Advisory Review Boards in Ontario) which hold hearings to determine whether or not involuntary mental patients are to continue to be detained in mental institutions in British Columbia. The Review Panel is an alternative to the right of Supreme Court Review under our legislation. In 1980 the regulations governing the conduct of hearings by Review Panels were amended to recognize that the patient has a right to have a lawyer present his case at the Review Panel hearing. Previously the patient had a right only to appoint one of the three members of the panel, who might or might not be a lawyer; but the role of that person was to sit as a voting member of the panel and to sit in judgment on the issue of whether or not the patient should continue to be detained rather than to argue that the patient should be discharged. Now that the regulations recognize a right to counsel in review panel proceedings, the patient can have a lawyer represent him/her at the hearing by presenting and arguing the case that the patient should be discharged from the institution. The Review Panels are now allowing the patient's lawyer to call evidence, cross-examine witnesses (including members of the medical, nursing and social services staff of the institution) and to make submissions of law. The result is that, in the cases of those patients who are able to obtain legal counsel, the hearing is a much more thorough procedure than it would have been had the right to counsel not been recognized in the Regulations.



ON OUR OWN

10th International Conference News

Press Panel Presentations

held Sunday, May 16, 1982 in Toronto during the Tenth Annual International Conference on Human Rights and Psychiatric Oppression (taped at Toronto City Hall in Council Chamber).

Carla McKague is an ex-psychiatric inmate and a member of ON OUR OWN. She's also a Toronto lawyer, an inmates' rights advocate and co-founder of Phoenix Rising.

"150 people from North America are here at the conference, out of an estimated thirty million people in North America who have been, are, or will at some time be in a psychiatric institution. I'd like to talk a little bit about the almost thirty million people who aren't here, and why they're not.

First of all, a lot of our brothers and sisters are not here because they're afraid to be; because they're afraid that people are going to find out that they're that terrible thing called a "mental patient." They hide it, they stay in the closet. They know it's going to make it harder for them to find a job, to have friends, to get married, to do almost everything you can do in our society. "Mental patients" are seen as terrible people, as irresponsible and dangerous people, as some sort of cross between a 6-year-old and Jack the Ripper. And they're afraid to let people know what's happened to them, and they're afraid to organize, and they're afraid to come for the kind of support that they would get in this conference or in the organizations represented here.

A second reason that many people aren't here is that they couldn't afford

to come. And they couldn't afford to come because they don't have jobs. And they don't have any jobs because, first of all, employers won't hire people who say, "I was in a psychiatric institution." Second of all, there are jobs that many of us can't do because in order to do those jobs, you have to be in full control of your mind and your body, and we're not. You can't run machines if you're on Thorazine, and you can't be at a job at 9 o'clock in the morning if you're taking an injectable drug which, for the first few days after you have the needle, keeps you in bed.

A lot of us have lost the opportunity to learn how to do a job because during the years when most people are doing that, we've been shut up and we haven't had access to job training. As a consequence, not too many of us are employed, and many of the people who did get here got here only because other people helped them get here, because there was no way they could have afforded it. They're on a welfare cheque or a disability cheque. In many cases, that cheque doesn't even come to them. In Toronto, many of those cheques go to the boarding home operators, who

give them \$25 out of it for everything.

The third reason that many of our brothers and sisters aren't here is because they're behind locked doors—right now. Not because they've committed a crime, because they haven't. Somebody *thinks* they may do something dangerous or antisocial, and so they're locked up. They're locked up sometimes not even because people think they're dangerous, but because they're a little bit different. They may wear different clothes, or look a little odd. They may have different sexual preferences, and people may think that's pretty awful. "We have to lock them up. Who knows what might happen?" They may have unpopular views. They may hear voices that some of us don't hear. But they haven't done anything wrong, and they're being sent to prison, and very often without any kind of due process.

Some aren't here because they've been so crippled by psychiatric "treatment," by shock or by drugs, or by abuse, that they're not able to come. And lastly, some people, including three Torontonians, aren't here because as a result of psychiatric "treatment," they're dead."

Judi Chamberlin is an ex-psychiatric inmate from Boston, Massachusetts. She's a member of the Mental Patients Liberation Front and the author of On Our Own: Patient-Controlled Alternatives to the Mental Health System.

"Some people seem to think that the problem of patients' rights is the problem of institutions, and once people get out of institutions there is no more problem about rights. But the way the system works now, people are not committed, they're not presumably under any kind of legal compulsion, and yet they're still forced to take psychiatric drugs which debilitate and control them

and which can cause tardive dyskinesia. People in the community not under any legal compulsion are often required to live in housing that's controlled by mental health authorities where every behaviour—whether they're too clean or too dirty, whether they get up too early or too late, whether they wash their hair too often or not enough—is looked upon as a "symptom." People

are often required to go to day activity programs where they have to play with clay. Or else they're required to go to "sheltered workshops," and as you heard someone say during the Tribunal, some people are working for 30¢ an hour. I've heard of people working for 50¢ a day in "sheltered workshops."

The way the system works is that even though you're not legally under

control, you are threatened with commitment unless you participate in these programs. And unless you do your work or your duties or whatever you're supposed to do willingly and cooperatively and supposedly voluntarily, somebody's going to come along and say 'you're still sick,' and send you back to the institution which is even worse.

Gradually we are seeing a system develop where former psychiatric inmates in this "community mental health system" are becoming legally defined as second-class citizens without the ordinary rights that people should be able to take for granted. If, for example, you live in a psychiatric boarding home or a community resi-

dence or a halfway house or a cooperative apartment under control of mental health authorities, the ordinary laws of landlord and tenant do not apply to you. We all know that landlord-tenant protections are inadequate. But to the extent that they exist in any city or jurisdiction, they're not applicable to people who live in these residences. You can be evicted with no right to confront your accusers, with no knowledge of exactly what it is that the complaint is against you, without proper notice, without anybody providing any substitute place for you to go, simply because of your status as an ex-mental patient.

Basic protections such as the right to privacy, which has been described by

the courts as the right to control your own body, don't apply. Minimum wage laws don't apply; neither does protection against self-incrimination or the right to confront one's accusers.

In Massachusetts right now, we are trying to establish the fact that being an ex-mental patient should have nothing to do with your rights as a citizen. And I think we all have to become aware—we are aware but we have to make the public aware—that we are going to fight for our rights; that we must have, first of all, the rights that everyone has, and second of all, we want to make sure that the basic rights that everyone has are increased, because people should have power over their own lives."

Leonard Roy Frank is from San Francisco; he's a member of NAPA, Network Against Psychiatric Assault, and Madness Network News. He's the editor of The History of Shock Treatment, which was published in 1978. He has been a member of the Psychiatric Inmates' Liberation Movement since 1972.

ECT causes brain damage, memory loss, learning disability and death as well. During my studies in preparation for my book on *The History of Shock Treatment*, I ran across 109 articles in the literature reporting on 384 deaths. Obviously, the psychiatrists are not going to report on all the people they are killing. One can imagine, however, the numbers of people who have died from electroshock. If they have reported as many as 384, I dare say that most of them don't even acknowledge to themselves that their procedure has caused the deaths of any of their patients. But again, just from one study that was done in 1959, there were 90 people given shock treatment,

electroshock, and three of them died. I have another study where 38 were given shock treatment and 2 of them died. In 1976, using the most modern methods of shock treatment, there were 2 elderly patients among 25 in one hospital in England alone in one year who died. They died within 48 hours after undergoing the shock treatment. Doctors were trying to pass it off as death from cardiac failure. But what caused that cardiac failure?! Electricity caused it.

This procedure results in an electrically-induced form of brain damage. Electricity in the brain is like a bull in a china shop. The difference is china can be mended; you can put the pieces back together again. Brain cells, human

brain tissue once destroyed is destroyed forever. It does not regenerate itself as skin cells do, for example. Brain damage from ECT is neither incidental or accidental. The prime function of this procedure is brain damage, and it is intentional.

The permanent memory loss is also intentional. One electroshock user described what it was like following an intensive series of electroshocks. He said of his patients who underwent this procedure: "Their minds are like clean slates upon which we can write." To me, that does more than just smack of brainwashing. In fact, electroshock is the closest thing we have to brainwashing in the most literal sense of that term."

Martha West is with the Alliance for the Liberation of Mental Patients in Philadelphia. She is a former airline flight attendant with Pan American World Airways. Martha has a special interest in the actual treatments in hospital which she feels to be in violation of the international rights guaranteed by the United Nations Commission on Human Dignity.

My father was one of the most famous lawyers in the world, James Mortimer West III. In 1940, my father went to Norristown State Hospital, after the fancy treatment that was breaking my grandmother. And the first thing the doctors ordered was lobotomy. I won't forget it and I won't forgive.

We lost the farm. I was in college working my way through Brown University, playing hockey, dating some nice New England boys. And mother had a depression; she missed me and Daddy was over at the state hospital, 'cause mother wouldn't sign those papers for lobotomy. So, they shocked him silly and he worked in a greenhouse—no pay at all, not even 30¢. Mother lost the farm because Dr. Digelman wanted that farm. And he put her under guardianship and she's

still under and she's 84. She outlived Dr. Digelman; he died a few years ago.

So, what was I going to say? Hospitals, yeah. I got there in 1963, the year Kennedy died. Grief for my sister, Connie's sister, shock on a post-partum. And my brother-in-law had to take care of my sister to keep her out of the hospital. She jumped off the balcony; she wasn't committing suicide, but she was thinking of doing it. I couldn't handle it. So, she went to Bellevue, and I followed two weeks later, studying for exams. I ran out of my house with grief talking about pop art and how it was a good life, it was a good life. Somebody called the police while I was in Bellevue. And I've been hospitalized now 23 times.

And this man here (points to Leonard Roy Frank) will tell you what goes on in hospitals in the way of treatment

that causes the living conditions to be so bad. 'Cause I had to drink my urine at Bellevue to survive, and I will tell you, if you want to know, that it's an individual decision when you have no water and you've been locked up for 48 hours on thousands of milligrams of Thorazine during an August heat wave. You'll drink your urine.

I've been raped, I've been isolated and I've been locked up. And I'm fighting for my credibility. And I have to say to this conference: Don't mourn. Organize."

Ed. Note: A fifth press panel presentation, by Virginia Raymond, is the basis for the feminist ex-inmate analysis of mental health and violence against women, which will be printed in its entirety in our next issue.

Declaration of Principles

The Tenth Annual International Conference on Human Rights and Psychiatric Oppression, held in Toronto, Canada on May 14-18, 1982 adopted the following principles:

1. We oppose involuntary psychiatric intervention including civil commitment and the administration of psychiatric procedures ("treatments") by force or coercion or without informed consent.
2. We oppose involuntary psychiatric intervention because it is an unethical and unconstitutional denial of freedom, due process and the right to be let alone.
3. We oppose involuntary psychiatric intervention because it is a violation of the individual's right to control his or her own soul, mind and body.

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4. We oppose forced psychiatric procedures such as drugging, electroshock, psychosurgery, restraints, solitary confinement, and "aversive behaviour modification."
5. We oppose forced psychiatric procedures because they humiliate, debilitate, injure, incapacitate and kill people.
6. We oppose forced psychiatric procedures because they are at best quackery and at worst tortures, which can and do cause severe and permanent harm to the total being of people subjected to them.

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7. We oppose the psychiatric system because it is inherently tyrannical.
8. We oppose the psychiatric system because it is an extra-legal parallel police force which suppresses cultural and political dissent.
9. We oppose the psychiatric system because it punishes individuals who have had or claim to have had spiritual experiences and invalidates those experiences by defining them as "symptoms" of "mental illness."
10. We oppose the psychiatric system because it uses the trappings of medicine and science to mask the social-control function it serves.
11. We oppose the psychiatric system because it invalidates the real needs of poor people by offering social welfare under the guise of psychiatric "care and treatment."
12. We oppose the psychiatric system because it feeds on the poor and powerless, the elderly, women, children, sexual minorities, people of colour and ethnic groups.
13. We oppose the psychiatric system because it creates a stigmatized class of society which is easily oppressed and controlled.
14. We oppose the psychiatric system because its growing influence in education, the prisons, the military, government, industry and medicine threatens to turn society into a psychiatric state made up of two classes: those who impose "treatment" and those who have or are likely to have it imposed on them.
15. We oppose the psychiatric system because it is frighteningly similar to the Inquisition, chattel slavery and the Nazi concentration camps.

iii

16. We oppose the medical model of "mental illness" because it justifies involuntary psychiatric intervention including forced drugging.
17. We oppose the medical model of "mental illness" because it dupes the public into seeking or accepting "voluntary" treatment by fostering the notion that fundamental human problems, whether personal or social, can be solved by psychiatric/medical means.

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18. We oppose the use of psychiatric terms because they substitute jargon for plain English and are fundamentally stigmatizing, demeaning, unscientific, mystifying and superstitious. Examples:

Plain English

Psychiatric inmate.....	Psychiatric Jargon <i>Mental patient</i>
Psychiatric institution.....	<i>Mental hospital/mental health center</i>
Psychiatric system.....	<i>Mental health system</i>
Psychiatric procedure.....	<i>Treatment/therapy</i>
Personal or social difficulties in living.....	<i>Mental illness</i>
Socially undesirable characteristic or trait.....	<i>Symptom</i>
Drugs.....	<i>Medication</i>
Drugging.....	<i>Chemotherapy</i>
Electroshock.....	<i>Electroconvulsive therapy</i>
Anger.....	<i>Hostility</i>
Enthusiasm.....	<i>Mania</i>
Joy.....	<i>Euphoria</i>
Fear.....	<i>Paranoia</i>
Sadness/unhappiness.....	<i>Depression</i>
Vision/spiritual experience.....	<i>Hallucination</i>
Non-conformity.....	<i>Schizophrenia</i>
Unpopular belief.....	<i>Delusion</i>

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19. We believe that people should have the right to live in any manner or lifestyle they choose.
20. We believe that suicidal thoughts and/or attempts should not be dealt with as a psychiatric or legal issue.
21. We believe that alleged dangerousness, whether to oneself or others, should not be considered grounds for denying personal liberty, and that only proven criminal acts should be the basis for such denial.
22. We believe that persons charged with crimes should be tried for their alleged criminal acts with due process of law, and that psychiatric professionals should not be given expert-witness status in criminal proceedings or courts of law.
23. We believe that there should be no involuntary psychiatric interventions in prisons and that the prison system should be reformed and humanized.
24. We believe that so long as one individual's freedom is unjustly restricted no one is truly free.
25. We believe that the psychiatric system is, in fact, a pacification programme controlled by psychiatrists and supported by other mental health professionals, whose chief function is to persuade, threaten or force people into conforming to established norms and values.
26. We believe that the psychiatric system cannot be reformed but must be abolished.
27. We believe that voluntary networks of community alternatives to the psychiatric system should be widely encouraged and supported. Alternatives such as self-help or mutual support groups, advocacy/rights groups, co-op houses, crisis centers and drop-ins should be controlled by the users themselves to serve their needs, while ensuring their freedom, dignity and self-respect.

iii

28. We demand an end to involuntary psychiatric intervention.
29. We demand individual liberty and social justice for everyone.
30. We intend to make these words real and will not rest until we do.

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PUBLICATIONS AVAILABLE

- **Phoenix Rising*, vol. 1, no. 1. Boarding homes in Toronto; Valium; gays and psychiatry; and more — not available at present.
 - **Phoenix Rising*, vol. 1, no. 2. Prison psychiatry; Thorazine; blindness and emotional problems; commitment; and more. \$2.50
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