



phoenix Rising

THE VOICE OF THE PSYCHIATRIZED

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Louise



*+ Copy Report on
Consciousness p. 36B*

Movement Issue

**The State of the
Movement in
California**

**Oak Ridge &
the Hucker Report**

INMATES UNITED WILL NEVER BE DEFEATED! THE





One in Five

- One in five Canadians of all ages is the victim of mental disease.
- 40,000 Canadians between the ages of 15-39 attempt suicide every year.
- More than 250,000 Canadians suffer from schizophrenia, the most disabling of mental diseases.
- Mental illness costs Canadian business more than \$1.7 billion in productive work time every year.

**There is a solution - more and better research.
But research is expensive. Please give to:**

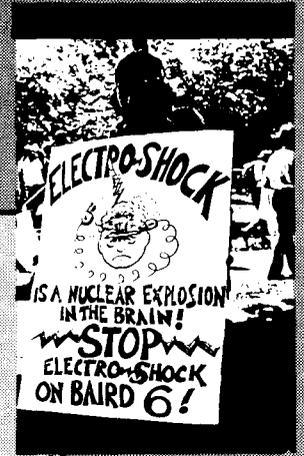
The Canadian Psychiatric Research Foundation 220 Yonge Street, Suite 206,
Box 607 Toronto, Ontario M5B 2H1
(416) 591-9289

Dealing from a Stacked Deck

This misleading, medical-model ad has been posted in subways, streetcars and buses in Toronto during the last six months. The Canadian Psychiatric Research Foundation, which paid for the ad, funds major biological-psychiatric research in Ontario. Its grants are chiefly awarded to psychiatrists studying "schizophrenia, depression and stress-related disorders...." From 1980 to 1985, over 40 percent of the Foundation's grants were given to Toronto's Clarke Institute of Psychiatry, a bastion of biological psychiatry, and a major shock shop in Ontario.

We urge our readers to protest this ad's propagation of the myth of "mental illness" by writing letters to: *Manuel Zack, Executive Director, Canadian Psychiatric Research Foundation, 220 Yonge Street, Suite 206, Box 607, Toronto, Ontario M5B 2H1 (416) 591-9289.*

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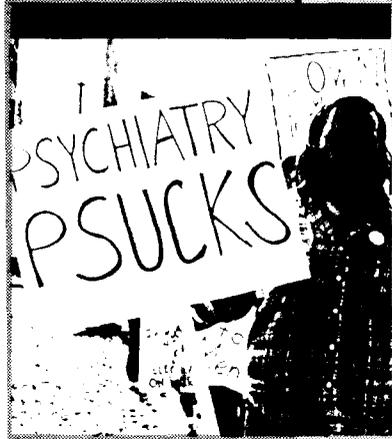
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If the plumage fits, wear it!



EDITORIAL

We dedicate this issue to all individuals and groups in the Psychiatric Inmates' Liberation Movement. The movement is now in serious crisis. People have divided into factions since the 13th Annual International Conference For Human Rights and Against Psychiatric Oppression, held last year in Burlington, Vermont. Right now, the movement is wracked by deep tensions and bitter disagreements over ideology, priorities, strategies and tactics, and government or "mental health" funding. (See Brian McKinnon's feature article.) This year, there was no 14th international conference authorized by last year's conference, although mini-conferences were held in the summer in Washington, DC and Ithaca, New York. If the crisis gets much worse, we may no longer have an antipsychiatry movement.

ON OUR OWN, including **Phoenix Rising**, has been very active in the movement over the last several years. We're proud of our membership and continuing support, and our efforts to reach out to our brothers and sisters who've been psychiatrized and dehumanized. We don't want the movement to die. We have a personal stake in its survival and growth — it's been good to us. The movement has validated and empowered thousands of us when we were down, burnt out, locked up, and released from the psychiatric warehouses. Through its annual conferences, teleconferences, protest demonstrations, and outstanding publications such as **Madness Network News** and **Constructive Action Newsletter**, the movement has brought many of us together to continue our struggles against involuntary committal and forced treatment, including electroshock and forced drugging, for more rights for our imprisoned brothers and sisters, and for our own humane alternatives to the psychiatric system. **On Our Own: Patient-Controlled Alternatives to the Mental Health System**, an outstanding book by ex-inmate activist Judi Chamberlin, inspired many of us in Toronto. We named our group after it.

Five years ago, we came out with our first Movement Issue (Vol. 2 No. 3, 1981), and we're indebted to Mel Starkman, who did much of the research for that issue.

We feel this Movement Issue tackles the current crisis and reflects continuing struggle and hope. In overcoming the crisis, we must reach down deep within ourselves and touch our roots. These roots are embodied in our **Declaration of Principles**. We are proud to reprint this historic and moving document, and we hope it continues to serve as a touchstone and reminder of where we've come from, and where we should be going.

Unfortunately, there is no antipsychiatry/liberation movement in Canada — there never was. There are only a few pockets of organizing and political activity in cities such as Toronto, Montreal, Regina and Vancouver. In our Charter Issue (1985), we listed fourteen Canadian groups in our Psychiatric Inmates' Liberation Directory. We were wrong. Many of these groups are not antipsychiatry or not against forced treatment. Also, SETI (Self Esteem Through Independence) in London, Ontario and NAPP (Newfoundland Association of Psychiatric Patients) in St. John's have disbanded in the last two years. Last June, we sent copies of a questionnaire to all the groups — only six replied; only two indicated their opposition to psychiatry: the Mental Patients' Association in Vancouver and the Ontario Coalition to Stop Electroshock in Toronto. All six indicated their opposition to involuntary committal and forced treatment. Obviously, a helluva lot of grass-roots organizing in Canada is long overdue!

We've been through the fires of madness and the hell of psychiatric institutions. We have survived because of our inner strength, our beauty, our courage, our humanity, our solidarity. Our suffering and victories over psychiatry have made us the real experts on the "mental health" system. Out of our pain and suffering was born our resolve to abolish it and establish our own alternatives.

Let us not forget this. Let us start healing our personal and collective wounds to build a stronger, more unified movement. Let us start celebrating our strengths and victories instead of mourning our weaknesses, losses and differences. Let us come together. **The movement must not die!**



phoenix rising

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Rip-off!

Dear Editors:

Here's my renewal — I wouldn't want my subscription to run out!

I wish I could send you more money, but I'm in extreme financial difficulty right now. The hospital where I was shocked in 1984 claims I owe them \$15,000. They've taken it to court and apparently have gotten the right to seize my bank account — all the money I had saved. They got my savings, but it's a long way from \$15,000.

The \$15,000 is a bill for being in the hospital for *one* month, *against* my will, including *fifteen* shock treatments. Apparently they think it's such a privilege to have electricity applied to my brain that I should be happy to pay them a small fortune for doing it!!!

Needless to say they will get another cent from me only over my dead body. However, legally they can probably torture me for the rest of my life.

I was never even given a *chance* to defend myself in court. The hospital's lawyers did not inform me of the court date, though they claim they did, so of course I couldn't show up. Therefore, the hospital very easily got a default judgement against me, probably simply by producing evidence that I had been in the hospital for a month without insurance.

Also, they had made me sign a promise to pay. This was *one week* after my last shock treatment — I was not exactly in a position to think about what I was signing! "Get 'em while they're organic," seems to be the hospital's motto. Naturally, I

would have signed *anything* in front of me at that point, so eager was I to comply with rules and be released.

I told a lawyer that I wanted to reopen the case and fight the judgement, on the grounds that I was "treated" against my will. He told me it could be done, for a fee (lawyers will do anything for a fee), but that there was very little chance of winning. In the eyes of the law, at least in this great country of America, the fact that you were held under coercion does not cancel your obligation to pay your bill! Imagine what would happen if all the involuntary patients in America refused to pay their bills! The hospitals would go bankrupt.

There's no such thing as a "fighting" lawyer — not in America. The only thing they'll fight for is money. I can't imagine that Canada is any different, but if it is, maybe I should move there at once.

I'd love to take this to court, if only for the satisfaction of having my say, but I can't afford to lose any more money than I've already lost.

The whole thing is outrageous, but no one ever said the law was fair. In struggle,
Linda Andre

Advocacy Program a sham

Dear Editors:

Since the Patient Advocacy Program came into operation in 1983, I've been waiting for a review of its performance (or lack of it) to date.

Pat Capponi's comments on this program in the June 1986 *Phoenix Rising* are the first I've seen, and these basically say that it is

ineffective, due to its lack of independence.

I personally can recall the happenings inside the "mental health" system prior to 1983 and the deserved negative publicity it was receiving.

At the height of this publicity the Ontario Ministry of Health announced its intention to institute the Patient Advocacy Program. It looked as if someone was admitting the serious problems within "mental health" facilities. That Mr. Grossman appeared to be a credible politician made the program look like a solution to the system's ills. Some prescription! Just what the Doctor (psychiatrist) ordered.

For the government, the Program's operation would mean stemming the tide of legitimate claims that could be going into court, accompanied by further publicity, when Section 15 of the *Charter of Rights and Freedoms* became law. This section deals with discrimination, and rights that may have been violated by the government or its agencies. If they allow the government, through the Advocacy Program, to set up an "affirmative action" group, patients will become unable to resolve issues of rights violations in court. A group of people chosen by the Ministry of Health will be deciding and interpreting our rights under the *Charter* in behind-closed-doors sessions. A situation no different than what goes on within the "mental health" system.

Predictably, the psychiatrists wanted "cooperation": the same manipulative ploy used by them on

patients to lead them down the garden path. The attendants union reacted (again predictably) with fear and hostility — their usual response to anything to do with enforcing or protecting patients' rights.

No wonder the handful of advocates who had to contend with this onslaught (like patients who are overpowered, intimidated and browbeaten) succumbed to the plea for "cooperation." It is hard to imagine they did not realize at the outset that this would mean compromising on patients' rights. Indeed the Program, when first proposed, stated that one of the functions of the advocates would be to "mediate disagreements." "Disagreement" is just a polite term for acknowledging that a legal right has been violated. Patient advocates should be prosecuting offenders rather than acting as "mediators" or sleuths in uncovering rights violations.

You cannot enforce rights through mediation when there are no consequences for those who violate and deny those rights. As long as the Patient Advocacy Program has no teeth, who can respect its purported function of protecting patients' rights?

Can anyone tell me who has met with any penalty for violating rights of patients as uncovered by the advocates? Or am I to assume that no one's rights have been violated or denied since the Program began?

While I was at Penetang, I knew the Mental Health Act was to provide me protection against being forced to take drugs or other forms of treatment, but this did not prevent it happening in my case and many, many others. Not until I charged them with assault under the *Criminal Code* was I taken seriously or was there any action.

When patients are held against their will in an institution, is this not unlawful confinement? If you or I held someone anywhere against their will we would be charged with this criminal offence. Why should it be taken less seriously if the state or a psychiatrist is the offender?

Then to add insult we have an Advisory Committee to report on the Advocacy Program, appointed by (who else?) the Ministry of Health.

And why should the advocates

need advice? If they don't already know what they should be doing, we are in more trouble than we thought.

When, if ever, will the patients themselves have some say in who represents them as advocates, advisors or in any other capacity seen as necessary to protect their rights?

While Pat Capponi, along with others, has made some gains in this area, she does not strike me as the kind of strong, uncompromising individual the Advocacy Program needs.

She says in her article that, from the outset, she foresaw the success of the Program depending on "voluntary respect for and cooperation with the advocates by the hospital staff members and administration."

To me this is unrealistic. If respect and cooperation could be expected, we would not need advocates.

For all my ten years in Penetang, we were told we had no rights. When it was somehow shown we had one somewhere, it was the Ministry and its agencies that decided to what extent we could exercise it.

I foresee the Advocacy Program ultimately practising discrimination against the mentally disabled while assisting indirectly and directly in the violation of patients' rights.

I urge anyone who agrees with this view, or feels that patients should have a more active part in determining who represents us, to speak up.

Perhaps unionizing patients across the province and the country is not too unrealistic: electing our own representatives, funding ourselves through membership dues and hiring our own lawyers to represent us in the courts. We might even ask certification of the union through the courts. Perhaps this would demonstrate our serious intent to have a say in who represents us in our struggle for equality and full benefits of the law regardless of mental disability.

Eldon Hardy

Can psychiatry be a cure?

Dear Editors:

In the editorial note to "An Anguished Father's Questions," you refer to the writer's "belief in... psychiatry's capability to achieve a

cure [for mental illness]."

I didn't find any such belief in his letter. Rather, it posited the reality of mental illness and illustrated the inefficacy of psychiatry in dealing with it. At most, he implied a *hope* that psychiatry would someday be capable of curing it.

In any case, the efficacy of psychiatry is not the issue. The question the father raises is how you would explain his son's death. Was his brain malfunctioning, was he having a "spiritual experience," was he troubled and tormented for no reason, or what? What is your answer?

Yours,
Marilyn Rice

Thanks for your letter questioning our editorial note on Norm Houghton's letter, published in our June 1986 issue. You're right that Houghton did not express the conviction or belief that psychiatry could "cure" his son's "mental illness." However, he did seem to have implied some hope. Although we have seen no medical evidence related to his son's death, experience leads us to suspect that he did not have a brain abnormality or brain disease. Of course, we could be wrong. Certainly he suffered considerable torment. We still reject the medical model in psychiatry, and believe that psychiatry cannot be "reformed" — it must be abolished.

Still Sane holds up

Dear People:

Thanks for another good issue. I have to respond to Lilith Finkler's review of *Still Sane*. Though pleased she liked my article, I am distressed that she felt it important that pages fell out of her book. It tends to cheapen the quality of the production in the reader's mind. I've used my copy at least 50 times and no pages are loose. I've asked other book owners and they've not had this difficulty. Unfortunately, Lilith received a copy that had binding difficulties. But perhaps she could have asked a few people how their copies were holding up before printing this statement of faulty merchandise. I hope it doesn't damage the image of an excellent project.

Deedee Nihera



Maggie's Bag

Late News

We hear with great sadness that *Madness Network News* is dying. We were also informed that the offices will be taken over by the California members of NAMP, with plans to produce a journal for the movement, or at least a NAMP Newsletter.

A copy of *MNN* was handed to me the day I started at *Phoenix Rising*, and it's been a constant reference point when things got tough — "If they can do it, so can we!" I can do no more than tell you how sad we are. We will sorely miss you.

"Some People Think We're Nuts / Some People Think We're Off Our Rocker"

Canada Homes recently used these slogans in a couple of very offensive ads, along with the terms "nuts"; "crazy"; "committed"; and "not playing with a full deck."

The ads were immediately withdrawn upon a number of complaints from concerned individuals and groups, including *Phoenix Rising*.

When you find something offensive, there IS something you can do about it. SPEAK UP! SPEAK OUT! YOU WILL BE HEARD!

A perfect example of something you could do would be to drop a letter of protest to filmmaker William

Friedkin, urging him not to use the proposed title "Schizophrenic Killer" for his next film. The title alone supports the vicious myths of "mental illness" and the "dangerous mental patient." This inflames the public's fears and rejection of people labeled "mentally ill," and encourages psychiatrists to mis-diagnose.

Mr. Friedkin's address is: 4640 Lankershire Blvd., 5th Floor, North Hollywood, California 91602.

Taking Aim: Job Search Strategies for People with Disabilities

The Ontario Ministry of Labour's Handicapped Employment Program has come out with this booklet, which is available *free*, and could be very useful to Ontario job-seekers. (If you are out-of-province, send a \$10.00 certified cheque or money order, payable to the Treasurer of Ontario.) The booklet is also available in French and on audio cassette (in French or English). Write to: Handicapped Employment Program, Ministry of Labour, 400 University Avenue, Toronto, Ontario M7A 1T7.

Three Years Later!

It was recently announced the City of Toronto has allocated 1.7 million dollars for a

community-based crisis centre. Based on psychologist Reva Gerstein's 1984 task force study, it is described as "an innovative support system to help former patients remain in the community staffed with social workers and psychiatric nurses organized by Queen Street Mental Health Centre, it will have a major hospital overseeing the project."

Question: Who the hell are they kidding? You don't even have to read between the lines to see this will be an extension for Queen Street Outpatients, as opposed to a legitimate crisis centre that would eliminate that initial "visit" to Queen Street. There is no question it will be staffed by professionals.

Support the Arts

Jennifer Moore, a self-professed humanist and ex-psychiatric inmate, and Colleen Howe, artist and musician, are busy raising much needed pre-production funds for their forthcoming film — working title "A Short Story in Gone."

"Gone" is based on the true story of a young girl whose parents are thinking about divorce. The girl is happy about it, and the parents find this "abnormal." The obvious answer is a psychiatrist (who is also the parents' marriage counsellor). The story takes you through her six-week incarceration, the bureaucracy

and politics of a psychiatric ward, drugs, isolation and behaviour modification, as well as her attempts to deal with a love affair.

As mentioned, they need bucks. To donate, or for further information, please write: Colleenifer Moon Productions, 530 English Street, Apt. 2, London, Ontario N5W 3K6.

Funding News

Now we know where all the funding goes! The magic little man who throws away money has just awarded our infamous Clarke Institute 10 million dollars for a six-year study that will answer the musical question What makes a good psychotherapist? They already have the therapists, but (here's the good part) — they require depressed people — lots of depressed people — 62 of them, to be exact! They also add that "schizophrenics," alcoholics and people with neurological brain syndrome need not apply. That in itself could make you depressed.

It's All in the Timing

There was a landmark decision recently to the effect that if sitting on Death Row drives you crazy, you may no longer be executed. Of course, if your timing is a little off and you go crazy before, I guess you're still eligible.

The Movement:

Issues, Problems and Hope in California

by Brian McKinnon

Brian is a graduate student at York University in Toronto and an active member of the Ontario Coalition to Stop Electroshock. This article is based upon some informal discussions and interviews he did with a number of ex-psychiatric inmate activists in the San Francisco-Bay area last April.



Some people fear that the Psychiatric Inmates' Liberation/Antipsychiatric Movement is about to collapse. The issue of factionalism, or splits in the movement, has caused a great deal of anxiety and bitterness, particularly since the 13th Annual International Conference for Human Rights and Against Psychiatric Oppression, held in Burlington, Vermont in August 1985. During the conference, the political unity of the movement was threatened by heated debate and frequent disruptions. The factionalism was very obvious at the conference, which ended without any decision about where and when the next annual conference would be held. (No international conference was held this year.) Many left the conference feeling angry and disillusioned because of the tensions. Many activists and other conference participants carried these tensions home, and continued voicing them within their local groups and with personal friends.

The issue that poses the most significant threat to the unity and future of the movement is government funding to ex-inmate self-help/advocacy groups. Many ex-inmate activists fear that such

funding will have disastrous effects on groups that accept it. They fear that groups taking government or "mental health" funding will lose their autonomy, and that they will be co-opted by and absorbed into the "mental health" system. These fears are not unrealistic or overstated. This has happened to other radical self-help organizations created as alternatives to the system.

Another controversial question is whether or not to establish a national (American) organization representing the interests of psychiatric inmates and/or ex-inmates. Some ex-inmates feel that such an organization is a necessary vehicle for political empowerment, and would enable greater outreach to a broader constituency. It is also argued that a national organization would accelerate the development of more local, user-controlled alternatives to psychiatry, and would act as the national advocate for the rights of the psychiatricized. Others dismiss these claims as empty rhetoric or posturing, and feel that a national organization would inevitably be controlled or co-opted by its funding body — probably the NIMH (National Institute of Mental Health, the US government's chief funding and research agency, controlled by psychiatrists). These critics also assert that, even if a national organization were able to maintain its autonomy, the centralized authority inherent in such an organization would be elitist and politically impotent due to its concerns about not offending government funders.

These controversies have effectively fragmented the movement. As a result, there are now three national organizations: fairly distinct factions that can be roughly described as "conservative," "moderate" and "radical." The "conservatives" have created the National Mental Health Consumers' Association (NMHCA), which was chiefly organized by Joe Rogers in Philadelphia. The "moderates" have formed the National Alliance for Mental Patients (NAMP). Its goals are strikingly similar to those of NMHCA. However, unlike the "conservatives," the "moderates" have taken a firm stand against forced treatment. The "radical" group is called the Network to Abolish Psychiatry (NAP). NAP is committed to abolishing the psychiatric system itself, and criticizes the other two factions for their reformism and betrayal of the movement's radical, abolitionist tradition. (See Draft Statement of Purpose of NAMP, Statement of Goals of NMHCA, and the Statement of Unity of NAP, in this issue.)

Splits threaten movement

These factions reflect major ideological and political conflicts that have taken a serious emotional toll on those who previously derived strength from their commitment to a common cause. Many movement people who have been friends become alienated from each other after splitting into different factions.

There is now little mutual trust. According to Leonard Frank (shock survivor and anti-shock activist, author, and highly respected movement leader), this alienation has become so intense that "we're no longer looking at each other as human beings who share the same victimization We seem to have subordinated that to our political roles, and as a result people are not relating to each other as friends, as brothers and sisters." In fact, barely-disguised insults have become part of many political discussions. The label "reformer" is used to dismiss certain people who have been fighting in the movement since its beginning in the 1970s. And people who are committed to a radical-abolitionist position are sometimes labeled "blinkered purists," and even "reactionaries."

This crisis situation also threatens the political integrity and credibility of the movement. One can imagine the satisfaction that a shock doctor or NIMH bureaucrat must feel about these developments. As Leonard Frank says, "It's a perfect thing from the establishment point of view to have so much of our energies drained off fighting against each other."

However, most of the people I talked with in California do not believe that the movement is doomed. Jay Mahler, an outstanding ex-inmate activist and patients' rights advocate in Contra Costa County, though he feels badly about the infighting, does not believe it spells disaster. He sees the conflicts as an indication of the relative youth of the

movement. And Sue Doell, a radical ex-inmate activist, member of NAP and of the editorial collective of *Madness Network News*, believes that there may be some real advantages in the split: "We're now better positioned to clarify some difficult issues... I think that the radical movement is going to become more radical... which is very positive and very exciting."¹

In short, the sadness, bitterness and factionalism within the movement do not tell the whole story. Although we cannot expect a prompt reconciliation between the estranged camps, there has been no cessation of political activism. The San Francisco-Bay area, Boston, Philadelphia, Baltimore and Washington in the United States, and Toronto in Canada are still major centres of ex-inmate organizing and protest. The struggle against psychiatry and forced treatment in North America is still very much alive.

Hope for the future

The San Francisco-Bay area encouraged me about the movement's future. Here are some of the organizing efforts that hold out hope — not only for the movement, but for all the people it seeks to liberate from psychiatric oppression.

The California Network of Mental Health Clients involves local and statewide organizing. It was founded in 1983. The Network struck me as being extremely well-organized; a powerful and influential voice for psychiatric inmates and ex-inmates. But it has been a target of criticisms from other ex-inmates who feel that this type of group not only fails to challenge but actually legitimizes the "mental health" system. Its critics

The struggle... in North America is still very much alive.



charge that whatever its good intentions, the resulting reforms will be cosmetic at best. They are also upset with the name of the group, claiming that the term "clients" promotes the myth of the voluntary mental patient. Perhaps most importantly, they are outraged that the Network is accepting "mental health" funds — specifically from California's Community Support System Project.

These criticisms are taken seriously by many in the Network, but they do not believe they are compromising their professed radical goals. In order to attract a broad constituency, the founders intentionally decided to tone down their rhetoric and organize an ideologically diverse group that includes radicals. Although they acknowledge the risks involved in accepting government money, they believe these risks are justified if they allow greater support for the rights and needs of the psychiatricized. As Jay

Mahler states, "When you think of the thousands of people still suffering, you can't just talk about abolishing [the system]. You have to use every strategy you can to change it."

One example of the Network's efforts is its legislative lobbying. It has succeeded in ensuring that the Community Support Services for the homeless (roughly 50% of whom have had contact with the psychiatric system) must be provided on a voluntary basis. In Bill AB 2541, for example, the Network secured a commitment from the state to allocate \$20 million to fund innovative programs that meet client-defined needs. These programs are supposed to be organized on self-help principles. They include centres for independent living (e.g., financial benefits, advocacy, housing resource centres, life-skills training), drop-in centres and client-controlled houses.

The Network is currently organizing to block the passage of various state, senate and assembly bills that would increase the power of psychiatrists to impose involuntary committal and forced treatment. Psychiatrists, conservative groups and fear-mongering politicians are seeking to erode the few hard-won civil rights that at least offer some protection to those who know of, or are strong enough to fight for, their rights. These regressive bills would enable California psychiatrists to enforce involuntary committal on the flimsy basis of one's psychiatric history or "substantial deterioration." Other California bills would strengthen the bonds between psychiatry and the prison system. For example, a "client" convicted of a misdemeanour would be forced to undergo outpatient treatment.² (See "involuntary outpatient" proposal in Canada's Uniform Mental Health Draft Act, in this issue.)

If passed, these bills would represent a serious setback in the movement's struggle for civil liberties and human rights. They must be fought and defeated, in California and in all other states and provinces where similar bills or laws exist, with whatever resources the movement can mobilize. The Network's tactics — such as political lobbying, letter-writing campaigns and ex-inmate testimonials and conferences — are

NATIONAL ALLIANCE OF MENTAL PATIENTS:

Draft statement of purposes

1. To further the development of user-controlled alternatives to the mental health system, including self-help groups of all categories, and to link these groups at the national level.
2. To improve the quality of life for current and former "mental patients" by addressing housing, employment, public benefits, education, and all other real-life needs.
3. To challenge negative attitudes toward people labeled "mentally ill."
4. To speak out on our own behalf, and to seek representation on all forums that affect our lives.
5. To promote and ensure the rights of people in and out of psychiatric treatment situations, with special attention to the absolute right to refuse psychiatric treatment, and to exercise freedom of choice.
6. To represent "mental patients" of all classes and races.
7. To be an open and democratic organization respecting the diversity of our constituency.



criticized by some activists for their reformist orientation. But such criticism is useful only if it is backed up with action. In the meantime, the Network should be recognized and supported for its efforts to win crucial reforms.

California's Coalition for Alternatives in Mental Health was formed in February 1984. One of its stated goals is a commitment to "the establishment of genuine alternatives to the present mental health system, where people in distress can go to find real help." In 1985, the Coalition opened a client-run drop-in centre in Berkeley, its first project.³ Sally Zinman, a key activist in the Coalition, is concerned about the current lack of this type of support work. She agrees that a lot has been done through direct action, but "so little has been done in terms of the alternatives... really not much has been accomplished or even attempted." She and other Coalition members are committed to changing this, since "alternatives are the manifestation of the political ends of the movement."

Coalition members are concerned, but not deeply worried, about the movement crisis. They are confident about their political position. In their support groups, they make direct connections between personal problems and issues of economic disparity and political domination, and use these connections to show the importance of solidarity and resistance. The Coalition is united in its opposition to forced treatment, including electroshock. It also plans to tackle local issues such as the

warehousing of ex-inmates in repressive board-and-care homes, and to become involved in the local mental health advisory board. It is confronting the usual government tokenism in, and professionalization of, community support services.

There are other examples that show that the movement has not ground to a halt. For example, the Alameda Network of Mental Health Clients, a chapter of the California Network, is deeply involved with community support projects for the homeless.⁴ New local chapters are emerging as a result of the Network's organizing activities. Thus the movement in California is growing by attracting a broad constituency, and is deepening its roots in the community.

One glaring note of concern is the seeming disappearance of radical street-level action in California. Among the people and groups I spoke with, there was little talk about public protest demonstrations as a necessary tactic to complement the more formal organizational work. This is probably a temporary lapse due to the splits in the movement. If it is not temporary, the California movement will have lost touch with an important part of its radical tradition, and will not differ significantly from consumer groups that have renounced militant action as being bad for their image.

This problem is compounded by the low morale, tensions and shrinking membership in some of the more radical groups in California. For example, members of NAPA (Network Against Psychiatric

NAP Statement of Unity

We are a gathering of people who have been active for many years within the psychiatric inmates' liberation movement. We are participating in this conference (Washington, DC, May 9-13, 1986) to ensure the survival of an autonomous antipsychiatry movement.

We oppose the acceptance of "mental health" monies to fund our movement groups. The National Institute of Mental Health intends to destroy our liberation movement. The recent intrusion of Community Support Program funding is a clear example of this calculated effort to disrupt and divide us. This funding has created a new psychiatric reform movement, which is distinct from our abolitionist movement. The psychiatric inmates' liberation movement does not recognize the political legitimacy of any self-proclaimed movement group that receives funding or compensation from the "mental health" system.

We believe that psychiatry cannot be reformed, but must be abolished. Psychiatry is an inherently oppressive system, and efforts toward reform only serve to strengthen that system. We call for radical social change in all aspects of our society. We are dedicated to working with other liberation movements in this effort.

Our immediate goal for this next year is to create a multi-media presentation about the anti-psychiatry movement for local organizing, community education and building coalitions with other liberation movements. Other goals for the future are to develop personal and collective economic alternatives; to work on community education; to further the political analysis of "voluntary" psychiatry; to address issues of language; to develop working models on group process, meetings and interaction; and to work on ways to offer each other support and maintain communication throughout the year.

As mad people, we are united in this struggle!

Unanimously adopted at the First NAP Gathering, Washington, DC May 13, 1986

Assault) are not meeting at this time. The Coalition to Stop Electroshock in Berkeley is also somewhat inactive, except for its crucial court case. (For an update, see Jenny Miller's "Measure T Goes to Court" in *MNN*, spring 1986.) *Madness Network News* is still intensely committed to being the radical voice of the movement. However, as of spring 1986, its editorial collective had only two ex-inmate members (see p. 38).

It's uncertain what these discouraging developments hold for the movement's future. For now, they are a cause for alarm. The movement cannot afford the loss of radical groups like NAPA, the Coalition to Stop Electroshock, and the people who put out *Madness Network News*. For many years, they have been a constant source of strength, support and networking for the movement, mainly because they have effectively channeled people's anger and energies into struggles against the psychiatric system and for humane alternatives. They have also provided invaluable information about numerous psychiatric atrocities masquerading as "treatment," as well as news about ex-inmate alternatives and victories. Without their radical perspective, it is likely that many of us in the movement would lack the political analysis that links psychiatric oppression with the broad political and economic oppression in our society.

I feel that at this time it would be presumptuous to say that the movement has betrayed its radical origins, or that it no longer poses a significant threat to the psychiatric system. Most of the people with whom I spoke in California are still deeply committed to the movement, and are showing that there are many ways in which people can contribute to and strengthen it. Their spirit and integrity give reason to believe that the movement will not be easily undermined by conservative forces. I also believe that most movement people will not betray their personal and political values, and will not condone their dehumanizing experiences in the psychiatric system. Jay Mahler summed it up when he told me, "I'm not going to be co-opted. I'm not going to forget what psychiatry did to me."

Notes

- 1 See Sue Doell's critique, "A Second Look" in *Madness Network News*, spring 1986.
- 2 See Sally Zinman, "Sabotaged But Not Stopped" in *Madness Network News*, Summer 1985.
- 3 California State bills: SB 1704 by Bergeson on mandatory outpatient treatment for defendants charged with a misdemeanor; SB 1708 by Russell, which would require a study of the expansion of the definition of

"grave disability"; AB 3337 by Hayden, which expands the use of involuntary treatment; AB 3338, also by Hayden, which requires mandatory outpatient treatment for clients convicted of misdemeanors; and AB 3765 by Wright, which requires past psychiatric history to be considered in certification hearings.

4 See Howie the Harp's outstanding article "On Homelessness: A Position Paper" in *Madness Network News*, summer 1985. Summer 1985.

National Mental Health Consumers' Association (NMHCA)

Preliminary goals:

To further the development of local mental health consumer-controlled alternatives, and link these groups together through a national clearinghouse and network. These alternatives can include, but are not limited to, self-help peer-support groups, drop-in centres, independent housing, cooperatively-run businesses, rights and advocacy, and holistic healing. What they all share is that they are structured and defined by the needs of the people creating and using the services, promoting empowerment, self-esteem, independence and self-determination over our lives.

To improve the quality of life for mental health clients by addressing housing and employment needs and ending discrimination in these areas. To address the needs of homeless and poor people, assuring that all persons have a liveable income. To advocate for increased public benefits without fear of arbitrarily being cut off benefits.

To become recognized as a viable and representative national voice of, by and for people labeled mentally ill. To make sure we have representation on all mental health boards, national commissions, committees, and any body that affects mental health issues, assuring that all decisions regarding mental health have input by "mental patients." We hope this will enable the mental health system to become more responsive to our needs and be held more accountable to us.

There is a diversity of theories and views regarding the causes and the existence of "mental illness." We respect that all people are entitled to their own opinion on whether "mental illness" exists or does not exist. No theory should be imposed on other people in defining themselves, their lifestyles, treatment or civil rights. None of these theories should be accorded the level and weight of established fact. The medical model is only one such theory. Another theory is that people who are experiencing distress are responding to real economic, social, spiritual and cultural pressures in their lives, and that labeling their real life problems as a mental illness does nothing but invalidate their feelings and experience.

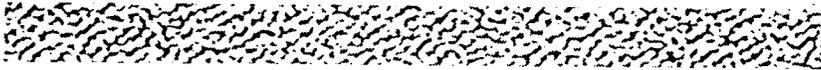
The stigmatizing attitude and lack of sensitivity of major segments of the media toward people who are currently and who have formerly been labeled "mental patients" is in large part responsible for the misunderstanding and consequent behaviour of the public toward this group of citizens. Our goal is to educate and influence the media as to the importance of a positive portrayal of, and understanding and sensitivity toward, current and former mental health clients and our issues and concerns.

National Mental Health Consumers' Association
311 South Juniper Street
Room 902
Philadelphia PA 19107



OUT OF THE ASHES

Phoenix Rising 11



When asked
where the nearest washroom was
the lady behind the desk
at the "mental hospital"
advised that I go to the far end
of the hall because
the washroom only a few steps away
was used by "The Patients."

Quietly and oh, SO politely
I asked if she felt that
having trouble coping with
some of the shit
life can dish out
was caught off a toilet seat.

She was perfectly flustered;
however, the sweetest aspect
of victory was in the knowledge that
she never realized
I was one of the
people
whom she so greatly
feared.

yvonne-marie

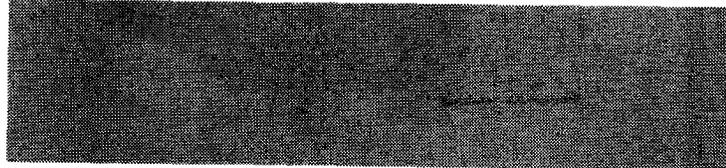
a clear solution

the inhalation of glass
the exhalation of stone

How small she looks
inside the hypodermic
her cylindrical scream
of open-mouthed silence
small bubbles of sound
behind the curve —

for children should be seen
not heard

laura ziegler
(for beth)



THE EGOISTIC INSANITY OF GOD

Lovely world!
Lovely newspaper!
Lovely genocide!
Lovely ice cream sandwich!

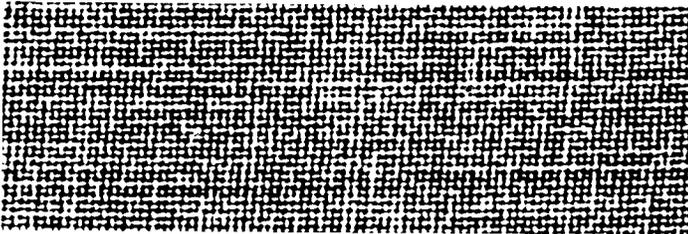
I feel radically secure knowing
His eye is on the sparring partner.

God loves to be worshipped.
I kiss God's ass all the time.
We live and die but God is immortal.
Why?

God is just another word for IBM.

Many psychiatric patients delusionally
Think they are God.
They think they could do a better job
And they are probably right.

Eric Gerstman



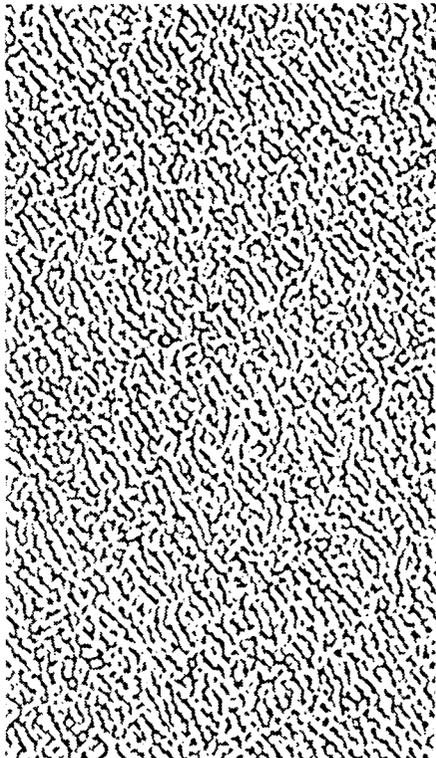
TERM-inal Illness

If you take away
my human credibility
what have you left
to me?

June Bassett

weve seen acute treatment wards
with their "refractory patients"
not yet broken in spirit
weve seen back wards
with their "chronic schizophrenics"
those who have been
victims of no disease
but treatment
by doctor double think demons
whose deeds betray their words
and so they mock their oath
weve seen these places
these pill palaces
these shock mills
these brainwashing factories
from inside we know their total rottenness
reforming them
nonsense
like putting axe to branch of dead tree
which must be struck at root

we must let out our madness
our anger
and demand that
these gracie squares
these pontiac states
these langley porters
these little auschwitzes be abolished
we dont go thru belsen extermination centre
and rebuke officials for
overcrowded gas chambers
we scream out our horror in face of
mass murder
then we FREE THE INMATES and
CLOSE DOWN THE PLACE
going thru belmont hills psychiatric centre
with shrink stink in our nostrils
we retch our disgust at spectacle of
mind murder
then we FREE THE INMATES and
CLOSE DOWN THE PLACE
throughout our land
in hundreds of these places
for hundreds of thousands we left behind
inquisition hasn't ended and 1984 has begun



we see them on wards
and in isolation
and in treatment rooms
we see them strapped onto beds and tables
writhing and convulsing
in their agony
we hear their pleas for mercy
their gasps
their screams
we feel their pain
their humiliation
their tears
rolling
down
our
cheeks

and our souls rebel within us
this barbarism must cease

Leonard Roy Frank

Reprinted with permission from *The History of Shock Treatment*,
(edited by Leonard Roy Frank, San Francisco, 1978). Also
published in Lenny Lapon's *Mass Murderers in White Coats:
Psychiatric Genocide in Nazi Germany and the United States*
(Psychiatric Genocide Research Institute, Springfield,
Massachusetts, 1986)

CRAZY AND PROUD

Well, they're always calling me crazy
And they're always putting me down
They always say they'll be my friend
But they never come around.
'Cause I'm not like normal people
I won't fit in their mold.
And for that crime
they either lock me up
or put me out in the cold.
'Cause I'm Crazeeeee, and I'm Proud!

Well I won't be a 9-5 robot
Well-oiled and made of chrome
I'll never have your ulcers
or your split-level home.
You tried so hard to change me
You bullied and you sneered
But I'll always remain just like I am
Loony, Crazy and Weird!
'Cause I'm Crazy ... And I'm Proud

Well, you say I'll always be locked up
Unless I stop being me
But I'm not like that so stay off my back
I just wanna be free
'Cause I'm telling all you people
Don't give me those funny looks
You think you're great but you're the
Kind I hate
American Psychiatry Crooks
'Cause I'm Crazy ... And I'm Proud
Howie the Harp

Reprinted with permission from Lenny
Lapon's *Mass Murderers in White Coats —
Psychiatric Genocide in Nazi Germany and
the United States of America* (Psychiatric
Genocide Research Institute, Springfield,
Massachusetts, 1986)

The Zoo Keeper

by Heather Duff

The older boy with the greasy overalls asked her to climb his castle.

To climb a castle would be romantic. She thought she'd become a princess.

He wanted to see how far she would go.

It was across the highway from the boarded-up junk shop with its giant red wagon wheels out front. Missing spokes grew into splintered brown grass. There was an overturned milkcan and a Singer sewing-machine treadle, both wedged into mud. Two automobile carcasses, their rusted seat-springs tangled with threads, blown into the ditch by the highway. And down into the ravine behind the shop.

He took her past the ten-pew stone church. Through the village with its porched orange brick houses. Where lived old Mrs. Crangston, who used to give him shortbread.

He took her through the field of thorns to the trail, bordered with shriveled brown fall raspberries dried to the stalks. The trail was a long mud cake, unwalked but for animal footprints. She didn't know this part of the woods, and the trail went not straight downhill, but criss-cross back and forth through the trees.

"Hey, that's it Katy," he said, rolling up his overall bottoms. "That's my castle, eh?"

"It really IS a castle."

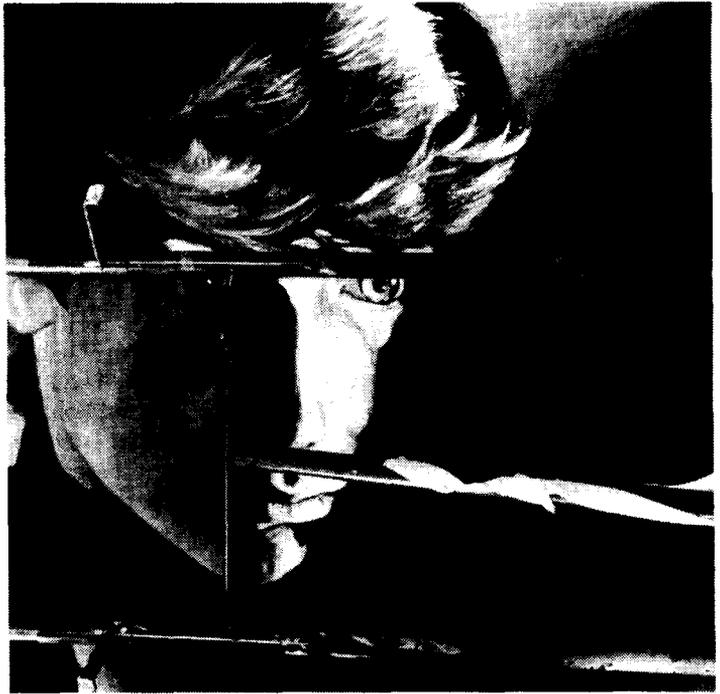
"Take my hand."

She took his hand, hard and cold. He pulled her over protruding tree roots toward the concrete tower. There was a thick iron cable sticking out of the side of the castle. He left her there in the roots and, using the cable, pulled himself up to a narrow ledge. Bits of gravel poured down on her head. All she could see was his leather cowboy boot swaying above her.

"They've been given their own rooms. I'd want my own room if I was one of them. I think of it as my freak collection of little sluts. (You hang around with street kids enough, you begin to talk like them.)"

"The rooms in the pod are little concrete cages with barred windows on the doors. The window inside each room has slats that open and shut with a crank, so they can look out on the government-landscaped front lawn. A shrub or two to look like natural surroundings. There's a washroom at the end of the hall with three cubicles, a shower and a fake unbreakable mirror the girls can't see themselves in anyway, so what's the point. Just a sheet of metal."

"I'm a Zoo Keeper at the Clovertown Holding Centre. Really, that's what it amounts to. They told me they wanted a healthy male model."



"I figure the creatures must be hand-picked. Terrible morning glories, exotic as all get out. Each represents some particular climate and locale. They were captured by zebra-striped jeeps in the dead of night, shot with a tranquillizer gun, then brought here for observation.

"I plan to screen the whole process on Wild Kingdom someday, with superb, award-winning photography. Close-ups of each of them, you know, at different phases of their capture. Delinquent juveniles running the streets (or perhaps, for emphasis, lying in the gutter). Handcuffed, bagged in the back of the striped truck, placed in their rooms, force-drugged (as needed), quietly brushing their hair, taking off make-up, undressing, sleeping in their rooms. Checked once an hour with a flashlight, but locked in for the night.

"Safe, though. Untouched here by the perils of the wild.

"I feel safe knowing they're safe."

He swung his free leg up to another foothold, wedging his pointed toe there. She looked up again and he was at the top of the castle, in a crouch, grinning down at her. "See Katy, anybody could do it. Even a chick."

"Not me."

"Sure you can."

"It's too high."

"Brought other chicks down here and THEY ain't been scared."

"Ain't scared," she said and grabbed the cable. The rusty grit from it stung her hands. She pulled on it, sweating, and then got her round-toed sneakers to the first ledge. When she got to the top she knew she'd be relieved. Or a princess. Or something.

But the castle was hollow in the middle. They had to perch on a ridge of concrete one foot across. He sat cross-legged, balancing himself and rocking.

"Welcome to my castle," he said.

"There ain't nothin' to hold on to."

"Hold on to me."

"Then we'll both fall."

"Nope," he said. "Just YOU will."

Frankly, I think each creature in the zoo ought to have an engraved wooden sign above her room. So visitors can identify them. They've been labeled already, so it

shouldn't be hard. Everybody reads their files: child care workers, social workers, students, psychologists, doctors. All the smut is packed into a filing cabinet in the main foyer. You just borrow a file, like a library book, for the latest update.

"It's better than working at a Red Hot Video store. If you're into that sort of thing. Ideally, I don't want to be, but there's not much choice with this job.

"I noticed the cabinet on my first day when they fingerprinted me. God knows why they did. A security measure, I guess. A secretary-looking woman took some black gummed ink and rolled it on my fingers with a rubber roller. She pressed each of my fingers on a different marked square of the page. Everything oozed black. Dotted circles inside circles, like sound waves shooting out from the centre.

"I thought I would never get away.

"I still wonder sometimes. Washing the ink off my hands was a hell of an ordeal."

She sat facing him on the tall concrete ridge, her denim legs dangling over each side. She clutched the concrete in front of her with red-cold fingers. They were among treetops with yellowed, crumbling maple leaves. A fat crow perched on the iron bar of a telephone pole, visible through the trees. It screeched. Katy jumped, almost losing what balance she had.

"Katy, which way'd you ruther fall," said the boy.

"Neither."

"But if you knew for fucksure you were goin' to fall anyhow."

"I am getting cynical.

"I figure these are the signs I would need to engrave for display in the pod:

"'Chest Slit by Father' over Room One. Jane from Northern Ontario who can't read and has a purple earthworm scar on her chest. Looks like heart surgery.

"'Ears Boxed by Pimp' over Room Two. Georgie, blonde and mostly deaf but she lip-reads a bit. Is she bothers to look at you. She doesn't look at me much. I don't blame her, you know.

"'Hairdryer Shoved up Twat by Mother' over Room Three. Mara, black-haired, the little witchy one. With an orange streak in her hair. Who says she's seen The Rocky Horror Picture Show ninety-nine times, and spends whole days in front of the mirror. God knows who for.

"'Gang-raped by Seventeen Bikers' over Room Four is my favourite. I mean the girl, not what happened to her. Little Katy. She was thirteen when it happened, about a year ago. Though she's not really little. I notice this one day when I catch her after her shower, thick dripping thighs beneath a towel, ribboned with cellulite. She looks about twenty-five. Even matronly. But she has a sweet, ethereal smile.

"Come to think of it, they all look twenty-five.

"I've been a child care worker for only six months now, so I'm still supposed to be idealistic. I don't think I am, really. No one is when it comes right down to it. But in the interview when they asked me how I'd, you know, counsel a pregnant thirteen-year-old, I told them what I figured they wanted to hear.

"Well, for one thing, I'd listen to her," I said. Only I wasn't concentrating on the interview, but on this rope wall-hanging in the office, of two dancers doing leaps.

"I remember the tour guide telling me in a hush that it's maximum security. He told me these are the toughest kids in the province, trying not to point directly AT the toughest kids in the province. Some of the boys yelled things at us, but mostly they were docile, half-drugged, herded through thick black doors that were opened from the main control booth with its computerized lock system.

"When I first saw them, the sliding doors reminded me of Get Smart. It seemed like a comedy show.

"You know, I couldn't take it seriously."

On her left, she could see a stagnant pond far below the castle turret, thick with algae and sewage, an overturned shopping cart sprouting dirty grass bits from its kiddie-seat. And a barbed wire fence running the length of the pond, tangled in the centre.

"When I think about Katy, I, you know, wonder how they knew it was seventeen. It seems crazy to be so accurate. Why not eighteen? Sixteen? What difference would it make to anyone — one biker more or less?"

"It occurs to me that Katy herself would have been counting. Maybe for something to do. I don't know. Maybe numbers matter when you're weighing pain. I can't help seeing it à la Sesame Street. A Muppet appears in a green scraggly coat and bulging eyes. The Muppet growls: "Seventeen Bikers!" All the bikers drive up to the green Muppet and smash into him. A number seventeen appears on the screen. All the children in the studio audience laugh.

"Except Katy.
"She guffaws."

"I'm gonna push you into my castle," he said. "Nobody's ever gonna find your body, Katy. People too fuckin' stupid to think of lookin' down there, eh?"

On her right, the hollow in the centre of the castle plummeted like a deep well. It was dark at the bottom, filled with gravel, broken concrete bits, wire cables and collapsed wooden rafters. You'd crack your head on it all.

"The files never lie. I wish to hell they did. I am half-disgusted with my own fascination for these truths typed on government letterhead.

"Though if this were half a fantasy, and I were half a hero, I'd like to think of myself as the good Zoo Keeper. The one who cleans up the debris left by the other seventeen. I'd give her a hot bubble bath. Oh, I don't know. Something. I only know that I need Katy to trust me. It's become a damned obsession, this wanting to know her, know her pain."

She wished everybody would think to look down there. She wished they'd get their helicopters out. Don't give up, she thought.

Look down. Down into the hollow castle.

She noticed some strands of fibreglass insulation, far below. It could easily be her own dead hair, sticking out of the rubble.

"There I am sitting in the pod office, smoking, doing the log. The other staff is out for a moment. I never know what to say.

Katy is very quiet this morning. She hardly speaks to anyone, even Jane, and she usually likes Jane. Georgie asked her to play pool. She just said "leave me alone" and is spending the morning looking at Mara's *Vogue* magazine....

"Mara is standing in the office doorway, twirling her orange-streaked hair, one hand slipped into her blue sweat-pants. 'I want a cigarette,' she says.

"'You know the rules,' I say.

"'I want to hear my Rush album.'

"'Just a minute, Mara.'

"'Now . . . Hey Lance, please!'

"So I close the log and pull her album out of the storage cupboard. She's the only one who seems to own anything. I put on the stereo in the sitting room. Katy just sits there cross-legged in jeans in her corner chair. When the music blasts, she begins to cry. She stands on the chair and rips the cover off the magazine.

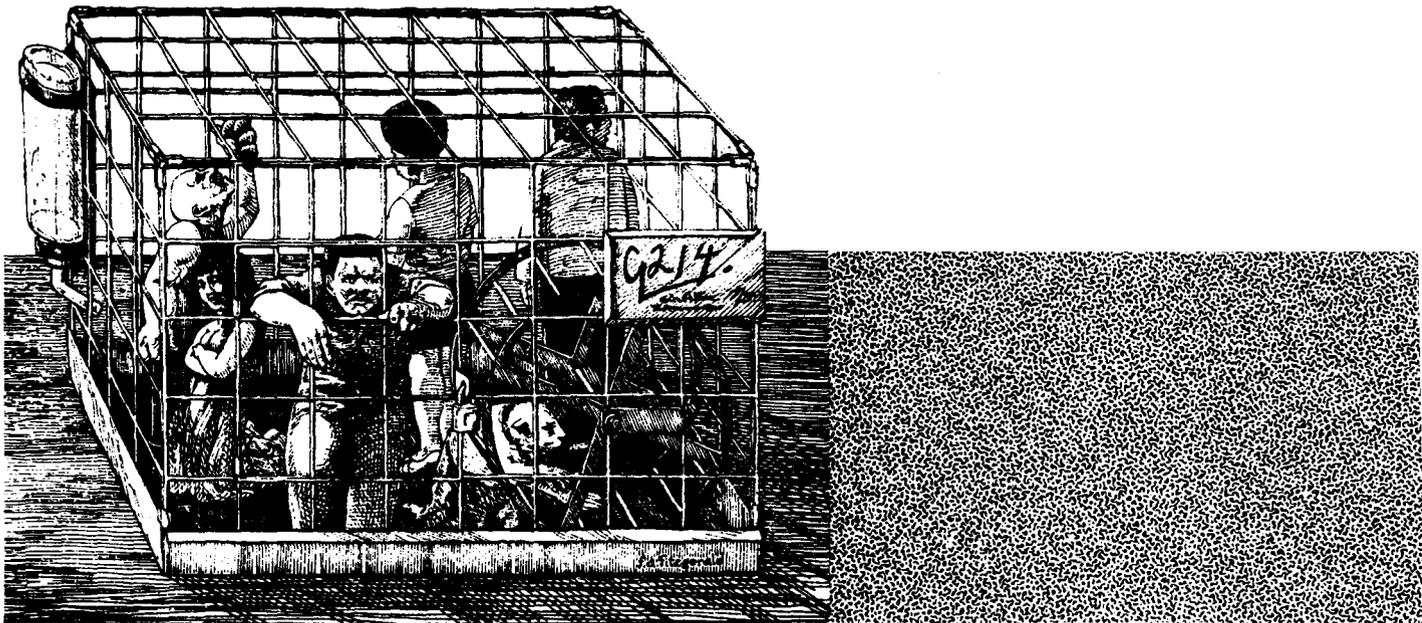
"'Hey Lance, that's my fuc-' says Mara, then looks back at me, cringing. I pretend I didn't hear. If they swear, they lose privileges. I'm so fascinated by what Katy is doing, I don't stop her.

"Katy is beginning to rip every page out, one by one. She watches them, flutter like leaves to the carpet. Georgie runs over to collect the pages, ripping each one until it seems the made-up heads are all separated from the bodies. She drops them onto the pool table. The billiard balls scatter, rolling over the magazine faces.

"'Hey Lance. Did you see that?' screeches Mara. 'Did you see what they did to my magazine?'

"Katy steps down off the chair.

"'May I please go to my room,' she says. Funny, she doesn't want to be told. So I note it down official.



...There was a little incident in the pod this morning. I'll discuss it with the afternoon shift, and I suppose after supper we shouldn't give them their allotted chips and pop. Jane refused to participate in the incident but sat at the kitchen table, working on her paint-by-numbers Siamese cat. She's a well-behaved kid..."

And when the castle was gone, she forgot about the dead insulation hair. In sneakers, the princess descended. His grimy fingernails pierced her palm as he held it.

She walked with him around the stagnant moat at the bottom, with its barbed wire shopping-cart island. And the crows and things, perching on branches. There had always been crows in the woods, but she had never really noticed them before.

He took her down into the woods to the bonfire of a campsite, blazing between the black trunks of trees. And it was growing black. It would be hourless, this night, though she didn't know it yet.

She didn't want to know anything.

"Hope you brought some marshmallows, Katy," he said.

"Hate marshmallows."

"Even the coloured ones? They come in yellow, green, pink, eh?" he said and pulled a large, two-pronged twig from the mud. He held it to the sky like a pitchfork.

"Ain't you seen coloured marshmallows before?"

"No."

"Toast us one, eh?" he said. "I like mine burnt all to hell. How you like yours?"

"Ain't that hungry."

She heard the sound of motors croaking, beyond the trees.

"For the life of me I can't figure out why I put things like that in the log. It's what they want to hear, I guess. It's a million-seller game called Behaviour Modification. For ages twelve and up. Try to collect as many plastic treats as possible.

"Earn a plastic chips and pop by landing on the paint-by-numbers square.

"Forfeit a plastic chips and pop by landing on the tearing-out-magazine-faces square.

"If you win, they'll let you go to a foster home so you can start collecting offence cards again.

"Everything I touch leaves black fingerprints.... My pen and log book, the buttons on the intercom, all the keys, buttons, and lights that unlock the double and triple doors. And the next set of sliding doors, and the next. The staff washroom door. My zipper.

"My fingers are still gummed up with rolled ink, and Katy's are white and pudgy.

"I'm not the good Zoo Keeper.

"I'm the eighteenth biker."

ANTHONY

Anthony, eight years old,
in the Ontario Hospital, classified
RETARDED, there is torture going on
in this country, in Ontario.

They dragged you like a broken flower
along the floor to the shower,
the water stung your eyes, strangled
your throat, in the Ontario Hospital,
there is no air, fire in the wall
the belly, the pinched ears,
the ripped souls, souls with
their tongues pulled out;
how is your soul these days,
Anthony, now you are a man,
and you will never know a woman,

yet, you can embrace, as you
did your little sister, picked
out her eyes, brown, like yours,
full of ponies and tents and
wild grasses and medicine men;

what medicine men heal you
these days, Anthony; in what way
did they train you not to eat your shit,
you gave it to others like a gift,
because you liked to give...

how is your soul these days,
Anthony? There are no letters
for your freedom written to
the United Nations... yet you are
missing, in Chile, in the Gulag,
in a prison, not in Turkey, in
Ontario... DID YOU EVER SEE THEM LOVED?

How dare I,
you are not for poetry, little martyr,
they will not believe me,
you and I we are the same,
strange, and slow,

I think an earthquake
released me from my prison;
if it is not you, Anthony,
another, in prison,
tortured, as they say,
right here, in Ontario.

Donna Lennick

"What I'm in for," you ask.

"Well, I had this lover, James was his
name, I got mad at him one day, and so
one Sunday dinner, I fed him my mother,
together with some pan fried potatoes.
He died, of food poisoning, the coroner
said; I was charged, tried, convicted
of murder in the second degree.

That
answer your question?"

Josephine Toews

LONGING FOR RELEASE

Can I not be myself to scan the air and sky? Can I
not be myself to look beyond mortality? Must I be
kept inside a cage made by others' thoughts and
desires? Must I forever long to be released so I
can reach my expanding hopes and aspirations? Can
I not be myself, regardless of my fate?

Doreen Buss

we are lonely fish
at sea
swimming upstream,
cadging for quarters
or an occasional cigarette

we stare empty eyed
at four walls all day
meandering through lonely halls
as the pleasures of others
slip us by

Karl Wendt

HOSPITAL VIEW

The lights of the city shimmer
like the sequins on a movie star's dress
Traffic flows smoothly
A child cries, her lusty anger unappeased
Across my window are imaginary bars
Most of us are silent,
lost in ourselves,
locked into our passive indifference
because we know no other way to be — for now.
Who knows what tomorrow will bring
with the light of the sun?

Sharon Alary

SYMPTOMS

I struggle to walk straight and agile, without stumbling.
I feel so bad, I cannot smile.
I stutter and stumble over my words when I speak — but who cares
to talk anyways?
I haven't any interest in anything.
I do not have any energy for one thing now.
My throat is so dry and parched, I can hardly speak — but what do
I have to say?
I am cold and frustrated, says my husband —
I just lie on my bed and sleep to pass the time away. I am so
bored with life now.
I feel so down, I just cry and cry the whole day through.
Nobody cares — nobody loves me anymore.
I always fight and argue with my husband and children now, it seems.
It is true that my *doctor is always changing and trying to regulate my
medications*. He does *increase the dosage quite often* you know.
My nerves are so bad, I am agitated over senseless things.
My hands shake so, I cannot write any letters, or do any of my hobbies
anymore.
My heart beats and throbs so fast and hard, it scares me.
My eyesight now is so bad, I have to get even stronger glasses.
My stomach is swollen and bloated, and my weight has soared to 204 lbs.
I can hardly walk with this weight, as my back is breaking.
Print is blurred and so is the TV.
The group therapy meetings seem so senseless and are so boring.
I cannot work anymore, I cannot keep a job.
My life is meaningless now, with nothing left to do — just sleep and
pass the hours away and take an unending supply of medications.
Just because I had a severe nervous breakdown, I have to remain
incapacitated!
I am a wasted so-called human being!

Who Am I?

An Ex-Psychiatric Patient!!

Linda Nixon

The State of Being Unhappy



Howard Blatt (photo), Mental Health Law Project (Washington, D.C.), brochure, 1977

I grew up with mental illness or, if you like, the state of being unhappy.

My nightmare came true out in Vancouver, when I was about 24 years old. I went seeking employment in 1977-78 and, finding none, I ended up on Vancouver's streets, with \$190 a month from Welfare to look forward to. I wasn't taking any drugs at the time, either legal or illegal, but I became very self-conscious, and I would drag my leg when walking.

Late one night, as I was walking by myself to my cheap boarding house, I passed a cop on Grenville Street who walked like I did. God, I thought, I hope it's not catching!!

That night, as was my habit, I opened the window for air. I was surprised to see about a half a dozen police cars outside. Not suspecting anything, I went to sleep. Upon waking the next morning, I thought something was wrong with me. My heart was beating so fast I figured it would burst. I could not connect it with the police from the night before, but I was scared almost to the point of "paranoia."

Some weeks later, I went to the Burrard Hospital to have my heart checked. The doctor who examined me said I was okay. Next night, I went back to the same hospital and was denied entrance by the head nurse, who told me to leave or she'd get the police!! No exaggeration.

Then I told myself I'd go to the media. Surely they would help. You must consider, I was getting desperate because of the damage being done to my heart. First I went to a radio station. I asked to come in, but was refused.

Then I went to the *Vancouver Province* and *Sun* newspapers. It was night-time. I was amiable enough, and called upstairs for a reporter to see me. A young-looking fellow appeared after a while, and asked me if I had a story for him. I told him that I thought the city police were trying to kill me, and that I was very frightened. I asked if he would help me.

He appeared reluctant to believe me, saying he needed proof. After a few more minutes of his precious time, he left me. I was alone, but I refused to leave the premises, thinking I was safe. After all, this is Canada, and aren't we all free?

Someone asked me to leave. I went outside and lingered. Then they threatened to call the police if I didn't leave (I might get the ground dirty). The police came and I left, disgusted.

I had no choice but to go to that great land of liberty south of us, and hope to escape there. I had enough money for bus-fare to San Francisco.

I never knew much about the US, other than that it was a free country. All the way down, my heart was pumping at an alarming rate. When I checked into a cheap hotel by the bus-stop, my heart was still beating erratically. I awoke that night in a sweat and, looking outside my window, I saw a sight that scared the hell out of me. Two policemen stood out there. I got my clothes on and ran out to the freeway and began hitch-hiking. Where? Anywhere!

The following months were spent eating and sleeping anywhere, and going — just going. All over the US and Canada.

Then the pain and voices began. The voices of women and small children saying "get him," "get him," or "stick him." Immediately, I began feeling excruciating pain all over me, as if someone was punching me with all their strength.

Finally, one night in Oregon, I said, "enough is enough." Ordinarily I am a very quiet, even docile person, but I was at my breaking point. I broke into a sporting goods store and armed myself with a rifle, hand

guns, and a packsack full of ammunition. I fired at a few cars and, before I knew it, I was surrounded by cops.

I gave myself up to the police, and was in the foul-smelling and dirty Cane County Jail for three months. Then I was sentenced to the Oregon State Hospital for 20 years. I wrote to Trudeau, Tip O'Neil, Pierre Berton, just about every goddam "reporter" at the CBC, newspapers and the government for help in my fight for justice.

I wrote to a friend to get external affairs on my case. One day the consul from Washington came down to see me, asked a lot of questions, and left. Then I got a knife from the kitchen, and when I had the chance at mealtime, I rushed past the orderlies, who shouted to alert security.

I jumped into the elevator and started pushing buttons. Eventually the damn thing got going. But it was too late. The security guard caught me on camera and closed the electronic doors. The social worker contacted the Immigration authorities and, in a few more months, I was deported from the United States.

"They," (and I can't say who "they" are because I don't know) have the technology today to make anyone go "insane," as I learned the hard way.

The voices are still here as I write this, seven years later. I take Stelazine and Ascenden, and visit the hospital at St. Johns every month. At present I am tilling the soil in Newfoundland and watching my vegetables grow. I try to forget what happened to me because I don't think people care. I have mellowed out a lot and thank God for being alive today.

George Vokey

OAK RIDGE:

Before and After the Hucker Report

by Bonnie Burstow

What is Oak Ridge? Officially, it is a hospital dedicated to helping the "criminally insane." But inmates who have been experimented on, cuffed and beaten, know better. As they know only too well, Oak Ridge is the most barbaric prison in Canada. It is a place where torture masquerades as "therapy." It is also a place of continuing public controversy. Again and again, the press has criticized what has gone on inside. Initially, the Ontario government responded by abandoning some of its most notorious programs. This was not good enough. The complaints continued.

In February of 1984, Ontario's Minister of Health (then Keith Norton) took a further step. He set up a committee to investigate Oak Ridge; it was headed by Dr. Stephen Hucker, a psychiatrist at Toronto's Clarke Institute of Psychiatry. In the fall of 1985, Hucker presented his report, complete with 89 recommendations, to the Ministry of Health. It is titled "Oak Ridge: A Review and Alternative." That report is the primary focus of this article.

My objectives are to familiarize readers with Oak Ridge's history and what is currently happening there, and to discuss the Report's major findings, recommendations, strengths, and weaknesses, as well as the significance of Oak Ridge to the Psychiatric Inmates' Liberation Movement.



The Hucker Report

The History

Opened in 1933, Oak Ridge was established as a maximum-security division of Penetanguishene Mental Health Centre (Penetang). Despite the rhetoric, Oak Ridge was meant to be a dumping ground for anyone the government did not want around and did not know what to do with. Specifically, Oak Ridge was to "house" people alleged to have committed a criminal offence and deemed unfit to stand trial; people charged with a criminal offence and found not guilty by reason of insanity; and "patients" whom other psychiatric institutions considered too violent, and wanted to get rid of.

The first two groups constitute the vast majority of "Ridgers," and they are sent to Oak Ridge under a Warrant of the Lieutenant Governor (WLG). This means that they are incarcerated indefinitely with no real avenue, or right of appeal.

What was established was a *long-term warehouse of bodies*. It was an uncomfortable warehouse, with toilets in the middle of the cells, and often without running water! Clearly, this was bad. But it got worse. The worst feature of Oak Ridge was introduced in the late 1960s and embellished upon in the early 1970s. It was called "therapy." Specifically, the "Social Therapy Program" (STP).

The STP was based on two premises: that "mental illness" derives from faulty communication, and that the "patient" can be "cured" by correcting faulty communication. Theoretically, this is far more palatable than the "chemical imbalance" theory. Unfortunately, the methods used to "correct faulty communication" were bizarre, to say the least. One was the use of highly experimental and dangerous drugs to break down "communication barriers." The agony caused by these drugs is described by ex-prisoner Roger Caron in *Go-Boy!* (McGraw-Hill Ryerson, 1978). Still more devastating was the use of the "capsule." An inmate was locked up with his therapist in a tiny room, or capsule, for 24 hours or longer. During this time, he was subjected to endless confrontation, which the staff called "encounter." Ironically, the capsule brought world-wide acclaim to Oak Ridge. Psychiatrists and "humanistic" psychologists alike praised the effort at "encounter." Oak Ridge was called "Buber Behind Bars."

The most insidious feature of the program was the development of the position of "patient-teacher," a special job awarded to inmates judged to be well. These people were

supposed to assist other inmates in their attempts to develop good communication skills. In fact, they presided over therapy. They virtually prescribed drugs for their fellow inmates, with medical staff rubber-stamping their suggestions.

They scored psychological tests. They maintained security. They watched over inmates, reporting infractions at every conceivable opportunity. In other words, these "patient-teachers" were lay assistants and professional stoolies. As a result, *inmate was pitted against inmate and solidarity was shattered.*

One particularly infamous program, which was part of STP and over which patient-teachers presided, was called MAP (Motivation, Attitude and Perception). Inmates unfortunate enough to be dumped into this program were forced to sit for hours on end without speaking or moving a muscle. If a patient-teacher caught you doing either, it could result in three more weeks of MAP.

In the 1970s, the public began to suspect that Oak Ridge's "communication therapy" was something less than Buberian dialogue. Highly critical articles began appearing in the press. The result was the formal abolition of the Social Therapy Program. No longer the darlings of the psychiatric community, the capsule and MAP were scrapped.

Oak Ridge Today

In Oak Ridge today, behaviour modification is the primary "therapeutic modality." The STP is gone, but vestiges of it clearly remain. The patient-teachers are still there in full force. Experimental drugs are still used. On some wards, the inmates are still forbidden to speak to anyone except the staff and patient-teachers — a silence rule left over from MAP.

Barbaric and meaningless punishment is still the norm. Inmates may spend up to five consecutive days in solitary lock-up. An inmate who is "acting out" may find himself chained or cuffed to a "good inmate" — to the chagrin of both.

The accommodations are still dingy, uncomfortable, unhealthy and undignified.

The toilet is there, as you can see, in full view of everyone. In some cells, it is the only source of running water — it's nicknamed "The Fountain of Youth." The only other piece of furniture in the cell is a concrete slab intended as a bed. There is no fresh air, almost no recreation, and almost no dental care.

The only promising development in the last few years has been the formation (by inmates, not by staff) of a self-help and advocacy group called HARD (Humane Awareness with Respect and Dignity — see HARD's Charter in this issue).

The Hucker Report

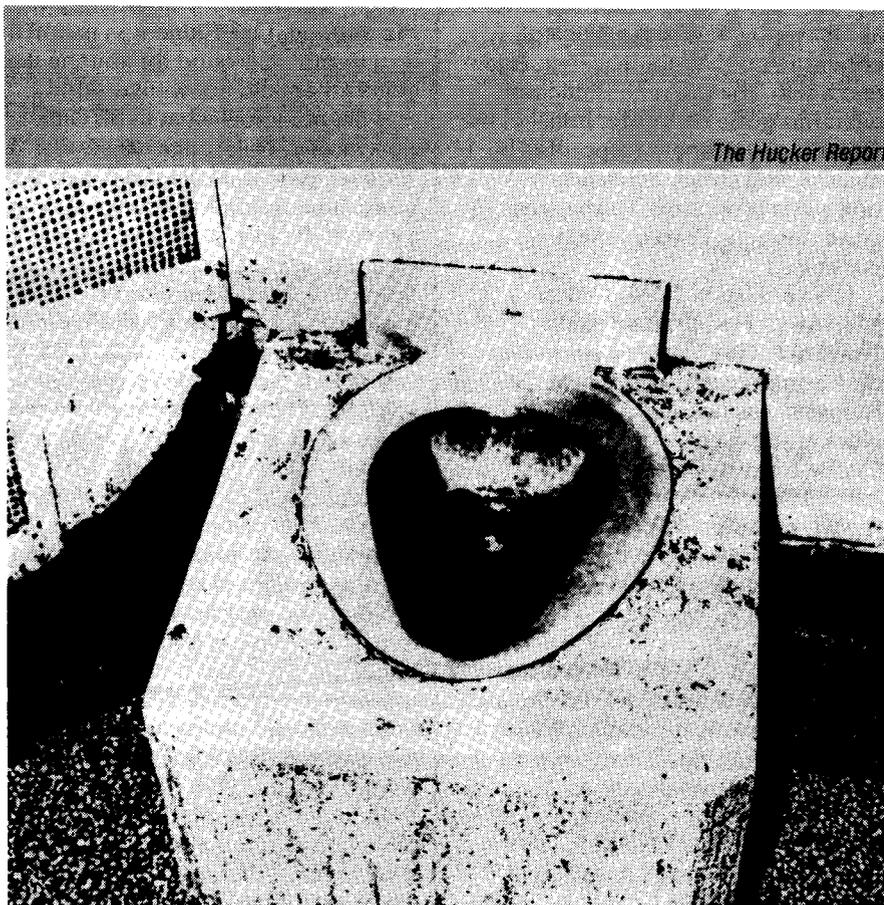
So what did the Hucker Report recommend that might improve the situation?

Alas, Hucker is no messiah, and the children of Oak Ridge are not about to be delivered to the promised land. Nevertheless, the Committee did see through some of the atrocities, and did come up with some valuable recommendations.

The Report is at its best when dealing with issues such as health, privacy and comfort. The Committee strongly objects to the lack of running water, the use of toilets for water facilities, the dinginess of the building, the lack of fresh air, the lack of recreation, the concrete beds and the dearth of proper dental and medical care. It recommends immediate action in these areas.

However, the Committee is at its worst when it comes to "treatment" issues. Hucker virtually raves about the high quality of the behaviour-modification techniques used. The only significant recommendations in the "treatment" section of the Report are to discontinue the use of silence, not to allow patient-teachers to suggest medication, and to give patient-teachers more instruction and supervision. There is no acknowledgement of the divisive role patient-teachers play.

There are a number of other recommendations concerning administration. The most far-reaching of these is to demolish the present building and erect two new buildings — one at Penetanguishene



The worst feature of Oak Ridge was introduced in the late 1960s.... It was called "therapy."

and one near a large urban centre. This would mean better living conditions, and the possibility of hiring some new staff not schooled in the old methods, to replace some of the "old guard" staff.

There are exciting recommendations regarding inmates' rights. The strongest is that "patients deemed competent" should be able to refuse treatment. The Committee acknowledges that inmates are generally not asked to consent, and recommends that they be asked, and that their refusal be accepted. This is a breakthrough. Unfortunately, however, the Committee questions neither the concept of competence nor the capacity of inmates to say "no" in an inherently coercive institution.

The Committee also expresses concern over "patient abuse," stating that "Physical mistreatment of patients can occur all too easily in closed mental institutions." (p. 99) Unfortunately, the Report never really states that such abuses have occurred at Oak Ridge — only that inmates have reported that they occur. Even more unfortunately, the recommendations dealing with mistreatment are quite weak, e.g., "that the Administrator of Penetanguishene Mental Health Centre continue to formally investigate complaints of abuse against patients and press legal action if necessary." (p. 100) All this does is recommend the status quo! A slightly more helpful recommendation is that a special psychiatric patient advocate be established for the Ridge.

Recommendation 80 is a promising one: "that staff members found to conceal abuses by colleagues against patients be

AN INMATE'S VIEW

Oak Ridge and the Hucker Report

by Denis McCullough

Denis is a psychiatric inmate who was incarcerated in Oak Ridge for about three years; a few months ago, he was transferred to North Bay Psychiatric Hospital. Denis is also the founder of HARD (Humane Awareness With Respect and Dignity — see HARD's Charter in this issue), an inmates' rights advocacy group with chapters in Oak Ridge and North Bay. With Denis' permission, we are pleased to publish these excerpts from his critique of Oak Ridge and the Hucker Report, which he sent us last March. We have done little editing.

The Hucker Committee spent 1984 investigating problems at Oak Ridge maximum-security facility, which is part of the Penetanguishene Mental Health Centre.

As emphasized in the report, a major problem is management by remote control. However, the report failed drastically to point out the little access patients have to upper-echelon management. In the three years I have been here, I have seen the Medical Director and the Administrator so infrequently that I wouldn't recognize them if I saw them.

Another problem here is the close relationship among the employees. Entire families work at this facility: fathers, sons, wives, uncles and cousins. Over the years, patients have found that most complaints are whitewashed or withdrawn because pressure is applied to patients who complain.

As well, employees have come to believe such phrases as "We have to work with the most dangerous people in Canada." Is this really true? Some patients who arrive here have committed previous offences that could have had them sent to prison. Others haven't had a single encounter with the law before the offences that sent them here.

The FATU, or Forensic Unit, is probably the most compulsive violator of patients' rights. Fear, intimidation and coercion are the rules governing this unit. The internationally recognized setting for therapy. Now, patients are forced to abuse each other psychologically and physically at the direction of the staff. Many staff are only RNAs (Registered Nursing Assistants); others are much less qualified. When patients decline to be involved in assessment or therapy, complain, resist, or question the program, they suffer more staff abuse.

The Hucker Committee and its recommendations fall short of the mark. It is doubtful that Committee members took into account the apathy, fear and despair of the many patients they talked to and observed. My recommendation is to trash the existing programs at Oak Ridge.

The Hucker Committee also failed to point out one of the most important aspects of therapy: the patient's input into his own recovery. Nowhere does the report say anything about what the patients in Oak Ridge want. One thing is definitely the *abolition* of this facility.

Despite its good intentions, the Hucker Report failed miserably in its mandate. It settled for compromise. As a result, it reinforced Oak Ridge and the "mental health" system. What a shame that I am forced to write this on my own behalf, so that no other patient is blamed or punished for this article. Does freedom exist only in the mind?



regarded as accessories and dealt with accordingly." (p. 100) Right now, staff not only cover up, but even retaliate for one another. Every attendant has a buddy. If an inmate complaint is lodged against an attendant, the buddy makes sure there are repercussions. The nature and extent of these repercussions come out loud and clear in the Report, even though their existence is not definitely stated:

The Patients' Advocate at the time of the Committee's visits gave an example reported to him in which the "buddy" would provoke a confrontation in some way with the patient and make a critical note in the patient's files. There were reports from patients of actual physical retribution Types of physical mistreatment included general rough handling, banging

the patient against metal doors, and one specific form of physical abuse referred to as "choking out." The latter "technique" involves seizing the patient by the neck in such a way as to occlude the airway or the blood supply to the brain, resulting in temporary loss of consciousness.

(pp. 99-100)

Recommendation 80 could help weaken the buddy system. Other important recommendations concerning abuse are the abolition of the use of silence and of solitary lock-up exceeding 24 hours.

But there is only one section of the Report that borders on the radical: the one that discusses the legality of what goes on at Oak Ridge. Curiously enough, most of this important discussion is relegated to the appendix.

It is clear that a sellout has occurred.



Some conditions and practices at Oak Ridge, the Report suggests, seem to violate Section 7 of the *Canadian Charter of Rights and Freedoms*, which guarantees "the right to life, liberty and security of the person." The Committee lists these apparent *Charter* violations:

- (a) Living conditions on the forensic unit:
 - (i) the silence rule (Ward 01)
 - (ii) the intermittent use of 24-hour light in the rooms (Ward 01)
 - (iii) the intermittent interruption of all water (Ward 01)
 - (iv) the cuffing together of patients (Ward 02)
- (b) General conditions in the hospital:
 - (i) the lack of appropriate exposure to fresh air...
 - (ii) temperature extremes in the ward
 - (iii) inadequate ventilation in the wards.
 - (iv) privacy concerns...

(p. 155)

The Report suggests that some of the more restrictive "treatments" might also violate Section 7.

Finally, the Committee questions the legality of the Warrant of the Lieutenant Governor.

An... element which makes for difficult clinical-legal problems in this area is the whole matter of the ability to predict dangerousness. The present WLG system relies on this kind of prediction to effect release and yet there is no evidence that mental health professionals can accurately predict dangerousness; in fact, it is salutary to note that the research carried out at Oak Ridge amply confirms this position.

(p. 110 — emphasis mine)

HARD's Charter

A self-help organization called "Humane Awareness with Respect and Dignity" has been created by a group of patients in the Oak Ridge Division of the Penetanguishene Mental Health Centre, better known as "Penetang."

HARD is devoted to the advocacy of changes through peaceful dialogue, and to speaking out on issues concerning rights, treatment and living conditions at Oak Ridge and other facilities.

HARD accepts the right of any patient *not* to be a member, and to present his or her own views on any topic. We also accept and recognize the right of any patient, ex-patient, or other person who feels concerned about our rights as psychiatric patients to be a member.

We recognize the special problems of the WLGs (those incarcerated under a Warrant of the Lieutenant Governor) and their need to have a voice in their plight.

We advocate the right of all psychiatric patients:

- to be treated with respect and dignity
- to be active partners in our treatment
- to be treated as individuals in a way that suits our needs

- to have our rights honoured according to the *Canadian Charter of Rights and Freedoms*
- to refuse treatment administered without informed consent
- not to be coerced, threatened or intimidated for any reason
- to peaceably pursue redress whenever our rights are violated
- to be fully and comprehensibly informed of all rules that are patient-oriented
- to be informed about our illness, and the benefits and drawbacks of available treatment
- to retain all personal clothing, jewellery, money, radios, toiletries, etc.
- to have a fair and impartial hearing by any body of jurisdiction
- to be allowed conjugal and familial visitation

HARD wants to change the attitudes, prejudices and stigma attached to being a psychiatric patient. We are patients of a system that treats psychiatric patients with coercion, brutality and intimidation, and without dignity. We hope that anyone who finds themselves in a psychiatric facility gains Humane Awareness with Respect and Dignity.

HARD
Box 698
Penetanguishene
L0K 1P0



In making this admission and pointing to evidence to support it, the Committee is opening the door to very radical changes indeed. It has not only provided grounds for the abolition of the WLG — something it was intentionally trying to do — but has also unintentionally *provided grounds for the abolition of involuntary committal itself*. The point is that if psychiatrists are unable to predict dangerousness, then they have *no grounds on which to commit anyone against his or her will*.

It is clear that the Report is an important one. While some of its recommendations are very weak, others could materially alleviate suffering in Oak Ridge. Also, there are analyses and discussions that have far-reaching implications.

The Response

It would have been nice if the Government of Ontario had responded to the Hucker Report by acting immediately on some of its recommendations. What happened was the exact opposite. Shortly after the Report was submitted last fall, Health Minister Murray Elston announced that he did not contemplate making any immediate changes in Oak Ridge. One wonders what in the Report made the government so reluctant to touch it. Was pressure applied by the Ontario Psychiatric Association or the "mental health" community to leave it alone? Was the government worried about the legal and ethical issues that had been raised? Was the government afraid of the Report's implications for institutional psychiatry as a whole?

Whatever the reasons, it is clear that a sellout has occurred. As psychiatric survivors, we have an obligation to publicly denounce this sellout and demand immediate action on the more humanistic recommendations in the Report.

Another important response has come from some of the Oak Ridge inmates themselves. The founder of HARD responded by submitting his own position paper. Not surprisingly, this was also ignored. Shortly thereafter, the Penetang administration decided to transfer him to another psychiatric institution. A protest is in order. (See excerpt of "Oak Ridge: An Inmate's View" by

Denis McCullough, and excerpt of HARD's letter to Attorney General Ian Scott, in this issue.)

Implications for the Movement

I can well imagine psychiatric survivors saying, "But why should we protest? What has this to do with us?" It is precisely because places like Oak Ridge have very much to do with us that I wanted this article published in this Movement Issue. The disowning of Ridgers and other prison inmates has been an ongoing problem in the Psychiatric Inmates' Liberation Movement. While Carole Stubbs and Don Weitz travelled to the Ridge to visit some members of

I look to the day
when solidarity is
established among
all inmates.



HARD last winter, other ON OUR OWN members are less than happy with the association. When ON OUR OWN members were recently asked to contribute to a legal defence fund for Eldon Hardy, a Penetang survivor, they responded with suspicion. (See "Write On" in this issue.)

The same reluctance and suspicion were apparent at a recent meeting of the Ontario Coalition to Stop Electroshock. Last spring, HARD wrote to the Coalition requesting membership. I was delighted and announced the news at one of our general meetings. I assumed that everyone else would also be delighted. Some were, but others agreed only reluctantly that HARD qualified for membership and could join the Coalition. They hastened to add that we should be

careful that the press not see us as being associated with prisoners — lest our reputation be ruined. This warning was delivered six or seven times by a number of members. The third time, my eye lit on Jack Wilde and Danny Barrer, both ex-prisoners, one a Ridger. Both had participated in numerous Coalition demonstrations. I felt ashamed and angry on their behalf.

At that moment, an image flashed through my mind of a well-dressed man with an English accent saying to another, "Of course, I agree that electroshock is a terrible thing. It wouldn't do to be seen at one of those demonstrations, though. Who knows what people would think if they saw you with a bunch of loonies!"

This image was quickly replaced by another — one that struck home to me as a Jew. It was an earlier time, a different place. One man was saying to another, "You know, there's nothing really wrong with the Jews, but I couldn't afford to be found socializing with them."

Here it was all over again — the same stigma; the same cowardice! It is all the more disturbing in our case because *it is our brother and sister inmates we are rejecting*.

When it comes to Oak Ridge, it is particularly important that we overcome the prejudices dividing us. *These are clearly our people. Oak Ridge is a psychiatric institution and these are psychiatric inmates*. I ask that we acknowledge that relationship and stand together.

I ask also that we join with prisoners in general. The relationship between psychiatric inmates and prison inmates is obvious (see Prison/Psychiatry Issue, summer 1980). *Both* are rejects of the system. *Both* are imprisoned by a society that would rather not deal with them. *Both* are routinely subjected to mind-altering, brain-damaging drugs and other psychiatric abuses. *Both* are routinely denied numerous civil and human rights.

I look to the day when solidarity is established among all inmates. I see protesting against the atrocities in Oak Ridge and against the Ontario government's neglect of the Hucker Report as an important step in this direction.

HARD Demands Action on Abuse



On January 6, 1986, HARD sent a letter to Ontario Attorney General Ian Scott. In that letter, they exposed some staff abuses of inmates and urged Scott to investigate. Scott responded by passing the letter to Health Minister Murray Elston. HARD members have also met with psychiatrist Stephen Hucker (see critiques of the Hucker Report in this issue), Oak Ridge Administrator Margaret Hagerman and patient advocates Denise Ashby and Marnie Hacker. As a result, there have been some changes in the Patient Complaint Procedure in Oak Ridge. With HARD's permission, we are publishing a few excerpts from its letter to Scott — with only minor editing.

Our purpose in writing to you is to express our members' grave concerns over the continuance of patient abuse ... Unfortunately, after years of hope and disillusionment, it has reached the point of intolerable injustice and of inhuman treatment of handicapped people.

The latest incident of patient abuse took place on December 20, 1985. Six employees have been suspended with pay pending the completion of an inquiry. This "alleged" brutality was toward a crippled patient. The patients who reported this incident were removed from their ward. One was threatened in an attempt to silence him; another was dissuaded by the Administration.

We fear this latest incident will go the way of all other inquiries to date.

It will be closed for lack of evidence or dropped because of pressures applied to the patients. This is common practice here. Is it not strange that in Oak Ridge's 50 years of operation, there has never been a case of alleged abuse prosecuted, in spite of the complaints?

Both physical and psychological abuse of patients are daily occurrences. These abuses take the form of prejudicial and degrading statements, excessive physical force, and so forth. This is done to WLGs (inmates under a Warrant of the Lieutenant Governor), involuntary committals, and Warrant of Remand patients. In a great many instances, it is the involuntaries and Warrant of Remand patients who are subjected to the most abuse.

We are aware of the several investigative committees that have looked at Oak Ridge in the recent past. The latest is the "Hucker Committee," which reports "little or no abuse existing."

Therefore, we are making a very strong request that you institute an immediate public inquiry into patient abuses within this facility.

A few months ago, the Ministry of Health established an "Implementation Committee" to act on the report's recommendations. An unnamed ex-inmate has been appointed to the Committee, but he is denied voting rights. So far, the Committee has not acted, and no public investigation into Oak Ridge is planned.



Phoenix Pheather

We proudly award this issue's Phoenix Pheather to all members of HARD, including its founder, Denis McCullough. HARD (Humane Awareness with Respect and Dignity) is an inmates' advocacy group that has two chapters — one in Penetang, the other in North Bay Psychiatric Hospital in Ontario. The first chapter was formed on the wards in the Oak Ridge division of Penetang in the summer of 1985. To the best of our knowledge, HARD is the only psychiatric inmates' rights advocacy group in Canada. Since its founding, it has consistently fought for more rights for psychiatric inmates in Penetang, and a public investigation into numerous staff abuses, particularly in Oak Ridge. We understand that a member of HARD was recently appointed to the Ministry of Health's Implementation Committee on the Hucker Report.

Because of their courage and commitment to inmates' rights, all HARD members should be proud, and they deserve our recognition, support and praise.

HELP will not
stop until you
are out of the
hospital....

—Daniel D. Mesic



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and Turkey Tail

Our Turkey Tail is justly awarded to *Toronto Sun* columnist McKenzie Porter for spreading his fascist views propagating the myth of "mental illness" and its "hereditary" basis, and advocating forced sterilization of "mental patients" and prisoners. A few of his statements published in the September 2, 1986 edition of the *Sun*, are worth quoting:

Every person entering hospital should be examined for hereditary mental disorders that may be passed on to children, and subpoenaed, if necessary, by a board of doctors, lawyers and clergymen with a right to order sterilization.

Every person committed for an indeterminate period to a mental hospital, or entering prison for the second time, automatically should be sterilized.

Persons who consistently prove incapable of holding down a simple job for more than a day or two should be persuaded to accept voluntary sterilization and a financial reward.

Porter and other fascists would feel right at home in Hitler's Nazi Germany, with its killing centres and concentration camps, where "people devoid of value" were murdered.

Women Survivors of Psychiatry:

A brief report on the Toronto conference

by Liz Powell

This conference was held on May 3 and 4 of this year, at the Ontario Institute for Studies in Education. It was the first women's antipsychiatry conference in Canada. Liz Powell was a conference participant.

Last spring, a group of radical feminists, all victims of the Canadian psychiatric system, organized a two-day conference on the female experience with psychiatry. This educational event was very accessible to women: admission was based upon one hour's pay for working women, the site was entirely wheelchair-accessible, and attendants and child care were provided. The atmosphere was not intimidating.

On Saturday, the first day of the conference, women were invited and encouraged to share their psychiatric experiences. Many testified about the abuses they had been subjected to, and affirmed their own strengths and capabilities to survive psychiatric oppression.

Many others felt safer and freer to talk on Sunday, when men were not allowed to participate. On this day there were small discussion groups, workshops, and screenings of relevant films and videos. Several

ideas came out of the discussions, among them the need for supportive environments for women in crisis, outside of psychiatric institutions and the need for crisis centres.

By the end of the conference, we knew we had much more to discuss and work on. Some of us who wanted to meet again formed a follow-up group, which has met several times since May. We have had potluck lunches at our meetings, and discussed our needs while others cared for any children present. In fact, we've become an informal mutual support system, one of the ideas we began to discuss during the conference.

This group will be meeting again during the fall. Our discussions and potlucks are wheelchair-accessible, and child care will continue to be available. We meet at 12 noon on the third Sunday of each month at Windmill Line Co-op, 125 Scadding Avenue, in the 10th Floor Meeting Room. Women who are interested in coming to our meetings are invited to join our group. If you need further information, please phone me: Liz Powell, (416) 531-5167. We look forward to welcoming women.

HELP

I, Daniel D. Mesic, who started the Human Enclave for Liberation from Psychiatry (HELP) here in South Carolina, was recently involuntarily committed to "Southern Pines," a psychiatric hospital, by a Charleston, SC shock doctor who I have a lawsuit against. I was locked up in the crisis intervention unit (their version of the snake pit) from November '85 to January '86. I was given two series of ECT (shock) — 10 to 12 per series — heavily drugged, put in restraints, starved, watched 24 hours a day, not allowed to take a shower, use the phone, talk to other patients, receive visitors or have any of my personal possessions. I had no freedom at all.

I was released with the help of several lawyers and HELP.

HELP is gathering legal support and detailed stories from ex-inmates exposed to involuntary commitment and ECT, and is presently taking on stopping the use of ECT in Charleston.

If you live in South Carolina, HELP will not stop until you are out of the hospital if you ask us for help. We will soon have hiding-place houses for temporary shelter from the shrinks who are trying to commit you. We will also find a way to get you out of the state.

Fighting for freedom, Daniel D. Mesic
Excerpted with permission from Madness Network News, spring 1985.



Alternative Graphics

Tenth Annual
International
Conference on
Human Rights
and Psychiatric
Oppression

Declaration



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

1. We oppose involuntary psychiatric intervention including civil committal 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 oppresses cultural and political dissent.

9. We oppose the psychiatric system because it punishes individuals who have had or claim to have had spiritual experiences and invalidates those experiences by defining them as "symptoms" of "mental illness."
 10. We oppose the psychiatric system because it uses the trappings of medicine and science to mask the social-control function it serves.
 11. We oppose the psychiatric system because it invalidates the real needs of poor people by offering social welfare under the guise of psychiatric "care and treatment."
 12. We oppose the psychiatric system because it feeds on the poor and powerless, the elderly, women, children, sexual minorities, people of colour and immigrants.
 13. We oppose the psychiatric system because it creates a stigmatized class of society that 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

of Principles

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:

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

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 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 program 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, and 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 realize our goals and will not rest until we do.

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

MY BROTHER'S PLACE:

Consciousness-raising in a Halfway House

by Kali Gower

Kali Gower is a staff person at My Brother's Place and a member of the Ontario Coalition to Stop Electroshock.

Over a year ago, Bonnie Burstow, Ruth Morris and others started fighting to get My Brother's Place off the ground. This halfway house in Toronto is for men who have been locked up for many years — some for most of their lives — in psychiatric institutions and prisons. It is a unique alternative to existing social services. The program has two main components: a positive peer culture, and ample opportunity for consciousness-raising.

The peer culture provides an environment in which the men can learn from and support one another. This is meant to counteract the effects of the highly individualistic and competitive prison culture, ruled by authoritarian staff and prison officials who see themselves as "experts." At My Brother's Place, we staff know that we aren't the experts — the men are.

Consciousness-raising challenges the men's self-image. They have been so dehumanized that they see themselves as "crazy" and "criminal." We want to show that, in fact, it is crazy to call forced drugging "treatment," and criminal to lock people up.

Counselling based on personal experience

As the house's executive director, Bonnie hired all of the original staff, including me. She looked for people who had strong humanitarian values; an ability to work with people who were suicidal, addicted to alcohol or drugs, depressed, or angry; and personal experience as inmates. Two

of the staff were ex-psychiatric inmates and one was an ex-prisoner. Other staff had had drug and alcohol problems and had attempted suicide. All of us did counselling based on personal experience.

Most of the staff were not very political. Some still believed in the medical model, including psychiatric drugs. This was frustrating for me. I hated hearing staff refer to the men as "schizophrenic," "sick," or in need of "medication." Bonnie, Brian McKinnon and I spoke out forcefully against drugs, shared what we knew and brought in antipsychiatry/ex-inmate literature for other staff to read. For example, while they were reading pharmaceutical or medical reports on drugs, we were reading and discussing *Dr. Caligari's Psychiatric Drugs* (an antipsychiatry drug booklet published by the Network Against Psychiatric Assault in California, 1984 — see review in February 1985 issue).

We finally made a policy decision that the men had the right to withdraw from psychiatric drugs if they wished. In carrying out this policy, we shared information about the effects and "side-effects" of various drugs, and did nutritional and herbal counselling. We closely observed men who were withdrawing, and gave them lots of emotional support. We helped a number of them to withdraw successfully, despite pressure from staff at Queen Street Mental Health Centre to monitor the drugs, accompanied by warnings that we would be "responsible" for the results. *The results were clarity of thought and speech, improved coordination, increased stamina and a greater depth of feeling. We*



sweated it out, and it was well worth it.

Continuing battle with Parole

None of the staff at My Brother's Place like to call Parole to report men for "violations." (It amazes me that some people who would be reluctant to call the cops won't hesitate to call the shrinks.) We've had a continuing battle with Parole over this. We've reported only violent behaviour and extreme drunkenness. We report the latter only because we're concerned about a possible incident, such as suicide. However, the Parole Board wants us to report any man who stays out all night, comes home late, drinks, or tells us something in confidence. We expect people with drinking problems to come home drunk. If they didn't drink, there wouldn't be a problem.

Many times we have had to call Parole when we didn't want to, because men were reporting on themselves and each other and we were getting calls asking why we hadn't reported a particular man. We don't "rat" on the men.

We want the men to be responsible for themselves. We've never imposed a curfew on them. However, we do expect a phone call from any resident who is staying out all night.

Another fundamental aspect of the positive peer culture is the men's right to veto any potential resident. Everybody (including staff) is asked to be flexible in accepting people they can live with, but no one is asked to live or work with anyone if they feel they can't. Bonnie knew that in order for the men to be committed to one another, they must be able to choose the people with whom they were going to live and work. After a man has moved in, he can still be asked to leave. The men are likely to be committed to those they've interviewed and accepted.

Pulling together to work things out

Of course, we have had some rough times. One man broke furniture in the house; another refused to pull his own weight; people yelled and argued; and one resident was hit (an absolute no-no).

Frequently, the men expected us to deal with the person causing

problems in the house, but we told them that it was their responsibility. We wanted them to learn how to deal with the day-to-day problems of living and working with other people.

One obstacle we've encountered a number of times is a division among the men (and sometimes the staff): some men identify with their prison background, others with their psychiatric background. The prison-identified men generally see the psychiatric-identified men as crazy and unpredictable; the psychiatric-identified men see the others as criminal and untrustworthy. We try to get the message across to all the men that no one deserves to be locked up and/or drugged, and that cops and shrinks are more alike than not.

We also have group discussions on labeling to deal with such issues. We talk about being labeled "crazy," "criminal," "queer," "broad," "nigger," and "alcoholic." All kinds of labels begin pouring out of the men: "brat," "stupid," "good-for-nothing," "weak," "pansy," "liar" and so forth. We talk about how being labeled feels, why people label other people. We talk about power and whose interests are being served by divisions among us. We talk about how we can counteract negative labels by using positive ones. The men's spirits lift for a while, and sometimes political discussion spills over into the afternoons and evenings.

Despite crises and disagreements, the men have pulled together and tried to work things out. We once had a close call with a resident who had overdosed. Another resident, Jack, saw the man turn white, and acted immediately. He half-carried and half-dragged him to his car, and drove him to a hospital emergency ward. Time and time again, I'm moved by the deep caring the men give to each other. We've been trying to build a community, and now we see it happening.

The men have come with us to prison abolition meetings and meetings of the Ontario Coalition to Stop Electroshock, and have participated in protest demonstrations. They built and carried a coffin for shock victims who have died, and they have done street theatre and printed antipsychiatry

posters.

Jack talked to the media last year about his shock experiences — he had been subjected to 102 sessions of electroshock "therapy." Jack was a prime mover and organizer during this time. He had been incarcerated for over ten years in Penetang (a psychiatric prison for the "criminally insane" in Ontario) and experienced many atrocities in both psychiatric institutions and prisons.

I'll never forget one demonstration in which Jack, wearing green institutional pyjamas, ran after people on the street pretending to inject them with Haldol from his four-foot cardboard syringe and broomstick needle. He was a big hit. Another resident, who initially believed we were trying to brainwash the men into accepting our politics, became a strong supporter. Although he once said he wouldn't be caught dead at a "demo," he ended up being a buddy of Jack's during the Coalition's sit-in at the office of Health Minister Murray Elston last March. Without Jack, it is likely that neither the men nor the staff would have become as involved as we did in public protest demonstrations.

**cops and shrinks
are more alike
than not.**

A third resident, Danny, was already a prison abolitionist when he came to our house. He'd never been psychiatrized, but quickly saw the connections and participated in our activities.

Sadly, Danny and Jack were at the Coalition meeting when some members said they did not wish to be associated with "criminals" from Penetang. (See Bonnie Burstow's article, "Oak Ridge: Before and After the Hucker Report," in this issue.)

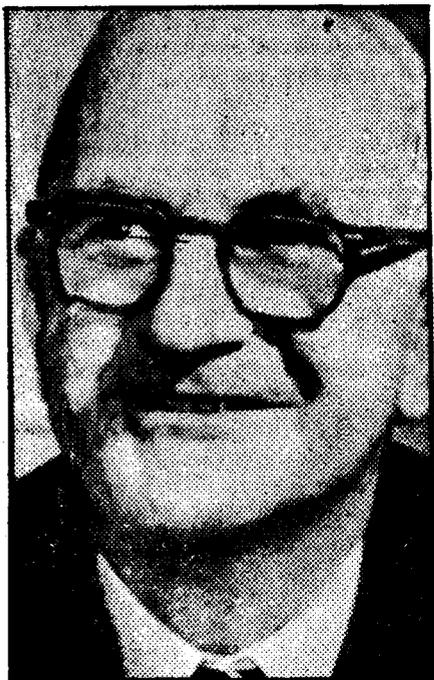
These divisions don't help us. In fact, they further the cause of the psychiatric and prison systems. I hope people in the antipsychiatry and prison abolition movements make the same connections as these men have made. The men at My Brother's Place have survived the oppression inherent in psychiatric institutions and prisons, and know that "every goddam last one of them is the same."

The Cooper Report:

Another Government Whitewash

by Bonnie Burstow and Don Weitz

A recently released government report concludes that neither the government of Canada nor the late Canadian psychiatrist D. Ewen Cameron was legally or morally responsible for the permanent damage many psychiatric inmates suffered as the result of brainwashing experiments conducted in the 1950s and early 1960s in Montreal's Allan Memorial Institute. Cameron's experiments involved sensory deprivation, "psychic driving" and "regressive" electroshock. They were co-funded by the CIA and the Canadian government (Health and Welfare). Nine of Cameron's victims are suing the CIA for permanent damage. His vicious experiments were called "treatment," and were inflicted, without their consent, on Canadians who thought they were receiving help. (See "A Psychiatric Holocaust" and "Canadian brainwashing victims still seeking compensation" in our June 1986 issue.)



The late Dr. Cameron

Recent media exposés have made it obvious to everyone that Canada was a senior partner in these experiments. Last year, former Justice Minister John Crosbie responded by commissioning Halifax lawyer George Cooper to investigate. The result is a total whitewash. According to Cooper, no one is responsible.

How did Cooper arrive at the brilliant conclusion that neither Cameron nor the government is responsible for the tortures that occurred? By a series of red herrings, coupled with some of the worst rationalizations that the Canadian government has come up with for years.

The first red herring is testimony from a number of psychiatrists that Cameron was "highly respected" in his field, and that he really cared about his patients. The question, however, is not whether Cameron

was respected, but whether he was *worthy* of respect. Cooper offers some of Cameron's psychiatric colleagues' glowing statements about him as evidence of his competence and compassion. This is no comfort to over a hundred psychiatric inmates whom Cameron terrorized and permanently disabled.

Another red-herring argument goes as follows: while the quality of Cameron's research was poor, most psychiatrists at the time had faulty research designs. **BIG FUCKING DEAL!** Though it is true that other psychiatrists were also poor researchers, research quality is not the issue here. No one is demanding reparation because the bastard didn't know his statistics or because he failed to include control groups. Reparation is being demanded because Cameron's experiments were intrinsically torturous and damaging.

Invalid arguments

If Cooper's red herrings are annoying, they are far less upsetting than the central arguments supporting his conclusions. The first of these, intended to vindicate the government, is that Cameron's research proposals did not receive preferential treatment, and were monitored as carefully as other experiments that Health and Welfare funded. In other words, that normal caution was exercised, and that the government is therefore not culpable.

In fact, Health and Welfare funded Cameron despite mutterings in the psychiatric community that there was something wrong or unethical about what he was doing. Cooper admits this. The implication is that if the researcher were someone less famous than Cameron, such mutterings would undoubtedly have led to an investigation or flat refusal of the grant application(s).

But what if rumours of immorality would *not* normally have led to an investigation — no matter who the psychiatrist was, or what he or she was doing? The claim that normal caution was exercised is no proof that the government acted responsibly. On the contrary, it is simply an indication that the government was *in the habit* of acting irresponsibly, which makes it clear how these practices could have occurred.

Cooper's next argument is that Cameron did not greatly exceed what was considered acceptable psychiatric practice at the time. After all, Cooper points out, other psychiatrists used "regressive" shock, drugging and sleep therapy.

But in fact, Cameron's techniques far exceeded what was then prevalent practice. His "psychic driving" and prolonged sensory deprivation procedures, for example, were not medically accepted treatments. And while a number of his techniques were used by other psychiatrists, none used them in combination with each other. It is this combination, especially of drugging and "regressive" electroshock, that caused the massive brain damage Cameron called "depatterning."

We also object to the notion of "cultural relativity" implicit in this argument: that since what Cameron did was not too far out of line with what other psychiatrists were doing, there is no culpability. There is individual conscience, and we do hold people responsible for perpetrating acts that blatantly violate our society's ethics.

No defence

During the Nuremberg Trials, some Nazi doctors were found guilty of war crimes, despite their acts having been acceptable to their fellow Nazis. The claim that other

Nazis killed and tortured people was no defence. The claim that other psychiatrists perpetrated torturous and brain-destroying acts should not be any defence in Canada.

Cooper's final argument is that unless someone has been damaged, it makes no sense to speak of reparations. He adds that there is "no patient of whom it could be said *with certainty* that they were worse off because of the depatterning...." (p. 72)

What we have here is the ultimate copout — a lie. The human evidence by which we normally reach conclusions is available. Cooper didn't bother interviewing any of Cameron's victims and didn't see their medical records. He says he had "no mandate." He should have had — it's his fault and the fault of former justice Minister John Crosbie that he didn't. The Allan Memorial victims have publicly testified in the media and in court about their permanent damage, and they all have witnesses to verify their stories. Before Cameron's experiments, Velma Orlikow could read and concentrate. Now, over 20 years later, she is unable to do either. Before Cameron's experiments, Robert Logie could sleep without terror. Now, he cannot. There were inmates who committed suicide in the Allan Memorial during these experiments.

We can imagine Cooper saying, "this is not *scientifically conclusive* evidence." Indeed, it is not. No one tested these people before and after they were tortured ("treated"). The would-be rapist does not make sure that his victim is given emotional tests before and after the rape, so that concrete test results can be compared. This is not the way the world works.

Nevertheless, subjective evidence is used in such instances to determine whether or not a person

has been harmed. Such evidence is amply available in this case, and should be accepted. Denying it is tantamount to deciding that psychiatry has the unique right of never being held accountable for its acts. Perhaps this is the hidden agenda behind Cooper's report: creating unreasonable criteria and a precedent whereby selected institutions can get off the hook, no matter what irresponsible acts they commit.

The Canadian government, the Canadian psychiatric establishment and the CIA must all be very pleased with Cooper's report. None of them is held responsible, even partly, for what the whole world knows is an atrocity! The stage is set for more psychiatric crimes and government cover-ups.

Copies of this report, "Opinion of George Cooper, Q.C., Regarding Canadian Government Funding of the Allan Memorial Institute in the 1950s and 1960s," can be obtained by writing to: Communications and Public Affairs, Department of Justice, Ottawa, Ontario, K1A 9H8, or phoning (613) 996-7192. We're not sure if it's free, so ask.



Phoenix Announcements

Madness Network News needs your help

The current *Madness Network News* Collective is dissolving. The paper's future is unknown. To continue, it urgently needs new collective members and volunteers. *Madness* is calling on people with strong antipsychiatry politics to join the paper. Otherwise, it could become a voice of the recently expanded "mental health client/consumer" reform movement, which would be an insult to its entire history.

Madness is also in dire shape financially. Donations are desperately needed at this time if the paper is to continue publishing. This may also be a good time (and last chance???) to order back issues, the *MNN Reader*, etc.

Madness update

A new collective is forming to put out the *Women's Issue*. They are looking for articles, graphics, poetry, fiction, etc. related to women's experiences with survival, psychiatry and/or prisons. The deadline is October 15, 1986. A sample copy costs \$1.00 (US).

More collective members, and more donations, are still needed.

Please send submissions and/or donations to *Madness Network News*, Box 884, Berkeley, California 94701.

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Brief announcement

On behalf of ON OUR OWN, Carole Snodgrass and Ali Jackson have prepared a brief on the psychiatrized, which they have submitted to Benoit Bouchard, Minister for the Status of Disabled Persons, Secretary of State.

You can get a copy of the brief for \$1.00, including postage, by writing to ON OUR OWN at Box 7251, Station A, Toronto, Ontario M5W 1X9.

FASTING FOR FREEDOM

Antipsychiatry activist extends 50-day fast

Lenny Lapon, author of the book *Mass Murderers in White Coats: Psychiatric Genocide in Nazi Germany and the United States*, has decided to continue his protest fast beyond the 50 days he has already completed. Lapon is protesting psychiatric killings and oppression.

Lapon is himself both a former psychiatric inmate/"mental patient" and a former "mental health" worker with a Master's degree in counselling. He is drinking only water and a small amount of juice.

Lapon accuses the American Psychiatric Association, the National Institute of Mental Health and other segments of the psychiatric system of continually violating the human and legal rights of people they designate "mentally ill."

Enclosed is a list of 50 ways in which psychiatry kills, harms and otherwise oppresses people.

Points of Psychiatric Oppression

by Lenny Lapon

1. Psychiatry kills people. Dangerous, potent drugs, such as Thorazine, Haldol, Prolixin and Lithium, can and do cause death directly and indirectly. "Sudden death" is listed as an effect of these drugs in the *Physicians Desk Reference (PDR)*. Indirectly, boarding-house residents have frequently died in fires that they couldn't wake up from to escape due to the heavy sedating effects of these drugs. The drugs also cause and contribute to deaths from heart attacks, choking on vomit and food, and heat-stroke. Electroshock and psychosurgery are also responsible for many deaths.

2. Psychiatric practices maim and debilitate at least tens of thousands of people each year in the United States alone. These intrusions cause severe organ damage, seizures and tardive dyskinesia (an irreversible nervous system disorder caused by drugs of the phenothiazine class, and characterized by uncontrollable facial grimacing and tongue and limb movements).

3. Psychiatry abuses the "medical model" to label certain people as "men-

tally ill." Psychiatry is a pseudoscience. There is no such thing as a "schizophrenia" germ or virus. Surely, people suffer from emotional pain, but that suffering has nothing to do with a socially concocted "illness."

4. Psychiatrists are especially violent in their "treatment" of women. Two-thirds of the victims of electroshock are women. Ninety percent of psychiatrists are male. These so-called therapists/the-rapists have been responsible for the sterilization of at least tens of thousands of women labeled "mentally ill" and "mentally retarded" since 1940.

5. Psychiatry's use of forced "treatment"/torture (such as drugging, incarceration, electroshock and "behavior modification") is a violation of basic human rights — the right to be let alone, the right to be free from harm, and the right to one's own thoughts, feelings and ideas. Obviously, these are antithetical to democratic practices.

6. Historically, psychiatry has gone hand-in-hand with fascism. Psychiatrists in Nazi Germany killed 300,000 of their "patients" in gas chambers, by letting them starve, by letting them die of drug and starvation. In fact, the gas chambers were first used for psychiatric patients (1939-1941) to kill psychiatric patients before they were used to murder millions of Jews. In our country today, the so-called "useless eaters," "schizophrenics" and "psychotics" die on the streets, in institutions and in boarding houses instead of in gas chambers.

7. Psychiatrists and others have advanced the notion that the vast majority of homeless people are "mentally ill." Two to three million people are homeless in the United States today because of the government's policies and the economic system. Psychiatry's role is to blame the victims of these political and economic forces. This cover-up allows the real issues involved in homelessness to be avoided — poverty, lack of decent affordable housing, unemployment and below-poverty wages. This alleged "mental illness" is also used as justification to forcibly lock the homeless and subject them to psychiatric institutions.

8. Psychiatry's use as a means of social control has been growing at an alarming rate. Psychiatric drugs and "behavioral

modification" are more and more being used not only in psychiatric institutions, but also in prisons, in schools (especially on so-called "hyperactive" children), in the workplace and in nursing homes.

9. The number of psychiatrists is also increasing way out of proportion to the population growth. The American Psychiatric Association had a membership of 1,300 in 1930. It had 5,800 members in 1950, and has more than 33,000 today.

10. Psychiatry has hidden much of its growing influence behind the mask of deinstitutionalization, the process of releasing large numbers of people from psychiatric institutions. Simultaneous with this release there has been an increase in the number of people being subjected to psychiatric procedures at "community mental health centres."

11. Psychiatry is a racist institution. A disproportionate number of blacks are labeled "mentally retarded." Nearly all psychiatrists are white. One often sees newly built, drug-dispensing "community mental health centres" in the midst of the substandard housing of the ghetto.

12. Psychiatrists are dangerous drug pushers — "legal" drug pushers, but drug pushers nonetheless. Psychiatric drugs are addictive and as harmful as street drugs like heroin and cocaine.

13. Psychiatrists continue to use electroshock on at least 100,000 people in the United States each year. Electroshock, which was first used in Fascist Italy, causes brain damage, severe memory loss and sometimes death.

14. There has been a recent upsurge in the marketing of "biological" psychiatry, the idea that "depression"/unhappiness is biologically caused; that emotional suffering and human behaviour are due to chemical imbalances in the brain and blood. These ideas are pseudoscientific attempts to medicalize social, economic and political issues. "Biological" psychiatry reached its peak in Nazi Germany. In fact, the Nazi concept of "racial inferiority," and their sterilizations and exterminations, connected closely with the views and deeds of the "biological" psychiatrists. Many of Hitler's infamous doctor-murderers were "biological" psychiatrists.

(Points 15-21 are adapted from the Declaration of Principles adopted by the Tenth Annual Conference on Human Rights and Psychiatric Oppression, held in Toronto, Canada in May, 1982. These principles were reaffirmed by the Thirteenth

Annual Conference, held in Burlington, Vermont in August, 1985).



22. Psychiatric drugs can and often do cause low blood pressure, kidney and liver damage, abnormal muscular reactions, lethargy, muscle spasms, constipation, sexual problems, weight-gain, eye problems and many other harmful effects.

23. The hearings that commit people to psychiatric institutions violate the principles of due process of law and the right to a fair trial. Lower standards of evidence are used to incarcerate people in "mental hospitals" than are used in criminal trials to lock people up in prison. Only psychiatrists (with their pseudoscientific testimony) are recognized as "experts" at these hearings.

24. Psychiatry's rejection of the democratic process was apparent in November 1982 when voters in Berkeley, California approved a referendum that made the administering of electroshock a crime punishable by up to six months in prison and a \$500 fine. The California psychiatric societies, in collusion with the courts, were able to "legally" overturn the ban on this deadly practice only 41 days after it took effect.

25. The "talking therapies"/"psychotherapy" focus on the individual, blaming her/him for her/his problems, rather than addressing the various forces and conditions in our society that cause people to have problems and emotional pain. These "therapies" are intended to adjust us to an unjust society, rather than to change the society by eliminating the injustices — inequality, economic exploitation, poverty and unemployment, racism, sexism, heterosexism and mentalism. (Mentalism is the oppression of people on the basis of their thoughts, ideas, perceptions, unpopular behaviour and presently or formerly alleged "mental illness.")

26. Psychiatry is especially abusive to veterans. Psychiatrists created an "illness" called "post-traumatic stress disorder" (PTSD) for Vietnam veterans, in order to cover up the nature of the war and its effects on human beings. They blame the victims, calling them "mentally ill." The Veterans Administration's psychiatric wards and "outpatient clinics" engage in heavy drugging and even more use of electroshock, psychosurgery and other experimentation than is found in the civilian sector. Veterans in the VA psychiatric system have fewer rights than civilian victims of psychiatry.

27. Psychiatry is also especially abusive in the military where it is frequently used as a disciplinary tool. There is little oversight or advocacy. Interestingly, the cri-



teria for psychiatrization/"treatment" are often the reverse of those in civilian life. In the military one is called "mentally ill" for refusing to harm others, while the civil codes for commitment usually provide for incarcerating those alleged to be "dangerous to self or others."

28. Psychiatrists are hired by corporations to deal with workers' stress. They employ their usual blame-the-victim approach, prescribing "tranquillizers" such as Valium and Librium and pushing "counselling" to force the workers to adapt to stressful working conditions. They assume the structure of the workplace is benign and do not address the real causes of stress in the workplace — lack of decision-making power on the part of the workers; constant pressure to increase productivity; harmful physical conditions such as poor lighting, toxic chemicals and fumes and extreme temperatures; and lack of decent, affordable child care.

29. Psychiatry is especially oppressive to gay people. "Homosexuality" was a diagnostic category, a "mental illness," according to the American Psychiatric Association (APA) until 1973, when the Gay Liberation Movement forced its elimination from the APA's long list of alleged "diseases." Today, many psychiatrists still view and treat gay people as aberrant.

30. Psychiatry oppresses millions of people in the United States by labeling them "mentally retarded." People with this pseudoscientific diagnosis are stigmatized, considered to be "subnormal" and "mentally deficient," and often locked up in institutions, drugged, sterilized and subjected to "behaviour modification." Children from poor, black and non-English speaking families are the most likely candidates for this type of stigmatization and "treatment."

31. Children are especially vulnerable to psychiatric assault. So-called "hyperactive" children are often given Ritalin, a form of the street drug known as "speed." This drug causes severely stunted growth and has other dangerous effects. Rebellious teenagers and runaways are also often psychiatrized.

32. Prisons are using psychiatric drugs and practices more and more to control the inmates. In some prisons as many as

half or more of the inmates are drugged. Other prisons, such as Butner in North Carolina, Marion in Illinois and Patuxent in Maryland, are run by psychiatrists and routinely employ such methods as 24-hour lock-ups, sleep-deprivation and brainwashing, and a policy of few or no visits.

33. Psychiatric "therapies" blame the victims of battering, rape and sexual abuse. They focus energy on readjusting women to our sexist, misogynist society, rather than on attacking the sexism and misogyny that allow these acts of violence to occur.

34. Psychiatry depoliticizes and invalidates legitimate fears by creating new "illnesses" and "phobias" such as "nuclear phobia" (the perfectly logical fear of nuclear war, weapons and power), "computer phobia" and so on. We also often see free counselling offered for the unemployed, while real help in the form of benefits or unemployment compensation is reduced.

35. Psychiatry is especially oppressive to people in the lower economic and social classes. Almost all "therapists" are from more privileged class backgrounds than their "clients" and consequently, cannot relate to the oppression they face.

36. Psychiatry is responsible for causing many people to commit suicide. Ernest Hemingway killed himself shortly after being released from the Mayo Clinic, where he had just finished being subjected to a second electroshock series. He wrote shortly before his death, "What is the sense of ruining my head and erasing my memory, which is my capital... it was a brilliant cure but we lost the patient." Others are driven to suicide by years of institutionalization, drugging, psychosurgery, tardive dyskinesia and other psychiatric tortures.

37. There is a high level of general abuse in psychiatric institutions — assaults and beatings, sexual abuse, degradation and dehumanization.

38. The drug companies, whose primary interest is in making huge profits, control nearly all the psychiatric research and the medical and psychiatric journals, as well as much of the training received at medical schools. They spend a fortune in advertising in these journals and in financing the psychiatrists' conventions, always pushing their drugs as "solutions" to people's problems.

39. More than a few psychiatrists are exploiting the vulnerability of their female "patients" by rape and seduction.

40. The psychiatric system drains billions of dollars from the economy — money that could be used to meet people's needs, including housing, jobs, transportation, food, clothing and education.

41. Former psychiatric inmates/"mental patients" are discriminated against in employment and housing and usually presented in a derogatory manner in the media.

42. The "talking therapies" further reduce the general level of alienation in our society by discouraging people's interaction, equal, mutual and supportive relationships. This is accompanied by a depoliticizing of the issues that cause emotional suffering.

43. Psychiatry is especially oppressive to older people. Large amounts of psychiatric drugs are used in nursing homes to control the residents. In psychiatric institutions it is very common for the elderly to be treated worse than other inmates.

Lenny's fast lasted a total of 60 days, ending February 10, and he lost 60 pounds.

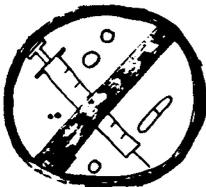
Says Lenny, "I am hoping to have an influence within our own movement as well, to put forward a strong antipsychiatry position for those who are hedging on taking a stand against co-optation. I hope those who have left our movement and are now on the NIMH payroll will reconsider what they're doing. I am taking a step toward preserving independence in the antipsychiatry movement."

Excerpted with permission from MadWorld Network News, spring 1986.

Many of those given electroshock are over 60 years of age, and it is for this group that it is most dangerous.

44. Psychiatry is a major tool for forcing conformity to traditional sex-stereotypical roles for women and men. Assertive women, women who refuse to be "good wife," or "good housekeeper"; men who are passive or "too sensitive" are often subjected to psychiatric procedures.

45. US psychiatrists often hypocritically criticize Soviet psychiatrists for using psychiatry as a tool of political repression. As shown throughout these points of oppression, psychiatrists in the US continually use oppressive political methods. There are, no doubt, more similarities than differences in the use of psychiatry in the two countries.



46. Most of the media support and advance the psychiatric system by employing columnists who parrot the positions of the American Psychiatric Association and present as *factual news*, often under the guise of "health and science," the pseudoscientific claims of psychiatry.

47. Psychiatrists assist the government in covering up political conspiracies behind the actual and attempted assassinations of US presidents and other political leaders. Literally before the gun stops smoking, we, the public, are presented with "lone nuts" (from Oswald to Hinckley). This quickly cuts off any serious investigation of the facts of the murder, the ballistics and the involvement of other people. Hinckley's trial, for example, focused on his alleged "schizophrenia" rather than on how he fired seven shots from a six-shot revolver.

48. Just as Nazi scientists and government officials immigrated to the United States after World War II, more than a few psychiatrists who practised and/or went to medical school in Nazi Germany also came to this country. Many of them studied under and/or worked with the psychiatrists who were responsible for the mass murder of the psychiatric inmates in the Third Reich. (See point 6 above.) Many of them are presently members of the American Psychiatric Association.

49. The growing national shame of suicide by teenagers is being psychiatrized. Instead of looking at the real reasons behind this loss of young lives — the tremendous alienation of our young people; a materialistic, competitive society; and the lack of meaningful opportunities for work and happiness — psychiatry blames the victims by labeling them "clinically depressed" and pretending it's a medical, rather than a social problem.

50. Psychiatrists, such as D. Ewen Cameron, former president of the American Psychiatric Association, have actively cooperated with the CIA and military intelligence agencies in illegal and sometimes fatal mind-control experiments on psychiatric inmates. These programs include the use of advanced brainwashing techniques, electroshock, hypnosis, electronic brain implants, prolonged sleep-deprivation and other forms of torture. Code-names for the programs include MK ULTRA, MK DELTA, BLUEBIRD and ARTICHOKE.

Excerpted from Psychiatric Genocide Research Institute news release (February 1986, Springfield, Massachusetts)

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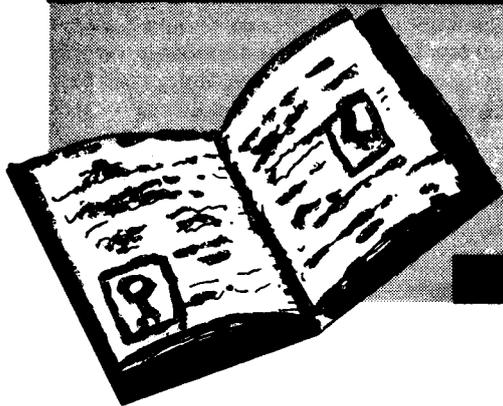
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THE BOOKWORM TURNS

THE HEALTHSHARING BOOK: RESOURCES FOR CANADIAN WOMEN,
edited by Kathleen McDonnell and Mariana Valverde.
Toronto: The Women's Press (1985), 199 pages, \$9.95

by Donna Lyons

The Healthsharing Book: Resources for Canadian Women is a beginning. As a Canadian women's health resource tool, it is easy to use, and its articles provide a valuable look at many of the issues in women's health care. An offspring of Women Healthsharing, a group of feminists who publish *Healthsharing*, a quarterly magazine, it is the collective effort of some of the individual women and women's groups across Canada who are working to improve Canadian women's health care services.

As women, we have too often been at the mercy of GPs and specialists, including psychiatrists, who are largely unconcerned with women's health problems. They often label their patients "hysterical" or "depressive" instead of providing insight into their problems. Left to our own resources, we gather most of our information from other women who have undergone similar experiences.

The book's topics include the traditional feminist issues of sexuality, pregnancy/childbirth, aging and fertility. There is a chapter

containing a number of articles on minority women's health concerns, which documents the need for more services for black, native, immigrant and disabled women. In addition, *The Healthsharing Book* raises a number of issues that have not been addressed adequately in print. These include the link between poverty and illness, and the problems faced by women who are in conflict with the law, such as the drugging of women in prisons and institutions as a means of "curing" them.

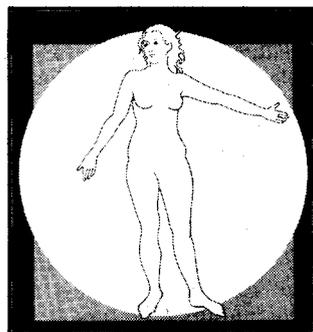
Bonnie Burstow, in her article "Women and Therapy," quotes statistics showing that twice as many women as men receive electroshock in Ontario, and that North American women receive shock treatment two to three times as often as men. Electroshock is a feminist issue. Burstow, a Toronto-based therapist, also looks at some of the problems with the new therapies: bioenergetics, assertiveness training and feminist therapy. (See February 1985 issue, "Mental Health and Violence Against Women: A Feminist Ex-Inmate Analysis.")

In "Memories of an Unlived Childhood," another issue is articulated — that of surviving incest. Lilith, an incest survivor, tells of the trauma of her childhood, and of how she has coped with the many problems it caused. Lilith had a well-organized support network, including self-help groups, friends, the local rape crisis centre, a chiropractor, and a therapist, who was also an incest survivor.

Each of the articles is followed by a list of some of the organizations, print and audiovisual resources available. Included in the print resources are K. Portland Frank's *The Anti-Psychiatry Bibliography and Resource Guide* (Press Gang, Vancouver, 1979) and a broadsheet put out by the Vancouver Women's Health Collective, "Alternatives to

Psychiatric Drugs," which discusses a number of techniques for withdrawing from drugs, as well as alternatives to their use.

The problem with *The Healthsharing Book* is that there isn't more — more articles, more information, more resources — more of everything. (The Women's Healthsharing Collective suggest that the *Healthsharing* magazine might be used as a supplement.) Nevertheless, this book is a valuable resource guide for Canadian women, and should be widely read and used.



Correction notices

We apologize for the following mistakes, which appeared in our June 1986 issue: The postal code we printed for Bonnie Burstow, who, along with Don Weitz, is editing *Breaking the Silence*, a book about psychiatric inmates' experiences, was incorrect.

If you have been incarcerated in a Canadian psychiatric institution or ward, would like to contribute to this book, and have not yet done so, the correct address is 17 Yarmouth Road, Toronto, Ontario M6G 1W7.

We also goofed on a figure in reference to research grants awarded to Dr. D. O. Hebb of McGill University by the Defence Research Board between 1951 and 1955. Two amounts were quoted: \$34,250.00 and \$195,388.00. The second should not have appeared.

Finally, Lenny Lapon has written us a letter in which he mentioned that we got the price wrong on his book, *Mass Murderers in White Coats*. The correct price is \$10.25 (US) including postage.

Uniform Mental Health Act Violates Charter

The draft *Uniform Mental Health Act* is the brainchild of a bunch of government-appointed lawyers, mental health bureaucrats and psychiatrists in Canada. If this draft Act becomes law in any province, it will undoubtedly be challenged in the courts as unconstitutional.

This controversial Act is the product of over two and a half years of discussion—including only two days of public hearings in Toronto last May—by the Uniform Mental Health Conference of Canada. Two of its most outrageous provisions are those concerning “emotional harm” and “involuntary outpatients.”

“Emotional harm to another person” is a new criterion for involuntary committal. This term is not defined and not included in any provincial mental health legislation. Lawyer and inmates’ rights advocate Carla McKague has criticized this provision: “It is . . . impossible to discern any such compelling state interest in preventing people from making one another unhappy.” She also believes it seriously violates Section 7 in the *Charter of Rights and Freedoms*, “the right to life, liberty and security of the person.”

The Act’s “involuntary outpatient” provision is equally outrageous, and undoubtedly unconstitutional. Basically, it allows any doctor (usually a psychiatrist) to forcibly treat or control any person in the community. While in the community, the “involuntary outpatient” must conform to

certain conditions laid down and enforced by the doctor. In short, this new category of oppression is similar to the “loosened” Warrant of the Lieutenant Governor or “mandatory supervision” in the prison system. Being re-committed to a psychiatric institution will be a constant threat. McKague believes that it, too, is unconstitutional: “The *Charter’s* equality guarantee becomes a sham”

There are rumblings that the “emotional harm” provision may be taken out of the final draft, but it seems that “involuntary outpatient” may still be left in. Fortunately, there is some government opposition to this Act. Lawyer Gilbert Sharpe, who represents Ontario’s Ministry of Health, has stated that the government is opposed to the Act because it’s probably unconstitutional. (See “Proposed mental health act goes too far, critics charge,” *Toronto Star*, May 29, 1986.)

As we go to press, this draconian Act is still not law, but some provinces may already have adopted it. Canada’s mental health laws are already unjust and oppressive. This Act legalizes our Big Brother police state.

To prevent the Uniform Mental Health Act from becoming law, we urge our Canadian readers to write strong letters of protest to their MPPs, and to the Minister of Health, Attorney General and Premier of every province and territory. We’d also appreciate your sending us a copy of your letters. Thank you.

Mental Disorder Amendments

When I was little, I used to be frightened by novels about evil psychic powers or beings from another world who steal people’s brains—yet I felt compelled to read them.

These days, I’m still compelled to read about similar subjects, but the genre is different. It’s non-fiction.

Last June, John Crosbie, former Minister of Justice, proposed some amendments to the section of the Criminal Code dealing with “mentally disordered offenders.”

It had come to Mr. Crosbie’s attention that under current laws, people can be held in custody longer on the suspicion that they *might* do something dangerous than they can if actually convicted of committing the offence, and that this would appear to conflict with the *Charter of Rights and Freedoms*.

After consultation with bigshots in government, psychiatry, the social services and the legal system (but not with inmates), Crosbie decided to “modernize and streamline” these laws.

“Not guilty by reason of insanity” is such an ugly verdict. The new wording — “the accused committed the act that forms the basis of the charge but is not criminally responsible by reason of mental disorder” — has a certain ring to it.

Other proposed reforms are equally progressive and helpful to inmates. Here are some examples:

THE REFORM: there will no longer be any such sentence as “Warrant of the Lieutenant Governor” wherein he has absolute and arbitrary power and can have an accused locked up indefinitely.

THE CATCH: a Board of Review appointed by the Lieutenant Governor, chaired by a judge or retired judge and including at least two “mental health professionals,” will be able to order limited terms of incarceration, at the end of which the accused can still be locked up by provincial officials.

THE REFORM: the “least intrusive or restrictive option possible” will be used to “treat” the accused.

THE CATCH: the fact that all options considered “possible” are intrusive and restrictive.

THE REFORM: there will be no treatment without consent.

THE CATCH: it doesn’t have to be the consent of the accused, but can be the consent of anyone deemed by the Review Board to be fit to speak for the accused. And incidentally, both the court and the Board can waive consent if either decides this is necessary.

THE REFORM: “qualified” medical personnel will have a limited amount of time (30 days with the option of a 30-day extension), in which to assess the mental condition of the accused while holding the accused in custody on remand.

THE CATCH: the likely effect of 30 to 60 days’ incarceration on the “mental condition” of a person who has not even had a trial yet.

THE REFORM: the accused will get to see the assessment of his/her mental condition, and to be present at his/her hearing before the Board of Review.

THE CATCH: these rights can be revoked at the discretion of the court or the Board if deemed to “interfere with the treatment or recovery” of the accused.

I find it terrifying that modern, streamlined laws would allow a person to get up to ten years in a psychiatric institution for “crimes” such as “buggery” or “acts intended to alarm Her Majesty or break public peace.”

Such documents as *Mental Disorder Amendments to the Criminal Code*, detailing the insidious, increasing control of our lives by bureaucracy are among the scariest things I’ve ever read. The kind of horror story that used to make my skin crawl seems like comic relief in comparison.

Irit Shimrat

SHOCK WAVES

Organizing Against Shock

This article consists of edited excerpts from the transcript of a taped workshop on electroshock held on August 3, 1985 during the 13th Annual International Conference For Human Rights and Against Psychiatric Oppression in Burlington, Vermont. The people quoted are Leonard Frank and Ted Chabisinski—both shock survivors and co-founders of the Coalition to Stop Electroshock in Berkeley, California—and Shirley Johnson, Fred Serafino, Brian McKinnon and Don Weitz, all members of the Ontario Coalition to Stop Electroshock in Canada.

LEONARD: Our organizing is crucial in eliminating electroshock once and for all. When I got together with others in the Network Against Psychiatric Assault, in 1974 in San Francisco, the first thing we did was campaign against shock at one of the shock mills, Langley-Porter Psychiatric Institute. We held demonstrations, marches and rallies there, as well as sit-ins, teach-ins and seminars, which we invited staff psychiatrists to attend. There was a lot of publicity in the newspapers and on television, and it worked. Within a few months, Langley-Porter announced that it was no longer going to use electroshock. They still haven't resumed using it.

We also lobbied for legislation in California to abolish all forms of electroshock, but unfortunately they only restricted its use. Bill AB 4481 (introduced by State Assemblyman John Vasconcellos in 1974, and

now part of California's *Welfare and Institutions Code*) was about as good as we could get at that time—but it didn't go far enough. It provided an informed consent process that the psychiatrists and shock promoters could easily get around.

TED: In 1981, we formed the Coalition to Stop Electroshock in Berkeley including such groups as the Berkeley Citizen Action (BCA), the Berkeley Free Clinic, Berkeley Support Services, a chapter of the National Organization for Women, an animal rights group, and the Centre for Independent Living. We became a very credible group right away. Through the efforts of consumers of the Berkeley Support Services, we got a city commission to hold a hearing on shock. It was great publicity—all three major TV stations were there, as well as a bunch of radio stations and local newspapers. Forty-five people testified, and there were only three in favour of shock—all psychiatrists.

A year before the city election, we held a demonstration in front of Herrick Hospital, the only place in Berkeley that does shock treatment. As we started to picket, Florence McDonald, a famous City Council member in her seventies, arrived. She marched around with us for awhile and then asked, "Haven't you people been to City Council before? I'm going to bring it (shock) up at City Council." Although Council voted against it, she made a motion and tried to have another public hearing, which resulted in more publicity.

The following month, we had another well-attended demonstration, preceded by a silent vigil in front of the hospital.

When election day was changed (to November 3, 1982), we had only three weeks to get something on the ballot. Shock turned out to be a galvanizing issue. People we'd never seen came out of the woodwork to collect signatures for our petition. A person who's now on City Council took the petition around—his mother had had 250 shock treatments. Another person from the school board whispered in my ear that what we were doing was great. She'd been in the "bin" and hadn't told anybody.

We collected 2,500 signatures, and were the first to get our petition ("Measure T"). We then made more alliances with other groups. For example, there was a group petitioning for stronger rent control. We carried their literature and they carried ours. We had the same arrangement with a zoning group, and with the BCA. So we didn't just do it ourselves.

Since we didn't have black organizations in our coalition, I insisted we get our literature out to them. We sent people to Southwest Berkeley, where about 20 percent of Berkeley's black population is concentrated. When we began collecting signatures there, I noticed that many people didn't know about the shock issue. During the second week, however, we handed out copies of a picture of a beautiful, young black woman, Lynette Miller, who died at seventeen after a bunch of shock treatments at a nearby hospital in Oakland. (The shock treatments were given by the same psychiatrist who still gives them in Berkeley.)

When the election results were in, we received 62 percent of the voters' support to ban shock in Berkeley—with more than 80 percent of black voters supporting us.

The shock issue unified us. People on the street really related to us, and we came over well without arguing. It's a good way to get allies. I think the Berkeley vote has

given this issue some credibility. I think we've accomplished a lot, because shock has become a national issue.

LEONARD: In 1983 at the Syracuse Conference, we had a demonstration against shock in front of the Benjamin Rush Psychiatric Centre. George Ebert just told me they have stopped doing electroshock there.

Around that time, there were several acts of civil disobedience—one in Toronto, one in New York City, one in Berkeley. I participated in all of them; I was really proud to have done this, and was energized by it. We were jailed for a few hours at the most, and had to pay a very nominal fine.

We can organize locally wherever we are, if we are determined enough to do it. And you don't have to have hundreds of people mobilized. You start off with a handful of dedicated people, and things begin to happen. You make them happen. We're not powerless, we can do things. In any middle-sized city, there is invariably a shock mill, and the most effective thing that can be done is to have a demonstration outside the hospital. That can start the ball rolling.

Consent Safeguards Urged

The ECT Review Committee, set up by the Ontario government almost two years ago to look into the use of electroshock treatment, has called for extensive legal safeguards around the right of consent.

In its 100-page report, handed down on December 20, the Committee acknowledged that there are risks and adverse effects associated with ECT, but recommended that it should continue to be available as a mode of treatment.

The report recommended that:

-a competent patient should have absolute autonomy to refuse treatment, must be



informed about expected results and risks, and must not be unduly influenced to choose or refuse treatment -competency must be clearly defined, and whether a patient is competent should be decided by an impartial tribunal

- the decision of the review board should be appealable to a court of law
- standardized records should be kept on the use of ECT
- research should be undertaken into how ECT produces its therapeutic effect, and on ways to improve the treatment's benefits.

The Ontario Coalition to Stop Electroshock strongly criticized the Report for endorsing the continued use of shock, and challenged the Committee's objectivity—most of its members are from the medical/mental health professions, and two are prominent shock supporters.

Carla McKague, a lawyer who has been active in defending the rights of psychiatric inmates, was added to the Committee.

The Coalition also criticized the fact that the Committee held no public hearings; the little space (three pages) devoted to efficacy, which is claimed without substantial scientific evidence; the report's refusal to accept long-term memory loss as a major indication of brain damage; and the inadequate consideration given by the Committee to alternative forms of therapy.

The Coalition called the recommendations concerning legal protections around consent positive, but noted that serious issues of coercion, intimidation and psychiatric domination, which are inherent in psychiatric institutions, were not dealt with.

It criticized the Committee's silence on age and sex biases in electroshock, (despite many submissions to the Committee that commented at length on these biases), noting that two to three times as many women as men are subjected to electroshock,

that women are frequently given shock as a "cure" for post-partum depression, and that elderly persons are more likely than younger ones to be prescribed shock.

The Coalition has been holding public demonstrations to protest the continued use of shock. It is also distributing fact sheets on shock, and on your rights if you are locked up in a psychiatric facility in Ontario.

The Minister of Health, Murray Elston, has asked medical, legal and public interest groups to provide him with any comments and concerns they have with the Report.

Reprinted with permission from the Canadian Human Rights Advocate, March 1986.

You may reach the Minister at the Legislative Building, Queen's Park, Toronto M7A 1A2.

The Ontario Coalition to Stop Electroshock can be reached at Box 7251, Station A, Toronto M5W 1X9, or by phoning (416) 536-4120. (Write to the Coalition for copies of its Critique of the ECT Committee Report. The cost is \$1.00 per copy, including postage.)

Demo Announcement

A protest demonstration, organized by the Ontario Coalition to Stop Electroshock, was held in Ottawa on October 6. The chief purposes of the demonstration were to show support for the Canadian victims of Dr. Cameron's brainwashing experiments at the Allan Memorial and to protest against the Canadian and US governments' refusal to offer them reparations for their permanent damage and suffering. A report of this important demonstration will appear in a future issue. (See criticisms of the Cooper Report in this issue.)

A Resolution to Abolish Psychiatric Drugs

WHEREAS psychiatric drugs are extremely powerful and dangerous chemicals;

WHEREAS psychiatric drugs have frequently caused severe pain and suffering, many serious and permanent disabilities, and sometimes death;

WHEREAS the neuroleptic or "antipsychotic" drugs (e.g. Thorazine, Stelazine, Mellaril, Haldol, Modecate), the antidepressants (e.g. Elavil, Sinequan, Tofranil), lithium and the anti-parkinsonian drugs (e.g. Cogentin, Artane, Kemadrin) have frequently caused many serious medical complications, neurological disorders such as parkinsonism and tardive dyskinesia, and brain damage;

WHEREAS these psychiatric drugs and the "minor tranquilizers" are generally habit-forming or addictive and cause severe withdrawal reactions;

WHEREAS psychiatrists and other physicians have generally prescribed these drugs to psychiatric inmates and ex-inmates without informed consent or by force, and have provided incomplete or false information about their effects and risks;

WHEREAS psychiatric drugs have generally been prescribed for non-medical conditions such as tension, emotional stress, mood changes, life crisis and unconventional or dissident behaviour;

WHEREAS the real purpose of psychiatric drugs is social control of people labeled "mentally ill" or "deviant" rather than cure or relief of medical conditions;

WHEREAS the use of psychiatric drugs for social control is unethical;

BE IT RESOLVED:

1. That ON OUR OWN affirm its strong opposition to the administration of all psychiatric drugs for any purpose, and affirm its commitment to the abolition of these drugs.
 2. That ON OUR OWN encourage its members and other individuals to exercise their human and legal right to refuse any psychiatric drug that may be prescribed for them;
 3. That ON OUR OWN provide emotional support and help develop safe and humane alternatives to assist its members and other psychiatric inmates and ex-inmates who voluntarily choose to withdraw from any psychiatric drug;
 4. That ON OUR OWN publish a booklet or handbook on psychiatric drugs; and
 5. That this resolution be widely publicized in the Psychiatric Inmates Liberation Movement media, including *The Mad Grapevine* and *Phoenix Rising*.
- This resolution was unanimously adopted by members of ON OUR OWN at a General Meeting held in Toronto on November 24, 1985.*

Psychiatric Inmates' Liberation Directory

Phoenix Rising will do its best to keep this list up to date. It is published at least once a year. Complimentary copies are available to any Movement group listed in this Directory, psychiatric inmates and prisoners upon request. To the best of our knowledge, most of the groups listed are antipsychiatry. Not all these groups are controlled by psychiatric inmates or ex-inmates, but most are. Please let us know about any addition or deletion in the name and/or address of your group as soon as possible, so we can update this Directory. We are particularly interested in hearing from newly-formed groups and organizations. Networking is vital. Keep the Movement alive! 'Please write us about any changes: Movement Directory, c/o Phoenix Rising, Box 7251, Station A, Toronto, Ontario M5W 1X9.

Canada

Cowichan Valley Psychiatry League

5834 Upland Ave.
Duncan, B.C. V9L 1L8

Mental Patients Association (MPA)

2146 Yew Street
Vancouver, B.C. V6K 3G7

By Ourselves

2054 Broad Street
Regina, Sask. S4P 1Y3
(306) 525-2613

On Our Own / Phoenix Rising magazine)

Box 7251, Station A
Toronto, Ontario M5W 1X9
(416) 699-3192/3194

Ontario Coalition to Stop Electroshock

c/o Bonnie Burstow
17 Yarmouth Road
Toronto, Ontario M6G 1W7
(416) 536-4120

Psychiatric Alternatives Network (SPAN)

c/o Shirley Johnson
39 Proctor Blvd.
Hamilton, Ontario L8M 2M2

Humane Awareness with Respect and Dignity (HARD)

c/o D. McCullough (4D)
Box 3010
North Bay, Ontario P1B 8L1

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(614) 271-1653

Groupe Auto-Psy

429 St. Jean No. 1
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United States

Committee to Stop Psychiatry/ Psychiatric Genocide Research Institute

Box 80071
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Alliance of Mental Patients/Psychiatric

Survivors of Western Massachusetts
Box 60845
Longmeadow, MA 01116-0845

Mental Patients Liberation Front (MPLF)

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Box 4138, Station A
Portland, ME 04103
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Vermont Liberation Organization

RR 1, Box 1440-2
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Catalysts for Change

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Manchester, CT 06040
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Cincinnati, OH 45219

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National Alliance of Mental Patients

(NAMP)

c/o Box 618
Sioux Falls, SD 57101

Project Acceptance

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c/o Sharon Jacobs
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Box 3301
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Coalition for Alternatives in Mental

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1720 Oregon, Room 12
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Network Against Psychiatric Assault

(NAPA)

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Psychiatric Inmates' Rights Collective

(PIRC)

Box 299
Santa Cruz, CA 95061
(408) 475-7904

Institute Against Tardive Dyskinesia
801 East Harrison St., Suite 706
Seattle, WA 98102
(206) 624-8266
Anti-Psychiatry Association (APA)
Box 85004
Seattle, WA 98105

England

Lawletter

90 Fawcett Estate
Clapton Common
London E5 9HX
Hackney Mental Patients Association
Box 48
136 Kingsland High Street
London E8

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
Campaign Against Psychiatric Oppression
18 Seymour Buildings
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Release Leopoldplaats 40
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Bevrydt de Waanzin
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GIA de Paris
c/o Bernard Langlois
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75013 Paris

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Mise A Pied
BP 2038
31018 Toulouse Cedex

Germany

Sozialistische Selbsthilfe Köln (SSK)
Liebigstrasse 25
5000 Köln 30
(0221) 556 189
Patientenfront
c/o G. Schuck
Postfach 211 227
6700 Ludwigshafen
Irrer-Offensive
Pallasstrasse 12
1000 West Berlin 30
(030) 2151638

Switzerland

Patienten Basel
Postfach 3839
Hammerstrasse 1600
Basel
Assoc. des Usagers de la Psychiatrie (ADUPSY)
22 rue Neuve du Molard
Geneva
(022) 219 575 (Tues. 6-9 p.m.)
Interessen Gemeinschaft Psychiatrie
Sektion Zurich
Postfach 104
8402 Winterthur

Greece

Movement for the Rights of Mental Patients
16A, S. Charalambi Str.
Athens 708

Australia

Campaign Against Psychiatric Injustice and Coercion (CAPIC)
182 Keele St.
Collingwood 3066
Victoria (Melbourne)
419-0926

Pala Society

Box 153
Waverley 2024
New South Wales (Sydney)

Committee on Mental Health Advocacy (COMHA)
Box A625
South Sydney 2000
New South Wales

Grow

209A Edgeware Road
Marickville NSW 2204

New Zealand

Wellington Patients' Organization
Box 10180
Wellington

Iceland

Gædhjálp
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25990

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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 August, 1985 issue, the names of 46 shock doctors have been added to the list, which brings our total to 105.

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.
Bagheri, A. Queen St. Mental Health Centre, 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.
Brown, E.W. Mississauga General Hospital, Mississauga, 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.

Freebury, D.R. Mount Sinai Hospital, Toronto, 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.
Hennessey, A. Clarke Institute of Psychiatry, Toronto, 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.
Joffe, R. St. Michael's Hospital, 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.
Matas, J. St. Boniface Hospital, Winnipeg, Ont.
McFarlane, W.J.G. Riverview Hospital, Port Coquitlam, B.C.
Menük, M. Clarke Institute of Psychiatry, Toronto, Ont.
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.
Orchard, B. Clarke Institute of Psychiatry, Toronto, Ont.
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.
Voineskos, G. Clarke Institute of Psychiatry, Toronto, Ont.
Ward, J.A. Sudbury Algoma Hospital, Sudbury, Ont.
Watt, J.A. Homewood Sanitarium, Guelph, Ont.
White, N.F. McMaster University, Hamilton, Ont.
Wood, W. Nova Scotia Hospital, Dartmouth, N.S.
Yoon, S. Nova Scotia Hospital, Dartmouth, N.S.
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