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Vol. 2 No. 4

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— A special feature on the aged

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Comeback from psychosurgery

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THE ELLERTON INQUEST

PHOENIX RISING

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Through the fire

Phoenix Rising is published quarterly or more often by: ON OUR OWN, Box 7251, Station A, Toronto, Ontario, Canada M5W 1X9. Telephone: (416) 699-3194 . Second class postage. No. 5432

EDITOR
Cathy McPherson

ADVERTISING AND PROMOTION
Annegret Lamure

EDITORIAL COLLECTIVE
Bonnie Armstrong
Scott Carthew
Don Weitz
Mel Starkman
Connie Neil
Allan Tenebaum

Printed and published in Canada.

Subscription rates:
Prisoners and psychiatric inmates: FREE while confined
ON OUR OWN members: $4/year
Individuals: $6/year
Institutions and libraries: $12/year
OUT OF CANADA ADD $2 MAILING COST.

APRIL ISSUE

I.S.S.M. 0710-1457

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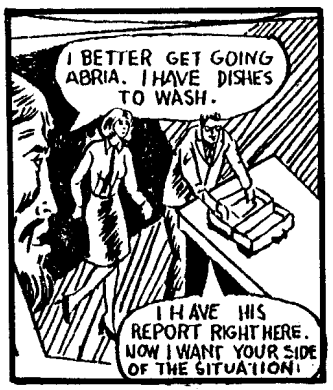


EDITORIAL

THE GREY YEARS–

the bleak prospect facing all of us

In the past psychiatric inmates died young. They died from disease, malnutrition and neglect in squalid "mental hospitals". Now they're living longer, but conditions aren't much better.

It's bad to be old in Canada. It's worse to be old and sick in Canada. It's horrifying to be old and psychiatrized in Canada.

The elderly face more difficulties than they did when they were young, yet have to struggle against them with greatly diminished resources. Often they have lost as much as half their body mass, half their vision, half their income, half their energy and half their friends. Many are crushed by the death of a loved partner, defeated by the necessity of moving out of their lifelong homes, and troubled by ill health. With nothing to fall back on, they often end up in institutions, and, once institutionalized, are further diminished by their environment.

Many seniors become confused and disoriented simply as the result of being removed from familiar surroundings—and are then dosed with powerful psychiatric drugs to combat their "senility". Many are upset by isolation, lack of financial and social resources or failing health—and are drugged for "depression". Many seniors are given drugs because nighttime wakefulness is diagnosed as "disturbance"—even though most seniors require less sleep (only five hours on average) than younger people. Also, institutional schedules (rising at 6:00, supper at 4:00, and lights out at 9:00), while convenient for staff, often don't meet the needs of inmates who, if they rebel, are labelled "uncooperative"—and dosed with drugs.

Often this "drug therapy" brings on side effects such as confusion, hyperactivity and depression, that are interpreted as further "mental deterioration" resulting in the administration of still more "medication". In addition, drugs commonly prescribed to combat high blood pressure and heart conditions can cause chemical imbalances that mimic senility. If psychiatric drugs are then mistakenly prescribed, the condition could be aggravated and become life-threatening.

The elderly are the most vulnerable to drug reactions, yet ironically they are proportionately the major consumers of medication. Acute staff shortages and overcrowded facilities contribute to the needless drugging of seniors. The result—incalculable waste. The elderly could be, and with proper support often are, a valuable resource.

Lack of federal and provincial government support, scarcity of community resources and public indifference result in the institutionalization of many seniors who, with adequate assistance, could live independently. At the same time, overdrugging and lack of stimulation, social interaction, and adequate care reduce many institutionalized seniors to pitiful shadows of what they could be.

The present situation is bleak, and the future looks bleaker. Canada's declining birthrate and drastically reduced flow of young immigrants will, coupled with greater longevity and the maturation of the "baby boom" of the fifties, result in more elderly, and, if present trends continue, more institutionalized people than ever before.

Since we're all getting older, and institutional facilities show few signs of getting better, it is up to those of us who still have the strength, the energy, and the resources to act. If we don't do something *now*, we'll all some day be living in the appalling conditions documented in our main article.

Annegret Lamure

Contributors to Phoenix Rising

Contributors: Carla McKague, Ron Welker, Gilbert Sharpe, Barbara Kelly, Chris Gordon, Morty Goldmacher, Allan Tenebaum, Norman Maynard, Roger Maynard, Jennifer Wolfe, Christie McQuarrie, Jim Moulton, Mary Stern, Carmen Schumen, Paul Bartlet, Anne Coy, Paul Weinberg. Cover photo by *Annegret Lamure*.

Dear reader,

The spring of 1982 begins *Phoenix Rising*'s third year of publication. We're getting older—but are we getting better? This anniversary issue seemed a good time to check it out.

When we started out (with big hopes and a tiny budget) we resolved to reach as many psychiatric inmates as possible. Economic realities (printing, paper and postage costs) and, to some extent, restrictive hospital policies didn't allow us to send a free copy to every inmate in every institution, as we would have liked, but *Phoenix*'s free subscription list is growing week by week. To many, *Phoenix Rising* is the only link to the outside world; we wish we could reach more. However, the fact that, according to reader reports, each issue is studied by many people is a source of encouragement to us.

Phoenix Rising was begun with the hope of effecting changes in the psychiatric system, encouraging the psychiatrized, breaking down the stigma and labelling of "mental illness", and educating people on their legal rights. We also wanted to inform consumers of the pros and cons of various treatment methods, the dangers and side effects of certain psychiatric drugs, and alternatives to the present system. As well, we wanted to stimulate the formation and growth of other self-help groups.

To some extent, we feel we have succeeded. Many readers write, expressing their appreciation of regular features such as the drug, legal and commentary sections, and tell us how much support and encouragement they get from hearing about other people and other groups. The magazine has been instrumental in sparking the formation of at least three other self-help groups, and requests for information on psychiatric issues are legion.

So, where do we go from here? Well, for one thing, as you may have noticed, the magazine, thanks to a reader who generously donated his services, is now being typeset for the first time. We decided on this for two reasons—it is more legible and looks more pleasant, and it saves space. We can crowd the same content onto fewer pages and cut printing bills. We hope you like it.

We *know* you won't like the second change—a price increase—but it was prompted by dire necessity. We just couldn't hold off any longer.

The increase was kept to a minimum by switching to the least expensive paper and the most economical printing process possible.

Another, less obvious, change is the computerization of our mailing list. Thanks to another generous reader, we will be able to provide you with quicker and more accurate service. Now if only a printer would come forward and generously donate the use of his press... .

Aside from that, we plan more personal stories and would like to print more contributions from you, our readers. Send us your poems, drawings (we are always desperate for more graphics), letters, criticisms, suggestions and *money*.

With your help we look forward not only to printing many more issues, but to printing better ones.

Sincerely,

The Phoenix collective

typical Phoenix collective member

write on

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

★ ★ ★ ★

I read only one issue of your *Phoenix Rising* and I am pleased! As a lady with a sixteen-year psychiatric history of hospitalization and a supporter of the Civil Liberties "Patients Rights Committee" I would enjoy receiving a *real* publication.

I am not a Pollyanna on rights—or the lack of them. I hope to contribute in some way to your venture in the future. Having the current issue would certainly help.

Laixey Anderson
Ottawa, Ont.

★ ★ ★ ★ ★

I liked the most recent issue of *Phoenix Rising* a lot. Don Weitz' report on the conference was very complete and well-written.

Mel Starkman's article on the movement was interesting but inaccurate in a couple of places. Project Release no longer has a community center and hasn't for a couple of years. Also his article seems to imply that the SSI Coalition in Berkeley formed during or prior to 1976, when in fact it didn't form until last year. The name of the hospital in Cohen's film is Norwalk, not Norfolk (and SSI stands for Social Security not Social Support).

BACAP has not ever "brought together NAPA and other groups". BACAP was formed by a group which split off from NAPA and remained completely separate from NAPA until it (BACAP) folded, a few months ago. I was also sorry that Starkman failed to mention NAPA's month-long sleep-in at the office of Gov. Jerry Brown in 1976—surely one of the most dramatic and effective actions in our history.

Although these are minor discrepancies, they could have been avoided if Starkman had checked out his information with the groups he was writing about.

Jenny
Madness Network News,
San Francisco, California

★ ★ ★ ★

Well, I suppose it was just a matter of time. After all, can oil and water mix? Can a rattlesnake and a mongoose peacefully co-exist? No, so how could the Friends of Schizophrenics and the Society for the Protection of Rights of the Emotionally Distraught ever continue as partners in common cause?

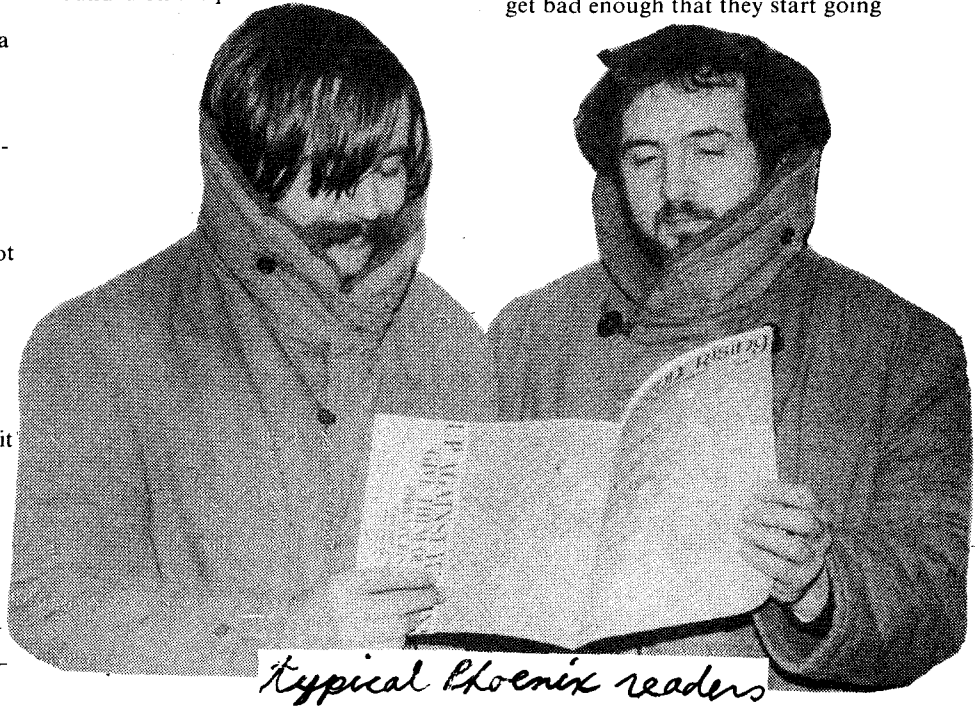
As of 1982, SPRED has been granted the right to operate as an independent body, or in other words we've been kicked out of F.O.S. and denied their sponsorship. It's probably just as well but one cannot help wonder why they would do this to a successful movement which has gained a lot of respect and credibility.

Technically, the reason for the split is that the philosophical basis of SPRED is diametrically opposite to the constitutional policy of the Friends of Schizophrenics corporation. SPRED is founded on the premise that mental illness is a sane or legitimate reaction to an insane world and that by practising self help and working towards reform of the status quo it can be remedied. Of course, F.O.S. believes that it's all a matter of faulty brain chemistry and that with drugs, research, machines and money, mental illness can be "conquered" and the American dream preserved.

There was a time when we felt that if F.O.S., acting in the capacity of "friends", would support our right to express our views and concerns, then we would support them in principle. Now it's no longer possible.

They have used their superior social and financial standing to assume a dubious paternalism which is not theirs to take, and though they may feel that they are sincere in their efforts, the drasticity of our plight leaves little room for such misdirected good intentions. They must stop ignoring the many serious social issues surrounding mental illness and start being honest with themselves and their siblings. Prophetic vision is required.

What it boils down to is that with friends like the Friends of Schizophrenics, who needs enemies? Ah, but we love them anyway and perhaps when things get bad enough that they start going



crazy too, then maybe we'll be able to offer them the benefit of our approach to the matter.

Fred Serafino.
Niagara Falls, Ont.

Editor's note: Since the above letter was written, the SPRED house in Hamilton has been closed down.

Says Fred, "Shirley and I moved to Hamilton 3 weeks ago. Our new address is 514 King St. East, Hamilton, Apt. 7, L8N 1C9. Within one week after moving the wolves pounced on SPRED and forced the closure of our house. One good reverend said it was demon possessed. Kind of like Nazism, eh? The owner of the house turned out to be pretty gutless.

It shouldn't matter though because some of the members will rent another house and no one can stop people from being friends.

Shirley and I are both working here in Hamilton and we'll probably start trying to get something going soon enough.

★ ★ ★ ★

Because I believe that it is important for those of us who have been victimized by ECT to have a forum in which to present our point of view, I have decided, for one month, to manage without a few selected items which I probably need: a plug for my bathroom sink, an economy-sized can of Sani-flush, Comet cleanser, hair conditioner, and cuticle remover (to pay for a subscription).

I will attempt not to run into problems with the health department and my bosses at work who like me to look my best!

However, all kidding aside, I believe the world would be a poorer place if those of us who have been incarcerated in psychiatric facilities and other institutions did not have a place in which to voice our opinion. Keep up the good work!

—name withheld

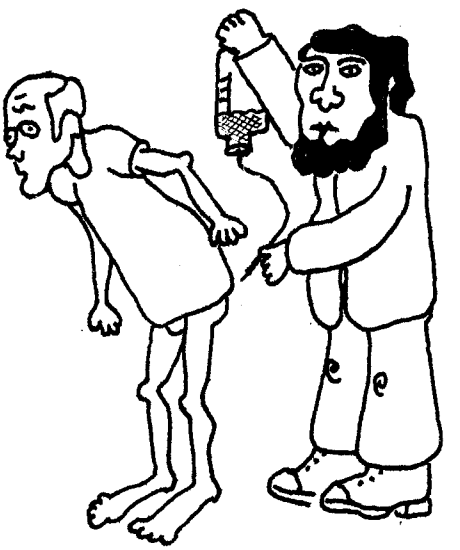
★ ★ ★ ★

It has been brought to my attention that my name has been included amongst those physicians who administer or authorize electro-shock treatments, in the magazine *Phoenix Rising*.

I would like to have my name *immediately* removed from this list as I have not used ECT since I left Women's College Hospital in June 1967.

In any case you are aware there are more recent and better methods of treating patients these days. I would also like to register my protest at my tax dollars being used for such a biased publication!

Sincerely,
Betty W. Steiner, M.B., F.R.C.P.(C), F.A.P.A.
Associate Professor
Department of Psychiatry
University of Toronto



I am sure you can imagine that thirteen years of hospitalization can leave a lot of scars.

All those years I promised myself that if I ever got out I would do something about all the injustices that are committed against people in a position where they can't do anything about it.

I wish you could interview these patients in private. Then you would realize what a predicament they are in. For the staff, I would like to see them psychologically tested to see if they are suited for their work. Those that have committed crimes against patients should be held accountable. Justice should be for all and these people should not be above the law.

I personally have been assaulted by staff on numerous occasions for refusing medications. In my file there is not one incident where I have struck staff or another patient.

I remember one occasion where I was placed on Moditen. I got my injection of three cc's and a few days later was in a bad state. I happened to see the nurse and told her that the next week I wouldn't take three, I'd take two and that's it. The following week, I was called to the front of the ward. They were waiting for me, but somehow I felt I could refuse.

I was brought up to the management ward and was told to strip naked. I told them again I refused to take the needle. They grabbed me; I struggled a bit to show protest. One on each arm and one grabbed me around the throat and he proceeded to choke me till I passed out. He let me regain consciousness and then he choked me again when I came to. I said I would take the needle.

That wasn't enough. He choked me again and by this time I was pleading to get the needle. He choked me again so I would get the message;I passed out five times.

I still have nightmares about it. This was in Penetanguishene.

I would like to know what you think about all this and if there is anything than can be done to keep this from happening in the future.

Name withheld,
Ontario.

Voluntary and involuntary inmates, as well as people committed under a Warrant of the Lieutenant Governor in Ontario, are entitled to refuse *treatment, according to the* Mental Health Act *of this province. If the doctor treating this person still feels the treatment is necessary, he or she must bring the matter before a review board, which decides on the matter one way or another. (See enclosed legal chart for the ruling in other provinces).*

Forcing a person to receive treatment against will, before the matter is settled by a review board, is against the law, *as is the common assault you described.*

If a person with psychiatric problems in Ontario is acting out or is violent, hospitals or facilities treating that person have the right to restrain through the use of physical or chemical means, within

In our next issue...

- ★ **Working — Vocational rehab, sheltered workshops, in the hospital, out of the hospital.**
- ★ **MAO Inhibitors**
- ★ **Your Right to Treatment**

reason.

Your best bet is to consult a lawyer through a legal aid clinic, if you can, or if you live in Toronto or the nearby area, the Advocacy Resource Centre for the Handicapped at (416) 482-8255.

★ ★ ★ ★

Just an update on our club for you. We moved to our new quarters at 1821 Scarth St. in November. The building is a bit of a dump but we are fixing it up a bit.

The big news is that we got a $26,000 federal grant to hire three staff until August. We will be hiring the week of January 11th, and the project will start on January 18th. So much for the salaries; all we need now is some money to run the club room. We are good until about April but by that time the spring budget of the provincial government should be out so we are hoping for the best.

We had a terrific conference with Carla McKague the end of November. We had about thirty-five people in attendance including a couple from Saskatoon. Carla did herself proud in meetings with the media. She got quite a bit of exposure while she was here and we hope to have her back.

That's all for now. Things are a little tough but I think we're here to stay.

Steve Stapleton
Regina, Saskatchewan

★ ★ ★ ★

I have been following your *Phoenix Rising* and I am much interested in your articles and comments on the Krever report on the protection of privacy and on the Human Rights Code (Ontario), which drags on and on.

First I would like to comment on a letter submitted by Mr. Paul Bartlet, on his experience and his magnificent victory getting out from under the psychiatric bureaucracy and getting his hospital records. I am glad to see some articles of victory and now a suggestion. I know there are many who would like to see more directives as to how to go about getting files and how to get your needs met. I do find that the many articles needed to expose the horrors of confinement to our hospitals in the name of psychiatric care tend to become tedious and upsetting without the balance of helpful areas and positive stories. I like the informative articles on Human Rights and the privacy act.

I too am trying to recover my records at the hospital. As Mr. Bartlet says, the doctors field your questions with counter questions that are so absurd as to question your intelligence as a person.

I have said often that the only way to get doctors to discharge you is to tell them you have no money to pay them. The doors close amazingly fast. Of course no explanation is offered. The only assurance that medical records will be put to rest is to obtain them and destroy them ourselves. Even then verbal statements continue. However, if the patient obtains the file it is their word against ours. I am concerned about the requests for the patient to sign a permission statement giving the doctor or social worker the right to reveal confidential information.

Don't sign forms...

I had a recent experience being faced with a hospital receptionist and a form held down by her hand on the far side of the desk where I couldn't see it and "You *have* to sign this form." I had not met the therapist. My advice is DON'T sign this statement until you see the therapist and have time to think about it—if at all—and DON'T ever sign any forms that you have no opportunity to read. If in doubt ask for one to show a friend, your minister or in the need a legal aid lawyer. Once your signature is on the line it is just like giving the doctors the right to reveal all information on your file and they do this.

The one thing I see about the Human Rights Code is that the onus is on the individual to prove discrimination that he has received. Again the steps are so complicated that most people who are ill or have been with mental problems could not succeed in such a battle. I know that many places and doctors just deny that they have said or done a discriminating thing and deny records. Any damaging information would be removed before the Human Rights officer arrived.

One area of concern regarding the Krever report and the privacy act is not noted in your *Phoenix Rising* or in the Krever report, and that is in Canada Manpower itself. For years they have had the authority to give out information to a voice on the phone. A doctor of mine called them as we agreed and told them he was hiring someone for his office and asked for information about me. He was appalled at the lies even he knew that he was told, and told me I would never get a job as a result. One of these lies was that I was "mentally deficient". I took a battery of tests that proved I could do their job and that the "mentally deficient" was balderdash.

The rules in respect of psychiatric files in hospitals and medical areas by the government only apply to medical areas. There are many non-medical counselling areas such as Family Counselling and areas that provide help for the mentally ill such as Canadian Mental Health and bureaus that offer volunteer placements and home visitors in case of illness. All demand records and do not ask for your permission to relay this information, false or otherwise. You have people in these organizations that do not know how to assess such information or use it. These organizations have poor executives that are not coordinated and no one is responsible once the situation damages your chances. It is particularly damaging in a small town. The question arises as to how much information do these places need, to allow you to drop in to a Centre and chat, have a cup of tea or play a game, or to have a home visitor to be a friend. Information is given out in volunteer monthly meetings and names used without our consent. You can't prove verbal discrimination or records. With no proof or code of honesty they will just go on using hearsay to our destruction.

I had a home visitor and I was not told it was part of a RNA course and that I would be discussed in front of the whole class. Where are our rights here?

I read a copy of the update for Ontario Housing. They too can use hearsay and do. The pension departments also rely on hearsay. I once had a UIC officer tell me, "It will go well with you if you reveal information on a cheater."

"Where are our rights here?"

I certainly don't believe medical information should be permitted to the FBI or the police. This is an invasion of our privacy and to say the least underhanded. The above organizations are just as damaging and used just as widely. I wonder why they were excluded by the Human Rights Code and the Krever report. Such revelations of personal medical records are a slap in the face for honesty and cooperation in answering doctors' questions.

A talk with Mr. Polly of the Human Rights Commission revealed the intention that government and organizations would be given two years to change over to the new Human Rights Code. All evidence would be destroyed by then and many like me would lose their supplemented housing.

I wonder if you realize (you probably do) that the change in policy of the OHC excludes the mentally ill. It is,

Continued on pg. 36

ON OUR OWN

THE ELLERTON INQUEST

Death at Queen Street...

News that Patricia Ellerton had died in August 1981 at the Queen Street Mental Health Centre hit Toronto like aftershock following the reported death of Austin Davis last fall in the same facility.

Ironically, both drug deaths made the headlines the day after Health Minister Dennis Timbrell had assured reporters Queen Street was safe.

Ellerton and Davis's drug-related deaths joined that of Aldo Alviani—who died at the centre a year and a half before—as two more grim statistics in the battleground called Queen Street Mental Health Centre, a facility that has been torn by staff cutbacks and the turnover of three administrators in one year.

At the inquest into Ellerton's death, held this January, the public learned about the short life of this troubled woman whose psychiatric problems started in 1963 and ended with her death from an apparent overdose of the drug levomepromazine (Nozinan) at the age of thirty-seven.

Ellerton was alternately described as "a whiny kind of patient constantly seeking attention" by the hospital physician responsible for her physical health, and as a person well-liked by her fellow inmates by a nurse

Her brother David told jurors Ellerton hated to take medication. "She did not like drugs in any way, shape or form...not even aspirin." He said that although she had made several pseudo-suicide attempts to get attention, she was not "serious" about killing herself.

Neither Marlene Berry, a registered nurse who knew Ellerton well, nor Delores Apps, her supervisor, felt Ellerton was suicidal at the time of her death, although they conceded any inmate at Queen Street could be unpredictable at times.

Jurors were told she would often try to take other inmates' medication rather than her own which she thought

Recommendations of the jury

MALL AREA

1) additional uniformed security guards to supervise the mall area
2) passes be issued (with photograph) to ensure only legitimate people make use of the mall
3) Restrict ingress and egress to one entrance to and from the mall to validate passes.
4) We support the establishment of a liaison group between the security force and Metro Police to monitor mall area for illicit activities.
5) We support the planned installation of surveillance cameras in the hospital wards; we would suggest in addition that such cameras be also considered for the mall area.

MEDIUM SECURITY CONCEPT

The jury supports the suggested medium security wing concept as mentioned by Dr. Durost. We would accept that such a concept would result in restrictions being placed on involuntary patients and those requiring special supervision.

INVENTORY OF STOCK DRUGS

The jury accepts that narcotic drugs are closely controlled within the hospital. We would recommend that planned periodic checks be made on stock drugs to ensure that individual dispersals equal actual consumption. This would be carried out under the supervision of the pharmacist. The more widely used drugs could be monitored at regular intervals with no prior notice of the drug to be checked.

HOSPITAL PROCEDURES

***Emergency Practice* (Code 99)**
We recommend that emergency procedures be conspicuously posted and reviewed with all staff at regular intervals.
Reinforce Bed Check
We recommend a) night lights in rooms; b) Set up an hourly checklist and have nurses initial check.

COMMENDATIONS

The jury commends:
1) the day staff of the Queen Street medical facilities for devotion, interest and care.
2) Swed Murtaza, the security guard, for volunteering his testimony to the inquest.

day—for her body weight (98 pounds at death), it was clear that somewhere, somehow, along the way she must have taken more of the drug.

When one of the nurses casually revealed that she had known that drug dealing had been taking place in the "mall" since she had started working at Queen Street three years ago, pandemonium hit the court room.

Since Ellerton had to walk unaccompanied through the "danger" zone to her occupational programs, could she not have bought some drugs along the way?

Sergeant Roy Teeft, investigating officer in the Ellerton death, told a hushed courtroom how he went undercover at the request of the coroner, and received any drugs he asked for through pushers who came into the mall area. He said he could have had drugs, alcohol and even sex if he had wanted it and was willing to pay.

Teeft, who has been with the narcotics division of the Metro police force for thirteen years, told jurors he did not know if levomepromazine was a common street drug. [It is. In the 1960s it was sold by pushers who called the pills "Honey Bees" because of their colour. Because it is commonly used as a pain killer, it is often sold in the place of Percodan, a commonly used drug that relieves the pain of cancer patients.]

Without a shred of evidence, he theorized that if Ellerton was sexually active, she probably prostituted herself to get some levomepromazine so she could treat herself. "I'm not saying she did that all the time." After all, reasoned Teeft, she wouldn't eat the hospital food, yet she bought chocolate bars, so it stood to reason she would do the same with drugs.

This theory was later questioned by Dr. Milton, who stated that with an IQ of 84 it seemed unlikely Ellerton would know the name of her drug and ask for it from the pushers.

Dr. Henry Durost, Medical Director of the centre at the time (he is now Clinical Director of the Clarke Institute of Psychiatry in Toronto), appeared shaken when revelations of an illegal drug market and stories of female inmates exchanging sex for drugs came out. In the face of sharp questioning on Queen Street's open door policy, counsel for the Ministry of Health valiantly attempted to defend the policy against suggestions that inmates of the facility be locked up.

To its credit, the jury did not find death by suicide, although most of their recommendations seemed to concentrate on security rather than quality of care issues. Perhaps they thought, as many spectators did, that the evidence was just too circumstantial to jump to any conclusions.

Some questions, however, remain unanswered by the inquest into Ellerton's death.

1. Why was Ellerton's room stripped of linen and cleaned before the investigating officer arrived? Is this standard procedure?
2. Was there any *proof* that Ellerton had exchanged sex for pills in the past? Did anyone actually *see* her buying pills in the mall area?
3. Why did her doctor allow her to get so thin, examining her only once in the entire year of her last commitment to Queen Street?
4. Why was Ellerton given such a high dosage of levomepromazine when she had such a low body weight?
5. Why did nurses seem unclear about the status of voluntary and involuntary inmates with respect to taking medication and the inmates' right to refuse?
6. What was Ellerton's status? Did she have the right to refuse treatment or was she under the legal guardianship of her family who could decide what kind of medication she should have?
7. Why did the crown pursue the possibility of death through suicide when accidental overdose by nursing staff was just as strong a possibility?
8. Why weren't the side effects of the drugs she was taking on a regular basis discussed in the courtroom, especially when one of fluphenazine's serious side effects is "silent pneumonia"?
9. The psychiatrist who prescribed the drugs for Ellerton was in Saudi Arabia at the time of the inquest and was not able to testify. Why did three psychiatrists and doctors associated with the Ellerton case (Dr. Durost is presently working at the Clarke; Dr. Lippert is working at St. Michael's Hospital) leave Queen Street before the inquest into the Ellerton death?

GIVING THEM THE BIRD

Our Turkey Tail for this issue goes to Dr. Elliott Barker, who told a provincial court judge that the Saskatchewan farmer who has been pursuing Anne Murray has the well-known "erotic paranoia". Barker stated that Robert Charles Keiling's illness might not be treatable—even with medication. "It's not an illness which is readily amenable to treatment," he told the court. We award a Turkey Tail to Barker for labelling what could only be called "pain in the ass" behaviour a mental "disease".

Our *Phoenix* Pheather goes to Leon Kamin, a Princeton University psychologist, who is challenging the "mental illness must be hereditary" school of thought, which has frighteningly close ties to the eugenics movement (let's keep the race "clean").

Kamin charges that the data which form the cornerstone on which the theory is based are distorted and subject to the personal biases of social workers who interviewed the patients of "schizophrenic" adopted children in Denmark. In some cases in which a parent was not available for an interview, that person was "diagnosed" according to the opinions of his or her estranged partner, relatives, or records. Eccentric persons were classified as "uncertain schizophrenics". Withdrawn but intelligent persons unable to handle jobs or school and considered emotionally "flat" were classified "latent schizophrenics".

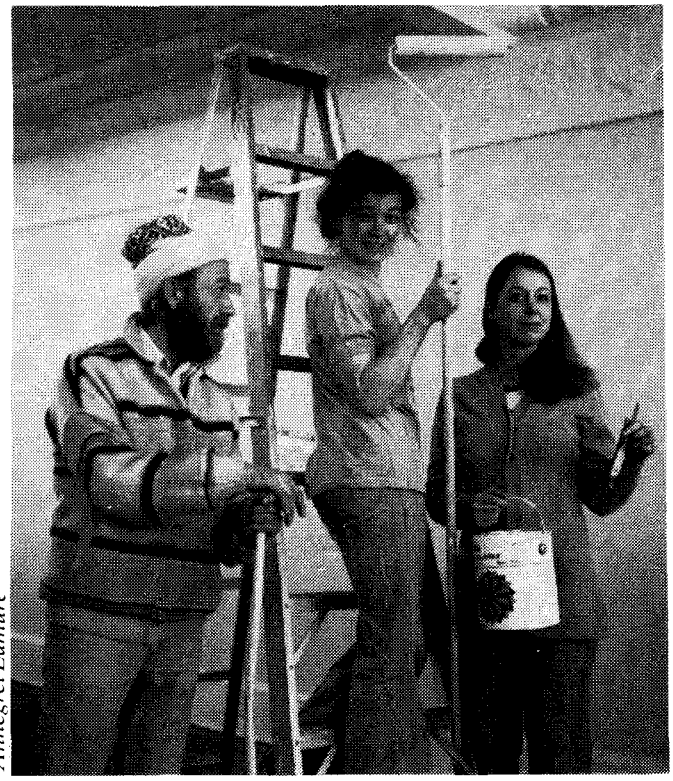
In an interview in the February 15 issue of *Maclean's*, Kamin says, "These [adoption] studies make my blood boil. What is 'uncertain schizophrenia'? It just means they couldn't make up their minds so why should they expect us to accept it as a diagnosis? It's obvious. Kids placed in crazy homes grow up crazy."

COPS carries on

In January and February, the Coalition On Psychiatric Services (COPS) discussed some of its many concerns about psychiatric treatment with Dr. Gilbert Heseltine, the psychiatrist appointed last fall by then Min ister of Health Dennis Timbrell to conduct an "in-house review" of psychiatric treatment in Ontario. He plans to complete his report sometime this May or June. With or without Heseltine's report, COPS will continue to press the Ministry to hold a public investigation into institutional psychiatry in Ontario.

COPS has also been making plans to participate in a province-wide study of the use of "rapid neuroleptization" (prescribing massive initial doses of major tranquilizers to psychiatric inmates). The Coalition has been planning the research since last December; it was put on hold when we learned that the Clarke Institute of Psychiatry was planning a drug study, thanks to a timely grant of $300,000 from the Ministry of Health. Fortunately, a recent meeting between COPS members and Dr. Paul Garfinkel, Research Director of the Clarke, confirmed that the Clarke study will not overlap or duplicate the COPS research, which will focus on patterns of drug use in psychiatric institutions and psychiatric wards of general hospitals. COPS is now busy drafting its research guidelines and funding proposal.

In the meantime, COPS will be closely monitoring the coroner's inquest into the Queen Street drug-related death of Norman Austin Davis, scheduled to start March 23rd.



Annegret Lamure

We've Moved! Volunteer Don Weitz, Hope Scoville the Mad Market's new manager and Jane Browden, On Our Own's secretary pause for a moment while painting our new drop-in office at 1860 Queen Street East, across from the Woodbine racetrack.

THE TENTH ANNUAL INTERNATIONAL CONFERENCE ON HUMAN RIGHTS AND PSYCHIATRIC OPPRESSION

As many groups and individuals are already aware, ON OUR OWN is hosting this year's Tenth Annual Conference On Human Rights and Psychiatric Oppression in Toronto, May 14-18. This is the first time the Conference will be held outside the United States. The Conference is open only to psychiatric inmates, ex-inmates and anti-psychiatry activists or supporters endorsed by ex-inmate controlled groups. We look forward to at least 200 participants, including European representatives, attending the Conference.

The meetings will be held at the University of Toronto campus. On May 16th, we will have a Public Day open to everyone. Traditionally, the Conference always has a press conference panel and tribunal during which ex psychiatric inmates give testimony about some of their personal psychiatric experiences. These events are usually followed by a large, well-planned (we hope) demonstration aimed at some target of the "mental health" system. This year, we will be demonstrating against the American Psychiatric Association, which includes some Canadian Psychiatrists. The APA is holding its Annual Meeting in Toronto in May. Details on this demonstration will be discussed at the Conference.

Publicity for the Conference will be extensive; it will include a large poster with the above title in different languages and print formats reflecting the internationalism of the Psychiatric Inmates Liberation Movement. ON OUR OWN members are invited, in fact encouraged to design and submit drafts of the poster and other ideas to the Conference Publicity Committee. One design will be chosen and announced shortly. Also, please hand in a resume and/or demonstration of work done if you want to be selected to design the poster. This must be done immediately.

At the Conference, art work, crafts and writings produced by members and other ex-inmates will be on display. Please submit them to the Publicity Committee for approval. Your suggestions and offers to help us organize the Conference will be most welcome and appreciated. The Conference Application Form, including cost, subsidy and registration information, will be available and mailed to all members, participants at least year's Conference and similar self-help groups across Canada in March. For more info, please contact: *Mel Starkman, Connie Neal, Jane Bowden or Annegret Lamure at* . LET'S ALL WORK TOGETHER TO MAKE THE CONFERENCE A BIG SUCCESS!

DUMPED & DRUGGED

– a special report on the aged

by *Connie Neil* with assistance from *Mary Stern, Morty Goldmacher* and *Don Weitz.*

Canada institutionalizes more elderly people than most other industrialized countries. Some scholars attribute this to our tendency to institutionalize *anyone* outside the norm at excessive rates; others suggest misdiagnosis and the lack of community alternatives as other causes.

And yet very little research is being done, despite the fact that older people also have the highest suicide rate and are proportionately the top consumers of drugs.

Knowledgeable professionals see one side of seniors' illness, treatment, appropriate placement and institutional conditions. Not surprisingly, patients have a different view.

"As a geriatric, it's assumed you have lost all interest in living."

"As a geriatric, it's assumed you have lost all interest in living and have lost the capacity to think. Using age [alone] as a criterion is extreme discrimination," says Evelyn, a 73-year-old widow with numerous readmissions to psychiatric institutions.

Judged incompetent by psychiatrists to handle her finances, Evelyn was admitted as a voluntary patient to the psychogeriatric ward at the Queen Street Mental Health Centre in Toronto.

Staff refused to inform her of her legal status and rights. No help was given by her doctor(s), ward nurses, or the Ontario government to obtain the legal and medical aid she requested.

Excerpts from a diary she kept during 1978-79 while institutionalized follow:

> "Patients are handled, fed and moved about roughly...pushed and forced to walk faster than they normally are capable of doing...forcibly placed in their chairs.
>
> Many are spoon-fed. In some instances, this consists of staff pushing full spoonfuls of food into the patient's mouth and not allowing time to chew or swallow.
>
> The patients' rooms are locked at 6:30 a.m. and not opened until 8:00 every night.... Patients are herded like sheep into two sitting rooms for thirteen hours. There is nowhere to go to escape violent or very disturbed patients to relax, read or write letters or just be quiet.
>
> Being on the geriatric ward means: no reading material, no newspapers, no books, no games, no hobbies or crafts. We have no volunteer visitors or entertainers, except possibly the odd visit from clergymen and Thursday night Bingo, which I find boring.
>
> My personal clothing was forcibly taken from me when I was admitted. I have worn pyjamas, housecoat and slippers for 18 days now. This is considered a form of punishment.
>
> Although mouthwash, tooth cleaner and denture receptacles are available, I've never seen any of them used—night, morning or any other time. Maybe three patients [out of 45] can and do take care of their own mouth and teeth.
>
> Patients are ushered to the dining area, always well before the time of meals. At the other end of the stick, trays are removed from patients while they are still eating. Some patients are spoon-fed, others have their trays taken from them without having had a bite of food.
>
> I'm usually awakened at 11:00 p.m. by the ruckus and noisy behaviour of staff at shift-change. This particular morning I was awakened at 2:20 a.m. ...one staff member opened my door and shouted, "Aw, shit!", then closed it.
>
> I saw my psychiatrist to try to find out my legal status in the hospital. When I asked him, he told me he did not know.
>
> I learned that while "informal" [voluntary], I should not be on a locked ward and should have "out" privileges at all reasonable times.
>
> Now I'd like answers to these questions.
>
> 1. Why was my name not placed before the legal aid intervewer at a much earlier time? Eleven days elapsed between the time I first requested legal aid and when I received information on how to proceed. I have complied by stating my financial position and submitting the names of three lawyers.

Annegret Lamure

2. Why am I being held on a locked ward if this is not consistent with my status?

3. Why am I not receiving medical assistance [for an arthritic condition and swollen foot]?"

It was only due to her personal struggles, and the help of a law student when appearing before the Review Board, that Evelyn was able to leave the institution with her competence rating re-established.

Unions Watch

In two provinces, British Columbia and Ontario, unionized hospital workers have brought to public attention deplorable conditions in institutions.

"When they are moved, they die..."

Last May, a report prepared by June Swanson for the B.C. Hospital Employees Union revealed that the aged in chronic care facilities were not getting proper care. Fire safety training was inadequate; staff shortages were causing health problems and an increase in the use of restraints and unsanitary conditions in chronic care facilities.

About 1,000 of the 21,000 residents, the study said, were routinely tied in restraints; half didn't participate in any exercise or activity; and staff, warned of inspectors' visits, rushed to meet government standards for these visits.

Privately-owned facilities were found to be more likely to provide inferior care. Swanson said owners had been evicting residents on short notice when rising land prices presented more lucrative business opportunities. "When they are moved, they die."

The study also said that at some homes enema rubbers and tips and disposable gloves were washed and re-used without being sterilized, and that bowls, denture cups, dentures and bedpans were washed in the same sink.

Since the union released its report, the B.C. government has cut back the building program for long-term and chronic care beds and stopped all construction. There has also been a thirty per cent cutback in home care services.

The union is presently negotiating with the Health Labour Relations Association to make quality patient care part of their contract so that if, for example, people who are not trained to give out medication are made to do so, they can lodge a grievance.

In Toronto last November, emergency action was taken as a result of a report from union workers that conditions at Greenacres, one of Metro Toronto's seven homes for the aged, were "grave and terrible" and "in a state of crisis".

The Toronto *Star* reported, "Some Metro politicians were not impressed by the union's report, apparently seeing it as a ploy for higher wages." However, Metro coroner Margaret Milton told a public meeting the report was "accurate", and that her own internal memos had been ignored for at least three years.

At Greenacres, a "special care" home where most of the 557 residents are ex-psychiatric inmates, sedated residents lined the halls, clamped in chairs by hinged trays. Blankets and clothing were in short supply. Rodents and cockroaches were common. Insufficient staff found themselves severely overworked.

A special report by Samuel Ruth, former executive director of Baycrest Centre for Geriatric Care in North York, confirmed what Milton and the unions had been saying all along.

Ruth recommended, and Metro Community Services quickly adopted, hiring thirty-nine new employees and a nursing coordinator, and immediately resupplying the home with new bedding and clothing.

Elsewhere, where union workers are not watchdogs, privately owned "special care" homes strain against government regulations. Many governments, however, faced with closing down already badly needed facilities, take a kid glove approach. With the government paying fully for "special care", this is a lucrative business, particularly when the care is not given.

Ninety per cent of the 220 residents at Elm Tree have psychiatric problems, the *Globe & Mail* reported in March 1981.

Although it had been called one of Ontario's worst for eighteen months by inspectors, still the government did not act to correct the unsanitary conditions, under-staffing, inhumane practices, and lack of nursing care and adequate food.

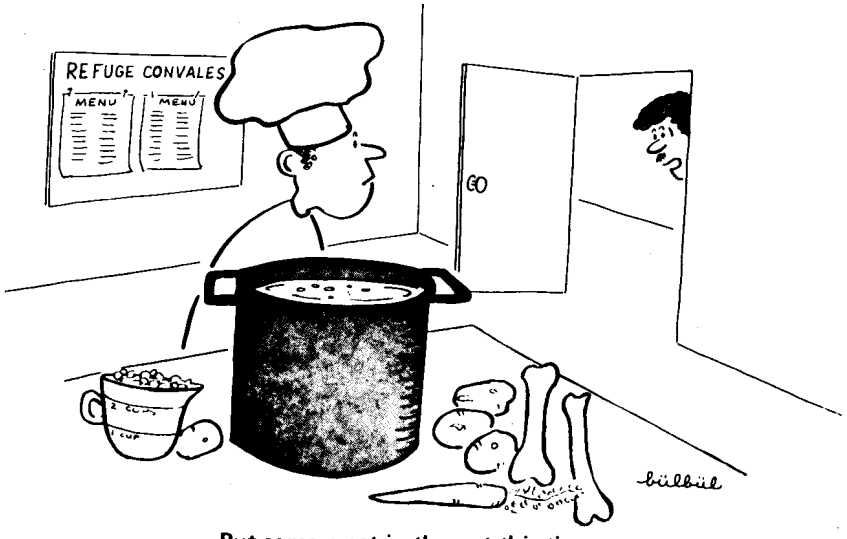
"...requires I lower my standards–to an un acceptable level."

One inspector wrote, "I cannot stress enough how the residents of this home are being forced to live in such a disgusting way as they do."

One staff member resigned after less than a month because to remain "requires that I lower my standards...to an unacceptable level."

Charges of forced group bathing, no privacy screens around beds, improper clothing and inadequate food were answered by owner Ingrid Pennelli, who said that she didn't realize that "things needed drastic improvement", that the inspectors were too harsh, and that she is negotiating to sell the place and retire.

One wonders if she intends to retire to Elm Tree.



Put some meat in the pot this time.
The state nursing home inspector is coming!

Everybody's Studying Us, ***available from Volcano Press, 330 Ellis Street, San Francisco, CA 95689 for $3.95 plus $1.25 postage.***

Improper Drugging

In the past two years, an increasing amount of public criticism has surfaced in Canada and the U.S. about the overuse and misuse of mind-altering drugs in

nursing homes.

"You see people treated more for the advantage of the providers—mainly the administrators, nurses and physicians—than the patient. You can have a quiet atmosphere if you zonk people with med-

"You can have a quiet atmosphere if you zonk people"

ication,"[1] says Dr. R.N. Butler, president of the U.S. National Institute on Aging, and Pulitzer Prize winner in 1976 for his book **Why Survive? Being Old in America.**

One woman's experience, as told to the House Select Committee on Aging in the United States, was published in June 1980 by the New York *Times*.

> "In May 1974 Esther Stanley, who was then in her late seventies, in good health, and self sufficient, fell and fractured her pelvis. She was admitted to a nursing home in California and placed on a daily regime of medication that included tranquilizers, an anti-depressant and a sleeping pill. In less than a month, Mrs. Stanley's condition had deteriorated to the point that a medical report described her as "confused", "paranoid" and "not capable of being left alone." She was declared mentally incompetent. Mrs. Stanley's daughter decided to take her out of the nursing home, away from the medication. Mrs. Stanley, who has recovered her physical and mental health, now lives in her own apartment and is active in community affairs."

The committee was told by numerous witnesses that the amount of drugs prescribed in nursing homes has led to "high rates of error, unnecessary sedation, adverse reactions and addiction".

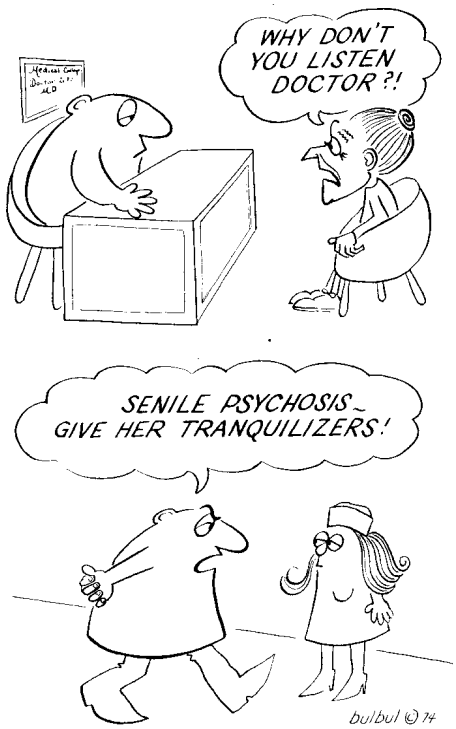
An unpublished 1981 Canadian study by Edison Sussman reveals that the tranquilizers routinely given in nursing homes are the ones most likely to cause damage to seniors.

Sussman, a University of Toronto medical student working under the supervision of Dr. Hurst of Mount Sinai Hospital, says that tardive dyskinesia (a generally permanent and irreversible condition of the nervous system characterized by awkward and restless involuntary movements of the face, hands and sometimes the whole body) occurs with alarming frequency in older people who have had prolonged (six months) treatment with phenothiazines, the most common psychiatric drugs.

Although Sussman warns that his findings cannot yet be considered accepted medical fact, he expresses concern that the drugs are used to control older residents without psychiatric disorders, and can be very damaging to those who suffer from Parkinson's Disease.

A 1978 Equipe de Recherche Operationnelle en Sante survey of people sixty-five and over in the Montreal south shore area found that 89.1 per cent of those receiving health and social services care or in institutions were receiving tranquilizers or sleeping pills.

A 1980 study published in the **American Journal of Public Health** found consistent misuse of psychiatric drugs in nursing homes. Reviewing prescriptions in 173 nursing homes in one state, the



Everybody's Studying Us, ***available from Volcano Press, 330 Ellis Street, San Francisco, CA 95689 for $3.95 plus $1.25 postage.***

study found that forty-three per cent of all patients received major tranquilizers, and nine per cent of this group received them every day of the year. Eighty-one per cent of these antipsychotic drugs were prescribed by general practitioners with a large number of nursing home patients. The larger the home, the more mind-altering drugs were prescribed.

These drugs are being used as a management technique to pacify and quiet people. Chemical control helps keep costs down by requiring fewer staff to interact with difficult patients.

This problem especially affects women, since they live longer and make up about three-quarters of the nursing home population. Thus the tendency of women to receive about twice as many mood-changing drugs as men throughout their lives continues in the nursing home, as shown by numerous studies.

In addition, an advertising campaign has been launched by the major drug companies, who have a big stake in seniors as a developing market; they comprise about eleven per cent of the population but consume twenty-five per cent of all prescription drugs because of their chronic illnesses such as arthritis, high blood pressure and heart conditions.

Directed at physicians and those who work with the elderly in institutional settings, the ads in journals for the aged and medical journals feature demeaning stereotypes that appeal to prejudices—little old ladies in rocking chairs, angry contorted seniors shaking their fists in a nursing home corridor, depressed older women looking sadly out of windows as life passes them by.

One is left with the impression that all older people are isolated, inactive, depressed or agitated, and out of control.

Defining a normal human biological function as a disease so people will take more prescription drugs may be happening now with aging. This is most clearly expressed in ads for antidepressants.

Here are the texts from two glossy full-page ads in the *Journal of Age and Aging.*

> "Motival. A Touchstone for Anxiety. Disturbed days can provide a touchstone for a diagnosis of anxiety. Motival tablets relieve the day-time symptoms while treating the underlying illness. Motival tablets do not cause problems of oversedation so leaving the patient free to cope with daytime stress."

> "Motipress. A Touchstone for Depression. Disturbed nights can provide a touchstone for a diagnosis of depression. Motipress tablets allow satisfying sleep by treating the underlying depression."

The ads move from only one symptom to a diagnosis.

"Disturbed days", an extremely vague term, sounds as if the person is upsetting the nursing home routine or bothering the doctor. Someone with sleeplessness as a symptom might be considered depressed and maybe an antidepressant will do the trick. As healthy seniors generally sleep only four to five hours nightly, and since antidepressants are powerful, complex and sometimes dangerous drugs, the pitch in the ads is disturbing.

Goodman and Gilman, in **Pharmacology of Therapeutics**, say of these drugs that "because of their toxicity indiscriminate use should be avoided."

What is not said is whether the older person has a justifiable reason for being depressed, which is often the case.

One pharmacist, commenting on the effect of institutionalization on the aging, said, "We know that the elderly person when institutionalized in a long-term facility may be confused and agitated. He may require phenothiazine therapy, or more frequently in males, anti-depressant therapy."[2]

Does institutionalization make people crazy?

This implies that institutionalization makes people "crazy", and that people unhappy in these settings should be given powerful mood-changing drugs rather than change the environment to one more humane.

But symptoms that masquerade as senility are often by-products of other treatable conditions. They can be produced by malnutrition, infection, reactions to supposedly harmless medicines, deterioration of various parts of the body, and, perhaps most commonly, by deep depression over the loss of a spouse, banishment to a nursing home, or crushing loneliness.

The fourth most common illness for which drugs are prescribed for seniors is mental and nervous disorders. Disagreement about the prevalence of seniors' mental disorders ranges from claims that they have more "mental illness" than other groups to ones that they have fewer mental problems. Most texts name depression as the most common "mental illness" of seniors while commenting that depression is very hard to diagnose and recognize.

There is a distinct split in opinion as to whether, in discussing depression, one should consider the poverty and loneliness and loss that seniors endure.

Dr. M.R. Eastwood, Chief of Geriatrics at the Clarke Institute of Psychiatry and past president of the Ontario Psychogeriatric Association, says,

> "The younger you get it [depression], the more likely it is to be inherited: the older, the less likely. So for the person who becomes depressed for the first time at seventy, chances are it is due to a social problem, an environmental problem, rather than inheriting a disease."

He believes the holistic approach—treating the whole person, not just an organ or symptom—is the answer.

But, Eastwood says, "there are not many doctors in geriatrics. We need to have more units where patients can come in on day care to get an assessment", rather than high technology medicine which does not extend life.

Treatable Conditions

Ironically, common "side effects" of the drugs used in institutions include confusion, hallucinations and other symptoms which could seem to nursing home staff to be a form of senility. The concept of "senility"—like that of "mental illness"—needs to be reexamined since it may be a handy catch-all for the effects of drugs and institutional living.

Senility is the major disease of the aged, divided into a benign form with minor memory loss, and senile dementia, with about eighty per cent of cases caused by Alzheimer's Disease, which produce a gradual untreatable slide into mental oblivion and death.

Treating the aged is just not profitable enough, says Dr. David Gayton, director of geriatrics at the Royal Victoria Hospital in Montreal. "The nursing homes don't want heavy care patients. They prefer to have someone who doesn't need as many nursing services."

Shocking Facts

When depressed seniors do not respond to drugs, often ECT (electroconvulsive therapy) is tried. With some doctors, it's the first choice or preferred treatment.

Eastwood is among those preferring ECT to drugs for seniors, as he believes it is more effective and safer than anti-depressant drugs, which have a toxic effect on the heart and may produce heart attacks.

> "ECT is very safe and you have a trained anaesthetist there who is controlling everything. So it's interesting that more ECT is given to older patients than to younger patients, because their particular depressions are responsive to ECT and they may well be undergoing a safer procedure."

Annegret Lamure

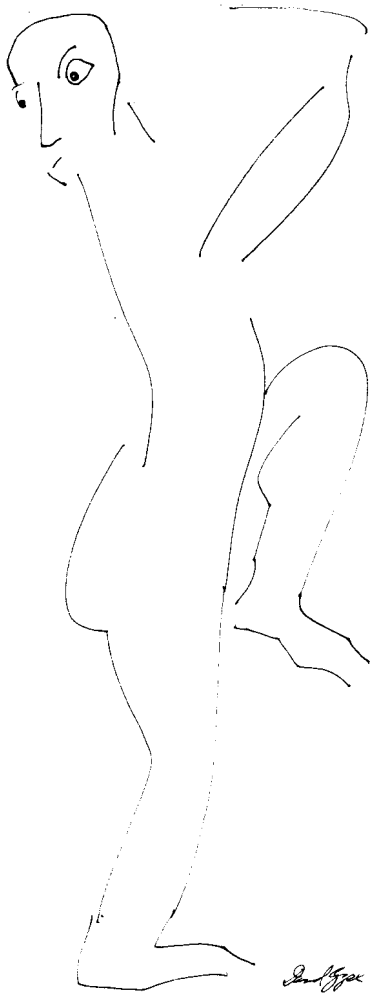
Dr. K.A. Kafato, a Burlington psychiatrist, is one of the rare ones who makes house calls on elderly patients. He finds that families with an aged problem member don't even consider treatment, but mostly ask where they can take him or her for institutionalization.

Some professionals, however, are critical of the use of ECT on the aged. Neither the American nor the Canadian Psychiatric Association has examined the issue in its most recent position paper on ECT.

Over thirty-five years ago (about eight years after shock was first introduced in

North America), psychiatrist Alexander Gralnick reported in a research article—a survey of 276 ECT cases in one New York hospital—that four people had died shortly after receiving shock treatments. In this 1946 article (published in the *American Journal of Psychiatry*), he warned: "Advanced age and pre-existing organic brain disease are the most common findings in those [shock-related deaths] so far reported."

Eleven years later, in 1957, psychiatrist David J. Impastato—a strong supporter of shock treatment—reported alarming findings of his detailed analysis of 254 shock-related deaths in **Diseases of the Nervous System**. A key finding was that the death rate from shock for older people was "approximately one in 200 patients or 0.5 per cent in patients over 50 years of age." In sharp contrast, the average overall death rate for shock victims of all ages is roughly one in 1,000 patients. In other words, a person fifty years of age or older is at least five times more likely than a younger person to die from electroshock. Impastato's important study has been generally neglected or simply not referred to in the recent ECT literature.



OLDER RESIDENTS' RIGHTS

Joan Christensen of Metro Social Services chaired a recent conference of the Ontario Association of Residents Councils that produced a nine-page bill of rights. The fact that they need to be declared as rights indicates in which areas residents want changes. Encapsulated, they include:
THE RIGHT TO:

—receive courteous, fair and respectful care and appropriate medical, nursing, socio-psychological diagnostic assessment and treatment.
—know the name of and be introduced to all helping professionals and volunteers assisting in the resident's care.

—have one's position, condition, care and treatment explained in comprehensible terms.
—be involved in decisions affecting one's life.
—not be made dependent.
—form friendships and enjoy normal and loving relationships with the opposite sex without hindrance or embarrassment.
—have personal, financial, medical or other records kept confidential.
—refuse treatment and medication and be informed of the consequences of refusal.
—write and receive mail without interception or interference.

—enjoy privacy in counselling, treatment or care for personal needs.
—hold private communications.
—present grievances without fear of reprisals.
—be given a written statement of rules and regulations prior to admission and to expect they will be complied with.
—have adequate nutritious meals attractively presented and served.
—be spoken to, clothed, sheltered and cared for as befits their status as adults and without threat of verbal or physical abuse by staff.
—not be confined to bed, chair or home unless written medical condition warrants.
—be free to refuse to participate in experiments of any nature, studies, surveys or polls.
—manage one's own financial affairs or receive an accounting of transactions authorised on one's behalf.
—receive a monthly comfort allowance.
—receive compensation for services performed or sale of items made in the home.

—bring and keep possessions as space allows and be assured of their security.
—be provided with opportunities to continue to develop as a mature adult.
—palliative care, death with dignity and burial service in accordance with one's last wishes.
—expect all staff to be informed of the above rights.

Psychiatrist Peter R. Breggin, an outspoken opponent of shock, has severely criticized—in fact totally condemned—the use of shock treatment publicly and in his book **Electroshock: Its Brain-Disabling Effects** (Springer, 1979). In the book, Breggin states that a "substantial number of people aged 65 and older are given ECT (16.1 per cent in general hospitals, 11 per cent in private hospitals). ...ECT is most dangerous when given to older people." He says that it causes a "worsening of pre-existing brain damage".

Many people question the use of ECT on the aged, especially when older people rarely receive a complete medical examination in psychiatric institutions, nursing homes or homes for the aged.

Nevertheless, the electroshocking of old people continues. People in their eighties or nineties have been shocked. There is even a reported case (*Minnesota Medicine*, 1974) of a ninety-four-year-old woman being shocked, simply because she refused to eat and was apparently suffering from "anorexia nervosa". After her fifth shock treatment, the staff found that she was "very co-operative, ate well and showed almost no paranoid thinking." The woman, probably damaged by ECT, was then sent to languish in a home for the aged.

Some doctors specialize in giving ECT to old people. California psychiatrist Allan Gunn-Smith once admitted to administering "more than 4,000 ECT treatments to 200 persons mostly between the ages of 65 and 100" during a six-month period in 1974 at Stockton State Hospital. At a hospital disciplinary hearing, Gunn-Smith was demoted and ordered not to shock anyone, because of the public outcry against his practices led by the Network Against Psychiatric Assault in San Francisco and Los Angeles (*On The Edge*, 1981).

Suicide

Seniors have the highest rate of suicide. When an elderly person talks of suicide, it's a very serious matter. The ratio of attempted suicide to suicide in a young woman is 250:1, an old woman 4:1; a young man 25:1 and an old man 2:1.

Dr. K. Shulman, an Ontario psychiatrist, believes that suicides of elderly people are the result of undiagnosed but treatable depressions. "The average elderly suicide has only a mild to moderately severe disorder, a condition common to many of our older population."

It seems that their social, political and economic situation is ignored or has been redefined as a series of private medical problems amenable to psychiatric treatment.

Interestingly enough, many of these suicides are caused by painkillers, sleeping pills and antidepressants prescribed by physicians. One study found that half the sample saw a doctor during the week before their suicide. In Britain there was an increase in suicide using antidepressants, while deaths from barbiturates were reduced in response to a public health campaign.[3]

Shulman quotes Simone de Beauvoir's book on aging in discussing suicides of seniors as "the normal reaction to a hopeless, irreversible situation that is bound to be unbearable". De Beauvoir encourages us to look honestly at the devastating social and econonomic position of older people.

Community Services

Studies show that the mortality rate increases dramatically when elderly people are institutionalized rather than being given community or home care.

Discharged psychiatric inmates and the elderly are presently sharing a common vulnerability at the hands of provincial governments, which have enacted a policy of deinstitutionalization and cutbacks without providing community-based support.

Joey Edwardh, formerly of the Health Advocacy Unit of Toronto and now working on an aging research project at the University of Toronto, feels that duplication of services from several branches of government results in fragmentation and large gaps in community services. The few services that bridge the gap between community and institutional living are flooded.

Meals on Wheels, a nation-wide volunteer service, delivers a warm noon dinner at a subsidized rate. Elizabeth Raby, who coordinates volunteers at the St. Christopher centre — Toronto's first branch — finds she now has many ex-psychiatric inmates in her program.

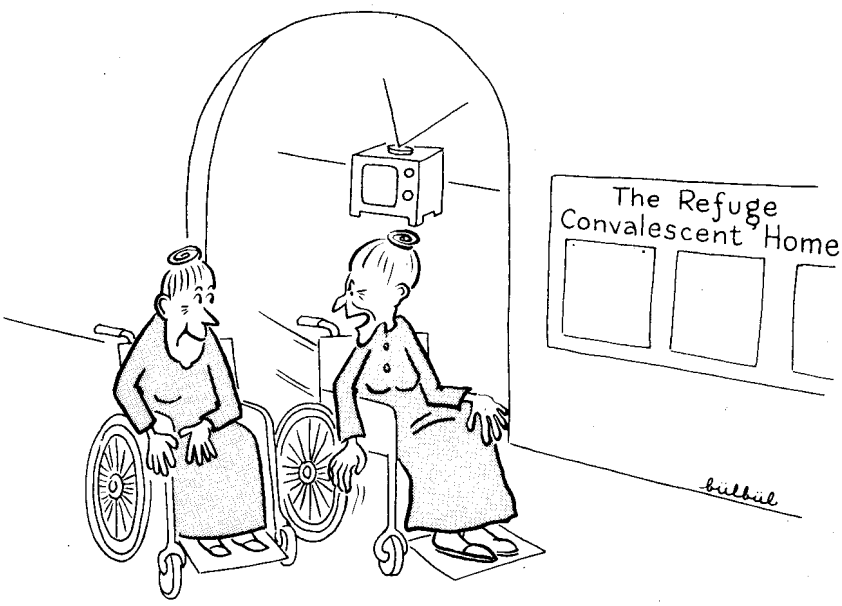
There are branches of the Alzheimer Society to counsel families with a senile member in Ottawa, Guelph, Hamilton, Kingston, Toronto, Montreal, Edmonton, Vancouver and Nova Scotia.

Other Ontario community services are provided by Home Help, Home Care, The Oshawa Day Hospital and Baycrest Centre for Geriatric Care, but these are only a handful of mostly volunteers, and too large a proportion of the elderly are inappropriately turned over to the institutional machines. What is needed to reverse this trend is better planning of services that make staying in their own homes possible.

Positive Alternatives

At the privately-run Spencer Nursing Home in Moncton, New Brunswick, all except life-sustaining drugs are omitted two days a week in an experiment that began last July.

"So far," says the home's head nurse, Emma Young, "we found it's worked very well. The guests are very alert and aware of their surroundings."



**We've locked the director in the broom closet—
we're busting out of the joint tonight.**

Drawn by Bulbul from* Everybody's Studying Us, *available from Volcano Press, 330 Ellis Street, San Francisco, CA 95689 for $3.95 plus $1.25 postage.

The Oshawa Day Hospital nurses do regular health maintenance on seniors to prevent illness, making it possible for them to stay in their own homes, "which most of us want", says Doris Marshall of DEA (Development, Education and Action), an intergenerational Toronto group.

As an example of their approach, the exercise bike wasn't being used until they tacked up maps of holiday places on the wall. Now seniors mark their progress, taking a trip in their imaginations; it became fun.

Included at Oshawa is a life planning course. "No matter what your condition, you must go on and plan your life," says Marshall.

Winnipeg Deer Lodge Hospital and Toronto's Baycrest Centre for Geriatric Care may be working toward this more humane approach to senior health care.

In December 1981, the Toronto *Star* reported that "Straps, bed railings and other restraint devices...can cause more injuries and distress than they prevent." At least two deaths occurred in Canada in the past few years when patients held captive in their beds by straitjackets strangled on the jackets' long ties as they tried to get out of bed.

A $60,000 grant from Suncor Inc. will pioneer restraint-free care in a ten-bed unit at Parkwood Hospital in London, Ontario, where beds can be lowered so patients can get out of bed easily. Minimum use will be made of wheelchairs because the aim is to keep the elderly mobile.

In Europe, parent-sitting services are being developed to give middle-aged children a vacation break.

In Montreal, a cooperative building is owned by elderly people who had an architect design and build it to their specifications and within their resources.

Says Doris Marshall of DEA, "This is the way it should be: older people plan and carry out a project."

Political activist and U.S. Gray Panther leader Maggie Kuhn in her book **Maggie Kuhn on Aging** argues that neither the disengagement (retiring from everything) nor activities (making useless ashtrays, playing Bingo, etc.) theory of aging is valid.

Seniors, she says, should take their rightful place in political power struggles based on accurate information understood by all participating.

"Old people often have an exaggerated case of inertia linked with cynicism, loneliness and despair. Much of the despair will lift when we realize that the power ultimately is in the hands of the people."

1. Richard Huges and Robert Brewin, *The Tranquilizing of America.* New York: Harcourt, Brace, Jovanovich, 1979.

2. Paul Lonfholm, Pharm. D., "Self Medication by the Elderly," in *Drugs and the Elderly.* Andrus Centre, University of Southern California Press, 1978, p. 13.

3. Kenneth Shulman, "Suicide and Parasuicide in Old Age: A Review," *Age and Aging* 7(1978), p. 201.

NO ATTEMPT AT HUMANE TREATMENT –reader

I did some work in a home for the aged in 1974 in St. George, Ontario, which is a small town outside Hamilton. While working on the night shift, I saw a woman in her eighties being made to dress at 4:30 in the morning, so that the people on the day shift, the staff, would not have to bother dressing her. I saw a woman with breasts the size of pumpkins being made to stuff them into a thirty-six-inch bra and when I mentioned this to my superior, she simply said, "There's no larger size."

In the Hamilton O.H. I saw zombies lining up for drugs, eating plastic food out of plastic plates with plastic forks and knives, breathing stale air and having all desire to live completely thwarted. No mention or notion of love and concern. No attempt at humane treatment or warmth. And this is where they are all at.

Just imagine if some of the drug fund went into art materials; if people were encouraged to express their pent-up emotions, their alienation, to come forth in expression that would be uniquely theirs and universally accepted. Imagine if instead of treating human beings as burdens the muses kept them full of spirit and the nurses and doctors acknowledged that their patients are the only things that give their life value.

Imagine if we had vision and reverence for the aged as do other cultures more successful than ours, with a greater history and greater Christian concept, to see that Christ lives in everyone if you give Him the chance.

Proper diagnosis of most diseases is the first step to the cure. Here we are giving names to things that we don't even know what they are, lumping human beings into categories and dismissing them.

People need to be reminded of the way things used to be, could be again. This whole culture is geared to the fast lane. How can we expect the healthy and intelligent minds to be still well when the world is a battle-field?

A.E. Shaw
Toronto, Ontario

THINGS TO WATCH OUT FOR

If you are caring for an aging relative or friend, or if you are a senior yourself, here are some things to remember.

1. The older person may be getting too high a dosage of a particular drug. Poor diet and a slower body system mean that drugs stay longer and act with more strength in the person's system.

2. Taking several drugs at the same time greatly increases the risk of harm from drug interactions, which seem to occur more frequently in the aging. The principle of simplicity should be applied—i.e., the physician should constantly attempt to reduce the number of medicines to the absolute minimum necessary and not continue to renew prescriptions indefinitely.

3. Older people seem more likely to have "paradoxical reactions", which are reactions in which the drug produces the opposite of the intended effect. This can occur with all the mind-altering drugs.

4. Older people who are given consistent doses of minor tranquillizers such as Valium can have extreme withdrawal reactions including seizures if the medicine is suddenly discontinued. This sometimes happens when a person is transferred from a nursing home to a hospital.

profiles

Coast Foundation Society

by *Carmen Schumen* and *Jim Moulton*

The Coast Foundation Society is a well-known community-run service for consumers of the psychiatric care system in Vancouver.

It offers a number of services ranging from assistance in finding food, shelter and sources of income to helping create group activities and resocialization projects for the psychiatrized. Its main emphasis, however, is offering alternative housing facilities of all kinds to the psychiatric consumer.

Coast became incorporated in 1974. It believes "a person cannot be healthy, independent and capable if they [*sic*] are treated as sick, dependent and inferior." Coast tries to steer away from the institutional or professional methods of relating to people. Attention is placed on the strengths of the individual and his or her potential for growth.

This organization is a mixed model of self-help and social services and tends to leave community organizing to the Mental Patients' Association (see our last issue on this and other psychiatric consumer-run self-help groups across Canada).

A majority of Coast's 60-plus staff members and some board members have received psychiatric treatment. Psychiatric treatment, however, is not a criterion for getting a job at Coast and no guidelines exist about the consumer/-professional make-up of its board.

Coast was set up when a number of people became aware that discharged psychiatric inmates had no systematic help in finding lodging, community services and/or sources of income. These conditions were contributing to the revolving door syndrome.

In 1972, several workers began visiting the Vancouver General Hospital to establish contact with inmates about to be discharged. They began by giving them assistance in finding housing, teaching budgeting, life and living skills and familiarizing them with their community services. They also helped them secure some source of income, be it social assistance or employment. They continued with follow-up work to see if the ex-inmates were adjusting well to their new environment.

Studies have shown that the recidivism rate of those involved in Coast programs has dropped significantly.

Today most funding for Coast programs comes from the province's Health Services and Human Resources. Federal grants pay for apartments and homes. Manpower funds its Traditional Employment Program.

Coast has received money from the Canada Mortgage and Housing Corporation to build four houses, which have 106 units. These are bachelor and one-bedroom units with a communal laundry. Various agencies and groups help the individuals to furnish their units. Each person is responsible for him or herself but great emphasis is put on group and peer support.

Each house has a live-in manager and a social director. Life skills are taught once a week and emphasis is put on persons using as many community resources as possible. Tenant councils meet once a month to encourage residents to run their own lives. Common-law couples as well as singles can rent space. If tenants are hospitalized, their apartments are kept for them until they get back.

Coast is hoping to receive funding to open more of these houses in the near future.

"Cherry Doors" is an example of one of CFS's four boarding homes that are run in addition to their housing projects. It is located in the elegant area of Shaughnessy. It is a very large, cosy, clean house in excellent repair with a large flower garden.

Fourteen women live in this home. Their ages vary from the early twenties up to the sixties. These are women who are motivated and capable of self-care. This is their home, not just a house, and the length of time they may stay there is indefinite.

The boarding home is licensed by both the city and the province and is regularly inspected. A health care team does regular follow-up with all the clientele. There are also a cook, a cleaning lady and a live-in staff member.

Jim Moulton

Welfare pays for the clients who live there at a per diem rate of $10.50 per day. Each boarder receives $40.00 per month spending money and may in addition do twenty hours per month of volunteer work to receive an extra $50.00.

The aim of the boarding home is self-care. The boarders are encouraged to do their own laundry and other tasks, and to participate as much as possible in the smooth running of the home.

Coast also operates three other boarding homes—Kitsilano, which houses fourteen men; the Crossroads, which is for thirteen men; and the Highlands, which is co-ed and houses eighteen people.

Another important aspect of Coast is its activity centre, which is open daily. A number of activities take place there, such as sewing, arts and crafts, games of various kinds, singing, music and dance therapy. A newsletter is published monthly and distributed free to all members of Coast. A bus and two vans donated by the city allow members of Coast to make several weekly outings to community events.

Some Coast members have formed a rock band that plays at various events to earn themselves some pocket money.

Coast Foundation Society
295 E. 11th Ave.
Vancouver, B.C.
Office: (604) 879-9612
Centre: (604) 879-2363
(604) 872-3502

New groups

A self-help group is forming in Red Deer, Alberta. For more information write:

Gary Lee
4126 47 Street
Red Deer, Alberta.

Groups that have recently formed in other parts of the world are:

The Hackney Mental Patients Association
c/o David Kessel, Acting Secretary
101 Median Rd.
London E5, England.

Mental Patients Resistance
1/38 Cumberland St.
The Rocks, NSW
N.Z. 2000.

Project Acceptance
P.O. Box 187
Lawrence, Kansas
U.S.A. 66044.

Jewish group

by *Mel Starkman*

The CHAI-TIKVAH FOUNDATION was recently incorporated to provide aftercare services in the Toronto Jewish community for the large number of Jewish ex-psychiatric "patients".

In November 1981 a group began to meet regularly at the Jewish Community Centre at Spadina and Bloor, with the support of the CHAI-TIKVAH FOUNDATION (CTF). Mel Starkman, the secretary of CTF, worked with Marci Besserman, and several other volunteers to have the CHAI-TIKVAH SOCIAL GROUP take responsibility for its own self-help endeavours. To date the volunteers still carry the ball, but several highly conscious ex-"patients" (they resist the designation "inmates") give promise of taking on responsibility.

There have been discussion groups, poetry readings, a Chanukah party, bowling and other outings. At this time a move is planned to the Beth Emeth—Bais Yehuda Synagogue's Hadima Centre Drop-in, which provides services in the north of the city to vulnerable groups of citizens in the Jewish community.

Those interested in contacting the CHAI-TIKVAH SOCIAL GROUP can call 665-0812.

Comeback from psychosurgery

People

DONNA LOVELL

by *Annegret Lamure*

There it sits, white, bulky, efficient, and humming comfortably, a perfectly ordinary fridge, but an extraordinary symbol of success. The refrigerator in the kitchen is Donna Lovell's personal badge of independence.

"I haven't been in a hospital for many years, but every time I look at that fridge I know I'm running my own life," explained Donna. "It's the little things you miss, and it's the little things that are important." She stopped to pet her cat and laughed, "Every time I open the fridge, it's a celebration."

Donna, 37, has a lot to celebrate. She not only managed to survive years of hospitalization that included countless electro- and insulin-shock treatments, long periods in solitary confinement (seclusion), maximum doses of powerful psychiatric drugs and their nightmarish side effects, and a botched frontal lobotomy, but managed to survive with spirit and style.

Her cozy, cluttered apartment, filled with momentos, innumerable photographs and toys, attests to a rich and busy life filled with work, pets, friends and children.

"Of all the horror stories in the world, I'm just one."

Donna prefers to forget her hospital experiences in favour of the here and now. "I'm a person that let the past go," she affirmed. "Of all the horror stories in the world, I'm just one."

However, not dwelling on the past does not mean forgetting about it.

Donna remembers only too well coming out of the institution and having nothing to go back to, "...no friends, no job, no family really either—mental illness takes your place in the family...", and is now committed to helping other ex-inmates who are in the same situation. She is presently working with six different groups and committees in Durham trying to improve mental health, aftercare, and community services. She is active on the executive committee for the Hope Centre (a self help group and drop in), is program chairman on the Committee of Mental Health Durham, serves on the executive committee for the Community Involvement program, is a member of the Standing Committee on Mental Health, is a board member of Mental Health Durham, and acts on the Self Help Committee of Mental Health Durham.

"It sounds like an awful lot," said Donna, "but basically I speak for patients' rights in our area. Every time I want to pull out, I realize there's no one else to speak for them."

Donna became a "patients' rights advocate" more or less by accident. She attended a public meeting regarding the building of a new twenty-seven million dollar facility at Whitby.

"They were going to build this grand and glorious edifice."

"They were going to build this grand and glorious edifice," said Donna, spreading her hands expansively," and I said to myself, 'I'm not going to let this asshole [an Ontario Ministry of Health representative] snow the public.' I'm afraid I got up and let him have it." Her mischievous brown eyes looked anything but regretful as she continued, "I asked him why the hell they were rebuilding the place when they should have torn it down." She folded her hands modestly and added, "except I was more diplomatic."

After the meeting she was asked to serve on the committee of Decisions for a Decade, the Re-Development of Whitby.

"The mandate was to look at the building of the hospital—bricks and mortar—not services, but as we talked to social agencies, the housing people and community groups, there was a lot of flack.

"Suddenly we were looking at services. There were all these needs--employment, housing, community support—the only thing they didn't need was a big hospital. They needed decentralization, a decrease of beds and the increase of community services."

As a result of the committee findings a governing board from the community is going to have a say in the running of the hospital.

"I'm sure I was placed on this committee [Decisions for a Decade] as the 'token nut,' laughed Donna ruefully, "but I believe when I left the committee, I left with a great deal of credibility. I was told [by other committee members] if anyone kept the committee down to earth it was me."

Donna viewed the committee work with satisfaction, but was amused by the irony of revisiting the hospital. "Talk about weird. I'm sitting there talking to doctors, supervisors and administrators who knew me as a patient. And they had to take me seriously."

"No one can help me. I've got to do it myself."

Being taken seriously, being respected as a person, is vital, Donna feels. She attributes her recovery to a handful of supportive people—including herself.

"When I was twenty-eight I had taken an overdose and they'd pumped me out. The next day I was to go to therapy. I was sitting there, watching people acting out drama or something, and it was like lightning hit. I thought, 'No one can help me. I've got to do it myself.' I realized I wasn't such a hot shot. I had a lot of things I didn't like about myself—a lot of things other people didn't like—and I decided to change. I haven't been in a hospital or seen a psychiatrist since."

Before this point, from age twenty-one to twenty-eight, she averaged about four overdoses a year. The worst period was the early twenties. "After that the revolving door took longer swings," said Donna. She attributes this improvement to a very good G.P. who refused to hospitalize her.

"He said to me, 'Donna, get on home and I'll see you in two days.' The only time I got back in was when he was on holidays. I'd take an overdose and some fool would let me in. Then he'd come back and he'd be furious."

"One day I woke up and realized I was in a mental hospital."

Donna was hospitalized for the first time at sixteen in Penetanguishine (not in Oak Ridge, the section for the criminally insane) following the death of her eighteen-year-old brother. "They said I was in schizophrenic stupor—I guess I was a veggie for three months. I got ten shock treatments in ten days. They had to feed me, dress me...I think it was the environment. Talk about the Dark Ages—they were still tying people to benches, people were using tin plates and spoons, there were seclusion rooms where people stayed all their lives—it was too much. Then one day I woke up and I realized I was in a mental hospital."

Her response to incarceration (after the initial catatonic state) was rebellion.

"I fought them every inch of the way."

"I fought them every inch of the way." Hospital staff retaliated by putting her in seclusion. "You were considered ill," explained Donna, "but they punished you."

And the punishment was severe. Endless days in a seclusion room, stark naked (no clothes permitted), no toilet (two male attendants came twice a day to escort her to the bathroom), no one to talk to, nothing to read, no mattress, no sheets, and no heat. "You lay at the crack near the door for heat," recalled Donna.

However, even in seclusion, she kept on fighting. "When they brought the food, I used to fire it right back at them," she grinned. "I was so angry, so frustrated, it was the only thing I could do."

"It was the fight that kept me alive."

Staff considered Donna violent and gave her maximum doses of drugs. "They'd pop you a pill and you couldn't close your mouth or your eyes would roll, but at least they knew you were alive when you went on a bender and wrecked the ward. But really I only fought shock treatment and sedation." Donna leaned back on her comfortable flowered sofa and put her fingers together thoughtfully. "You know, I wasn't like that [violent] when I went in. It was the institution that caused it. It wasn't an illness. If I'd become placid, if I'd given under, I wouldn't have survived. It was the fight that kept me alive."

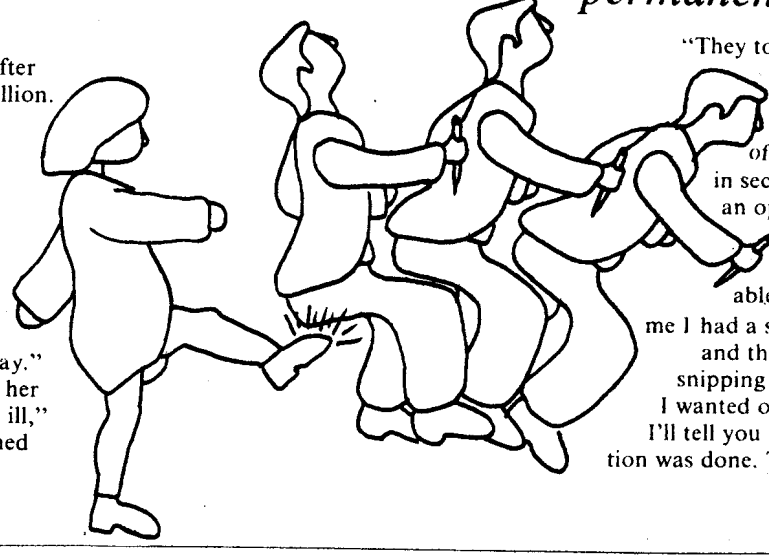
Survive she did. In Penetanguishine, then Lakeshore Psychiatric Hospital, where she received the new "miracle cure"—over a hundred insulin shock treatments that caused her to gain 150 pounds in six months. "Talk about self image at seventeen," commented Donna. She fought against the daily insulin injections (she got the maximum dosage, 500 mg.) and was subjected to "the pack". "They wet the sheets and let them shrink around you—every muscle in your body was in agony, they were so tight. When you got out you couldn't walk," she recalled.

When she was shipped (much against her wishes) back to Penetanguishene, her rebellion continued. "They used to shove 1200 or 1500 mg. of Mellaril in me at a time, but they'd never flatten me on it. Oh, my mouth was dry, I couldn't swallow, but they never zapped me out." With much enjoyment, she recounted how during a struggle one of the nurses holding her down got injected by mistake. "It put her out for three full days," said Donna with satisfaction. She also recounted the events leading up to the melee without regret. Apparently her doctor had prescribed a lot of drugs which she didn't want to take.

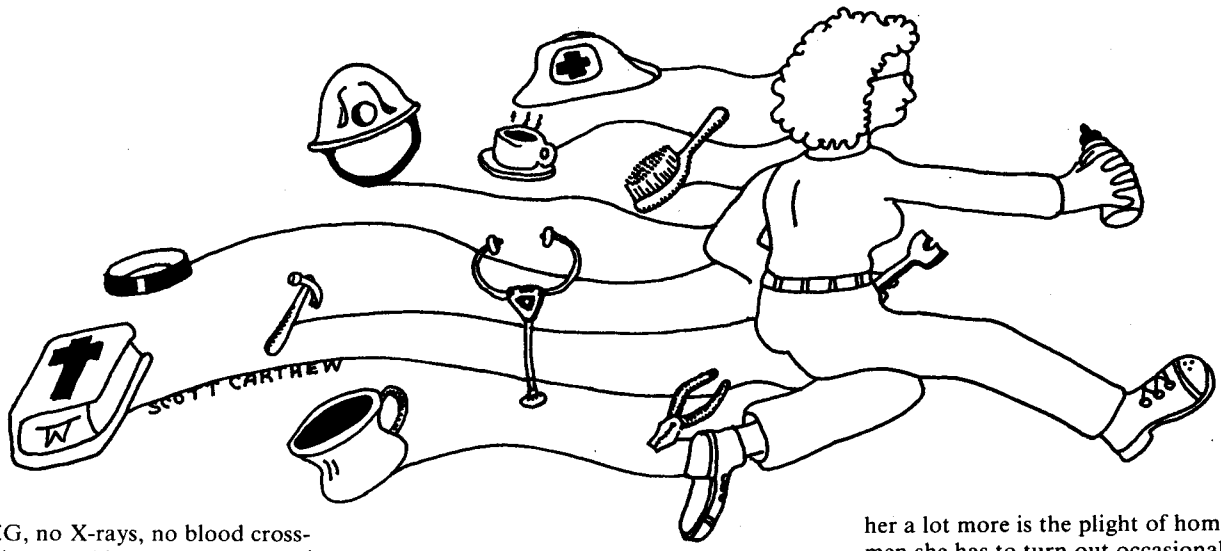
"I started yelling, 'Take them yourself!' "

"I started yelling, 'Take them yourself,' and then he ordered me to be put in the seclusion room. I knew if you weren't a basket case when you went in there, you'd be one when you came out, and I started swinging. Two nurses grabbed me, but I had a foot free and gave him a lifter in the pants." Donna's eyes danced. "He was in such a state of shock he left without locking the ward door and I went right after him. Unfortunately he stopped suddenly and I stepped on his foot. I was a big gal and—I broke it." However, the doctor had the last laugh—shortly afterwards, her mother and brother were persuaded to consent to a lobotomy operation on Donna. She was only seventeen.

"They told my mother and older brother my illness was permanent."



"They told my mother and older brother my illness was permanent. I would have to spend the rest of my life in an institution in seclusion rooms. They said an operation would cure me, or at least I would be easily controlled and able to function. They told me I had a short circuit in my brain and that they would fix it (like snipping a wire). I didn't fight it, I wanted out, I wanted to act well. I'll tell you roughly how this operation was done. They did no blood tests,



no EEG, no X-rays, no blood cross-matching—nothing. I never saw the surgeon before the operation, and I don't believe I saw him after.

"They opened my skull on both sides—and I'll tell you, the operating room was so small, so primitive that they had trouble giving me anesthetic. They couldn't find a vein in the arm opposite the surgeon and there wasn't room to give it in the other arm.

"They went in on my right side, put in a cutting instrument and turned it blindly. Normally there shouldn't have been a big blood vessel there, but there was. I started hemmorhaging, so they never finished. They patched it up as best they could and got out. So they never did the other side. But the hemmorhage was similar to a stroke and did damage, so now my left side [of her body] is smaller than my right, because when they did the operation I had not yet stopped growing.

"Afterwards I was told the operation was a success. But eventually the anger came back and I was transferred to Whitby."

It was here that Donna first got some badly needed support from a doctor—an internist. "I came down with typhoid and salmonella poisoning," she explained, "so I was Typhoid Mary and Crazy Lizzie." She battled her illness for almost two years, going back between the general hospital and Whitby, and the internist did his best to prolong her stays at the general hospital as much as possible. "That's when I first realized that there were caring people in the world. That's when I realized that I didn't have to be crazy to get attention," said Donna, and then added ruefully, "I learned I only had to be sick. If I was sick I got lots of loving care. I guess for a while I became the typical hysterical female. I had sinus problems, infections, asthma, you name it. It wasn't until I made up my mind to be healthy that I stopped getting sick."

Donna believes that attitude, at least for her, has a great bearing on health.

Shortly after leaving the hospital for the last time she got a job in a nursery school. She worked there quite happily for about three months when "Lo and behold an old nurse from the psychiatric hospital spotted me. No more job," Donna shrugged. However, she landed another job the next week and has been working ever since.

For several years she was employed as a Red Cross Homemaker and found the experience very valuable. "Again, someone cared and gave me a chance," Donna explained, "and having to go from one home to another, adapting to different people, taught me not to be afraid of change, of losing people."

Now Donna works at the YWCA in Oshawa as night supervisor for the women's residence and the emergency shelter for battered women and their children.

I've been your plumber, your doctor, your priest."

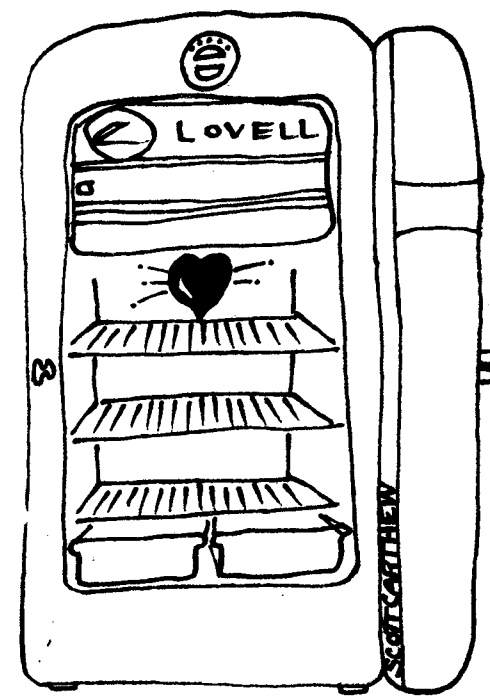
"I handle anything that occurs, and that means everything. I've been your plumber, your doctor, your priest, your nurse, your therapist. I talk to people with problems, nurse people that are ill, and," she said with an impish grin, "I spoil their fun."

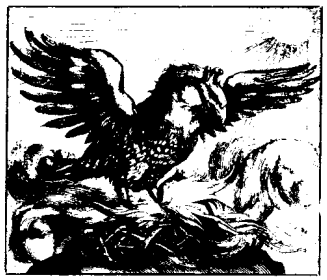
Part of her job is to prevent the smuggling of young men into the upstairs of the girls' residence. "The last time, I found a young man hiding in a closet," she chuckled. What troubles her a lot more is the plight of homeless men she has to turn out occasionally.

"The biggest problem is misplaced psychiatric patients. We now have a whole society of misplaced people. They have nothing and nobody. Since the dumping out of the hospital they have nowhere to go."

Luckily Donna is no longer one of them. She has her job (this is her sixth year at the Y), her community work, her friends, her hobbies, her apartment, her cats, and, of course, her fridge.

"Basically, I enjoy my life," Donna confided as she got out the cat bowl and opened the fridge door. "I don't have many hours to myself but"—she paused to feed the cats—"there are times when I shut off. I have to." She straightened, replaced the food and closed the door with a solid, satisfying thunk. The sound of independence.





phoenix pharmacy

Phenothiazine related deaths

by *Don Weitz*

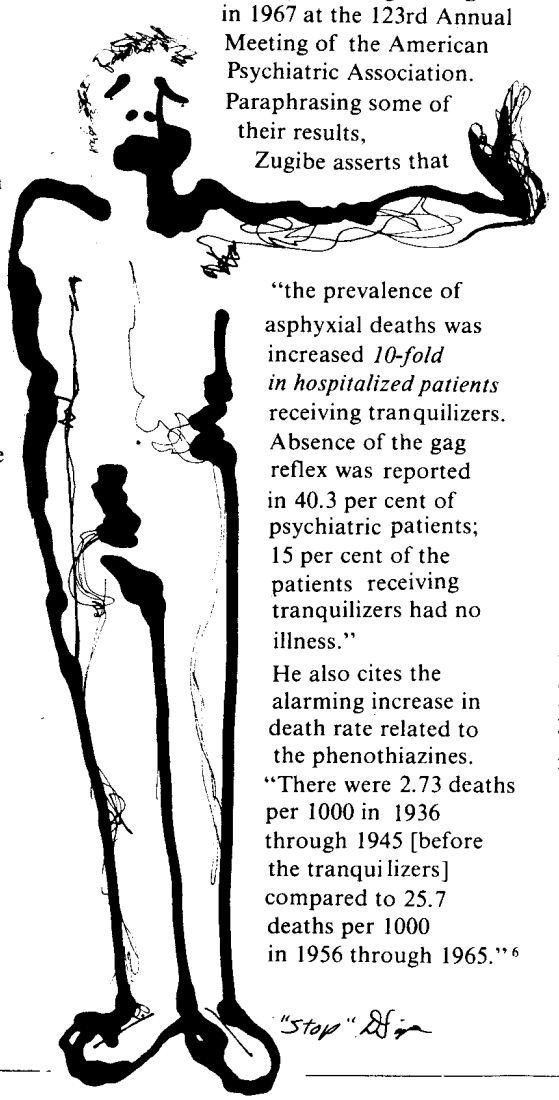
Sudden, unpredictable or mysterious deaths linked to the use of psychiatric drugs—particularly the phenothiazines—are unfortunately not so rare as many people believe. Since the early 1950s when the "miracle" tranquilizers were introduced, there have been thousands of drug-related deaths; a few hundred have been reported in the medical-psychiatric literature.

The drug-related deaths of Aldo Alviani, Patricia Ellerton and Norman Austin Davis within the past one and a half years at the Queen Street Mental Health Centre have heightened our awareness of the lethal risks of these drugs. (See report on Ellerton inquest in this issue.)

Phenothiazine-related deaths have been reported since 1956, two years after chlorpromazine (Thorazine) was first introduced. In a review of the English-language medical literature from 1957 to 1966, reports of sixty-four phenothiazine deaths were found; the reviewers reported twelve additional deaths.[1] Another review of the literature from 1963 to 1966 revealed that fifty (86%) of fifty-eight reported deaths involved three major tranquilizers—chlorpromazine, thioridazine (Mellaril) and trifluoperazine (Stelazine)—or a combination of them. The investigators concluded that there is a "real entity of sudden death caused by phenothiazines," and that the "two major types of sudden death [were] aspiration and rapid asphyxia" (strangling or choking on food) and cardiac arrest.[2]

There have been a number of other disturbing reports on phenothiazine deaths. For example, Hollister and Kosek reported six deaths chiefly involving chlorpromazine, Mellaril and Stelazine.[3] Two Canadian studies published in the 1960s are also noteworthy. One reported two deaths of psychiatric inmates in Kingston Psychiatric Hospital in Ontario; the inmates were receiving extremely high doses of Mellaril (1500 and 3600 mg daily) at the time of death, and both died from a heart attack and other serious cardiac complications caused by the drug.[4] In the other Canadian study, investigators reported three female deaths at Douglas Hospital in Verdun, Quebec. The drugs involved were chlorpromazine, methotrimeprazine (Nozinan, which caused Patricia Ellerton's death), and imipramine (Trilafon).[5]

The ability of phenothiazine drugs to suppress the gag or cough reflex was known over ten years ago. Miller and Chinoy reported this alarming finding in 1967 at the 123rd Annual Meeting of the American Psychiatric Association. Paraphrasing some of their results, Zugibe asserts that



"the prevalence of asphyxial deaths was increased *10-fold in hospitalized patients* receiving tranquilizers. Absence of the gag reflex was reported in 40.3 per cent of psychiatric patients; 15 per cent of the patients receiving tranquilizers had no illness."

He also cites the alarming increase in death rate related to the phenothiazines. "There were 2.73 deaths per 1000 in 1936 through 1945 [before the tranquilizers] compared to 25.7 deaths per 1000 in 1956 through 1965."[6]

Marvin

Marvin's in the cupboard
staring very strange
Chewing at his fingernails
nibbling on his brains

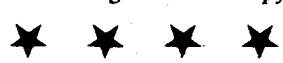
In 1965, Plachta first described the mechanisms involved in aspiration pneumonia and asphyxia, which he claimed was the cause of death in seven cases, all of whom were on various tranquilizers, including chlorpromazine. Plachta had evidence showing that sometimes the phenothiazines suppress or interfere with the gag and cough reflexes, which could lead to death.[7] In 1977, Solomon reported 17 deaths proven to be caused by aspiration.[8]

In a landmark retrospective autopsy study (late 1970s) of 203 deaths of psychiatric inmates in two psychiatric institutions in New York State (Rockland County), Coroner Frederick T. Zugibe conclusively shows that the phenothiazines frequently suppress the gag reflex, causing choking on food, and that this occurred shortly before death. He asserts that "over 30% of these deaths were ascribed to pulmonary [lung] aspiration of food or gastric contents, as compared to only 2% of cases...from outside these institutions...." Also, "of the patients from these institutions, 85.5 per cent were on psychotherapeutic and/or sedative drugs...." The probable cause of death in roughly sixty-four cases was "suppression of the gag and/or cough reflex". Incidentally, six pathologists independently examined all these deaths and confirmed Zugibe's major findings.

Furthermore, Zugibe cotinues, the **Physicians' Desk Reference (PDR**—a standard medical reference on all prescription drugs) specifically lists asphyxia and aspiration as some of many adverse effects of the phenothiazines. For example, the PDR states: "Thorazine can suppress the cough reflex; aspiration of vomitus is possible."; "In some cases the cause of death

was apparently cardiac arrest or asphyxia due to failure of the cough reflex."; "Autopsy findings have usually revealed aspiration of gastric contents."

Serious heart problems such as cardiac arrest have also been reported as a major cause of death in people receiving various tranquilizers. Death can occur even at *therapeutic* doses. The ability of the phenothiazines to cause fatal heart attacks and numerous other medical emergencies has been documented over the past ten to fifteen years [9] [10] [11] [12]. However, such risks are rarely, if ever, communicated to psychiatric inmates before or during "chemotherapy".



There are other medical complications or crises produced by the phenothiazines which can cause death. In a recent article from *On The Edge*, Dr. Caligari (pen name for Dr. David Richman) describes them. We summarize and paraphrase them here; although some are rare, they still are worth noting.[13]

1. *Disordered body temperature regulation.* The brain's "thermostats" are disturbed; the person is very vulnerable to dangerously low or high temperatures.

2. *The neuroleptic malignant syndrome.* A rare disorder characterized by very high fever, mutism, profuse sweating, muscle rigidity, rapid heartbeat, difficulty breathing and swallowing. The person also becomes delirious and disoriented. In about 20% of these cases death is the outcome.

3. *Bone marrow poisoning.* A rare condition in which the drugs have poisoned the bone marrow which makes white blood cells; the person becomes more vulnerable to overwhelming and potentially deadly infections.

4. *Drug-induced epileptic seizures leading to death.* Drugs often lower the person's "seizure threshold", which makes it easier to have a convulsion.

5. *Drug-induced blood clots.* While on these drugs, people can develop blood clots going to their lungs or brain—apparently a direct effect of the drugs.

6. *Paralysis of the intestines.* Rarely, the drugs can completely paralyze the intestinal muscles causing a medical emergency which often requires surgery Shock and death may result.

7. *Death after surgery.* Surgery and anesthesia may increase the risks of some of the drug's lethal side effects.

8. *Drug-induced suicidal state.* Cases have been reported of suicidal depression caused by drugs.

9. *Death secondary to tardive dyskinesia*, a potential cause of or contributor to death. No deaths have been directly

Reports on Drug-Related Deaths

CALIFORNIA

In October 1976, California's Department of Health contracted with the Department of Consumer Affairs to conduct an investigation of all deaths which occurred in state hospitals during a three-year period, beginning October 31, 1973. Private physicians were hired as medical consultants to assist the investigation. In addition, nurses were selected to evaluate nursing staff practices in these cases. The investigative teams reviewed 1285 deaths. The team concluded that there were serious quesions regarding the circumstances surrounding the patient's death in 120 cases. Deficient psychiatric-drug prescribing practices were cited 47 times in seven hospitals, with 25 of these cases being at Napa State Hospital. Deficient nursing practices (relating to drugs) were cited in 17 cases at four hospitals, 11 at Napa State. (Source: *Summary Results of Task Force Investigation of State Hospital Resident Deaths (1873-1976).* Office of Planning and Program Analysis, Sacramento, CA, 1978)

MASSACHUSETTS

In August 1980, a Massachusetts Senate panel investigating the state's mental health system listed 40 "unexpected deaths and disappearances" over a three-year period, 27 in state facilities and 13 in private facilities. At least four of the deaths were drug-related. Excerpts from the Boston newspaper article covering the story: " 'Drugs had been overused' in the case of Michele Montero, 22, who strangled while tied in a chair Sept. 19, 1979 at Taunton State Hospital." "Female, 61, Sept. 13, 1979, Taunton State Hospital. Cause unknown but may have been drug-related." "Male, 30, April 19, 1979, Solomon Mental Health Center. Question of over-medication." "Male, 51, Glenside Hospital, a private facility in Boston. Found dead of cardiac arrest in seclusion room shortly after placed there under chemical restraint." The Senate panel reported that none of the 40 cases was "appropriately investigated" by the state's Department of Mental Health of other state agencies. (Based on "Mental Care . . . A Deadly Nightmare," Anne Beaton, *Boston Herald*, August 6, 1980)

NEW YORK

"Heavy doses of tranquilizers given to patients at two of New York State's biggest mental institutions, both in Rockland County, were a contributing factor in the deaths of numerous patients, the county's medical examiner said yesterday. The official, Dr. Frederick Zugibe, said in an interview that studies by his office involving the Rockland Psychiatric Center in Orangeburg, N. Y., and the Letchworth Developmental Center [for the mentally retarded] in Thielles, N. Y., had showed that 'many' of the patients who died at those institutions were tranquilized to the point where they were unable to feel pain that would act as a warning of the presence of severe medical illness. 'A large percentage of deaths from the two institutions that we study are tranquilizer-related,' said Dr. Zugibe, who declined to release figures. . . . He said that most of the deaths studied by his office had resulted when patients vomited into their lungs because certain nerves necessary to prevent this from happening had been deadened by tranquilizers . . . Dr. Zugibe urged last night that the review board investigate deaths of patients in all state mental institutions because, he said, the abuses he had accused Rockland and Letchworth of were endemic to other state facilities as well." ("Tranquilizers Held an Agent in Deaths of Mental Patients," Pranay Gupte, *New York Times*, , July 17, 1978, p. 1)

SAN FRANCISCO

One day in August 1980, a woman believed to be about 52 years old, whose identity and medical history were unknown, was committed to San Francisco General Hospital. She was twice administered moderate doses of Prolixin and put in restraints. The following morning she was found dead.

TEXAS

"In Texas, a clinical psychiatrist who has toured nine hospitals at the request of the Department of Justice will soon testify in a federal suit [U.S. District Court in Dallas] that 15 patients died in 1980 by choking on food or vomit while on heavy doses of psychotropic drugs. Hospital records, obtained through the Freedom of Information Act, documented the deaths. 'All these drugs cause neurological problems,' the psychiatrist explained, 'and when they are given in combination and in high dosages without strict monitoring, this is what happens.' " (Mental Hospital Deaths," *Institutions, Etc.*, January 1981, p. 6)

UNITED STATES

Based on statistics gathered in 24 cities between May 1976 and April 1977 the National Institute of Drug Abuse estimated that there were 5800 drug-related deaths in hospital emergency rooms for 16 of the more widely used psychiatric drugs. The statistics did not include deaths from these drugs occurring in places other than emergency rooms: nor did the statistics reveal the number of these deaths that were caused by intentional overdosing as opposed to those resulting from compliance with physician-ordered prescriptions. The figures for deaths from psychiatric drugs used singly or in combination with other drugs broke down as follows: *major tranquilizers*–Mellaril (200), Thorazine (100): *minor tranquilizers*–Valium (900), Librium (200), Equanil and Miltown (200); *antidepressants*–Elavil (700), Adapin and Sinequan (200); and *sedative-hypnotics*–Seconal (800), Nembutal (600), Luminal (500), Tuinal (500), Amytal (300), Quaalude (100), Doriden (100), Dalmane (100). During the same period there were 1700 emergency-room deaths related to the use of heroin/morphine, which is 4100 fewer than the estimated 5800 psychiatric drug-related deaths. (From information in "The Organized Drugging of America," Peter Barry Chowka, *East West Journal*, Mar. 1979, p. 34)

linked to TD so far.

10. *Sudden death phenomenon.* Many factors are involved; it is impossible to calculate all the risks.

WARNING: BEFORE YOUR DOCTOR PRESCRIBES ANY MAJOR TRANQUILIZER FOR YOU, ASK HIM OR HER ABOUT THESE RISKS. GET AS MUCH INFORMATION ABOUT THE DRUG(S) AS POSSIBLE ...EN DECIDE WHETHE... ...ING THE DRUG(S) IS WORTH THE RISKS.

[1] Matthew T. Moore and M. Harold Book, "Sudden Death in Phenothiazine Therapy," *Psychiatric Quarterly* 44 (1970), pp. 390-402.
[2] Jan E. Leetsma and Kenneth L. Koenig, "Sudden Death and Phenothiazines: A Current Controversy," *Archives of General Psychiatry* 18 (1968), pp. 137-48.
[3] Leo E. Hollister and Jon C. Kosek, "Sudden Death During Treatment with Phenothiazine Derivatives," *Journal of the American Medical Association* 192 (1965), pp. 1035-38.
[4] H. Garfield Kelly, J.E. Fay and S.G. Laverty, "Thioridazine Hydrochloride (Mellaril): Its Effect on the Electrocardiogram and a Report of Two Fatalities with Electrocardiographic Abnormalities," *Canadian Medical Association Journal* 89 (1963), pp. 546-54.
[5] H. Warnes, H.E. Lehmann and T.A. Ban, "Adynamic Ileus During Psychoactive Medication: A Report of Three Fatal and Five Severe Cases," *Canadian Medical Association Journal* 96 (1967), pp. 1112-13.
[6] Frederick T. Zugibe, "Sudden Death Related to the Use of Psychotropic Drugs," in Cyril H. Wecht (ed.), **Legal Medicine 1980**. Philadelphia: W.B. Saunders, 1981, pp. 75-90.
[7] Aaron Plachta, "Asphyxia Relatively Inherent to Tranquilization," *Archives of General Psychiatry* 12 (1965), pp. 152-58.
[8] Kenneth Solomon, "Phenothiazine-induced Bulbar-like Syndrome and Sudden Death," *American Journal of Psychiatry* 134 (1977), pp. 308-311.
[9] Hollister and Kosek, *op. cit.*
[10] Kelly *et al., op. cit.*
[11] Robert Cancro and Russell Wilder, "A Mechanism of Sudden Death in Chlorpromazine Therapy," *American Journal of Psychiatry* 127 (1970), pp. 368-71.
[12] T.A. Ban and A. St. Jean, "The Effect of Phenothiazines on the Electrocardiogram," *Canadian Medical Association Journal* 91 (1964), pp. 537-40.
[13] Dr. Caligari, "Psychiatric Drug Deaths," *On The Edge* (June 1981), pp. 3-6.

Welcome to Penetanguishene

by *Philip Giglio*

Justice does not wear a blindfold
of balance scales for us
mental cases are like six packs
rolling from one fridge to another

the needles are the same
inducing crippling convulsions
on a cement floor
guards look through a wire mesh window
in a sliding metal door
they show concern like amateur actors
bright light is doled out as punishment
darkness is a privilege
(this year anyway)
a mattress, blankets, privileges
the coarse dress is a punishment
pretend you're a scotsman

Welcome to penetang
you'll learn

does anger dissolve like salt?
or is it just distributed
like flame from a lighter?

SHOCK DOCTORS

Wallace Mitchell, Greater Niagara General Hospital, Niagara Falls, Ont.
Werner John Pankrantz, Lions Gate Hospital, North Vancouver, B.C.

If you, a member of your family, or a friend, have been shocked by a Canadian doctor and want her/his name added to our list, please send us the doctor's name and hospital affiliation. Names submitted anonymously will *not* be included, but we will of course withhold the informant's name.

Listed psychiatrists who no longer use ECT, or who have been mistakenly included in the list, may ask *Phoenix Rising* to remove their names.

what's happening

World Health Organization study on Valium

The World Health Organization (WHO) is deciding whether Valium and its sister tranquilizing drugs, the benzodiazepines, need more regulation.

Dr. Ellinwood of the U.S. Food and Drug Administration's Drug Abuse Advisory Committee has called Valium an "exquisitely safe" drug in comparison to barbiturates and alcohol. It is now the fourth most popular drug in the U.S. after being number one for years. Since 1975 the number of Valium prescriptions has dropped by about one-half.

Mitchell B. Balter of the U.S. National Institute of Mental Health has done comprehensive research into drug abuse and does not believe Valium is being taken indiscriminately for trivial reasons. He reports the use of anti-anxiety drugs in the U.S. to be average compared with nine European nations.

Balter's research concludes that Americans are conservative drug users because they think tranquillizers are immoral and a sign of weakness. He suggests patients who abuse their prescriptions usually decrease their dosage, not increase it. His research also shows Valium to be safer than barbiturate hypnotics, which are ten times deadlier than the minor tranquillizers (the benzodiazepines), killing one per, 5,000 users.

But Dr. Jere Goyan, commissioner of the Food and Drug Administration last year, charges that Valium is being used by millions of Americans, most of them women, to handle the everyday stresses of life. And Dr. Sidney Wolfe of Ralph Nader's Health Research Group has gone on record as saying "therapeutic doses of Valium are addictive." "This public health problem," he claims, "involves 1.5 million Americans receiving benzodiazepines for a long time."

A British study this year noted nausea and anxiety, symptoms of withdrawal, in patients taken off benzodiazepines after prolonged usage. The symptoms are most obvious when a patient stops treatment abruptly rather than tapering off a dependency using other medicines that control withdrawal problems.

The manufacturer of Valium, Hoffman-La-Roche, in its studies, finds no withdrawal symptoms.

More disturbing are Montreal researcher David Horrobin's claims - which Canadian authorities are now investigating - that Valium speeds cancer growth.

The WHO's decision after the international review may have a bigger effect on Canada than on the U.S. however, because that country already imposes restrictions on benzodiazepines. A prescription can be refilled only five times without a doctor renewing his authorization. Manufacturers are required to inform doctors of proper use, side effects and risks involved with the drugs. And doctors are not to prescribe benzodiazepines to combat normal anxieties of everyday life.

A proposal by the FDA for a simple explanatory leaflet discussing the drug a patient buys is currently being stalled by the Reagan administration. Drug companies, doctors, and druggists are strongly opposed to the proposal.

Study shows patients often given wrong drugs

A recent story in the Toronto *Star* (Feb. 12, 1982) reports that two drug researchers have discovered that many patients are being given the wrong drugs for their condition. In **Medication Errors: Causes and Preventions**, Michael Cohen and Neil Davis (professors of pharmacy at Temple University in Philadelphia) report many cases of people receiving other people's drugs. They also report other errors, such as the case of a man being treated for a painful right ear.

Hard hitting brief on human rights

Last December, Carla McKague and Don Weitz, members of ON OUR OWN, wrote a hard-hitting, 30-page brief on human rights at the request of consultants to the Ontario Human Rights Commission. The brief is titled "WHAT RIGHTS?"; it details numerous violations of the rights of psychiatric inmates and former inmates under the *Canadian Bill of Rights*. The issues discussed include housing, employment, sheltered workshops, and "cruel and unusual treatment or punishment" (such as drugging, electroshock, behaviour modification and solitary confinement). One of the brief's ten recommendations urges the government to change the *Ontario Human Rights Code* so that "the Commission has jurisdiction to investigate and act upon *all* violations of human rights ... within psychiatric facilities and other institutions for the handicapped." (Copies are available for $2.50 each plus $.50 mailing costs. Copies can be ordered by writing to: Publications, Box 7251, Station A, Toronto, Ont. M5W 1X9.

The nurse misread the words "r. ear" in the doctor's order as "rear", and gave the antibiotic/anaesthetic drug in the rectum three times before the mistake was discovered.

The "error rate" in most hospitals is about twelve per cent. "In a hospital with 300 patients getting medicine, that means 131,400 medication mistakes a year...." Anybody want to guess the error rate in a psychiatric institution such as Queen Street?

Silent march in Switzerland

A silent march by ex-psychiatric inmates and their supporters on June 29 in Geneva, Switzerland, outside the gates of the Belair Psychiatric Institution, has put a focus for the first time in that city on the issue of overdrugging in mental hospitals.

The demonstration, organized by the Association des Usagers de la Psychiatrie (ADUPSY) was commemorating the first anniversary of the death of one of its members, Alain Yrban. While Yrban's friends and family pursue a suit against the hospital through the Swiss courts, it has been revealed that he and three other patients may have died from a "deep sleep therapy". One of the three was given the treatment even though he had had several heart attacks.

ADUPSY, with about 160 members, is split among its ex-inmate membership on the issue of public demonstration because of the fear by some that they could be locked up again if they become involved in any illegal actions.

The organization holds drop-in hours when people can call or come in with problems every Tuesday evening from 6:30 to 9. They see themselves as an alternative to psychiatry and, among other things, inform people of their rights.

Psychiatric guidelines are offensive

Many Jews may be surprised at the psychiatric guidelines set out in a 1980 book.

Jewish Medical Law — A Concise Response, by Avraham Steinberg, MD, sets a tone that is offensive to humanity in general and to those of the Jewish faith in particular.

The most distressing dictates say: *Mental illness that may result in the patient harming himself or others is considered a life-threatening disease.*

It is permitted to perform psychosurgery on such a mentally ill patient, even if, as a result, his personality may be changed. Such surgery is permitted even though it involves exposing the patient to the risks of surgery.

No warning for consumers of prescription drugs

The U.S. Food and Drug Administration (FDA) has decided not to require drug companies manufacturing popular prescription drugs to supply leaflets along with them, listing their dangers and how to use them.

The FDA has reported it believes the Patient Package Insert Program "imposed unreasonable constraints on the health care system." They plan to set up a Committee on

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