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phoenix RISING

THE VOICE OF THE PSYCHIATRIZED

The Charter Of Rights and Freedoms vs the Psychiatric System

DOUBLE ISSUE:
"CHARTER" SUPPLEMENT

PHOENIX RISING

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phoenix rising

Through the fire

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Regular Features

Canadian Charter of Rights Supplement

This issue funded by The Human Rights Law Fund of the Federal Department of Justice.

EDITORIAL

— by Editorial Collective

Although it is our country's supreme law, the *Canadian Charter of Rights and Freedoms* is no more than a piece of paper — unless and until we make it a reality in our lives.

In our lives? What could the Charter mean to us, as inmates of Canada's psychiatric prisons? Why would we, who seek freedom for our incarcerated brothers and sisters, find any use in an elaborately devised litany of ideals? Why would this piece of paper hold such enormous potential for the victims and survivors of the medieval maze known as the Canadian mental health system?

To answer those questions, let's look quickly at some of the horrible realities we endure in this system today, when hundreds of thousands of psychiatric prisoners are denied:

- access to an independent hearing or trial before being imprisoned in institutions.
- appeal against decisions by such tribunals as Review Boards.
- the right to vote, examine one's medical records, and even wear one's own clothing.

Let's also consider the even more grim reality that we, who have endured such archaic rules — or continue to endure them — are further brutalized and dehumanized by being forced to undergo the chemical, electrical and psychological torture which, in typical euphemistic fashion, is referred to as "medication," "electroconvulsive therapy," and "psychotherapy."

Think, too, about a law that would deprive a Canadian citizen of his liberty for 17 years after being arrested on a charge of attempting to steal a purse.

But what do all these unthinkable injustices have to do with the Charter?

In fact, *every single one* of these gross abrogations of human rights are dealt with in clause after clause of this landmark document. The right to hearings and appeals? In the Charter. The means to exercise one's voting franchise? That's in there, too. The power to decide the precise nature and course of one's treatment in an institution; the unhampered access to counsel before *and* during incarceration; the ability to insist upon such basic choices as what clothing one will wear. They're all spelled out in the Charter. And much, much more besides.

So why is this Charter little more than a piece of paper as yet?

Well, most psychiatric inmates and ex-inmates distrust rights that are spelled out on paper alone. We know, from the bitter experience of trying to get various "mental health" acts enforced, that such laws are rarely carried out and more often exist to further deny us our civil and human rights.

However, the Charter *is* superior to these pieces of legislation — even though, like them, it does spell out "paper rights," not real ones. But it *does* spell them out; all of them. And this offers us a great opportunity — and a great challenge.

Let's face the facts: these rights will not just be handed to us. To make them real will demand a lot of study, understanding, organization. And to make them real will demand a struggle.

Yet, in *our* hands, the Charter can be, *must* be, a powerful legal weapon. We *must* get to know and learn to use this weapon in our continuing battle for the rights and freedoms outlined in the Charter; rights and freedoms that could put an end to the nightmare of injustice we now suffer.

Why don't *we* start using the courts to seek justice from the same psychiatric hierarchy that has for so many years, violated *our* human rights and wilfully deprived us of our freedom — all in the name of "appropriate treatment." Now that would be the sort of "appropriate treatment" most of us would seek with great enthusiasm!

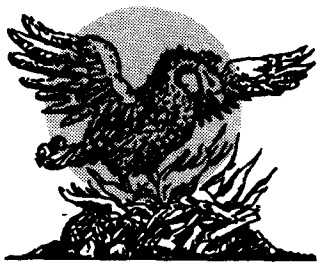
In this issue of *Phoenix Rising,* we explore many of these crucial issues which could so extensively affect the pattern of our lives, imposed on us by a system whose continued inhumanities are threatened by the fundamental principles of the Charter. We discuss legal battles that are being waged at this very moment; we consult some of the leading civil rights advocates engaged in these battles; and we offer our brothers and sisters some of the ammunition we will all need if we are to win the war.

Let this be the beginning of an end to psychiatric oppression, brutality and injustice!

CONTRIBUTORS:

ARCH, Steve Atell, Michael Berman, Dr. Peter Breggin, Dr. Bonnie Burstow, Pat Capponi, David Draper, Heather Duff, Nira Fleischmann, Leonard Frank, Liane Heller, Rich Herrin, Myra Hewitt, Philip Kienholz, Linda King, Dan McDonald, Carla McKague, Harry Peters, Kathleen Ruff, Denise Russell, Harvey Savage, Bobbie Jean Smith, Lynne Supeene, Maggie Tallman, Hugh Tapping, Dr. Tyrone Turner, Don Weitz.

Note: *Free copies of the* Canadian Charter of Rights and Freedoms *are available. To order copies, write to:* Communications and Public Affairs, Department of Justice Canada, Ottawa, Ontario—K1A 0H8.



Write On

NOTE TO READERS: *Phoenix Rising assumes any correspondence sent to us may be reprinted in part or in full 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.*

Defends Feminist Therapists

I just picked up and eagerly read your "Women and Psychiatry" Issue.

I am an undergraduate psychology student at Western University who is also a feminist and wishes very much to practise feminist therapy one day. I believe this magazine is extremely insightful and informative and should be mandatory reading for future psychiatrists, psychologists, social workers and therapists.

In reference to the article entitled "Mental Health and Violence Against Women: A Feminist Ex-Inmate Analysis," I feel a need to comment on the author's proposition the "feminist therapy is part of the psychiatric system and as such it is a method of social control which mirrors larger society." I strongly disagree with this statement. I feel the authors are erroneously clumping feminist therapy with other therapies which *are* oppressive. Feminist therapy does not have an arbitrary distinction between therapist and client. It does *not* spend all of its time individualizing, personalizing, or therapizing women's problems and thereby isolating them and reinforcing their powerlessness.

From my personal readings and from how feminist therapy has been explained to me, it involves three main components: information, anger, contact. Feminist therapy informs women of the social-cultural and physical oppression which is at the base of their so-called (not by feminist therapists) "psychosis." It then helps women get in touch with their anger which can be such a positive, empowering, healing emotion and one that has been systematically denied to women. The therapist then tries to get women in contact with other women to gain a sense of sisterhood; to tear down the barriers between women so that they can collectively work towards the abolition of this patriarchal, capitalist society which has a stranglehold on people's lives and leads to the slow, silent murder of every woman's mind and soul.

Feminists also have not abandoned women in psychiatric hospitals. Phyllis Chesler and P. Penfold to name two have written extensively of the psychiatric system and its social control upon women. Perhaps more energy in the feminist movement should be devoted to fighting the psychiatric system and its violence against women. But feminist therapists are not your enemies; they are your allies and I find the authors' accusations about feminist therapy completely unfounded.

In Sisterhood,
Brenda White,
London, Ontario.

Electronic Nightmare

Greetings People at *Phoenix Rising:*

After a lapse of two years, I got hold of *Madness Network News* and noticed your ad and offer of a subscription. I would appreciate it very much if you would indulge me and send your paper.

Presently I'm confined in an electronic nightmare here in Wisconsin run, by the way, by a Dr. from your area—a Dr. Gary J. Maier, who was a unit Director at a Mental Health Center at Penetanguishene, Ont.

This joint is really tight!! Mental Health shit! Security is what matters and all the rest is a game. I detect it's nothing but a big business with these people. It seems to me that the staff try and keep the units to full capacity so their jobs are not threatened. If everyone got well on a unit it would close and they'd be out of a job.

Over the years Wis. has really gotten into a punishment security thing with the Mental Health front. They issued Patients' Rights and have 10 ways to circumvent them. I'm disgusted and tired! They violated my mail rights by opening my mail out of my presence for an inspection (which is supposed to be the policy). It's the trip where they try and give you a feeling of helplessness — we'll see, since I'm going to stick it to them legally.

Well, I'm going to close and hope this finds you fine and in the best of spirits.

Thanking you in advance.
Sincerely
With
Solidarity,

James E. Szulczewski
Madison, Wis.

Reader Likes Us

Phoenix Rising is excellent. I've heard so much and been around so long I thought I'd seen it all. But knowing about these treatments is one thing, to put together a magazine as effective as yours is devastating. It left me in awe. In all the

years of my incarceration I haven't felt anything — I *felt* everything in *Phoenix Rising*.

After three and a half years of isolation I was just recently released to enter back into main prison population.

Take care, Be easy! Later!

Scott Smith,
Walla Walla, WA

We appreciate your appreciation. Glad to hear you're back with people. Keep reading!

Skeleton in Doctor's Closet

The February 1985 issue of *Phoenix Rising* contains an article entitled "Women and Shock Treatment" by Paula Fine, which originally appeared in 1974 in *Issues in Radical Therapy*.

One paragraph mentions the work of Dr. John Rosen, who is said to treat patients "with the love and understanding of the therapist, and hours and years of caring (p.56)," and quotes him as urging psychiatrists to avoid doing harm to their patients.

For the record, I would like to bring to your attention the following excerpt from Thomas Szasz's *Schizophrenia* (New York: Basic Books, 1976), concerning a malpractice suit brought against Dr. John Rosen in 1960 by the parents of Alice Hammer, one of Rosen's patients. Szasz quotes from the court records:

> It was brought to the attention of the patient's family that the defendant made claims to dramatic success in the treatment of schizophrenic patients. The defendant was sought out, requested to, and did agree to treat the patient. Nurse H. Louise Wong, who attended the patient for 12 days during September 1948, testified that on two occasions she took the patient to the defendant for treatment ... After completion of the treatment on the first occasion, Nurse Wong observed that the patient's body was covered with bruises, and her clothes were torn and dishevelled ... Apart from the testimony of Nurse Wong, there was ample evidence in the record of the defendant's assaults of the patient on various occasions in the course of his treatments. Mrs. Hammer testified that after treatments she observed her daughter was "beaten up" and had "blue eyes"; that her daughter returned from treatments "black and blue." Mrs. Hammer also testified to conversations with the defendant wherein he stated that the assaults complained of were part of the treatment.
>
> In his defense, Dr. Rosen argued, that the treatment was knowingly and freely consented to by reason of the fact that the patient's mother testified that if beating was a means of a cure, she was agreeable to the treatment (pp. 119-120).

Yours truly,
David M. Cohen
Berkeley, California.

Thanks for the information and for keeping us on our toes.

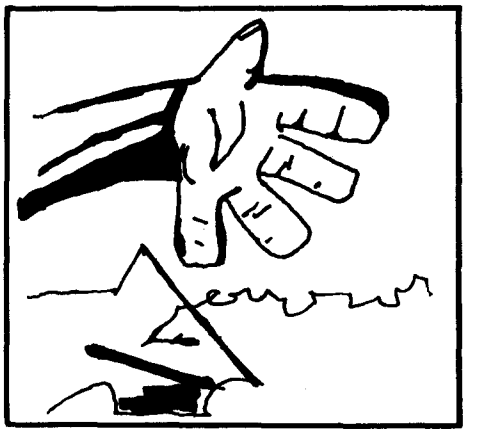
Drugged For "Illogical Thinking"

I was able to get hold of your volume 4, numbers 3 and 4 to read and was overwhelmed by the stories within. I read that Thorazine and other drugs can cause serious effects to one's body. I think that may explain why my teeth are in such bad shape at present. I was placed on Thorazine in 1983 for what the psychologist here said was nerves and illogical thinking.

After I was on various drugs for one-and-a-half years the doctors took me off them "cold turkey," which at the time put me through withdrawals. But now my teeth are doing better, although I'll need dental work some day in the future.

Thank you for such a wonderful magazine to help people keep in touch with reality.

Sincerely,
Ralph H. Darding,
Lansing, Kansas.



The side-effects of "therapeutic" drugs are not even fully understood. Thorazine is the grandaddy of tranquillizers and one of the most damaging.

Law Condemns People

Thanks for your letter of May 20th.

Very interesting to note in the newspaper article you enclosed, the continued deprivation of involuntary patients' right to legal counsel.

I'm still unsure if the addendums made to the *Mental Health Act* in March 1984 have actually, in a way, done away with the act, giving all people the right to a trial, and to a lawyer to represent them. Certainly if, as you say, one cannot appeal a psychiatrist's judgement of incompetence to a review board, then it hasn't. I must say I find any law that condemns people — rather than specific acts of human behaviour — to be totally unacceptable, unscientific, and totalitarian.

I sincerely look forward to the day, and to the moments in between now and then, when that little pocket of totalitarianism which is the "mental health care system" in it's present form (i.e. routine forced drugging), is finally excised from our society.

In continued support of your most courageous and pioneering endeavour.

Sincerely,
James Armstrong,
Thessalon, Ontario.

Well, the 'Acknowledgement Department' really goofed up royally in the Women's Issue. The following list of Contributors as well as a couple of credits are included late — but with both our apologies and sincere thanks.

LIST OF CONTRIBUTORS FOR THE "WOMEN AND PSYCHIATRY" ISSUE

Pamela Allen, Persimmon Blackbridge, Anne Boldt, Wendy L. Decker, Heather Duff, Barbara Findlay, Paula Fine, Sheila Gilhooly, Jillian, Linda King, Julie Marks, Mary Marshall, Carla McKague, Brian McKinnon, Pam Munro, Holly Near, Greta Hoffman Nemiroff, Mary K. Newman, Della D. Nihera, Bobbie Jean Smith, Katherine Tapley, Al Todd, Colleen Wagner, Sally Zinman.

CREDITS OMITTED WERE:

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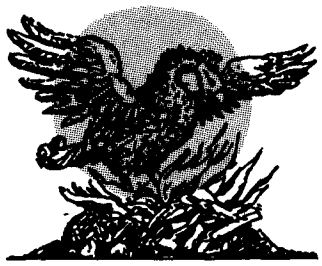
"Women and Therapy" by Pam Munro reprinted with permission from *Kick It Over*, No. 9, December, 1983.



maggie's bag

NOTE:
Maggie Tallman, *Phoenix* Business Manager, has a sharp eye for everything that crosses her desk and her path.

Rights for teens

There's an "easy-to-read" booklet available now that explains the basic legal rights of young persons in Ontario.

Under 18: Your Rights summarizes the law dealing with education, employment, welfare, parental support, custody and access, medical treatment, counselling, child protection (The Child Welfare Act), the Young Offenders Act, residential placements and rights when in detention, custody or residential care.

Sounds like a handy guide for young and older alike; reasonably priced at $2.00 per copy for institutions and $1.00 for individuals. 40 pages, with illustrations. Contact Justice for Children (the publishers), 720 Spadina Avenue, Suite 105, Toronto, Ontario, M5S 2T9; phone (416) 960-1633.

Letter opens doors

The Coalition for Alternatives in Mental Health in Berkeley, California recently raised $4,000 from a fundraising letter and has opened the doors to a centre, staffed by former "mental patients." The groundswell of support they received for a user-controlled centre confirms that current and former psychiatric inmates, wherever they are, yearn for alternatives — real choices.

Jesse James rides again

Just by way of information from other 'Network' publications, I noted an interesting paragraph in a letter sent to us by *The Prison Mirror,* Box 55, Stillwater, MN 55082 — and I quote: *"The Prison Mirror* is the oldest continuously published prison newspaper in the United States. It was founded by members of the Jesse James gang incarcerated at the old territorial prison near here in 1887."

The thought came to mind that it would be great to have that name on our letterhead as a founding member, or listed on the board of directors — and last but hardly least, in charge of our fundraising. The "Mirror" is a great publication from which we hope to hear more. Keep on riding!

Our brothers' keeper

Major steps forward are possible! For five years a group has been working toward a new Halfway Home for chronically institutionalized people. The dream began five years ago when a Catholic priest, Father Massey Lombardy, and a Quaker prison abolitionist, Ruth Morris, shared friendship with a very institutionalized prisoner. Even though they were unable to help Mike last 48 hours on the street, from that failure they conceived a kind of home which would welcome the Mikes of our world: men who have spent most of their lives in prisons and mental hospitals, few knowing homelife in the usual sense.

Because of their long record of failure in all settings, they are diagnosed as "unmotivated," and yet by their late 20's and early 30's they are as motivated as they can be by a real terror of life inside and outside. What they need is a small, caring, intensive, helping atmosphere that will offer them a real home, even this late.

For 2 1/2 years they fought for adequate funding to insure plenty of staffing. After Ontario Ministry of Community and Social Services — supplemented in part by both correctional ministries — came up with this, they spent the next 2 1/2 years struggling for a location. This summer, they will be opening their doors at last.

They are determined that "My Brothers Place" will offer a first chance at many basic rights to a group of people who have seldom had that chance before.

(*Ed. Note:* It is appropriate to celebrate this event in an issue dealing with human rights — our congratulations.)

Making the time count

The economic rights of people with disabilities were spoken for recently by ON OUR OWN co-ordinator, Carol Stubbs. On June 18th, Carol spoke at a public hearing of the federal government's *Task Force Committee on Equality Rights* held in Toronto.

Although the Committee only allowed her and other spokespersons for the disabled (Beryl Potter, Mike McHenry and Sheri Stein) five minutes each, Carol's impact on the committee was such that they congratulated her for her outstanding presentation. It was clear, definitive, truthful and positive — and in five minutes that's a major accomplishment in itself. But WE ARE BEING HEARD! Hopefully, soon we'll be answered.

Keep in touch

Please, Please, Please — Keep us in mind when you move, are released, discharged, paroled, change your name, leave the country, go underground or whatever. Losing your address means your issues of *Phoenix Rising* are returned to us. Every copy returned costs us full postal charges, which depletes our small postage budget considerably. We need to know where you are, we need to know how you are ... please keep us up to date.

We'll miss you, Margaret

There are times in our life when news is not good, or easy to write. In this particular case, it is with great sorrow that we inform our readers of the death of Margaret Frazer, on June 20, 1985.

More important than all the credits that could be listed is the number of tangible and intangible ways this lady has touched so many lives.

As a retired school teacher, she became very involved with "Nellies" a Toronto Hostel for women in crisis. Early in 1984 when Nellies opened a home for women ex-psychiatric patients, it became "Margaret Frazer House."

Margaret's choice was to die at home — and this she did. But, she didn't die alone — she was with part of the family of 60 people, friends who loved and respected her, and for the last four months of her life cared for her in shifts. Margaret Frazer was never alone.

As June Callwood, a Toronto writer, founder of Nellies and a good friend of Margaret's stated in her article in the Globe and Mail "Nothing in her beautifully realized life, however, used her inner splendor so completely as her dying."

She shall be sadly missed — but lovingly remembered.

Way to go, David

OUR CONGRATULATIONS TO DAVID REVILLE FOR WINNING A SEAT IN THE ONTARIO PARLIAMENT DURING THE MAY '85 PROVINCIAL ELECTION.

DAVID REVILLE — "ON OUR OWN" MEMBER, A FORMER TORONTO ALDERMAN, RIGHTS ADVOCATE AND NEW DEMOCRATIC PARTY M.P.P. FOR TORONTO'S RIVERDALE RIDING — WE SALUTE YOU!

Still Barred just out

— Social Injustice in Canada
Claire Culhane Author
Paperback - $12.95
Cloth - $25.95
Available from: Black Rose Books,
3981 boul. St-Laurent,
Montreal, Quebec
H2W 1Y5

In 1976 Claire, as a member of the Citizens' Advisory Committee at the B.C. Penitentiary, was an eyewitness to the events described in her book *Barred From Prison: A Personal Account* (Pulp Press 1979)

Since then her work as a member of the Prisoner's Rights Group has taken her across Canada and to the United States and Europe. She has been active in the International Conferences on Prison Abolition (Toronto 1983, and Amsterdam 1985). *Still Barred from Prison*, her new book, tells by its very title how much work is still to be done.

She shares her unique experiences as a prisoners' rights activist struggling to reform the criminal justice system, and provides an extensive history of Canadian prison upheavals in recent years. She offers alternatives to this inhuman and costly system and even makes a case for shutting down prisons altogether.

Hopefully folks, we will have a review of "Still Barred" in our next issue. Claire isn't resting between books, and we're trying to follow her example.

Happy 25th, Constructive Action

The latest issue of the *Constructive Action Newsletter* just arrived in our office. CAN, put out by Shirley Burghard, R.N., of Syracuse, New York is one of the oldest Newsletters in existence—celebrating its 25th year of publication in 1985. As Shirley says, "25 years of fighting the depersonalization, dehumanization and victimization of psychiatry — the peer mutual group and personal self-help way." She has let none of the usual deterrents stop her and has constantly moved on. CAN is self-supporting — "We do not accept any government grants or money from shrinks." The subscription rate is $10.00 per year for twelve issues. We would urge any Canadian subscribers to send a Postal or Bank money order IN AMERICAN FUNDS. Donations are gratefully accepted, because the subscription fee doesn't even cover the printing and handling.

Good wishes, donations and subscription requests may be forwarded to *Constructive Action Newsletter,* c/o Shirley Burghard, 710 Lodi Street, B1104, Syracuse, New York 13203. Shirley's a lady who's put action where her heart is, and we wish her all the best in the future.

Turning over a new LEAF

The founding meeting of the Women's Legal Education and Action Fund was held in Toronto mid-April with representation from every province across Canada. LEAF's aim is to assist women to exercise their constitutional rights under the new equality guarantees of the Charter of Rights and Freedoms.

Addressing the meeting, LEAF's newly appointed president Sheilagh Day said, "It is essential that women exercise these new rights, since women's equality is still a promise, not a reality. It is our object to advance women's equality by supporting strong cases which address the real disadvantages of Canadian Women. We also intend to provide public education and research on equality issues."

She further commented: "As a new organization our first task is to raise the money needed to do this important work on women's behalf. The Charter guarantees will be of no real value if women who need to use this legal tool cannot afford to do so. We begin this new era for equality rights with a real hope. We hope that as the Charter guarantees are interpreted and applied, they will seriously and broadly express the real equality which Canadians experience."

Ms. Day brings to her position a long background of 'standing up.' She is the former director of the Saskatchewan Human Rights Commission and the President and Editor of the *Canadian Human Rights Reporter.*

To prove that LEAF is not sitting on its laurels, the organization has already backed a case in Ottawa wherein Sheila Beaudette launched a legal challenge under the equality rights provision of the Charter.

Ms. Beaudette was denied mother's allowance benefits under the "man-in-the-house" clause of the provincial *Family Benefits Act.* The regulation says that a parent loses his or her benefits if he or she does not live as a "single parent." As the mother of a six-year-old son, she received mother's allowance for about four years until July 1984, when the Provincial Ministry of Community and Social Services decided she was no longer living as a single person because she was having a relationship with a man.

After two unsuccessful appeals to the Social Assistance Review Board she is now appealing to Divisional Court using Section 15 of the Charter which guarantees equal treatment to all Canadians.

Beaudette's lawyer, Helena Orton says that "The effect of the regulation is that if a woman has a relationship with a man, it will be assumed she is economically dependent on him and that he will financially support her and her child ... even though he has no legal obligation whatsoever to support her or her child." The case is not expected to be heard until later this year.

LEAF is also sponsoring a case in which Suzanne Cowan of Whitehorse is appealing to revert to her maiden name. The Yukon Territories' *Change of Name Act* says "no married woman shall, during the life of her husband, apply for a change in the surname acquired from him."

The Women's Legal Education and Action Fund seems determined to live up to its name. We welcome this new "action" organization.

Still Sane: the film . . .

STILL SANE — This new Canadian film is so hot-off-the-celluloid that we're pressed for details. Everyone who saw our last issue, "Women and Psychiatry," will remember the striking cover photo of a sculpture by Persimmon Blackridge and the series of sculptures combined with dramatic text by her friend Sheila Gilhooly, a survivor of the institutional system. This 60-minute colour film is an extension of their creative partnership; it includes an interview with its creators.

Produced by Brenda Ingratta and Lidia Patriasz, *STILL SANE* can be rented from Women in Focus, 204 - 456 West Broadway, Vancouver, B.C. V5Y 1R3. Phone (604) 872-2250. (Non-profit organizations $40.00; others $70.00.)

As soon as we see it we'll review it.

. . . and the book

STILL SANE, coming from Press Gang Publishers, fall 1985. based on sculpture series by Vancouver artists Persimmon Blackbridge and Sheila Gilhooly. Combines visual images with narrative text. A document of three years Gilhooly spent in psychiatric institutions for being a lesbian.

The publisher says: "Many of the images are disturbing and painful, but the overriding theme is defiance and survival. The final piece is a smiling figure with the words 'still sane' emblazoned triumphantly across her chest."

"In a world where we are kept in line with the often unstated threat of being locked up, it is crucial to know that we can maintain our choices and identities

even in the face of psychiatric oppression. This is the message of *Still Sane.*"

27 reproductions (colour and black and white) of the original sculpture series, articles by the artists and others, and a resource list of anti-psychiatry and mental patients' liberation groups in Canada and the U.S.

An expensive production by a small publisher. Contributions requested so selling price can be kept low. Contact Press Gang Publishers, 603 Powell St., Vancouver, B.C. V6A 1H2, Canada.

Love and Kisses

The Network is so important! On Our Own's Mad Grapevine, under the free and endless efforts of Jane Bowden, with free and endless assistance from Anna Schwab, helps keep our membership together and informed. It also strikes me at the moment, that we may never have publicly said thanks. So, here you are — a belated immense hug of love and thanks. You really are appreciated.

In fact, how about some of our other patient groups dropping a line just to let them know the problems and personal profits we've all gained from being together — but ON OUR OWN.

Rave review for Riverview Reporter

Riverview Reporter deserves one helluva pat on the back. It's a patient-produced paper from New Westminster, British Columbia, started out as an idea from reading a copy of *Phoenix Rising* (Yes, Virginia — we do accept minor credits too!)

But, no matter where the "idea" came from, the important thing is it has gone past that to become a reality. More important the idea worked!

Anyone interested in submitting material to *Riverview Reporter* please write to Michael Faith, 380 Pioneer Place, New Westminster, British Columbia, Canada V3L 3S8.

We are being heard

Speaking of being heard — Don Weitz, member of the Phoenix Rising Editorial Staff is at it again! As a mover within the Ontario Coalition to Stop Electroshock, he attended the Consensus Development Conference on Electroconvulsive Therapy (Electroshock), from June 10-12 in Bethesda, Maryland.

The Conference was sponsored by the National Institute of Mental Health and had a definite pro-shock/pro-psychiatry bias. However, Don and a number of shock survivors and other ex-inmates publicly criticized the conference and shock. Once again — WE ARE BEING HEARD.

It isn't sufficient that we only associate with those that agree with our beliefs — we must be around to answer for our opinions, and possibly more important, let them be heard. Even having a pro-shock doc come up to buy a "stop shock" button for *nostalgia* purposes lets us know that the movement cannot rest.

It's all in *our* minds

A dozen people, all past or present psychiatric patients, get together at a house in the country. Among them are Louise who is recovering from a recent relapse, and Raymond who is again struggling to stay afloat. For Suzanne, confronting her insanity remains a distant goal.

Followed by the film crew, the group talks about insanity, attempting to convey the roles played by hospitals, family and friends, recreating on video scenes from their psychiatric experiences. They support each other in their search for themselves and their anguish, avoiding neither confrontation nor questioning.

Not Crazy Like You Think is a documentary on insanity with strong emotions, moments of extraordinary patience, and intense conflict. But, it is also about making a film that runs the risk of voyeurism, because here the participants refuse to be exploited for who they are or to have their experiences reinterpreted by experts. Instead, they insist on a vision of craziness that is all their own.

Jacqueline Levitin, a professor of Film History and Criticism at Concordia University in Montreal, decided it was time for a look at insanity without the usual authoritative gospel from those in the psychiatric field. The "actors" belong to a self-help group called Solidarité Psychiatrie; they present an alternative view of psychiatric patients — ordinary people who are too often assigned to the clinical studies of doctors.

Ms. Levitin insists that the viewers acutely sense the thin wall "between what is sane behaviour and what is considered insane behaviour. What I'm trying to say in the film is that all people have the potential to become insane. Some of us are just lucky enough to never have been caught." She labels her film an "anti-institution" documentary, a film that questions the drug-doling activities of our hospitals and institutions.

She has packed one-and-a-half years work with the group into 73 minutes which she hopes will reach an ordinary audience and get them involved with a serious problem in society.

Pas Fou Comme On Le Pense has been highly praised as an example of the "dramatic" documentaries now being made in Quebec; it will be featured at the Festival of Festivals in Toronto this fall.

French/English version available from:

Cinema Libré, 4872, rue Papineau, Montreal, Quebec H2H 1V6	DEC 229 College Street, Toronto, Ontario M5T 1R4.

How's this for a lesson in true sanity?

Just the other day, I got on a crowded bus right around rush hour. Everyone was hot, tired, and just a little bit grumpy — but nothing to compare with the surly mood of the bus driver, who grumbled, griped and growled at each passenger as if it was all he could do just to force himself to accept their fares.

As I groped for an inch of floor space, I noticed a very slight, timid-looking man, clutching a bus ticket and leaning questioningly toward the driver. "Excuse me, sir?" he asked, haltingly, "but do you know... does this bus go to Eglinton?"

The driver glared at him as if he'd suggested the commission of a criminal offence, perhaps the murder of a close personal friend. An accusing finger jabbed the corner of the fare receptacle. He snapped, "Put it in the box, buddy!" and promptly turned his less-than-welcoming attention to the next passenger.

Gripping his ticket even more tightly, the bewildered passenger looked down at the box, then gazed up at the driver even more tentatively than before. "I'm sorry, sir?" he asked again, "but I'd like to know if this bus goes to Eglinton?"

Closing the doors (somehow avoiding the amputation of a struggling passenger's foot) and jerking the bus with spasmodic deliberateness toward the still-red traffic light, the driver pointed his ever-accusing finger and bellowed again, "In the box, buddy!"

"Excuse me, sir," the man said, speaking in the same quietly deferential tone — but this time addressing his request directly into the opening of the fare box, "Does this bus go to Eglinton?"

Prison alert

The PRISON JOURNAL just arrived at our offices and was read from cover to cover — great! Further correspondence to the Prison Education Programs brought forth the following response which I am sure will be of interest to our readers. "It can be distributed on request to individuals in prisons, halfway houses or other institutions. We are asking for subscriptions from anyone else interested in receiving copies. We also welcome written submissions to the Journal from any interested parties."

$7.50 will pay for Issues No. 4, 5 and 6. Requests, donations and/or subscriptions may be forwarded to: The Editor, *Prison Journal,* SFU/Prison Education Program, Office of Continuing Studies, Simon Fraser University, Burnaby, B.C. V5A 1S6.

Closing the Psychiatric

Away from the "madhouse" mentality: first step

by Pat Capponi

First, let me say categorically, that I wholeheartedly support and endorse the closure of Italy's psychiatric institutions and the liberation of the patients encased within them. Mistakes have certainly been made in the process, but that in no way diminishes the great victory progressive psychiatrists and leftist politicians have won. The time of large, dehumanizing institutions is long past, and anyone who looks at them objectively must reach the same conclusion: they must close.

In Canada today, concern for the welfare of the incarcerated individual remains secondary to the determination to retain provincial hospitals at all costs. Governments are reluctant to take on the medical establishment, pharmaceutical companies, and unions, all of whom are more interested in preserving their lucrative positions than in ensuring that those roles are therapeutic and constructive.

Our provincial hospitals exist primarily to provide many people with regular paychecks; to keep off the street those individuals who might offend the public's sensibilities, and to serve as a punitive foster home for people whose families are unable to cope with their behaviour.

Victims of institutionalization

Institutions cause more illness than

Institutions in Italy

they purportedly cure, and the staff is no more immune than are the patients. Any ward of any provincial hospital reveals the same scene: patients bombed on medications sprawled across couches and chairs; others placed in front of television sets, staring blankly at screens that are turned on all day and most of the evening, as nurses huddle in glass-walled offices for mutual protection. Psychiatrists dash in and out, clutching file folders and looking professionally harassed, so that none dare approach. It is easy to pick up on the patronizing tones staff members use when addressing patients; as though they were speaking to a recalcitrant child, or confronting the manifestation of a psychosis. To patronize anyone in this way is a form of personal abuse—denying them autonomy in the name of authoritarian demands or paternalistic concerns. And all too often patients are subjected, as well, to direct verbal abuse.

The staff are as much victims of institutionalization as the patients; hospitals tend to dehumanize them and blunt their humane responses and emotions. Custodians develop a self-protective insensitivity that allows them to continue working in an environment which clearly does more harm than good. They *must* perceive the patients as existing on a radically lower level than everyone else in order to rationalize the way they treat their charges.

This concern for the maintenance of the institution and the livelihood it provides, rather than for the welfare of the clients, manifests itself most clearly when a patient is discharged. The community outside the hospital walls is seen as an amorphous holding pen for chronic patients until they are readmitted.

For years no effort was made to help provide a viable existence for discharged patients. Administrators of provincial hospitals could point to a 50 percent recidivism rate as proof of the need for institutional care. Now—here at Queen Street Mental Health Centre at least—token efforts to expand the lists of available accommodation, and a feeble attempt to create an outpatient department, are used as smoke and mirrors to hide the lack of real activity. (Of course the hospitals are full: we may be crazy but we're not fools. At least there are three meals a day, a roof over one's head, and enough dope to make the hospital bearable.) Were there real alternatives out there—in housing, education, recreation and vocation—and if there were a chance of earning an income within a stone's throw of the poverty level, the numbers in the hospitals would drop drastically.

It is too easy for doctors to believe their own propaganda; it is too easy for some families of "chronic patients" to take refuge in the word chronic—to stop hoping for anything different or better for their son, daughter, wife, or husband. I suppose it is emotionally easier to distance oneself from the person and only consider the disease, but that leads to outrageous demands upon basic freedoms and individuality: demands like the automatic arrest, for failure to take their medications, of those labelled schizophrenic. A person's rights cannot be tailored to fit others' needs, even if those others are relatives.

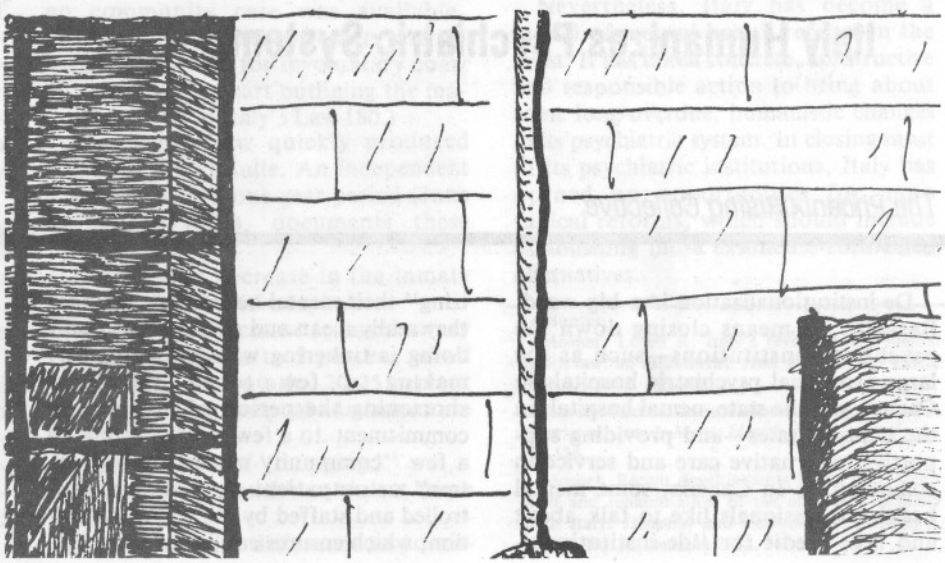
Ravaged by the system

It is too easy for therapists to believe that they know what is best for patients, and to complacently argue against hospital closures. The most pious and self-serving statements came from professionals and union leaders during the debate over the closure of Lakeshore Psychiatric, and they are being repeated as ComSoc (Ontario Ministry of Community and Social Services) closes the institutions which have for so long isolated the mentally handicapped. We never hear from these people until their livelihood is threatened, then they gear up to "protect their clients." There was no concern expressed about the ravaging effects of neuroleptics, no concern that people were being turned into drooling automatons . . . because the needs of the institution were being met by such "treatment."

Of course, there are individuals so ravaged by the system and its labels that they would be hard pressed to survive outside. Italy's conversion of some wards to dormitories is a good compromise, as long as it is not practised too extensively.

I have some concern that Italy has chosen to make mandatory the hiring of institution staff for work in their community mental health centres, while not mandating funds for their re-education and retraining. Although it is possible that that country had a better mix of staff, (because there were no psychiatric wards in general hospitals), it has been our experience in Ontario that provincial hospitals attract those most comfortable with rigid hierarchies, rules, keys, and non-involvement. Staff psychiatrists tend to be those who need the training background, or who are unable or unwilling to take their chances in the more lucrative open market. There are exceptions—those people who want to make a difference—an impact. All too often these few are frustrated by co-workers, or distrustful administrators, and either succumb to the general inertia, toe-the-line, or quit.

A community setting is very difficult



from the ultra-structured ward environment, with its 'safeguards' of authority figures and Code 99's (institutional emergency codes)—and where a captive audience has to play by the hospital's rules. Staff who have succumbed to institutional life have also adopted institutional attitudes; there is a large question whether, without substantial reorientation, they will ever be able to see the individual rather than the "patient"—the latter being someone who must listen to what's best, and passively comply with a variety of "medical treatments." Institutionalized staff trying to work in the community will naturally attempt to carry their walls and their authority with them, and to recreate the hospital environment in mini-institutions outside. We have seen this here in Parkdale, at Archway Mental Health Clinic, an aptly-designated "satellite" of Q.S.M.H.C. (Queen Street Mental Health Centre). The hospital, perhaps sensing its death throes, shows great distrust and confusion when confronted by real community mental health workers. It distrusts the "new, unhealthy" perception of numbered patients as individuals, free to accept or reject therapy; it is suspicious of community involvement on what was formerly its private turf; it distrusts the community's lack of awe in the face of official directives. The ingrown city-state that Q.S.M.H.C. has become forbids the development of genuine community care, and fearfully tries to replace community oriented therapists with institutionalized staff who suffer agoraphobia when they step outside their offices.

While it would be an exaggeration to say that all institutional staff are incapable of working in the community, it is ludicrous to think that they are all capable of making such a profound transition—or that they even sincerely want to. Chronic patients are keenly sensitive to tone and realities; that is why more and more of them are rejecting traditional psychiatric care—even at the risk of going it alone. We must do more than just remove the institutions' walls: we must ensure the dignity of the client by ensuring the quality of the worker. Our primary concern must be for the victims of our mental health systems, not for its employees, or others who benefit from its existence.

I was troubled as well by Dr. Mosher's description of the typical staffing component of the community mental health centres in Italy. The list included two to four psychiatrists, 20 nurses, two to four social workers, and two to four psychologists; they describe the " . . . most critical aspect of their work . . . as dealing with their clients' social problems, such as vocational adjustment, living arrangements, and social support." In my experience, Canadian psychiatrists would be hopelessly outside their own realm of experience and knowledge in trying to advise people on such practical matters.

Seeing the person first

The emphasis on "professionals" is an alarming continuation of the institutional approach—an unhealthy concession to the medical establishment, especially since the team leaders are psychiatrists. Although I am lead to understand that psychiatrists in Italy earn a lot less than their counterparts here, and are regarded with less awe (even to the point of being required to make housecalls,) I have yet to meet a psychiatrist who could deliver frontline, hands-on assistance. Nurses, as well, are trained in care-giving, rather than in facilitating an individual's growth and independence. Surely the community and clients would be better served by para- or non-professionals who are less likely to have learned all the wrong techniques, and who still have the audacity to see the person first and the problem second.

The most disturbing aspect of Italy's radical moves is that, according to Dr. Mosher's article: "the quality of life of the ex-patients . . . their possible exploitation in the community, their level of functioning, the readmission rates . . . remain largely unevaluated." It would seem that the first priority of the liberation movement should be to ensure that ex-patients, once released, are not left friendless and to their own devices.

Having heard Dr. Crepet and Dr. Mosher, I remain uneasy. Those labelled mentally ill have always been on the receiving end of other people's decisions: to incarcerate them, to lobotomize, tranquilize, shock, sterilize, and then to release them. In Canada this callous process affects so many, and community preparation is so inadequate, that their suffering usually increases greatly when they are released. In Italy there have been at least some efforts to properly prepare, and there seems to be no fiscal motivation to clear people out quickly.

Nonetheless, I would feel happier if representatives of the de-institutionalized of Italy had been here today with Dr. Mosher, to tell how it is for them. Nothing can take away from the great achievement of closing the institutions, but that should and must be the beginning and not the end of the liberation of the psychiatric patient.

(Ed. Note: Pat Capponi is an ex-psychiatric inmate and the editor of The Cuckoo's Nest. *She delivered this speech during a public symposium on de-institutionalization, co-sponsored by the Toronto Board of Health and Queen Street Mental Health Centre, at 'Queen Street' on October 11, 1985. We've edited the speech slightly.*

Italy Humanizes Psychiatric System

The Phoenix Rising Collective

De-institutionalization is a big word. Basically, it means closing down the psychiatric institutions—such as the large provincial psychiatric hospitals in Canada and the state mental hospitals in the United States—and providing supportive, alternative care and service in communities. In Canada, some mental health professionals like to talk about and take credit for "de-institutionalizing" their mental health system. What they really mean and what they're really doing is tinkering with the system by making a few token reforms—shortening the period of involuntary commitment to a few weeks; setting up a few "community mental health centres" or outpatient drug clinics (controlled and staffed by the parent institution, which ensures continued drugging, dependency and alienation); or funding a few, strategically located halfway houses or group homes (also usually staffed by mental health professionals).

More psychiatric abuse

During the last five to ten years in Canada and the United States, one direct effect of government-led de-institutionalization has been the tragic

epidemic of "dumping"—institutional discharging of psychiatric inmates into the street with little or no money, no jobs or job-training opportunities, no decent affordable place to live, no solid social or community support, no hope. This practice has had a sad but predictable result—the return of thousands of ex-inmates (usually involuntarily) to psychiatric institutions or prisons, sometimes two or three times in the same year. The mental health professionals like to label this horrendous, institutionally-created crisis the "revolving door syndrome" or "recycling patients." Psychiatric inmates and ex-inmates just call it more psychiatric abuse. (The average yearly readmission rate in Ontario's psychiatric institutions has been 60-66 percent for many years.) So long as psychiatric institutions and psychiatric ideology exist, no real de-institutionalization is possible.

However, in Italy, de-institutionalization is becoming a reality. Because of the intitiatives of the Society of Democratic Psychiatry and the Government of Italy (a coalition of social democrats and communists), many of its large institutions have been closed and humane, community-based services are being set up to replace them. So far, Italy is the only Western industrialized country which has committed itself to radically reforming its mental health system.

The reforms began in the late 1960s and the early 1970s, (particularly in 1972), with the birth of the Society of Democratic Psychiatry, a vocal group of leftist psychiatrists and mental health workers who broke ranks with the traditional psychiatrists. Democratic Psychiatry, under the leadership of the late Dr. Franco Basaglia, committed itself to these policies and principles.

(1) Psychiatry is political

(2) Traditional psychiatry supports the existing political establishment.

(3) Traditional psychiatric standards of normality and deviance ("mental illness") have led to the oppression of certain minority groups.

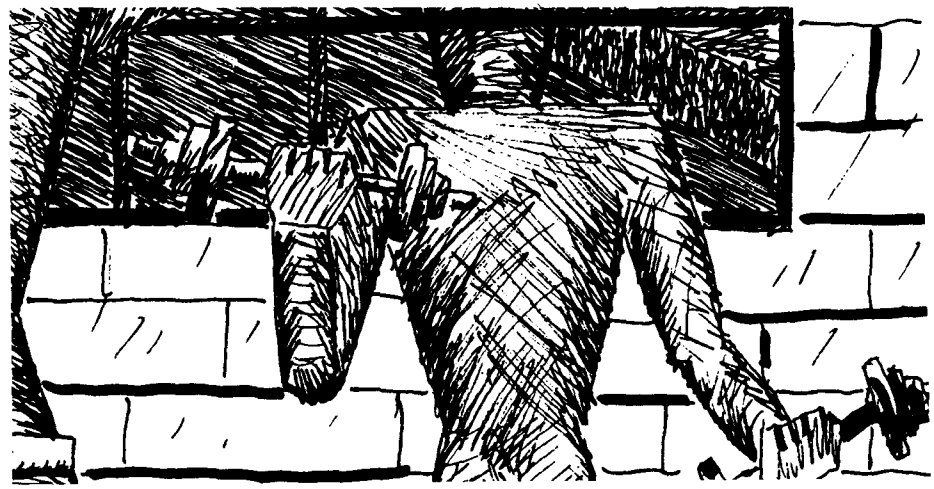
(4) Commitment to non-medical approaches to therapy and rehabilitation including job-training and community involvement.

(5) Abolition of electroshock, lobotomy and mechanical restraints in the mental hospitals. (Electroshock still exists in some hospitals.)

(6) Closing all mental hospitals because they're dehumanizing and damaging.

(7) Providing community-based social and vocational services for patients such as community mental health centres.

(8) Breaking down the traditional patient/staff barriers, including stereotyping "mental patients," in hospitals and communities.[1]



Phasing out hospitals

Dr. Basaglia and his co-workers put most of these principles and policies into action in Trieste and a few other towns in Italy in the 1960s and the 1970s. Impressed with the good results of these social experiments and the political pressure and growth of Democratic Psychiatry, which aligned itself with the union movement, the Government of Italy passed its historic mental health law in 1978—Law 180. Although the new law (the first revision of Italy's mental health laws in 74 years) did not specifically order the closing of all mental hospitals, it did encourage their phasing-out and their replacement with community-based programs and services. For example, under Law 180, no new mental hospitals could be built starting in 1979; all new patients could only be admitted to small psychiatric wards (maximum of 15 people) in general hospitals; these wards must be linked to community programs and services. Also, people could only be involuntarily committed to existing mental hospitals, if their condition was judged "urgent" by two psychiatrists *and* the Mayor, if they refused hospital treatment, and if no community care was available. Dangerousness to self or others was no longer a criterion for involuntary committal. (See the chart outlining the major provisions of Italy's Law 180.)

Italy's new law quickly produced some startling results. An independent study covering a one-year period (June 1978-June 1979), documents these results:

(1) 18 percent decrease in the inmate population in mental hospitals.

(2) 60 percent decrease in involuntary committals (down to 5 percent of all admissions—in Ontario, 20-25 percent of all psychiatric hospital admissions are involuntary.)

(3) little evidence of "dumping."

(4) no increase in suicide or violent crime by ex-inmates.

(5) no significant difference in admissions to private psychiatric hospitals.

(6) no increase in the inmate population in forsenic hospitals (similar to Penetang, or METFORS in Queen Street Mental Health Centre.)[2,3]

Model of reform

Encouraging as the "Italian experiment" is there are still problems. For example, virtually all of Italy's community mental health centres are staffed by psychiatrists and other mental health professionals instead of ex-psychiatric inmates and lay people. However, in these community health centres, which are under local or regional control, there is much more power-sharing than there is in similar centres in Canada or the United States, and people's problems are generally not medicalized or psychiatrized. Also, the closing of Italy's mental hospitals and their replacement with the community health centres has not been uniform or total. Most of the closures have occured in Italy's northern and central regions. Southern Italy and the traditional psychiatrists are still resisting these radical reforms, and the federal government is apparently not providing sufficient funding to speed the closing of all of its mental hospitals.

Nevertheless, Italy has become a model of mental health reform in the West. It has taken concrete, constructive and responsible action to bring about some long-overdue, humanistic changes in its psychiatric system. In closing most of its psychiatric institutions, Italy has opened up opportunities for more radical reforms, which should include establishing more ex-inmate-controlled alternatives.

Footnotes:

1. Mosher, Loren R. Italy's revolutionary mental health law: an assessment. *Am. J. Psychiat.* 139:2, February 1982, 199-203.

2. Mosher. Radical de-institutionalization: the Italian experience. *Int. J. Ment. Health.* Vol.11, No.4, pp. 129-136.

3. Mosher. Recent developments in the care, treatment and rehabilitation of the chronical mentally ill in Italy. *Hospital and Community Psychiatry.* Vol.34, No.10, October 1983, 947-950.

Italian reform hampered by lack of community focus

by Dr. Tyrone Turner

(Ed Note: Dr. Turner is the Administrator of the Ontario Health Ministry's Psychiatric Patient Advocate Office. This report is based upon his recent visit to Italy where he attended the Eleventh International Congress of Law and Psychiatry held in Florence on March 18-20, 1985.)

The general consensus of delegates at the Congress was that the 1978 Italian psychiatric reforms have been only partly successful. Many reformers, psychiatrists, lawyers, jurists and consumers agreed that the principal problem has been the failure to provide community alternatives to replace the old mental hospitals. Except in some regions, community-based care, housing and jobs have not been provided to people who were de-institutionalized by Law 180, which in 1980 closed all state-run mental hospitals.

Ongaro Basaglia, the widow of Dr. Franco Basaglia, founder of the Democratic Psychiatry movement, and a senator from Venice, blamed the government for avoiding its responsibility to psychiatric inmates and former inmates. In fact, the problem was built into Law 180, because it provided no money to implement the reforms. Basically, the responsibility for funding alternate community-based services and programs was passed from the federal government to regional governments (similar to our provincial governments). Some regional governments followed the spirit of reform and provided money for community care, others did not.

Overall improvements

There have been notable successes in the regions of Tuscany (surrounding Florence), Emelia (surrounding Bologna) and Rome. For example, some Tuscan cities have a full array of supportive housing which even includes independent apartments. In Rome, psychiatrists actually make house calls, and suicidal persons can be cared for at home by a 24-hour attendant, instead of going to a hospital. However, in some areas where the reforms have not been accepted, de-institutionalized patients with nowhere to go ended up back at the old mental hospitals, which have been renamed "hostels." One such "hostel" in Verona in the north of Italy was originally a hospital for 1,000 patients. Now, it houses approximately 600 residents — many behind locked doors.

Nevertheless, some overall improvements have been made. A nation-wide network of community mental health centres has emerged. Some are attached to general hospitals, others to community health centres. Nurses, social workers and psychiatrists provide care at these centres. The centres are linked to both general practitioners, who provide most of the country's mental health care, and psychiatrists who administer beds in general hospitals (a maximum of 15 beds are allowed in any one hospital). The mental health centres make it easier for mentally distressed people to obtain care outside the hospital. (The greater reliance on community-based care is reflected in the number of psychiatric beds per 1,000 population in Italy, as compared to Ontario. In Italy, there is 0.5 bed/1,000 population. In Ontario, there is approximately 1 bed/1,000.)

Compulsory admissions drop

The reforms have also helped to bring about a major reduction in coercive hospitalization. In the first year after the reform was enacted, there was a 60 percent decrease in compulsory admissions. Now, only two percent of all psychiatric admissions are compulsory. This is very similar to generally low civil commitment rates in other European countries. In Denmark, West Germany and Great Britain, the civil commitment rates are less than five percent of all psychiatric admissions. However, in Ontario, the commitment rate is 20 percent, at least four times higher than the European rates. Participants at the Congress attributed Italy's low commitment rate to increased legal safeguards built into the commitment process, and increased availability of community-based psychiatric care. One psychiatrist said, "If, instead of being taken away to the hospital, you could get care at home, or in your community, you would be more likely to volunteer."

In summary, the Italian reform began dramatically with an attempt to resocialize psychiatric patients, but it has been frustrated by the lack of community alternatives to replace the old mental hospitals. Nevertheless, there has been some increase in community-based care and a marked reduction of compulsory hospitalization.

Mental Health Laws in Italy

Major provisions of Italy's mental health law of 1978 (Law 180)

Inpatient care of involuntary admissions

As of the law's effective date, January 1, 1979, no new (that is, never-hospitalized) patients may be admitted to large state hospitals. Former hospital patients may be admitted voluntarily until December 31, 1980; after that, no patient may be admitted.

Patients may be admitted to psychiatric wards in general hospitals; the wards can have no more than 15 beds and must be an integral part of community-based programs. Construction of new psychiatric wards or use of state hospitals as general hospital psychiatric units is prohibited.

Compulsory admissions

Compulsory admission to a general hospital ward may take place if urgent intervention is required, the necessary treatment is refused, community treatment cannot be opportunely implemented, and two doctors and the mayor or his designate deem care and rehabilitation necessary.

Independent judicial review is required at two and seven days.

The patient and his or her relatives may appeal the decision to the mayor or the courts.

These standards must be applied to patients currently held involuntarily in mental hospitals.

The constitutional rights of involuntarily admitted patients must not be violated.

Other provisions

Community-based programs will be responsible for a prescribed geographic area of about 100,000 population.

All facilities will be staffed by existing mental health personnel.

As of October 1, 1980, medical and social welfare monies will be pooled and distributed on a per capita basis within each region.

(*Reprinted from* Hospital and Community Psychiatry, *Vol. 34, No. 10, October 1983.*)

Rights and Wrongs

Hospital cited in Haldol overdose

HALDOL OVERDOSE: FAILURE TO RESPOND TO PULMONARY CONDITION: RESPIRATORY ARREST: WRONGFUL DEATH: SETTLEMENT.

(Source: *Association of Trial Lawyers of America Law Reporter,* vol. 27, September 1984.)

Moran v. Botsford General Hospital, Mich., Wayne County Circuit Court, No. 81-225-533 NM, Oct. 1, 1984.

$437,500 settlement for the wrongful death of a 21-year-old tool and die maker-trainee following an overdose of Haldol at defendant hospital.

Decedent suffered severe traumatic injuries in an auto accident with an intoxicated driver. He was taken to defendant hospital where a series of corrective operative procedures were performed. While recovering, decedent developed a lung infection and abscess which impaired his respiratory status. During treatment for this, defendant psychiatrist was called in for a consult due to plaintiff's increased fear of physicians. After an examination, Haldol was prescribed. After three administrations of Haldol, decedent suffered a respiratory compromise requiring oxygen therapy. Although Haldol was noted as the cause of decedent's respiratory distress, it was readministered by another physician. The next day, plaintiff suffered respiratory arrest. Unsuccessful attempts were made to contact the attending and treating physicians. By the time a house resident responded, decedent had suffered irreversible brain damage and was comatose. He remained in a coma for 5½ months, until his death. Decedent, who earned approximately $7,500 annually, is survived by his parents and three siblings.

Suit alleged negligence in failing to respond to decedent's pulmonary condition, overly sedating him with Haldol despite known side effects of inhibiting proper respiratory function and failing to follow appropriate hospital policies regarding attending physician's responsibilities.

The parties agreed to the following settlement: the hospital contributed $225,000, the internist $90,000, the psychiatrist $67,500 and the surgeon $55,000. In addition, plaintiff received $40,000 from the driver of the auto which struck him and $70,000 on a dram shop claim, for a total recovery of $547,000.

Man faced federal discrimination

HANDICAP DISCRIMINATION: DENIAL OF FEDERAL EMPLOYMENT ELIGIBILITY: PROOF OF RECOVERY FROM MENTAL ILLNESS REQUIREMENT VIOLATES REHABILITATION ACT:

(Source: *Association of Trial Lawyers of America Law Reporter,* vol. 28, April 1985.)

Cook v. United States, U.S. District Court, D. Colo., No. 81-F-1298, Mar. 13, 1984.

Bench award of $58,871 in back pay, attorney fees and costs in favour of plaintiff applicant for employment under the Federal Selective Placement Program, who was denied eligibility on the grounds that he was unable to obtain medical certification that he was "mentally restored." The federal district court for Colorado previously found that the Office of Personnel Management's requirement that plaintiff submit medical proof of recovery from mental illness constituted handicap discrimination in violation of sections 501 and 504 of the Rehabilitation Act of 1973, 29 U.S.C. 791 *et seq.*

Plaintiff had been hospitalized twice for a "nervous condition" while serving in the U.S. Air Force during 1954-1963. After his honorable discharge, plaintiff regularly applied for federal employment although he was continually employed elsewhere. As a person with a history of mental illness, plaintiff was deemed a handicapped individual. To establish that he was an "otherwise qualified" handicapped individual eligible for federal employment, the Office of Personnel Management required that plaintiff show not only that he posed no danger to himself and others but also that he was recovered from mental illness. Plaintiff brought suit alleging that the requirement of proving recovery from mental illness constituted a violation of section 501 of the Rehabilitation Act which imposes an affirmative duty on federal agencies to afford equal opportunity in employment of the handicapped and that the interpretation of "otherwise qualified" to mean recovered from mental illness with respect to a mentally handicapped individual constituted discrimination under section 504 of the Act.

The court granted plaintiff's motion for summary judgment, finding that the federal agency's proof of mental recovery requirements were inconsistent with the spirit and purpose of the Rehabilitation Act. Plaintiff was awarded $58,871 in back pay, attorney fees and costs.

Girl attempted suicide in hospital

HOSPITAL LIABILITY: DRUG INDUCED PSYCHOSIS: FAILURE TO OBSERVE AND SUPERVISE: PATIENT JUMPS FROM ROOF: TEMPORARY PARAPLEGIA:

(Source: *Association of Trial Lawyers of America Law Reporter,* vol. 27, September 1984.)

Buckley v. Washington Adventist Hospital, Md., Health Claims Arbitration Panel, No. 80-196, Mar. 27, 1984.

$1,531,225 arbitration decision for a 17-year-old girl who broke her back when she jumped from the roof of defendant hospital while under the influence of PCP.

Plaintiff was admitted to defendant hospital suffering PCP-induced psychosis. She was medicated and placed in seclusion until she calmed down. Several hours after she was taken out of seclusion, plaintiff broke through a glass window, climbed onto the roof and jumped fifty feet to the ground in an attempt to leave the hospital. Plaintiff suffered a dislocation fracture of the spine at T-12, L-1, causing paraplegia and damaging various nerves in the pelvic area. Following two surgeries to insert metal rods to stabilize the spine, plaintiff was required to wear a full body cast for seven months. Although the

paraplegia terminated, the nerve damage is permanent, resulting in loss of nerve function, urinary and fecal incontinence and numbness in the vaginal and labial areas.

Plaintiff sued the hospital for the negligent failure to provide her with the supervision and observation required for a patient suffering drug-induced psychosis. The arbitration award included $1.5 million for plaintiff and $31,225 for her medical expenses.

Two psychiatrists penalized for sexual misconduct

ONTARIO PSYCHIATRIST EXPLOIT WOMEN PATIENTS

An Ethical Physician . . .

3. will ensure that his conduct in the practice of his profession is above reproach, and that he will take neither physical, emotional or financial advantage of his patient.

(*Code of Ethics*. The Canadian Medical Association, September, 1982.)

Recently, there have been a number of reports and press stories regarding the sexual misconduct of psychiatrists in Ontario. For example, two psychiatrists were recently exposed and penalized by the Discipline Committee of the College of Physicians and Surgeons of Ontario. These cases were reported in the College's November 1984 issue of its "Interim Report," as well as in *The Toronto Star* and *The Globe and Mail.*

Case 1: The College charged psychiatrist *Michael Stephen Ross* with "professional misconduct." Specifically, Dr. Ross had sexual relationships with two of his women patients in 1980 (ages of women not mentioned). In its charges, the College claimed that Dr. Ross: "(1) failed to maintain the standard of practice of the profession expected of psychiatrists, and (2) displayed sexual impropriety with these patients, and (3) displayed conduct or an act relevant to the practice of medicine that . . . would reasonably be regarded by members as disgraceful, dishonourable or unprofessional."

Ross pleaded guilty to the first and third charges only and admitted he was "clearly emotionally involved" with both women:" "I've done wrong and I know I've done wrong," he confessed to the committee. He also admitted he lacked "personal insight" and failed to "recognize his own need for support by senior colleagues." The College also noted that Dr. Ross "was unable to control himself."

The Discipline Committee penalized Dr. Ross by: (1) suspending his licence for only two months, (2) ordering that Dr. Ross's practice be supervised by a "specialist psychiatrist" who will screen "all new female patients under the age of 30 years" for the next two-and-a-half years, and (3) ordering his psychoanalyst to submit reports to the Registrar of the College every six months during a two-and-a-half year period.

Case 2: The Discipline Committee also charged psychiatrist *German Alvarez* of St. Catharines with "professional misconduct" under Ontario's *Health Disciplines Act.* Dr. Alvarez had a sexual relationship with one of his women patients when she was 17 or 18 for about two years, 1981-1983. This "sexual intimacy" always occurred in Dr. Alvarez's office and involved "mutual petting, leading eventually to sexual intercourse." As a result of this relationship, the woman became pregnant and then had a therapeutic abortion.

After finding Dr. Alvarez guilty of professional misconduct, the College penalized him by: (1) suspending his licence for one year; (2) ordering that during this period, Dr. Alvarez "continue psychotherapy," (3) ordering that his psychiatrist submit "reports of his progress" after six and twelve months, and (4) ordering a psychiatrist to monitor Dr. Alvearez's practice for the next two years, following the end of his licence suspension. Should Dr. Alvarez and Dr. Ross fail to meet any of these conditions, their licences will be revoked.

We hasten to point out that these two cases of psychiatric exploitation of women are only the tip of the iceberg in Ontario and elsewhere. There are at least two major obstacles to exposing this inexcusable exploitation of women: (1) women clients' fear and/or shame of exposing their psychiatrists, and (2) psychiatrists' great reluctance to report on their colleagues. In our opinion, these psychiatrists were inadequately penalized for the great and perhaps permanent psychological damage they inflicted on the women.

We urge all women who have been sexually exploited or abused by their psychiatrists to expose and charge them. In Ontario complaints of abuses by doctors should be sent to:

Dr. Michael E. Dixon
Registrar,
College of Physicians and Surgeons
of Ontario
80 College Street,
Toronto, Ontario
M5G 2E2
Tel. (416) 961-1711

Immigrant woman wins freedom from hospital

by Hélène Grandbois

Last March, as a member of the Montreal section of Auto-Psy, I had to defend the cause of a woman who had been hospitalized in a psychiatric ward by her husband because she wanted a divorce. She came to see us at Auto-Psy the day before she was incarcerated, telling us she was frightened of her husband, who was telling her that she was sick and that he would hospitalize her if she came home late — let alone if she sought a divorce.

The woman was a Spanish immigrant, who had just arrived in Canada three years before. She told us that she was terrified by the idea of being forced into a psychiatrist's hands by her husband. That same day, she and her husband had a quarrel, and the husband called an ambulance to take her *by force* to the nearest hospital. She was hospitalized against her will; the psychiatrist using the excuse that she had been violent with those who had forced her into the hospital.

After her call I went to see her, and she asked me to do something to get her out. The next day, I got to the hospital with the official form to make an appeal to the Commission of Social Affairs in Quebec City. She had to wait three weeks before the Commission heard her cause, as the Commission's psychiatrists were on holidays. During all of that time, she was harassed by both her psychiatrist and by the staff-members. She was also drugged with massive doses of lithium and Haldol. Maria-Theresa said: "They would come to me each day to tell me that I have no rights and all that thing about rights was a complete lie." After two weeks, she was just not sure anymore if she should appeal, in case she would not win and, consequently, be mistreated even worse. Her thoughts of getting a divorce were all confused, and she was not sure anymore if they were right or, if she was, perhaps, "sick" after all.

Maria-Theresa won her cause. The decision of the Commission was to let her go — if she promised to "go back to her husband and take her pills like a big girl." It could not have been more sexist, and it turned my suspicions regarding psychiatry as being a way to control people, into a certainty.

When the Commission's decision was made, the psychiatrist who had hospitalized Maria-Theresa tried to use the fact that she was on very high lithium and Haldol dosages, as an excuse to keep her in the hospital. At that point, the psychiatrists from the Commission changed their minds about their

decision. Then, when I asked if lithium could not be given in out-patient treatment, one of the two psychiatrists from the Commission hesitated. He next said to the other that he always gave lithium to out-patients, and did not see the need for keeping her on the ward if she got the proper blood tests as an out-patient. Her psychiatrist — his ego hurt — refused to give her an appointment for blood tests. We had to find another hospital in order to let her have the essential blood tests.

I am quite positive that without the support of an *ex-inmate* advocate, Maria-Theresa would have remained in the hospital for a few weeks more. It is in cases such as these that ex-inmates' support can especially be useful, because they alone know what it is like to be drugged against their will, and forced to be kept on a psychiatric ward for many reasons that have nothing to do with "mental illness."

Psychiatrist charged with fraud

(Ed Note: The case of Dr. Nundy was remanded until June 21. PR *had gone to press by the second trial date.)*

A resident psychiatrist at the Queen Street Mental Health Centre in Toronto has been charged with defrauding the Ontario Health Insurance Plan of more than $100,000. The charge is the culmination of a four-month investigation by the Ontario Provincial Police anti-rackets branch. According to police, the fraud was carried out through a private practice that the psychiatrist ran from her home between 1982 and 1984. OHIP was billed for psychotherapy on more than 50 patients. The treatments had never taken place. The psychiatrist has been suspended by the hospital. Dr. Jyotirmoyee Nundy of Mississauga is charged with fraud over $200. She will appear in provincial court in Brampton, Ont., on May 24.

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mad news

From the Southern Front

by Leonard Roy Frank

Psychiatrist ordered to pay fees in failed libel suit.

On December 14, 1984 San Francisco Superior Court Judge Roy Wonder ordered psychiatrist Allan M. Gunn-Smith to pay $10,000 to the law firm of Morrison & Foerster, which free of charge had successfully defended me and the Bay Area Committee for Alternatives to Psychiatry (BACAP) in a $6,000,000 libel suit filed by Gunn-Smith in 1979. The suit was dismissed last October because Gunn-Smith failed to actively pursue the litigation. Judge Wonder, in rejecting Gunn-Smith's defence that incapacitation from heart disease had prevented his doing so, ruled that the suit had not been "maintained" in good faith. Morrison & Foerster sought payment under a 1981 California law that allows libel defendants to recover legal fees in cases where a court rules that the suit was "not filed or maintained in good faith and with reasonable cause." This was one of the first successful actions under the new law.

Before proceeding with an account of the case and its significance, I would like to express on my own behalf and that of the other BACAP members our deep appreciation to attorneys James Bennett and Karl Olson of Morrison & Foerster, and Judith Rosenberg, formerly of that firm, for their fine work and to the firm's partners for their willingness to take on our defence as a public service.

Gunn-Smith had contended that BACAP and I defamed him in a 1979 letter mailed to more than 20 community organizations and individuals. Among other things, the letter had called attention to the fact that the California Department of Developmental Services had demoted Gunn-Smith from his position as Project Director of Stockton State Hospital's geriatric-psychiatric ward for violating Department of Mental Health policy concerning the administration of electroconvulsive treatment (ECT). The letter also charged that during the previous 15 months six elderly patients, three of whom were in their eighties, had died soon after Gunn-Smith electroshocked them.

Looking back on the case, while I felt vindicated by Judge Wonder's ruling, Gunn-Smith's $10,000 payment to Morrison & Foerster did not make up for what I had to go through during five years of litigation. First, there were my efforts to obtain legal representation and the time I devoted to preparations and consultations with the attorneys, especially in connection with a lengthy deposition I gave. There was also the responsibility I felt and the concern that I, as author of the letter, had for my coworkers in BACAP whose financial well-being I had put at risk. After all, had the case been lost, technically they would have been as liable as I.

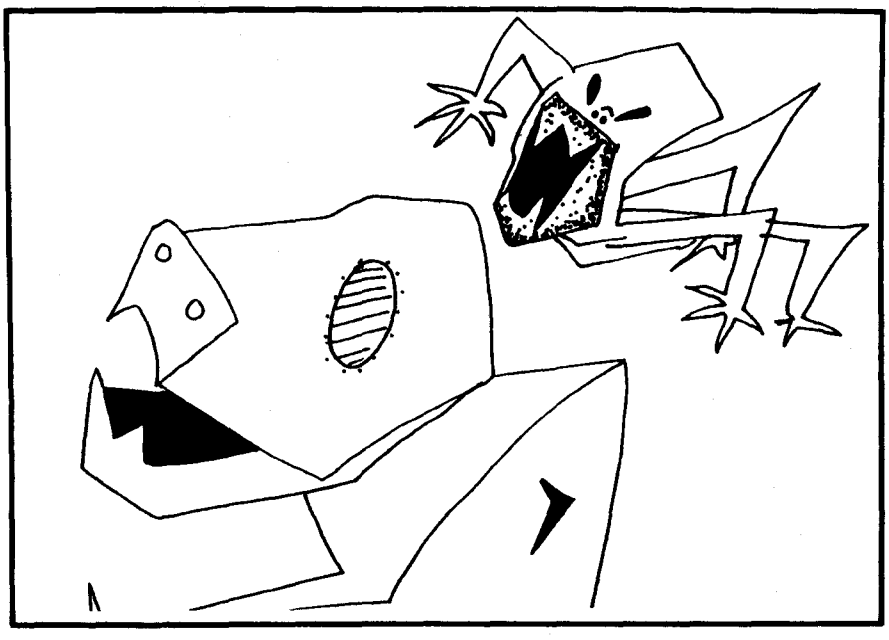
But the suit's heaviest cost to me was the limitation it imposed on my freedom of speech. I believed then and still believe that the charges I made against Gunn-Smith were substantially true. They were based on information provided to me by a top official at the state Department of Mental Health (DMH). But for five years, on advice of attorneys, I did not publicly discuss these charges. With the case pending, doing so would have jeopardized my position and that of the BACAP membership as well.

However, my losses from the Gunn-Smith lawsuit were small compared with the price paid by those who during the last five years might have been able to avoid electroshock had my information concerning Gunn-Smith been more widely circulated. And I'm thinking here particularly of the elderly.

I have been publicly attacking the use of electroshock since 1974, and the facts given me by the DMH official provided some of the best anti-electroshock ammunition I've ever had.[1] In researching my book, *The History of Shock Treatment,* I found 109 English-language sources, published between 1941 and 1977, reported 384 electroshock-related deaths. (These were listed in the book, along with a statement that psychiatrists had probably suppressed many other ECT-death reports in order to avoid lawsuits and public or professional criticism.)

My research strongly suggested that elderly people are at much greater risk of dying from ECT than younger people. One study reported an ECT mortality rate of 1 in 200 for the elderly, which was four or five times higher than the overall rate. This conflicted with then- and still-current claims by ECT specialists about the safety of their procedure for the elderly. It also raised serious questions about the growing, already disproportionately large numbers of elderly people being shocked.

Using DMH published statistics (state law requires ECT facilities to submit quarterly reports which include the number of people shocked) I estimated that 150 elderly people had been electroshocked on Gunn-Smith's ward at Stockton State Hospital during the year-and-a-half before his demotion. The six deaths, assuming all of them occurred during this period (I was only told they were recent deaths) represent a mortality rate for the elderly of 1 in 25 (4 percent), which is eight times greater than the figure from



the study cited in my book.

Was this seemingly high death rate primarily attributable to Gunn-Smith's method of selecting ECT subjects or to the way he administered the procedure, or was it owing to the procedure's inherent lethality, especially for the elderly, which the psychiatric profession has consistently underestimated?

The lawsuit muzzled me for five years, and there have been no further investigations and no public discussion of the urgent issues I raised in my letter. Now more than ever, the elderly are bearing the brunt of electroshock violence; for instance, according to DMH ECT reports, during a nine-month period in 1983 at Providence Hospital in Oakland, people 65 years of age and older were given electroshock more than twice as often as those under 65. While this figure may not be representative of the country as a whole, I fear it soon will be what with the rapid growth of the elderly population and the public's increasing reliance on psychiatry to solve the problems associated with aging.

It's horrible to think about anyone having to undergo the ordeal of electroshock; but for the elderly, because of the infirmity, isolation, and poverty so common among them, it is especially tragic.

How long will the victims and potential victims of electroshock have to wait for the independent investigation and public airing that will surely lead to the abolition of this brutal procedure?

Shock-ban Bill defeated in Vermont.

Some bad news from Vermont. A state Senate committee defeated a bill abolishing electroshock. The bill, which Paul Dorfner and the Vermont Liberation Organization were instrumental in introducing, would have made Vermont the nation's first state to outlaw ECT.

The Senate Health and Welfare Committee held a formal hearing on the proposed bill March 14th. Our side was represented by electroshock survivors Mikell Russell and Barbara D'Amico, and by Richard Musty, Ph.D., Chairman of the Dept. of Psychology at the University of Vermont, Peter Breggin (by speaker-phone), Lee Coleman, Berkeley neurologist John Friedberg, and myself. Two ECT specialists, two other physicians, a psychologist and an attorney represented the opposition. No pro-electroshock survivors testified.

Paul reports that we clearly got the better of them at the hearing. Not only did we embarrass them, but on a number of occasions they embarrassed themselves. For instance, Lory Holm, a radiologist, claimed that the legislators had neither the authority nor the knowledge to deal with the issue. Senator Vincent Illuzzi, the bill's author, responded for the offended committee in words to this effect: How can you presume to tell us we don't have the necessary information or expertise to make a decision on whether or not to ban ECT, and at the same time tell us that people facing ECT are fully informed when they give their consent without their having heard both sides of the issue as we here today have heard them? The informed consent aspect of the controversy was further dramatized when John Ives, an ECT specialist and lead spokesperson for the opposition, acknowledged that he did not inform shock candidates about ECT-induced brain damage because there was none.

The hearing lasted about three hours, and while the committee expressed concern about the informed-consent issue, it was unable to accept the whole truth about electroshock. The committee invited Senator Illuzzi to draft a bill outlining an informed-consent procedure for electroshock candidates for consideration during the Senate's next session. Paul said he would submit a full account of the hearing for publication in our next issue.

And in Berkeley

There are no new developments regarding the Berkeley electroshock ban. The court's summary judgment, which nullified the ban and denied the Coalition to Stop Electroshock's petition to intervene in the case, is currently on appeal. There is still no word from the Court of Appeals (1st Appellate District, CA) on a hearing date.

Teleconference program set up

Last year, a new Teleconference system was established in the United States, organized by ex-psychiatric inmates in the Psychiatric Inmates Liberation Movement. Its major purposes are to share information, make tentative decisions and establish closer relationships between self-help/anti-psychiatry groups across the United States.

A Teleconference is held about once a month; on the May 9, 1985 link-up, 27 ex-inmates from 22 states discussed several important issues on a prepared agenda. Minutes of each Teleconference are recorded and mailed to all participants and interested people.

For more information on the Teleconference, please write to: *Judi Chamberlin, Teleconference Coordinator, National Ex-Patient Teleconference Center for Rehabilitation and Research and Training, 1019 Commonwealth Avenue, Boston, MA 02215.*

Ex-inmates criticize system

At the Annual Meeting of the American Psychiatric Association (APA) held in Dallas, Texas last May, several ex-psychiatric inmates were invited to express their criticisms of the psychiatric system during a forum called "The Future of Psychiatry: Patients Speak Out." Sally Zinman (California Network of Mental Health Clients, San Francisco), Judi Chamberlin (Mental Patients Liberation Front, Somerville, Mass.) and Leonard Roy Frank (Network Against Psychiatric Assault/Coalition to Stop Electroshock, San Francisco) were among those who strongly criticized psychiatric abuses and advocated self-help alternatives.

There was also a panel debate on the resolution: "That the Policies and Practices of the APA are Oppressive." The two ex-inmate debaters speaking for the resolution were Judi Chamberlin and Joe Rogers (Philadelphia); speaking against it were Drs. Harvey Ruben (Associate Professor of Psychiatry at Yale U.) and Cynthia Rose

(Associate Professor of Psychiatry at the University of Colorado Health Sciences Center in Denver).

Judi Chamberlin reports: "There were about 30-40 audience members at the panel "In Search of Common Ground", about 50-60 at the forum, and about 80-100 at the debate. All the presenters were forceful, articulate spokespeople for our movement, and although we probably didn't convince any psychiatrists, we certainly had to impress them with our strength and solidarity."

The APA meeting in 1986 will be held in Washington, D.C. in May, when there will be more opportunities to confront the shrinks.

Anti-shock video released

A documentary titled "Electroshock," produced last year by the Upstate New York Coalition to Stop Electroshock, is now available. The videotape is on a 1/2" VHS cassette, in colour and is 30 minutes long. This outstanding anti-shock video features 15 interviews with shock survivors, other ex-psychiatric inmates and mental health professionals. The tape costs $30 (US) plus $2 postage. Your payment is a donation to the Coalition. To order a copy of "Electroshock," please send a cheque or money order for $32 made payable to "The Coalition To Stop Electroshock," and mail to: *The Coalition To Stop Electroshock, Box 875, Ithaca, NY 14850.*

New U.S. Bill of Rights proposed for Psychiatric inmates

A bill to protect psychiatric inmates' rights in the United States was introduced in the U.S. Senate this April by Senator Lowell Weicker Jr., Chairman of the Subcommittee on the Handicapped, but it will have to be approved by both the House of Representatives and the Senate in order to become law.

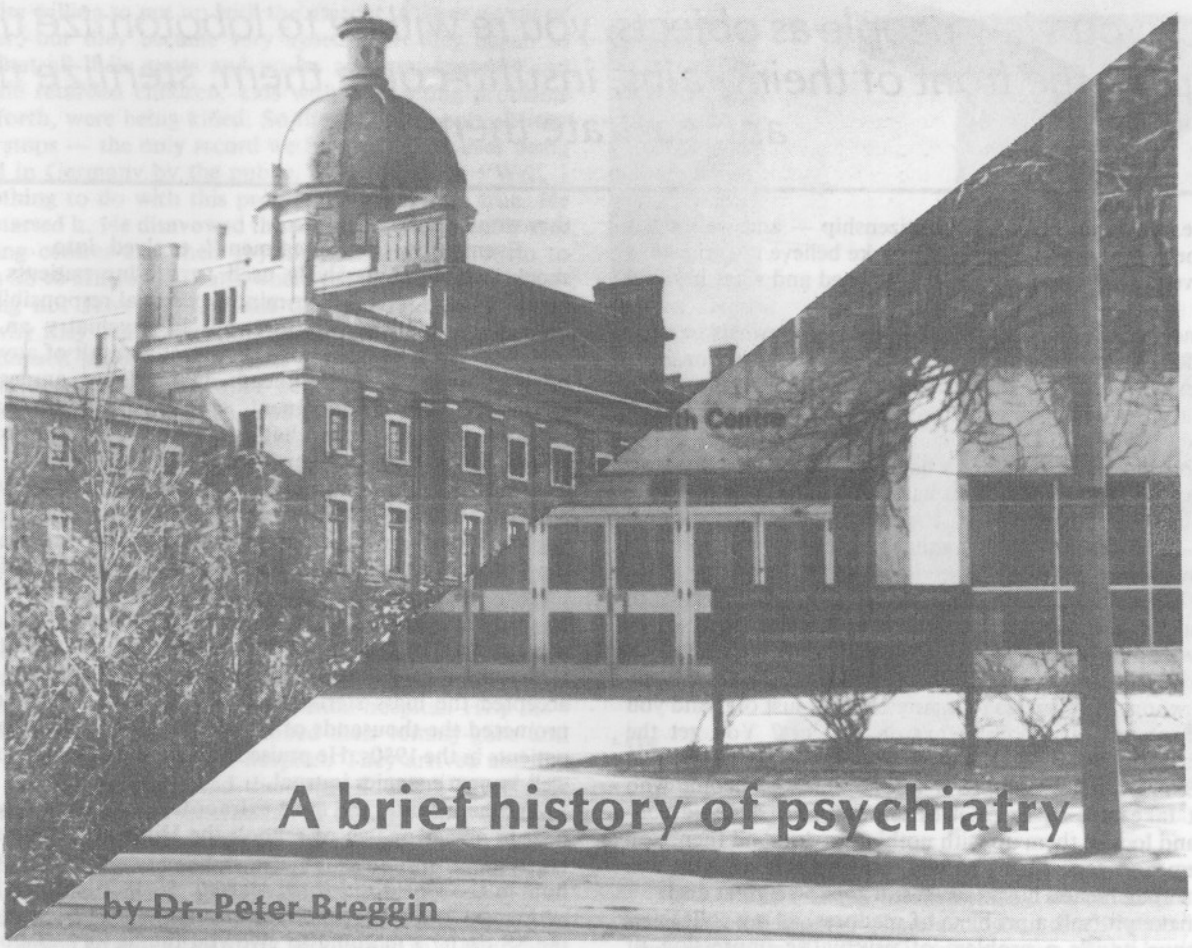
According to Senator Weicker, the chief purpose of *The Protection and Advocacy for Mentally Ill Persons Act of 1985* is "to ensure that the rights of mentally ill citizens residing in institutions and other residential treatment facilities will be protected. It provides for the establishment of a protection and advocacy program for the mentally ill in each state to allow for investigation on reported incidents of abuse and neglect of those citizens, and the protection of their rights through enforcement of federal and state statutes and the U.S. Constitution."

The following rights are spelled out in the Bill:

1. "appropriate" and "humane" treatment which supports "personal liberty;"
2. individualized treatment;
3. participation in treatment planning;
4. "informed, voluntary, written consent" to any treatment (informed consent is defined in bill);
5. to refuse any treatment, except in emergencies or when court-ordered;
6. if found incompetent by a court, right of person's parent or legal guardian to consent to any treatment;
7. to refuse to participate in any experiment — participation requires informed consent;
8. confidentiality of medical records;
9. limited right of access to medical records;
10. private communication, including "convenient and reasonable access" to telephone, mail and visitors;
11. to be "informed promptly at time of admission and periodically thereafter" of all rights in bill;
12. to "assert grievances" and to have grievances considered before a "fair, timely, and impartial grievance procedure;"
13. right to a "rights protection service" in the institution or service;
14. to exercise all rights "without reprisal;"
15. to be referred to other mental health professional(s) "upon discharge."

Judi Chamberlin — one of several ex-inmates who testified during the public hearings on the bill — states that the bill "would apply to people in institutions and permit investigation of reported incidents of (staff) abuse and neglect. Ten million dollars would be authorized the first year (1987), and $10,500,000 the second. Obviously, the bill doesn't cover everything we want, but it's part of what we are working for."

(Ed. Note: So far, no government in Canada has drafted or passed a bill of rights for psychiatric inmates. See ON OUR OWN's *Bill of Rights in this issue.)*



A brief history of psychiatry

by Dr. Peter Breggin

(Ed. Note: Dr. Breggin is a practising psychiatrist, and the Director of the Center for the Study of Psychiatry in Bethesda, Maryland. He is one of the leading critics of biological and involuntary psychiatry, an internationally respected leader in the fight to abolish electroshock, drugging and psychosurgery, and author of the critically acclaimed books: Electroshock: Its Brain-Disabling Effects *(1979), and* Psychiatric Drugs: Hazards to the Brain *(1983). This article consists of excerpts from a lecture on psychiatry which Dr. Breggin delivered on February 13, 1985. Our thanks for his permission to publish his material, and to Dennis F. Nester for providing us with the tapes of Dr. Breggin's lectures.)*

What I'm going to do is take you through a history of psychiatry. The history of psychiatry is almost entirely the history of the biological-behaviouristic model. Psychiatry begins in the 17th century in France with the state mental hospital system. Before the state mental hospital system, there is virtually no psychiatry.

In the 17th and 18th centuries, we get the beginnings of the Industrial Revolution and large cities. In these cities, there are poor people, helpless people, people without families, evil people and so forth — all kinds of humanity now in a huge disorganized social system with a vast amount of unemployment. This presented a new problem to the authorities. Somehow, the leprosariums had become empty in France. Since there were these vast empty institutions and a vast social problem, it was decided to use these institutions to take care of, to house and perhaps rehabilitate the social dropouts. The laws for these places, which were called "hôpitaux générales," empowered a physician -- they wanted to make it look medical — to administer a hospital and to bring into the hospital at his will anybody who was destitute, chronically ill, unemployed, insane.

If you go to your state mental hospital today, you find the great grandchild of this system — it's identical. There have been a few more limits placed on the law, but basically we still have physicians able to commit human beings to hospitals in vast numbers under the guise of "rehabilitation," and most of the people in these hospitals are poor. That's their main characteristic — they're not necessarily crazy. This is called civil commitment. And the reason it developed was because even in the 17th and 18th centuries there were criminal codes which made it difficult to lock up and label a criminal; so instead, a civil code was developed without the usual protections, and this is still true today. You can't get a *writ of habeus corpus* to get somebody out of a mental hospital. The criminal laws are not relevant to this situation.

If you go to a mental hospital, you're taking your life in your hands, even today. If you go to even a "good" mental hospital, you're still taking your life in your hands, maybe even more so, because the good ones especially like to drug you and shock you, whereas in a state mental hospital you might possibly be left alone and maybe get better on your own.

This system of mental hospitals was based on the medical model, on involuntary treatment and civil commitment, and it is today the backbone of psychiatry. Psychiatry doesn't get its power and government support from the analyst or the counsellor, it gets it from government-empowered involuntary treatments. It's as if General Motors got the government to say that it could make people consumers of cars. Or more directly, it's as if a religion took over the government and said we will define who's good and evil, who should go where, who should

"once you view people as objects, you're willing to lobotomize them, chop up the front of their brains, insulin-coma them, sterilize them and castrate them"

stay here, who should lose their citizenship — and we'll do it under special statutes, and we'll all make believe it's science. I do believe that's exactly what has happened and what is going on.

The medical model is the essence of what allows us to treat so-called "mentally ill" people as if they're non-responsible, as if they're not involved in value conflicts, as if the whole issue is respect for society and adjustment, rather than the fundamental Western values such as the right to be free unless you're injuring somebody. You have a right to live your own life unless you're bringing direct harm to another human being and violating criminal codes. I'm not against the criminal system — I'm against what is a much more abusive system, the civil commitment system.

In the 1930s, the psychiatric system got totally out of hand. The hospitals were getting bigger and bigger — thousands of people were locked up in antiquated facilities. If you take a bunch of poverty-stricken, uneducated, feeling human beings, some of whom are even crazy, many of them just old, and you dump them into dungeons, what do you get? You get the snake pit. You don't get it because the people are crazy; you get it because you've dumped a whole bunch of people who couldn't take care of themselves anyway into horrible conditions and locked them up with nothing to do. And then, you beat them and rape them, at will, which until recently was typical of state mental hospitals. It still goes on a great deal.

The snake pit isn't a problem of madness, as my colleagues would have it; it's a problem of psychiatric oppression of people. In the 30s, governments throughout the world were saying: Enough money. We're not going to put in more than fifty cents a day or whatever — just enough to feed and house somebody. We're not going to pay any more staff salaries. The situation has got to stop.

So what happens? The physical assault on the brain begins in order to control the people in these giant lockups. Before this, the typical treatment in a state mental hospital was starvation — that was the general "therapy," that's what you got. On top of starvation, you were bled, you were put in spinning chairs, you had leeches attached to you. Read something like Kraepelin's *One Hundred Years of Psychiatry*. Kraepelin's a great psychiatrist, supposedly. He's describing what happened even in the 19th century: bleeding, spinning, purging, forced vomiting, whipping, beating. The "Father of American Psychiatry," Benjamin Rush, who also happened to have bled George Washington to death and locked up his own son to die in a state mental hospital, also invented the "tranquillizer chair" which immobilized people for agonizing hours.

So in the 1930s, it was discovered that beatings and whippings and bleedings didn't really do it — they only resulted in a limited amount of conformity. Besides, it looked so bad to the profession. It's then discovered that you can assault the brain directly. You can really stop them dead in their tracks. So we get shock treatments, the first of which is insulin coma. You're given an overdose of insulin, the brain loses its sugar and begins to die, the cells shrivel up and die as the patient convulses. And lo and behold — there are descriptions of this — as the patients come out of the coma, they're grateful for their own orange juice, they're grateful for a little pat on the head, they're docile for months. But too many died from insulin shock, and it was very costly to keep a person in a coma for hours — you had to have nurses, you had to give them sugar so they wouldn't die.

Eventually, this "treatment" evolved into ... electroshock, which is massively used to subdue patients by obliterating their selves, their minds, personal responsibility. It's done by producing what we call in psychiatry an "acute organic brain syndrome" or delerium, the result of any general blow or trauma to the head. It produces amnesia, disorientation, loss of judgment, emotional instability. That's what electroshock does, that's what it always does to everybody — dogs, cats, monkeys, people.

Along with this movement of assaulting the brain began another really heavy phenomenon called eugenics. Eugenics was the idea that we had better start sterilizing these people. In the United States, we sterilized tens of thousands of mental patients. We became the laboratory for Hitler. There's a man on the West Coast, Dr. Paul Poponoe, who's retired now; he was the head of the largest family planning centre in the U.S. He used to go over to Nazi Germany and report how well accepted the mass sterilizations were in the U.S. He highly promoted the thousands of sterilizations of California mental patients in the 1930s. He praised Hitler's eugenics program in a well-known eugenics journal.

And here comes the most extraordinary disclosure you may hear in a year or two of school: the Holocaust couldn't have taken place without psychiatry. You've probably all wondered how in the world did it get started. How in the world did a people exterminate so many of its own? How in the world did the SS do it? I'm going to give you the history of how it got started. As you can see, once you view people as objects, you're willing to lobotomize them, chop up the front of their brains, insulin-coma them, sterilize them and castrate them — all of which was being done in the United States, Great Britain and Germany. Germany was the most advanced psychiatric nation in the world then, so more was being done. "Advanced psychiatry" is always the worst.

What happened in Germany began as early as 1920. In 1920, a professor of psychiatry named Hoche wrote a book with a lawyer named Binding on exterminating mental patients. They were called "useless eaters," a cost to the state. They weren't individuals to be protected and nurtured — they were objects to be eliminated.

By 1939, German psychiatry's top professors had organized a massive euthanasia program. They began murdering their mental patients. This is three years *before* the Holocaust. William Shirer, a *New York Times* correspondent, wrote a book called *Berlin Diary*. In *Berlin Diary*, Shirer says that he has reliable reports from conservative informants that a hundred thousand mental patients were murdered in Germany. He says this is very hard to believe. It was so hard for poor Willie to believe that he happened to leave it out of his other book, *The Rise and Fall of The Third Reich*, to protect psychiatry. German psychiatry organizing killing centres whose names you don't get in the history books — such as Sonnenstein and Hadamar. You've heard of Buchenwald because that's what they want in the history books. Hadamar and Sonnenstein and five or six other places were psychiatric killing centres to which all the patients in the state hospitals were sent. They even brought in patients to state hospitals just to kill them. They were organized around an elaborate system headquartered in Berlin; they even had euthanasia forms.

The reaction to this slaughter was interesting. The Germans were quite willing to put up with the murder of Jews a year or two later, but they became very upset when they began to realize that all their aunts and uncles and grandparents and their little retarded children, kids with bedwetting problems and so forth, were being killed. So they started booing Hitler at train stops — the only record we have of Hitler ever being opposed in Germany by the public. So Hitler said, "Well, I have nothing to do with this program," which was true. He hadn't started it. He disavowed the program, and he took over the killing centres and their psychiatrists and used them to train his SS to kill Jews. That's where the SS learned to kill — by killing not Jews but German Christian mental patients. That's why they could do it (kill Jews). Adolph Eichmann, to defend himself in Jerusalem, said it's a "medical matter," but the press doesn't tell you what he's talking about because people don't want his story made public.

After the killing of patients stopped in the euthanasia centres, German psychiatry continued doing it in the state mental hospitals — right in their own locales. When I told this story in public, I got a phone call from a New York publisher named Abrams. He said, "By God, I've got an outlet for my story at long last." He said, "I liberated a state mental hospital in Bavaria," and he described how he was sitting in his office in the Occupied Zone. The war was over; a German soldier, a Wehrmacht doctor, came in and said, "I'm a doctor. I've been on the front saving lives and I've gotten home and they're killing patients in my state mental hospital. Help us." So Abrams and another guy grabbed their tommy-guns and went to the local state mental hospital. They arrived and the director hanged himself. And there they found a psychiatric concentration camp, an extermination centre with ovens and patients being killed with drugs and starvation.

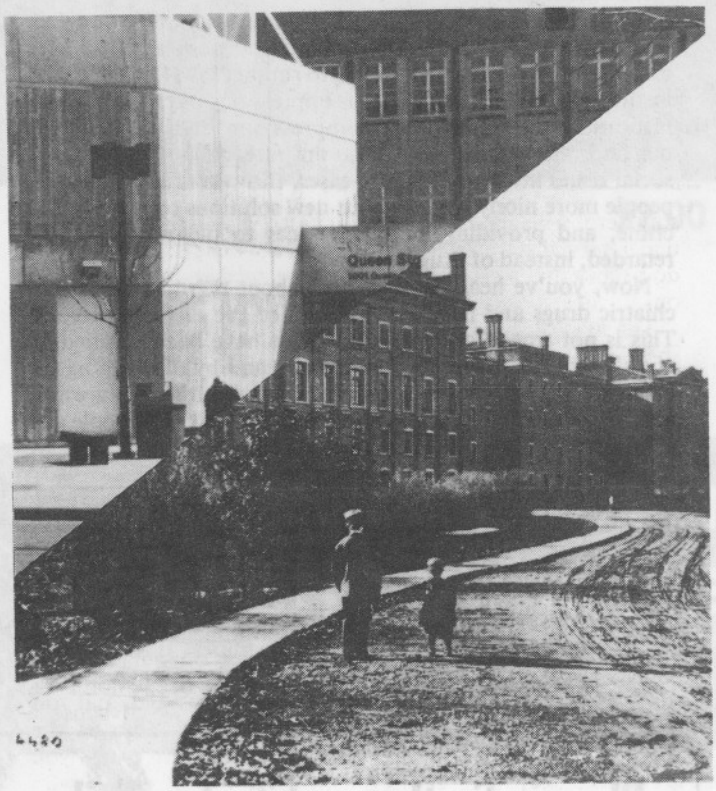
Why hasn't this story come out? It didn't come out because people like Shirer believe that psychiatry is the new religion to be protected and nurtured. People don't want this story. I'm the first person to make this story very public in a *Penthouse Magazine* article. Why *Penthouse?* Because it just happened to have a very radical editor at the time who was willing to publish something after he checked all my quotes. One of the quotes he wanted to check was an editorial in the *American Journal of Psychiatry* in 1942 which advocated the murder of retarded children in the US — 1942, here in the US. It (murdering retarded children) never made it here, because the American public didn't buy psychiatry quite as much as the German public did, and because we didn't have a psychiatrically-indoctrinated Hitler to implement it.

I want to read you some quotes, because you're really going to have trouble believing what I'm going to tell you. We had a number of observors at Nuremburg. (*Ed. note:* The German city where the Nazi War Crimes trials took place shortly after World War II.) One of them was Dr. Andrew Ivy; he was the A.M.A. (American Medical Association) representative — hardly a radical organization. This is what Ivy said about the killing of mental patients — this is part of what motivated me in my work:

> Had the profession (psychiatry) taken a strong stand against the mass killing of sick Germans before the war, it is conceivable that the entire idea and technique of death factories for genocide would not have materialized.

None of you have heard that quote. It's literally expurgated from the books. The equivalent of the A.M.A. in Germany also had a medical representative at Nuremberg. Speaking of the murder of mental patients, he said it was:

> The starting point for the line of development that inexorably led to enforced mercy death for the incurably insane on the one hand, and during the war on the other, to exterminating races declared to be inferior — Poles, Russians, Jews and Gypsies...



Now, what was the mechanism by which all this was repressed from history? There's one man that's rather key to it, but one key man only reflects the power of the institution of psychiatry, so it's not all his fault. He didn't do it himself, but he fits into the picture in an interesting way. His name is Leo Alexander. The day my first publication on Nazi Germany came out — the day that I distributed it at a national meeting of the American Psychiatric Association — Leo Alexander libelled and slandered me in public — so much so that he finally settled out of court for $30,000 in 1974. And what got me a little upset was that Leo was our (U.S.) Nuremberg psychiatrist. Now, how did Leo make his living as a psychiatrist before he got to Nuremberg? He made it like many other psychiatrists did. He believed in electroshock and drugs; he was even a lobotomist. In fact, Leo praised Hitler's sterilization programs; he said that they closely paralleled modern eugenic theory — before he got to be our Nuremberg psychiatrist. With Leo as our psychiatric investigator, how could we expect psychiatry to be indicted at Nuremberg? However, it's not Leo's fault alone that no psychiatrists got indicted at Nuremberg. Leo was the embodiment of psychiatric thinking and psychiatric excuse-making in general.

In Russia today, there's a system of psycho-prisons for the worst of the dissenters. It's been reported in the *New York Times* and the major magazines. In the psycho-prisons, they take the Russian dissidents and they blow their brains away — with drugs. Then, the dissidents, if they escape to the West, talk about how they were given these drugs, how they couldn't think anymore politically, they couldn't think anymore about their lives, they couldn't focus on anything. Eventually, they lost interest in themselves and began to deteriorate. And what drugs were they given in the Russian psycho-prisons? The favorite one is Haldol — the same drug being used throughout this city for mental patients. In other words, in Russia they treat Russian dissidents as if they're "mentally ill," and in that manner control the society. And of course, it's ironic that a

drug that tortures political dissidents is allegedly good for mental patients.

In the U.S., what we do is use psychiatry in a whole bunch of more subtle ways, including shoving the poor and the aged under the rug. We use psychiatry to suppress the "retarded" in institutions for the retarded, to suppress our old people in our institutions for old people, to suppress our "mental patients," our poor and our crazies and so on, rather than deal with the social issues involved. In most cases, this would mean treating people more nicely, figuring out new solutions to poverty and crime, and providing human services to old people or the retarded, instead of drugging them.

Now, you've heard a great deal about the miracle of psychiatric drugs and how they've emptied the mental hospitals. This is not true. The mental hospitals have been emptied by not allowing as many new patients in, and by discharging the ones that were there, even against their will. It's been a whole administrative change since the 1950s. We took old people and poor people and shoved them out of the hospital to create street people. When I was a psychiatric resident in the 1960s, all you had to do to get a patient in a state mental hospital was call the hospital, and they'd send men in little white coats to pick him up. They were eager — stuff them in like sardines. Now, you've got to have "pull" to get some patients into the local state mental hospital.

On top of this, we're causing brain damage, because the major psychiatric drugs, called the "major tranquillizers" or the neuroleptics — they include Haldol, Stelazine, Thorazine, Prolixin (Moditen or Modicate in Canada) — all cause a disease called *tardive dyskinesia.* This disease begins with twitches around the mouth and progresses to a whole twitching-out-of-control-body. The data is so bad that you're not going to believe me, so I'm going to read to you from ... the American Psychiatric Association's *Task Force Report on Tardive Dyskinesia.* You can't expect them to show the worst side, because they don't want to be taken to court, so they're naturally going to doctor their statistics. These are the percentages from the report. If you are a man under 40, you have a 20 percent chance of getting this disease — this *permanent neurological disorder* from taking the drugs. And the rate increases for older people. There's a lot of people over 60 getting these drugs in the nursing homes; it's a 54 percent rate for men, and for women it goes up to 60 percent in this age group. More than half of the treated elderly population is going to get the disease. As I've tried to show in my book (*Psychiatric Drugs: Hazards to the Brain*, 1983), it's not just a disease of twitching and odd movements of the body. It's a disease of brain deterioration in the patient's mental centres. I was the first person to openly describe that.

Now, why is psychiatry so harmful? It's because there are some approaches to life that are good, and some that are evil. And it's evil whenever you treat people with emphasis on conformity to the society; when you treat the self as a mirage and enforce "adjustment" and "value-free control" of people. It's evil to act as if human beings aren't responsible and that "mental illness" is biological and determined. If you pursue the psychiatric philosophy, you end up oppressing people. You absolutely must — there is no other way.

Phoenix Feather and Turkey Tail

We are awarding this issue's Turkey Tail to both Anton Turrittin and Ian Gomme, professors in the Sociology Department of York University. In their department's Supplemental Calendar (1985/86), a course on "Conformity and Deviance" is described in these terms:

> Many of you are doubtless intrigued by the exotic world of pimps, perverts, queers, and sluts. Descriptive and explanatory material on these "unique" creatures and their "unusual" activities is contained in the text ... it is the stuff of which scintillating party conversation is made.

This course description was written by Professor Gomme who teaches the course and we can only assume it was approved by Departmental Chairman Turrittin. Such language, we feel, is extremely sexist and demeaning to *all* women, including lesbians, and to gay people, psychiatric inmates and ex-inmates ("nuts"). Such a description belongs in the garbage — not in a university course calendar or any other publication.

Although we understand the insulting references have now been recently deleted from the calendar, the damage has been done. It is inexcusable that such bigotry and prejudice are still condoned in an institution of "higher learning." Professors Turrittin and Gomme and all other "learned" people who communicate these prejudices and stereotypes should be publicly criticized. Our Turkey Tail looks good on them.

(Ed. Note: We sincerely thank Sharon Stone for bringing this issue to our attention.)

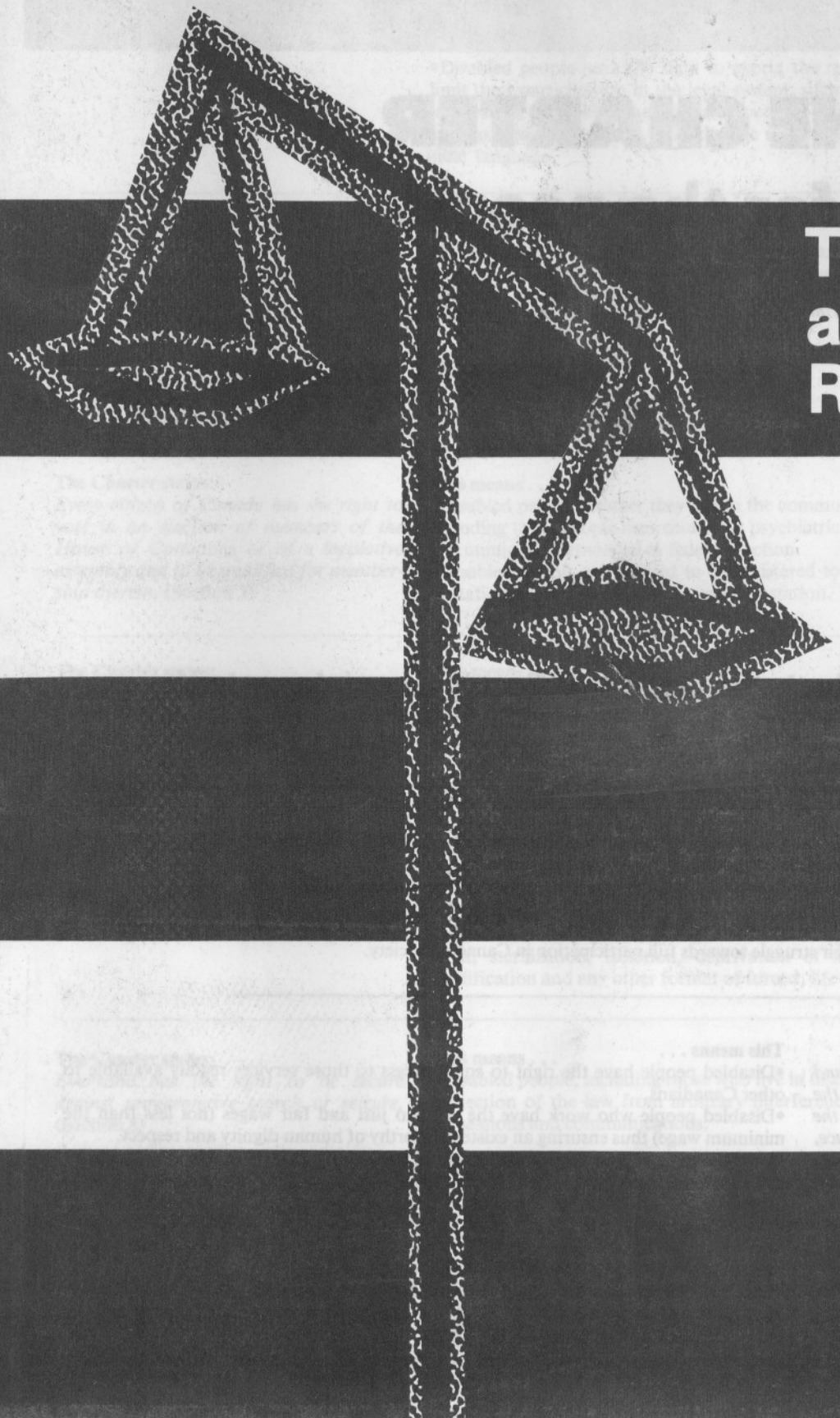
We proudly award this issue's Phoenix Pheather to Carla McKague, an ex-psychiatric inmate, ON OUR OWN member, co-founder of *Phoenix Rising,* shock survivor, and lawyer/patients' rights advocate in Toronto. Since 1978 when she joined ON OUR OWN, Carla has been a great source of strength and support for many members, and the group as a whole. For example, she drafted the group's first by-laws and Constitution, was largely responsible for getting ON OUR OWN incorporated as a non-profit charitable organization, and once served as treasurer on the Board.

On many occasions during the past four years, Carla has successfully represented many psychiatric inmates and ex-inmates at Review Board hearings and in Court. During the "Mrs. T." case, for example, she argued in the Ontario Supreme Court that electroshock is a form of psychosurgery because it causes brain damage. Although the case lost, Carla did succeed in preventing her client from being subjected to shock. (See her article Electroshock and the Law in this issue, and "Shock case: a defeat and victory," in *PR,* vol. 4, nos. 3-4, 1984.)

Last September, Ontario's Ministry of Health appointed Carla to its Electroconvulsive Therapy Review Committee, which is currently investigating the medical, legal and ethical aspects of shock in the province. Carla is the only ex-psychiatric inmate/shock survivor on this medically biased committee. Recently, she also organized a new advocacy-research group of lawyers committed to mental health reforms — Committee on Legal Information in Psychiatry (CLIP).

We're sure Carla will continue to be a strong and persuasive advocate for thousands of us who have suffered from electroshock and other forms of psychiatric oppression, and will challenge this oppression under the Charter. Congratulations, Carla, and keep fighting!

$2.00



The 'Charter' and Inmates' Rights

Published by Phoenix Rising

THE CHARTER— for the people

(Reprinted from Just Cause, *vol. 1, no. 4. By permission.)*

The Canadian Charter of Rights and Freedoms as interpreted by and for people with disabilities

Preamble

WE BELIEVE that all Canadians have certain fundamental rights which the Charter of Rights and Freedoms has enshrined in the Constitution of Canada.

WE BELIEVE that disabled Canadians have been denied many of these fundamental rights.

WE BELIEVE that disabled people should expect the Charter of Rights and Freedoms to assist their struggle towards full participation in Canadian society.

The Charter states:
Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental and physical disability. **(Section 15 (1))**

This means . . .

- Disabled people have the right to equal access to those services readily available to other Canadians.
- Disabled people who work have the right to just and fair wages (not less than the minimum wage) thus ensuring an existence worthy of human dignity and respect.
- Disabled people have the right to support services which will enable them to independently and actively participate in their local communities, in particular, and society, in general.
- Disabled people have the right to full protection from actions or inactions which deny their rights to equal access to public services, such as transportation, health care, recreation and social services.
- Disabled people have the right to full recognition as persons before the law which includes the presumption of the ability to consult with and instruct a lawyer and the presumption of the ability to serve on a jury.

WE BELIEVE...

•Disabled people have the right to expect the removal of barriers which prohibit or limit their participation in the legal system; such barriers include buildings which are inaccessible to mobility handicapped people, absence of material in alternative media such as braille and on cassette, and the unjustified use of complex and incomprehensible language.

The Charter states:
(Section 15) (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. **(Section 15 (2))**

This means . . .
•Disabled people have the right to expect programs and services which will enable them to overcome historical disadvantages which have been created, in part, by the assumption that disabled people could not participate in education and the work force and should depend upon charity.

The Charter states:
Every citizen of Canada has the right to vote in an election of members of the House of Commons or of a legislative assembly and to be qualified for membership therein. **(Section 3)**

This means . . .
•Disabled people whether they live in the community or in institutions or in hospitals, including those people incarcerated in psychiatric institutions, have the right to vote in any municipal, provincial or federal election.
•Disabled people are entitled to be registered to vote and to access (including transportation when necessary) to any polling station.

The Charter states:
Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice. **(Section 7)**

This means . . .
•Disabled people have the right to live in their communities and to equally enjoy the benefits of an adequate education, social and support services, recreational services, transportation and other community services enjoyed by other Canadians.
•Disabled people have the right to an adequate standard of living including adequate food, clothing and housing.
•Disabled people have the right to protection of the law against any arbitrary interference with, or disruption of, their privacy, sexual and family life, home or mail.
•Disabled people have the right to proper medical care and the enjoyment of the highest attainable standard of physical and mental health.
•Disabled people have the right to marry and to raise a family.
•Disabled people, including those in institutions or hospitals, have the right to protection from physical, medical and psychological abuses such as corporal punishment, sterilization, isolation, deprivation of adequate food or drink, behaviour modification and any other format of forced, life-threatening or degrading treatment.

The Charter states:
Everyone has the right to be secure against unreasonable search or seizure. **(Section 8)**

This means . . .
•Disabled people, including those who live in institutions or hospitals, have the right to protection of the law from arbitrary interference with the privacy of their personal possessions and communications.

The Charter states:
Everyone has the right not to be arbitrarily detained or imprisoned. **(Section 9)**

This means . . .
•Disabled people forced to live in institutions or hospitals, including psychiatric hospitals, have the right to freedom from arbitrary detention.
•Disabled people have the right to freely live in the community unless it can be proven that they constituted a threat to the safety of others.
•Disabled people have the right to be free from arbitrary imprisonment or detention in any institution or hospital.

WE BELIEVE...

The Charter states:
Everyone has the right on arrest or detention
(a) to be informed promptly of the reasons therefor;
(b) to retain and instruct counsel without delay and to be informed of that right; and
(c) to have the validity of the detention determined by way of habeas corpus and to be released if the detention is not lawful. **(Section 10)**

This means . . .
•Disabled people have the right to be immediately informed of the reason for any detention in a hospital or institution.
•Disabled people have the right to an independent advocate to assist them in protecting their freedom and they must be informed of this right.
•Disabled people have the right to a public hearing before an impartial tribunal or court to decide without delay on the legality of their detention.
•Disabled people have the right to be told how long they are likely to be detained in any hospital or institution.
•Disabled people can expect to be immediately set free if the court or tribunal finds that there are no good reasons for their detention.

The Charter states:
Everyone has the right not to be subjected to any cruel and unusual treatment or punishment **(Section 12)**

This means . . .
•Disabled people cannot be subjected to torture or to cruel and degrading treatment or punishment such as electroshock, psychosurgery, isolation, massive drugging and other forced or life-threatening treatments.
•Disabled people cannot be subjected to any medical or scientific experimentation without their consent; such consent shall be based on full understanding of the nature and risks of the experimentation by the disabled person.
•Disabled people cannot be subjected to any medical treatment without their informed consent.

The Charter states:
A party or witness in any proceedings who does not understand or speak the language in which the proceedings are conducted or who is deaf has the right to the assistance of an interpreter. **(Section 14)**

This means . . .
•Disabled people have the right to understand what is taking place during any proceeding which directly involves them, especially when their freedom is at stake; such instances include:
•the right to sign interpretation for deaf people
•fully adequate explanations and implications of legal terms to persons with mental handicaps
•availability of written material in alternative media for print handicapped persons (e.g. cassettes, braille, use of Bliss symbolics).

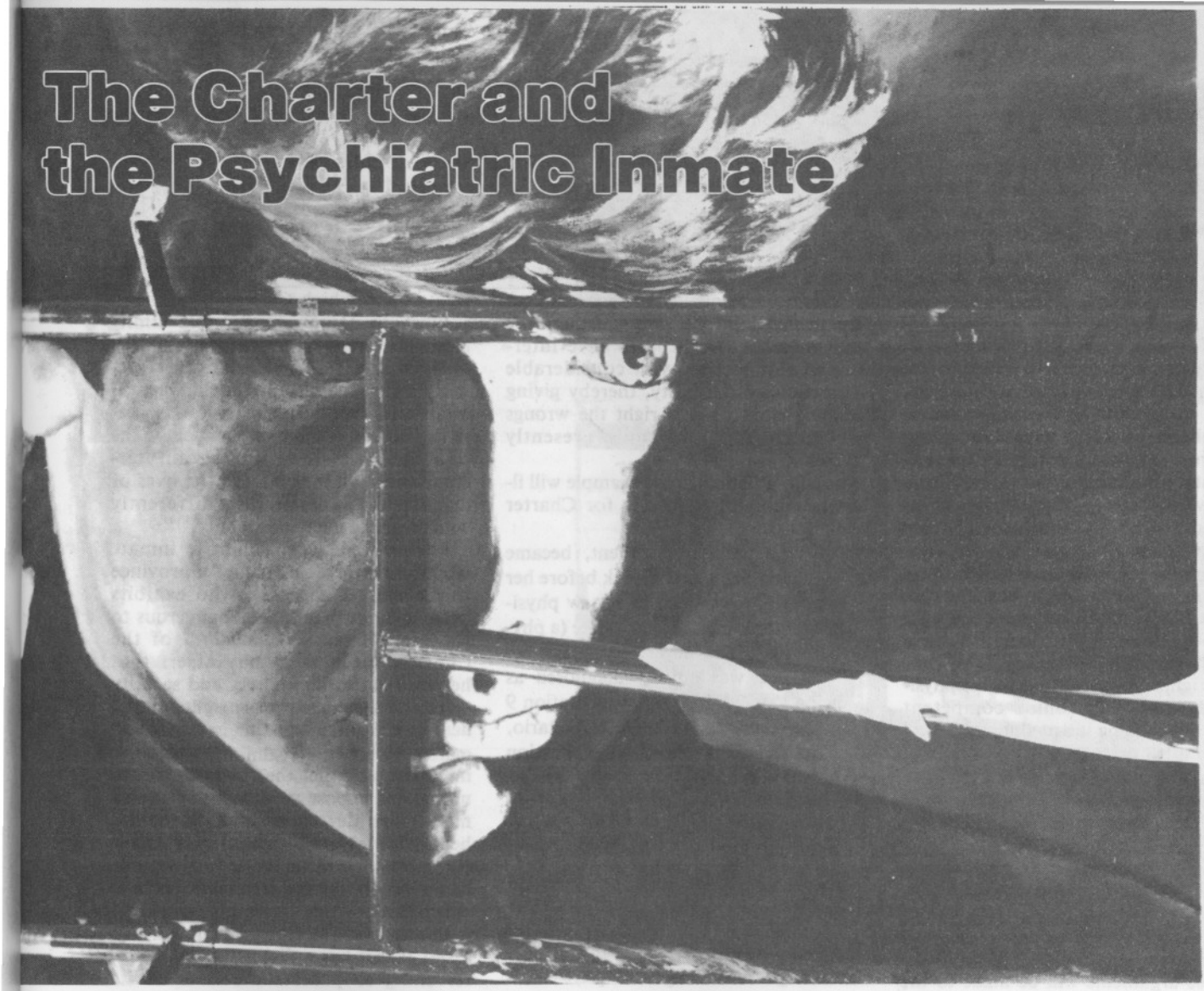
The Charter states:
Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances. **(Section 24 (1))**

This means . . .
•Disabled people have the right to expect that any law which violates or denies their rights as guaranteed by the Charter will be changed by a government or ruled null and void by a court of law.

The Constitution states:
The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect. **(Section 52 (1))**

This means . . .
•Disabled people have the right to an effective remedy if any of their rights guaranteed by this Charter are violated even if the violation has been committed by government officials.

The Charter and the Psychiatric Inmate



Contributed by the Advocacy Resource Centre for the Handicapped

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

This is not a statement of morality—it's a statement of law. It is the language of Section 15 of the *Canadian Charter of Rights and Freedoms*, which section came into force on April 17, 1985, three years after the Charter was officially proclaimed as part of our Constitution.

"Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." This is the language of Section 7 of the Charter, which came into force on April 17, 1982.

The proclamation of these statements of law represents the boldest political step which Canadians are likely to witness in their lifetime; they probably signal the beginning of a significant era which will change the way government can intervene in the lives of psychiatric inmates.

It is important, therefore, to understand what the Charter is and how it can help in the development of more enlightened service provision and "treatment" in the mental health field. In this article, we intend to provide some orientation to the Charter and some examples of how psychiatric inmates may begin to flex their Charter muscles.

What is The Charter and how does it apply?

The Charter is a unique kind of law and has a unique application. It is part of the Constitution of Canada and creates the framework within which all federal and provincial legislation must operate. The task for the Courts in applying the Charter is that of examining the legislation in question, deciding whether it violates any section of the Charter, and arriving at a suitable remedy for the aggrieved individual or group. Should a Court determine that a law violates the Charter, that law will be struck down.

For example, consider this fictional scenario which raises a potential challenge to Section 35 of Ontario's *Mental Health Act*.

> John was involuntarily committed to a provincial psychiatric hospital. His psychiatrist prescribed ECT (electroconvulsive therapy) as the treatment of choice for John's symptoms of depression. John refused the treatment. Although the psychiatrist felt John to be mentally competent to consent, Section 35 of the *Mental Health Act* enables the physician to ignore John's wishes and to seek consent to the treatment from the patient's wife. John's wife consents to ECT.

Let's see how the Charter applies to John's situation. He has grounds to challenge the constitutional validity of Section 35 of the *Mental Health Act*. His lawyer will argue these three points:

1. Because Section 35 of the *Mental Health Act* provides that the choice of a mentally competent person may be disregarded, it violates Section 7 of the Charter. The right of all mentally competent citizens to choose their forms of treatment is a matter relating to the per-

"Every individual is equal before the law and under the law and has the right to equal protection and equal benefit of the law, without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability." Section 15, Canadian Charter of Rights and Freedoms

son's life, liberty and security of the person.

2. If anyone's right to life, liberty and security of the person is to be infringed, the Charter requires that any infringement occur only after a process throughout which the individual enjoys the protection of principles of fundamental justice. So, John would argue, the government may not interfere in his life and restrict his enjoyment of these rights without some fair legal process, during which he will have a lawyer, have a right to be heard and to hear the case against him in court, and have the right to appeal an unfavourable decision. (In law, these rights are called "due process" rights or protections.) The physician, by ignoring John's competent choice and seeking instruction or consent from another person, is depriving him of due process and the right of appeal.

3. Finally, John will argue that he is, according to Section 15, entitled to the kind of protection under law to which any medical patient is entitled; that his right to self-determination is just as important as the right to self-determination which all other Canadians enjoy.

These arguments will be made to the Court in support of the position that this section of the *Mental Health Act* violates the Charter and is therefore invalid. If one or more of these arguments is successful, Section 35 of the Mental Health Act will be declared invalid and may no longer be applied in the case of *any* inmate. It will then be the government's responsibility to change its practice, policy and laws so that they conform to the Court's decision.

How can a Charter challenge help the psychiatric inmate?

If the fundamental application of the Charter is to test and challenge current laws, how does this help the psychiatric inmate whose life, liberty or security is placed in jeopardy by the operation of an offensive law? Does the Charter enable the Courts to provide remedies for the individual as well as declarations regarding the validity of legislation?

The answer to the last question is clearly yes. In Section 24, the Charter states that "anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances." Although there is not yet a great quality of reported case law in this field, the available literature indicates that the Courts have interpreted this section with considerable discretionary flexibility, thereby giving it some clout to help right the wrongs which Charter violations presently allow.

Again, a fictional case example will illustrate possible remedies for Charter violations.

> Mary, a university student, became extremely depressed a week before her exams. She was seen by a new physician at the student health office (a physician who had never seen Mary before) and was quickly diagnosed as being "suicidal." Following section 9 of the *Mental Health Act* of Ontario, the physician processed an application for admission for psychiatric assessment, and Mary was hospitalized involuntarily for five days. Under the Act, the application of only one physician is sufficient to authorize the hospital to detain Mary, to restrain her, and to observe her. The Act also denies Mary the right to appeal or a hearing to challenge the physician's opinion or involuntary committal during this period.

Mary may do a number of things to seek justice through the Charter:

1. She may immediately bring an application for *habeas corpus*[1] before the Court to have the validity of her detention determined.

2. She may also, in that application, try to persuade the Court to order her immediate release if the detention is found to be invalid.

3. Further, Mary may claim financial compensation for her wrongful detention, including compensation for the lost year of education which resulted from the inability to take her examinations.

Such remedies can be sought under the Charter, without limiting any previous remedies she may have had under common law and statutory remedies.

Are there limitations on Charter guarantees?

The rights and freedoms guaranteed in the Charter are not absolute. Neither the right to life, liberty and security of the person nor the right to equality are unlimited. Instead, they are guaranteed rights upon which Canadians rely but subject to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." In the mental health field, there is little doubt that the Courts will interpret these "reasonable limits" to include the right of the state, in certain circumstances, to intervene in the lives of its citizens and to legislate differently with regard to mental disability.

For example, a psychiatric inmate might challenge the right of a province to incarcerate a person who exhibits behaviour which is judged dangerous to her/himself. Under Section 7 of the Charter, the person may assert that her/his right to life, liberty and security of the person includes the right to take her/his own life; that this is a personal matter within the realm of self-determination, and that the government has no right to impose its will. The Government, in order to defend its mental health law(s), will categorize this intervention as one of those "reasonable limits" upon liberty, prescribed by law, which can be "demonstrably justified" in this society. The Government will also assert that it has a direct interest in intervening to protect the lives of its citizens.

The Courts will then weigh the competing interests—the need to protect the liberty and autonomy of the individual against the interest of the state in preserving life; they may well conclude that individual rights should be limited in a case such as this.

The Charter is now part of our Constitution and part of our heritage; it defines the boundaries for government intervention in the private lives of all Canadians; it influences thought, government action, policy and administration, as well as legislation. The Charter is relevant not only in courtroom debate but in discussion with doctors, administrators, advocates, service providers, legislators and planners; it may change thought and law in the absense of litigation, by fostering greater concern for our freedoms and more respect for human dignity.

Ensuring this growth is the job of all Canadians, especially advocates for psychiatric inmates and other people who have suffered disability, discrimination and injustice. We must learn how to translate the language of the Charter into affirmative action for psychiatric inmates across Canada.

Institutional Injustice: Inmates Denied Rights

by Kathleen Ruff

The purpose of the *Canadian Charter of Rights and Freedoms* is to set an equal standard of protection around the rights and freedoms of every person. This guarantee of protection should do the most for persons who are most at risk of having their rights and freedoms abused, such as persons with little money or influence, persons who are stigmatized, members of minority groups, persons who are seen as "different," persons who do not conform to the dictates of our plastic culture with its commercial value system.

What the Charter says is that denial of rights and freedoms that the good folks of society would not like to happen to them should also not happen to other persons, no matter if they live under a stigmatizing label, such as "psychiatric patient," or are poor. According to the Charter, the standard that ought to be applied is this: if the denial of freedom or rights would not be tolerated by those with status in our society, then equally it should not be tolerated for a person who is stigmatized and powerless. A double standard is not permitted.

Fundamental freedoms

In order for there to be freedom, there must be choices. If we have no choice as to what work we do, it is indentured labour. If we have no choice as to where we live, we are prisoners. If we have no choice about what happens to us, we are slaves.

What freedom do people in psychiatric institutions have? What options are available to them?

We know without a shadow of doubt that none of the "good folk" in society would choose to live in an institution with its inherent dehumanizing denial of privacy, autonomy and individuality. Why should we think that a "psychiatrically disabled" person would like it?

The fact of the matter is that people end up in psychiatric institutions through one of two routes — either as an involuntary patient or a voluntary patient, neither of which presently stands the test of the Charter.

Involuntary inmates

A 30-year-old Ontario woman was recently released after being kept involuntarily for nine months in Toronto's Queen Street Mental Health Centre ("Centre" sounds nicer than institution) under a warrant of the Lieutenant Governor. She was held in a double-locked Forensic and Special Observation Unit. She was offered no psychiatric treatment. Her case was heard several times during the nine months by a Review Board, but they refused to allow her her freedom. The reason for her involuntary incarceration in the institution? She allegedly had refused to pay her fare on a bus. This incident shows the abysmal and discriminatory level of protection the present system provides for the freedom of persons who have been labelled "psychiatric patient." This person was held involuntarily, not because it was to her benefit, not because it was necessary, but because she fell foul of our social norms and niceties. We may find this person's behaviour inconvenient, embarrassing or a nuisance. She, and many like her, are deprived of their freedom to suit society's convenience.

The grounds on which this woman was deprived of her freedom were that she was found "unfit to stand trial" on the charge of not paying her bus fare. Most persons labelled "unfit" are denied their freedom on the grounds that they pose a threat to the safety of others or themselves. The standard

applied and the procedures followed do not measure up to the guarantee of section 7 of the Charter (not to be deprived of liberty except in accordance with the principles of fundamental justice), and section 15 (equal protection and equal benefit of the law without discrimination on the basis of mental disability).

The standard for depriving any person of her or his liberty should be the same high standard for all. There should not be a lower standard just because someone has had a label "psychiatrically unfit" placed on them.

Many persons in our society conduct themselves in a way that is a threat to the safety of others and themselves — they get intoxicated, drive too fast, smoke, have unhealthy life styles, hit their wives and children. Only in the most extreme cases, and with full due process having been respected, does our society even consider depriving them of their freedom. The procedure for depriving a non-stigmatized person of his/her freedom is stringent. There must be an open hearing, legal representation of the person, the right to cross-examine, access to the evidence, an independent and impartial judge or jury, the right to appeal. If the Charter is to protect the freedom of all persons with equal vigilance, then no-one, including persons labelled "psychiatrically disabled," should be involuntarily deprived of their freedom unless these principles of fundamental justice have been observed and it has been proven beyond a reasonable doubt that the person has, in fact, committed an offence or is, in reality, a threat to the safety of others.

"Voluntary" patients

Persons who needs help or services should have the option of receiving that help or service without having to give up their liberty. At present, the choice for most persons is between receiving the help or service in an institution, or receiving no help or service. The choice for the person without personal wealth or resources is often the institution or the gutter. In other words, there is no choice. There is no freedom. The person is nominally a "voluntary" inmate of the institution, but in fact has no choice. Frequently, voluntary inmates become involuntary whenever they try to leave the institution. Large sums of money are spent by the state to support the institution and its hierarchy. However, an equivalent amount of money is not made available to support the person in the community, even though the person might wish that and might benefit much more from that. Because the person has no option, she is in the institution on an inferior footing, without equality and without freedom. She is powerless and

"If we have no choice as to where we live we are prisoners. If we have no choice about what happens to us, we are slaves."

at the mercy of the institution. This distorted power relationship between inmate and institution paves the way to further abuse of rights and dignity, and jeopardizes healthy relationships and healing between professional and patient.

The Charter guarantees the "equal benefit" and "equal protection" of the law without discrimination for persons who have a physical or mental disability. The inspiration for the Charter comes from United Nations human rights documents. The U.N. Declaration on the Rights of Disabled Persons states: "Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible."

Forcing a person with a psychiatric disability into an institution by providing no alternative is not providing the benefit of equal freedom as promised by the Charter, nor is it respecting the right to enjoy "a decent life, as normal and full as possible" as set forth by the U.N. Declaration.

Denial of rights in institutions

Inmates of an institution lose many rights. Often they are denied the right to wear their own clothes, which attacks their individual identity and self-respect, and increases their sense of powerlessness and worthlessness. Individual identity and self-respect are fundamental human rights, without which a person's mental, emotional and physical well-being are harmed.

The right to privacy is also offended in institutions. Inmates do not have private rooms, private places or private possessions—including control over their own money. Even for activities such as washing and going to the toilet, privacy is not respected. For example, toilets on psychiatric wards may lack doors; there may be no toilet paper. In short, bathroom and bedroom are treated as public places. Further, the right to autonomy, to control one's own life, is denied. The staff decide when the inmate gets up, eats, washes, goes outdoors (if at all), when to take "medication," and when to go to bed. Every aspect of the inmate's life is controlled by others—just as for prisoners.

The right to information and uncensored mail is also denied. Inmates are generally not informed of their legal rights, despite the good intentions of the patient advocates. Typically, inmates do not know what treatment they are given; they may not even know why they are on a locked ward or how and when they will ever get out. Informed consent is not respected; indeed "respect" is virtually impossible in a psychiatric institution, because the institutional situation is inherently coercive, and inmates are given little or no information about the effects and risks of treatments such as drugs and electroshock. Under Ontario's *Mental Health Act,* inmates' mail can be censored, seizured or withheld—except for correspondence with lawyers, the chairman of a Review Board and members of parliament.

Access to legal aid, especially for involuntary inmates, is not provided. The right to legal counsel and representation means nothing if this right is simply on paper in someone's office and if, in practical terms, the inmate has no access to a lawyer.

Rights in institutions will never be respected until this imbalance in power is corrected. Fresh coats of pain or new forms to fill out may prettify the situation, but so long as the inmate has fewer rights than the staff the abuse of inmates' rights and dignity will continue. The individual must have the same freedoms and rights as any other citizen over her own life and body. The relationship of the institution and the psychiatric profession towards the person must be one that respects the right of the individual to control her own life and make her own decisions.

The Charter promises that the rights and freedoms of persons who have been stigmatized by the label "psychiatrically disabled" or "mental patient" will be respected with as much vigilance and seriousness as those of Prime Minister Mulroney or Governor General Sauvé. We must make it clear, on both legal and political levels, that this is what we expect of the Charter's promise of equal protection and equal benefit without discrimination, and that we will accept nothing less.

(Ed. note: Ms Ruff is editor and publisher of the Canadian Human Rights Advocate, *past Director of the B.C. Human Rights Branch and former host of the C.B.C. program "Ombudsman.")*

Charter Challenges Involuntary Committal

by Michael Berman

The Canadian Charter of Rights and Freedoms has already helped to bolster the rights of psychiatric inmates — particularly those held against their will under the *Ontario Mental Health Act*.

A case in 1983 involving an 18-year-old woman involuntarily committed in St. Thomas Psychiatric Hospital illustrates the potential power of the Charter. After losing her appeal before a Regional Review Board hearing and being ordered incarcerated for a further three months, the young woman went to County Court and appealed the Review Board's decision; she argued that many of the procedures followed by the Board in coming to its decision failed to fulfill the requirements of the Charter. In particular, she referred to Sections 7 and 9:

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

Long-overdue improvements

The Provincial Government's reaction to the appeal was to enact improvements in the *Mental Health Act* (Sections 66 and 67), effective March 1, 1984. The Government had passed these changes five years earlier but never proclaimed them; it was the power of the Charter, and this woman's determination to employ it in her appeal, which helped to convince the Government to make the changes law.

These long-overdue improvements in legal protection for people facing involuntary committal are far from perfect, but protections such as the following are a beginning which can be built upon: (1) All Review Board hearings must have stenographers present so that there is a written record of all the evidence for appeal if necessary. (2) Clear disclosure provisions allow access to the inmate's medical record by both the inmate and his/her representative or lawyer. Doctors still have the right to refuse this access, but the inmate has the right to request to see his/her record, and to appeal this refusal to the Supreme Court of Ontario. (3) The rights of appeal are clearly set out, allowing the inmate to appeal any decision of the Review Board to a Divisional Court Judge. (4) The Act requires all psychiatric facilities to notify Legal Aid of all involuntary committals. (Unfortunately, no action has been taken by Legal Aid after such notification. There are still many important weaknesses or loopholes in these procedures.)

These changes are a step towards observing "the principles of fundamental justice" (as guaranteed in Section 7 of the Charter) at inmates' hearings by ensuring fair and unbiased procedures; but there are other procedures in sections 66 and 67 of the Act — such as time delays in holding hearings, form of questioning, the role of doctors, and hearings held before a Review Board rather than a judge — which remain unfair to inmates and are open to Charter challenges.

Involuntary committal in a psychiatric institution raises many other civil rights issues: (1) The person (doctor/psychiatrist) making the decision is often influenced by family or friends who may not have the best interests of the inmate at heart. (2) There is no automatic hearing or review by an independent decision-maker such as a Judge. However, in criminal law, the accused has the right to a release hearing (bail hearing), which usually occurs within 24 hours of the arrest. (3) No outside or independent investigation into the psychiatric inmate's complaint(s) is required. (4) The inmate's right to a Review Board hearing occurs only when the inmate makes an application (Form 16 or 17); even then, delays of one to four weeks are not uncommon.

Equal treatment provided

Section 15(1) of the Charter (the equality clause) states:

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

This section asserts that all Canadians must be treated equally, and that all procedures and laws affecting Canadians must not discriminate on the basis of mental or physical disability, among other prohibited grounds. Such a declaration should be of great significance in protecting the civil rights of people with disabilities, including psychiatric inmates.

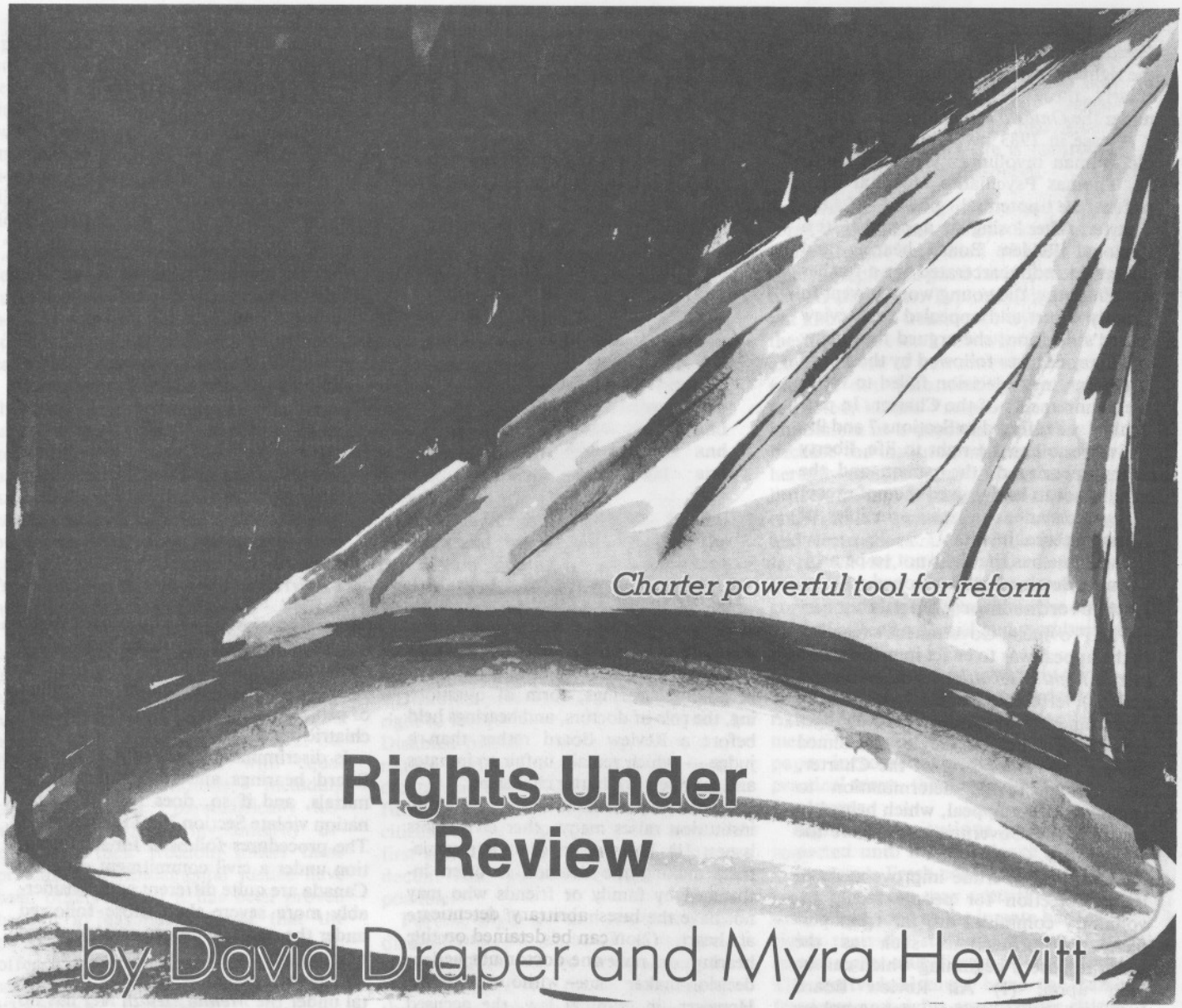
Is discrimination practised at Review Board hearings and involuntary committals, and if so, does such discrimination violate Section 15 of the Charter? The procedures followed for incarceration under a civil commitment order in Canada are quite different and considerably more severe than those followed under the criminal detention procedures or immigration detention procedures.

A person facing involuntary committal under the *Mental Health Act* has no specified rights, whereas detention procedures under criminal and immigration law require that the person detained be informed immediately of their right to a lawyer.

A person facing criminal procedures has the right to be brought forward for a release hearing within 48 hours; under immigration procedures a release must be held every seven days; but the psychiatric inmate may have to wait as long as three months for a release hearing. This is clearly a form of discrimination based on mental disability.

The Charter can substantially affect the civil rights of psychiatric inmates. In fact, the very concept of involuntary committal may be found to violate the Charter — particularly Sections 7, 9, 10, 11 and 15. Only time and more test cases will help clarify and, I hope, strengthen these rights.

(Ed. Note: Mr. Berman is a Toronto lawyer who has represented psychiatric inmates at Review Board hearings.)



Charter powerful tool for reform

Rights Under Review

by David Draper and Myra Hewitt

(Ed. Note: David Draper is a staff lawyer with the Parkdale Community Legal Services in Toronto. Myra Hewitt is a student at Osgoode Hall Law School.)

Decisions made by psychiatrists and other mental health professionals have a profound effect on the lives of their patients. In Canada, psychiatrists — not the Courts — are empowered to make decisions about many crucial issues such as involuntary commitment, patients' capacity to consent to treatment and manage their financial affairs, "privileges" within the psychiatric institution and transfers to other facilities.

Each province has enacted its own mental health laws. Although each province conducts a review of some psychiatric decisions, the scope and specifics of the review processes differ from province to province. The *Canadian Charter of Rights and Freedoms* (the Charter) provides a powerful tool for reform, because all provincial laws must comply with the Charter. Provincial mental health laws must now ensure that psychiatric patients are dealt with according to the "principles of fundamental justice" (Section 7), and are not unreasonably discriminated against on the basis of mental disability (Section 15), and are not "arbitrarily detained" (Section 9), or subjected to any "cruel and unusual treatment or punishment" (Section 12).

In this article, we discuss the review process in Ontario (the Review Board system was established under Ontario's *Mental Health Act*) as the focus for considering the potential impact of the Charter on psychiatrists' and patients' rights.

There are five Regional Review Boards in Ontario. Each Board consists of panels of three to five members to hear cases. The members are lawyers, psychiatrists and lay people, who are appointed by the Government. The Board is responsible for hearing three distinct and important types of cases: first, it hears cases involving involuntarily committed patients who can apply to the Board to appeal or protest the legitimacy of their committal; second, it deals with applications by doctors for treatment orders involving patients who have refused any treatment; third, the Board hears appeals from patients who have been declared financially incompetent to manage their money. It is important to note that the Board has no authority to review certain major psychiatric decisions such as hospital "privileges" and transfers.

Commitment hearings

Section 7 of the Charter states that everyone has the right to life, liberty and security of the person and that these rights cannot be taken away, except in accordance with the principles of fundamental justice. It is clear that involuntary civil commitment constitutes a deprivation of liberty, and therefore the commitment process must conform to the principles of fundamental justice.

"Fundamental justice" is a new term

in Canadian law; its meaning is still unclear. Although the specific procedural requirements of fundamental justice will need to be determined by the Courts, some observations are possible. Unfortunately, Canadian Courts have been hesitant to interfere with the psychiatric process. Generally, they have seen psychiatric interventions as "therapeutic" rather than punitive and therefore believe that some limitation on personal liberty is justified. The Courts have also resisted recognizing a similarity between imprisonment under the Criminal Code and involuntary civil commitment in a psychiatric institution under mental health laws.

The situation in the United States has become more relevant because the "due process" clause of its *Bill of Rights* is similar to the requirement of fundamental justice in our Charter. The U.S. *Bill of Rights* provides that no person shall be deprived of life, liberty, or property, without *due process* of law. This has been held by U.S. Courts to require effective and timely notice of a review hearing; notice of rights; an initial review within 48 hours of detention; a full hearing within two weeks; right to legal representation and proof beyond a reasonable doubt.[1]

In fact, the Canadian provision is at least as powerful on paper as the U.S. due process clause. However, our Courts have rejected U.S. interpretations where the U.S. experience is seen as negative. The due process clause has been used to establish procedural protections for psychiatric patients in the United States. We wonder whether our Courts will be eager to follow the same path in interpreting the Charter. Despite these comments, there are a number of Review Board practices which appear to be open to judicial scrutiny under the Charter.

The Charter will not be interpreted in a vacuum; reference must be made to the rights which already exist in Canadian law. Before the enactment of the Charter, there had been a trend toward giving greater procedural protections at administrative tribunals such as the Review Boards. When the *Mental Health Act* was substantially changed in 1978, two sections (66 & 67) were not proclaimed into law. One section requires that the psychiatric institution notify the Area Director of Ontario's Legal Aid of each certificate of committal and certificate of renewal. The other section guarantees patients a number of procedural rights during a Review Board hearing. There now is a right to an in-person hearing, a right to see the medical record which will be presented to the Board, and a right to cross-examine witnesses. These sections were finally proclaimed on March 1, 1984, apparently because the Ontario Government became concerned about possible Charter challenges if it failed to guarantee these rights in the Act.

Under the *Mental Health Act,* a patient may apply for a review of his/her commitment only when a certificate of involuntary admission or a certificate of renewal comes into force, or when the patient's status is changed from voluntary to involuntary. This means that when a patient is detained in a psychiatric institution or ward for psychiatric assessment (which can last up to five days or 120 hours), there is *no opportunity* to apply to the Review Board or Court for a hearing during this time. However, under the Charter, the Courts can now be asked to consider whether a system which allows detention for up to five days without access to review or appeal violates the principles of fundamental justice. It can also be argued that this system constitutes abritrary detention, because a person can be detained on the signature of only one doctor not necessarily a psychiatrist — without access to appeal.

A major problem with the practice of Review Boards is the long time it takes to schedule a hearing. Review Boards operate on a part-time basis; as a result, a considerable amount of time can pass between the patient's application for review and the actual hearing. Also, certificates of commitment are valid for a limited period (eg., 2 weeks, 1 month, 2 months, etc.). It is all too common for a patient to apply to the Board for a review of his/her certificate, and then discover that the hearing is scheduled for a date after the certificate is due to expire. Is this in accordance with the principles of fundamental justice?

Section 10 of the Charter states that, upon detention, everyone has the right to retain and instruct a lawyer immediately and to be informed of that right. As a result of the recent proclamation of sections 66 and 67 in the *Mental Health Act,* the Area Director of Legal Aid must be notified of all involuntary committals and renewals of involuntary committal. The problem is that the Act does not state just what the Area Director must do with that notice. In fact, Area Directors are doing nothing, so that many involuntary patients in Ontario are not obtaining legal advice. Although some patients are represented by lawyers before the Regional Review Board, most are not. There is some scope here to argue that psychiatric patients are entitled under the Charter to better access to lawyers, which was strongly recommended in the Abella Report.[2]

The procedural rights of psychiatric patients before the Boards have been greatly improved by the proclamation of sections 66 and 67 in the Act, but basic questions remain, which affect the fairness of the process. Neither the Boards nor the Courts have stated clearly whether it is the institution's responsibility to prove that an involuntary commitment is valid, or whether a patient seeking release must personally prove that he/she does not fit the commitment criteria. If it's the hospital's responsibility, the standard of proof is also unclear. In other words, we do not know whether the hospital must prove its case on a balance of probabilities, beyond a reasonable doubt, or according to some standard between the two.

In Ontario, involuntary commitment under the *Mental Health Act* is based on the opinion of a doctor that the patient is suffering from a mental disorder and that unless the person is detained in a psychiatric facility, the "mental illness" likely will result in serious bodily harm to the person or someone else. In other words, the commitment is based on a prediction of future behaviour. However, many studies have clearly shown that psychiatrists cannot accurately or reliably predict dangerous behaviour. It therefore can be argued under the Charter that a system which relies on this type of speculative evidence violates fundamental justice and constitutes arbitrary detention. This argument was made in the context of Federal Dangerous Offender Legislation. In one case, a single Justice of the

Supreme Court of Ontario decided that although this type of evidence was somewhat speculative, a system which relied on it did not necessarily violate the Charter.[3] It is possible that higher Courts might reach a different conclusion.

Treatment hearings

In cases where the attending doctor or psychiatrist wants to use a particular treatment but cannot obtain a valid consent, he/she can apply to the Review Board for a treatment order. It is equally important to consider what the review procedures do not provide. Under the *Mental Health Act,* the attending doctor must evaluate each patient's competence to consent to treatment. If the patient is found incompetent, consent to treatment can be obtained from the patient's nearest relative. As a result, the incompetent patient loses the right to accept or reject treatment, and has no right to appeal the doctor's decision of incompetence to a Review Board, because the Act provides no review or appeal mechanism. This serious omission in the Act is certainly open to Charter challenges because it violates the principles of fundamental justice.

The issue of treatment leads to consideration of Section 12 in the Charter, which states that everyone has "the right not to be subjected to any cruel and unusual treatment or punishment." Some patients may wish to challenge controversial treatment procedures, such as electroshock or neuroleptic drugs, under this Section. One recent case, which did not use Charter arguments, challenged the right of the Review Board to order electroshock (ECT) for an involuntary but competent patient who refused electroshock. As a result of this case, last year the Government of Ontario established an ECT Review Committee to investigate the medical, ethical and legal aspects of this procedure in the province.[4]

A competent person can refuse *any* medical treatment, even if everyone else feels the treatment should be given. Although the Review Board can ignore or override the refusal of a competent patient, as it did in the "Mrs. T." case, its decisions can now be appealed to the Courts under the *Mental Health Acts.*

The Charter prohibits discrimination on the basis of mental disability. This situation is certainly a good example of discrimination, but the Courts can still decide that the discrimination "is justified in a free and democratic society."

Financial competence

Under the *Mental Health Act,* the attending doctor must also decide if each patient is competent to manage his/her financial affairs. If not, the government's Public Trustee is appointed to manage the person's money. This procedure requires the judgement of only one doctor, who then fills out a special form. However, persons who are not psychiatric patients cannot lose control of their financial affairs, except under sections of the *Mental Incompetency Act.* This fact represents a clear discrimination against psychiatric patients, which can be challenged under the equality clause of the Charter (Section 15) as an unjustifiable discrimination because of mental disability.

Privileges and transfers

Mental health professionals make other significant decisions which currently cannot be reviewed by the Review Boards. Refusal of the psychiatric staff to allow patients "privileges" can be the most degrading aspect of psychiatric incarceration. For example, patients' complaints of being denied "privileges" such as wearing one's own clothes (instead of hospital pyjamas) and moving freely outside (instead of being kept on a locked ward) are very common. Currently, the Review Boards have no authority to review or hear such complaints. It can be argued that by refusing psychiatric patients these "privileges," psychiatric staff are depriving patients of liberty, and fundamental justice requires access to a review hearing or Court appeal.

The Courts have held that the Review Boards have no authority to review decisions to transfer patients to other facilities. However, the patient can make the same argument as mentioned above: namely, that transfer to another psychiatric institution without review is a deprivation of the person's liberty. Support for this position can be found in judicial decisions involving prisoners. Transfers to more "secure" parts of the prison or to another prison have been found to require procedural protections. As previously mentioned, our Courts have been reluctant to make comparisons with the criminal justice system.

Using the Charter

Taking the potential Charter challenges out of the realm of discussion and into the courtroom presents some practical problems which cannot be ignored. First, challenging possible rights violations under the Charter presumes that patients have ready access to lawyers or legal services. The provincial government has not yet decided how to comply with those newly-proclaimed sections of the *Mental Health Act* which were intended to improve patients' access to lawyers.

Even assuming that access is improved, the expense and time involved in Charter arguments lead to other difficulties. As for timing, a patient may be released long before the Charter issues get raised in Court. Charter cases are not only time-consuming but expensive. Although the Ontario Legal Aid Plan and community legal clinics can provide legal assistance to those who cannot afford legal fees, the patient/client will have to show that the Charter challenge is worth public expense.

In addition to these practical problems, there is the underlying problem of powerlessness which all psychiatric patients face. In this respect, the role of advocacy groups becomes very crucial. Lobbying efforts which demand better protection from the government for patients' Charter rights, and efforts focussed on seeking remedies for rights which are being violated, can be effective strategies.

Probably the best way to turn the Charter chatter into Charter challenge is to focus attention on remedies that are potentially available under the Charter. The Charter states that someone whose rights have been violated or denied can apply to a Court for a remedy which the Court considers appropriate and just in the circumstances. This provision is very broad and has the potential for innovative remedies. Psychiatric patients have generally gone to Court for the main purpose of securing their release. The Charter now gives patients the opportunity to ask the Courts to provide other, more creative remedies such as ordering the institution to change its practices, improve its facilities, or even compensate the patient by paying damages.

Any number of patients could together claim that their Charter rights have been violated. This is a very powerful strategy which could be used to force changes in government or institutional practices. In the United States, some courts have responded aggressively to this type of action and have required hospitals to comply with very specific directions. The directions have included all aspects of institutional care, including physical environment, food, clothing, exercise and treatment. U.S. Courts have been willing to take this action based on Constitutional language which is probably less powerful than that of the Charter.[5]

Conclusion

The Charter offers a powerful tool for ensuring that the rights of psychiatric patients are respected. The impact of the Charter may be not so much the establishment of new rights but the clarification, strengthening and enforcement of existing rights.

Footnotes:

1. *Lessard v. Schmidt,* 349 F.Supp. 1078 (Wisc. 1972).
2. *Access to Legal Services by the Disabled.* Report of a Study by Judge Rosalie S. Abella, 1983.
3. *R. v. Moore* (January 10, 1984, unreported decision of Evaschuk, J., Appeal reported, 1985, 48 O.R. (2d) 1 (C.A.).)
4. *Re T. v. Board of Review for the Western Region* (1983), 44 O.R. (2d) 153.
5. *Wyatt v. Stickney,* 344 F.Supp. 373 (1972).

a first for the Charter

Fighting Emergency Committals:

The Theresa Lussa Story

by Harry Peters

Everyday in Canada, hundreds of allegedly "mentally ill" persons are arrested on warrants or certificates of committal issued by administrative officials on the strength of only one doctor's signature. This is frequently done without prior notice, to people who present no danger to themselves or others. It is most unjust.

This is what happened to Theresa Lussa in November of 1983. Her case is particularly important, because it was the first time that the *Canadian Charter of Rights and Freedoms* was used successfully to release a non-dangerous, "mentally ill" person from a locked psychiatric ward. I hope Theresa's fight and victory will give courage to many other psychiatric inmates and ex-inmates facing a similar situation. I also hope that Theresa's victory and the fact that some judges are prepared to listen to legal arguments made on behalf of psychiatric inmates will encourage many other people and lawyers to use the courts to challenge and overcome the injustices and oppression of the psychiatric system.

"Assumed" crazy

Theresa Lussa had been involuntarily committed on several other occasions before November 1983. Despite these devastating interruptions in her life, she still managed to keep a home that she purchased from the proceeds of a divorce settlement. Her only income was the rent she collected from a tenant. Because of her eccentric behaviour, she never held a job for very long. Because she was poor, she was forced to wear second-hand clothes—one might mistake her for one of the infamous 'bag ladies' who survive or try to survive in our Canadian cities.

However, Theresa was getting tired of these unjustified abuses of her person and freedom. In early 1983, she had sought help from other former psychiatric inmates. Through Last Boost Club founder Kendra Russell, Theresa obtained my advice about her incarceration in a psychiatric ward, which is where I first met her. Before her case was brought to court, Theresa's doctors felt she was behaving more "appropriately," so they discharged her on condition that she: (1) keep her appointments with her psychiatrist, and (2) take any drugs which he might prescribe for her.

Of course, Theresa soon stopped taking the "medication" because it drained her of feeling and will power, and caused her to faint and to sleep most of the day. Once off the drugs, Theresa was soon up to her usual antics—hanging out late at

night in coffee shops, talking to friends and strangers about the meaning of life and her favourite topic, the English language and dictionaries. Unfortunately, she antagonized a stranger, and the management at a local Salisbury House (a Manitoba restaurant chain) called the police to have Theresa removed from their premises. If Theresa had been an obnoxious drunk, the police would have arrested her and probably released her after she sobered up. At worst, she might have been charged with causing a public disturbance, and the next morning, a judge would have released her on her own recognizance. If she had pleaded guilty to such a charge, she might have been fined a few hundred dollars—at the most.

However, when the police arrived at the Salisbury House, Theresa's previous involvement with the psychiatric system caught up with her. Since she was not drunk, the police soon realized that Theresa was not a criminal; they immediately assumed from her conduct that she was crazy and that the best place for her was the psychiatric outpatient office in Winnipeg's Health Sciences Centre. When Theresa arrived with the police, the doctors-in-charge discovered that she was a former psychiatric inmate. With the help of Manitoba's *Mental Health Act,* they quickly obtained a 21 day warrant of committal and within a few hours the woman was heavily drugged.

Judge ordered release

Despite the drugging, Theresa was able to remember her contact with me, but it took her six days to overcome the drugs' powerful effects and to telephone me. A week later, her case came before a judge, and after a full day's argument by the Crown, Mr. Justice Kroft ordered her immediate release. Theresa had been illegally incarcerated for two weeks.

Why did Mr. Justice Kroft release Theresa Lussa when a doctor had signed a medical certificate on the day that she was arrested, stating that she was "loud and abusive, cursing at staff and police"? And why did he order Theresa's release knowing that she had been committed on several occasions for "mania"?

One general answer to these questions is that Mr. Justice Kroft was convinced that Theresa's rights, as protected by the Charter, had been ignored without justification. In ordering her release, Mr. Justice Kroft found that Theresa had never been in danger to herself or others. This was very important, because although persons prove gross violation of their rights, under the Charter the courts are not empowered to strike down laws which are "shown to be reasonably justified in a free and democratic society." This section of the Charter is frequently used by the courts when they believe the law is unfair but necessary. In a welfare state such as Canada, emergency committal of dangerous persons may be unfair under our Charter but justified by this provision. For example, if your case involves violence or threats to the person or others, the chances of release through the courts are slight. Fortunately for Theresa, her psychiatric history disclosed only bizarre non-threatening and non-violent behaviour.

Decision based on Charter

After he had decided that Theresa was not dangerous, Mr. Justice Kroft proceeded to give her the same benefits of the law that the Charter confers upon every Canadian. His decision was based upon three major findings:

First, he found her incarceration to be contrary to the principles of fundamental justice; it therefore violated Section 7 of the Charter which states: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." Mr. Justice Kroft also stated that the magistrate who granted the 21 day warrant of committal was required to exercise discretion, and in the absence of evidence of danger to herself or others, the magistrate had failed to properly exercise his discretion. The law states that a decision-maker such as a magistrate cannot properly exercise discretion without hearing both sides of a story. Since Theresa was incarcerated and probably heavily drugged by the time the magistrate was asked to sign his Order, she had no time to contact a lawyer, let alone make representations as to her sanity or the lack of need for an immediate committal.

Second, Mr. Justice Kroft found that Theresa's incarceration was also arbitrary; it therefore violated Section 9 of the Charter which states: Everyone has the right not to be arbitrarily detained or imprisoned. Since Theresa wasn't dangerous, she should not have been locked up. Her freedom had been taken away with a good and valid reason, and it therefore was arbitrary.

Third, and finally, Mr. Justice Kroft considered Section 10 of the Charter which states: Everyone has the right on arrest or detention (a) to be informed promptly of the reasons thereof; (b) to retain and instruct counsel without delay and to be informed of that right. In this respect Mr. Justice Kroft was not satisfied that a sign posted in the halls of a psychiatric institution amounted to compliance with the rights stated in Section 10. Because the institution had failed to give him evidence about Theresa's capacity to understand her rights, he ruled that Section 10 had not been complied with. Once again, he decided that Theresa's rights had been violated.

It was on these grounds—violations of Sections 7, 9 and 10 of the Charter—that Mr. Justice Kroft decided that Theresa's incarceration in a psychiatric institution was unlawful, and he therefore ordered her immediate release.

Similar challenges unsuccessful

Since the Theresa Lussa case was decided in 1983, other psychiatric inmates facing similar circumstances have also tried, for similar reasons, to be released from psychiatric institutions in Manitoba. Many have failed. In some cases, the judges considered them to be dangerous to themselves and ruled that their continued detention was "justifiable in a free and democratic society," despite the fact that their detention was unjust. Other people have encountered a common prejudice that their lawyers could not overcome, namely that the courts sometimes refuse to hear their cases on the assumption that doctors are dedicated to doing good in our society, so their actions should not be questioned. In fact, some lawyers have been criticized for daring to represent psychiatric inmates or ex-inmates, on the grounds that "mentally ill" patients cannot properly instruct counsel.

However, since Section 15 was proclaimed on April 17, 1985, its effect in fighting emergency committal warrants may be far-reaching. Section 15(1) of the Charter states: Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or *mental* or physical *disability* (my underlining).

Under this section of the Charter, the courts will no longer be able to say that allegedly "mentally ill" persons are not able to properly instruct counsel. The courts will also no longer be able to say that these persons' freedom is subject only to the opinion of doctors or psychiatrists who are presumed to be always right. At long last, psychiatric inmates will have the right to their day in court whenever their freedom or life is threatened. They will have the right to prior notice of any hearing which could lead to the loss of their freedom or ability to earn a living.

When psychiatric inmates and former psychiatric inmates are treated with the dignity and respect which they and all other human beings deserve; when they are fully informed of their constitutional, civil and human rights, and when these rights are enforced, then all Canadians will benefit and Canadian society will become more just.

(Ed. Note: Mr. Peters is a Winnipeg lawyer associated with Community Legal Services. He successfully represented Ms Lussa, winning her release from a psychiatric ward.)

Ottawa undermining charter, law professor charges

The federal government is engaging in a sinister attempt to undermine the equality provisions of the Canadian Charter of Rights and Freedoms, says law professor Ken Norman, former head of the Saskatchewan Human Rights Commission.

Federal Justice Minister John Crosbie has appointed a Parliamentary Committee to hold hearings across the country to find out what the majority think about equality. "This is a deliberate, sinister attempt by the federal government to build up a consensus against change and give the federal government an easy way out for not doing anything to implement equality. Even more sinister, the government is also attempting to create a record against equality that it can then introduce into court cases to try to justify limiting the way equality is interpreted in the courts."

Section 15 of the Charter states — "Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability." The coming into force of Section 15 was delayed for three years until April 17, 1985 in order to give the federal and provincial governments time to bring their laws into conformity with this Section.

Minor cosmetic changes

At the end of the three years, however, instead of taking strong leadership action to change its laws and practices in line with equality, the federal government made only a few minor cosmetic changes. Instead it presented a Discussion Paper in the House of Commons called *Equality Issues in Federal Law* and appointed the Parliamentary Committee to travel across the country holding hearings.

The Discussion Paper makes it clear that the government is seeking majoritian attitudes and will implement "the consensus that emerges." In radio interviews on the day Section 15 came into effect Crosbie indicated that he would disregard what groups who are informed and committed to human rights want. "These people are on the leading edge, they are the activists," said Crosbie. He wants to hear from the "tens of millions of Canadians who know nothing of the issues raised by Section 15 of the Charter."

Section 1 of the Charter says that the rights and freedoms it guarantees are subject to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." Ken Norman's point is that the government's purpose in setting up the Charter hearings is to deliberately build up a record of "majoritarian views" against equality that can then be used in the courts under Section 1 to justify a narrow, conservative interpretation of equality.

The Chairperson of the Charter Committee, J.P. Boyer, MP, has stated his opposition to such concepts, already written into the Charter, as affirmative action. Says Boyer, "Personally I have problems with affirmative action as it is reverse discrimination. I find it difficult to see how two wrongs can make a right." Boyer takes the view, common among white able-bodied males, that white able-bodied males monopolize positions of status, power and wealth in our society because they are inherently better qualified and more competent. He does not see affirmative action as a means of allowing qualified women, minorities and persons with disabilities finally an equal chance at opportunities that have been denied them because of entrenched discrimination. Instead, he sees affirmative action as giving incompetent women, minorities and persons with disabilities opportunities they do not deserve.

Oral or written presentations

It is essential that as many individuals and groups as possible make oral or written presentations to the Parliamentary Committee. A deadline of May 15 was set by which to notify the Committee of the wish to make a presentation.

However, many groups and individuals did not know of the government's Discussion Paper, nor of the Parliamentary Committee, nor of the May 15 deadline. Little publicity has been made to inform people of these important hearings which will impact on how the equality provisions of the Charter are implemented for years to come. If you did not know of the May 15 deadline, write to the Committee and insist on your right to make a presentation.

Write immediately to J.P. Boyer, MP, Committee on Equality Rights, House of Commons, Ottawa K1A 0A6 (no stamp needed) and say you want to appear before the Committee when it is in your area. If you do not already have it, ask for a free copy of the government's Discussion Paper *Equality Issues in Federal Law.*

Advise others also to make presentations. If you make a written submission, send the Advocate a copy, and inform them this submission was late because the Committee failed to inform you or your group of the hearings and/or the deadline. Advocate address is: Canadian Human Rights Advocate,

No. 1703 - 500 Murray Ross Parkway,
Downsview, Ontario
M3J 2Z3

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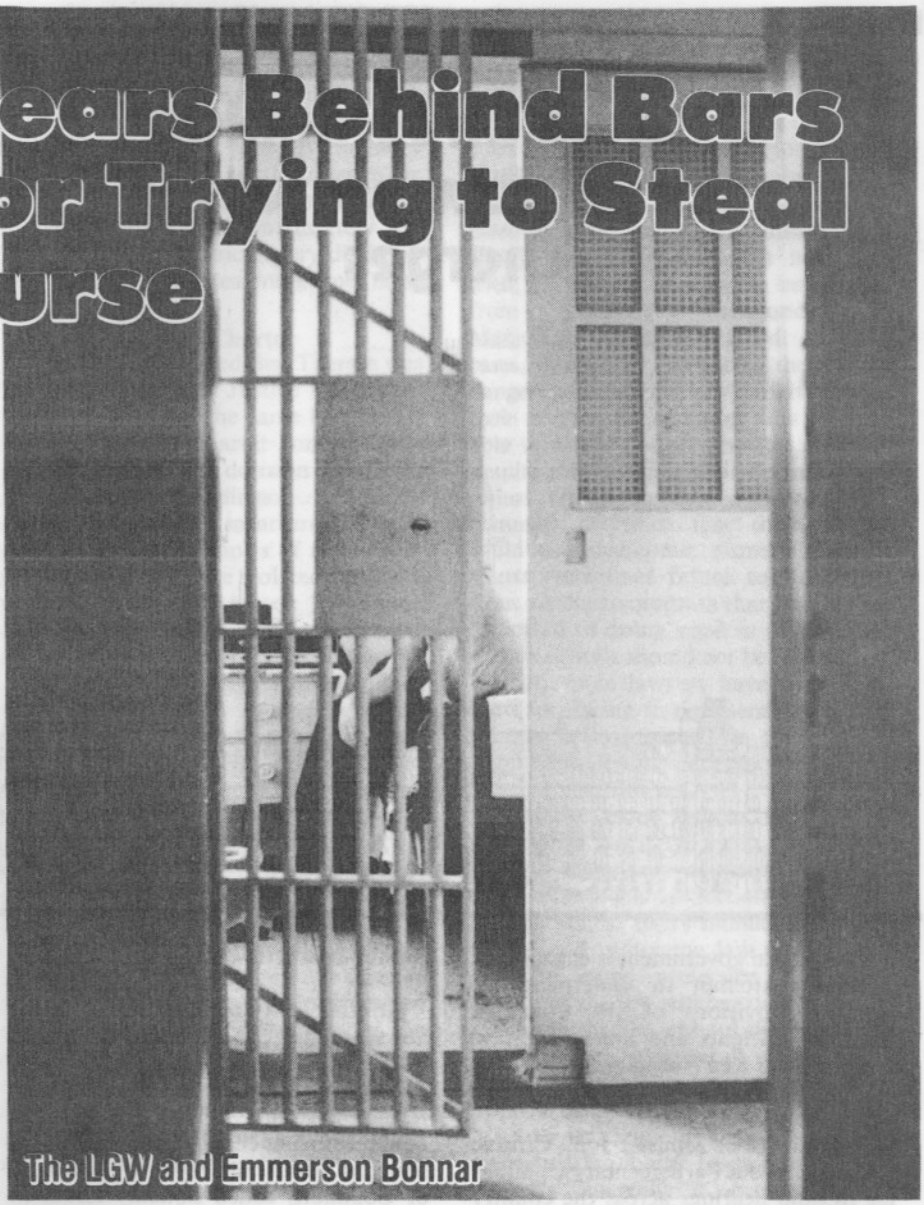
17 Years Behind Bars For Trying to Steal Purse

by Harvey Savage

(Ed. Note: Harvey Savage is a Toronto lawyer and advocate of psychiatric inmates' rights. With lawyer Carla McKague, he is writing a book on mental health law and practice in Canada.)



The LGW and Emmerson Bonnar

In 1963, a 19-year-old New Brunswick youth fumbled an effort to steal a woman's purse; a comic tug-of-war on the street soon brought the police. Caught in the act, Emmerson Bonnar was charged with attempted robbery, under the Criminal Code of Canada. Bonnar had no criminal record, and at his first court appearance he told the magistrate that he intended to plead guilty, that he did not wish to be represented by a lawyer (there was no legal aid in New Brunswick then), and that he simply wanted to get it over with. The magistrate accepted his guilty plea and adjourned sentencing for two weeks in order to obtain a pre-sentence report. This is the report (generally ordered by a judge when dealing with a young offender with little or no criminal record) which assists him in the most appropriate disposition. Bonnar, it's worth repeating, had *no* previous criminal record.

During the two-week adjournment, the accused was examined for approximately one hour by a psychiatrist who had treated him previously as an outpatient. Bonnar had been on psychiatric drugs intermittently for several years and had also been treated for emotional problems. It is worth noting that the magistrate didn't question Bonnar's intellectual or mental capacity when accepting his plea of guilt.

Given all these facts, and legal precedent, the sentencing hearing should have been routine. The judge would hear from the psychiatrist and probably read the report, which would undoubtedly include statements from other members of the community. Considering Bonnar's age, that he had no criminal record, that the attepmted theft had been bungled, and that no injuries had been inflicted, the harshest possible sentence would probably be about 30 days in jail. In all likelihood he would receive a suspended sentence with probation.

What actually happened has become a much publicized example of questionable justice, and unquestionable personal tragedy. At the hearing, psychiatrist Robert Gregory gave evidence based upon his one-hour observation of Bonnar. He asserted that I.Q. test results showed the defendant was probably "borderline retarded" or a "moron," and when asked by the magistrate whether or not Bonnar could instruct a lawyer, he said, "probably not." Bonnar was not asked by the magistrate whether he now wished to obtain a lawyer — since the pre-sentence hearing was evidently turning into a fitness to stand trial hearing; further, he was not even asked whether he wished to cross-examine the witness, or if he had any closing comments to make before the judge passed sentence. Instead, the magistrate, after hearing five minutes of evidence from the psychiatrist, struck out Bonnar's guilty plea, declared that in his opinion Bonnar was unfit, and placed him under a Lieutenant Governor's Warrant.

Under authority of the Warrant, Bonnar was committed to a provincial hospital for the criminally insane in Campbellton, New Brunswick where he spent the next 17 years, until pressure from the Canadian Association for the Mentally Retarded and the C.B.C. Ombudsman program led to his release. (See "At the lieutenant-governor's pleasure" in *PR*, vol. 1 no. 2, 1980) For the first seven years, there was not even a review of his detention; once reviews were conducted, they were more or less legal routine, with little or no input from Bonnar, no right to see or review his files independently, and with no lawyer present. Bonnar was rubber-stamped unfit from review to review until he was finally released. While incarcerated, he received no particular therapy which could be described as improving his own well-being. Like many other inmates, he was involved in an intensive drug therapy program, and over the years he became increasingly withdrawn and uncommunicative.

How could this have happened; why are similar injustices still being perpetrated under Warrants of the Lieutenant Governor? A Lieutenant Governor's Warrant is an authorization given to the Crown to detain an accused person at its pleasure — generally indefinitely. This is a troublesome concept, and it bears closer examination in the context of how apparently mentally disordered persons are "treated" under Canada's criminal laws.

In the Criminal Code of Canada, there are two procedures by means of which an accused person's fitness to stand trial may be questioned. First, if the magistrate or judge suspects, even at a pre-trial hearing, that the accused person may be "mentally ill" or that his mind may be "disturbed," he may order him to attend "at a place of observation," generally for no more than 30 days. The place of observation is usually a custodial setting such as a maximum-security psychiatric institution, although the language of the text leaves room for argument that the accused may attend as an outpatient. During this period the accused person is seen, for observation purposes only, by a psychiatrist or other physician, who then writes a report for the judge or magistrate on the accused person's fitness to conduct a defence. Nowhere in the Criminal Code are criteria spelled out as to what constitutes fitness to conduct a defence; that decision is left to the judges. On the basis of the observor's or psychiatrist's report, the judge does one of two things: he considers the accused person fit and proceeds with the trial, or determines that there is sufficient reason to doubt that the accused is, "on account of insanity, capable of conducting his defence." If he reaches the latter decision, he then directs that a hearing be held into the question of the accused person's fitness to stand trial.

The second procedure for determining fitness occurs after a trial has already begun. The judge or magistrate may, at any time before a verdict is reached, interrupt the trial and conduct a separate hearing to determine whether the accused person is "on account of insanity" incapable of conducting his/her defence. There are no procedural rules specified for conducting this hearing, even though a person's freedom hangs in the balance. Should not the accused person be guaranteed legal counsel? What are the criteria for determining "fitness" or "unfitness"? What should be the standard of proof required in order for the judge to establish fitness: should it be the strict criminal evidence standard of proof beyond reasonable doubt, or the less rigid, civil standard proof of a balance of probabilities? Should not the accused be allowed the right to make a closing statement? What should be the qualifications of the expert witness testifying on the issue of fitness? Should there not be a right of appeal following a verdict of unfitness? The Criminal Code of Canada is silent on all of these points; hence, a five-minute hearing can determine whether a person may ever again taste freedom — as happened in the Bonnar case.

"... questionable justice, and unquestionable personal tragedy."

The Warrant of the Lieutenant Governor is vulnerable to challenge as being unconstitutional under the *Canadian Charter of Rights and Freedoms,* because it denies due process during and after a trial. At least six sections of the Charter guarantee rights which are routinely ignored by LGW procedures. Section 7 entrenches, among other things, every person's right to liberty and the right that this liberty not be taken away, except in accordance with "the principles of fundamental justice." Does this not, at the very least, guarantee everyone facing a fitness hearing access to due process rights — the right to a lawyer, the right to cross-examine, the right to make closing statements, and so forth? The lack of clear criteria in the Criminal Code for determining "unfitness" may also violate Section 7. It can be argued that "fundamental justice" requires knowing exactly what a judge has based his decision on so that the accused person may properly present his/her case. After all, the consequences of being found unfit are severe in the extreme.

Section 9 affirms that everyone has the "right not to be arbitrarily detained or imprisoned." If one faces the risk of a lifetime detention for a failed attempt at purse-snatching, is this not a form of arbitrary detention or imprisonment?

"The Warrant of the Lieutenant Governor is vulnerable to challenge..."

Section 10 asserts everyone's right, upon arrest or detention, "to retain and instruct counsel without delay and to be informed of that right." This provision alone would have been of immense benefit to Emmerson Bonnar had it been in force in 1963.

Section 11 declares the right of "any person charged with an offence ... to be tried within a reasonable time;" one can remain "unfit" for a very long time under a Lieutenant Governor's Warrant. Does not the Charter require that a person found unfit by the courts either be appropriately treated and released, tried within a reasonable time or, failing both alternatives, be immediately released? Emmerson Bonnar would undoubtedly have appreciated the exercise of this right.

Section 12 declares that "everyone has the right not to be subjected to any cruel and unusual treatment or punishment." Is it not cruel and unusual punishment to give someone an indefinite sentence without right of appeal, supposedly because they need treatment, and then not to guarantee in law the right to appropriate treatment? Under a Lieutenant Governor's Warrant, the inmate receives neither criminal justice nor beneficial therapy. All too often, the person deteriorates during their indefinite incarceration in a psychiatric institution. And is that surprising? Under these circumstances, the Warrant certainly is a form of cruel and unusual punishment — not "treatment."

Section 15 of the Charter explicitly guarantees every Canadian the right to "equal protection and equal benefit of the law" without discrimination based on, among other things, mental or physical disability. However, a person found unfit to stand trial or not guilty because of alleged insanity has far fewer rights than others accused under criminal justice system. All other accused persons face a definite jail sentence, sometimes followed by parole; they have clear avenues of appeal, the right and opportunity to know what evidence the state has used against them, and statutory rights of appeal. No such rights or opportunities are offered to the alleged offender who is labelled "mentally ill."

This double standard of "justice" violates both the letter and spirit of Sections 15 and 7 of the Charter. If we are to prevent such gross miscarriage of justice as suffered by Emmerson Bonnar and many others, we must take the *Charter of Rights and Freedoms* seriously, and extend its protection to all Canadians.

The following information on Lieutenant Governor's Warrants (LGWs) in Ontario is taken from *Hansard: Official Report of Debates*, the printed record of House of Commons proceedings. These figures were given by former Health Minister Keith Norton in response to questions from NDP health critic David Cooke on May 18, 1984. This information covers a 12-month period from April 1983 to March 1984, and it includes the number, status and location of the LGWs in Ontario.

"Facility" (Psychiatric Inst.)	"No. Placed With Facility") (Incarcerated)	"No. In Secure Wards" (Max.-Security)
Brockville	53	53
Hamilton	3	0
Kingston	8	4
Lakehead	2	0
London	9	0
North Bay	4	4
Penetanguishene	122	117
Queen Street	31	6
St. Thomas	24	18
Whitby	6	6
TOTAL	**262**	**208**

Note:

The numbers in the maximum-security wards are included in the numbers "placed with the facility." Almost half of the LGWs in Ontario are incarcerated in Penetanguishene or 'Penetang'. The largest number of LGWs (80%) are incarcerated in Penetang, Brockville and Queen Street Mental Health Centre.

In addition to these 262 incarcerated LGWs, another 171 were under a "loosened warrant" as out-patients in various "mental health" programs in Ontario's psychiatric institutions and hospitals. In other words, a total of 333 people were under an LGW in Ontario during 1983-1984.

Institution	*No. LGWs on "Loosened Warrant"
Brockville	4
Hamilton	3
Kingston	2
Lakehead	3
London	11
North Bay	4
Penetanguishene	0
Queen Street	35
St. Thomas	6
Whitby	3
Owen Sound and Marine Hospital	1
Royal Ottawa Hospital	3
Clarke Institute of Psychiatry	3
TOTAL	**71**

***Note:**

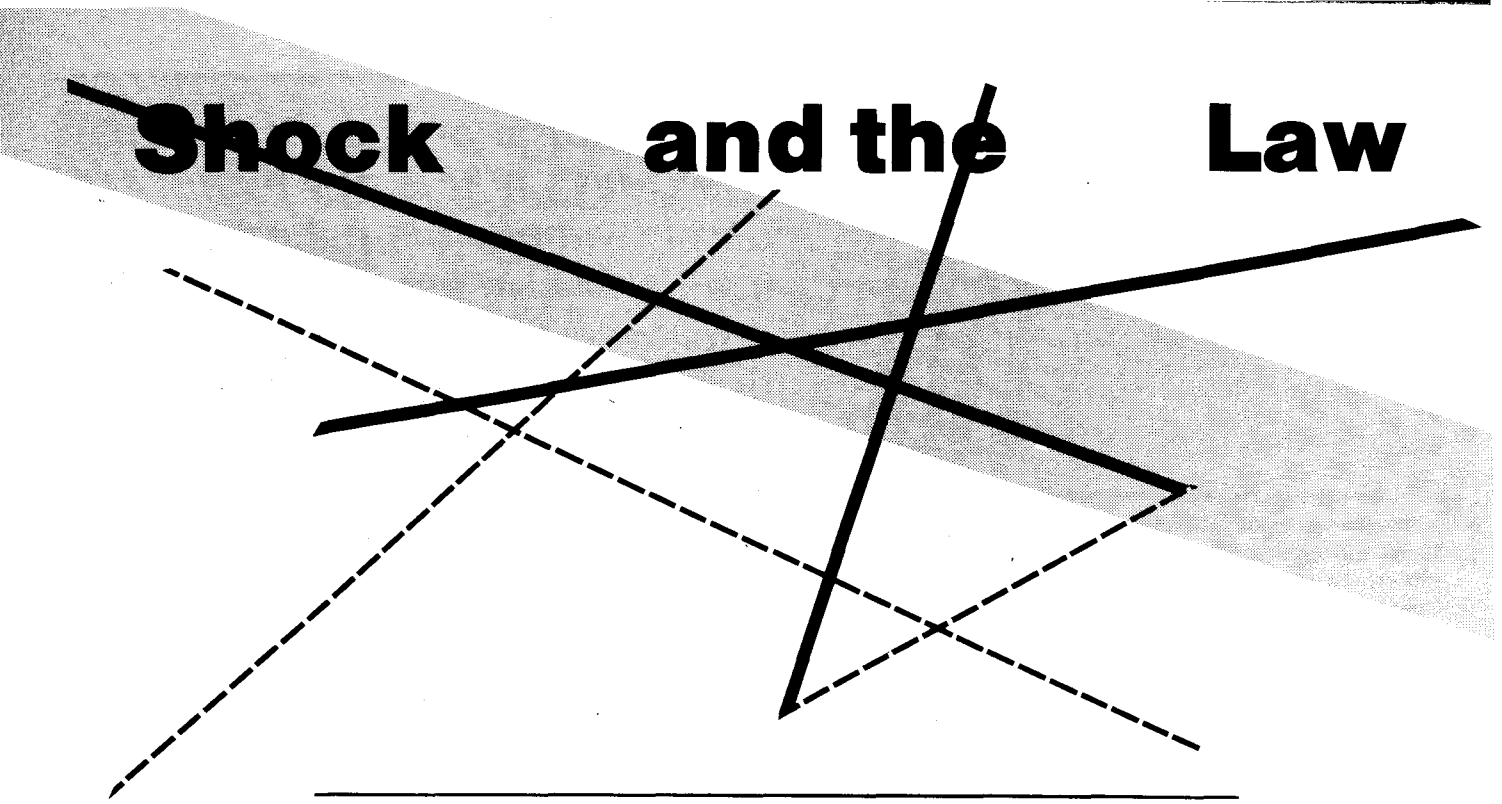
Under a "loosened" warrant, the person is still under the authority of the LGW but the terms of the warrant may be flexible. For example, the person may temporarily leave the institution or make brief home visits but must return or report to the institution periodically. The "loosened" warrant is similar to the Temporary Absence Program of the prison system; any violation of the terms of the "loosened" warrant can result in immediate or longer incarceration.

THE SWAIN CASE AND THE LGW:

AN UPDATE

On June 7, 1985, District Court Judge Hugh O'Connell sentenced Owen Swain to Toronto's Queen Street Mental Health Centre under a Lieutenant Governor's Warrant (LGW). Under an LGW, a person is incarcerated indefinitely "at the pleasure of the Lieutenant Governor." Although Swain had been living peacefully with his family in the community and showed no signs of dangerousness or "mental illness" during the previous year-and-a-half, Judge O'Connell believed him to be insane and dangerous. In an earlier court hearing in May, Judge O'Connell declared Swain "not guilty by reason of insanity," and was about to place him under an LGW and sentence him to Penetang, a maximum-security psychiatric institution in Ontario. Just before Swain was to be sentenced, criminal lawyer Marlys Edwardh intervened and challenged the LGW on Constitutional grounds under the **Canadian Charter of Rights and Freedoms.** This was only the second time that the LGW had been challenged in an Ontario court. Mr. Swain is now appealing Judge O'Connell's latest decision to the Ontario Court of Appeal. We are following this important case closely and will report recent developments in forthcoming issues.

Shock and the Law



Paper presented to the Canadian Bar Association—Ontario, Health Law Division, November 6, 1984 in Toronto

by Carla McKague

(Ed. Note: Ms McKague is a Toronto lawyer, an outspoken advocate of psychiatric inmates' rights, a member of ON OUR OWN, and a member of the Electroconvulsive Therapy Review Committee of the Ontario Government. This article is an edited version of her paper.)

If someone is receiving electroshock as an out-patient, the common law right to refuse treatment stands firmly in place. The situation changes once the potential shock patient is admitted to a psychiatric institution, and the provisions of mental health legislation come into play. It is not possible to deal with the legislation of all the jurisdictions in Canada, and I shall confine myself to the Ontario situation, except for the general statement that *no* Canadian jurisdiction distinguishes in its legislation between electroshock and other forms of psychiatric treatment, applying the same rules to all. The sole exception is that two provinces (Ontario and Prince Edward Island) grant special status to psychosurgery, as will be mentioned later. Several American states do single out electroshock for special consideration—such as California, Massachusetts and New Jersey.

In Ontario, in theory, the voluntary or "informal" psychiatric patient retains all the rights she would have had as an out-patient; she may accept or refuse any form of treatment. In practice the situation is not so simple. Once a person admits herself to the hospital, she may at any time be made an involuntary patient upon the doctor's completing a form stating that she meets the criteria for commitment. It is not unusual for a refusal of treatment to quickly lead to commitment.

As well, a psychiatric ward is an inherently coercive setting, and it is very difficult for a patient to make a truly voluntary and informed choice about whether to have any treatment. The typical voluntary patient for whom electroshock is suggested is likely to be a woman suffering from severe depression, listless, apathetic, uncritical of her doctor, aware that she is liable to the additional stigma of commitment if she does not cooperate, and very susceptible to persuasion or intimidation by staff, and often by family. I hesitate to carry this argument too far; I do not mean to suggest that *by definition* a psychiatric patient is incapable of making a voluntary decision, but only that special care must be taken to ensure that a choice is truly voluntary and informed. Persuasion or coercion by staff and family is generally not ill-intentioned; on the contrary, it is usually based on a sincere belief that electroshock will alleviate the patient's distress and restore her mental well-being. Nonetheless, coercion it is, and it therefore invalidates the consent.

The involuntary patient faces the same hurdles and more. First, the treating doctor must make a determination as to the patient's competency to make a decision about electroshock. This determination is not reviewable; in contrast, the doctor's determination that a patient is not competent to manage her financial affairs *is* reviewable by a Regional Review Board. A finding of incompetency to make treatment decisions is of immense significance, since its effect is to deprive the patient of all rights whatsoever to make decisions about her treatment. Such a finding might be susceptible to attack under the Charter (Section 7) as depriving the patient of security of the person in a manner not in accordance with the principles of fundamental justice. A particular concern in practice is that the question of the patient's competency is rarely raised except when treatment is refused. I leave you to speculate on the legal implications of administering treatment to a consenting but non-competent adult, which happens daily in our psychiatric institutions.

If the patient is found not to be competent, the right to make a decision about whether she should receive electroshock passes to her nearest relative, if there is one, and otherwise to the Review Board. This raises further questions. First, suppose that the nearest relatives, as defined in the *Mental Health Act,* are the parents? What if they disagree? Is the consent of either of them enough? Is the doctor bound by the reply of the first one he asks? In *Re T,* you may recall, the doctor appears to have used a sort of 'shopping list' approach.[1] First, Mrs. T. was considered *competent* to make her own decision about electro-

"electroshock can be ordered over the refusal of a competent patient in a hearing of which she gets two days' notice, at which she is probably not represented by counsel, without the patient or her counsel getting access to the clinical record, in the absence of any chance for the patient or her counsel to test the doctor's evidence by cross-examination. I believe this falls far short of being in accordance with the principles of fundamental justice."

shock. In spite of this, the doctor sought consent from the family. The husband refused, and he went to the father. The father refused, and he went to the brother. The brother also refused, at which point the doctor appears to have given up on the family. This sort of approach is clearly totally unacceptable, and probably represents an extreme, but the danger is obvious.

Also, as already mentioned, if a relative is empowered to give a substituted consent, it should be on the basis of what the patient would have decided had she been competent. The forms in use in at least one of our psychiatric institutions for obtaining a substituted consent state explicitly that the person consenting has satisfied himself that the treatment is for the patient's benefit; no reference is made to the proper basis for determination. A family member consenting on an improper basis might well be liable to legal action as a result, and there is in my opinion an obligation on the doctor to inform the family of its responsibility to consider what the patient's wishes would have been if she had been competent.

There has recently been an experiment in having people who wish to avoid particular treatments such as electroshock, should they ever be found incompetent to decide, prepare in advance a declaration of their wishes, accompanied by a statement by a physician that at the time of making the declaration they are competent to do so. Such a declaration should in theory be binding upon family members; it will be interesting to see the result if and when one of these declarations is challenged.[2]

The refusal of a competent patient, or of the nearest relative of an incompetent patient, can be overridden by a Regional Review Board. This is the only example in law where a competent refusal of treatment can be disregarded, and it is difficult to see any justification for it. A person has the right to suffer pain by refusing painkillers, even to die by refusing life-saving treatment, but not to remain depressed by refusing electroshock or antidepressants. This provision of the *Mental Health Act* appears ripe for a challenge under the Charter as denying security of the person (Section 7). I should add that there is already one legal decision confirming what probably no one ever doubted—namely, that medical treatment can constitute an infringement or assault on security of the person.[3]

The Charter does, of course, provide that one may be deprived of security of the person so long as the deprivation is done in accordance with the principles of fundamental justice. I would submit that the procedures before the Regional Review Board do *not* accord with those principles, and that if there is to be any forum in which this right can be infringed it should be a courtroom, in which at least basic protections are offered. As well, the criterion provided in the Act for the Board's decision is explicitly a "best interests" one, which is in my view an illegitimate use of the state's power to safeguard its citizens; that power should be exercised only by a court, not to protect the incompetent, and even then, to cite the *Dion* case from Quebec, "this jurisdiction is exercised in order to determine which decision the incapacitated person would have made if he had been competent to decide."

Since March of this year there are some procedural protections in Review Board hearings which were formerly lacking but there is still great scope for abuse. It not only is possible, but actually occurs, that treatment is ordered at a hearing of which the patient has less than 48 hours notice (bear in mind that in general it takes a lawyer four days to gain access to the clinical record). The Review Board—at least the one with which I am most familiar—does not require the attending physician to be present at the hearing unless a request is specifically made by the patient, who may well be unaware of the need to make the request. (In contrast, at a recent hearing at which I represented a patient, the Board refused my client's request that *she* not attend, and that I be allowed to argue her case in her absence.) Since the physician need not be present, the patient is deprived of her right of cross-examination. Even more disturbing, the Board is very lax about evidentiary rules, examining in advance of the hearing any documents submitted by the doctor and any documents copied by the patient's lawyer from the clinical record, on the ground that obviously these are going to be put into evidence, and so they have a right to read them in advance. (This sometimes presents a great temptation to order copies of such irrelevant items as the patient's clothing list for the satisfaction of imagining the Board puzzling over them.) In fact, if the doctor does not attend it is difficult to understand how the board can accept *any* documents into evidence to support the application to treat, as there is no one there to introduce them. The Board has also been known to insist that the patient present her case first, without knowing the doctor's reasons for wanting treatment ordered. Examples abound of such disregard of fundamental procedural protections, and complaints are shunted aside with the assurance that the Board only wants what is best for the patient, and that undue technicalities or analogies to the protections provided to a criminally accused are misguided.

In short, electroshock can be ordered over the refusal of a competent patient in a hearing of which she gets two days' notice, at which she is probably not represented by counsel, without the patient or her counsel getting access to the clinical record, in the absence of any properly admitted evidence supporting the application, and in the absence of any chance for the patient or her counsel to test the doctor's evidence by cross-examination. I believe this falls far short of being in accordance with the principles of fundamental justice.

Section 15 of the Charter guarantees equal protection and equal benefit of the law, without discrimination based on, among other things, mental disability. The statutory provisions setting different rules for treatment for voluntary and involuntary patients, and for competent and incompetent patients, may well be open to challenge under this section as well.

The Charter also guarantees freedom of thought in Section 2(b). It has been argued successfully in a number of American cases that various psychiatric treatments are unconstitutional because they drastically alter the patients' mental processes.[4] Even the strongest proponents of electroshock would concede that it has this effect—in fact, that is the whole purpose of its use. Following electroshock, the patient is often confused and disoriented, with at least short-term and frequently permanent

memory impairment, so that a challenge under Section 2(b) might well be effective.

Section 1 of the Charter does, of course, allow for such limitations on the rights provided by the Charter as are demonstrably necessary in a free and democratic society. I, frankly, fail to see how that section could be used to justify the present *Mental Health Act* practiceor procedure.

All of what I have said so far applies not only to electroshock, but also to any other psychiatric treatment, with the sole exception of psychosurgery, which cannot be performed on an involuntary patient in Ontario, even with the patient's consent. In *Re T,* I attempted to demonstrate on behalf of my client that electroshock fell within the definition of psychosurgery in the *Mental Health Act* (Section 35), in which case the Board would have had no jurisdiction to authorize treatment. That argument failed at the trial level, even though Madam Justice Van Camp conceded in her decision that there were many unanswered questions about electroshock and that further research was needed. Because of subsequent events, the argument was not tested at the appeal level, where Charter arguments would have been made.[5]

The argument does, however, raise the question of whether electroshock should have some special status among psychiatric treatments, as psychosurgery does. The American case of *Wyatt v. Alderhold* has held that electroshock should *not* be considered as "just another somatic treatment."[6] Electroshock may well be the most controversial treatment in common use today. Its advocates say it is safe and effective; its critics say it is harmful and ineffective. Opinions range from suggesting that it should be used whenever the doctor deems it appropriate, whether consented to or not, to demanding that it be totally banned, in the same way that our society has banned such purported treatments as Laetrile, and such substances as cyclamates and heroin. It is to be hoped that the Electroconvulsive Therapy Review Committee appointed this year by the Minister of Health will make some definitive findings about the risks and benefits of electroshock, and provide a solid foundation for determination of what our laws should say about its use.

"Once a person admits herself to the hospital, she may at any time be made an involuntary patient upon the doctor's completing a form stating that she meets the criteria for commitment . . ."

If the findings of that Committee are that electroshock is safe and effective, there will be no reason to consider it as different from any other treatment. I remind you, however, that the present laws regarding psychiatric treatment in general may be drastically changed through the application of the Charter.

If the Committee's findings are negative, and electroshock is found to present substantial risks for little benefit, it will require special consideration. Possibly it will be banned. Possibly it will be classed with psychosurgery as legitimate only for voluntary patients. Such a finding might well open the door to an attack on at least involuntary electroshock under Section 12 of the Charter, the provision forbidding cruel and unusual treatment or punishment. This suggestion has been raised by, among others, Morris Manning in his recent book on the Charter.[7]

At present, given the diversity of opinion about the merits of electroshock, a doctor who wishes to obtain an informed consent to the treatment is in somewhat of a quandry. What

"A person has the right to suffer pain by refusing painkillers, even to die by refusing life-saving treatment, but not to remain depressed by refusing electroshock, or antidepressants."

information should he give? I would suggest that at the very least the information should include the fact that it *is* a controversial treatment, and the psychiatry community itself is divided on the question, with some specifics as to the points in dispute—in particular, its therapeutic effectiveness, the possibility of permanent memory loss, and the risk of brain damage.

I would also suggest that the use of electroshock for the purpose of restraint rather than treatment, reported last year in the *Canadian Journal of Psychiatry,* is totally without legal justification, and that a treatment of this sort should never be used for non-therapeutic purposes and without proper legal authorization.[8]

As for the future, I would argue that at the very least the psychiatric patient is entitled to the same legal protections as the patient with physical illness. That includes, for the competent patient, the right to full information, the absence of coercion, and *the right to say no* without the possibility of being overruled by a paternalistic body presuming to know better what the patient should do. It includes proper safeguards to ensure that a person found not competent to make these decisions is *in fact* not competent, and not just disagreeing with the doctor. And in the case of the truly incompetent patient, if we are to allow a decision to be made on her behalf, I can only echo the words of Mr. Justice Durand of the Quebec Superior Court in the *Dion* case, as he quoted the Supreme Court of Massachusetts:

> We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent. . . Such questions ... seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government has created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.[9]

Footnotes:

1. *Re T v. Board of Review for the Western Region* (1983), 44 O.R. (2d)153; also see Don Weitz. Shock Case: A Defeat and Victory. *Phoenix Rising,* vol.4 nos. 3-4, April 1984, 28A-30A.

2. See Don Weitz. The Statutory Declaration: A Legal Way to Save Your Body, Mind or Life from Psychiatric Treatment. *The Mad Grapevine,* (ON OUR OWN newsletter), October 1984, pp.6-9. (see edited version this issue).

3. *Petersen v. Minister of Health for the Province of Ontario et al.,* No.18495 (Ont. S.C., Dec. 23, 1983).

4. For example, *Kaimowitz v. Department of Mental Health,* Civil Action No. 73-19434-AW (Cir. Ct. Wayne County, Mich., July 10, 1973).

5. See note 1 above.

6. *Wyatt v. Alderhold,* 503 F. 2d 1305 (5th Cir. 1974).

7. Morris Manning. *Rights and Freedoms and the Courts: A Practical Analysis of the Constitution Act 1982.* Toronto: Edmond-Montgomery Ltd. (1983).

8. J.J. Jeffries, and V.M. Rakoff. E.C.T. as a form of restraint. *Can. J. Psychiat.* Dec. 1983, vol.28, No.8, pp.661-663. Also see critique by Elaine Newman, ECT as restraint: illegal and undesirable. *Phoenix Rising,* vol.4, Nos.3-4, April 1984, pp. 24A-26A.

9. *Institute Philippe Pinel de Montreal v. Dion* (1983), 2D.L.R. (4th) 234.

Inmates' Fight

Gaining the VOTE

by Don Weitz

The right to vote is the most fundamental right in a democratic and free society; most of us take it for granted, but not the many of us who have been unjustly denied our right to vote while incarcerated in psychiatric institutions, institutions for the "mentally retarded," and prisons. At present, thousands of inmates across Canada cannot vote—they are disqualified from full citizenship.

The Canadian Charter of Rights and Freedoms specifically guarantees the right to vote to all Canadians. Section 3 states: "Every citizen has the right to vote in an election of members of the House of Commons and to be qualified for membership therein."

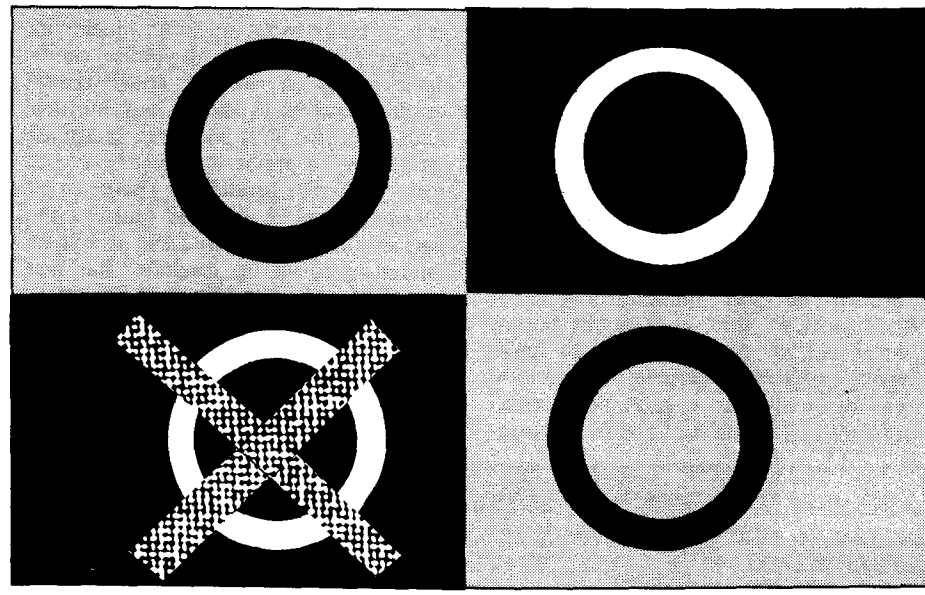
But traditionally, in Canada, our municipal, provincial and national election acts have stipulated that certain groups cannot vote. The *Canada Elections Act* disqualifies (e) "every person undergoing punishment as an inmate in any penal institution for the commission of an offence;" (f) "every person who is restrained of his liberty of movement or deprived of the management of his property by reasons of mental disease:..." (section 4, R.S.C., 1970).

In the case of psychiatric inmates, notice that the Act denies the right to vote to those who are involuntarily committed ("restrained of his liberty of movement"), or judged incompetent to manage their own property (including money). In Ontario and probably in most other provinces, the judgment of incompetence (financial) is made by only one doctor or psychiatrist on the basis of little or no evidence. Besides, what has the ability to manage your property got to do with your ability to make political

decisions or vote? The fact that physicians in Ontario are given the power to make such non-medical decisions for their patients is clearly discriminatory, unjust and probably unconstitutional.

Since the equality clause (Section 15) of the Charter came into force on April 17, 1985, it can and will be argued that all election acts which deny the right to vote to any group of people is unconstitutional. Section 15(1) of the Charter states:

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



Fighting to win

It's important to keep in mind the key terms "equal protection and equal benefit of the law without discrimination based on . . . mental . . . disability." The vast majority of psychiatric inmates, people labelled and incarcerated as "retarded" and prisoners are denied this equality through the violation of their civil rights.

Some psychiatric inmates and prisoners have already started fighting to win the right the Charter says is theirs. Robert Gould, a prisoner in Joyceville, (a medium-security penitentiary near Kingston), last year challenged the government's denial of his right to vote in the forthcoming federal election. Gould's lawyer, Queens University law professor Fergus O'Connor, used the Charter to challenge the *Canada Elections Act* as unconstitutional. Madam Justice Barbara Reed, of the Federal Court of Canada, ruled in favor of Gould; however, the appeal division of The Federal Court overturned Judge Reed's ruling in a split decision, so Gould couldn't vote.

Already, too, there have been victories. Martyn Humm, an inmate in Rideau Regional Centre (an institution for the "mentally retarded" in Smith's Falls, Ontario) successfully challenged the "enumerator's refusal to include his name on the voters' list" (*Toronto Star,* Aug. 30, 1984). He was represented by lawyer David Baker, Executive Director of ARCH (Advocacy Resource Centre for the Handicapped). At the time, Humm was officially labelled incompetent under a "certificate of incompetence." The case was settled out of court; the victory enabled Humm and 28 other inmates to vote in the federal election.

Some politicians and governments are finally expressing concern about this injustice, which so clearly violates Section 15 of the Charter. In a discussion paper entitled *Equality Issues In Federal Law,* published earlier this year, federal Justice Minister John Crosbie questions whether competence or "ability to understand the (voting) process" should continue to be a criterion, and adds "there are no criteria that might recognize differing degrees of mental disability . . . Because of the nature of mental disability, it is difficult to draw boundaries between those who can understand the consequences of actions such as voting and those who cannot." Crosbie, referring to the *Canada Elections Act,* also raised the possibility of removing the disqualification of mental disability altogether.

An outstanding example of what can be done to win inmates' rights is the pressure put upon the Government of Ontario last year by rights advocates. Thanks largely to their determination Ontario has become the first province in Canada to guarantee all psychiatric inmates and mentally disabled people their right to vote. This did not, of course, come about without a struggle; the process is instructive of what must continue to be done.

At a public hearing (December 13, 1984) on proposed amendments to the *Ontario Election Act* (Bill 17), the Government's Standing Committee on Government Services heard strong opposition to a section of the Bill (16(2)2) which would have denied visiting rights to psychiatric inmates judged "incompetent," and to all prisoners. The offensive section stated:

The following persons are disqualified from voting:

1. Every person who is an inmate in a penal or correctional institution.
2. Every person who is a patient in a psychiatric facility and in respect of whom a Certificate of Incompetence, issued pursuant to the *Mental Health Act,* or a declaration under the *Mental Incompetence Act* that he is a mentally incompetent person, is in effect.

Had this whole section become law it would have given another stamp-of-approval to the longstanding prejudice against psychiatric inmates. Critics attacked it for its vagueness and for using the stigmatizing label "incompetent." *(Ed. note:* see excerpts of Testimony.) It was pointed out that the term "incompetent" was not defined in the Section, and could be arbitrarily interpreted to include inability to manage one's property or money, inability to fully understand the nature of one's "mental illness," inability to understand the nature and effects of one's "treatment," and/or refusal to accept whatever a psychiatrist orders. The result of the hearing was a partial victory: the part of Section 16 affecting psychiatric inmates was removed, but prisoners remain disenfranchised.

Bill 17 is now law in Ontario, and for the first time all people in psychiatric institutions and institutions for the mentally disabled are guaranteed the right to vote in this province. The next step—a big one—is to put theory into practise, which involves overcoming deeply entrenched prejudice against the "mentally ill." To exercise their voting rights inmates must be enumerated (counted) before they can be registered. This poses a practical problem in psychiatric institutions, where the staff is conditioned to treating patients as second-class citizens and routinely fails to inform them of their rights and legal status. (People generally need encouragement and information to get them to the polls, and it would be all too easy to interpret an initial lack of enthusiasm amongst inmates as "apathy" and further proof of their "incompetence." Such circular reasoning is insidious.)[1]

Encouraging signs

The new bill has already had its first test, in the May 2, 1985 Ontario elections.

Ontario's Chief Electoral Officer Warren Bailey and the Psychiatric Patient Advocate Office are pledged to informing psychiatric inmates of their voting rights and to helping them to vote (at least in the province's 10 public psychiatric institutions, such as the Queen Street Mental Health Centre and "Penetang"). According to Dr. Tyrone Turner, Administrator of the Advocate Office, the advocates informed as many inmates as possible of their right to vote, and mobile booths were sent around the wards to make voting easier. Each psychiatric institution was designated as a rural poll, which (under the Election Act) allowed registration to be extended up to and including the day of the election. All political candidates were given "free and equal access" to the psychiatric institutions in their ridings and the staff was advised against influencing or pressuring inmates to vote for a particular candidate. These are all encouraging signs of good faith on the part of the Government, and it will be interesting to see the results of this first step. (*Ed. note:* See "Election Results.")

Within the next few years, other provinces and territories will probably follow Ontario's lead; if they don't, they'll undoubtedly face court challenges under Section 15 of the Charter. And there will be more challenges to Section 4 of the *Canada Elections Act* — until it is declared unconstitutional and removed.

While Ontario's initiative represents a great civil rights victory for psychiatric inmates and the mentally disabled, prisoners are still denied the right to vote. Prisoners' rights organizations and other advocacy groups must continue fighting for that right. When all inmates are guaranteed the right to vote, the fight for other civil and constitutional rights for inmates should be easier, but no less important.

ONTARIO ELECTION RESULTS IN PROVINCIAL PSYCHIATRIC INSTITUTIONS

MAY 2, 1985

Psych. Inst.	Inmate Pop.[1]	No. Enumerated	Per Cent Enumerated	No. Voted	Per Cent Voted[2]
Brockville	529	165	31.2	128	77.6
Hamilton	368	41	11.1	52	126.8[3]
Kingston	422	142	33.6	103	72.5
Lakehead	243	162	66.7	30	18.5
London	477	644[3]	135.0[3]	188	29.2
North Bay	308	344[3]	111.7[3]	227	65.9
Penetang	510	233	45.7	202	86.7
Queen Street	588	160	27.2	154	96.2
St. Thomas	465	134	28.8	137	100.0
Whitby	407	400	98.3	114	28.5
TOTAL	**4317**	**2425**	**(avg) 58.9**	**1335**	**(avg) 70.2**

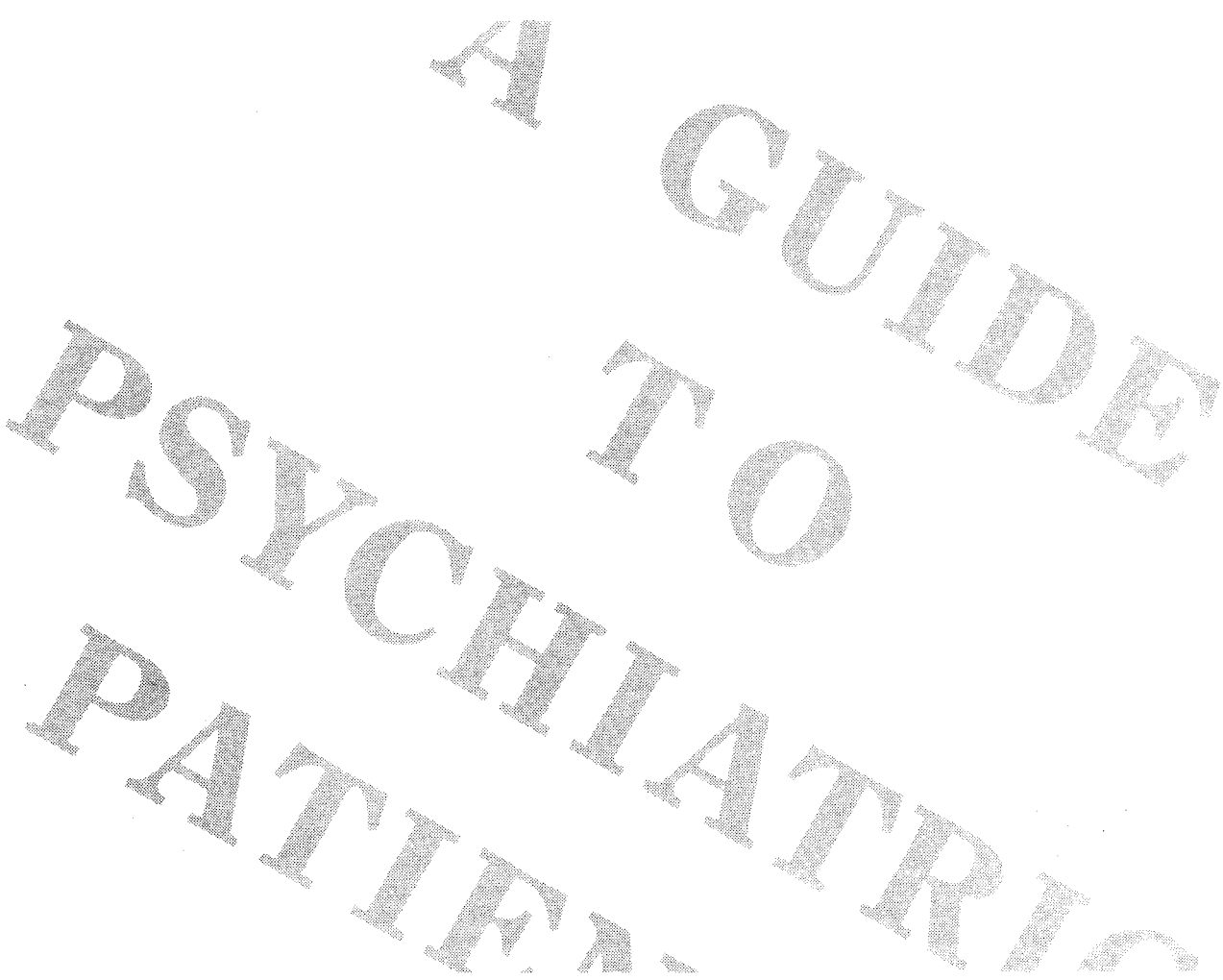
1. Figures based on last census taken by Ministry of Health on April 30, 1985; courtesy of Communication & Information Branch, Ministry of Health.

2. Percentages calculated from number of inmates who voted — $\frac{\text{No. voted}}{\text{No. enumerated}}$

3. These figures are inflated because: a. additional inmates and/or staff were enumerated on voting day, and/or b. an increase in the inmate population after April 30.

(Ed. Note: In the last provincial election in Ontario on May 2nd, a total of 5,952,146 people were on the polling list — registered to vote. Of this number, 3,662,225 (61.5%) voted. This figure is close to the election results in the province's ten psychiatric institutions, where 55% of the inmates voted. Our thanks to the Ministry of Health for providing us with inmate population figures and to the Chief Election Office of Ontario for giving us other information on enumeration and voting. Phoenix Rising *calculated the percentages from this information.)*

Note: *Free copies of the* Canadian Charter of Rights and Freedoms *are available. To order copies, write to:* Communications and Public Affairs, Department of Justice Canada, Ottawa, Ontario—K1A 0H8.



ONTARIO MINISTRY OF HEALTH SANITIZES PATIENTS' RIGHTS BOOKLET

The Government of Ontario has one of the less oppressive mental health acts in Canada. In Ontario, psychiatric inmates have a few legal rights, appeal through the Courts (as of March 1984) and Legal Aid assistance in hiring a lawyer.

by Hugh Tapping

The problem is that laws exist on paper. Making these laws effective requires an organization of people called a bureaucracy. The word bureaucracy has acquired an emotional meaning — it implies mindless inefficiency, human degradation and ultimate futility. Many of our bureaucracies have earned their reputations honestly — they're useless. No matter how hard-working, intelligent or dedicated the individual bureaucrats may be, the system forces people into mistakes, inefficiencies and ultimately irrelevance. That system is not some vague and shapeless abstraction — it is the hierarchy of who talks to whom about what, who makes the decisions, who has power.

The story of a small booklet titled *A Guide To Psychiatric Patients' Rights* shows how good beginnings can be bureaucratized, how more and more time and money can be spent to produce less and less. Let's assume, for the sake of the story, that this project was undertaken in good faith — that the psychiatric establishment, bowing to increasing pressure to treat inmates more like human beings, was prepared to take the small but useful step of producing a readable guide to patients' rights ... something written in plain English. It could explain, for example, such obscure but important terms as "legal status," "Review Boards," "informed consent" — maybe even answer questions such as "How do I get outta here?" Sounds too good to be true? Well, it was!

In May 1984, two psychiatric patient advocates at Toronto's Queen Street Mental Health Centre (Queen Street) drafted and printed a 16-page booklet, *A Guide To Psychiatric Patients' Rights,* which was to be distributed to all psychiatric inmates in Ontario's 10 public psychiatric institutions — but it never was distributed. Rumblings were

"The Queen Street Guide encourages the person to take the risk of getting committed; the Whitby Guide makes it sound like a requirement."

heard that administrators and medical directors did not "like" the Guide. It seems the authors went too far, that they forgot the difference between making real changes and just changing appearances. In February of this year, *The Cuckoo's Nest* reprinted a leaked copy of the Guide and reported that the Psychiatric Patient Advocacy Program and the Ministry of Health had supressed its publication. Instead of being distributed, the Guide became a "first draft" which each of the 10 advocates could use as inspiration for producing 10 different versions.

Toronto, for example, now has two versions of the Guide, one distributed by the Queen Street Mental Health Centre (QSMHC) which incarcerates only people who live west of Yonge St., the other by Whitby Psychiatric Hospital, 45 km east of Toronto. So anyone who suffers the misfortune of being admitted to either of the institutions "serving" Toronto will receive a somewhat different interpretation of their rights depending which side of Yonge St. they live on. "Split personality" indeed!

It's instructive to compare the Queen Street and Whitby versions of the Guide with the first unpublished draft. The tone or style of the current Guides is now watered-down and polite, instead of clear and assertive. On the inside of the back cover of the first draft, we read, "YOU HAVE THE RIGHT TO KNOW YOUR RIGHTS AND ASSERT THEM." That has disappeared. The Queen Street Guide has added a couple of patronizing and social work-sounding paragraphs to its Foreword. While the first draft speaks of "making you more aware of your legal rights and what you can do to assert and protect (them)," the Queen Street version rhapsodizes about how the advocates hope "that a greater understanding of your rights will give you a secure feeling and enable you to cooperate fully in a treatment program..." It's a siren song inviting willing surrender, rather than a guide to help you assert and protect your rights.

The Foreword of Queen Street's Guide also states, "Through this mutual spirit of respect and cooperation more positive therapeutic outcomes may result." Queen Street is the snake pit that provokes calls for a Royal Commission investigation into the "mental health system" from its own employees union (OPSEU); the same institution that provokes its nursing staff to picket the place protesting the understaffing, the low pay and intolerable conditions! The Queen Street Guide says, "the staff ... are required to be aware of and respect each patient's rights"; no such claim, however, is made for the Whitby staff.

One symptom of our insane "mental health system" is the process whereby a person voluntarily seeking help in an institution finds it intolerable, decides to leave, and cannot. As for voluntary admission and involuntary commitment, the first draft was simpler and more straightforward than the current Queen Street and Whitby Guides. For example, the first draft states, "You have a right to leave at any time. No one has a right to stop you ... unless the doctor first makes you an *involuntary* patient by signing a Form 3." In contrast, the Queen Street Guide says, "You can choose to stay in the hospital or leave the hospital at any time. The decision to stay or leave is an important one. You may wish to get the advice of people you respect, including your treatment team, before making up your mind. You can learn about the rights of involuntary patients later in this Guide." And the Whitby Guide states, "If you are a voluntary patient, you are in the hospital because you wish to be here and you can choose to stay in the hospital or leave at any time. Before you leave you will be asked to see a doctor."

The first draft is perfectly clear and legal and contains an explicit warning about what can happen if a person "chooses" to "see a doctor" after announcing a decision to leave. However, the Queen Street Guide actually encourages people to stumble into a "Form 3" (involuntary commitment) and gives only a hint that one should search the rest of the booklet for clues about "involuntary patients."

The Whitby Guide is equally misleading. For example, it states, "You will be asked to see a doctor before you leave and if the doctor believes that you are not certifiable, then you can leave." Which is it? "Asked to see a doctor", or "then you can leave"?

Doublespeak, double-talk, 'double trouble'

The simple truth is that an "informal patient" (voluntary) can decide to leave and do so — at least in law. Unless the inmate is clearly informed that seeing a doctor is optional and that anything said to that doctor may be used as evidence to order immediate incarceration, the law is being seriously bent, if not broken. The first draft noted that a doctor must *first* make a person involuntary by signing a special form. Both the Queen Street and Whitby versions of the Guide are vague on the person's right to be free from arbitrary confinement, as guaranteed in Section 9 of the Charter. The Queen Street Guide encourages the person to take the risk of getting committed; the Whitby Guide makes it sound like a requirement. Should a person be involuntarily committed under a "Form 3," all three versions of the Guide agree that the inmate has the legal right to appeal his/her incarceration to a Review Board. However, none of the versions explains how an order for a two-week committal can be appealed to the Board, which usually meets once a month. (At Queen Street, the Board tries to meet more often but sometimes it doesn't meet, because none of the six government-appointed psychiatrists can attend.)

"Restraints" are another abusive psychiatric "tactic" — one with a dishonourable tradition centuries old. Under Ontario's *Mental Health Act,* these restraints include: mechanical restraints (straps, belts, bedsheets, etc.), physical restraints (aides wrestling you to the ground, grabbing your arms and legs or shoving you into "seclusion" or the "quiet room" — euphemisms for solitary confinement), and chemical restraints (staff forcibly administering shots of Haldol, Modicate or other chemical lobotomies). The first draft of the Guide states, "If you feel that restraints used on you were too strong, lasted too long, or were not justified, you can contact your Patient Advocate or lawyer right away." In the current Queen Street Guide, the phrase "right away" is replaced with "at any time," which is a little more vague. And the Whitby Guide states, "you can discuss this with the staff or contact your lawyer or the Patient Advocate." Nothing is said about just when this "discussion" may occur. Let us be very clear that what is being practised here is assault or assault and battery — a crime. The Whitby Guide gives not a hint that such criminal acts are anything more than a

"So anyone who suffers the misfortune of being admitted to either of the institutions 'serving' Toronto will receive a somewhat different interpretation of their rights depending on which side of Yonge St. they live on. 'Split personality' indeed!"

difference of opinion.

Unlike the first draft or the Whitby Guide, the Queen Street Guide states that restraints may be used to control the dangerous behaviour of inmates who are incarcerated under a "Form 1" (a 5-day assessment or initial involuntary committal), "Form 3" or "Form 4" (involuntary committal orders for two or more weeks). This implies that "voluntary patients" at Queen Street are not subjected to such "holding," bondage and forced drugging which inmates know all too well. In the Whitby Guide, there is also no mention of how your legal status affects the use of restraints, which can be used "if you are behaving in a way which is dangerous..." No mention here of who defines dangerous behaviour or appropriate restraint, or on what basis.

If the Charter guarantees equality to all Canadians, why does a line drawn through the centre of Canada's largest city become the basis for deciding what is or is not an assault? Why does a line drawn on a map determine whether a person can even *read* his/her rights?

The first draft and the Queen Street Guide are printed in CAPITALS and the text is double-spaced, mainly because of the well-known visual impairments and blurring caused by the "medication." The Queen Street version has been made more difficult to follow by replacing referral to a particular page with "later in this Guide." The Whitby version is single-spaced and typed in small letters, and it takes a more patronizing approach.

After the Patient Advocates and Ministry of Health officials worked for about a year on producing a potentially useful booklet on inmates' rights, the educational project became contradictory, patronizing and gutless. The Guide, which was supposed to clearly and honestly explain the legal rights of psychiatric inmates under Ontario's *Mental Health Act* has become less "disturbing" to the institutional psychiatrists and administrators. Once again, the inmates, who were supposed to benefit from this Guide, have been forgotten.

Legal Aid turns blind eye

There is another bureaucratic snafu right now which further shows how the legal-psychiatric system works to deny legal rights and justice to psychiatric inmates. In March 1984, when reforms in the *Mental Health Act* (Sections 66 and 67) finally came into force (after a 6-year delay, thanks largely to the anti-rights lobbying of the Ontario Medical Association and Ontario Psychiatric Association), one of the changes required all psychiatric institutions to send a notice of each involuntary committal to Legal Aid — specifically the Area Director. However, because of a loophole in one section, Legal Aid directors are not required to automatically send a lawyer to any involuntary patient upon receipt of the notice. Instead, Legal Aid officials have been simply "filing" these notices — literally throwing them into the wastebasket, which saves them a lot of paperwork. As a result, hundreds, if not thousands of inmates have been unjustly denied their constitutional right to a lawyer. (See "Involuntary psychiatric patients — Right to legal counsel is being denied," *Globe and Mail,* May 7, 1985). Ontario Ombudsman Dan Hill is now trying to sort out this bureaucratic mess among Legal Aid, the Ministry of Health and the Attorney General, and decide which government department is responsible for providing lawyers to the inmates. Of course, the Patient Advocates Guide does not mention the fact that the inmates' right to a lawyer is ignored by Legal Aid, the agency that pays its lawyers.

It does not seem cynical, in light of the ill-fated "Guide," to question the psychiatric establishment's commitment to reforms. What other possible reason for suppressing it but that someone with power thought it went too far in explaining to inmates their rights? And if telling people their rights is going too far — well, you know what you're up against. But uphill battle or not, psychiatry must be stopped from breaking the law and violating inmates' rights with impunity. It will be stopped — but only by making public every example of psychiatric injustice, and by challenging this discrimination in the Courts.

Section 16(2)2 of Bill 17 excluded psychiatric inmates

Revised Election Act lessens Voting Discrimination

One day before Ontario's revised Election Act was made law, legislators decided to eliminate one section of their proposal which would have denied many psychiatric inmates the right to vote. This decision was taken as a result of strong criticisms at public hearings, voiced by—among others—David Baker, Executive director of the Advocacy Resource Centre for the Handicapped (ARCH), David Solberg, legal counsel for the provincial health ministry, and Don Weitz, a member of our editorial collective. Here are excerpts from their speeches:

DAVID BAKER: The section provides that an inpatient in a psychiatric facility who is certified as incompetent under the *Mental Health Act* or is certified mentally incompetent under the *Mental Incompetency Act* should be denied the right to vote. We are asking that the paragraph be removed from the act altogether.

The rationale or explanation in law underlying the request relates, first, to *The Charter of Rights and Freedoms,* Section 3, which provides, "Every Citizen of Canada has the right to vote in an election of members of . . . a legislative assembly." It obviously applies to this piece of legislation and, therefore, it can be struck down.

I refer to that because in the last federal election we represented a client in the Rideau Regional Centre in Smiths Falls, Martyn Humm. The chief electoral officer federally permitted Mr. Humm, to vote even though he was under a certificate of incompetence at the institution in Smiths Falls. The case was founded on a number of legal issues, including the Charter of Rights. It never got to court because Mr. Humm was permitted to vote in that case.

I do not want people to assume that the certificate of incompetence speaks to mental competence. That was the issue that decided the Humm case. It was a certificate of incompetence in the Humm case. The chief electoral officer was prepared to look behind the certificate of incompetence to determine if it did not make him so mentally incapacitated that he could not vote in the last federal election. As a result of the Humm case, every person in that institution who expressed the wish to vote was permitted to vote.

In my view, it does not follow at all the people are any less competent to vote . . . just because they are in a psychiatric facility, when we are really saying people in the community who are certified incompetent are permitted to vote.

The *Ontario Human Rights Code* appears to apply to this as well. Subsection 46(2) provides that unless the Election Act states that the section I am referring to applies notwith-

standing the Human Rights Code, then it is subject to the Human Rights Code. In other words, the paramount provisions of the *Ontario Human Rights Code* would apply to the *Ontario Election Act*. Those are issues in law.

Competence to vote

In our experience, there are a large number of people in psychiatric facilities who sincerely wish to vote, care about the outcome of elections and feel deprived of the right to vote. That is not an academic matter in our experience.

The *Mental Health Act* speaks in terms of people who are incompetent to manage their affairs, not mentally incompetent to manage their affairs. That is very important distinction in practice because people are admitted voluntarily or involuntarily to provincial psychiatric facilities and they have property outside the facilities which they are unable to manage in practical terms.

I put it to you that the stereotype of the raving lunatic going to the voting booth and somehow demeaning the concept of the vote is not applicable in our present situation. Most of the facilities we are talking about—well over 100 of them—are in our community hospitals, which have an open-door policy. The only place with a permanent closed-door policy that I am aware of is the Oak Ridge division of the Penetanguishene Mental Health Centre.

There have been a number of studies . . . of how psychiatric patients vote when given the opportunity. Some of these studies are based on mock polls staged in psychiatric facilities. If the fear is that psychiatric patients will somehow abuse the right to vote by all voting in some fringe direction, these studies all suggest that the voting patterns of psychiatric patients closely reflect those of the community in which the institutions are located.

To conclude . . . we are affecting people who in all likelihood are going to be out in the community, and depriving them of the right to vote because of the enumeration process. We run the risk of challenges under human rights legislation and the Charter of Rights. Psychiatric patients given the right to vote will not distort the electoral process.

DAVID SOLBERG: It is important to recognize that the disqualifications contained in paragraph 16(2)2 of the bill are a two-pronged qualification. That is, the person must be a patient in a psychiatric facility, and he must be one who has been declared incompetent under either the *Mental Health Act* or the *Mental Incompetency Act*.

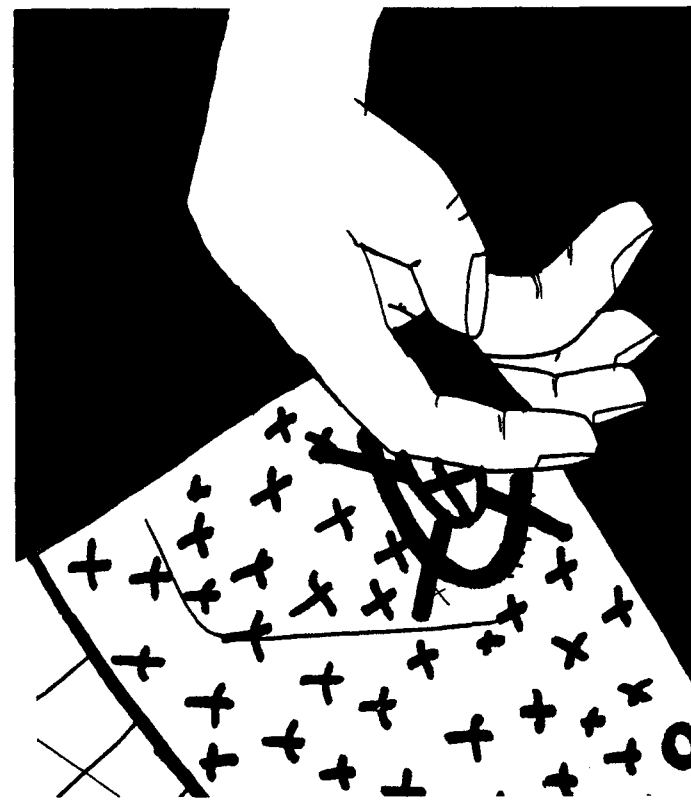
It is important to note that this distinguishes between mentally incompetent people in a psychiatric facility and mentally incompetent people elsewhere. When you have those kinds of distinctions, you had better have a justification for them. I do not believe there is a satisfactory one.

We have two kinds of mental incompetence here. One of them is judicially declared, and the other is on the signature of a physician. The greatest number of judicially declared mentally incompetents will not be in mental hospitals. They are going to be elsewhere. To get judicially declared mentally incompetent costs a great deal of money. It is not likely to be applied to run-of-the-mill, indigent psychiatric patients.

What is more likely to happen is that they will be declared mentally incompetent under the *Mental Health Act*, which is a quick, summary procedure. It is on the signature of one physician. It was designed to deal with a crisis on admission—a financial crisis, not a personal guardianship crisis that arises at some time during the admission to the hospital.

You have probably all read about the case of *Lawson Hunter et al v Southam inc.*, or at least you will have read the newspaper clippings about it, wherein the court said that removing Charter rights by non-judicial proceedings, particularly by bureaucrats, is just not permissable in a post-Charter era.
era.

Section 15 of the Charter comes into force on April 17. It



guarantees that, "Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination, and in particular, without discrimination based on . . ." Then there is a shopping list concluding with "mental or physical disability."

I submit that the few mental patients who are incapable of exercising the franchise, and who actually tried to exercise the franchise, would be met with the same response in the polling booth as every other citizen who is in some other kind of institution or who is out in the community, and who in fact is incapable of exercising the franchise.

When such a person arrives at the polling booth and wants to vote for Thomas D'Arcy McGee and does not even know what a ballot paper is, the deputy returning officer is perfectly capable of handling the situation, and has no business interfering with people who may be incapable of exercising the franchise but just look good. There are a lot of them voting.

There is no detectable justifiable basis for distinguishing between patients in psychiatric facilities that would withstand a challenge under The Charter.

DON WEITZ: I come here today to represent a magazine, *Phoenix Rising*, which is published by ON OUR OWN, a self-help group of former psychiatric inmates. However, I'm speaking only for *Phoenix Rising* which has consistently spoken out in favor of more human rights, civil rights, legal and constitutional rights for all psychiatric inmates in Canada.

I want to identify myself as a person who had psychiatric treatment many years ago in the United States. I also worked as a psychologist for 15 years—I no longer do so—in the United States and Ontario. I once worked at Queen Street Mental Health Centre for two years. I have also done a fair amount of research into the rights—I should say lack of rights—of psychiatric inmates in Ontario and Canada.

The right to vote is a democratic right in all democratic and free societies. There are no exceptions. That right is sacrosanct and it is one of the distinguishing characteristics of a democratic society. The right to vote is one of our most important

rights—to be able to elect people to represent us.

I believe there are only four rights (for psychiatric inmates) under Ontario's *Mental Health Act.* There is the right to appeal your involuntary committal; the right to appeal a judgement of incompetence; the right to refuse treatment—all of which can be overridden by a review board which is usually stacked against the psychiatric inmate. Also, there's the right not to have your name or other information in your file (medical records) released without consent—the right to confidentiality. That's it. No mention of the right to vote in the Act. (*Ed. note:* Also, since March 1984, inmates have the right to appeal any review board decision to a court.)

BILL 17

I am very sick and tired of reading statements in government bills and papers that threaten to take away the right to vote and other rights of people in institutions, particularly psychiatric institutions. You want to continue the injustice of the denial of the right to vote in this bill. The only difference between the current *Election Act* and this bill is that you have to be judged "incompetent" to be deprived of the right to vote.

I should point out that research and clinical practice show that the judgement of incompetence, a very global concept including the inability to understand and make certain decisions, is made by only one physician or psychiatrist. I must tell you there is overwhelming evidence to show that psychiatrists are incompetent to make such a judgement. Competence or incompetence is not even a medical or psychiatric concept. It's a legal-social one which should be decided by a court—not a doctor.

The stipulation that people have to be judged incompetent to be denied the right to vote flies in the face of *The Charter* which states: "Every citizen of Canada has the right to vote in an election of members of the House of Commons or of a legislative assembly and to be qualified for membership therein."

Not second-class citizens

I will also read a statement from *Just Cause,* the Charter of Rights issue. Its People's Charter gives a more down-to-earth explanation of what this right means:

> Disabled people, whether they live in a community or institutions or in hospitals, including those people incarcerated in psychiatric institutions, have the right to vote in any municipal, provincial or federal election. Disabled people are entitled to be registered to vote and to access, including transportation when necessary, to any polling station. (vol. 1 no. 4 1983-84)

What you are doing with this bill is perpetuating second-class citizenship for people in psychiatric institutions, and we are fed up with this. We are not second-class citizens. My brothers and sisters in institutions have just as much competence as you, sir, or anybody else in this room.

How dare you decide, despite your professed interest, who is qualified to vote. It should be sufficient that a person has attained a certain age, which is somewhat arbitrary because there are people 14 or 16 years old who can make competent decisions, and be a citizen and resident of Ontario or Canada. Because people end up in institutions, often through no fault of their own and often because of hardship, they are being further penalized.

When I was a psychologist, we took a straw vote in the Cleveland Psychiatric Research Institute in 1960 during the Kennedy-Nixon campaign in the United States. The voting pattern was about the same among the inmates and staff.

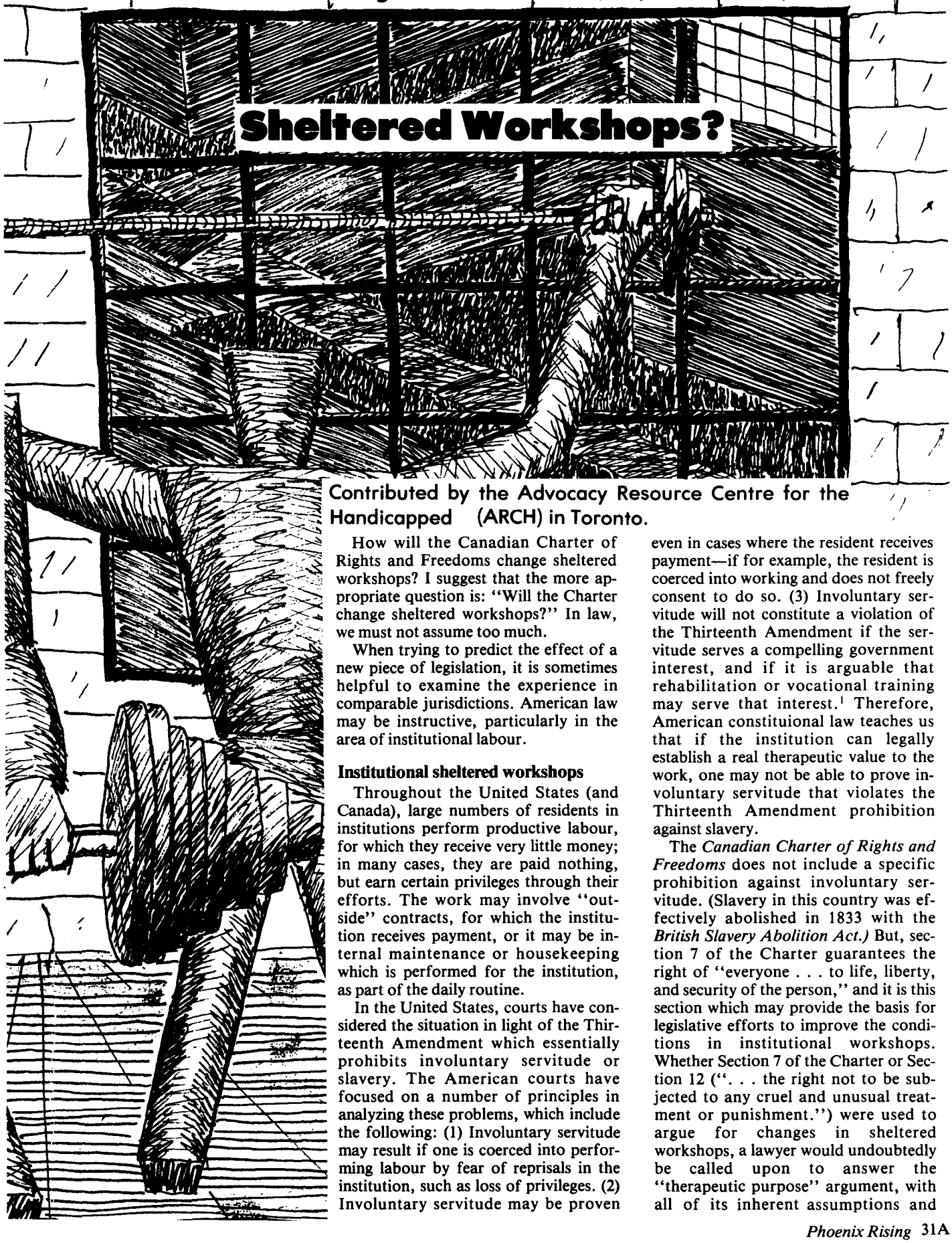
The point is a democratic right. Are you going to allow it? If you do not allow it for one class of citizens, then you are discriminating against a whole class of people. We are sick of being discriminated against. This province prides itself on being democratic, open, whatever. When you put restrictions on the right to vote for psychiatric inmates and prisoners, you are perpetuating classism and elitism in our society, which is totally unjust and undemocratic.

Clause 16(2)2, in which these offending statements are found, can not be justified on ethical, constitutional or even humanitarian grounds. I urge this committee to rescind it, strike it out, so the right to vote is allowed for all people. Otherwise, you will be found guilty of perpetuating a serious injustice.

I confidently predict that a number of people I know will go to court and challenge it, and quite rightly. I will be there with them, cheering them on in their constitutional challenge, which will happen if this clause is allowed to stand.

Phoenix Rising stands behind everything I have said. We represent quite a constitutency of people who have been victimized by the psychiatric system which does not give a damn about our human, civil and legal rights. We hope this government is more enlightened than the psychiatric profession.

Will the Charter Change



Sheltered Workshops?

Contributed by the Advocacy Resource Centre for the Handicapped (ARCH) in Toronto.

How will the Canadian Charter of Rights and Freedoms change sheltered workshops? I suggest that the more appropriate question is: "Will the Charter change sheltered workshops?" In law, we must not assume too much.

When trying to predict the effect of a new piece of legislation, it is sometimes helpful to examine the experience in comparable jurisdictions. American law may be instructive, particularly in the area of institutional labour.

Institutional sheltered workshops

Throughout the United States (and Canada), large numbers of residents in institutions perform productive labour, for which they receive very little money; in many cases, they are paid nothing, but earn certain privileges through their efforts. The work may involve "outside" contracts, for which the institution receives payment, or it may be internal maintenance or housekeeping which is performed for the institution, as part of the daily routine.

In the United States, courts have considered the situation in light of the Thirteenth Amendment which essentially prohibits involuntary servitude or slavery. The American courts have focused on a number of principles in analyzing these problems, which include the following: (1) Involuntary servitude may result if one is coerced into performing labour by fear of reprisals in the institution, such as loss of privileges. (2) Involuntary servitude may be proven even in cases where the resident receives payment—if for example, the resident is coerced into working and does not freely consent to do so. (3) Involuntary servitude will not constitute a violation of the Thirteenth Amendment if the servitude serves a compelling government interest, and if it is arguable that rehabilitation or vocational training may serve that interest.[1] Therefore, American constituional law teaches us that if the institution can legally establish a real therapeutic value to the work, one may not be able to prove involuntary servitude that violates the Thirteenth Amendment prohibition against slavery.

The *Canadian Charter of Rights and Freedoms* does not include a specific prohibition against involuntary servitude. (Slavery in this country was effectively abolished in 1833 with the *British Slavery Abolition Act.)* But, section 7 of the Charter guarantees the right of "everyone . . . to life, liberty, and security of the person," and it is this section which may provide the basis for legislative efforts to improve the conditions in institutional workshops. Whether Section 7 of the Charter or Section 12 (". . . the right not to be subjected to any cruel and unusual treatment or punishment.") were used to argue for changes in sheltered workshops, a lawyer would undoubtedly be called upon to answer the "therapeutic purpose" argument, with all of its inherent assumptions and

fictions.

Non-institutional sheltered workshops

Outside the institutions, voluntariness is less at issue. For the most part, people in workshops attend because they want to—they want some structure in their lives, they want social contact, they want vocational training, and they want some hope for personal occupational advancement.

We know, of course, that the sad reality is that although structure and social contact may be achieved, the more important goals of training and development of occupational potential are often not attained.

There have been few challenges in Canadian law to the workshop system. The recent case of *Kaszuba v Salvation Army Sheltered Workshop*[2] sought a ruling that the applicant was an "employee" within the definition of the Ontario *Employment Standards Act*.[3] The court adopted the same sort of test which the Americans apply in institutional labour cases, and looked for a therapeutic function in the relationship; it ruled that because this was "therapy," it could not be "employment."

Using the Charter for change

The Charter also provides another argument for a lawyer seeking a remedy for a wronged client—one which may prove to be the most effective in court.

Section 15 of the Charter states that "Every individual is equal before and under the law, and has the right to equal protection and equal benefit of the law, without discrimination based on . . . disability." This may mean that if one can establish in court that there is an employer-employee relationship in the workshop, it would be unlawful to pay an employee less than the minimum wage, and to deny them the other protections of *The Employment Standards Act*. Presently, Section 24 of this Act specifically authorizes the *payment of less than minimum wage to a handicapped person*. It may be argued that the section itself violates the equal protection section of the Charter, and is therefore unconstitutional.

The Charter also states that the equality section does not preclude any law, program or activity that has as its objective the improvement of conditions of disadvantaged individuals or groups, including those who are disadvantaged because of disability (Section 15(2)). The expected pro-workshop argument would be that the workshop program is defined as aiming to improve the condition of disabled persons, and therefore is exempt from the equality section.

In the context of this argument the workshop could then be challenged to state its objectives and to demonstrate the ways in which it seeks to meet them; it may also be challenged to prove its success in accomplishing objectives. This process may force a reevaluation of the present system of vocational rehabilitation, training and job placement; it could lead to workshop wages being related to productivity, rather than imposed arbitrarily as they are presently.

Our Charter, provides the grounds for arguing some of the pressing issues in the workshop field, and these arguments may generate some change within the troublesome workshop system. The Charter can, therefore, be an important tool in stopping the treadmill of demeaning menial labour, which is still turning in our Sheltered Workshops.

Footnotes

1. See for complete discussion, Friedman, The mentally handicapped citizen and institutional labour, (1974) 87 *Harvard Law Review*.
2. 41 *O.R.* (2d), 316 (1983)
3. *R.S.O.*1980, c. 137

Note: *Free copies of the* Canadian Charter of Rights and Freedoms *are available. To order copies, write to:* Communications and Public Affairs, Department of Justice Canada, Ottawa, Ontario—K1A 0H8.

Rights ..... Freedoms ..... Principles .....

Declaration of Principles

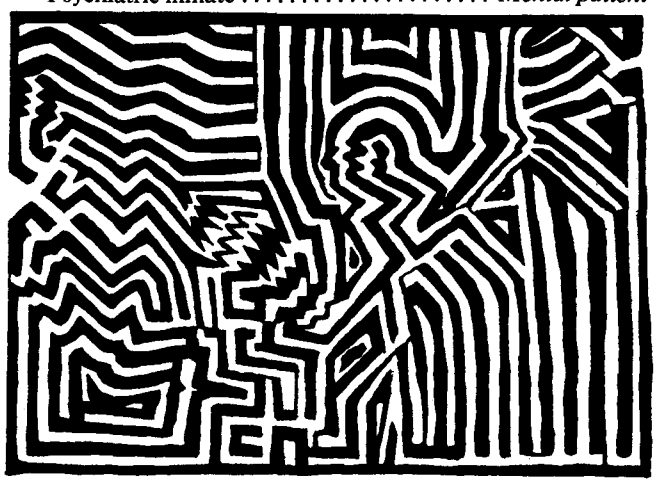
The Tenth Annual International Conference on Human Rights and Psychiatric Oppression, held in Toronto, Canada on May 14-18, 1983 adopted the following principles:

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.
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.
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."

PRINCIPLES

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



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 centres and drop-ins should be controlled by the users themselves to serve their needs, while ensuring their freedom, dignity and self-respect.
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.

Bill of Rights for Psychiatric Inmates in Canada

(Ed. Note: This Bill of Rights was officially adopted by ON OUR OWN on October 29, 1982. These rights apply to all people incarcerated in any psychiatric institution, any psychiatric ward or unit in a general hospital or prison in Canada. On Our Own is a self-help group of present and former psychiatric inmates.)

Definition of *psychiatric inmate:* a person incarcerated in a psychiatric institution who has no control over his/her own life.

1. The right to remain free of incarceration in any psychiatric facility. Alleged dangerousness or criminal acts should be dealt with in the criminal justice system.
2. The right to due process—the right to a court hearing or trial by jury *before* incarceration or loss of freedom.
3. The right of access to free legal advice, legal counsel or advocacy upon our request.
4. The right to be represented by a lawyer of our choice during any or all steps of the civil commitment or admission process, Review Board or Advisory Review Board hearing.
5. The right to remain silent during civil commitment or admission to any psychiatric facility.
6. The right to be warned that information communicated to psychiatric staff during examination for civil commitment or admission to a psychiatric facility is *not* privileged or confidential.
7. The right to refuse *any* psychiatric treatment, whether as a voluntary or involuntary inmate, without threat of reprisal or coercion of any kind.
8. The right to refuse to be labelled or diagnosed since psychiatric diagnostic terms (e.g. "mentally ill," "psychotic," "schizophrenic," etc.) are unscientific, invalid mystifying and stigmatizing.
9. The right to informed consent to *any* treatment—to be fully informed by a doctor about: (a) the nature and type of any treatment planned for us; (b) the alleged "benefits" of the treatment; (c) the known side effects, adverse reactions or risks of the treatment(s), and (d) the known and safe alternative(s) to the treatment—*before* giving our consent. To be valid, our consent must also be freely given without any external pressure, threat of reprisal or coercion.
10. The right to refuse the participate in any research or teaching program while incarcerated.
11. The right to be fully informed within 24 hours of admission about the institutional rules and regulations and about our legal rights, including the right to a Review Board or court hearing. This information must be in plain language which we can read and understand, or interpreted for us in our native language.
12. The right to wear our own clothes at any time while incarcerated.
13. The right to sanitary and humane living conditions while incarcerated.
14. The right to choose our own doctor or therapist while incarcerated
15. The right to consult with any doctor, therapist or community health worker not affiliated with the psychiatric institution, unit or ward in which we are incarcerated.
16. The right to immediate and competent medical treatment by a doctor of our own choice at our request.
17. The right to be provided with nutritious food, including a vegetarian or kosher diet at our request.
18. The right to refuse to participate in any activity or program in any psychiatric facility without threat of reprisal or coercion of any kind.
19. The right to uncensored communication by telephone, letter or in person with whomever we wish at all reasonable times.
20. The right to complete confidentiality of our medical and psychiatric records.
21. The right of access to our own medical and psychiatric records, including the right to see, copy and/or correct any part of these records.
22. The right to be paid *not less than the minimum wage* for any work we have performed for the institution. Such work shall include any task(s) performed in any so-called "industrial therapy" or "vocational rehabilitation" program or "sheltered workshop."
23. The right to vote in any municipal, provincial and federal election, including the right to be enumerated (officially counted) and fully notified of the date, time and place of voting and assistance in travelling to the polling place at our request.
24. The right to be provided with adequate financial assistance while incarcerated *and* upon leaving any psychiatric facility.
25. The right to manage our own money and retain our personal possessions while incarcerated.
26. The right to be informed of available housing alternatives and to be assisted in finding adequate and affordable housing in the community *before* our release from any psychiatric facility.
27. The right not to be subjected to any form of cruel and unusual treatment or punishment as guaranteed under the *Canadian Charter of Rights and Freedoms* and the *United Nations' Universal Declaration of Human Rights.*
28. The right to sue any psychiatric facility or staff member(s) for any physical abuse, assault, forced treatment or violation of our civil, legal or constitutional rights which we have suffered while incarcerated.
29. The right to be treated with dignity and respect at all times.
30. The right to control our own body, mind and life.

ON OUR OWN
P.O. Box 7251
Station A
Toronto, Ontario
M5W 1X9
(416) 699-3192

PATIENTS' RIGHTS

A doctor can legally give you medical treatment only with your consent. This is so even if the treatment is good for you. There are only two exceptions to this rule. First, a doctor may treat you in an emergency. You have to be physically or mentally incapable of giving consent. A delay in treatment must be seen to endanger your life or health. Even in an emergency, the doctor must try to get the consent of your spouse, parent, or next of kin. The doctor won't try if a delay would endanger you.

Second, your consent is not needed when treatment has to be done by law. In Ontario, a doctor may treat you if you have what's called a communicable disease. Tuberculosis or venereal disease are examples. Even if you object to treatment for a communicable disease, you must be treated.

Also, the law says that you may be kept in a psychiatric hospital against your will. You must suffer from a mental illness that is so serious that you are a danger to yourself or others.

What Does "Consent" Mean?

Your consent to medical treatment is legally valid only if it is both **voluntary** and **informed.**

Voluntary consent is consent that you freely give. You must not be forced to consent. Consent that is given under pressure is not valid.

Informed consent is consent that you give after you are told about the purpose, nature, and risks of the proposed treatment. You must also be told about the risks of not having treatment and about any other treatments. If you cannot understand the nature and purpose of the medical treatment, your consent is not valid.

If you need medical treatment, but cannot understand its nature and purpose, the consent of your spouse, parent, guardian, or next of kin is needed.

If a doctor treats you without your consent, you can sue him or her. For example, if you consent to one type of surgery, but the doctor performs another type, you can sue the doctor. You did not give consent to the treatment.

Usually, you will sign a form before an operation that allows the surgeon to give you any treatment that he or she decides is needed. If a doctor does not adequately explain the purpose, nature, and risks of an operation to you, and the operation goes badly, you can sue the doctor. In such cases, you will get damages. A judge or jury must conclude that a reasonable man or woman, in the situation that you were in, would **not** have consented to the treatment if he or she had been fully informed.

Children and Consent

A child under the age of 16 may not legally consent to surgical treatment in a public hospital. The hospital must get consent from the child's parent or guardian. Once a child turns 16, he or she may give consent.

A child of any age may consent to any medical treatment that is not done in a hospital. This is so only if the child can understand the nature and purpose of the treatment. If the child cannot understand, the child's parent or guardian may give his or her consent.

Is Medical Care Free in Ontario?

Medical care is not free in Ontario. However, you can pay insurance premiums to the Ontario Health Insurance Plan (OHIP). Under OHIP, almost all medical treatment that is needed is insured. People who cannot afford to pay OHIP premiums get government assistance.

Not all doctors are covered by OHIP. You should ask about this when you make an appointment. Even if you are not covered by OHIP, or if you have not kept up the payment of your OHIP premiums, a hospital must give you medical treatment in an emergency. A hospital must treat anyone when there is an emergency.

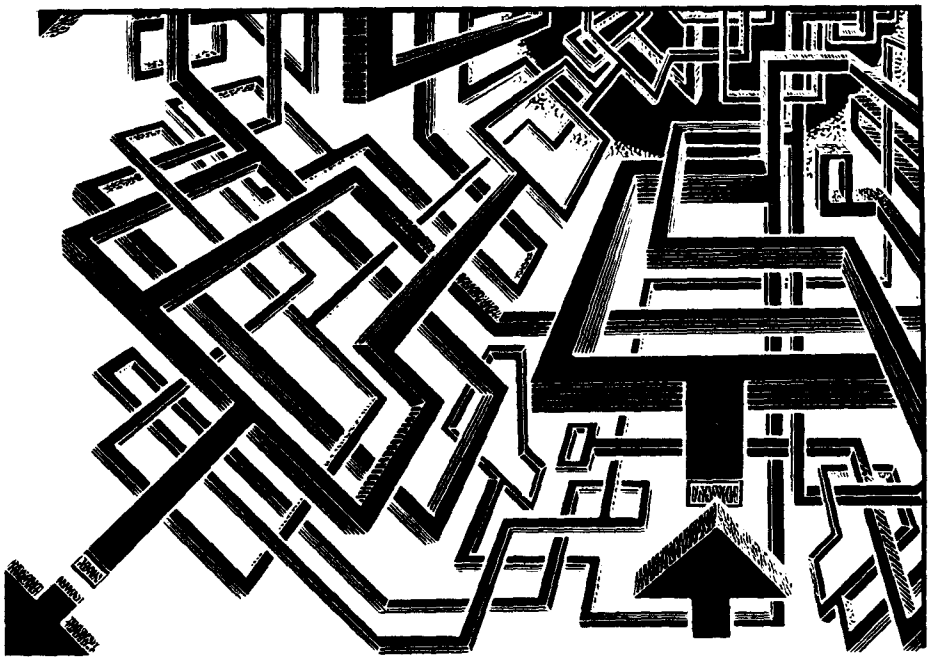
Do Patients Have a Right to See Their Medical Records?

Your medical record has all the medical information collected by your health workers. You have a right to information about what is happening in your case. But you do not have a right to see your medical record unless you are suing your doctor, hospital, or nursing home.

Do Mental Patients Have Rights?

There are two groups of mental patients: voluntary and involuntary. Members of both groups have rights. You are a **voluntary mental patient** if you believe you're mentally ill and go to a psychiatric hospital for treatment. **A voluntary patient has the same rights as any other patient.** You can leave the hospital whenever you want. No treatment can be given to you without your consent.

Your rights are different when you are an **involuntary patient.** When a doctor finds that you are so mentally ill that you are a danger to yourself or to other people, the doctor may sign a paper "committing" you to hospital treatment. Commitment makes you an "involuntary" patient. This means that you must stay in hospital for five days. At the end of five days, another doctor may sign an order extending your involuntary admission up to two weeks. After that, you are free to go. But a doctor may have the case reviewed and have you re-classified as an involuntary patient. If you are re-classified, you must stay for one month or more. Each time your case is reviewed, there is a longer period of time before the next review. After the second review, you must stay in hospital for two months. After the third review, three months.



What If An Involuntary Patient Wants to Refuse Treatment?

If you are "mentally competent" (that is, if you can understand the nature and results of the treatment) the hospital **cannot legally give treatment without your consent, unless it first gets an order for treatment from a Review Board.** This means that the doctor must first convince the Review Board that the treatment is needed.

If you are **mentally incompetent** (can't understand the nature and results of the treatment) the doctor can give treatment, **but not without the consent of either the patient's relative or the Review Board.** Unless the doctor gets the right consent, or a Review Board order, you or someone acting for you, can sue the doctor and the hospital.

If you do not want to stay in the hospital, you can apply to a Review Board (alone, or with the help of a relative or a lawyer). The hospital staff must give you the application form. Your letters to lawyers or to the Review Board may not be read by anyone at the hospital.

Complaints About Medical Care

If you have received incompetent or negligent treatment, you may wish to sue your doctor and/or the hospital where you were treated.

If you can't afford a lawyer, there are two ways to get help.

1. You can apply for a Legal Aid Certificate. If granted, it will pay all or part of your legal fees. Look under Legal Aid in the white pages of your telephone book for the office nearest you.

2. You can call or go to a Legal Aid Clinic in your area. To find out if there is a clinic near you, call the Lawyer Referral Service. In the Toronto area the number is 947-3330.

If you are outside the Toronto area, you can call the Service toll free, at 1-800-268-8326. In Thunder Bay, Rainy River, Kenora, and Fort Francis, call Zenith 5-8600.

If you want to complain about the medical care you received from a doctor, write to:

Registrar, College of Physicians & Surgeons of Ontario,
64 Prince Arthur Avenue,
Toronto, Ontario M5R 1B4

If you want to complain about the care you received from a nurse, write to:

College of Nurses of Ontario,
600 Eglinton Avenue East,
Toronto, Ontario M4P 1P3

IMPORTANT: PLEASE READ

This material contains general information about one area of the law. It is designed to help you recognize when the law can assist you with a problem. It does not provide a complete statement of the law in the area. **If you have a legal problem, you need legal advice that this pamphlet cannot provide.**

To get legal advice, contact a lawyer or a Community Legal Clinic in your community.

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Where To Go When You Have A Problem

General Legal Help
Free Advice and Assistance

BELLEVILLE
Hastings & Prince Edward Legal Services, 194 Front Street, Belleville K8N 2Y7 **(613) 966-8686**

CHATHAM
Legal Assistance Kent, 78 Wellington Street West, P.O. Box 97, Chatham N7M 5K1 **(519) 351-6771**

CORNWALL
Stormont, Dundas & Glengarry, Community Legal Clinic, 4 Montreal Road, Cornwall, Ontario L6H 1B1

GEORGETOWN
Halton Hills Community Legal Clinic, 5 Wesleyan Street, Georgetown L7G 2E2 **(416) 877-5256 (519) 853-2400**

HAMILTON
Dundurn Community Legal Services, 426 Main Street West, Hamilton L8P 1K6 **(416) 527-4572**

McQuesten Legal and Community Services, 360 Queenston Road, Hamilton L8K 1H9 **(416) 545-0442**

HAWKESBURY
Clinique Juridique Populaire de Prescott Russell, 577 Rue McGill, C.P. 156, Hawkesbury, K6A 2S2 **(613) 632-9664**

KENORA
Kenora Community Legal Clinic, 336 Second Street South, Kenora P9N 1G5 **(807) 468-8888**

KINGSTON AREA
Queen's Correctional Law Project, Queen's University, Kingston K7L 3N6 **(613) 547-5803**

Rural Legal Services, c/o Faculty of Law, Macdonald Hall, Queen's University, Kingston K7L 3N6 (613) 547-5860

North Frontenac Community Services Corp., P.O. Box 70, Sharbot Lake K0H 2P0 **(613) 279-2928 (613) 279-2223**

KITCHENER AREA
Waterloo Region Community Legal Services, 30 Francis Street South, Kitchener N2G 2A1 **(519) 743-0254**
CAMBRIDGE (519) 653-1640

LONDON
London Legal Clinic, 121 Queen's Avenue, London N6A 1H9 **(519) 679-6771**

MOOSONEE
Keewaytinok Native Legal Services, Box 218, Moosonee P0L 1Y0 **(705) 536-2981**

ORILLIA
Simcoe Legal Services Clinic, 43 West Street North, Orillia L3V 5C1 **(705) 326-6444**

OSHAWA
Durham Legal Clinic, 3rd Floor, 40 King Street West, Oshawa, Ontario L1H 1A4

OTTAWA
Community Legal Services (Ottawa-Carleton), 71 Daly Street, Ottawa K1N 6E3 **(613) 238-7008**

West End Legal Services, 2835 Dumaurier Avenue, Ottawa K2B 7W3 **(613) 596-1641**

RENFREW
Renfrew County Legal Services, Suite 3, 180 Plaunt Street South, P.O. Box 810, Renfrew, Ontario K7V 4H2

SAULT STE. MARIE
Algoma Community Legal Clinic, Suite 503, 123 March Street, Box 1333, Sault Ste. Marie P6A 6N2 **(705) 942-4900**

ST. CATHARINES
Niagara North Community Legal Assistance, 8 Church Street, P.O. Box 1266, St. Catharines L2R 3B3 **(416) 682-6635**

SIOUX LOOKOUT
Sioux Lookout Community Legal Clinic, 56 Front Street, P.O. Box 187, Sioux Lookout P0V 2T0 **(807) 737-3074/5**

SUDBURY
Sudbury Community Legal Clinic, 215 Elm Street West, Sudbury P3C 1T8 **(705) 674-3200**

TORONTO
Advocacy Centre for the Elderly, 20 Holly Street, Suite 405, Toronto M4S 2E8 **(416) 487-7157**

Advocacy Resource Centre for the Handicapped, 40 Orchard View Blvd., Suite 255, Toronto M4R 1B9 **(416) 482-8255**

Bloor Information and Legal Services, 835 Bloor Street West, Toronto M6G 1M1 **(416) 531-4613**

Canadian Environmental Law Association, 243 Queen Street West, 4th Floor, Toronto M5V 1Z4 **(416) 977-2410**

Central Toronto Community Legal Clinic, 364 Bathurst Street, Toronto M5T 2S6 **(416) 363-0304**

Centre for Spanish Speaking Peoples, 582A College Street, Toronto M6G 1B3 **(416) 533-0680**

Community Legal Education Ontario, 62 Noble Street, Toronto M6K 2C9 **(416) 530-1800**

East Toronto Community Legal Services, 932A Queen Street East, Toronto M4M 1J6 **(416) 461-8102**

Flemingdon Community Legal Services, 747 Don Mills Road, Suite 110, Don Mills M3C 1T2 **(416) 424-1965 (416) 424-1984**

Industrial Accident Victims Group of Ontario, 845 St. Clair Avenue West, Suite 304, Toronto M6C 1C3 **(416) 651-5650 (416) 651-5686**

Injured Workers Consultants, 815 Danforth Avenue, Suite 402, Toronto M4J 1L2 **(416) 461-2411**

Jane Finch Community Legal Services, 1977 Finch Ave. West, Suite 201, Downsview M3N 2V3 **(416) 746-3334**

Justice for Children, 720 Spadina Avenue, Suite 105, Toronto M5S 2T9 **(416) 920-1633**

Landlord's Self Help Centre, 110 Atlantic Avenue, Toronto M6K 1X9 **(416) 532-4467**

Metro Tenants' Legal Services, 366 Adelaide Street East, Suite 203, Toronto M5A 3X9 **(416) 364-1486**

Mississauga Community Legal Services, 30 Stavebank Road North, Mississauga L5G 2T5 **(416) 274-8531**

Neighbourhood Legal Services, 238 Carlton Street, Toronto M5A 2L1 **(416) 961-2673 (416) 961-2625**

Parkdale Community Legal Services, 1239 Queen Street West, Toronto M6K 1L5 **(416) 531-2411**

Rexdale Community Information Directory, 1530 Albion Road, Rexdale M9V 1B4 **(416) 741-1553**

Scarborough Community Legal Services, 695 Markham Road, Suite 9, Scarborough M1H 2A4 **(416) 438-7182**

Tenant Hotline, 1215 St. Clair Avenue West, Toronto M6E 1B5 **(416) 656-5500**

York Community Services, 1651 Keele Street, Toronto M6M 3W2 **(416) 653-5400**

THUNDER BAY
Kinna-aweya Legal Clinic, 233 Van Norman St., Thunder Bay P7A 4B6 **(807) 344-2478**

WELLAND
Community Legal Services of Niagara South, 27 Division Street, P.O. Box 128, Welland L3B 3Z5 **(416) 732-2447**

Crystal Beach Satellite Office **(416) 894-4775**
Toll free from Welland **(416) 382-2536**

WINDSOR
Legal Assistance of Windsor, 85 Pitt Street East, Windsor N9A 2V3 **(519) 256-7831**

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THE STATUTORY DECLARATION:
A Legal Way To Save Your Body, Mind Or Life From Psychiatric "Treatment"

by Don Weitz

A Statutory Declaration is a legal term for a sworn statement which affirms your right not to be subjected to certain medical procedures or treatments. Since the Declaration has never been challenged or tested in a Canadian court, it's uncertain whether it has any legal force.

Anyway, last April I decided to make a Statutory Declaration with the invaluable help of Carla McKague, a lawyer in Toronto and ON OUR OWN member. In my Declaration, I asserted that I intended to refuse electroshock (''electroconvulsive therapy''), psychiatric drugs such as "major tranquillizers" and "anti-depressants," psychosurgery and behaviour modifications if I'm ever judged "incompetent" to make these treatment decisions. On the advice of Carla, I also managed to get a letter from a physician stating that I am competent to make this Declaration. In other words, if I should end up in 'Queen Street' or any other psychiatric institution and the staff try to force any of these brain-damaging, soul-destroying "treatments" on me the Declaration just might stop them. In any event, they're in for one helluva legal battle which I expect to win!

What follows is an easy-to-understand list of instructions for making out a Statutory Declaration, a model letter from a physician supporting the person's competence and right to refuse electroshock, and the Statutory Declaration itself which asserts the person's wish not to be subjected to electroshock. Of course, the Declaration can specify other psychiatric procedures such as neuroleptic drugs or psychosurgery instead of or in addition to electroshock.

As I mentioned before, there's no guarantee that this Declaration carries any legal weight. But damn it, I want to ensure my human rights to be presumed competent, to say NO to any psychiatric treatment or procedure I don't want—to control my own life. Right now, neither the law nor psychiatry can give me this protection and respect, especially if I'm involuntarily committed and labelled "incompetent" in a psychiatric institution. A psychiatrist, relative or guardian making these decisions for me in my own "best interests"? Without my knowledge or informed consent? NO WAY!

Instructions For Statutory Declaration Regarding Treatment

STATUTORY DECLARATION — ONT. A BURNHAM CO. LIMITED FORM NO. 141

Canada
PROVINCE OF ONTARIO

In the Matter of THE INSTRUCTIONS OF (Name) Jane Doe RESPECTING THE USE OF ELECTROCONVULSIVE THERAPY ON HERSELF

To Wit:

I, (Name) Jane Doe

of the City of Toronto in the Municipality of Metropolitan Toronto

Solemnly Declare, that

1. I am over 18 years of age, and believe myself to be of sound mind and fully competent to make decisions regarding medical treatment.
2. I have over several years informed myself about electroconvulsive therapy (ECT) through reading and study, and in the past personally underwent ECT.
3. I am informed by my lawyer, (Name), that there is a body of law to the effect that, if a person is not competent to make a decision regarding his or her medical treatment, and a substituted decision is made by another person, that other person is legally obliged to make the decision which would have been made by the patient if competent, where this can be ascertained.
4. It is my firm wish, and I so instruct any person who at any time may be called upon to make a treatment decision on my behalf, that under no circumstances is ECT to be authorized for me.

AND I make this solemn Declaration conscientiously believing it to be true, and knowing that it is of the same force and effect as if made under oath.

Declared before me at the City of Toronto in the Municipality of Metropolitan Toronto this (date) day of (date) 198

(Signature) Jane Doe
(Name) Jane Doe

A Commissioner, etc.

These documents *can not* be prepared without the assistance of a *lawyer* and a *doctor*. As well, the examples given here are just that — examples. Details will vary according to your own background and the type or types of treatment involved.

You will need to have a lawyer assist you in preparing the *statutory declaration*. You can give him or her this sample as guidance, but you will have to provide the information about your own background and knowledge.

As close to the same date as possible, you should obtain a *letter* from a doctor similar to the example here. It will be to your advantage if the doctor is a psychiatrist, as a psychiatrist's opinion will carry more weight legally than that of a general practitioner.

When the documents are prepared, make sure you have several copies. Keep one copy yourself in case you need to present it to a doctor or hospital. Leave one copy with your lawyer, who you will want to call if you have problems with forced treatment. Give one copy to your nearest relative so that he or she will be aware of your wishes well in advance of any difficulty.

(date) _____

To Whom It May Concern:

On **(date)** _____, I examined **(name)** _____ and found her to be fully mentally competent. In particular, it is my opinion that **(name)** _____ is competent to make decisions regarding medical treatment of herself and that her expressed wish that under no circumstances should electroconvulsive therapy be authorized as a treatment for her has been arrived at rationally and on the basis of considerable information respecting this mode of treatment.

(Doctor's signature) _____

(Doctor's Name)

UNDERSTANDING
Scarey Words

A glossary to help you sort through the maze of legal and psychiatric terminology

by Phoenix Rising Editorial Collective

*(**Ed. Note:** Since psychiatric inmates are rarely given clear and simple explanations of many important legal and psychiatric terms, we have prepared this special list of definitions for inmates—in plain English. The information applies primarily to Ontario. Our thanks to lawyer Carla McKague for her invaluable advice and suggestions.)*

Appeal:	The right to ask a court to review the decision of a Review Board about involuntary treatment or financial incompetence.
Assessment Period:	Under the Ontario *Mental Health Act,* the first five days of involuntary incarceration for the purpose of "observation" and "assessment." During this period, the person can not be "treated" without consent but can be restrained by drugs, physical and/or mechanical restraints. Virtually all inmates are subjected to restraint. Any one doctor (not necessarily a psychiatrist) can authorize this incarceration for any person by signing a 'Form 1'. During the assessment period, the inmate can not legally challenge his/her detention before a Review Board.
Canadian Charter of Rights and Freedoms:	Part of Canada's Constitution. Except for section 15, which guarantees equality under the law for all Canadians, the Charter came into force on April 17, 1982. Section 15, probably the most important section, came into force on April 17, 1985, a three-year delay given to the federal and provincial governments to change any laws which conflict with or violate Section 15. Many Canadian laws still violate the Charter and will probably be challenged soon in the courts.
Certificate of Involuntary Admission: (Commitment)	A legal, provincial government "document" ('Form 3') authorizing the involuntary commitment of a person to a psychiatric ward or institution for two weeks, after the five-day assessment period. Under Ontario's *Mental Health Act,* a person can be involuntarily committed if he/she (a) has a "mental disorder," and (b) as a result is dangerous to him/herself &/or to others, or is unable to care for him/herself. Two doctors must sign each commitment certificate.
Certificate of Renewal:	A legal, provincial government document ('Form 4'), like the certificate of commitment, authorizing the continued incarceration of a person in a psychiatric ward or institution. This certificate is issued when the Form 3 expires and orders one month of additional incarceration. The second renewal certificate is for two months, and the third and subsequent ones are for three months. Since an unlimited number of certificates can be issued, the person can be incarcerated indefinitely. The person can challenge his/her involuntary commitment to a Review Board each time a new certificate is issued.
Civil Commitment:	Involuntary detention or incarceration of a person in a psychiatric ward or institution.
Common Law:	Unwritten law developed over many years through court decisions.

Competency/ Competent: A person is competent to make a particular decision if he/she understands the nature and consequences of the decision. In mental health law, competency" usually refers to: (a) the ability to make decisions about treatment; (b) the ability to manage one's own money or property (financial competence); and (c) the ability to instruct a lawyer.

Criminal Code: The federal law defining all criminal offences and their punishments.

Criminal Justice System: Includes the police, crown attorneys, prisons and other correctional facilities.

Detention: Locking up a person in any place which he/she is not free to leave, such as a psychiatric institution or prison.

Fundamental Justice: Procedural rights guaranteed by the Charter to anyone threatened with loss of life, liberty or security of the person. It includes: (a) the right to a speedy and fair hearing or trial and (b) the right to know the charge against you and answer it. (See Section 7 of Charter.)

Incarceration: (See detention.)

Incompetency/ Incompetent: Exact opposite of competency/competent. Psychiatric inmates judged incompetent to make treatment decisions have no easy way to challenge this. Those found incompetent under the *Mental Health Act* to handle their money can apply to a Review Board to challenge this judgement. Other people such as the mentally handicapped must be found incompetent to manage their money under *the Mental Incompetency Act,* which offers much greater legal protections than the *Mental Health Act.*

Informal Admission: (See voluntary admission.)

Informed Consent: A legal and ethical requirement for any medical or surgical treatment or procedure. To be valid, consent must satisfy these basic requirements: *(a) Voluntary:* The person must not be subjected to any pressure, coercion or threat before giving or withholding consent; *(b) Informed:* The person must be given sufficient information about the proposed treatment(s) or procedure(s) including: (1) the nature of his/her illness including diagnosis, (2) the type of treatment(s), (3) the known or probable effects and risks, and (4) available alternatives. *(c) Competent:* Consent or refusal can only be given by a person whose doctor considers them competent to understand their illness and/or treatment. (See "Substituted Consent.") In psychiatric institutions, informed consent is virtually non-existent, mainly because the vast majority of psychiatrists routinely fail to inform inmates of the dangers of treatments such as drugs and electroshock, and because the psychiatric ward is always coercive and intimidating.

Insanity/Insane: A legal term in the *Criminal Code* meaning, "a state of imbecility or a disease of the mind to an extent that renders him/her incapable of appreciating the nature and quality of an act or omission or of knowing that an act or omission is wrong." Legal and medical definitions of insanity are different, so that a person can be legally but not medically insane, or vice versa.

Insanity Defence: A legal defence allowing a person to claim that he/she is not guilty because he/she was legally insane at the time of the offence. If it succeeds, the result is indefinite incarceration in a psychiatric institution. (See Lieutenant Governor's Warrant.)

Involuntary Commitment: (See civil commitment.)

Lieutenant Governor's Board of Review: A special tribunal which reviews the cases of psychiatric inmates held under a Lieutenant Governor's Warrant. This board is composed of three to five government-appointed members, including at least one lawyer and two psychiatrists. Under the *Criminal Code,* the first hearing must occur within six months from the time the warrant was first issued, and hearings must

occur at least yearly thereafter. The decision to release an inmate under an LGW is made not by the board but by the Lieutenant Governor, following the recommendation of the board. The Lieutenant Governor rarely overrules the board's recommendation.

Lieutenant Governor's Warrant: A legal warrant authorizing the indefinite incarceration of a person judged "not guilty by reason of insanity" or "unfit to stand trial." This warrant exists in all provinces and territories of Canada. Under this warrant, the person is usually incarcerated in a psychiatric institution and cannot legally be given treatment without consent.

Medication: A medical-psychiatric word for pills or drugs. In psychiatric wards or institutions, overdosing or 'drugging' psychiatric inmates is common practice. The prescribing of two or more psychiatric drugs simultaneously is also very common and is called "psychopolypharmacy."

Mental Health Act: A law in most Canadian provinces (some provinces use different names) governing the operation of all psychiatric institutions. A number of these acts have been recently amended — many more will probably be amended shortly because various sections violate the Charter.

Mental Illness /Mental Disorder: A psychiatric term applied to people judged or assumed to be crazy, weird or strange. Other common psychiatric diagnostic terms for craziness or nonconformity include: "psychosis," "schizophrenia," "mania," "depression," "manic-depressive psychosis" or "bipolar affective disorder." A growing number of psychiatric critics, including many ex-psychiatric inmates and radical mental health professionals, believe that "mental illness" does not exist — it's a euphemism or myth used to control culturally dissident or nonconformist people in society. Nevertheless, all medical and psychiatric associations, mental health associations, and the media, actively promote the medical model of "mental illness"/"mental patient."

Medical Model: The theory that all physical and mental problems are caused by a disturbance in the body; that medical or surgical treatment is necessary to cure or control them; that the disease has a definite course or predictable outcome; and that it can be prevented or cured. In psychiatry, this theory has been applied to non-medical or social conditions, or non-conformist behaviour, thoughts and feelings. As a result, people exhibiting such conduct are labelled "mentally ill," "psychotic" or "schizophrenic" and then treated with experimental and dangerous procedures, especially "tranquillizers," "antidepressants" and electroshock ("ECT"). Biological psychiatry, a relatively recent branch of psychiatry, reflects the dominance of the medical model, and claims that all forms of "mental illness" are caused by a "biochemical imbalance" or genetic condition, and that physical therapies such as drugs, electroshock and psychosurgery ("lobotomy") are the only cure.

Psychiatric Inmate: A person incarcerated, usually against his/her will, in a psychiatric institution or psychiatric ward of a hospital. While locked up, the person is generally treated against his/her will and without informed consent, is typically not told what rights he/she has, and loses control over his/her life. Since such people are denied the right to a hearing or trial before this loss of freedom and generally do not know when or if they will be released, psychiatric inmates have fewer rights than prisoners.

Psychiatric Facility: A hospital or hospital ward which admits and "treats" people labelled "mentally ill."

Public Trustee: A provincial government-appointed official who has the power to manage all money of a person judged financially incompetent. (See incompetency/ incompetent.)

Regional Review Board: A regional government-appointed tribunal which has the power to hold hearings concerning involuntary commitment, treatment and a judgement of financial incompetence. There are five such boards in Ontario; three to five members including at least one lawyer and one psychiatrist sit on each board. The boards generally rule against inmates' appeals. Under recent amendments to the Ontario *Mental Health Act,* inmates can now appeal an un-

favourable decision of the board to District Court. Until March 1984, psychiatric inmates could not appeal any board decision.

Restraint: Using physical, mechanical or chemical methods to restrain psychiatric inmates judged "out of control." No consent is required. Examples of such restraints include: straps, bedsheets, belts, solitary confinement ("seclusion"), and heavy doses of major tranquillizers or antidepressants.

Statute: A written law or regulation enacted by the federal government or a provincial government.

Substituted Consent: When an involuntary inmate is judged incompetent to make treatment decisions, his/her nearest relative can consent to any treatment. (If there is no relative, the Review Board can make treatment decisions on his/her behalf.) These decisions must also be informed and voluntary. (See informed consent.) The relative should decide not what is in the inmate's best interests, but what the inmate would have decided if competent. A refusal of treatment by an inmate or relative can be overturned by a Review Board.

Voluntary Admission (Informal) Entering a psychiatric ward of a hospital or psychiatric institution of your own free will. As a voluntary or "informal" patient, the person is legally free to leave the ward or institution at any time. However, it is common knowledge and practice that when a voluntary patient tries to leave the institution or gives notice to staff of intention to leave, the doctor or psychiatrist frequently certifies him/her as involuntary — sometimes within minutes. Under these circumstances, the term "voluntary" really means involuntary.

Writ of Habeas Corpus: A legal order demanding that a person be immediately released from a prison or any other institution where he/she is being held, because the imprisonment or incarceration is illegal. In theory, any involuntary psychiatric inmate has the right to seek release through habeas corpus. However, there are some legal obstacles to this route. An inmate should follow his/her lawyer's advice as to whether to apply for habeas corpus.

Recommended Readings on the Charter and Human Rights

A. Charter Papers: (Prepared by David Baker, Executive Director of ARCH. For copies, please write to: ARCH, 40 Orchard View Blvd., Ste. 255, Toronto, Ontario, M4R 1B9, or call: (416) 482-8255.)

An Introduction to the Equality Section of the Charter of Rights and Freedoms was presented to the Ontario March of Dimes in March, 1985. It is aimed at the lay person. Cost $3.00.

Equality Rights of Disabled Persons. Excerpts from a speech to the Law Society of Upper Canada given on March 2, 1985. Of interest to lawyers. Cost $3.00.

Equality for Disabled: A Preliminary Analysis of the Impact of Section 15(1) on the Charter of Rights and Freedoms. A 90-page paper. Cost $12.00.

B. Rights Issues: (Prepared by members of ON OUR OWN. To order copies, write to: ON OUR OWN, Box 7251, Station A, Toronto, Ont. M5W 1X9, or call: 416-699-3192.

What Rights? A Brief to the Ontario Human Rights Commission Concerning Present and Former Psychiatric Inmates. By Don Weitz and Carla McKague. Toronto: December, 1981. Unpublished. Cost $2.00 + 50¢ mailing charge.

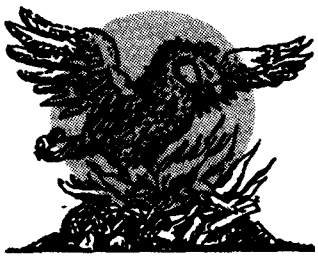
Some Comments on the Child and Family Services Act: A Brief Summary. By Don Weitz. Submitted on behalf of ON OUR OWN to The Standing Committee On Social Development Legislative Assembly of Ontario. Toronto: July 12, 1984. Unpublished. Cost $1.00 + 50¢ mailing charge.

Civil Rights for "Mental Patients"? A Brief Submitted to the Committee on Mental Health Services for the Ontario Council of Health. Toronto: April, 1978. Unpublished. Cost $1.50 + 50¢ mailing charge.

Employment Issues for Ex-Psychiatric Patients: Some Considerations and Concerns. A Statement to the Commission of Inquiry on Equality in Employment. December, 1983. Unpublished. Cost $1.00 including mailing charge.

The Canadian Charter of Rights and Freedoms Section 15 (1)

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



the BOOK WORM TURNS

The Politics of Schizophrenia: Psychiatric Oppression in the United States

By David J. Hill, PhD
University Press of America, 1983
Washington, D.C.
567 pp.

Reviewed by DON WEITZ

David Hill is an outspoken, politically aware clinical psychologist who is not afraid to attack the mental health system, particularly psychiatry. This immediately sets him apart from all those other mental health professionals who obediently follow the medical model party line and mindlessly mouth the myths of "mental illness," "mental health" and the alleged effectiveness of psychiatric "treatment."

The Politics of Schizophrenia, Hill's first book, based upon his doctoral thesis, is one of the most powerful attacks on schizophrenia and psychiatry that I've read in many years; while focussing upon schizophrenia (the most pejorative diagnostic label in psychiatry, equivalent to leprosy in medicine), it condemns the power and violence of psychiatry itself, challenging its very right to exist. This book achieves several important things: (1) exposing schizophrenia as a pseudo-scientific construct or medical myth; (2) showing how the label schizophrenia is a metaphor for unwanted or rule-breaking behaviour and a social control mechanism for invalidating or punishing non-conformist people; (3) showing how psychiatry's brain-damaging "treatments" such as psychosurgery, electroshock and the neurotoxic drugs are used to neutralize cultural dissidence; and (4) making the connection between psychiatry and capitalism by showing that they support each other. Hill's socialist perspective informs his entire study. He demonstrates clearly, for example, that psychiatric diagnosis and treatment (particularly in psychiatric institutions) are forms of oppression by the powerful (the psychiatrists and ruling class) over the powerless (psychiatric inmates and the unemployed working class), and are ridden with class prejudice, sexism and racism.

The most absorbing parts of the book for me are those relating to schizophrenia itself (Parts II-IV) and the brain-damaging treatments (Part IV—"Psychiatric Violence"). In Part II, Hill asserts that schizophrenia was invented—not discovered in the late 1800s and early 1900s. In the mid-1800s, psychiatry was desperate to prove itself a medical science—as it still is. While other branches of medicine were classifying new diseases and documenting scientifically their anatomical and physiological causes, the pioneer "mind doctors" scrambled to discover a "mental disease," and thereby gain credibility. To this end, psychiatry began classifying what was then considered immoral behaviour as "sick" or "abnormal," and moral or conventional behaviour as "normal."

Emil Kraepelin, a German psychiatrist still hailed by the psychiatric establishment as the founder of modern psychiatry, coined the name "dementia praecox" to identify the mental illness he claimed to have discovered and diagnosed. Its "symptoms" were numerous and perplexing; they led, he believed, to irreversible deterioration ("dementia") after beginning in early adolescence ("praecox"). Hill systematically exposes the tissues of illogical reasoning, distortions, and lies, upon which this "discovery" was based—and the lack of scientific evidence to corroborate it. He points out, for example, that Kraepelin arbitrarily lumped more than 40 different behaviours or "symptoms" (which included hallucinations, so-called paranoid ideas or delusions, a host of strange mannerisms and gestures) into one all-inclusive "diagnosis." In 1904, Kraepelin nervously admitted that "dementia praecox" wasn't a very accurate term, since, as Hill also points out, many of the symptoms of the people so diagnosed "neither began in adolescence nor resulted in dementia."

In one critical respect Kraepelin helped establish a tradition which the psychiatric establishment practises to this day—circular reasoning and other forms of faulty logic. He classified his patients according to whether they got better or worse. Those who improved were diagnosed "manic-depressed;" those who did not were diagnosed "dementia praecox." In other words, outcome was made a defining characteristic of this so-called disease. Certain behaviours were seen as indications of the disease, while the disease was identified by the behaviours; anyone who has received psychiatric treatment will recognize this "Catch-22." Like Bleuler a few years later, Kraepelin openly admitted that he really didn't know the cause(s) of "dementia praecox" but hoped or speculated that someday a physiological or hereditary one would be found; he could only speculate vaguely about a "single morbid process." In classifying and naming a disease before its cause was established, Kraepelin violated a basic rule of science. However, to his credit, he admitted that his diagnosis of "dementia praecox" was tentative; nevertheless, psychiatry in its eagerness to be accepted into the medical club, immediately and confidently interpreted Kraepelin's tentative findings as scientifically proven facts.

Eugen Bleuler, a Swiss psychiatrist, largely accepted Kraepelin's claim of a new type of "mental illness" but disagreed with his belief in "dementia." Bleuler renamed "dementia praecox" "schizophrenia," which literally means splitting of the mind. Actually, Bleuler meant a psychological split between thought and feeling. For Bleuler, schizophrenia was primarily a thought disorder, a disturbance in associations. While frequently using the term "disease" or "disease" process" in his descriptions of schizophrenic symptoms, Bleuler also admitted that he wasn't really sure about all of this. Hill quotes some of Bleuler's statements:

> We do not as yet know with certainty the primary symptoms of the schizophrenic cerebral disease . . .
>
> It is impossible to establish any definite . . . prognosis.
>
> The pathology of schizophrenia gives us no indication as to where we should look for the causes of the disease.
>
> . . . we know of no measures which will cure the disease . . .
>
> We do not know what the schizophrenic process actually is.

Like Kraepelin, Bleuler never seriously considered the possibility that the strange, unpredictable behaviours he was labelling as "symptoms" could be more realistically understood in terms of a social-control model for nonconformist behaviour. In fact, Bleuler never really satisfied such basic scientific requirements for a disease entity as anatomical evidence of tissue or cell abnormalities, course of illness, fundamental disturbance and specific symptoms. Instead, he described the "schizophrenic symptoms" in such broad, vague and moralistic terms that virtually any "symptoms," including what he called "flat affect" and "ambivalence" can be found

in everyone at some time in their life.

Hill rightly concludes that Bleuler's claim of a "disease process" was sheer imagination. I would add the words classism and sexism to imagination, since many of Bleuler's and Kraepelin's descriptions of symptoms were blatantly classist and sexist; for example, Kraepelin points to symptoms such as "making sexual experiences public . . . obscene talk . . . shameless masturbation . . . untidy and dirty clothes . . . speaking familiarly with strangers . . ." Bleuler remarks on some of his patients' "perversions such as homosexuality . . ." He recommends as treatment for schizophrenic girls and women, ". . . housework . . . under strict supervision . . . routine, mechanical officework . . ." Both female and male patients were to be given warm baths, bed-rest, special diets and, of course, continued institutionalization—especially if they violated the traditional sex-role stereotypes. In reality, Kraepelin and Bleuler were describing nonconformity and alienation, which today's psychiatrists are still pathologizing as schizophrenia.

In Part IV, Hill demonstrates just how unscientific the concept of schizophrenia really is. In study after study, investigators repeatedly assert a striking lack of reliability and validity. Psychiatrists can agree on a diagnosis of schizophrenia only 30 to 40 percent of the time, half the time at best. In one 1962 study, under "optimum conditions" the average "level of agreement . . . was 53 percent."

A 1967 study criticizes the obvious lack of precision in psychiatric diagnosis, including that of schizophrenia: ". . . the present system must be considered a failure since . . . a diagnostic label tells us very little about etiology, treatment or prognosis." In the 1973 pilot study of the UN's World Health Organization, the authors admit that, ". . . an etiologically based concept cannot be established today;" however, this fact doesn't stop them from describing schizophrenia as a "mental illness."

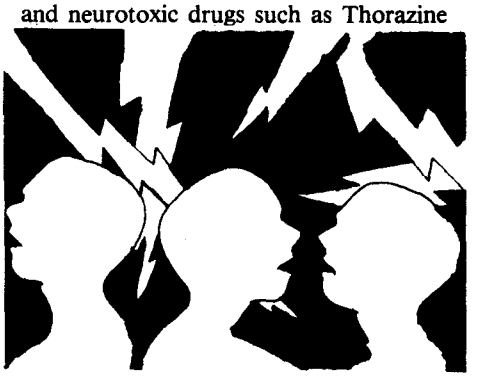
Psychiatry's inappropriate use of the medical model was obvious 100 years ago, just as it's still obvious today. As a result, psychiatrists routinely fail to perceive people's behaviour in a social or cultural context. Hill writes: "The sociopolitical aspects of craziness do not seem to exist in the experience of mental health professionals." He is even more blunt regarding the social control function of schizophrenia:

> The diagnosis of "schizophrenia" is used to discharge people from society; people who are contributing nothing to the continuation of the official version of reality as determined by the dehumanizing values of our competitive society, who are unusable, simply not worth their economic salt . . . to the mental health profession falls the task of draining off this vast reservoir of unsuitable individuals through the diagnostic channel of "schizophrenia". (pp. 226-227)

"Draining off" is an understatement. As Hill also points out, both Kraepelin and Bleuler advocated the sterilization of schizophrenics and other mentally-disordered inmates, presumably because their offspring would carry the "schizophrenic tainting." Without any scientific evidence, both of these psychiatrists presumed that schizophrenia was probably inherited. Less than 30 years later the Nazi psychiatrists started killing almost 300,000 psychiatric inmates and mentally handicapped ("retarded") people in the mental hospital gas chambers as part of their "euthanasia" program, or "final solution." The Nazi psychiatrists rationalized these murders by labelling the slaughtered inmates as "useless eaters" or "people devoid of value," terms very similar to those used by Kraepelin and Bleuler.

Since schizophrenia is a metaphor for unwanted or rule-breaking behaviour, it obviously must be punished. Punishment is the real but hidden purpose of many psychiatric "treatments" today, especially the brain damaging procedures such as psychosurgery, electroshock and the neurotoxic drugs ("major tranquillizers" and "antidepressants"). This psychiatric violence is routinely denied by psychiatry. Hill recalls witnessing psychiatric inmates being shocked when he worked as an orderly on a psychiatric ward in Montefiore Hospital in the Bronx: ". . . the most unsettling aspect . . . (was) the powerlessness of the victims." He appropriately titles his chapter on shock "Electrocution" and documents its many brain-damaging effects. I've always felt that one of the classic power plays in psychiatry involves a male chauvinist psychiatrist forcibly administering electroshock to a protesting female inmate. (Radical feminists rightly label this and other forced treatments psychiatric rape.)

The two other, major "treatments" to which schizophrenic inmates are frequently subjected are psychosurgery (intentional destruction of healthy brain tissue for the purpose of social control), and neurotoxic drugs such as Thorazine



and Prolixin (Moditen or Modicate in Canada). Inmates are considered "improved" when they become docile, passive, or stop protesting, which is invariably the case after months or years of "medication." Hill points out that the major tranquillizers frequently cause brain damage in the form of tardive dyskinesia, a permanent, drug-induced neurological disorder which affects roughly 50 million people in the world. Hill adds that this tragic epidemic of psychiatrically-caused brain damage is usually underestimated or under-reported in the psychiatric journals.

Psychosurgery, or stereotactic surgery, (previously called "lobotomy") needs little comment except to say that this most brutal psychiatric atrocity is continuing, making a "comback" since the 1970s, especially in the United States and Great Britain. (A cousin of mine, also labelled "schizophrenic," was subjected to psychosurgery in Boston in 1974. She's still experiencing serious problems, is less creative, and permanently brain-damaged —thanks to the "treatment.")

Near the end of the book, Hill talks about the "forces resistant to change" in the mental health system. The "disconnecting" process, he says, is at work in all too many psychiatrists and other mental health professionals who distance themselves emotionally from their patients, project negative traits or stereotypes on them, and treat them as cases instead of human beings. These professionals also become alienated from themselves, so that they lose touch with their own feelings, their own violence, which is usually denied.

In his chapter titled "The Politics of Psychiatry," Hill identifies the power grab of psychiatry—"the right of the powerful to maintain their power by oppressing the less powerful." Of course, the mental health professionals who have the most power to oppress people by diagnosing, treating and locking them up against their will are the white, middle/upper-class, heterosexual male psychiatrists. It's precisely this power and propaganda (I prefer the term psychiatric lies.) which must be strongly and publicly challenged and resisted, if we are to share power instead of compete for power, over our lives.

The International Psychiatric Inmates Liberation Movement has been confronting psychiatry for almost 12 years; it's had some notable successes. *The Politics of Schizophrenia* will assist the movement in its continuing struggle against psychiatric power and violence masquerading as "treatment." David Hill is a brother. His book gives us more ammunition to use in our fight against psychiatry, mental health ideology, and capitalism, which feed off each other and oppress all of us.

The Iatrogenics Handbook (1983)
Electric Shock (1984)

Robert F. Morgan, Editor
IPI Publishing
Toronto, Ontario

Reviewed by HUGH TAPPING

These are important books. I want to recommend them, but I want to add a warning—do not read the "Handbook" if your anger is greater than your sense of humour.

The *Iatrogenics Handbook* is subtitled—"A Critical Look at Research and Practice in the Helping Professions." It a is university-level textbook but is written (mostly) in English. Some chapters suffer from intimidating labels, for example, Iatrogenic Defeatism and Other Null Assertions." Don't let the academese turn you off—this book is important.

The Introduction offers this definition: "Iatrogenic behaviour refers to those incidents where the cure is worse than the disease, where (often) well-intentioned *helpers* create substantial problems for themselves or others through *helping* . . . mature professions must endure and even seek out data-based criticism of this iatrogenic dimension of their activity."

More than two dozen authors have contributed to this book. They ride off in all directions at once, questioning and criticising the theory and practice of helping people. Different authors take different approaches, ranging from satire and ridicule to such classic brain fog as "Table 2: Regressions of Age-Sex Standardized Death Rate on Structural Characteristics and Medical System Resources."

Although psychiatry/psychology are singled out for special attention, the entire field receives a good going over. One chapter, for instance, explains how belief in TV commercials can kill your kidneys.

Here's the warning. No matter how well-intentioned, how "on our side" the professionals may be, they still live in another world. Some of the satire and in-jokes can sound rather heartless to those of us living with the results of "therapy." One short chapter that had me laughing all day provoked a friend to snarling rage—"Balloon Therapy."

Dr. Morgan has a modest proposal, à la Jonathan Swift. He has invented a therapy consisting of fastening large helium-filled ballons to clients' ears. The shape, colour, length of string, etc., will be a product of the therapist's clinical expertise. After a week of 24-hour-a-day balloon therapy, the client returns and the balloons are removed. Remarkable results are reported: relief of depression—client feels elation at no longer having balloons on ears; relieves anxiety neuroses—anything relieves anxiety neuroses; self-confidence—having survived this, client can face anything; alcohol abuse—client is refused service.

However, there are contraindications. Balloon therapy is not recommended when client: (1) has a poor sense of humour, combat experience, or an attorney; (2) has not had Erhardt Seminars Training; (3) is financially insolvent or (4) can spell iatrogenic.

Questionable-taste (and medical-model) humour serves to sweeten the mixture. There is plenty to feel bitter about: families of M.D.s in Alberta received surgery *one third* as often as the general population. Native people had a surgery rate *five times higher* than average, particularly for women, and particularly for tubal ligations. A professional viewpoint sees this as a tragedy, and praises the courage of physicians "willing to criticise their own." I call it genocide and would prefer an attack on the whitecoat criminals.

I must praise any book that calls Thomas Szasz "the appropriately much-honoured leader of the self-criticism movement within psychiatry." Any author willing to simultaneously praise and commend Szasz while trying to sneak him back "within psychiatry" is a subversive element, and we can always use more of them. Anyone working in an institution, from primary schools to the back wards and prisons, could benefit from a dose of this book. I recommend it highly as an eye-opener and thought-provoker. There is a complete lack of political perspective—no analysis of how a system so corrupt maintains such power in our society. Consequently, even students may safely read this work—it won't leave you feeling that you must actually *do* anything.

Four chapters of *The Iatrogenics Handbook* have been reprinted, with a new introduction, as *Electric Shock*. The chapters cover resistance in the 60's, 70's and 80's. Authors are Robert Morgan, John Friedberg, Peter Breggin and Berton Roueche. If you are interested in a professional, clear, concise and thorough denunciation of "ECT," read this book.

John Friedberg's contribution is an improved (with thanks to Marilyn Rice) version of his classic paper presented to the 1976 APA annual meeting.

I know there are professionals who read the Phoenix but still can't bring themselves to believe what so many survivors say. I urge them to read this book. It may not give the integrity or courage to join the fight, but after reading about how Marilyn Rice was "recruited" to our movement, you might understand the origin of our strength and tenacity.

Survivors Speak Out at Shock Doctor Conference

INTRODUCTION

By Leonard Roy Frank

Opponents of electroshock met in NY to demonstrate at, attend and participate in the First International Conference on Electroconvulsive Therapy, held at the Barbizon Plaza Hotel January 16-18, 1985.

Judi Chamberlin came with several other activists from Boston, Joe Rogers arrived with a van-load of "homeless" friends from Philadelphia, and George Ebert journeyed in from Ithaca, Don Weitz from Toronto, and myself from San Francisco. On hand from the New York area were Nancy Lindmann, Louise Wahl, and Bill Cliadakis (their excellent organizing work made our involvement possible), as well as Rosita Libre de Marulanda, John Parkin, Laura Zegler, Renee Ellman, Kalisa, Paij Wadley-Bailey, and others.

The eerie feeling I experienced when I walked alone into the auditorium for the conference's opening session is hard to describe. There were these 500 or so ECT specialists and supporters, looking more like IBM executives than doctors, listening attentively as their fellow devotees regaled them with the latest studies, stories, and opinions about electroshock. I found myself gradually sinking deeper and deeper into my cushy seat: it was as though a heavy weight were being piled onto my shoulders.

All the speakers had impressive credentials, were very articulate, and often enough gracious in their manner; all of which contributed to the creepy effect. What they said was even more frightening.

Dr. Shervert Frazier (Harvard Medical School) assured the audience that there would soon be biological tests showing in advance who will benefit from ECT.

Dr. Sidney Malitz (New York State Psychiatric Institute) said that it was "essential to bring together as many serious researchers as possible." (So long as they all shared the same enthusiasm for ECT, I added to myself. Not one professional ECT critic had been invited to speak at this supposedly scientific conference. The prestigious New York Academy of Science had been suckered into co-sponsoring not a scientific, but a promotional conference.)

Dr. Max Hamilton, from Leeds, England, lambasted ECT critics as "civil rights groups, radicals and various peculiar sects," and he talked in glowing terms about the effectiveness of ECT in

treating depression. When someone from the audience asked him how soon after a stroke he would use ECT, Hamilton responded that in the few cases of this type he had had, it was within a week; thus he ignored the even greater risk of brain damage ECT carries for stroke victims.

I left the auditorium soon after Hamilton's talk to demonstrate in front of the hotel; only after joining our group did my heaviness begin to lift. The demonstration itself was a spirited affair that lasted about two hours. We all felt an incredible unity and determination that the freezing weather and our numbering only 25 did nothing to diminish. We were there; we cared about each other; we shared a sense of higher purpose. Electroshock had to go, and somehow our presence there was helping to bring that about.

The next night we were back at the hotel for a showing of the videotape on ECT which George had brought with him. Produced by the Upstate New York Coalition to Stop Electroshock, this tape is one of the best educational tools to come out of our movement. (For information on obtaining a copy, write George Ebert, Box 875, Ithaca, NY 14850.) The showing, to which everyone at the conference had been invited, packed the small room with about 50 people—a few more of "them" than "us."

The discussion that followed the showing led to some heated debate. Of course, the psychiatrists criticized the videotape for its anti-shock bias, but there was not a word from any of them about the pro-shock bias of the conference. Don was particularly effective in rebutting some of the more outrageous statements by ECT proponents. The face-off went on for about an hour, and, as might have been expected, there were no defections from either side.

That evening we got together in Marilyn Rice's hotel room to plan for the next day's event, our panel presentation.

The next morning Janet Gotkin, (who came in from Croton-on-Hudson with her husband Paul), and Lenny Lapon, (who drove in from Athol, Mass.,) arrived at the hotel to join the panel.

Others on the panel were Rosita Libre de Marulanda, Don Weitz, and myself, with John Parkin serving as moderator. As mentioned earlier, no professional opponents of ECT had been invited to the conference, but thanks to the determined efforts of Bill Cliadakis and others, the organizers decided at the last minute to grant us ECT survivors and movement activists a "survivors' panel." Although we were relegated to the lunch break on the last day of the conference, and commenced 45 minutes late because of carryover from the morning presentations, I think we presented ourselves very effectively. After John's introductory remarks, the six of us only had about 10 minutes each for our talks. The audience, though shrunk to about 150 following the last morning session, was quiet and attentive throughout these moving personal statements.

"Electroshock is not a medical 'treatment' that is occasionally abused. It is, in and of itself, an abuse:"

Lenny Lapon

The history of psychiatry in general, and electroshock in particular is inseparably linked with the history of fascism. This so-called "treatment," ECT or electroconvulsive therapy, is actually a form of torture and I will properly refer to it as such throughout my presentation. In its modern form this particular method of torture was first used on a human being by Ugo Cerletti in Italy in 1938. Of course, Italy at the time was a fascist country under the rule of dictator Benito Mussolini. Also present at this first administration of electroshock was Lothar B. Kalinowsky, a speaker at this shameful conference and a prolific electro-torturer and pro-shock polemicist in the United States. Kalinowsky's affinity for fascism has been exhibited not only by his six years (1933-1939) at the University Hospital for Nervous and Mental Diseases in fascist Rome, but also by his publication of *Die Hallervordensche Krankheit* (The Hallervorden disease) in Hitler's Nazi Germany in 1936.

Now that I have your attention, I will continue to trace Herr Doktor Kalinowsky's history. From 1940-1959 he worked as a psychiatrist at the New York State Psychiatric Institute, an institution well represented by speakers here at this conference. In fact, the conference co-chairmen, Sidney Malitz and Harold Sackeim are also employed by this infamous psychiatric hell-hole, this den of mind-control experimentation for the CIA and the U.S. Army under such project titles as MK ULTRA, MK DELTA, ARTICHOKE and BLUEBIRD. If these charges seem extreme to anyone here, I refer you to the not-so-radical *New York Times*—specifically the editions of August 13 and 14 and September 10, 1975. For six years, from 1953 to 1959, conference co-chairman Malitz was the responsible investigator, the chief of an Army-sponsored mind control experiment with hallucinogenic drugs, namely LSD and mescaline, that were given to psychiatric inmates at the New York State Psychiatric Institute.

Historically, electroshock has been one of the key components of brainwashing research, experimentation and operations of the United States' intelligence agencies. Psychiatrist D. Ewen Cameron, former president of the American Psychiatric Association, the World Psychiatric Association and the Canadian Psychiatric Association used this terrifying torture intensively and extensively in brainwashing psychiatric inmates at Allen Memorial Hospital in Canada while under contract to the CIA.

Electroshock is not a "medical treatment" that is occasionally abused. It is, in and of itself, an abuse. Dr. Peter Breggin wrote of the deadly effects caused by this torture in his book, *Electroshock: Its Brain-Disabling Effects.* He included death, amnesia and other kinds of memory loss, brain hemorrhages, cell death, brain death, bleeding and brain-tissue destruction. Electroshock is commonly used, along with other coercive and deceitful psychiatric procedures, such as drugs, psychosurgery, shackles, and the totally anti-democratic technique called behaviour modification—used to control, to terrify, to brainwash, to force psychiatric inmates and other, usually powerless, people to conform to particular ways of acting and thinking.

Psychiatry does kill! Leonard Frank has documented several hundred deaths caused by electroshock alone in his book, *The History of Shock Treatment.* This documentation is from the psychiatric literature. Most murders by means of electroshock never reach the pages of the psychiatric journals, but are covered up and attributed to heart attacks and other so-called natural causes.

The National Institute of Mental Health and the same drug companies that are funding this conference also foot the bill for other forms of psychiatric killing and maiming as well—the powerful and harmful mind-controlling drugs, the brain mutilation known as psychosurgery and the training of large numbers of psychiatrist-torturers. Hundreds of millions of NIMH dollars have increased the number of psychiatrists in the United States from about 1300 in 1930 to well over 30,000 today.

I have written a book concerning these

issues. It is entitled *Mass Murderers in White Coats: Psychiatric Genocide in Nazi Germany and the United States.* I will be self-publishing it in 1985 through the Psychiatric Genocide Research Institute.

Being as this is an international conference, I find it particularly important to point out the shameful parallels between this meeting and the practices it represents and similar institutions and events in Nazi Germany. Psychiatrists in Nazi Germany killed 300,000 or seven-eighths of their so-called "patients," beginning in 1939 and continuing until 1945. They used starvation, lethal injections and the first gas chambers. They called this project "treatment," namely "euthanasia." It was not until two years after their use on psychiatric inmates that these gas chambers and the rest of the psychiatrically perfected killing technology was exported to the infamous death camps such as Auschwitz, Treblinka and Sobibor. Many of the doctors who later chose Jews and others to go to the gas chambers in these deaths camps were psychiatrists.

Nearly all German psychiatrists participated in this mass slaughter, at least at the level of transferring inmates to known killing institutions. In fact, one such psychiatrist, Gisela Ebert Fleischmann, who, in 1944, worked at the psychiatric clinic at the University of Freiburg, Germany, admitted to me, in an interview, that it was rather common knowledge that the mental patients were being killed and she stated, and I quote, "some of them we had to transfer. There was, you know, revue boards and so on." After the war, Gisela Ebert Fleischmann, along with many other psychiatrists educated in Nazi Germany, came to the United States. She is presently a member of the American Psychiatric Association and lives in New York.

The German Nazi psychiatrists and other doctors called their mass murder of psychiatric inmates, Jews, gays, communists and Gypsies scientific, medical treatment. Just as this conference is sponsored by a prestigious scientific institute, the New York Academy of Sciences, the Nazi pseudoscientists had the sponsorship of world-renowned scientific institutions including the Kaiser Wilhelm Academy and the Max Planck Institute.

Just as conference co-chairman Harold Sackeim heralds from the Department of Biological Psychiatry at the New York State Psychiatric Institute, Carl Schneider and many other leading Nazi psychiatrists described themselves as biological psychiatrists. Schneider was one of the chief so-called "experts," or "consultants," who reviewed and approved the forms filled out by other psychiatrists for each inmate, a process that directly sent thousands of psychiatric prisoners to their deaths. Schneider was a professor at the University of Heidelberg and an internationally known author of several psychiatric textbooks. He is still praised as a pioneer in biological psychiatry in psychiatry textbooks in the United States. I spoke with psychiatrist Franz Hornung, a student of Schneider's at the University of Heidelberg. Hornung received his medical degree there in 1945. He told me that Schneider was a good teacher and gave good lectures, and that what else Schneider may have done, he had no idea. Hornung also related that Schneider committed suicide after the war. Hornung also came to the United States and he too is presently a member of the American Psychiatric Association.

The philosophy that you espouse here is nearly identical with that of Adolf Hitler and his Nazi psychiatrist-cohorts. You brand us as "mental patients," "schizophrenics," "mental defectives," "useless eaters," *Untermenschen* (subhumans) and genetically inferior. Much of this labelling has its basis in the eugenics movement of the 19th and 20th centuries. Both here in the United States and in Germany, England and other European countries, eugenicists have sought to "purify the race" by selective breeding—by forced sterilizations and by genocide. You claim we have defective genes and brain chemistries. You assault us with your physical tortures—electroshock, psychosurgery, drugs and imprisonment—and you call it all medical, scientific "treatment."

Unfortunately, only a few of the Nazi psychiatrists and other doctors were brought to justice for their crimes against humanity—in trials such as that at Nuremberg. You too are guilty of crimes against humanity—of murders and brain mutilations and violations of human rights. You constantly violate international law, the Nuremberg Code. You torture human beings with experiments, with techniques that you are unwilling to perform on yourselves and on each other. Of course, you do this without your victims' informed consent. You are most comfortable in closed, authoritarian, fascistic societies. You fear dissent. You exist to quell it. You cannot operate where there is democracy and free choice. The real issues around the use of electroshock have not been addressed by this conference. The real issues are not medical and scientific ones, but rather moral and political issues.

Thousands of us whom you have harmed are fighting and will continue to fight for freedom from psychiatric intrusion and torture. We slowly but surely move toward the day when you will pay for your crimes.

"I speak for those who cannot or are afraid to speak for themselves:"

Janet Gotkin

Between 1961 and 1971 I had over one hundred shock treatments, some with anesthesia, some without, in public hospitals and private institutions. I never signed a consent form and was never told what the procedure would consist of or what lasting debilitating effects I might endure.

In some ways I am rather a miraculous case. I survived more than one hundred electrical assaults on my brain. Oh yes, I have large, unpredictable blank spots in my life history and unexpected, gaping, empty space I cannot fill. But years of drugs and shock did not destroy my body or my brain, did not incapacitate me as they have so many thousands of others.

Yes, ECT caused me excruciating pain, both psychic and physical, but I did emerge intact. I was very lucky. And I have felt, by virtue of this dumb luck—or perhaps sheer physical resilience—that I owe it to my less lucky sisters and brothers to speak out on their behalf; in a sense, to tell their stories, all of our stories.

As I sat down to plan this presentation I asked myself things I've asked many times over the past number of years—and never successfully answered. They were questions about the people who give ECT, the "shock doctors."

"Are these men evil?" I asked, using "men" since 95 percent of all shock doctors are males. "Are they stupid? Are they really heartless and sadistic and cruel? Are they morally deficient? Or, perhaps, do they suffer from a kind of self-induced blindness, an unwillingness to see what they are truly doing to the people they purport to help?"

Once again, I was unable to answer these questions, or if I did, the answers did not shed any light on the phenomenon of men devoted to a profession of healing who embark upon and continue to practise a procedure which

causes the wholesale suffering and damage of ECT. Instead, I chose to be charitable and, rather than assuming malicious intent, to assume a kind of benign but powerful avoidance on the part of these shock doctors of some painful truths about the nature of their chosen "therapy." We have all come here today to tell some of those truths, in the belief that all people are capable of change, that all people can, if they truly want to, be open to new ideas and long-hidden truths.

Of course, as I tell my story, and the rest of this panel tells theirs, you can easily dismiss us with that once picturesque and now pejorative phrase that says our accounts are "anecdotal" and therefore meaningless. We, in turn, can counter by saying that your "clinical impressions" that you use to assess our "progress" are also anecdotal—and we can, in effect, cancel each other out.

Instead, why don't you listen to what I have to say—and be aware that my testimony, my story, is only one of thousands and that I speak, rather than someone else, because and only because, I am a lucky, articulate, and favoured survivor. I speak for those who cannot or are afraid to speak for themselves.

Each year, by your own estimate, you shock at least 100,000 people. Seventy percent of these people are women and, by conservative estimates, 80 to 85 percent of them are over 65. At least 70 percent of them are fully covered by medical insurance. If we figure, again conservatively, that each of these people will receive 10 to 12 shocks and will spend three to four weeks in a hospital, we can safely estimate that each of the 100,000 individuals will incur a bill of at least $10,000. In other words, each year, the practice of ECT and its concomitant hospitalization yields one billion dollars.

After I did this figuring I was staggered, quite literally, by the sum. In spite of knowing the ECT doctors earn on average twice what general psychiatrists make, I was, if you'll forgive me, shocked. That is an awful lot of money. It made me think—and question. Who are these 100,000? What are they paying for? What are they receiving?

You may not want to hear what I am going to say. You may wish to again indulge in self-induced selective deafness. But I will tell you who receives ECT: the most vulnerable and helpless people in our society; the most passive, the least likely to resist; the feeble, the old, the lonely, the dispirited. You may counter by saying that women and elderly people suffer more frequently from depression and thus are likely candidates for shock. But I will tell you that we know better. Maybe your colleagues will swallow that one, but we know better.

We have been coerced, we have been misinformed, we have been labelled and forced or manoeuvered into undergoing your procedures, euphemistically called "treatments." Some of us, like me, have resumed our lives, emerging relatively unscathed: so very many others have not.

Yes, your treatment is a lucrative one and we have all heard you—many of you during this conference—congratulating yourselves and each other on the humanitarian and noble impulses that motivate your giving ECT. You discount our stories of loss. You turn deaf ears to inchoate pleas to stop. And you continue to try to give scientific credence to a procedure whose efficacy, after more than 35 years, is still completely undemonstrated.

What has been proved? I will tell you: that ECT destroys healthy brain tissue; that your treatments cause anguish and misery and permanent damage each and every time they are inflicted; that there are no consistent criteria for improvement; that patient accounts of memory loss and suffering are discounted—for elderly people, as signs of senility, for the rest of us as indications that our so-called mental illnesses remain, unabated.

Who "gets well" from ECT? I will tell you: those whose confusion is so intense they can, for awhile, forget their suffering; those who are incapacitated into a passive acceptance of their allotted roles; those who are cowed into quietness, assaulted into a nether world of obedience. For a time their wild, mad, annoying rambunctiousness is quelled —and you marvel at their "improvement." You bloody them into quietude, terrorize them into aquiescence and call it a cure.

For sure, gentlemen, you are engaged in a highly questionable activity, both medically and ethically—and a profoundly controversial one. There really is no getting away from that. You can hold your self-congratulatory conferences and not include anyone but your most ardent supporters, but the questions and issues will not go away!

Finally, a few questions for you. Do you tell your patients, ever, the price of the trade-off—permanent brain damage for temporary relief, perhaps, from pain? Do you tell them you are systematically and methodically burning portions of their brains—for a possible moment's surcease? *Do you tell yourselves? ever?*

"The family needed tools to resolve conflict, but electroshock was brought in to aggravate the problems we already had:"

Rosita Libre de Marulanda

It is my pleasure and my privilege to speak to a roomful of hopeful problem solvers, sisters and brothers in the helpful sectors of society.

I'm here to share with you my experience in the hope of throwing some light on the controversy over how electroshock affects the receiver.

I am the sister of a victim of electroshock. If you were to see her you could not dispute that she's a victim. Although she's a victim of much more than ECT, I hope to show you how ECT did not help her circumstances and how ECT did not help my circumstances in the light of a family conflict; in the light of socio-economic conflict; in the light of sexual-social conflict; in the light of sexual-political conflict.

You see, part of the problem of psychiatry is that sometimes it fails to see the client in the context of the larger scope, and ECT is often used with no facts about the person's life conflicts; often the person is already in shock about the conflicts that life presents to them.

At the time my sister received electric shocks I was 11 years of age and she was 13. Our sexuality was budding and we were both dealing with the onset of puberty and all the changes and issues that life had prepared for us.

The conflict that developed in my family centered around sexuality and violence. My sister Rita was retarded and mute; . . . when she began masturbating all over the place my mother felt terribly embarrassed and tried to stop her by beating her. My father was his passive self and approved from the background.

Rita became angry—and since you don't bite the hand that feeds you—she turned that anger laterally towards us and would hit us. The brothers would beat her back and the sisters would avoid her blows.

Imagine this going on for about a year before my parents sought help: it didn't matter that she was 13, mute, and mentally retarded — the treatment pre-

scribed for her was electroshock. What she needed was privacy and a kinder family surrounding but electroshock was what she got. The family needed tools to resolve conflict, but electroshock was brought in to aggravate the problems we already had.

The shocks were administered in a local city hospital in Barranquilla, Columbia, South America on an outpatient basis . . . They would anesthethize her and she would come home smelling like ether, smelling dead, and looking confused. My mother would let her lie down — something that she would never let us do during the day... In my young and vulnerable mind the adults (authorities) inside and outside the home had allied and were now killing her.

Now, in some parts of Africa and the Middle East young girls in puberty have clitoridectomies performed. In the West, the ritual takes a more subtle and psychological form. And I feel that this is how electroshock was used during this period of our transition.

This gave me the following choices at age 11: of challenging the family sexual belief system (and risking the consequences); or of putting the conflict aside until such time as I found a safe, non-hurting environment in which to resolve this conflict.

So I took the second choice and I went through the rest of my puberty without any eventful circumstances. My Western clitoridectomy had been performed along with my sister's—it ensured that I would never touch my clitoris again. I lost touch with it, and lost any recollection of ever having been in touch, or of having touched my clitoris before that.

I say that ECT was not helpful in the situation that I survived because: it did not address itself to Rita's muteness; it did not address itself to Rita's retardation; it did not deal with our issues of puberty or with our budding sexuality (or didn't it); it did not resolve the family conflict; it gave us no tools with which to resolve our family disagreements.

There is a range of feeling in my family about the effect of ECT. If you ask my parents they tell you, "Oh, yes, they fixed her." And so today you find Rita sitting on a chair, not allowed to have friends or go outside or be involved in any kind of physical activity. If you ask another one of my sisters she'll tell you that they have harmed her. If you ask me, I'll tell you that they have harmed her,that they solved nothing, and that they have hurt me too.

Which goes to show you that human conflict cannot be resolved in such a fashion but rather that machines can be brought in to stack the power on one side of the conflict—the side that can afford to pay for them.

Now, I have taken the time to speak to persons who have received electroshock themselves and find so far two things in common with them. The first is the haziness of the year in which the electroshock occurred. By reconstructing the years I believe they took place in 1956 or 57. Another thing I have in common with them is my inability to talk about this experience for the next 20 years. To talk meant to relive the experience. I thank the progressive movements—the Women's Liberation Movement, the Lesbian Feminist Liberation Movement, the Mental Patients' Liberation Movement for providing a safe environment in which I could relive my experience.

Now I hear that some people actually feel that ECT has been helpful to them and that they come back for more. I think that what's going on for these people is that: (a) their conflict is still unresolved and that they come back to try to resolve it; (b) that the same feelings are coming up again and they need help in putting them away, forgetting about them; (c) they may be looking for reassurance that such cruel and inhuman treatment will never again take place—and so it is a way to continue testing their environment; (d) it is a form of slow suicide, a way to further hurt themselves.

The reason why the psychiatrist sees remarkable "improvement" is because the client who is already in shock, and who receives further shock from the helpful profession has two choices: to conform to the expectations of society; or to succeed in killing themselves. There's no more fooling around—the choices in-between have been taken away. The client's choices have been narrowed to self-destruction with the help of the professional, or to self-destruct. Suicide attempts, acting out and other forms of getting attention can no longer be used as a genuine call for help.

"I wish I had a dollar for every ex-inmate I know who has told me they were not warned about the health hazards of shock and drugs:"

Don Weitz

I am a shock survivor myself. Although I did not have electroshock, I was given insulin shock treatments 34 years ago. Insulin shock, like electroshock, is still not officially outlawed in the United States or Canada. I was diagnosed "acute undifferentiated schizophrenia" and committed involuntarily at Mclean Hospital near Boston in 1951; in fact, I was just an angry young man rebelling against my parents. It's interesting that the list of "symptoms" in my discharge summary (which I have kept a copy of) did not even fit the traditional, textbook symptoms of "schizophrenia."

It is painful for me to talk about my shock experiences, but I think it's instructive to recount, briefly, those horrors. I was more fortunate than Leonard Frank and the countless other shock survivors who suffered through electroshock or insulin coma shocks. I was given only insulin sub-coma shock; believe me, it was agonizing torture. Like most shock victims I had no right of refusal. In 1951 in Boston, there was no court of appeal and no other recourse—just as there is none in most jurisdictions in North America today.

Within 15 to 20 minutes after an injection I had an insulin reaction, feeling pains throughout my body more intense than I had ever imagined could exist. During this ordeal I became totally drenched in my own sweat. My psychiatrist would try to talk with me while I was still trembling; my confusion and disorganized thoughts were, for him, further evidence of "schizophrenia." For more than a month I was injected two to three times a day; as the dosage was increased my reaction intensified. I once went into a coma. No one had prepared me for it, no one told me it was a risk of insulin shock, and I was sure that I was dying. The real source of my problems at Mclean was insulin shock.

I was given no information about these risks before the treatment—just as there is no information given to electroshock victims today about brain damage, memory loss and learning disabilities. This is totally unacceptable and unethical. You talk about "informed consent." You don't know what consent means if you haven't told the person not only the nature of the so-called illness for which s/he's being treated, but the risks and alternatives as well. I wish I had a dollar for every ex-inmate I know who has told me they were not warned about the health hazards of shock and drugs.

I now want to talk about something I'm very proud of—the movement in Canada and the United States to stop this atrocity masquerading as a treatment. We have made some progress in Canada, inspired mainly by the fine work of the

Coalition to Stop Electroshock in Berkeley, California. While attending the International Conference for Human Rights and Against Psychiatric Oppression, in Syracuse in 1983, we were inspired to start a coalition of shock survivors and supporters in Toronto. Four or five of us founded the Ontario Coalition to Stop Electroshock. Our objective is to totally abolish this so-called "treatment".

In Ontario—and throughout Canada—it's virtually impossible to get any shock statistics, because the governments see fit to not publish them; so, if we get hold of shock statistics, it's through leaks or at the discretion of a minister. We know that in Ontario, in 1983, at least 22,000 shock treatments were administered to roughly 2,000 patients. That's documented. I can't give you figures for the whole country, but trying to extrapolate from Ontario to the rest of Canada, I estimate about 80,000 shocks a year for 8,000 patients.

During the last year and a half the Ontario Coalition to Stop Electroshock, in conjunction with other organizations, has taken several major initiatives to have shock abolished and end the suffering of our brothers and sisters.

On October 21, 1983 we held a successful protest demonstration against shock at the Clarke Institute of Psychiatry in Toronto, which gives more shocks than any other institution in Ontario. They give about 1,000-1,200 shocks a year to about 120 inmates—that's a rough average.

On October 22, the first International Day of Protest Against Electroshock, we had a successful panel at City Hall—the first time a public hearing on shock had been held in Canada. Six of us, including myself, talked on a panel that was chaired by Toronto Alderman David Reville, who also happens to be an ex-psychiatric inmate.

In December of 1983, many of us supported "Mrs. T.", a woman who brought a case to court because she was threatened with electroshock against her will while competent to refuse. Fortunately, she was spared shock, but she lost the case.

On January 17, 1984, seven members of the Coalition gave strong testimony against shock at a meeting of the Toronto Board of Health. Those speaking in favor of shock included three shock doctors and one psychiatric social worker. As a result of our testimony, the Board of Health adopted a motion calling for an immediate moratorium on shock in Ontario without informed consent. This was the first time that any board of health or health body in Canada had taken a public stand against shock. Since the Board has no (legal) power, because health is under the jurisdiction of the province's Ministry of Health, it could only make recommendations. Nevertheless, that action was significant.

On the following day, Health Minister Keith Norton announced an ECT Review Committee to investigate the medical, legal and ethical aspects of shock in Ontario—largely a result of our pressure and the "Mrs. T." case.

Last July, we held a peaceful sit-in-demonstration in the Minister of Health's office after he repeatedly refused to answer our requests for consumers to be on the ECT Review Committee, and because of his failure to call a moratorium on shock without informed consent, at least until there was more research. That drew a lot of press, and, partly as a result of the media coverage of our non-violent civil disobedience, shock has become a public issue across Canada.

The ECT Committee of the Ontario Government has steadfastly refused to hold public hearings on electroshock, while public hearings on potatoes and so forth are OK. So, last October, the Coalition again held its own public hearings in Toronto's City Hall. At least 50 people talked about their personal shock experiences—to an audience numbering hundreds. Only one person spoke in favor of electroshock, no pressure was exerted and the panel was neutral.

I come here today with a mandate to speak for the Ontario Coalition to Stop Electroshock. I'll have to summarize a lot of its testimony in a few sentences. My sisters and brothers who have had electric shock have suffered permanent memory losses and brain damage; fortunately, they are speaking out more, not remaining silent. As Lenny Lapon said, we must speak out against electroshock and other forced treatments. And I confidently predict that within the next year electroshock will be challenged in court as unconstitutional under the *Canadian Charter of Rights and Freedoms,* which is the cornerstone of our constitution in Canada. I believe that electroshock clearly violates Section 7 of the Charter which establishes "the right to life, liberty and security of the person" and Section 12, "the right not to be subjected to any cruel and unusual treatment or punishment." It is the official position of the Coalition that electroshock is a form of cruel and unusual punishment, not a "treatment," and should be immediately abolished.

"Like torture, electroshock 'works' by means of intimidation, pain and disablement:"

Leonard Roy Frank

I welcome the opportunity to address the participants in and guests of the First International Conference on Electroconvulsive Therapy. As far as I know, this is the first occasion on which shock survivors have spoken to shock specialists in such a setting.

Twenty-two years ago this month there began for me the most horrible and painful experience of my life. It was the start of a "treatment" series of 50 insulin comas and 35 electroshocks. According to my psychiatric records, which I obtained in 1974, I was not working, was "withdrawn," "secretive," and "negativistic," and had "piercing eyes," "religious preoccupations," and "food idiosyncracies" (I was a vegetarian). I had also grown a beard. I was pronounced "paranoid schizophrenic, severe and chronic" and under court order given the shock series against my will.

From the beginning of my period of institutionalization the psychiatrists urged me to shave off my beard. Because I wouldn't comply, they ordered my beard removed while I was in an insulin-induced coma. Thus, in addition to the shock "therapy" I was also subjected to what some might call beard-removal therapy.

The major effect of the beard-removal therapy, in itself a serious violation of my religious freedom, was deep humiliation. The major effect of the shock therapy was the obliteration of my memory for the then most recent two-year period of my life. It also rendered permanently vague the memory of my entire earlier life. I was 30 years old at the time.

I want to discuss this conference briefly before going on to my main points. I believe The New York Academy of Sciences and the National Institution of Mental Health have done a great disservice to the public by co-sponsoring this conference, and thereby validating it as a scientific meeting. This is not a scientific meeting: it is a promotional meeting arranged to hype a brain-damaging, spirit-crushing pseudo-medical procedure and make the procedure's

users, promoters, and apologists feel good about themselves and each other.

I attended an all-day ECT conference at the American Psychiatric Association meeting in Chicago in 1979. Late in the afternoon someone from the audience, himself a psychiatrist, commented that he felt he was at an "ECT rally." Save for our small voice, the lay members of this panel, that describes accurately what this conference is. The reason why this is a sham-scientific meeting is that not even one of the major critics of ECT from within the field of psychiatry, psychology and medicine has been invited to present his or her views and findings on this admittedly controversial subject.

Noticeably absent is Dr. Peter Breggin, a practicing psychiatrist and the leading professional critic of ECT. Since its publication in 1979, by a major medical publishing house, his influential book *Electroshock: Its Brain-Disabling Effects* has been translated into German, French and Italian. It has been favourably reviewed in a number of professional journals, including *The British Journal of Psychiatry*. Excluding Dr. Breggin from this conference reflects its built in bias and makes a mockery of its claim to being a scientific meeting.

The reason for the absence of ECT critics from any of the sciences is clear: the shock specialists do not want to hear the truth about what they do from fellow professionals. They can tolerate listening to us shock survivors because shock specialists easily dismiss what we say. After all, we're not scientists, and moreover we've been diagnosed as "psychotics," "schizophrenics," "depressives," and the like, and obviously, from their point of view, some of our thinking is still "delusional." Incidentally, we were invited here only at the last minute, and then only under pressure from members of the Psychiatric Inmates Liberation Movement.

The truth that shock specialists don't want to hear and have tried to prevent others from hearing is that ECT almost always causes significant permanent brain damage, irreversible memory loss, learning disability, apathy, emotional and physical pain, and debilitation. There is also a considerable risk of death from ECT. Based on figures published in the *APA Task Force Report No. 14* on "Electroconvulsive Therapy" (1978), I estimate conservatively that there are 88 electroshock-related deaths a year in the United States alone. Electroshock death is far from being a rare occurrence, as virtually all shock specialists contend.

In addition, after 47 years of use, there is still no scientific proof of ECT safety and effectiveness. Moreover, the reports of electroshock survivors, and the methodologically soundest studies —including human autopsies, animal studies, and brain wave studies—provide strong evidence of ECT's destructiveness.

Dr. Breggin's "brain-disabling hypothesis," merits serious investigation. In a nutshell, he suggests that the apparent "effectiveness" of ECT results from the brain-damage it causes. ECT produces euphoria, more commonly apathy, denial (of difficulties), dependance and submissiveness. Shock subjects, while suffering ECT-induced amnesia, also complain less—at least for a time. All of these conditions are symptoms of brain damage which shock specialists arbitrarily (and perversely) reinterpret as evidence of improvement or recovery.

I would like to suggest that for at least some ECT specialists brain damage is not an unfortunate, "side-effect" of electroshock, but rather, a desirable and intended result. As psychiatrist Paul Hoch (an electroshock enthusiast in his day) wrote in 1948: "this brings us for a moment to a discussion of the brain damage produced by electroshock. Is a certain amount of brain damage not necessary in this type of treatment? Frontal lobotomy indicates that improvement takes place by a definite damage of certain parts of the brain." *(Journal of Personality, 17: 48)*

Electroconvulsive therapy is a misnomer. An accurate term for this procedure would be electroconvulsive brainwashing. ECT is a brainwashing technique in the most meaningful sense of the term. By destroying brain cells, electroshock washes the brain of its memories. As such, it is a powerful instrument of social control and conformity enforcement. Like torture, electroshock "works" by means of intimidation, pain and disablement.

We're here today because we want to end the use of electroshock. We're here today because we don't want to be counted among the silent ones, those who keep their mouths shut instead of speaking the truth about electroshock: the silent ones who by their silence become accomplices of the wrongdoers and thus betray themselves.

phoenix pharmacy

Valium: Big Business, Mounting Casualties

VALIUM: TRANQUILITY UNMASKED
by Denise Russell

(Ed. Note: This article consists of excerpts from two sources: The Corporate Game in the Pharmaceutical Industry *by John Braithwaite (Routledge & Kegan Paul, 1984), and* Dr. Caligari's Psychiatric Drugs *by Dr. David Richman (Network Against Psychiatric Assault, 1984). Denise is a Professor in the Philosophy Department of the University of Sydney in Australia. Our thanks to her for compiling and sending us this material, which we have edited slightly.)*

The corporation as pusher: a bit of history

Some quite direct links between the licit and illicit drug trades can be made. Today the Swiss company Hoffman-La Roche is the world's leading seller of legal psychotropic drugs. Elmer Bobst was president of Hoffman-La Roche in the United States until the end of the Second World War, and president of Warner-Lambert until he resigned in the 1960s. In his autobiography, Bobst revealed that Roche was heavily involved in the supply of morphine to the underworld during the years between the First and Second World Wars. The Canton Road smuggling case, heard by the Mixed Court of Shanghai in 1925, linked Hoffman-La Roche to the illegal drug trade. The case involved 180 chests of opium shipped from Constantinople and sold in China, and 26 boxes containing mostly heroin imported from Basel, Switzerland by a Chinese dealer known as Gwando. "Documents produced at the trial revealed that a considerable trade had been plying between Gwando and the Swiss drug firms Hoffman-La Roche and MacDonald and Co."

The minutes of the League of Nations Opium Advisory Committee meeting of 1927 reveal that when another case of traffic involving Roche was discussed, the chairman of the British delegation, Sir John Campbell, stated that he "had no doubt whatsoever that Hoffman-La Roche and Company was not a firm to which a license to deal with drugs should be given." Hoffman-La Roche was not unique. Many supposedly law-abiding pharmaceutical firms were almost equally notorious. At the 1923 meeting of the Opium Advisory Committee, the Chinese representatives pointed out that Germany, Great Britain, Japan, Switzerland and the United States were all turning out "morphine by the ton, which was purchased by the smugglers by the ton."

Some of the great pharmaceutical companies of today are built on profits from the heroin and morphine trade during an era which laid the foundations for the self-perpetuating cycle of addiction to these drugs in today's societies. The next generation might look back to the activities of Hoffman-La Roche in pushing Valium and Librium with disgust equal to that we feel today towards their heroin sales between the wars. It is fair comment to say that the company has always been one step ahead of public opinion, making massive profits from drugs of addiction in the era before these drugs becomes a matter of widespread public concern.

Dr. Richard Burack compares the cost of Valium to the price of gold. He discovered that the wholesale price of Valium is 25 times the price of gold; but even that astounding statistic said nothing about the profit to Roche. This was revealed in a patent hearing in Canada, initiated by Canada's Attorney General. Here's what was found. The raw material for Valium, (known by its generic chemical name as diazepam) costs $87 per kilo (2.2 pounds). Processing the raw material into tablets, and labelling and packaging them brings the cost up to $487. This is a generous estimate of production costs; they are probably less. The final retail price for that original kilo — which has now produced 100,000 ten-milligram tablets — is $11,000. The selling price is 140 times the original cost of materials and 25 times the total production cost.

Valium and Librium have been better than gold for Hoffman-La Roche, the Swiss patent-holders of these tranquillizers. Sales of Valium in the United States alone approached $200 million for 1972 making it the top-selling prescription drug. International price variations for Valium reflect the capacity of the multi-national company with a legal monopoly to charge whatever the traffic will bear, even within the EEC (European Economic Community). In Germany Hoffman-La Roche sells Valium at almost four times the price it charges in Britain (1976 prices). Roche has quoted the Sri Lankan government a price for Valium 70 times higher than the price charged by an Indian company. The Papua New Guinea government has been offered Valium at one-tenth the price charged to the neighbouring Australian government.

"Valium and Librium have been better than gold . . ."

In the late 1960s the British government decided that Hoffman-La Roche was abusing monopoly power by its pricing of Valium and Librium. Negotiations with the company led to payments of $1.5 million to the government for excess profits between 1967 and 1969. Roche regarded paying some of the profits to the government as preferable to cutting their prices for fear that the latter course would lead to demands from other countries for equivalent price reductions. Valium was also given free of charge to hospitals in the National Health Service. *(Ed. Note: England's health insurance program).* There were compensating benefits from this expense. Patients started on Valium in hospital would continue on it when discharged, and young doctors would acquire the habit of prescribing the drug during their hospital training.

Then there is the more basic strategy of defining indications such as depression as widely as possible. Dr. Richard Crout, Director of the FDA's (Food and Drug Administration in the US) Bureau of Drugs, gives the example of a Pfizer videotape distributed to hospitals. *(Ed. Note: Pfizer is a multi-national drug company.)* The tape begins by asserting that 4 to 8 million Americans suffer from depression, but later we are told that under a definition of depression as "absence of joy" the figure would be 20 million. Crout concludes that Pfizer

was attempting to create the impression that depression was "everywhere and being underdiagnosed."

"The over-use of Valium has brought a frightful cost."

Valium has been the drug which has been most heavily and successfully promoted in this kind of way. The overuse of Valium has brought a frightful cost. For a twelve-month period in 1976-77, one study found that 54,400 sought hospital emergency room treatment in the United States concerning the use, overuse, or abuse of Valium. During the same period, the study, conducted by the National Institute of Drug Abuse, found at least 900 deaths attributable to Valium use, plus another 200 deaths linked to its chemical predecessor, Librium. Many of the deaths were due to either accidental or intentional overdose. Hence the conclusion of Dr. Edward Tocus, chief of the Drug Abuse Staff at the FDA that, "We are developing a population dependent on this drug equal to the number of alcoholics in the country. We are in a situation now where we see at least as many people being hurt by this drug as are being helped by it."

People who foster dependence on illicit drugs such as heroin are regarded as among the most unscrupulous pariahs of modern civilization. By contrast, pushers of licit drugs tend to be viewed as altruistically motivated purveyors of a social good. Yet dependence on Valium or Darvon can have consequences just as frightening as heroin addiction. The media constantly tells horror stories of bizarre exploits of people under the influence of illicit drugs. It took the drug dependence of the wife of a president, Betty Ford, to get headlines about Valium addiction into American newspapers. Valium in interaction with alcohol can produce a "paradoxical rage reaction" — paradoxical because Valium is supposed to bring calm, not rage. FDA adverse reaction files tell of a woman who, having had a few drinks, had an argument with her husband. When he left the house, she took several Valium tablets to calm down and went to sleep. Woken by the return of her husband, she took out a pistol and shot him dead. The story proves nothing. Perhaps the FDA was wrong to classify this as an "obvious adverse rage reaction" to Valium. She might have shot him without the Valium. The point is that there is no news value in anti-social conduct presumed to be caused by licit drugs. Comparable cases where illicit drugs might be presumed to cause anti-social behaviour decidedly are news.

"A whole New World of Anxiety."

Medical Journal advertising

She is standing alone before a darkened background: a young college girl, carrying books. The corners of her mouth are turned down. It is not a grim expression but it exhibits concern and suggests uncertainty. The copy under her picture reads: "A Whole New World ... of Anxiety." Surrounding her on the background are italicized suggestions of what the anxious world might be. "The new college student may be afflicted by a sense of lost identity in a strange environment." Another suggestion: "Exposure to new friends and other influences may force her to reevaluate herself and her goals." Yet another: "Her newly stimulated intellectual curiosity may make her more sensitive to and apprehensive about unstable national and world conditions." If world affairs and peer pressure don't make her anxious, the ad suggests another cause. Maybe it's "unrealistic parental expectations" or "today's changing morality" and "new freedom" that are doing it. Even though this last problem seems to suggest her need for birth control pills more than anything else, the real answer to her woes is something different. To help free her of excessive anxiety . . . adjunctive LIBRIUM." Of course. "When mounting pressures combine to threaten the emotional stability of the anxious student, adjunctive use of Librium can help relieve the symptoms caused by her excessive anxiety. Together with your (the doctor's) counselling and reassurance, Librium, if indicated, can help the anxious student to handle the primary problem and to 'get her back on her feet.' "

Valium and Librium have been promoted as solutions to almost every psychological state which falls short of total serenity. At the same time Valium has been promoted for "psychic support for the tense insomniac" and for the "always weary." Perhaps most appealing of all to the medical profession, Valium has been advertised in a doctor's magazine as an aid in producing "a less demanding and complaining patient."

I. GENERAL INFORMATION

As psychiatrists (and other physicians) often "treat" what they regard as major mental disorders (psychoses) with neuroleptics, or "major tranquillizers," so they often use anti-anxiety drugs or "minor tranquillizers" for so-called minor mental disorders (neuroses). Anti-anxiety drugs are very similar to barbituates. Both are sedative-hypnotics and have depressant effects, with serious habit-forming potentials. They are used in an attempt to chemically control anxiety, nervousness, tension, sleep disorders and medical problems related to stress, such as ulcers, as well as medical problems that cause serious stress, such as heart conditions.

II. DRUG EFFECTS

1. Frequent effects: sedation, lethargy, drowsiness, dizziness, lightheadedness, problems with balance and walking, and dry mouth.
2. Occasional effects: confusion, depression, headaches, blurred vision, nervousness, constipation, menstrual problems, sexual problems, muscle stiffness, lack of coordination, and weight gain.
3. Rare effects: hallucinations, nightmares, severe depression, extreme restlessness, freak-outs, double vision, insomnia, nausea, stomach upset, bladder and urination problems, slurred speech, tinnitus (ringing in the ear), unusual skin sensations, muscle tremors, low blood pressure, and allergic hepatitis (jaundice).

Landmark Drug Lawsuit

For the first time in Dutch history users of a drug, Triazolam, trade name Halcion, a sleeping pill, filed a class action suit against a drug manufacturer, Upjohn. Representing the 42 users of Halcion, Mr. E. Dommering stated before the Court of Justice that Upjohn had given insufficient warnings against the side-effects of the drug when they introduced Halcion, that tablets with too high a dosage had been brought out on the market, that wrong directions for use had been given, and that an aggressive campaign had been carried on.

In our country it isn't common to start a lawsuit against a medicine manufacturer, and the users of medicines in our country are, unfortunately, very seldom in the mood to attack their medicines and to see that a cause of the harm done to them lies in the pills they take.

Unfortunately, the 42 users of Halcion did not win their case, Upjohn did. But I hope you will publish this news so that people in other countries who have criticisms against this sleeping pill know that a serious lawsuit has taken place in The Netherlands. I mean: let's hope others will follow!

(Reprinted from Madness Network News, Vol. 7, No. 5, Winter 1985.)

(Ed. Note: According to the Physicians' Desk Reference *(1981), Haldol can cause: "respiratory depression, apnea (breathing stops)... laryngospasm, bronchospasm and increased depth of depression... A number of cases of bronchopneumonia, some fatal, have followed the use of major tranquilizers, including haloperidol." Haldol is one of the most dangerous of the "anti-psychotic" drugs — still prescribed in virtually all psychiatric institutions in many countries including Canada and the United States.)*

OUT OF THE ASHES

. . . FEATURES, POEMS, PROSE, GRAPHICS, PHOTOGRAPHS—writing or artistry of any kind by anyone who has been psychiatrized.

Between the Silence

The silence of one life reaches
to the silence of another
and between the silence,
among the shadows,
something warm and human grows.

First the words and then the touch
shatter our separate body shells
and we trust each other
because despite our fears we must.

The alien universe, dark, untouched,
the deep intruding from afar
threaten to extinguish love.
The defiant brilliant stars
are lonely fires like ourselves.

Nira Fleischmann

Poem Found at Klinic

Elavil (aenjil dust, PCP
—1
(a hit th siiz uv a larj pin point
beer — 17 or 18 beer
—on the floor
—out of it
—foaming at mouth
—cant see
—cant hear
(uezd to treet
mentl ilnes
or
bedweting

Philip Kienholz

VANISHING ACT (For C.W.)

You wear your madness like a mantle,
a bright green bilious mantle,
swirling into your entrances,
flourishing its fantastic mottled
folds into your
exits

You liked it safe and pacing warm linoleum
corridors in the hospital, lining up for
meds the capeswirl
round the gentle
swallowed jargon meds

easy you came and easy

Went to the school board, told The Truth
about cerebral fissure, waved the madcloak
in the teeth of your tormentors; quit,
retired early, started a magazine
(pages flutter,
poems swathed
in silken folds)

and covered your eyes. Easy
in spring light to fling mad mantle
down,
a shimmering gauntlet
to the dark and slender
lady at the next table.

Fanfare in brown olive
eyes yet wear chameleon colors
mottled greenmud bilious
fantastic folds,

swirling
flourishing
disappearing

Liane Helle,
June 1985

HELL

Now
I know
Some things I
Didn't know

Before I
Descended into Hell
On the edge of
A razor blade

And
Climbed back up
To Earth
Over the edge of
A tranquilizer bottle

(For one thing
My eyesight is
Sharper—)

Heather Duff

a little reassurance

my therapist tells me
not to worry

nobody ever died
of an anxiety attack

i am calmed for the moment
until i realize
it's not the sort of thing
that shows up
in an autopsy report

Linda King

Living with the spirits

Journal—Lynne Supeene

Dear Graeme,

The past has been present lately. This writing about the time of my trouble five years ago keeps it in mind and it's odd to live, as it seems, in two times simultaneously: it amounts almost to two lives, the differences are so great. But of course it isn't two lives — it's one. Mine.

It was surprising the other day when that vivid image came to mind. Somehow it shows the relationship of my life now to what it was then: an animal caught in a leg-hold trap, who escapes and survives by leaving part of itself in the trap. Then if the wound heals, as mine has, eventually the animal roves around again, with a canny sense for similar traps. This image might have felt sentimental once but it doesn't now. Almost the opposite: there's a ruthlessness to an animal gnawing off its own paw. It escapes without tears.

Your question as to what part was caught and left behind has proved thought-provoking. It was a bit of a shock when I answered promptly and without thinking that it was the right foreleg. I don't know what to make of it. I *am* right-handed after all. Makes me wonder what *was* left behind. Or for that matter, what the trap was.

So, about that weird time. The incessant ringing sound came first, and then the lights and glints in the air; and then my apartment and finally my whole life was invaded by the spirits. You know, a couple of years later I told Helen, my psychic friend, about it and asked her what I should have done, and she said, "What would you do if *any* strangers walked into your home unasked? You ask them what they want and if it turns out they've got no good reason to be there you kick them out." (Actually she didn't say "kick them out," she said to "send them away, firmly but with love.") Easier said than done, but still the point is well taken: they were intruders and had no call to threaten me. It's too bad I was so slow to resent the intrusion: it took a couple of months to catch on that they weren't friendly.

It must be hard for you to imagine what all this was really like. Having spirits hanging around and materializing unexpectedly is just as bizarre as it sounds. What was even stranger was that I got used to it and after a while it didn't seem bizarre. That was before they became hostile, when they weren't nearly as bothersome and distracting as the ringing. The ringing was so loud I sometimes mistook it for the phone. I was trying to write essays and I couldn't think unless it was drowned out with music.

Once the spirits started threatening to take me over, of course, my attention was riveted to them. I never knew when they were going to appear. By this time I was having bad headaches and eating and sleeping poorly. I was afraid to sleep. One night I woke up to find one standing at the foot of my bed looking down at me. He was the one who wore the 1940s trenchcoat and had a thin face.

This time was discordant, chaotic, and fractured, but I remember a moment of lucidity. I was lying in bed, waiting to fall asleep out of sheer exhaustion. I turned over on my side (in vain: I could never sleep except on my back so I'd have a good view of the room). The closet door was open. I remember staring into it and saying to God, "I think I'm going to be needing a lot of help." It really was a terrifying way to live.

It was also isolating. I was afraid to talk about it in case people thought I was crazy. I wished I belonged to a church or knew some religious leader who could help. I prayed a lot and heard no response. I couldn't make head nor tail of what was happening. By the time I

"Being on perphenazine was like having my thoughts, movements, emotions and spirituality all shackled and weighted."

ended up on the psych ward my concentration was shot. Everything looked and sounded unfamiliar and distant. The air was like jelly. My thoughts were scattered.

And then, in the hospital I was given a neuroleptic called perphenazine, and it actually stopped me from seeing the spirits!

You know what I think of psychotropic drugs. I do without them. They made my thoughts heavy, and turned my tongue into a dead animal. They made my body jerky and slow and alien. But as an emergency spirit-fighter, perphenazine wasn't bad. (Of course, the emergency didn't last two years and the perphenazine shouldn't have either, but that's another story.) I was profoundly thankful to be free of the spirits. Relief and the sedation of perphenazine and serax combined so I slept and ate better. And I was a real fighter.

I wasn't prepared for what came next, or rather, for what didn't come: I remained confused. The world wasn't so vividly awry or so immediately threatening, but it was still distant, foreign and frightening. There was no sense or meaning.

By the end of the first admission a lot of the fight had gone out of me, and I was very timid and dependent. It's really no wonder. The psychiatric theories located the problem of the spirits squarely in my personality. The theory went that the spirits were imaginative versions of my fears. Along with perphenazine I got a lot of verbal therapy, which consisted of rummaging about in my mind for spirit-material. To no avail! All the rummaging turned up was unpleasant and disheartening support for the doctor's contention that my self-image was "nebulously defined." (Nebulously defined? It was in shreds.) The parts of myself thus unearthed offered no clue or connection to what was happening to me-in-the-world. This naturally made things worse — more confusing and therefore more scary.

There were a couple of very telling exchanges with the doctor. The first occurred during the initial screening session, when I said the spirits didn't make sense in Christian terms. He said, "So that's the problem too," and it was never mentioned again. Another time he actually said he "wouldn't believe in the spirits even if they were real"! There was no room in his outlook for non-material layers of reality, and therefore no help for a real live spiritual crisis.

The doctor was very sure about what was wrong, too, and he could think and talk rings around me. He was so certain that in all important respects the world is known — at least its main structure if not the details. He had answers for me, and he was kind, but he didn't understand the questions.

When I got out of the hospital after the first admission, I took a two week trip to visit a friend on a farm in California. The farm was a community which was part of the San Francisco Zen Centre. There were no spirits there. *None.* It hit me the first night and I was astonished. Everywhere else, though the perphenazine kept me from seeing them, I still "felt" them, and I'd come to accept that as the freest I'd ever be. But on the farm their absence made a positive quality of peace. When I made this discovery, my friend just said, "No, the roshi (spiritual leader) keeps them away." And of course, having studied Buddhism, I knew there were regular ceremonies for feeding the hungry "ghosts" and that they were kept away between ceremonies. But I'd never connected this to everyday experience or felt the significance of such ceremonies before. To this day, I've never been anywhere with that striking quality of spirits-less-ness, except when I've felt the presence of God.

But in California I didn't feel the presence of God; it was to be another year before that happened. I just felt space and air and it was good.

Perphenazine dulled my sensitivity to lights, noises and spirits at the price of slowing my thoughts and dulling my sensitivity in other ways. I wonder whether God's unbroken silence that year wasn't due in part to the perphenazine. Now I know that I 'sense' Him with the same faculty or sixth sense which senses the spirits. Being on perphenazine was like having my thoughts, movements, emotions and spirituality all shackled and weighted.

I still think of the time as one when the sky was falling, when sense broke wide open and everything became possible. Who can live when nothing's impossible, and nothing's even either improbable or likely?

Well, this has been a little walk down memory lane. I haven't forgotten the trapped animal business by the way. It's coming. But first to get back to the present, guess what's the first comparison that leaps to mind? You'd think it would be some major difference between then and now, some moral to the story, tidy and triumphant. But actually what springs to mind is that by some people's standards my life is still as weird as can be. For example, the Saturday Carol and I had coffee in a department store cafeteria. The place was *wild* — noise, distractions, lights, etc. We sat down and I heard a chicken clucking behind me. When I got up the nerve to look, it turned out to be someone moving and sqeaking a chair or something but I swear I expected a hen when I turned around. Then I saw Michael looking at me from across the room, but it wasn't him after all — just another man with a beard. Then there was this neat picture, but it wasn't a picture; it was rolls of tape or wire or something in the hardware department. I was so freaked out. Then someone in the kitchen began banging trays and even Carol was bothered. We fled.

What can I say? I still 'pick up' things — voices, music, auras, things in the air. The spirits are still around sometimes, though not visible. I see, hear and feel (as in actual touch) things a lot of other people don't. The state of mind in which these things happen, what I call the "bright space," can interfere with discursive thought, reading, writing, shopping, talking. But suppose other people's routine activities are interfered with too, by tiredness or worry or preoccupation. The results are much the same even if the causes are different. And people make up their own explanations for my odd behaviour. If I'm not "with it" people assume I'm tired or nervous or bored or thinking about something else. There's no getting away from it: the bright space is part of what's normal for me. And it can be pretty even if it is sometimes a nuisance.

To get back to the image, and what it says about what's different now. The picture of an animal in a trap is compelling because it's so definitely about something abandoned, about a price paid then for what is now; and unexpectedly it rings so true.

What does seem to have been left, and is less and less regretted, is a capacity for volatile highs and lows. The lows are well lost. The highs were the price paid to lose them. I used to miss the highs — those soaring moments of elation, too rarified for words or thought, and the joyful enthusiasm and energy they brought with them. I'm happier without them because they were treacherous, coming at their own whim and leaving just as suddenly, always followed by a low. It was like being on a treadmill I couldn't get off.

I expect before an animal leaves its paw it tries other things. A fox for

example? Does it howl? Does it chew on the trap and break its teeth before it gnaws its own body? I did a lot of secret howling, and less secretly broke some teeth. But come the moment of stillness when there is only one thing left to do, I imagine a fox acts just like I did. Silent concentration, tearing free, then running like hell. No crying till later.

What else did I leave? Certainty, I think: the unthinking confidence that I could always get by, that I could do anything I put my mind to. And with that, some impulsiveness.

Maybe the most obvious loss was curiosity. I've always been a very curious and inquisitive person, so when the aura and spirit business first happened it was more interesting than frightening. As far as anything resembling the supernatural goes, I don't follow my curiosity up any more. Picking up some things can't be helped so I've learned enough about them to live with them, and I know of several possible explanations for them other than the psychiatric, but it doesn't matter much to me how far any of them go.

So that's different, isn't it? I'm not much fun to talk to any more about auras or astral travel. I was more fun to talk to before all this happened, when I knew less about it but was more eager to find out. This is one of very few things I'm not curious to know more about.

Oh and one last thing: the music I played then. It got left inadvertently. In particular a record of Bach and Telemann flute concertos was good for drowning out the ringing; Chopin's Nocturnes were consoling and a certain record of Pentangle was friendly and good late at night to bring on the spirits so I could get their visit over with and go to bed. And Beethoven's Archduke Trio, which I miss most. That one is too beautiful to lose. Someday I plan to have it back.

A Tree Branch Ran Across the Mess Hall Floor Tonight

It happened during the evening meal. It was a gray, furry tree branch with four scrambling legs, thick, tapering tail, pointed snout, and invisible whiskers. Truly a biological and botanical curiosity, this tree branch.

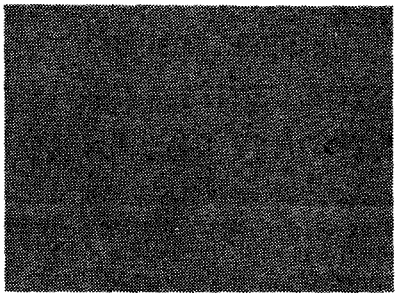
We inmates had never seen a tree branch run before, especially not in the middle of the mess hall during a meal. But there it was, in all its leafless glory, dashing between table legs and people legs until it finally found sanctuary in its customary hole under the serving counter.

There was no doubt that it was a tree branch. You see, our warden just recently instructed us on the environmental impact that tree branches have on our buildings. This valuable lesson was given at the latest meeting he had with the Inmate Liaison Committee, when he was quoted as saying: "Regarding the issue of rats in the ceiling, it is not rats but it is branches that scratch against the ceiling that causes the noise."

As I said, a tree branch ran across the mess hall floor tonight.

By Rich Herrin

NOTE: A true story from the Arthur Kill Correctional Facility, Staten Island, N.Y.



Untitled

Years a life ago I carved myself
a space using only hand tools
it was exquisite a safe little
niche could be reached only by
calling down the world and
running away
looking over my shoulder
as I ran
banging into it as if by accident
a risk, this took courage
but they called it
madness
thinking the risk was in staying

This space like a cave had
top, bottom and sides coloured
soft gray pearl fit my body
like a second skin
another world
rules topsy-turvy but
they worked like magic

I have fled there again
I have taken its risks
I have followed its rules
and the world
has gone mad with its
labels and pills

I may stay here this time
in this budget hotel
warm where the world's cold
my frown is a smile here
my sleeping a waking

The children are puppets:
they sit on my lap
I move their wires to make them walk
chuck their chins to make them talk
and when I cry they think I'm the
happiest mummy ever

And I am
I know something they don't know
I know something you don't know
Nyah nyah nyah nyah nyah

by Bobbie Jean Smith

SHOCKWAVES

Electroshock Victim Describes his Ordeal

Note: *(A speech delivered at the Scarborough Community Legal Clinic on March 7, 1985 by Steve Atell, co-chairperson of the Ontario Coalition to Stop Electroshock)*

Dear Sirs and Madams of the legal community. Fifteen years ago, I was identified as a "catatonic schizophrenic" and have been seeking recovery ever since. Being a survivor of the inhuman treatment of psychiatric patients, my purpose in speaking with you today is to do my part to see to it that no more of these sensitive vulnerable victims are subjected to a similar ordeal. And with the present situation and research, I will now present a profile of my experience.

In 1970, I was 20. I had to deal with my mother's death in 1969 and my first scholastic failure in 14 years of schooling. I was on probation for possession of marijuana, and it was my first year on my own. To cope, I tried to escape that reality by delving into street drugs. They produced for me a more tasteful immediate experience of reality. In 1971 came the FLQ crisis, martial law in Canada, and war abroad in Viet Nam.

These were the internal and external pressures that drove me to say to myself it's not OK, I'm not OK, or both. I was led to Centenary Hospital. I could not steer my own ship anymore, so someone had to do it.

The first thing I lost in the hospital was my clothes. I found myself in a hospital foyer or at the bus stop seeking freedom, but I was led back to the oasis of cruelty. But I had no idea how far this medical monster would go if allowed. After two hospitalizations and seeing two doctors, I wound up with Doctor Barron—in January 1973 I think. Dr. Barron asked if I wanted shock treatment, but having seen the corpse-like figures parading down the halls, I refused. He approached my family and they too refused consent. He walked into my room one day and told me I was to receive three courses (of shock), and since I was certified at the time (involuntarily committed) there was nothing I could do about it.

"What it comes down to is that I feel I was a specimen in an experiment. If the hospital had its way, I would still be dependent on it today."

I lost my memory. I didn't know who I was. I knew only that I was. During the course of my 40 shock treatments over three months, my existence was eating, sleeping and getting shocked. My awareness had no depth to it. My attention span had virtually no past or future to it. I just was. A vegetable is a vegetable. I am not a vegetable. How could they reduce me to one and say it was in my "own best interest"? When they had finished, I had a grade three retention level. I remember sitting watching Sesame Street with my pre-school niece, and although I was much bigger than her, I felt little more than her peer learning the morals of the program as for the first time.

It has taken me 10 years to recuperate and I am still recuperating. Some of my memory is lost to me forever. They hollowed out my inside and left me an empty shell. Their form of recuperation consisted of a chemical straitjacket, 200 milligrams of Moditen, and if they had their way, I would still be in it today. Under its influence, I could not hold a job and I'd be damned if I'd sire a child in this state.

The only specific records relating to my shock ordeal were somehow misplaced up until just recently. I still have not seen them. What it comes down to is that I feel I was a specimen in an experiment. If the hospital had its way, I would still be dependent on it today. I am living in a group home, so I'm not quite weaned yet. The hospital system did little to improve my condition. I had to fight that whole system in order to get well, and any improvement I made was under my own initiative with help from friends and professionals outside of the psychiatric care structure.

What I am getting at is that it is a sickness-oriented system. If the issue were seen from the health perspective, then the approach would be completely different.

"Schizophrenics" transgress and shatter social norms. In the initial stages of their "illness," one is sick. But to call a person sick for life is going too far. I like the analogy of a swamp for this initial stage. The swamp looks ugly and smells and is stagnant, but within it are the seeds of new life. Swamps are one of the most abundant life-supporting environments. If they are allowed to take nature's course, then they become the most fertile of lands.

What gives one human being the right to judge another human being's life experience as erroneous, and on that evaluation or opinion proceed to eradicate the memory of that life experience? We all make mistakes but we will never learn from them by pretending they didn't happen. Sometimes, life crises pile up and the stress buildup is too much for the body and mind of the individual to take and breakdown occurs. This is a built-in safety valve in our metabolism. It may be more healthy to shut down and take stock of the situation than go on living a lie. Somewhere, the path to autonomy has been blocked and self-forgiveness is the first step toward self-awareness. Eradicating the record of human experience is no solution, for nothing is learned.

Mengele Electroshocked Women in Auschwitz

In a *NEW YORK TIMES* "op-ed" page essay (March 6), Auschwitz survivor Ernest W. Michel described one of his experiences while assigned to the infamous Dr. Josef Mengele's death camp hospital. Michel had been ordered to take certain inmates to and from the hospital barracks. "When the truck arrived, I found six to eight women in various states of despair . . .

"We took the women into the barracks where a separate room had been fixed up. A number of SS officers were in the room. Since I went back and forth into the room several times, I saw the faces of the officers and recognized Dr. Mengele.

"After an hour, we were summoned back to remove the women. In the room where the 'medical services' were performed, one was still connected to an electrical machine, presumably for electric-shock experimentation. We had been instructed to have a stretcher ready in order to carry the women out. We found two of them dead . . . Two obviously were in a coma; the others were breathing hard and irregularly. None was conscious. I noticed that the teeth of those still alive were clenched and that wads of paper were placed in their mouths."

Psychiatric Inmates' Liberation Directory

Reprinted with changes, additions and thanks from Madness Network News, 2054 University Avenue, Room 405, Berkeley, California 94704. (Winter 1985, Volume 7, Number 5). Phoenix Rising will do its best to keep this list up to date. It will not be published in every issue, but a current list may be obtained anytime from Phoenix Rising (see ad elsewhere in this issue). Do your part! We want to know about additions, deletions or change of name or address. Our own group "On Our Own" would like to know your accomplishments and problems. We can always learn and maybe assist. Keep the network alive! Please write Group List, c/o Phoenix Rising, Box 7251, Station A, Toronto, Ontario M5W 1X9.

CANADA

Calgary Association of Self Help
1117 Macleod Trail SE
Calgary, Alberta T2G 2M8
(403) 266-8711

Mental Patients Association
2146 Yew Street
Vancouver, British Columbia
V6K 3G7
(604) 738-5177

Last Boost Club
330 Edmonton St., 2nd Floor
Winnipeg, Manitoba
(204) 924-1027

Phoenix Project
170 Arlington
Winnipeg, Manitoba

P.A.L. Executive
c/o 9-280 River Avenue
Winnipeg, Manitoba R3L 0B8

Newfoundland Association of Psychiatric Patients
11 Church Hill St.
St. John's, Newfoundland
A1C 3Z7
(709) 753-2143

Society for the Preservation of Rights of the Emotionally Distraught
c/o Shirley Johnson
Fred Serafino
195 Wellington St. S., No. 242
Hamilton, Ontario L8N 2R7

Self Esteem Through Independence
c/o 355 Princess Ave.
London, Ontario N6B 3J7

On Our Own/Phoenix Rising
Box 7251, Station A
Toronto, Ontario M5W 1X9
Office:
1860A Queen St. East
Toronto, Ontario
(416) 699-3194

Coalition To Stop Electroshock
Box 7251, Station A
Toronto, Ontario M5W 1X9
(416) 461-7909
(416) 536-4120

Soliditairé Psychiatrie
7401 St. Hubert
Montreal, Quebec H2R 2N4
(514) 271-1653

Auto-Psy,
419 Rue St. Jean No. 1,
Quebec City, Quebec
G1N 2S8 (418) 529-1978

Project P.A.L.
3957 Wellington
Verdun, Quebec H4G 1V6
(514) 767-4701

By Ourselves
2054 Broad Street
Regina, Sask.
S4P 1Y3 (525-2613)

UNITED STATES

Coalition To Stop Electroshock
P.O. Box 3301
Berkeley, CA 94703
(415) 548-2980

Center for Independent Living
Mental Disabilities Independent Living Project
2439 Telegraph Ave.
Berkeley, CA 94704 (415) 841-4776

Alameda County Network of Mental Health Clients
c/o CIL
2439 Telegraph Ave.
Berkeley, CA 94704
(415) 841-4776

Madness Network News
2054 University Ave., rm. 405
Berkeley, CA 94704
(415) 548-2980

Network Against Psychiatric Assault
Women Survivors of the Mental Health System
2054 University Ave., rm. 406
Berkeley, CA 94704
(415) 548-2980

Mental Health Consumer Concerns,
T.A.L.L.Y. — Take a Loving Look at Yourself,
2500 Alhambra Avenue,
Martinez, CA 94553
(415) 372-4220

California Network of Mental Health Clients
7111 Magnolia Avenue, Suite A
Riverside, CA 92504
(714) 684-6159

SF Network of Mental health Clients
c/o PRAS
890 Hayes
San Francisco, CA 94117
(415) 552-9101

Psychiatric Inmates Rights Collective
Box 299
Santa Cruz, CA 95061
(408) 475-7904

Network Against Psychiatric Assault — Los Angeles
Box 5728
Santa Monica, CA 90405

CAPABLE — Citizens Against Psychiatric Abuse and Bureaucratic and Legal Entanglements
Box 373
Talmage, CA 95481
(707) 462-9059

Women Psychiatric Inmates Liberation Front
c/o Twelfth International Conference Committee
Box 61307
Denver, CO 80206

Alternatives to Psychiatrity Assoc.
P.O. Box 694
Lake Worth, FL 33460

Project Acceptance
P.O. Box 187
Lawrence, KS 66044

Advocates for Freedom in Mental Health
c/o Sharon Jacobs
1026 S. 56th Terrace
Kansas City, KS 66106
(913) 287-6498

Portland Coalition for the Psychiatrically Labeled
Box 4138, Station A
Portland, ME 04101

Psychiatric Genocide Research Institute,
c/o Lenny Lapon,
Box 80071,
Springfield, MA 01138-0071

Mental Patients' Liberation Front
Box 514
Cambridge, MA 02238

Psychiatric Alternatives Alliance
Box 4433
Ann Arbor, MI 48106

Paychiatric Alternatives Alliance
615 Hoak Ct.
Kalamazoo, Mich. 49001

F.O.C.U.S./*Voices Heard*
600 Cass SE
Grand Rapids, MI 49503
(616) 245-8633

Dawntreader, Inc.
P.O. Box 8432
Ann Arbor, Michigan 48107

Minnesota Assoc. to Stop Psychiatry and Psychology
Box 13027, Dinkytown Station
Minneapolis, MN 55414
(612) 874-0228

Client Peer Support Group
c/o Susan Yudelman
Wasie Residence
2745 Chicago Ave.
Minneapolis, MN 55407
(612) 874-5077

Project Overcome
6331 Bryant Ave.
Mpls., MN 55430
(612) 874-7600

For Ourselves
P.O. Box 231
Epsom, NH 03234

Channel One
P.O. Box 6005
Sante Fe, New Mexico 87502
(505) 982-5834

Project release
Box 396, FDR Station
New York, NY 10022
(212) 816-7418

Association for the Preservation of Anti-Psychiatry Artifacts
Box 9
Bayside, NY 11361

Women Free Women in Prison/ *No More Cages*
Box 90
Brooklyn, NY 11215
(212) 499-8177

Mental Health System Survivors
P.O. Box 22
Brooktondale, New York 14817

Mental Patients Alliance of Central New York (Syracuse)
Box 158
Syracuse, NY 13201

Mental Patients Alliance
Box 875
Ithaca, New York 14850
(607) 257-6291

Coalition to Stop Electroshock
Box 875
Ithaca, NY 14850

The Sayville Project Club
251 South Main Street
Sayville, NY 11782

People Against Psychiatric Oppression
Box 19404
Cincinnati, OH 45219

By Any Other Name
2332 Rohs Street
Cincinnati, Ohio 45219

Alliance for the Liberation of Mental Patients
Box 30228
Philadelphia, PA 19103

Mental Health Advocacy Coalition
Box 618
Sioux Falls, SD 57101
(605) 334-4067

Human Enclave for Liberation from Psychiatry (HELP)
c/o Danny Mesic
3103 Hartnett Blvd.
Isle of Palms, SC 29451
(803) 886-6965

Vermont Liberation Organization
RD No. 1
Johnson, VT 05656
(802) 635-7547

Anti-Psychiatry Association
Box 85004
Seattle, WA 98105

ENGLAND

PROMPT
c/o 11 Ottershaw House
Horsell Rd., St. Paul's Cray
Kent
(01) 693-0011 (MWF 3-10pm)

Lawletter
90 Fawcett Estate
Clapton Common
London E5 9HX

Inquest: United Campaigns for Justice
22-28 Underwood Rd.
London E1 5AW
(01) 247-4759

Hackney Mental Patients Assoc.
Box 48
136 Kingsland Hight St.
London E8

Matthew O'Hara Committee
c/o 177 Glenarm Road
London E5 ONB

Depressives Associated
c/o Mrs. Janet Stevenson
19 Merley Ways
Wimborne Minster
Dorset BH21 1QN

Protection for the Rights of Patients at Rampton
University of Nottingham
Nottingham, Nottinghamshire

HOLLAND

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3500 AP Utrecht
(070) 631 276

Clientenbond Bulletin
Postbus 13 541
Den Haag

Gek-ooit
Postbus 43097
Amsterdam

GO-ON
Stichting Goed Onderkomen
Postbus 82097
2508 EB Den Haag

Stichting Pandora
2e Constantijn Huijgensstrat
1054 Amsterdam
(020) 127 552

Helse Hex
Minagassastr. 1
Amsterdam

BELGIUM

Group Information Asyle
p/a Yves Conreur
rue Landeveld 146
Brussels

Mensen Onder Mensen
Koning Albertplein 20
Kessel-Lo

Werkgroep Psychiatrie
Release Leopoldplatts 40
Hasselt

Passage 144
Tiense Steenweg 144
Leuven

Pica
Wolstraat 31
Antwerpen

FRANCE

G.I.A. Lyon
c/o Maurice Dumoulin
BP 8461
69359 Lyon Cedex 2
NOTE: There are also G.I.A. (information centers?) in Paris, Maisons Alfort, Chambery, Toulouse.

Mise A Pied
BP 2038
31018 Toulouse Cedex

SWITZERLAND

Patienten Basel
Postfach 3839
Hammerstrasse 1600
Basel

Assoc. des Usagers de la Psychiatrie
22 rue Neuve du Molard
Geneva
(022) 219 575 (Tues. 6-9 p.m.)

Interessen Gemeinschaft Psychiatrie
Sektion Zurich
Postfach 104
8402 Winterthur

GERMANY

Sozialistische Selbsthilfe Koln (Socialist Selfhelp Cologne)
Liebigstrasse 25
5 Koln 1
(0221) 556 189

Beschwerdezentrum Psychiatrie Bonn
Krausfeld 10

Bonn 53
(0228) 655 409
NOTE: There are Beschwerdezentrum (Information Centers) in Koln, Bielefeld, Munster, Kropp, Dortmund, Dusseldorf, Muchel, Aachen, Bremen, Wurzburg, Stuttgart, Marburg, Bochum, Paderborn.

Patientenfront
c/o G. Schuck
Postfach 211 227
Ludwigshafen

Irren-Offensive
Pallasstrasse 12
1000 West Berlin 30

Schocks und Antischocks:
c/o Vera Kruse
Admiralstrasse 18
1000 Berlin 36

GREECE

Movement for the Rights of Mental Patients
161, S. Charalambi Str.
Athens 708

DENMARK

Amalie
Linnesgade 26
1361 Kobnhavn
NOTE: This is the paper of the Danish madmovement and contains a listing of groups in Denmark.

ICELAND

Gedhjalp,
Veltusand 3B 101 Reykjavik,
Iceland

NEW ZEALAND

Wellington Patients' Organization
P.O. Box 10180
Wellington, New Zealand

AUSTRALIA

Campaign Against Psychiatric Injustice and Coercion (CAPIC)
10 - 14 Johnston Street
Collingwood 3066,
Victoria Australia (Melbourne)

Pala Society
P.O. Box 153
Waverley 2024,
New South Wales Australia (Sydney)

Committee on Mental Health Advocacy (COMMA)
P.O. Box A625
South Sydney 2000,
New South Wales Australia

Grow
209A Edgeware Rd.
Marickville NSW 2204

Foundation for the Abolition of Compulsory Treatment
Post Office Box 3
Subiaco

ELECTROSHOCK AS A FEMINIST ISSUE

by Dr. Bonnie Burstow

WHAT IS ELECTROSHOCK? It might plausibly be described as THE WAY A GENTLEMAN BEATS UP ON A WOMAN, or alternately, a GENTLEMANLY FORM OF RAPE. It is, at any rate, a highly damaging psychiatric 'treatment' which enforces what is traditionally 'female' at a time when we are trying to break out of those roles, which is sexist through and through, and which should be abolished. As such, it is something which we as women simply cannot afford to ignore.

THE BASIC SEXIST FACTS

- Two to three times as many women as men get electroshock.
- Shock docs openly recommend it for *women* and *men whose jobs do not require a lot of thinking.*
- Women often receive it for post-partum depression — a natural occurrence which can be addressed naturally and which disappears on its own in the course of time.
- Women have a higher seizure threshold than men. They are administered more electricity per treatment, accordingly, and probably sustain greater damage.
- Over 90% of all shock doctors are male.

OUR SHOCKED SISTERS SPEAK OUT

"I came home from the office after that first day feeling panicky. I didn't know where to turn ... All my beloved knowledge, everything I had learned ... during twenty years was gone ... I'd lost my experience, my knowing. But it was worse than that. I felt I'd lost myself." (Marilyn Rice, Washington, D.C., 1973).

"Since shock treatment, I'm missing between eight and fifteen years ... I was a trained classical pianist ... Well, the piano's in my house, but ... I don't have that kind of ability any longer ... I've lost people too. People come up to me and tell me about things we've done. I don't know who they are, I don't know what they're talking about." (Connie Neil, Toronto, 1984).

"I was given ... shock treatments for depression ... after my fourth child was born. I did not give my consent ... My former husband ... signed the paper ... I had ... the feeling of being led to the slaughter ... I feel so alien ... because of the damage ... One of my children's interviews was terrifying me because I didn't want to reveal what I had experienced, and the gaps in my memory — I was still in the closet. Finally, the anxiety got so bad I would completely avoid people. (Shirley Johnson, Hamilton, 1984).

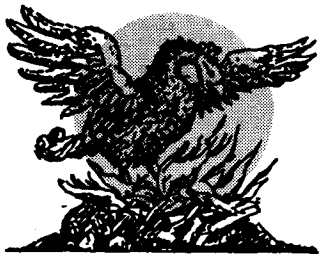
"Then something bent down and took hold of me and shook me like the end of the world. Whee-ee-ee-ee-ee, it shrilled, through an air crackling with blue light, and with each flash I thought my bones would break and sap fly out of me like a split plant. I wondered what terrible thing it was that I had done." (Sylvia Plath, *The Bell Jar*, 1971).

WHAT CAN YOU DO?

- Start reading about electroshock and speaking with electroshock victims.
- Be aware of other forms of sexist oppression — both psychiatric and non-psychiatric — and their relationship to ECT.
- Warn women against electroshock — especially women who have recently given birth.
- Join the Ontario Coalition to Stop Electroshock.
- Encourage feminist groups which you are involved in to take up the fight.

IF YOU WANT TO DISCUSS ELECTROSHOCK OR GET MORE INFORMATION ABOUT IT, FEEL FREE TO CALL DR. BONNIE BURSTOW, CO-CHAIR OF THE ONTARIO COALITION TO STOP ELECTROSHOCK.

ONTARIO COALITION TO STOP ELECTROSHOCK, Box 7251, Station "A", Toronto, Ontario, Canada M5W 1X9 — Phones (416) 536-4120 or (416) 461-7909.



phoenix flashes

Big Brother comes to St. Thomas

In May of this year, the *Globe and Mail* revealed that some psychiatric inmates incarcerated in St. Thomas Psychiatric Hospital (a maximum-security psychiatric prison in Ontario) will be forced to wear a special bracelet with an electronic chip. Should an inmate dare to stray too far from the locked ward or hospital, the chip will immediately activate a central computer (probably located in a nursing station), which will then alert the staff, so they can return the "dangerous" inmate to the ward. Inmates who refuse to wear the bracelet must remain in the locked ward.

This electronic surveillance of inmates is being tried out this summer as a pilot project — the brainchild of U.S. electronics manufacturer Ralph Devoy and the Ontario Ministry of Health. It's only a matter of time before thousands of other psychiatric inmates, prisoners, the mentally handicapped and old people in nursing homes will also be privileged to wear the bracelet — for their own security, of course.

We urge all inmates and prisoners to refuse to wear the bracelet, and to consider suing the institution and government for violating their human rights to dignity and privacy, and their Charter rights, such as the "right to life, liberty and security of the person." (Consult a lawyer first!)

Women and Law Association supports rights of handicapped

At its biennial conference in Ottawa in February the National Association of Women and the Law passed the following motion supporting the rights of women who have been labelled mentally handicapped.

Whereas there is evidence of abuse by the imposition of non-therapeutic sterilization on mentally handicapped women and girls, be it resolved that:

- women support the banning of non-therapeutic sterilization of mentally handicapped children who are not capable of giving informed consent
- women support the banning of non-therapeutic hysterectomies of mentally handicapped women and girls who are not capable of giving informed consent.
- women support proposals that non-therapeutic sterilization of mentally handicapped adults who are not capable of giving informed consent be permitted only after a hearing before an independent body where the handicapped person has independent legal advice and counsel.

(Reprinted from Canadian Human Rights Advocate, *Vol. 1, No. 4, March 1985.)*

Charter to be used in shock case

The first lawsuit against electroshock in Canada was decided in the Supreme Court of Ontario in December 1983. At that time, a competent woman inmate ("Mrs. T.") in Hamilton Psychiatric Hospital refused shock, after her psychiatrist and the Review Board ordered 15 shocks. Through lawyer/inmates' rights advocate Carla McKague, Mrs. T. claimed that electroshock, like psychosurgery, would damage her brain. Although she lost the case, "Mrs. T." was not shocked and was transferred to another hospital. In that case, there were no Charter arguments. (See April 1984 issue, "Shock Case: Defeat and Victory.")

Ontario's second shock case is about to take place, and it could be historic because there will be Charter arguments. This June, the *Globe and Mail* ran a story about a 22-year-old psychiatric inmate, incarcerated in Penetang, who was subjected to two shock treatments against his will. ("Board authorizes shock treatment at MD's request," June 14, 1985). The man's doctor, Julia O'Reilly, decided to give him shock because he was "catatonic" and "not eating." As if this weren't bad enough, the decision to administer shock was made as an "interim order" in a telephone conversation between Review Board Chairman John Gignac and Dr. O'Reilly. Ontario's *Mental Health Act* does not authorize any "interim order" but states that any board decision must be based on evidence presented during the hearing.

Lawyer Carla McKague asserts there was no such evidence. The inmate and his sister are suing the Review Board, Dr. O'Reilly, Penetang and the Ministry of Health for assault and damages. We'll report on the latest developments in this important case in future issues.

Child abuse alleged at Montreal hospital

A confidential report obtained by CBC's French-language arm, Radio-Canada, accuses a suburban Montreal psychiatric hospital of forced child prostitution and the beating of its young patients. In one incident, hospital staff and patients allegedly paid $10 to have sex with a 10-year-old girl; other complainants claimed that hoods were placed over the heads of the children so they couldn't see who was inflicting the beatings.

The Quebec government has launched an investigation into these allegations at the Riviere-des-Prairies hospital in north-end Montreal.

(Reprinted from Globe and Mail.*)*

10-year-old denied right of appeal

On Friday, April 26 the B.C. Court of Appeal overturned the ruling of B.C. Supreme Court and authorized a non-therapeutic hysterectomy on a 10-year-old child. The Appeal Court gave no reasons. They refused to grant a stay which would have prevented the operation before their written reasons are handed down.

On Tuesday, April 30, the second working day after the Decision came down, in spite of the fact that the Supreme Court of Canada was scheduling an emergency hearing within a matter of hours to consider a motion for a stay, the doctors, presumably with the blessing of their lawyer, rushed ahead and performed the hysterectomy on the child.

(Excerpted with permission from Canadian Human Rights Advocate May 1985 issue.)

Update:

On June 3, 1985 the Supreme Court of Canada decided, without giving reasons, not to hear any further arguments in the Infant K case.

Canadian Shock Doctor Roster:

UPDATE

Here is *Phoenix Rising's* revised and updated list of Canadian psychiatrists who administer or authorize electroshock ("ECT"). Listed psychiatrists who no longer use ECT, or have been mistakenly included in this list, may ask *Phoenix Rising* to remove their names. Since this list was last published in our April/1984 issue, the names of 36 shock doctors have been added to the list, which brings our total to 95.

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

Ahmad, K. Nova Scotia Hospital, Dartmouth, N.S.
Allodi, F. Toronto Western Hospital, Toronto, Ont.
Ananth, J. McGill University School of Medicine, Montreal, Que.
Aquino, M. Nova Scotia Hospital, Dartmouth, N.S.
Arndt, H. Northwestern Hospital, Toronto, Ont.
Barton, C. Homewood Sanitarium, Guelph, Ont.
Bergen, P. Homewood Sanitarium, Guelph, Ont.
Bhattacharyya, A. Nova Scotia Hospital, Dartmouth, N.S.
Bickle, G.S. Homewood Sanitarium, Guelph, Ont.
Boyd, B. Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.
Brennagh, M. York County Hospital, Newmarket, Ont.
Buffet, L. Nova Scotia Hospital, Dartmouth, N.S.

Camunias, E.R. Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.
Chandrasena, R. Royal Ottawa Hospital & University of Ottawa. Ottawa, Ont.
Conn, B. Belleville General Hospital, Belleville, Ont.
Cornish, D. Alberta Hospital, Edmonton, Alta.
Dale, R.M. Mississauga Hospital, Mississauga, Ont.
De Coutere, I. Nova Scotia Hospital, Dartmouth, N.S.
Denew, P. Hamilton Psychiatric Hospital, Hamilton, Ont.
Eades, B. Riverview Hospital, Port Coquitlam, B.C.
Eastwood, M.R. Clarke Institute of Psychiatry, Toronto, Ont.
Ferguson, K. Homewood Sanitarium, Guelph, Ont.
Fleming, R.I. Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.
Foley, P. Hamilton Psychiatric Hospital, Hamilton, Ont.
Giles, C. Alberta College of Physicians & Surgeons, Edmonton, Alta.
Glumac, G. Homewood Sanitarium, Guelph, Ont.
Gordon, M. Mount Sinai Hospital, Toronto, Ont.
Gosselin, Y. Ottawa General Hospital, Ottawa, Ont.
Grant, P.M. St. Catharines Hospital, St. Catharines, Ont.
Gulens, V., Jr. Chodoke-McMaster Hospital & St. Joseph's Hospital, Hamilton, Ont.
Halket, P.J. Hastings and Prince Edward Counties Health Unit, Belleville, Ont.
Harvey, M. Misericordia Hospital, Winnipeg, Man.
Heath, D.S. Kitchener-Waterloo Hospital, Kitchener, Ont.
Hoaken, P. Hotel Dieu Hospital, Kingston, Ont.
Hoffman, B. Clarke Institute of Psychiatry, Toronto, Ont.
Holland, L. Nova Scotia Hospital, Dartmouth, N.S.
Hopkins, D. Homewood Sanitarium, Guelph, Ont.
Horne, S.D. Homewood Sanitarium, Guelph, Ont.
Indrajit, R. Homewood Sanitarium, Guelph, Ont.
Jeffries, J. Clarke Institute of Psychiatry, Toronto, Ont.
Jeney, L. St. Joseph's Health Centre, Toronto, Ont.
Jun-Bi, T. Homewood Sanitarium, Guelph, Ont.
Karlinsky, H. University of Toronto, Sunnybrook Medical Centre, Toronto, Ont.
Kedward, H.B. Clarke Institute of Psychiatry, Toronto, Ont.
Khan, Z.A. Oshawa General Hospital, Oshawa, Ont.
Kingston, E. McMaster University, Dept. Psychiatry, Hamilton, Ont.
Kolivakis, T. McGill University School of Medicine, Montreal, Que.
Litch, S.W. Homewood Sanitarium, Guelph, Ont.

Littman, S.K. Foothills Hospital, Calgary, Alta.
Mackay, J. Queensway General Hospital, Etobicoke, Ont.
Male, T.W. Homewood Sanitarium, Guelph, Ont.
Martin, B.A. Clarke Institute of Psychiatry, Toronto, Ont.
Mason, R.J. Windsor Western Hospital Centre, Windsor, Ont.
McFarlane, W.J.G. Riverview Hospital, Port Coquitlam, B.C.
Mitchell, W. Greater Niagara General Hospital, Niagara Falls, Ont.
Nkansah, J. Toronto East General & Orthopaedic Hospital, Toronto, Ont.
O'Brien, J. Nova Scotia Hospital, Dartmouth, N.S.
O'Reilly, J. Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.
Page, W.E. Brant County District Health Unit, Brantford, Ont.
Pankratz, W.J. Lions Gate Hospital, North Vancouver, B.C.
Peacocke, J.E. Clarke Institute of Psychiatry, Toronto, Ont.
Plumb, L. Women's College Hospital, Toronto, Ont.
Pond, R. Homewood Sanitarium, Guelph, Ont.
Poulos, H. Nova Scotia Hospital, Dartmouth, N.S.
Prowse, A. Homewood Sanitarium, Guelph, Ont.
Rapp, M.S. Sunnybrook Medical Centre, Toronto, Ont.
Rassell, J. Ottawa Civic Hospital, Ottawa, Ont.
Rodenberg, M. Kingston Psychiatric Hospital, Kingston, Ont.
Roper, P. Douglas Hospital, Montreal, Que.
Sauks, A.A. North Bay Psychiatric Hospital, North Bay, Ont.
Schowalter, B. Queensway-Carleton Hospital, Nepean, Ont.
Shoichet, R.P. Toronto Western Hospital, Toronto, Ont.
Shugar, G. Clarke Institute of Psychiatry, Toronto, Ont.
Shulman, K. Sunnybrook Medical Centre, Toronto, Ont.
Silverman, M. Ottawa Civic Hospital, Ottawa, Ont.
Sim, D.G. Hamilton General Hospital, Hamilton, Ont.
Singh, M. Nova Scotia Hospital, Dartmouth, N.S.
Sirchich, I. Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.
Smith, S.M. Royal Ottawa Hospital & University of Ottawa, Ottawa, Ont.
Solursh, L. Toronto East General Hospital, Toronto, Ont.
Stacey, D. Nova Scotia Hospital, Dartmouth, N.S.
Stevenson, C.M. Kingston Psychiatric Hospital, Kingston, Ont.
Stokes, R.E. Penetanguishene Mental Health Centre (Oak Ridge), Penetanguishene, Ont.
Swinson, R.P. Toronto General Hospital, Toronto, Ont.
Tatham, M.R. Homewood Sanitarium, Guelph, Ont.
Tomlinson, M. Nova Scotia Hospital, Dartmouth, N.S.
Varan, L.R. Ottawa General Hospital, Ottawa, Ont.
Villacastin, S. Nova Scotia Hospital, Dartmouth, N.S.
Vincent, M.O. Homewood Sanitarium, Guelph, Ont.
Ward, J.A. Sudbury Algoma Hospital, Sudbury, Ont.
Watt, J.A. Homewood Sanitarium, Guelph, Ont.
Wood, W. Nova Scotia Hospital, Dartmouth, N.S.
Yoon, S. Nova Scotia Hospital, Dartmouth, N.S.
Zamora, E. St. Joseph's Hospital, Hamilton, Ont.
Zielenko, W. Guelph General & St. Joseph's Hospital, Guelph, Ont.

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— Jean Cocteau