

**Identity, Inmates, Insight, Capacity, Consent, Coercion:  
Chemical Incarceration in Psychiatric Survivor Experiences of  
Community Treatment Orders**

by

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## **Abstract**

This is a qualitative analysis of forced treatment by someone who has been forcibly treated. Inspired in part by institutional ethnography, this interpretive inquiry assembles and analyses: focus group and interview transcriptions, psychiatric tribunal texts, literature on coercion and institutions, and personal narratives involving so-called 'mad' experience. Through psychiatric workers' and activists' perceptions, I explore psychiatric survivor experiences under a 'Community Treatment Order', or 'CTO', a new legal mechanism in Ontario, Canada, which can be used to compel psychiatric drug treatment for people leaving psychiatric facilities. Participants discuss force, coercion, and problems related to the medico-legal status of CTO's, including 'consent to treatment' rights, and 'insight into mental illness' tests. This analysis highlights cyclical practices of power that sustain psychiatric institutionalization as it expands beyond physical sites into the private sphere. I argue the CTO constitutes a chemical imprisonment within the body.

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## Table of Contents

|   |     |
|---|-----|
| Abstract  | ii  |
| Acknowledgements  | iii |
| Table of Contents   | iv  |
| Lists of Tables and Figures                                       | vi  |
| Chapter i   |     |
| Contemporary Institutional Psychiatry                             | 1   |
| The Community Treatment Order                                     | 1   |
| Cyclical Practices of Power                                       | 3   |
| Scope of this Research and Problems with CTOs                     | 6   |
| Chapter ii  |     |
| Tempflux~a (24), numen 1 ion: Dear Editor,<br>Achieving 'Madness' | 9   |
| Necessary Narratives  | 10  |
| 'Madness' is not a Violence                                       | 11  |
| 'Mad' Standpoint When No One is Mad                               | 13  |
| Advocacy in Modern Institutions                                   | 16  |
| Chapter iii   |     |
| Participants, Perspectives and Language                           | 21  |
| Lack of Information and Rights Under CTOs                         | 23  |
| Wishing to Flee Canada  | 28  |
| Targets of CTO Treatment  | 32  |
| Purposes and Effectiveness of CTOs                                | 37  |
| Chapter iv  |     |
| A Brief Local History of the CTO                                  | 41  |
| Reflecting Upon Local Research                                    | 43  |
| Echo From Vancouver   | 43  |
| Pharmaceutical Lobbying and Intervenors                           | 45  |
| The Insight and Capacity to Consent to Treatment                  | 46  |
| The Consent and Capacity Board                                    | 48  |
| Mental Health Act Forms and Criteria for CTO                      | 49  |
| Substitute Decision Makers and Families                           | 51  |
| Assertive Community Treatment Teams                               | 52  |
| CTO Research  | 53  |
| Chapter v   |     |
| Amongst the Free and Untreated                                    | 55  |
| Institutionalization: Diagnosis, Treatment and Education          | 56  |
| Chemobotomy   | 58  |
| Confinement from Within   | 61  |
| Separation without Walls  | 62  |

|  |              |     |
|--|--------------|-----|
|  | Chapter vi   |     |
| Chemical Institutionalization                              |              | 64  |
| The Cycling of Evidence                                    |              | 68  |
|  | Chapter vii  |     |
| Dreams of Escape   |              | 73  |
| Gender Under CTOs  |              | 76  |
| Choice and the “Harness”                                   |              | 80  |
| Drugging Control and Technology                            |              | 83  |
| Coercion Literature  |              | 86  |
| Coercion and Acquiescence                                  |              | 88  |
|  | Chapter viii |     |
| The Right to be ‘Sound’ or ‘Mad’                           |              | 92  |
| Cold Turkey, Cold Comfort                                  |              | 94  |
| Consumption and Survival                                   |              | 96  |
| Consenting to Force  |              | 97  |
| Insight and Capacity in Perception and Literature          |              | 101 |
| The Management of Ontology                                 |              | 103 |
|  | Chapter ix   |     |
| Violence as Illness, a Futile Resistance in Psychiatry     |              | 106 |
| More Painful Injections                                    |              | 109 |
| Supporting Self-Empowerment versus Rehabilitating Selfhood |              | 111 |
| The mess...  |              | 115 |
| Legislated Review of CTOs                                  |              | 117 |
|  | Chapter x    |     |
| Summary and Conclusion                                     |              | 119 |
| <i>Reference List</i>                                      |              | 126 |

## List of Tables

|         |  |     |
|---------|--|-----|
| Table 1 | Research Participants' Fictional Names   | 22  |
| Table 2 | List of institutionalization's methods and potential resistance                                | 71  |
| Table 3 | Published Consent and Capacity Board Decisions revoking a Community Treatment Order in Ontario | 110 |

## List of Figures

|          |   |    |
|----------|---|----|
| Figure 1 | Violence is distinguishable from 'madness'                    | 15 |
| Figure 2 | Any worker will need to know these systems                    | 19 |
| Figure 3 | This schematic presents views on psychiatry                   | 21 |
| Figure 4 | 'Madness' can be conceptualized as part of a range of feeling | 65 |

i.

### **Contemporary Institutional Psychiatry**

This is a qualitative analysis of forced treatment by someone who has been forcibly treated. I am interested in Ontario's 'Community Treatment Order' or 'CTO', which is a new form of compulsory treatment beyond the psychiatric facility. A CTO legally compels a person to accept psychiatric treatments and appointments as a condition of their release or continued freedom from involuntary hospitalization. Failure to comply with such orders can result in police returning an inmate to the psychiatrist who issued the CTO. I argue that 'CTOs' are a chemical restraint, an incarceration *within* the body. CTOs extend the powers and practices of psychiatry out of modern institutional sites and into the private sphere. My research uses my own experience, legal and academic texts, and transcript data from a focus group and several semistructured interviews.

My research participants are psychiatric workers in various positions and functions within the psychiatric system, including one psychiatrist. I asked them how CTOs function, who is targeted and why, and how individuals experience these orders. Participants related problems and experiences of people they know under CTOs, often suggesting CTOs are used arbitrarily and that rights under the psychiatric system seem meaningless or are routinely ignored. I analyze and explore such perceptions using medical-legal texts to inform an organizational 'map of ruling relations' of contemporary psychiatric practices (Campbell & Gregor, 2002; Smith, 1987; Smith, 1990a). For example, in conveying psychiatric practices, participants might use terms used in psychiatry: '*patients with insight into their illness have the capacity to consent to treatment; otherwise treatment may be coerced*'. Such rules and terminology limit participants' work and provide a ground for considering the experiences of people they know under CTOs. I will use Erving Goffman's portrayal of 'mental patients' as *inmates* in 'total institutions' (1961) in contrast with contemporary uses of what I call chemical institutionalization to explore CTO inmate experiences. These experiences inform *psychiatric survivor identity* (Chamberlin, 1978; Starkman, 1981; O'Hagan, 1993; Shimrat, 1997). I seek to show how CTOs clarify the relations of ruling in postmodern psychiatric institutionalization.

### **The Community Treatment Order**

Ontario passed a law introducing 'Community Treatment Orders' on June 21, 2000, and enacted that legislation on December 1, 2000. Ontario's *Mental Health Act*

provides the rules with which to impose CTOs (subsections 33.1-33.9). A CTO enforces a *treatment plan* defined under the *Health Care Consent Act* (*Health Care Consent Act*, subsection 2.(1)). As such, the law defines the CTO in terms of ‘treatment’ rather than as an involuntary legal status. In fact, an inmate must be asked to *consent* to a CTO treatment plan, or a “Substitute Decision Maker” may consent for her if a psychiatrist deems the inmate *incapable* of making treatment decisions. This often occurs when the inmate is believed to lack *insight* into her condition. Incapacity (which normally results in forced treatment) and incarceration are determinations based on psychiatrists’ discretion, though increasingly psychiatrists are elaborating general standards regarding them, such as can be found on the Canadian Psychiatric Association website. Such determinations can be challenged at a psychiatric tribunal, but it consists of one (or two) psychiatrists, one lawyer (or two, with two psychiatrists), and a layperson. This research will utilize tribunal texts and legal forms to investigate how such determinations are made and whether *insight*, *consent* and *capacity* are meaningful in the context of a CTO, let alone a psychiatric facility or a prison facility.

People often stop their treatment upon release. This can lead to repeated hospitalization. Preventing this so-called “revolving door” pattern of release/reentry is the purported purpose of CTOs (Ontario Ministry of Health, 2000; Torrey & Zdanowicz, 2001). The *Mental Health Act* declares the CTO to be a less restrictive method than involuntary hospitalization or institutionalization. Outside psychiatric wards and hospitals, people under CTOs share many of the same rights as ‘voluntary patients’ and ‘out-patients’ who cannot be physically restrained, forcibly drugged, or confined in a small room. Nevertheless, unlike ‘out-patients’, people under a CTO are formally monitored and legally forced (not physically forced) to comply with appointments, treatments and other requirements as per the CTO ‘treatment plan’. Should they refuse, their legal status can easily be changed so that physical force can be delivered. Because CTO inmates are not physically forced to do anything, not officially, the CTO is understood to be less restrictive than an involuntary detention. It is seen as a legally ratified coercion, a sort of parole-like obligation. Such distinctions defend the constitutionality of CTOs in other jurisdictions, as Appelbaum has noted in reference to a decision that struck down a challenge to New York State’s version of a CTO (2005; New York State Office of Mental Health, 2005). As such, the CTO represents the overt legalization of ‘coercion’ outside facilities, an entrenchment of questionable clinical rules and practices beyond the



psychiatric hospital. This thesis interrogates these distinctions and explores the CTO as a new kind of inmate status.

### **Cycling Practices of Power**

Before introducing specific concerns of this thesis, I will consider three 'cycling' practices of power that weave through this exploration.

"Think of being on a CTO as a kind of jail sentence," said a psychiatric worker to a potential CTO inmate. This statement was reported to "Martina", a participant in this study, by an inmate who avoided being put under a CTO. This worker was suggesting inmates released from involuntary legal status by use of a CTO retain their inmate status. Dare we assume this story was more than a lie, exaggeration, inaccurate hearing, mistaken meaning, or 'delusion', a 'persecution fantasy' borne of the teller's supposed 'mental disorder'? Before we can consider CTOs, we must recognize how difficult it is for anyone to contemplate complaints by psychiatric inmates. This considerable list of objections to inmates' complaints belies more than a distrust of people 'in trouble' with authorities, or people reduced in economic status as those involved with psychiatry often are (Read, 2004). Inmates' emotional pain or confusion can be met with ambivalence or distrust because they are considered mentally or biologically unable to construe reality. For example, people given medical diagnoses involving 'neurological disorder' and 'mental illness' are seen as more unpredictable than others deemed simply 'emotionally disturbed', even by psychiatric practitioners (Read & Haslam, 2004:139). Who can believe someone whose perception is fundamentally deranged by a mysterious illness, albeit one still contested and undemonstrated in medical observation (e.g., Modrow, 1995; Seidel, 1998; Valenstein, 1998; Whitaker, 2001; Joseph, 2003; Greenman, 2004; Jackson, 2005)? Such definitions can ultimately be used to dismiss objections and complaints, and any action that is suspicious can be interpreted as evidence of disorder (Goffman, 1961; Smith, 1990b). Inmate narratives without evidentiary support, especially inside institutions, can be used to dismiss and manage inmates. I would call this practice of power a **cycling of evidence** (i.e., psychiatric evidence). People who now call themselves *psychiatric survivors* have reported this dynamic over the centuries (Belcher, 1997), and continue to do so (Burstow & Weitz, 1988; Grobe, 1995; Burstow *et al*, 2005). But why should a psychiatric worker tell an inmate the CTO is a prison sentence?

The worker's statement can be interpreted in several ways. She may have been taunting the inmate. She may believe the inmate will forget the statement since she is

'deranged', or will be disbelieved by others later. If the inmate eventually comes 'to her senses', she will be expected to thank workers for their intervention rather than accuse them of abuse. Some inmates do in fact seem to welcome medical intervention, even incarceration, such as when signing 'Ulysses contracts' to abdicate any prior legal wishes that may impede intervention. But many resist incarceration and forced treatment. Perhaps inmates are too vulnerable to defend their collective rights, or maybe they do not have the strength to negotiate for alternative kinds of attention from government. Their learned or real helplessness fits well under the lens of biological 'mental illness', and an inmate's initial feelings of alarm at strangers' suddenly imposing a treatment can be ignored, quelled through distractions. Workers can thus use chiding or mockery to distract an inmate from her distress at being forcibly treated (Dennis & Monahan, 1996; Alty and Mason, 1994). In her book, *The Butterfly Ward* (1976), survivor Margaret Gibson describes such paternalism through a nurse's repeated phrase, "There, There." Thus, a second practice of power occurs in which any explanation for behaviour is reduced to biology to make interventions and what Goffman calls "tinkering" acceptable (1961). I see this as a **cycling of biology**, (i.e., biological theory of behaviour). Psychiatric workers' behaviour is not reduced in the same way, but is generally sanctioned as purposive, guided by professional knowledge.

The worker may have hoped to provoke a therapeutic outcome. The assumption that confused people may be a danger to themselves or others without knowing it provides a strong rationale for using problematic techniques or force and presenting these as beneficial treatment or therapy. But why would the worker risk 'distressing the patient', as workers say, by saying CTOs are an imprisonment? Did this worker not believe authorities that say, "Despite the non-consensual image of the term "order," CTOs *cannot* exist without the informed consent of the person subject to them, if capable..." (Goldbloom, 2003)? Or did she agree with many Toronto psychiatric workers who believe CTOs are an infringement of 'patient rights', as reported in a recent study by the Centre for Addictions and Mental Health and Canadian Mental Health Association (2005)? If the latter is true, perhaps the worker was attempting to alert the inmate to her compromised situation. Then not only is the worker telling the inmate that treatment is an incarceration and her rights are moot, but she does so without institutional sanction. Her surreptitious admission implies that some psychiatric workers may labour under a code of silence, or at least have radically unorthodox views. But it seems more likely that the worker was employing sarcasm to dismiss the idea that CTOs are anything but a

beneficial treatment. As my own experience will attest, the worker may even have been trying to antagonize the inmate to prod behaviours that could later be used to dismiss and manage the inmate, perhaps to make her eligible for the proposed CTO ('cycling of evidence'). There are more global processes of power that inform the statement 'CTOs are an imprisonment'.

Psychiatry affects our liberties in all medical contexts and beyond. Increasing numbers of Westerners and others are administered psychiatric drugs and becoming involved with psychiatry voluntarily or involuntarily (Larkin *et al*, 2005; World Health Organization, 2002). People have told me they were strongly encouraged to take psychiatric drugs by general practitioners and therapists and when they reported difficult feelings related to having Crohn's Disease and cancer. Is it assumed patients would rather not experience what they are feeling? Psychiatric drug use occurs in hospitals, schools, jails, and is also used to restrain or torture political dissidents (Human Rights Watch, 2005). Unlike other forms of medical involvement, psychiatric diagnosis is primarily based on 'behaviour', self-report, and 'hearsay' rather than on physical diagnostic tests (American Psychiatric Association, 1994). Diagnoses and forced treatment have been linked to discrimination and social bias such that marginalized groups are far more likely to receive the most grim diagnoses and treatments; there is no simple technical determination of 'insanity' (Rosenhan, 1973; Caplan, 1995; Caplan, 2004; Read, 2004; Waters, 2005; Sharfstein, 2005). Diagnoses can be changed several times in a short period, and treatments are changed just as often. In fact, treatments may cause diagnosable behaviour which may result in psychiatric intervention (Crane, 1973; Breggin, 1994; Whitaker, 2001; Cohen, 2003). This creates a third performance of power, a **cycling of chemistry** (i.e., altered brain chemistry) in which drug effects decrease a person's ability to control behaviour, including diagnosable behaviour, which leads to additional prescriptions of drugs. Because few inmates (and prescribers) know much about psychiatric drug effects, and because there is little independent research to monitor these effects, this process goes unchallenged.

Three cyclical processes of power inform psychiatric practices and interventions, and the use of CTOs specifically. Any behaviour can be made a part of the case file of evidence that a person is unstable such that complaints may be ignored. Any behaviour can be reducible to unexplained biological causes such that the individual's complaints may be ignored. And psychiatric treatment may engender behaviours that are diagnosable, supporting the need for further treatment, in turn supporting prior biological

and evidentiary determinations, such that complaints may be ignored. These cycles work to break trust and erode the supposed therapeutic aims and values of both the worker and inmate. They also instill inmates' and others' beliefs that inmates cannot be understood, believed, or trusted, and cannot help themselves, cannot escape their predicament (neither the illness nor the incarceration). The inmate may attempt to override such problems by dividing the self into 'sick' and 'normal' parts, but this does not confer more will or control to an already compromised, medically determined half-self. How do Community Treatment Orders clarify such practices of power?

### **Scope of this Research and Problems with CTOs**

Research participants' perceptions of CTOs (listed in detail in the thesis summary) present CTOs as a new form of incarceration with several problems.

- **Abuse** ~ First, if we accept CTOs on face value, they can be abused such as when someone is required to change residence as part of her CTO 'treatment plan', or when CTOs are imposed arbitrarily on some groups.
- **Efficacy** ~ Likewise, if we accept CTOs, if only because they promise treatment 'adherence' or *compliance* (inmate 'staying on medication') or a reduction in hospital use, some CTO inmates 'escape', leading some psychiatric workers to complain CTOs "have no teeth" (Centre for Addictions and Mental Health and Canadian Mental Health Association, 2005:19).
- **Services** ~ Third, if CTOs promise new resources to bring 'services' together for people in need, participants suggested services are not sustained and often focus on 'treatment compliance' rather than needs like housing or interpersonal supports.
- **Status** ~ Fourth, CTOs do not resolve the underlying paradox in institutional psychiatry: wishing to support 'recovery', yet often forcing treatment. All support is underwritten by force. A person's legal status can be changed quickly from 'voluntary' to 'involuntary'. The indefinite threat of incarceration for those labeled 'mentally ill' and the lack of any finality in 'cured' medical status in psychiatric theory suggests there are simply varying degrees of institutional 'commitment'. However imposing, treatment orders are considered a 'treatment' in the law; they are not designated as a legal status, obfuscating the involuntariness of CTOs.
- **Rights** ~ Fifth, CTOs move clinical rules and the scene of treatment into an inmate's 'home'. One's family and privacy are interwoven with clinical practices and treatment regimens. If CTOs are supposedly less restrictive, they seem more

invasive. While the provision of rights information is a primary justification for any psychiatric force, participants say many CTO inmates do not know what CTOs are, let alone that they are under CTOs.

- **Constitutionality** ~ And sixth, CTOs have been found constitutional in New York, for example, because they are merely a coercion to 'comply with treatment', rather than a force in themselves. I argue CTOs simply extend the force of the psychiatric facility beyond the physical site, and that they offend people's human rights by denying freedom of conscience, if not consciousness.
- **Chemical Imprisonment** ~ This leads to one more problem that CTOs make most transparent: the legal use of drugs to restrain rather than treat. Consider Janet Gotkin's testimony before a U.S. Senate subcommittee:

I became alienated from myself, my thoughts, my life, a stranger in the normal world, a prisoner of drugs and psychiatric mystification, unable to survive anywhere but in a psychiatric hospital. The anxieties and fear I had lay encased in a Thorazine cocoon and my body, heavy as a bear's, lumbered and lurched as I tried to maneuver the curves of my outside world. (Gotkin, J., quoted in Whitaker, 2001:176).

I argue that CTOs are not less restrictive, but rather they enable a kind of physical force that shifts the locus of institutionalization from the physical plant, as in Goffman's studies (1961), into the body itself. Within us, at the chemical level, restraint and isolation are achieved not with bars or walls but by physical means just as real. By preventing the flow of certain brain chemicals, compromising the central nervous system, an incarceration is imposed from within the body and occurs 'in the life', *in vivo*. The experience of 'tranquilization' can be frightening and debilitating, but to others this chemical silencing may seem a relaxation and an improvement. Institutionalization, as Goffman explains, is achieved by continuously restricting movement and free association with others. Using this definition, I will explore how CTOs expose drug 'treatment' as a form of somatic imprisonment.

Could chemical restraint be considered an incarceration in law? Medical-legal definitions of imprisonment are broad and leave aside 'chemical restraint' (a short term drugging), 'physical restraint' (being tied down), and isolation (being locked in a room) as auxiliary practices, though these seem elementary to psychiatric survivors. Such practices are mentioned in the *Mental Health Act*, but their usage is not dignified with procedural forms under the *Act*, like commitment itself. These practices appear superfluous, invisible, unmentionable, to be regulated in facility policies, such as I have

seen in a prior work site. Conversely, these practices are not 'consented to' nor dignified as 'treatments' under the *Health Care Consent Act*, as is the CTO. So, why are these procedures not readily defined in legal and medical texts on a continuum with the broader practices of incarceration that sustain them? Perhaps because they are short-term practices only. There is a parallel in criminal law. We do not charge a person who forcibly drugs another person with false imprisonment, but with assault. I contend that the CTO is a long-term form of chemical restraint that should be seen as incarceration. Its contractual elaboration as a 'treatment' is misleading, as the psychiatrist participating in this study suggested. Using participants' perceptions, psychiatric and legal texts, and Goffman's work on 'total institutions', I will further explore how people under CTOs are inmates, not patients, under CTOs. I will argue the CTO is a chemical form of imprisonment which *somnolizes* rather than bars inmates. Institutionalization is achieved through the body, conceivably without need for facilities.

The question of **identity** will be helpful in this research. The issue of how neurochemical interventions affect the body leads to how interventions are experienced and how they affect our social presentation, our 'behaviour'. From both an epistemological and pharmacological view, I ask how drugging can affect perception, understanding, memory, motivation, feeling, which inform identity. I assume we all depend on consciousness and memory to describe and name our experience into who we are, what we are. Through personal accounts, I will explore identities before and after psychiatric intervention. I suggest that these subjectivities are crucial to tacit awareness and decision making (including, of course, medical decisions). I reference participants' descriptions of how clinicians and others perceive the results of drugging as improvement, and how this lends to the moral defense of force, and its authorization and expansion. Moreover, people who cannot or *will* not claim 'sane' narratives, their 'mental health', are privileged in this thesis as having 'being', as deserving autonomy rights and even respectful society. As such, I will argue that madness is not a violence. We who have been seen as absent in our bodies, vacant of selfhood, 'sick in the head', and 'mad' by others, are real, feeling, thinking people even at our most vulnerable, most emotional, most explorative. This is not a rationalization or romanticization of 'neurological impairment', which many mistakenly see as a prelude to violence. It is a remembrance of self.

ii.

**Tempflux~a (24), numen 1 ion: Dear Editor,**

I have been “accelerating” (diary, 1984).

I “min the opposing” (1981).

“This” is no “thisism”, living so indescribable (1988).

There’s a secret (T. Yanni, personal communication, 1976).

We’ll invent a language (P. Fabris, personal communication, 1974).

1993. I have experienced new experiences. I have changed myself to perceive new realities (again). I have danced for spirit, ready for escape. But this time, no friend laughs and enters the folly. No smirks like in the Burnaby Mall. No smiles across the counters of monetary intercourse. Retrieved to the bakery where I work, my supervisor tells me to stand outside, lest the customers see. He reports me. My ‘dance’ is his evidence. Now, just pity comes, stern, waiting, cautious. I watch this pity while living within my private experience. While inside my desocialized body, I cannot insist, ‘Wait, I’m still in here, I just need time (...to dance).’ It’s only me. There is no confusion. An ambulance attendant steps in, asks whether I’d rather he call the police. I rationalize my acquiescence: maybe his priests will help me understand my newfound insights.

I fret in my hospital gown as I wait for my psychiatric assessment. I will finally know whether I am insane after years of evasion. My psychological weaknesses will be splayed out before me, positively assessed using the best instruments of modern technical science. This is what I’ve been afraid of since my mother’s hospitalizations for ‘schizophrenia’ in the 1970s. Like her, I was brought here because I began to change, to sense life differently. This change is seen as logical error, seen as chemical dysfunction, seen as social deviance or laziness. My transformation is believed to belie a potential danger, to myself, others, property. No one but me knows in this new city that these transformations have never led to destruction or violence.

After what seems like 15 minutes, I come out of my waiting room to see if anyone will see me. I call meekly, “is anyone there?” Shadows shift behind plants and counters in the emergency ward. A second later I am surrounded by waving arms and bodies pressing on me without touching, perhaps six males of different sizes, some aggressively hunched, yelling! My hands instinctively open in a motion of surrender. They holler, “Get back in the room!”, repeatedly, their inflection rising as if provoking. I

disarm them and reassure them with, "Okay... okay..." and slowly walk back to the cubicle, a space just large enough for a gurney. There's no talking my way out now. They usher me into a flat, prone position and roughly bind my arms to the metal railings, right arm above my head, left to my side. My mother never told me about this treatment.

A few seconds later a nurse approaches my tense form with a needle. She stabs it into my left thigh deeply and injects a fiercely burning pain. I wince, then lay quiet, unmoving. She swabs the pricked wound with alcohol. I am barely breathing from fear. I lie as still as I can, anything to prevent further violence. The caregivers leave. I begin to shiver with cold. I'm becoming drowsy. A moment or two passes. My lover enters the room, a look of shock on her face.

"Look at what they're doing to me. I'm an animal," I say.

"Listen!" she exclaims in a whisper, "Whatever they ask you, say no!" I say okay. Suddenly a white-clad clinician enters. Her blonde hair is pulled back; she wears small wire-rimmed glasses. My lover is allowed to stay. The clinician speaks the words on the clipboard, her ten questions.

"Have you been depressed recently?" she asks, not consolingly but clinically. No. "Have you had strange thoughts?" No. I play through the exercise as instructed. Consciousness breaks and I fall into a dreamless sleep before she finishes.

Fourteen hours later? I'm awoken, parched and afraid. The snoring of three other men in a dark room makes me start. Trolleys rattle and echo in the recesses above the ceiling. I have no clue where I am. Is this a mistake, a fluke?

### **Achieving 'Madness'**

The experience of unreason cannot simply be forgotten; we must form a new idea of reason. (Merleau-Ponty, 1964)

I have experienced 'madness' as a process of achievement. It began with a creative and spiritual drive to merge my everyday life with my symbolic life, but when 'madness' emerged all articles of faith and principles of beauty receded in stature. The search brought me to see, to perceive, in ways that depended less and less on the norms I had grown up with, the usual turns of phrase, the usual expressions of feeling. I found myself behind the curtain of language and logic, able to modify these programs tacitly. It was a positive experience which, for brief periods yet not as consciously, I had entered privately in my youth several times. This was a transformative yet natural 'capacity', before I was incarcerated and drugged in Vancouver in 1993. Psychiatrists



called this private achievement a 'psychosis (not otherwise specified)', then, because I later admitted to feeling sad in the institution, as 'bipolar affective disorder'.

My mother had already been labeled 'a schizophrenic' in 1970, but she seemed quite positive about her 'madness' from my childhood recollection. I think she was less troubled by her explorations, visions, and ideas than by the fact that others continuously refused her reality. Many 'mad' people are awestruck by their experience, even overcome with joy, but then are silenced and rejected and come to fear it before they can try to understand it or accept it. I raise positive considerations of 'madness' in part to disarm stereotypes of 'mad' people as biogenetically predisposed to violence, lacking in control, unable to relate to others or to work. Positive experiences suggest that 'madness' can be achieved, recovered in its own right, rather than recovered from. Biological changes may indeed occur, but they need not be seen as 'causes'. They may be generated, modified, sustained by the will; the brain-computer of bio-psychology may have an operator.

This standpoint privileges 'madness' as a way of life rather than as a lack in understanding, will, or biological integrity. We need not depict 'madness' as a stumbling on the road to spiritual enlightenment, artistic production, or 'mental health'. There may be difficult processes 'in madness', especially when we are driven to deep dread or shame by others and discover our capacity for 'madness' while isolated, or under horrible circumstances. Experiments have shown how 'madness' can be invoked by tormentors (Waring, 1987). This does not mean 'madness' is a facet of horror, or an escape from horror, or that it inevitably leads back to horror. It only means that we find ourselves 'there' when we are pushed. We might just as soon find our way 'there' without force, without negativity, if emotion and perception were free in our society. And though we may find ourselves stuck 'in madness', its negative 'spaces', this does not mean that 'madness' is the pain itself, or that we will always be stuck with pain.

Ultimately, the label 'madness' must be interrogated. We may not be able to discard the word, so negative already, so necessary to dominant society. Can 'mad' people not author a new narrative of 'madness', or does the word by definition prevent us from speaking of self and reality?

### **Necessary Narratives**

Paulo Freire says that to declare a perspective is both a necessity of being and a necessary objective in education and in understanding society (1994). As such all telling is a narrative, though standardized 'extralocal' narratives claim to represent millions

(Smith, 1990a). My old nightmare above is shared by millions of others trapped or discarded by the mechanization of care, each with her own story. But justice is elusive. This account cannot 'represent' others, scientifically or politically. My story cannot be reproduced, validated, generalized. It is what some discard as 'anecdotal'. Legislators cannot, based on one person's 'story', or hundreds or even thousands it seems, prevent the unthinkable. In this age, experiences like mine are only narrative. Few accept them as non-fiction, or if they do, they may be acceptable because of the cycle of biology: 'madness' leads to ruin and violence.

I account narrative an important role in ethics, particularly regarding interventions on the self. It is unconscionable that anthologies recalling institutional abuses are still circulated by psychiatrists, yet have impacted so little on the chauvinism, *mentalism* (Chamberlin, 1978), *sanism* (O'Hagan, 1993) amongst 'helpers', let alone the solidity of their institutions. Narrative and metaphor have recently been taken up in the sidelines of the neuronal sciences (Glicksohn, 2001), no less the social sciences related to mental disability and health industries (Mcclimens, 2004; Mishler, 2005). Very recently, they have found their way into evaluative research methodology (MacNeil 2000; MacNeil & Mead, 2005).

Can there be a 'neutral' story? In the philosophy of mind and action, Finn (1999) contrasts Taylor's 1<sup>st</sup> person hermeneutic, reflexive approach to interpreting action, mental states and character, with Dennett's 3<sup>rd</sup> person empirical, naturalistic intentionality and argues that Dennett dismisses agency outright. By trying to espouse what ethnomethodologists in sociology might have called an inter-objectivity, Finn says Dennett eschews ethics when he ceases to privilege "what matters to us". Despite this, both Dennett and Taylor reject psychology in explaining agency (i.e., psychosocial models of "behaviourism", "mentalism" and neurophysiological reductionism), and as such arrive at moral decisions without relying on a science of behaviour and 'affect' (emotion). As "interpretivists", they champion a sort of "folk psychology" without generalization to provide grounds for reflexive and integrative ethics. They see the process of ethical decision and agency as already occurring, unrelenting in the breach of scientific intervention and narrative: the biological, the psychological.

But I have also been around hundreds of people who have gone through situations similar to mine. I have been fortunate, very fortunate, to escape the nightmare of helpers that judge, categorize, manage, and even suffer people because it is their job. Though some helpers try to 'relate to their clients', many survivors do not escape their

logic of paternalism and the cycles of power necessary to existing psychiatric systems. They walk the streets of our cities ridiculed, kicked, bleeding for days, drinking solvents, waiting to die, playing with their own destruction, yet ironically they have no welcome in psychiatric facilities or any other kind. I owe them this paper. They are the 'lost causes' of psychiatry. Seldom approached by others, forgotten by their families, 'the institutionalized' can only be 'helped' by a minority of workers who will talk with them personally, have a stake in their survival. Usually these workers share some knowledge of poverty or institutional abuse. Yet, the stories of this small minority of workers is drowned out by the rush to 'help' the seemingly unconscious 'mentally ill' with more coercion and technology. Technology has included forced sterilization (until 1972 in Alberta), forced euthanasia (in the T4 program in Nazi Germany), forced lobotomy (whose inventor, Egas Moniz, was the only psychiatrist to win the Nobel prize), and forced treatment is still in use today. Desperate help for desperate complaints.

### **'Madness' is not a Violence**

Psychiatric survivors, people who have experienced psychiatry directly as an oppression (have been 'psychiatrized'), have been active as a civil rights movement since the 1970s (Chamberlin, 1978; Starkman, 1981). However, theirs is a less well known movement than those made up of people of 'sound' mind. There is scant literature on this movement. This study, an analysis of forced treatment, is as such a soliloquy within 'sound' literatures closed to psychiatric inmates, whatever their concern with our lot. Professional literatures, acceding to the public image of the 'mental patient' as incomprehensible, unpredictable, only accessible by psychiatric expertise, ignore inmates who cry foul as 'mad', or as merely 'misdiagnosed'. The 'cycling of biology' prevents a consideration of their being, and so what would be horrifying treatment for 'sound' people is thought harmless or acceptable for 'mad' people. Our biological lack prevents our construction of experience, it is said, so our complaints are disregarded. Should my analysis be seen as unfounded complaint, my prior purpose is to make it conceivable for 'mad' people to complain, and for 'sound' people to listen.

We have identity 'in madness', and this is crucial to debates about state powers of force and coercion. Identity weaves together theory and experience. We have no 'mad' people's 'theory', only a medical theory about 'madness'. Questions of forced treatment assume medicine can bestow consciousness, block 'mental illness', manage the unpredictable, while we 'mad' people call for humanization and feminization of the 'forced treatment' debate (Breggin, 1991; Grobe, 1995). Yet, our experience has been

theorized by others, including antipsychiatry writers, as a socially constructed distress. Our 'trauma' (meaning 'injury' rather than 'disease', but still borne of medicine) is caused by environment, oppression, or conflict. It is difficult for me to objectify my living experience as a result of neuronal misfiring or the trauma of environment or oppression. Psychiatric survivors can only dream of a 'modification' of society (O'Hagan, 1993); others would only see this as being seduced by our disorder. Is there a problem with the objectification of mental events, heart rate changes, facial expressions in psychological and psychiatric language that blocks our identity? Do we undermine experience when we speak of 'denial', 'projection', 'presentation', and other psychologisms?

In this analysis, what I call 'madness' could conceivably overlap with what psychiatrists call 'depression', 'obsession', 'anxiety', 'dementia', 'personality disorders', but I am more concerned with what psychiatric law tends to target specifically: 'psychosis'. The psychiatric definition of 'psychosis' is itself nebulous, but usually this objectified 'state of mind' is believed to cause experiences labeled 'hallucinations' (e.g., perceptions without sensory data) and 'delusions' (e.g., strong beliefs no one else believes). These terms also bear nebulous definitions (Whitaker, 2001). In medical (psychiatric) law these experiences are generally theorized as potentially *dangerous* (i.e., probably leading to violence, some form of harm, or destructive damage) despite statistical evidence to the contrary (Steadman *et al*, 1998). While such 'states' can be arrived at 'artificially' by use of drugs or even torture (Lee & Shlain, 1985), psychiatry tends to focus on 'psychosis' as a pre-existing biological abnormality. Certainly, cultural, racial, gender, class, and other differences have been shown to steer 'diagnostic' practices (Read, 2004), and an entire population of a municipality was found to suffer 'symptoms' diagnosable as 'schizophrenic' in 1970s (Whitaker, 2001:168). When people share such 'symptoms', see the same 'hallucinations' in what used to be called '*folie a deux*' and is now called 'induced psychotic disorder' (American Psychiatric Association, 1994), what role does biology play? I cannot exhaust arguments against biopsychiatry here, but experiences which I prefer to understand as a process of living rather than a 'state' are occluded by psychiatry.

Though psychiatrists gave me the 'psychotic' label and convinced me I had a 'mental illness' for a time, my experience was not informed or improved as a result. Yet folk labels such as 'madness' also fail to provide explanations. Our experiences are seen as grist for the creative mill or stumbles on the road to enlightened being. 'Mad' people are seen as having dormant creativity, latent imagination, all of it useless because of

their 'sickness'. Yet artists are often viewed as somewhat 'mad' simply because they engage imagination, which itself courts irrationality and other disasters. Religious, spiritualist or occult explanations for 'mad' experiences, which propose the materiality or reality of possessions or spirits for example, see 'madness' as an initiation into a deeper cosmos. I don't wish to disparage folk beliefs, which inform personal experiences and can help us answer questions of meaning, but one need not venture into parapsychology to recover our experiences from biological reductionism (Laing, 1967; Fadiman & Kewman, 1979; Clarke, 2001), or to see that they are not always confusing or dangerous but in fact common (e.g., Romme & Escher, 2000). In an hypothetically anti-sanist culture, we might define such experiences as radically free self-determinations (or just living itself), despite the potential for injury in any free action. Whatever explanation we attach to consciousness and freedom (see Pestana, 2001, Jibu, 1997), some of us simply engage in perceptual shift as 'just part of life', as with any ordinary feeling.

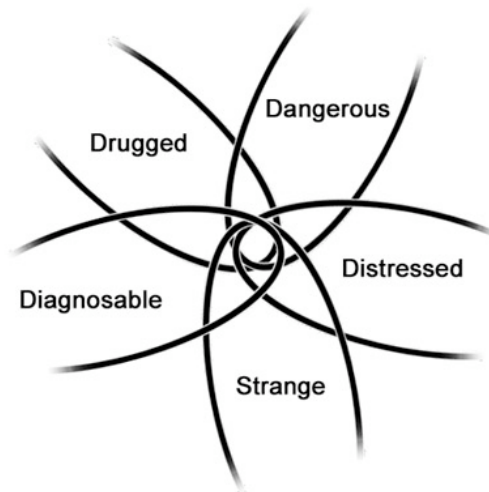


Figure 1: Violence is distinguishable from 'madness'. Someone may become distressed because she fears 'madness'. Others may become 'mad' because they fear their rage. Still others may simply be violent because of chronic brain damage sustained from psychiatric drugs (Whitaker, 2001). Any such categories may or may not overlap, and are not stable or closed categories in themselves. Yet for most people, even legislators and clinicians, all these categories together seem to define 'madness'.

'In madness' we are alone, yet attached to people (and the rest of nature) like never before. However, when we enter the social world during these processes, we are on the whole confronted with fear, mockery, repulsion. Our personal experiences, dismissed as 'madness' and 'mental illness', are difficult to communicate, and become impossible to discuss in mentalist or sanist society. Most importantly, they are used as

examples of the horrors that befall those who do not abide by rational law ('cycling of evidence'), whether or not harm is done. In these periods, some of us attempt to communicate through metaphor, or even 'perform' through ideas, our living circumstances, because logical and grammatical sequencing fail to express or explain the feeling (Glicksohn, 2001). The only words we have to describe ourselves are mocked, crazed by others, used to sell furniture. They are shocked or dismayed at our seemingly bizarre 'babble', 'puzzles', 'trips', 'rituals'. From 'within madness' we notice their response and begin to avoid them. Yet, most of us still stop at red lights and refuse to kill anyone. We are still 'here', still 'real'. But we are feared because 'madness' denotes fear and confusion; people believe our strangeness drives our moral sense, though our crimes are often motivated by the same drives that motivate others. What drives this fear of 'madness'?

### **'Mad' Standpoint When No One is Mad**

No one is mad. 'Mad' or 'sane', we all survive and benefit by claiming 'mental health'. It is a mark of competency and power. I see *sanism* as a competition in rationality and judgement, in which popular forms of communication serve as the only standard. In this way, we impose one 'sanity' to construct society, one view of collectivity. Yet there are many ways to communicate experiences, feelings, needs. Sanism is more simply the rejection of people, expressions and thoughts that fall into conflict with patriarchal constructs of 'universal' or 'modern' rationality and judgement (though 'crazy' ideas are sometimes allowed in some arenas). Sanism punishes lived or embodied idealism, fantasy, romance, tragedy, absurdity, comedy, especially when communicated through the body. If as-yet unexplained brain processes belie my 'psychotic state', my 'seeing things' and 'believing the absurd', I would liken these processes to that of pheromones bounding during a 'state of love'. I define my 'sanity' as encompassing such deep emotional experiences, an expression of self that may alter physical processes of perception and 'reality'. But why valorize sanity? Why is everyone 'sane' and no one 'mad'?

Sanism may occur in society whether everyone is deemed 'mad', if only some are, or if no one is. However, if no one is mad, and all behaviour is deemed sane, we have a better chance of escaping tautologies born of an essential 'irrationality' ('cycling of evidence'). If this were the case, a person's need might be more easily expressed and understood empathetically rather than through a battle of rational wit. Psychiatric survivors have a history of cutting through the form of someone's expression and getting

to what the person feels and needs. It is ironic that psychiatric survivors are physically attacked and brutalized with impunity, then publicly blamed for the 'incomprehensible', 'unpredictable', 'chaotic', 'irrational', 'mad' violence in society (Torrey, 1997). How can this misplaced fear not be seen as a rejection, an accusation, a hatred like any other xeno- 'phobia' (to use a psychologism)? However, when 'mad' people are surrounded by other 'mad' people, we escape 'sane' fear and prejudice (Chamberlin, 1978). We realize ourselves through each other's experience, such as through the 'mad' narrative of Margery Kempe of 1436 (1982). How is it that people deemed 'irrational' can understand each other across the centuries? Experience and identity.

Sanist labels, both folk and biological, that make us available to practices of power, that simplify and offer up our 'behaviour' to bureaucracies, can undermine our own experiences, identities and our relations with others, sometimes in very subtle ways. The whole discourse on 'madness' is a presumption of exclusive rational power, of boundaries to reality, of morality without extenuating circumstances, that may serve whoever attributes madness to another's behaviour. For a person experiencing tremendous new feelings, being called 'mad' or 'ill' seems unbelievable, irrational, because she still feels her reality. Yet under a 'cycling of evidence', such disbelief or resistance is easily ascribed to madness and eventually eroded. To evade further diminution of the self, we may paradoxically accept the label of 'mental illness' to appear 'sane'. To fail to do so however does not suggest a lack of judgement, but a principled and steadfast resistance as seen in the narratives of psychiatric survivors (Reaume, 2000a).

Survivors have begun to organize, to work around the hatred and emotional privation, defying prognostications, declaring that we are or can be 'fit', 'sound', even by sanist standards. Heresies arise, like the 'recovery' of the self (Deegan, 1988; Clay, 2004). Our 'self' may look different to us than the organized, liberal, mastered self of modern and neoliberal capitalism (Bach, 2004). This liberal view of self requires a legal capacity to claim human rights, leaving behind those who have less 'voice' in sanist and mentalist arenas (the latter is a more general ground for exclusion for people labeled 'psychiatrically disabled' and 'intellectually disabled'). Many movements have left behind psychiatric survivors because they value their sanity foremost. Emily Murphy, one of the Famous Five who won Canadian women the vote in 1919, strongly supported the sterilization of the mentally 'unfit'. Thomas Szasz, a capitalist libertarian and a psychiatrist evidently opposed to psychiatry, deems the mythical 'schizophrenic' to be

someone who refuses to accept reality in order to avoid work and responsibility (2004). This is still an image of 'madness', as seen in the mirror of the sane and privileged psychiatrist. Survivors do more than 'normalize' madness; we represent it, communicate it, discuss it, not by re-objectifying 'it', but by living. This is not to say that we are the object, madness.

This analysis derives from psychiatric survivor standpoint, based on the work of Dorothy Smith (1990a). Somewhere between unrelenting genetic 'discoveries' in the media (Joseph, 2003), sensational copy about violent mental patients (Blizzard, 2000), hushed reports of teen murderers on drugs called 'selective serotonin reuptake inhibitors' (Breggin, 2003/2004), and news flashes about degrading abuses in institutions (Lopez, 2005), people wonder about the truth. In academic circles, the psychiatrized are honoured as emotionally 'traumatized' (meaning injured), or as frail revolutionaries (Everett, 2000). Such discourse engenders "psychological hegemony" (Myers, 2002) in which psychiatry may be seen as abusive or even oppressive, but ultimately necessary as a 'service'. 'Sanity' is reified and guarded as 'health' rather than rationalization. Is there a sanism beyond interlocking oppressions of ability, sexuality, race, gender and class? I believe there is, though deep feelings and needs are attacked differently under each of these oppressions. Sanism attacks a particular kind of feeling and need, one not necessary to other identities, that often challenges the group dynamic altogether.

Erick (researcher): It may have something to do with how we [people regarded as sane] don't look at our own power. If I see someone who's berating me, is nasty, whatever, I'm going to attribute to this behaviour some kind of dangerousness because I feel threatened. I think a lot of this attribution of dangerousness to—

Martina (participant): somebody who's a misunderstood 'monster'. Monsters come in many shapes and forms, and some of them are highly misunderstood because they're—

E: So monsters can be benign...

M: Absolutely. I know some monsters who are quite loud and fuckin' raging and they're actually— if you're able to relax enough and not get freaked out when you talk to them— they're actually quite fine.

To inform the issues of forced treatment and psychiatric oppression as seen by psychiatric survivors, I have attempted to discuss the importance and possibilities of *identity* in experiences called 'madness'. A theory beyond illness and trauma is required to address why and how 'mad' people are regarded as 'monsters'. I have worked in the psychiatric system, the crown of institutional sanism, where I was constantly exposed to the objectification of differences attributed to an essential 'madness'.



## Advocacy in Modern Institutions

1996. Middle-class staff pass by our human island. I sit with Ian, a veteran inmate, who introduced me to Gurdjieff. He sips the coffee I brewed in the vast basement of this monolithic, modernist complex. The Centre has a budget of about \$100 million. The psychiatrized accrete here in the store-less 'Mall' of the Queen Street Mental Health Centre. The Mall is a towering atrium and gangway located between the administration building and four towers, each stacked with five ward 'units'. My weekly 'Coffee Hour' is a way for our \$58,000 'patient's council' project to connect with inmates. Incorporated in 1995, the Queen Street Patients Council was a peer advocacy organization run by inmates and survivors (Queen Street Outreach Society, 2002a).

Usually inmates in the Mall are silent, subdued, motionless; it is hard to get anyone to talk let alone rise up. Sluggishness is spoken of as part of one's 'illness' or a lack of natural motivation, but I know better having decreased my dosage to nothing, slowly in 1993 after becoming involved with the survivor movement. Lethargy and listlessness can be offset by the stimulating effects of cigarettes, so everyone smokes if they have them. There is a cigarette trade by which people relate, as Goffman described in his work.

|  |   |
|--|---|
| <b>Rent Geared to Income Housing</b>             | <b>Public Guardian and Trustee</b>                |
| <b>Supportive Housing</b>                        | <b>Ontario Disability Support Program</b>         |
| <b>Personal Needs Allowance</b>                  | <b>Ontario Works (formerly Welfare)</b>           |
|  | <b>Canada Pension Plan (CPP)</b>                  |
|  | <b>Employment Insurance (formerly UI)</b>         |
|  | <b>Long Term Disability</b>                       |
| <b>Mental Health Court Diversion Program</b>     |   |
| <b>Legal Aid Ontario</b>                         | <b>Dual Diagnosis</b>                             |
| <b>Citizenship and Immigration</b>               | <b>Concurrent Disorders</b>                       |
| <b>Consent and Capacity Board (&amp; ORB)</b>    | <b>Psychogeriatric Services</b>                   |
| <b>Correctional Services</b>                     | <b>Addictions Services</b>                        |
| <b>Psychiatric Patient Advocate Office</b>       | <b>AIDS</b>                                       |
| <b>Ontario Human Rights Commission</b>           | <b>Acquired Brain Injury</b>                      |
|  | <b>Personality Disorders</b>                      |
| <b>Ministry of Municipal Affairs and Housing</b> |   |
| <b>Ministry of Child and Youth Services</b>      |   |
| <b>Ministry of Community and Social Services</b> |   |
| <b>Ministry of Health and Long Term Care</b>     |   |
| <b>Mental Health Act</b>                         | <b>Tenant Protection Act</b>                      |
| <b>Health Care Consent Act</b>                   | <b>Social Assistance Reform Act</b>               |
| <b>Substitute Decisions Act</b>                  | <b>Personal Health Information Protection Act</b> |

I also work as a casual employee of a Toronto non-profit, supportive housing agency. I learn that it is very difficult to 'help' people in obtaining 'services', such as better 'housing' or employment, especially if they have what the government calls a 'mental disability'.

Figure 2: Any worker will need to know these systems, issues, agencies, laws, regulations, and the loopholes therein to feed and house anyone (Fig. 2 developed with 'Carmen', a participant)

A large slightly bearded man walks by wearing false pearls, a maroon skirt, and a bronze-coloured amulet. As an artist, I am thankful the drugs do not work so well. I say, "Ian, I love the way he's dressed. People here know how to dress!" Ian replies wryly, "I think the staff attire is far more interesting." I realize that after only three years working part-time, I share the perceptions of the staff ever so subtly. It is so easy to forget the perspective of people who have no voice. I do not see staff costumes as outlandish or notable (the gold, the watches, the tucked tops, the matching colours), but I see inmates' improvisations as imaginative and noteworthy. Ian and other inmates psychoanalyze, sociologize and anthropologize their captors. This can include any 'helper' when help has been forced.

People outside poverty have told me that Canadians do not experience real poverty or political oppression as others do elsewhere. Yet here starvation is not caused by droughts or corrupt overlords, nor is second-class citizenship caused by *coups d'etat* or religious persecutions. Freedom is extinguished here by bureaucratic means, by comfortable busybodies. Real Canadians live in filth and flies. Many are detained and abused having committed no crime. The other classes prefer to see deprivation elsewhere. The experiences I have had at both these jobs, working with psychiatric survivors especially, has opened my eyes to how humans survive despite economic and social erasure. People who should be despicable misers can show amazing compassion and fine sensitivity in dealing with pain. Some exercise a unique form of liberation, an embodied politic. But their work is liberation without theory. Their commitment to feeling and human company eludes our imagination, we who are paid to help them.

iii.

### Participants, Perspectives and Language

Having considered general issues related to this analysis, I will present participants and their perceptions of my topic before exploring legal and medical issues directly related to CTOs in the next chapter. This thesis presents data from transcripts of one focus group and five interviews, as well as data from informal interviews and ongoing communications with individuals closely involved with CTO inmates. To reach these participants, I emailed posters to local organizations in the ‘mental health system’ seeking individuals now working in that system to speak with me about the experiences of people under CTOs. My poster mentioned that I am known and have worked in the psychiatric system and most of those who responded were people I associated with in my prior work. Three of us have worked in the psychiatric survivor movement, each of us with different concerns about that movement and its allies.

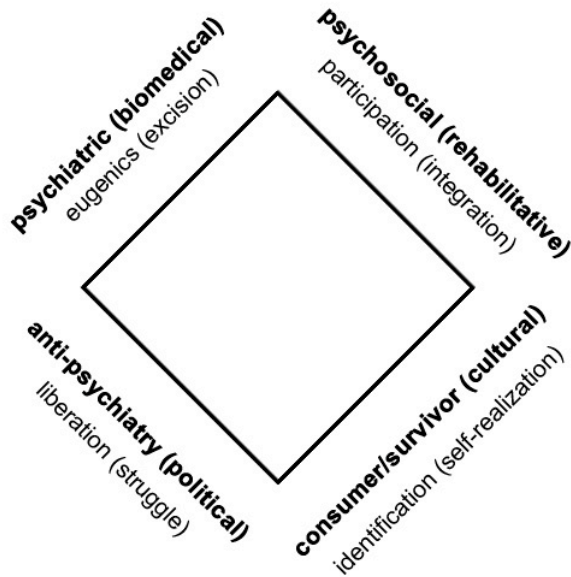


Figure 3: This schematic presents views on psychiatry that may overlap. Psychiatry’s roots in eugenics and destructive treatments is not commonly known. Psychiatry’s initiation of the Nazi’s T4 program, which was a model for the holocaust, is instructive (Friedlander, 2001). Its ‘biological’ model of ‘madness’ is challenged by newer models of social integration of ‘mad’ people, and more radically by antipsychiatry’s rejection of biological determinism and struggle to liberate us from state control. People who have been psychiatrized are distinguishable in that their view is born of psychiatry’s direct intervention. Generally, they identify as patients/clients, (ex-) inmates, mental health consumers, psychiatric survivors.

My study involves nine individuals in various positions of power with respect to the enforcement of CTOs. Participants cross lines of gender, race, class, sexual orientation, ability, and former *involuntary or incapacity* status (some having been detained or treated against their will); most participants are themselves former inmates. All identify as psychiatric survivors, except one who identifies as a ‘mental health

consumer'. Consumers accept the psychiatric medical model and believe partnership with professionals will improve the system. Conventionally, survivors reject psychiatry and are often associated with antipsychiatry. These definitions overlap however, and many survivors attempt to leverage the system by working through it in empowerment-oriented organizations (though any participant could claim to empower people, wherever they stand in Fig. 3). Three participants enforce CTOs, and one of these is a psychiatrist. Their perceptions were candid, offering us a closer view of people's experiences under CTOs. Six participants had met me through my work with the Queen Street Outreach Society (which used to advocate against CTOs when it was still funded). Three interviews involving people in two cities outside Toronto, Ontario, were conducted by telephone. Three participants formed a focus group in Toronto that helped to guide me in designing later interviews. One focus group participant was later interviewed a second time.

Table 2: Research participants' fictional names, relative positions, and activities as psychiatric professionals, workers and activists, with date of discussion and method of communication.

|                    |   |  |
|--------------------|---|--|
| "Kim"              | psychiatric survivor advocacy worker, activist  | 03 2005 (focus group)                              |
| "June"             | legal clinic worker, activist   | 03 2005 (focus group)                              |
| "Tyler"            | housing support worker  | 03 2005 (focus group)                              |
| "Rudy"             | psychiatric survivor agency worker, activist  | 08 2005 (long-distance, semi-structured interview) |
| "Victor"           | <i>Assertive Community Treatment team</i> 'peer support' worker, mental health consumer | 08 2005 (long-distance, semi-structured interview) |
| "Danielle"         | <i>Assertive Community Treatment team</i> psychiatrist                                  | 08 2005 (long-distance, semi-structured interview) |
| "Carmen"           | psychiatric survivor agency worker, activist  | 08 2005 (semi-structured interview)                |
| "Martina" or "Kim" | psychiatric survivor advocacy worker, activist  | 08 2005 (semi-structured interview)                |
| "Emilia"           | <i>Assertive Community Treatment team</i> case worker                                   | 09 2005 (casual interview)                         |
| "Fran"             | Rights Advisor with the provincial <i>Psychiatric Patient Advocate Office</i>           | 09 2005 (casual interview)                         |

I found my discussions revealing on many levels. CTOs were not a great priority to most participants (for example, the new Local Health Integrated Networks were a pressing concern for workers). Once I transcribed interviews, I coded them for recurring themes. Everyone discussed *coercion* and *consent*, and often discussed medical-legal usages such as *insight*, or social issues in psychiatry such as *autonomy*, *best interests*, *identity*, and *power*. I compared perceptions of such themes to explore CTOs. For

example, whereas Martina (a survivor) defined power in terms of knowledge and experience, saying professionals attempt to “own knowledge” borne of survivor experiences, Danielle (a psychiatrist) defined power inside an economic and legal arena in which “patients” have the deck “stacked against them”. Further themes, including *drugs, status, services, CTO ‘efficiency’*, helped to contrast participants’ perceptions of CTOs, positive and negative. Defining *coercion, consent* and *efficacy* through the psychiatric literature helped to situate participants’ beliefs. Conversely, participants helped to reveal the assumptions in research that theorizes such concepts.

Participants used terms quite differently from one another reflecting the orientations in Figure 3. Some psychiatric terms are used by survivors in mockery of institutional (psychiatric) or academic (expert) definitions, rather than out of a lack of knowledge or ‘false consciousness’ (Freire, 1970). Because of the cyclical practices of power in psychiatry, sanist language used by psychiatric workers is complex and refractory. Kim expressed exasperation at the legal rampancy of ‘Community Treatment Orders’, which promise: community integration and acceptance, ‘safe and effective’ treatment coordination, and of course obeisance under ‘orders’. She said, “Just on a visceral level, it felt like another layer of a gray cloud. It’s out there and it affects us, but there’s also a lack of a way to talk about it.” Double meanings and Orwellianism have become commonplace in Ontario with the rise of neoliberal ‘globalization’, but psychiatric language has always presented jarring oxymorons. Each neologism underwrites sanist control reminiscent of punishing institutions, family ‘shut ins’ and ‘closeting’. Inmates shiftlessly wandering or rocking back and forth in rooming houses strike poses that call back old asylum photographs. Emilia asked in exasperation whether by using CTOs her ‘treatment team’ is doing to people today what she saw in those historic images. Language mollifies her coworkers, who believe they are freeing people using ‘major tranquilizer’ drugs called ‘neuroleptics’, a contemporary drug term meaning ‘seizing nerves’. (Also called ‘antipsychotics’, these designations replaced the more guileless ‘chemical lobotomy’ of the 1960s). Professionals often say inmates’ languid rocking is a result of ‘side effects of medications’. Many layers of language obfuscate phenomena, in ways that deny people’s lived experience, which participants often present with emotive clarity.

### **Lack of Information and Rights Under CTOs**

In considering participants’ perceptions, I will highlight themes rendered in bold in the introduction of this thesis, under “Problems with CTOs...”, in italics below.

In the initial focus group, participants commented on inmates' lack of knowledge about CTOs. Workers had met very few CTO inmates, in part because there are only a few hundred such inmates in Ontario at present, according to Michael Bay, a principal researcher in the legislated review of CTOs (personal communication, February 24, 2005). This quantitative fact seemed to suggest to some that CTOs were of minor concern. However, as they considered the few people they knew, several concerns arose for them. A consistent comment by psychiatric workers who did not impose CTOs was that inmates are rendered invisible by these orders. As they sought to empower inmates or discuss their *rights*, they could not simply ask people to disclose whether they were under CTOs.

Kim (peer worker): If somebody's an out patient... meeting with their psychiatrist or something and they have a problem, we sort of talk about it a little bit.... I [once] said "You know, if you're on a Community Treatment Order—" and they said, "Well, I don't know. Am I, like, on it?"... They don't know if they're on a Community Treatment Order. They said, "I [do] have a community worker. [Is that the same thing?]" It kind of creates a little bit of confusion for me because I think generally people who are on a CTO should know they're on a CTO. Maybe they do know they're on a CTO [but don't bring it up]. But for other people I'm talking to who have other issues, for them to say to me that they don't know—it's just crazy making for me....

•••

Kim (peer worker): It's confusing, cause if I'm going to advocate for somebody, I'd need to know if they're on a CTO, and if they can't tell me yes or no, what am I gonna do?

From Kim's statement, it appears few inmates know *about* Community Treatment Orders. As such, inmates lack general knowledge about their legal situation and what few advocates there are in the psychiatric system must attempt to increase knowledge system-wide. She also suggested inmates may not know their legal *status*, whether they are under CTOs themselves, which Carmen discussed in a later interview.

Carmen (peer worker): I have a suspicion that there are a number of people on [CTOs] who come to [our organization] but they don't understand them or know what they're on. Because people's understanding of what's going on in terms of their legal situation, whether it's with their landlord or whether it's with their doctor, is so minimal that—

Erick: Why is that?

C: Well they don't get rights advice at whatever juncture these deals are cooked up. So then they come to believe in whatever's transpired, and then— you as an advocate, I'm sure you've had this experience— you keep telling people, 'No it's not that way, they can't do that', and then they tell you, 'But they did!' [laughs] 'And I just don't want to make any more trouble.'

Ignorance about CTOs, indeed about whether one is under a CTO, makes it impossible for inmates to seize their rights. A general ignorance about institutional rules results in fear, apprehension and ultimately rights *abuses*. Carmen suggested that one of these abuses is some inmates do not actually get 'rights advice', which will be explained in more detail below. Rights advice is required by law and may be performed and logged but still be poorly conducted.

Kim (peer worker): I can't keep up with the individual advocacy that I have to do because the mechanisms in place to deal with individual advocacy [the Psychiatric Patients Advocate Office, a provincial organization that provides advocacy support, rights 'monitoring' and 'rights advice'] aren't working for people. They're too bureaucratic and people don't understand them— I don't think people even know [these] mechanisms have been around for a number of years.... They don't know about them, and across the hospital system, the Patients Advocate Office, I think they help some people, but some people when they need to talk, they need to talk in a certain way. They need to have a certain space to talk about what's going on, and it doesn't always fit into the box or the method that's happening at the Patient Advocate Office.

Fran, who provides inmates with 'rights advice', has recently confirmed that her work seems impossible. She said she has too many cases, which limits the amount of work she can do in each, and when people are told about their *rights*, they often do not act on them. Some do not even seem to care, which will be further discussed below.

Fran (rights advisor): I tell [inmates] that they will have to comply with their CTO. They just say, 'I know, I know, I got it this morning [the 'Form 45' which issues a CTO]'.

As such, 'rights advice', one of the cornerstones of the government's justifications for implementing CTOs and an indicator that information and rights are being established at all, is frustrated by resource management issues.

Another justification for CTOs is they provide or better coordinate '*services*' for 'mental health clients'.

June (legal worker): I've been figuring out that people [are] on CTOs, because of [unrelated] issues around what they want to do and [because] they've lost that nurse or doctor or social worker that's been coming in regularly [under a CTO 'treatment plan']. That's when I start asking questions and figure out, 'Oh, you're on a CTO!' Then I did a Form 14 [the procedure required to see a clinical record, before 2004 privacy legislation changes]. 'Let me talk to talk to your doctor.' So actually it's been a backward process, which is terrible. It's like being in jail, and not being told why you're charged, how long your sentence is going to be and what you have to do to get out.

June intuitively likened the CTO to a jail sentence, but suggested people in jails have more knowledge and therefore rights. She also mentioned that desired '*services*', in the

form of visits by psychiatric workers, might not be provided continuously in all cases. This suggests *efficacy* of CTO 'delivery' is unstable, though many workers would argue all 'service delivery' is hampered by lack of resources. But in a Centre for Addictions and Mental Health study (2005), psychiatric workers said one of the greatest benefits to the CTO was that it helped coordinate services. June suggested such arrangements are not consistent or may not be sustained. Inmates who 'agree' to be put under a CTO in hope of obtaining scarce 'services' can actually lose those services over time.

Inmates may not know they are on a CTO because they do not actually agree to the CTO. If a doctor declares someone 'incapable to consent to treatment', a Substitute Decision Maker may agree for the inmate. Conceivably, the inmate may never be told of their *status* (i.e., under CTOs) as the conditions of the 'treatment plan' are being met. This is not to say that psychiatrists will not try to 'negotiate' directly with an inmate, as Kim reported.

Kim (peer worker): I've had a couple of people come to the office when they're in the hospital, really alarmed that— one woman came in saying she was... upset because they [hospital staff] were saying, 'If you don't get on a CTO, you know, you have no choice: you're either going to stay in the hospital or you're going to get on a CTO.' And she didn't want to get put on a CTO because the CTO meant a bunch of things that she didn't want to agree to. One of them was that she had to live in [Etobicoke] and she didn't want that. She wanted to stay in Toronto and all this stuff, so she was really upset.

Erick (researcher): Why were they telling her to live in [Etobicoke]?

Kim: Because they wanted to connect her with the service at the hospital there, which she had had contact with before. But she didn't want that, she didn't like that hospital. She didn't like that doctor, and she wanted to stay in Toronto. That's where her friends are. And so then I tried to have a discussion with her about rights. "You don't have to agree to a CTO you know?" And she was all stressed out about this, but then sort of said, 'I think I'll just decide to say yes because it seems like the better thing to do.'

Kim suggested that treatment decisions are being made based on convenience for psychiatric workers at least as much as for the 'best interests' of their 'client'. That would be a reversal of the traditional client-producer relationship, which normally privileges the client. It seems an *abuse*, but relocating inmates without consent under the rubric of a 'treatment plan' has been officially challenged at the psychiatric tribunal and upheld (*M.B.G.*). Participants scoffed at the notion that CTO 'treatment plans' might include 'alternative therapies', as they are called, such as herbal remedies, psychotherapy or art therapy.

Kim: I had somebody else call me up, and they were threatening him with a CTO, and the first thing I asked him was "has anyone come up to tell you your rights?"



And he said, "No." Then I said, "Okay, well you should ask for that." He was also stressed out, not knowing what this was... because he had no sense there was a 'rights' aspect to it. Then he said, "Can you set up a meeting?"... and so I'm meeting with his parent who wanted him on a CTO, a partner who didn't want him on a CTO, and a social worker.

E: He was distressed about the fact that he hadn't known there was a rights—

Kim: Yeah, and again, he has no sense of understanding, of what this thing [the CTO] is. He came— actually... we talked on the phone, and then at a later date he came to the office and he was... considering being on a CTO, and I said "Did you get any information about Community Treatment Orders?" and he said, "Yes." And he gave me the standard pamphlet.

Again, a lack of information creates as much fear as confusion, such that an inmate cannot know what rules apply and whether they can alter their apparent legal *status*. Such reports were common when Kim held a focus group with seven CTO inmates.

Kim: [CTO inmates said] they were on a CTO, they wanted to come off a CTO, but they felt really stuck, that they couldn't come off a CTO.

Though a CTO expires automatically after six months, it can be renewed indefinitely.

Again, the complexity of the law is a problem, especially for people who may be distressed and obviously desire fewer complications. But even psychiatric workers lack knowledge about CTOs. According to Anita Szegeti, a Toronto lawyer with the Mental Health Legal Committee, the provincial government did little to educate lawyers and psychiatrists regarding the new law and its regulations after it passed (personal communication, June 6, 2001). This again raises questions about the *efficacy* of CTOs or their implementation.

June (legal worker): ...people are either calling or coming in to have someone put on a CTO, or they're calling and coming in because they don't want to be put on a CTO.

The problem of professionals not knowing how the law works is that this ignorance is transferred to inmates, whom will bear the brunt of inefficiencies and oversights.

One would hope that in the 'mental health system' workers strive to respect the dignity and vulnerability of people in emotional or psychological distress. A lack of information about 'treatments', including CTOs, can be detrimental emotionally. Should an inmate wish to alter her situation under a CTO, a lack of information is all the more troubling. Participants suggested and a local study (Centre..., 2005) seems to confirm that psychiatric workers know little about CTOs (if they do not impose them), which will

greatly reduce the ability of inmates to educate themselves or defend their rights. Further, as CTO inmates' apparent status is not exposed as it would be in the institutional setting, advocates and activists have fewer opportunities to help CTO inmates protect their rights. Appropriate rights advice was promised as a way to ameliorate such concerns, but advocacy services are at least as poorly resourced as other 'services'. And while CTOs are being recommended as a way to coordinate services, or for an inmate to obtain them when they are scarce, it seems overtaxed services can disappear.

### **Wishing to Flee Canada**

Abuses affect *identity*, both inwardly and with regards to how psychiatric workers perceive and deal with inmates. Participants discussed the emotional experiences of people under CTOs and, as Kim's focus group revealed, fear and confusion were very often reported.

Kim (peer worker): People are so much a part of the system that they have no—they're just kind of like being swept through and they have no agency and then it's really problematic.... And CTOs just add again another layer of a confusion to that.

Such feelings increase over time and result in apathy and lack of interest in rights. Frustration about inmates' rights is palpable. Kim talked about the fact that few complaints about the system ever go anywhere. "I mean there was an article in the Star the other day about those two family members who are going to court because there's no inquests into the deaths at psychiatric hospitals." In contrast, deaths that occur in correctional facilities must be immediately investigated.

Community Treatment Orders were legalized to provide a less restrictive way to control inmates who failed to 'comply with treatment'. Chemical control is not necessarily less restrictive than physical detention, and the *constitutionality* of CTOs should not rest on such an assumption. Rudy spoke of a middle aged male inmate who felt he was better off in a psychiatric facility than in his apartment under a CTO.

Rudy (peer worker): Well actually he's back in the community because of a Community Treatment Order. This was a gentleman who had an experience that they labeled 'psychosis' and he was hospitalized for a fairly lengthy period of time. He was satisfied with that. He was able to take a medication [a neuroleptic drug] in the hospital orally. That was the medication that was prescribed. The hospital decided they didn't want him in the hospital, that they wanted him to be in the community, and they wanted him to take the medication by injection, because they did not trust that he would take the medication orally. He did not wish to have the medication by injection. He did not want that at all. They made the decision to apply for a Substitute Decision Maker, the [Public] Guardian [and

Trustee] of Ontario, who was appointed [and] agreed with the hospital that he would be put in the community and given his injections. He was put back in the community into his own apartment, and this was an apartment he'd had for a period of time, and he did not wish to have the injections, so they had the police come, take him to the hospital, which was a forty-five minute drive, inject him, and the police returned him to his home, and this has happened on a number of occasions since his release from hospital.

In this example, the inmate has already acceded to taking psychiatric drugs. It is the demeaning method of injection which he refuses, and only based on this preference was he found to be 'incapable' to consent to treatment. This is an example of power using a 'cycling of evidence': anything the inmate does can be construed as incapacity once a conflict is established. In this case, a government office provided 'substitute consent' for him, not a family member. The Public Guardian and Trustee rarely challenge a psychiatrist, nor do family members, as we will see. Rudy told me about the inmate's experience.

Rudy: He's bothered in his life now because of the CTO. Recently he talked to me about wanting to leave this country. He felt that strongly about it! He said, "I'm not safe here. This is what they do to me. They come— the police take me away when they choose to take me away and do this to me— inject me when I don't wish to be injected." You know? It was a sadness in him, and some fear, a loss of control in his life, which disturbed him very deeply. And again, he's talked a number of times, "How can I get out of this country?" In practical, real terms, I think it would be extremely hard for him to leave the country, first of all financially. And then, what border can he cross given that he is on a CTO and there is a Substitute Decision Maker for his affairs? Yeah, there's a sadness. I have a sense of sadness around it as well. Here is a person that is being hurt. I don't know what the word is; I was thinking of the word 'coerced'— it's a stronger word than that [which] should probably be used to describe that. It's 'oppressed'. He's being oppressed, and that's the reality of his life....

There's a sadness about it because he also just accepts that this is his fate in some way. It's like, 'Okay, I'm not going to make too much trouble. I don't really want to be doing this. I don't see that I have much way out of this. There doesn't appear to be. The quote "authorities" are saying that this is what they're going to do, this is best for me. They're making that decision. I don't really have any protection. I don't really have any way of stopping that.' I mean, at some level I think he's right. You know you have psychiatrists who have, in their expert opinion, said that this is what he requires. That's reality, you know, and I think that's life in this province under CTOs. Absolutely. I've seen that happen in other situations not to do with CTOs as well, in terms of Consent and Capacity and that's what happens.

E: So ultimately the psychiatrist's word is the last word.

R: Absolutely.

This man wants to escape Canada in order to escape his CTO. He has already accepted psychiatric interventions on so many levels; I see no exaggeration in his dejection. On a

*constitutional* level, he feels the Charter of Rights and Freedoms cannot protect him. As we shall see, other inmates who had experiences of torture in other countries felt the same way and also wanted to leave Canada when they were put under CTOs.

Rudy (peer worker): Anyway, the gentleman just doesn't object to a lot of things. He lets life kind of flow. So when he says 'no' he means 'no', but in this case [of the CTO] it didn't seem to matter. Part of [the hospital staff's] argument or position was that it was too costly to keep him in the hospital. When he was put back into the community, just to let you know, there was no additional community resources made available to him.

Erick: Was there any worry, for him, with regard to leaving the hospital [and] costs outside the hospital?

R: No. I think he recognizes the limitations that the income supports put on him. Is the right word 'content'? I think he recognizes, 'This is my life, this is my source of income, this is the amount of money I have, and I'll live within my means.' He does have a bad back. His back gives him problems quite a bit so it really limits— he's wanted at times to be able to work, but he's quite limited at times. He can't engage in physical activity, so he hasn't really considered much else in terms of possible employment to supplement some of his income. So at this point, over the last few years, he hasn't worked any additional hours to try to get any additional money. He lives on that pretty meager amount of money and he's, uh, should I say 'content'?

The impact of the CTO for this inmate is worse than institutionalization, despite his acceptance of 'medication' and 'hospital'. Again, there is no coordination of 'services' provided with a CTO here. Drug treatment without choice constructs a broken, hopeless *identity*. This man has resigned himself to a lower standing in life in Canada and all the debilitating, self-oppressing feelings and responses that brings.

Advocating for inmates in the psychiatric system under such circumstances is not easy. The bulk of this thesis might have frightened me if I had read it after my brief incarceration. I had put all my faith in medical authorities and was uncomfortable with asking them questions they might interpret as 'uncooperative' or 'defiant'. Advocates are sometimes dismayed at how meek inmates can be, and advocacy can only work with trust and time.

Kim: You have to be careful; you don't want to overwhelm people and start giving them a whole bunch of information and sort of invade their space.

•••

Kim: I wish I could write about this, cause what I've noticed is that I have built relationships with people just by virtue of them coming in and hanging out. Like people come in... just shoot the breeze for like 3, 4 or 5 times, and then the 6<sup>th</sup> time they have a legal issue or a shrink issue.... I say, 'Okay, have you tried the Patient Advocate Office?' and sometimes they go, but then they come back with the same issue, so I have to follow it up—

Erick: [to June] Do you find the same thing?

June: I have the same trouble as Kim. I'm supposed to do systemic advocacy; they're calling me for service that the Patients Advocate Office should do.

With so few advocacy resources available, and with such great emotional pressure for inmates under the psychiatric system, there is little incentive to fight for *rights*. If a CTO is renewed every six months, it must reviewed by the psychiatric tribunal (called the *Consent and Capacity Board*) once per year. Yet, CTOs are rarely challenged before the Board (S. Fraser, personal communication, October 5, 2005). Rudy discussed how hopeless survivors feel about making such challenges.

Rudy (peer worker): In this province... people who commit crimes have more rights than some people who have a psychiatric condition. Not all, but—absolutely. If you go out and commit a horrendous crime— theft, rape or murder or something— immediately you're given a right to an advocate, to a lawyer.... In terms of a person who is deemed to have a mental illness and [to] be incapacitated they're 'formed' [apprehended under the *Mental Health Act* by use of a legal form] and brought to the hospital. They have no civil rights.

Erick: So it's almost as though they should get their own psychiatrist on their side, as it were, in order for their rights to be somewhat comparable to having a lawyer.

R: Have you ever heard of a person going into the Consent and Capacity Board and having a psychiatrist with them to argue with them against the psychiatrist who's treating them? If you went into a murder case, I've certainly heard of situations in murder cases where the Crown will bring in a psychiatrist and the defendant will bring in a psychiatrist. That's extreme, and we're not really talking about crime here, but they have the opportunity to have a counter-argument to what somebody's suggesting around the reason for their— anyway, you don't have that opportunity here. You're not going to get a psychiatrist who's saying, "You know I'm not sure if you're treating this patient appropriately."

E: So you're saying that there are no advocates for this person on equal footing with the psychiatrist.

R: Absolutely.

...

E: So are lawyers not able then— why are they not [as] good representatives [as] a psychiatrist [might be]?

R: Well what the lawyer can do is argue the *law* of the case. So if I go to the Consent and Capacity Board, the lawyer's going to ensure the *process* [of detention or treatment] is followed appropriately, and fair. Clearly the lawyer has no ability to question or challenge the psychiatrist's diagnosis or treatment, their medical opinions and profession and so forth.

E: Or the capacity of the patient according to the psychiatrist?

R: Right, right. They can in a very cursory way ask in terms of common knowledge but they don't have any medical expertise. So it's sad in some way. Of course, on the Consent and Capacity Board itself there is a lawyer, there is a psychiatrist [and the third member is a layperson]. So, you know, the psychiatrist on the Consent and Capacity is supposed to be there to ensure that the psychiatric treatment and the medical treatment is appropriate. Well, I don't know

about you but I don't see too many psychiatrists that challenge other psychiatrists. I believe, in listening to a former head of the Consent and Capacity Board talk, I believe the rate is 99.5% of cases that are brought are upheld [statistics from 2001 indicate 94% (Chambers, 2003)]. So a person going in and contesting an Order has a chance of 0.5% of succeeding, very rare."

The question of success at the psychiatric tribunal will be taken up again, but Rudy is describing what appears to be a relationship between the law and medicine that almost entirely defers to medical determinations. While the tribunal operates above any *abusive* decision making practices by psychiatric workers, it seems to fit squarely into the 'cycling of evidence' which sustains the system.

The psychiatrist participating in my research also felt that inmates had little chance of beating the odds at the Board, and that inmates were inured to their plight.

Erick: And yet [inmates are] not all that interested at times, they're not interested in their own rights?

Danielle (psychiatrist): They are, but you know what happens to any seasoned patient? And they're right to think this way. It's so stacked against them. They decide, what's the point. And it is stacked against them, I'm just saying from their point of view, unless the person who put them on a CTO is very cavalier.

E: So you're saying that CTOs are in and of themselves quite a reduction in the person's liberty, right?

D: Absolutely.

### **Targets of CTO Treatment**

Legal decisions about inmates reveal treatment decisions are made for various reasons. I asked participants how CTO decisions were made. This brought descriptions of how people were chosen for CTOs but just as often what their lives were like under CTOs. Victor described how a treatment regimen seemed inescapable for one CTO inmate and how workers find themselves providing '*services*' inmates neither want nor need.

Victor (peer worker): Another woman we work with has schizophrenia as well. She's on a CTO and part of her requirements [in the 'treatment plan'] are that we see her almost every day and give her medication [neuroleptic drugs]. I'm not a big fan of that kind of idea, seeing the client every day. I think it's disempowering, and for this person, we see her every day and she still has pretty fixed delusions [strange beliefs], and she has problems with her illness sometimes, but generally she tends to function fairly well. She has her own finances, her own apartment. She's been out of hospital for a few years now. So in some ways, she's someone that the CTO has helped; she's been able to stay out of hospital, but I ask, how long would you keep renewing the CTO? You know how the CTO works: it comes up for renewal every 6 months. If this person wanted to get off a CTO, would she have the capacity to do so? I think that's the problem with CTOs. If someone really doesn't want to be on them, they can get off them if they really

choose, but if they're not in the right frame of mind it can be hard. So here's someone who's on a CTO because she doesn't argue with it so much. I guess in some ways it's been helpful but in other ways I find we don't really do a lot with her. She tends to do her own thing [i.e., avoids contact]. She's really independent. So as far as recovery, she's probably at a level where she's probably okay, but things might be better for her.

This example shows how unwanted help results in withdrawal and resignation, a lack of independence. Victor was concerned with whether the CTO is *effective*. The inmate can 'function' in society without being incarcerated, but she still carries her 'mad' beliefs; the CTO has only worked to control her. However, he wondered if there could not be more to her life, and this is central to the issue of whether CTOs 'work': do they improve a person's life, and by whose standards?

Erick (researcher): How might [things] improve?

Victor: I think giving her more responsibility for her own medication, taking her medication on her own. Maybe even just seeing her three times a week [and no more], at least try it. I think there's this problem with CTOs and in general with mental health care providers, that they need to coddle everybody and make sure they're okay, and that they're not just faking it [being okay]. Everyone's worried about risks, and to me it's not all about risks. People need to be able to take chances and to fail and to do their own thing. I think on a CTO the person tends not to have a lot of say on what their treatment is about. If you're not in control of your own treatment it's hard to move past that.

Victor's account shows that people whom workers and the public normally consider beyond help, 'unmanageable', or 'incurable', are perceived otherwise by peers such as himself. As he said, managing legal or medical risk is primary to psychiatric workers, but people need to make their own decisions, to take risks for what he calls 'recovery'. Recovery is defined in the psychiatric literature as a personal process by which people become independent of psychiatry and its 'illnesses' (Jacobson, 2004). It flaunts prognostications in psychiatric textbooks, based on Bleuler's hundred-year old observations, that less than 5% of people 'recover from schizophrenia'. Many studies have shown that half to two-thirds of such supposedly 'chronic patients' find jobs and relationships, and report no 'symptoms' (Jacobson, 2004; Deegan, 1997; Harding, 1987). Nevertheless, as Victor suggested, drugging and 'symptom management' continue to be primary treatment objectives in the psychiatric industry. As such, neither the worker nor the inmate has faith in the inmate alone, which entrenches institutional identity and faith in chemical treatments: a primary aspect of *chemical institutionalization*.

Who is put on a CTO and why? Participants described the kinds of medical determinations used in imposing CTOs: 'lacking insight', 'non-compliant', 'mentally deteriorating', 'repeated hospitalizations'. These overdetermined usages are sufficient to communicate why an inmate is being held against her wishes in psychiatric settings.

Victor (peer worker): They're put on CTOs with the idea that this is something that will keep them out of hospital. That's usually why: if they have repeated hospitalizations and are not taking their medication.

Erick: Can you describe what's happening with someone living in the community and is in a 'revolving door' situation [in and out of hospital], from your perspective or from what you've seen. What does it look like on the ground?

V: Well, for example, I might work with people on a CTO who aren't taking their medication. Usually it ends up that they need to be brought into hospital if it comes to the point where their lives are disturbed, or they're having a problem with living, [or] if they choose not to get on medication. Sometimes, I think a lot of it comes down to people having a hard time with their insight into their illness. Families get the services."

Illustrating the flux of language, Victor used both the antipsychiatry usage, 'problem with living', and the psychiatric nomenclature, such as 'insight into their illness', to describe people targeted for CTOs. Again, this shows how all language can be drawn into the 'cycling of evidence' and 'cycling of biology' in psychiatric power practices. These are used as the basis for deciding who gets 'services' including CTOs.

It was noted by several participants and others I have met that often CTOs are imposed on people with family members rather than those without. This is an important development since the implementation of CTOs, since it was primarily a family lobby group that managed to convince government to adopt this new legal mechanism, a fact we consider below. Families benefiting from CTOs is a perception that other participants took up independently:

June (legal worker): I'm finding that the group that is less likely in the neighbourhood to be put on a CTO is somebody who's transient, or homeless, and has no supports in their life. I'm suspecting that's because of the complex issues that somebody has when they're living on the streets and they're poor and homeless. They're a little more difficult to serve in mainstream organizations because they don't fit the criteria that gets service, like 'catchment area addresses'. And, because they don't have family contacts, nobody wants to assume responsibility, and doctors and nurses and social workers won't assume responsibility if there's not somebody else to ensure the CTO is followed through in the community, which is going to be a family member.

This problem of selective provision of 'services', intrusive or not, cannot be explained by the fact that the 'patient' must be "able to comply" with the CTO as stated in the *Mental Health Act* (Subsection 33(4)(c)(iv)). 'Homeless' people can certainly comply with



treatments if they are forced into their bodies. CTO services are usually restricted to psychiatric drugs and a worker who 'delivers' them to the inmate. Sometimes this is done by an "Assertive Community Treatment" or "ACT" team. ACT teams received a great deal of resources when CTOs were initially legislated. Their approach, of bringing services out of the institutions and into the 'community', has been contested for various reasons and will be reviewed again later.

Erick: Have you noticed what sorts of people are usually on a CTO? One person told me that most people who are on a CTO are not homeless. Some people feared it would be a kind of a 'sweep the streets' [of the 'homeless'] thing [like what was being planned in New York], but in fact they [Ontario CTO clients] have supports in the community.

Victor (peer worker on an Assertive Community Treatment team): Someone that's homeless generally wouldn't be on a CTO because a homeless person wouldn't have access to services or wouldn't be accessing them. So someone that's on ACT is generally someone that's connected with the mental health care system.

E: So someone who's not connected with that system because they're homeless and therefore aren't accessing services would not normally come into view of a psychiatrist who might suggest they be on a CTO?

V: Exactly.

Refuge, cloaking, concealment, are all exercised in various ways by inmates, the untreated, and those previously forced. Sometimes this leads to extreme isolation on the part of homeless people. So, in practice, are 'homeless' individuals thought unable to 'comply' with a CTO because they refuse treatment, or because monitoring by family or others is unavailable? What sort of *efficacy* can a CTO have if psychiatry will only treat those who cannot escape seizure? Could this deference to families of 'people with schizophrenia' (the 'anti-stigma' label) be a way of demonstrating that psychiatry is not involved in social control? Some community workers successfully deal with isolated 'homeless' persons, however, without using force and by eschewing clinical interventions. It seems psychiatric professionals avoid situations they cannot manage with 'medicine' alone.

Erick: What's happened to people on the streets since Bill 68 [Brian's Law]?

Rudy (peer worker): I don't think the changes in Bill 68 made a lot of difference. There are some programs, I think, in Toronto that I'm aware of. There's a couple of outreach programs that have occurred. Some agencies are making some attempts to help people on the streets. It's not that they're being totally ignored. I'm just saying that Bill 68 didn't make any difference to that population, no significant difference. It was a political bill, in response to the Schizophrenia Society of Ontario [a family group lobbying for more medical interventions and research].... [A]ll of a sudden we've got a law that many people labeled 'draconian', a step backwards, not a step forward for any kind of

enlightened care of people in our community. These aren't just my words, that's not my cynicism or my opinion. In fact, that was well written about and documented at the time.

...

Rudy: ...following the statistics, you will find the vast majority of people who are served by [workers who impose CTOs] in fact have a diagnosis of schizophrenia, and that's interesting to me.

Erick: What does that suggest to you.

R: I'm curious as to why it happens to be one diagnosis. All it suggests to me is the influence of the Schizophrenia Society of Ontario, and the parents of people who experience schizophrenia lobbying strongly, and the government putting a lot of money behind it. They talk about 10% of people with schizophrenia committing suicide. I'm saying look at the people who are depressed; huge numbers of people who are depressed commit suicide.

Again, families benefit from CTOs, specifically families who might have lobbied for them. Ontario's CTOs may simply be seen as more applicable and 'effective' for inmates labeled 'schizophrenic' who are not homeless. In terms of fiscal *efficacy*, police, clinicians, and ACT Teams are coordinated in the management of this group at a premium cost.

Participants believe CTOs are not being utilized on the homeless, like 20% of CTO-like measures in New York State called Involuntary Outpatient Commitment (New York State Office of Mental Health, 2005), and that this arbitrariness is indicative of *abuse* of CTOs. This does not mean people who are homeless or otherwise are not being considered, however.

Danielle (psychiatrist on an Assertive Community Treatment team): ...the only person I demanded a CTO upon discharge (and that's a complicated story), the guy was very, very high risk according to others and did not have the cognitive capacity [he was labeled "developmentally handicapped"] to stay on treatment by himself. There's just no way that he could be managed without a CTO. So, he's one of those people who's kind of beyond ACT anyway. Not that we're in the business of protecting the public, but for people who have a high risk directly related to their untreated state, then the CTO becomes more of an option because that's the only way you can get them out of an institution.

In this example, we see that the CTOs are *effective* in 'managing' or controlling individuals that our society would rather forget. The psychiatric system is not simply being used to detain people who fall under categories of 'mental illness', but others as well. Danielle (and Carmen) complained that the manner by which people are ushered into various institutions, whether they be correctional, mental or custodial, is rather arbitrary. In this context, Danielle voices her concern about *abuse*.

Danielle (psychiatrist): I guess, another thing about the CTOs, and you know just to generalize out of my context, I think it's very important; the research shows if

they're not going to be abused, [CTOs] have to be used at the end of a spectrum of [choices of] professional support, so that I would never, unless the patient comes to me on a CTO which is rare, although I've had that happen, when patients are referred to me from the institution and that's usually where they are referred, because they have trouble keeping them out of the institution for any length of time. It's very rare. Only one case have I asked for the CTO upon discharge. All the others, no matter how many admissions they've had per year, it doesn't matter to me, I will always start without a CTO. I'll give them a year or two without a CTO and see how they do with our support. If that can't alter the pattern of illness at all, and that's the other criteria that I talked to you about, [wherein] my own personal sort of criteria applies, then I will try a CTO.

### **Purposes and Effectiveness of CTOs**

As the targets of CTOs are not fixed, we may never know whether they work. I was interested in how participants gauged positive elements of CTOs. Not all psychiatrists believe in using CTOs; some of them feel they will be ineffective in ensuring 'treatment compliance' or that they impinge on rights (Centre..., 2005). Indeed, a Canadian Mental Health Association study (2005) found that more CTO inmates than non-CTO inmates felt coerced. I asked Danielle who she believed should be on a CTO.

Erick: What sort of factors might lead to you putting them on CTOs?

Danielle (psychiatrist): Well, that's always changing over time. I must say that philosophically I've never been very, I didn't lean towards CTOs, but given the job that I'm in and certain social mandates that come with it, I do have to think about it. But I guess what I've selected over time in terms of bench marks or guiding principles for me has been the gradient between the untreated person (so the person with no medication, how they function), what their life is like, and how they are when they're medicated. That gradient has to be extremely large. And what I mean by gradient is the perceived change in their life, in their eye, even though, throughout all of my patients, they wouldn't attribute that change to medication or the CTO. So, if that gradient is not large, I will not put them on a CTO. It's not worth it. In fact the larger that gradient is the more I will consider it. .... I don't issue CTOs unless the person's deemed 'incapable' to make treatment decisions.

For Danielle, CTO *efficacy* is achieved if drug treatments improve the ability of the inmate to 'function' in society. However, if that inmate does not see great improvement, Danielle does not believe drugs should still be imposed. When do drugs 'work' and how?

Danielle (psychiatrist): So when he's untreated, okay I've told you what he's like, but when he's treated, when we did keep him for a year on a CTO, from the outside it looks good. He maintained housing for a year.

Generally, psychiatric workers and inmates will agree that having a job and relationships is a good thing, especially after an inmate endures weeks or months of institutionalization. Psychiatric drugs make it easier for inmates to 'fit in' for various

reasons, including the fact that they are responding positively to workers ministrations. Thus, perceived 'improvement' is related to social values and 'functioning'. This common objective becomes complicated, however, when people expect a person to achieve 'functioning' through drugs. Leaving aside for a moment the addictive properties of psychiatric drugs, participants explained that even landlords may demand their tenants be 'on medication' to ensure fewer problems. Thus, to improve one's life, one must access housing and other needs, which become available if one is being drugged. A 'cycling of chemistry' is established, whereby drug 'compliance' secures needs, but is perceived as treatment success, an obvious *abuse*. So, while some inmates may agree that their lives have changed positively, they may disagree that their treatment has itself caused that change, or at least that their rights should be withheld to that end.

Danielle: So an example would be a person, and this is a true example of a young, well not a young man actually, he's late-forties, with 30 years of illness, and when untreated went off meds. In treatment he responds to small doses of antipsychotics and when off meds he is unable to stay out of an institution. He's catatonic in the middle of a street. He cannot escape an institution because that's just the way our society works, you don't want someone like that out on the street. So he ends up being picked up by police and brought into hospital every time and every time it's one hundred percent predictable: when out of hospital he will not use medication because he doesn't think he has an illness.

In this case, the inmate disagrees that he is 'mad', or that his experience is due to an illness. This seems utterly absurd to anyone trained to see some kinds of experience as illness. Treatment is seen as a hope for stabilizing the person's experience, rather than a distortion of their *identity*.

Danielle (psychiatrist): And when on small doses of medication on a CTO he is able to maintain independent living, attend college, register for a medical technician's course and continue with that. The gradient is incredibly huge. But even when treated there is no connection in his mind between his state of studying and living independently and the Community Treatment Order and the medication. There is no connection in his mind.

E: What does he attribute the improvement to.

D: Oh, he just won't answer the question, or circumstances, or his efforts. Usually the question is debated. So it's a high, high level of what we would call 'denial'. They just do not at all integrate a psychiatric formulation of their life situation. But a person like that, you could ask him, is his life, does he prefer going to college and living independently to being in a hospital? And absolutely that's very important to him. But the more that the importance [of 'functioning' exists for the person]— that's what I mean by the perceived quality of life: the difference in treated state is very great and is very important to them— for me it's worth the emotional and the resource investment in implementing a CTO. But it's also worth the moral or ethical dilemma that it puts you in.

Danielle seems more attuned to psychiatric understandings than the need her “patient” has to believe he can master his situation. Even if this demonstrates “denial” of psychiatry on his part, it is useless to expect him to deny himself agency. But this impasse is not a matter of clashing beliefs such that the worker believes in illness and the inmate in himself. This impasse is a matter of experience and *identity*, which no treatment can correct: the inmate wants to be fully alive. Inmates may ascribe success to anything but the ‘treatment’. A shock survivor in the 1940s (Alper, 1948) said the reason multiple shock treatments (without anesthesia and muscle relaxant in that era) ‘worked’ for him was that “there existed a ‘love relationship’, a relationship similar to that between father and son, between myself and Mac [the attendant who held him down for these treatments], a relationship such as is established between psychiatrist and patient in narcosynthesis [emotional ‘catharsis’ through drugging, in the language of that era]. I believe this lucky accident proved to be the focal point of the entire treatment.”

The role of placebo has been demonstrated also. For example, pharmaceutical companies have to run many studies before they find two that show neuroleptic drugs work better than placebo (Vedantam, 2002). Assuming low levels of neuroleptics do arrest unwanted feelings and promote calm without substantial negative effects including addiction, at least for a short time, someone might choose such a ‘trade-off’. Even so, can an inmate properly ‘choose’ to be drugged under a CTO? This problem of choice under coercive contexts complicates the question of whether CTOs are *effective*.

Victor (ACT peer): I’d say there are a few clients we work with that [the CTO] might be beneficial for and it’s helped them. They manage to get out of hospital for periods of time and they seem to be okay with it. But there’s other clients for whom it hasn’t worked. I think the problem with CTOs is that they don’t seem to be— they’re basically the “one option for everybody” kind of, and not everybody will benefit from having to be put on CTOs.

All participants were engaged in questioning the *efficacy* of CTOs. None were convinced that CTOs were a panacea. In fact, all accounts were tinged with failure. A positive story would trail off into negative experiences and indications emerged that the CTO had not improved, let alone solved, the person’s quality of life. Most participants kept an open mind to CTOs providing more ‘services’, or ensuring treatment ‘objectives’, or enabling ‘functioning’ even if they were critical of psychiatry.

June (legal worker): So I’m finding that people that want the support of a CTO [because services are so scarce otherwise] are not getting it.... The ones that are on a CTO? They get abandoned a couple of weeks after it starts working. Then they’re back in my office a couple months later, or the police come because there’s some crisis on the street. So its—

Erick: You've found that in several situations?

June: Yeah. Two of them are in Scarborough and one of them is in Parkdale. And, so, it's hard because I can't get them back on the CTO. That's not what my role is.... And once they're off there's a lot of crises that happen, and you can't get the people that were named on a CTO [treatment plan as psychiatric workers] to support them [anymore].

Three participants felt CTOs were useless, especially in that they did not provide 'services' for the inmate.

Carmen (peer worker): Now as far as what he got from the CTO, what initiated him being put on a CTO... was that he lost his housing. The other thing was that he got arrested. You know there was a number of things that happened in his life, but in terms of the services that he got as a result of the CTO, I didn't see any differences in the services. We [our peer organization] were the ones— and we're not part of his 'Order' [as 'providers' of services], we're not named in the Order— we were the ones that had to secure him housing and arrange for his money to move.

E: So his treatment plan didn't do that?

C: The treatment team? No. no.

Even if drugging can be enforced by a CTO, other 'providers' named and 'services' listed in the 'treatment plan' may not be available, at least for long, especially the services inmates repeatedly say they want like housing and employment (Queen Street Outreach Society, 2002b). People who get housing and other services may no longer require 'medication' in the view of prescribers (Marshall, 1982:43). Nevertheless, drugging is the only enforceable treatment, demanding the least resources. To fully understand how drugs 'work', in the fifth chapter we will peer into the chemical action of drugs and the history of their development.

### **A Brief Local History of the CTO**

A full account of the historical, political, or economic contexts that gave rise to the CTO in Ontario is beyond the scope of this research. The CTO 'mechanism' differs in each jurisdiction. Saskatchewan has CTO legislation, enacted by a New Democratic Party government. Nova Scotia passed CTO legislation on October 31, 2005. A form of CTO called an "extended leave" provision is enforced in British Columbia and Manitoba. Australia and New Zealand use CTOs, as well as Israel, Romania, and a few other countries. "Involuntary Outpatient Committal" laws, which initially inspired Canadian CTOs, have been adopted in 42 U.S. states since the 1970s, and most fervently during the 1990s (O'Brien & Farrell, 2004; Appelbaum, 2005). Many social factors are related to these policy shifts, including *deinstitutionalization*, the production and consumption of *psychopharmaceutical drugs*, and 'managed care systems' in the U.S. (see Simmons, 1990; Bachrach, Goering and Wasylenki, 1994; McCubbin, 2004).

Deinstitutionalization, very briefly, began as a move away from the abuses of institutions uncovered during the 1950s and 60s. This project was not taken up so enthusiastically by governments and bureaucracies, which failed to provide the finances, security, and supports for people exiting institutions (Burris, 2004). It was assumed the new psychiatric 'wonder drugs' would make deinstitutionalization possible. The community did not open up to the institutionalized, in any case, while hospital 'bed closures' have continued to the present. Occasional allocations of government resources are made to clinical programs outside the hospital sector, but rarely to non-medical supports (Jacobson, 2004; Simmons, 1990; Marshall, 1982; Burris, 2004). The result is many inmates were, and still are, left to the streets penniless, adding to the number of people without shelter and assistance. Thus, during the 1990s, pharmaceutical lobbyists in the U.S. strongly advocated for more intensive chemical programs that would deal with those left out on the streets (Torrey, 1997). Such programs as 'Assertive Community Treatment' teams seem to fulfill this mandate, and are commonly associated with 'involuntary outpatient committal' laws in the U.S. (Ridgely *et al*, 2001; Dennis & Monahan, 1996). 'Deinstitutionalization' can be seen as a recycling of institutionalization processes (Black, 1982).

Psychiatric literatures deal with the questions of adopting CTOs, enhancing CTO efficiency, and managing perceived coercion assuming an underlying biological problem. Sociological literatures present problems with psychiatry, such as an overwhelming

prevalence of diagnoses and detentions based on class and race differences (Read, 2004), that suggests psychiatric assumptions are not so biological, logical, or ethical. This has led to “incommensurate games” between psychiatric epidemiology and sociology (Pilgrim & Rogers, 2005). Thus shifts in the practice of psychiatry, through policy ‘reform’, have been contentious and repetitious, founded less on scholarly debate than media exegesis (Blizzard, 2000; O’Neill, 2005; Appelbaum, 2003; Corrigan *et al*, 2005). How legislative changes are won and lost in specific locales may help inform a working “map” of psychiatric “rules of relation” (Campbell & Gregor, 2002).

Ontario’s CTO was introduced through “Brian’s Law” (Bill 68), which was inspired by New York’s “Kendra’s Law”, which also inspired California’s “Laura’s Law” (Torrey, 1997; National Empowerment Center, 1999; Appelbaum, 2003). Brian’s Law was passed in 2000, named in memory of Brian Wilson, a sportscaster shot dead by a man later deemed ‘schizophrenic’. The law meant to address such tragedies squarely, but such a provocative tribute caused concern that the government was playing on public fears of the stereotyped ‘violent mental patient’ (No Force Coalition, 1999), attributing violence to ‘the mentally ill’. Activists and vocal psychiatric workers decried CTOs as coercive and contrary to therapeutic relationships (Canadian Mental Health Association, 1998) and vocal lawyers warned that CTOs could be applied arbitrarily (Canadian Civil Liberties Association in: Ontario., May, 17, 2000). Psychiatric survivors said CTOs violate their human rights (People Against Coercive Treatment, 1998). I personally co-founded the No Force Coalition, a group inaugurated by a ‘town hall’ meeting focused on CTOs, in which approximately 40 people who experienced psychiatry voted to educate others about forced treatment (1999). This coalition grew to include 88 organizations opposed to the CTO, including feminist, health, survivor and other groups. I think the Coalition succeeded in informing and letting others know that opposition to the legislation was widespread. Psychiatric survivors and their allies, including some families and professionals, denounced CTOs in government hearings, but to no avail. A single government-funded organization, the Schizophrenia Society of Ontario, with financial support from pharmaceutical drug manufacturers (Oaks, 2000; Schizophrenia Society of Canada, 2005), lobbied government to enact CTOs, and continues to do so successfully, as we have just seen in Nova Scotia (Schizophrenia Society, 2002; Schizophrenia Society, 2005). Their campaign drew from the efforts of the National Alliance for the Mentally Ill and the Treatment Advocacy Centre in the U.S. (Torrey & Zdanowicz, 1999;



Treatment Advocacy Centre, 2005). Bill 68 was finally passed by a vote of 82 to 10 Members of Provincial Parliament (Ontario., June 21, 2000).

### **Reflecting Upon Local Research**

Research on CTOs seems to elude the voice of psychiatric survivors. According to a recently conducted legislated review of CTOs (to be released by the Ontario government), several hundred people are under CTOs, more than the number expected by extrapolating from Saskatchewan's numbers, which CTO proponents denied would happen in 2000. Government contract researchers have admitted in public forums that they do not have the capacity to reach inmates and survivors as readily as they would reach professionals to review CTOs. There has been a sharp decline in discussion about CTOs since their adoption, not only as a result of poor governmental education, but because CTO resources were released into an increasingly competitive 'mental health sector'. The Canadian Mental Health Association, well endowed in that sector and touted as a defender of psychiatric patients' rights, hedged their anti-CTO position (compare Canadian..., 1998 and Everett, 2001) or took funding to 'coordinate' CTOs (compare CMHA Metro Toronto: Ontario. May 17, 2000 and Centre..., 2005). This kind of slippage suggests pragmatism is not explicit in local psychiatric discourse.

Such facts, histories, and considerations are the contexts of forcible treatment rules and cannot be addressed directly through biological or quantitative research. Yet such research continues to determine practices. 'Progress' and 'reform' in psychiatry are sharply contradicted by contemporary experiences of institutional abuse (Grobe, 1995; Burstow *et al*, 2005), in political economics (McCubbin, 2004) and several other literatures (Read, 2004; Breggin & Cohen, 1999; Perlin, 2000). Institutional practices seem to be moving out of reach, becoming invisible as institutionalization restructures beyond the clinic. This institutional drift continues to be focal in the work of survivors and allies.

### **Echo From Vancouver**

To begin addressing CTOs in medical-legal terms, I will begin by linking my experience with a remarkably similar experience in the public domain. In August 2005, an inmate won an exceptional legal suit against a hospital, namely the Vancouver General Hospital where my incarceration took place. Suffering anxiety from grieving two deaths in his family, Steven Mullins sought help voluntarily. Shortly after being seen by a psychiatrist who was prepared to release him, he ventured to leave his room. Guards blocked his way and ordered him to stay, so he tried to push through. They overpowered

him, dragged him to an isolation room and cut away his clothing. Clinicians administered an 'intramuscular injection' of the 'major tranquilizer' haldoperidol (trademarked Haldol). Mullins was held for five days and only released after he agreed to continue 'treatment' and 'supervision' as an 'out patient' (*Mullins v. Levy*, 2005 BCSC 1217). Such events are rarely discussed openly, far less argued in court. It would seem attendants' methods at the VGH continue, provoking 'behaviour' that feeds a 'cycling of evidence'.

Mullins' was far more fortunate than most inmates: within hours, while still unconscious, a lawyer arrived and began scrupulously documenting clinicians' activities, especially noting their use of legal forms. Despite a number of problems in procedure, some of them substantive, the staff members were generously protected by British Columbia's *Mental Health Act* (subsection 16). They argued they performed their functions without malice, complying with established protocols, which are based in sound medical knowledge and ethics. For example, an unconscious patient who is unable to consent to treatment must be treated so physicians can save her life. By extension, they argued a 'delusional' person who is 'agitated' (meaning excited or abusive) might reject her 'diagnosis' and 'treatment'. The 'illness' is said to rob her of the ability to think correctly, to understand and appreciate her illness and need for treatment, so they must be seized to deliver a remedy. One doctor boasted that he had subdued several 'psychotic' patients in this manner daily, seeing it as a fine and necessary technique (S. Mullins, personal communication, Sept. 12, 2005). In fact, clinicians unofficially name Haldol "Vitamin H", providing cavalier instructions on subduing 'patients' online (Rosenberg, 2002; Forrest & Forrest, n.d.). In *Mullins*, Justice Holmes ruled that clinicians were indeed acting in good faith, and that the attendants did not "punish [Mullins] and the intention was clearly to aid him" (*Mullins v. Levy*, at para. 224). His Section 7 Charter right to "life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (*Canadian Charter of Rights and Freedoms*, 1982) had not been violated. Mullins had no authority to question the constitutionality of such aid because he did "not claim to be mentally ill" (*Mullins v. Levy*, at para. 226). The judge found the attendants merely breached the *Mental Health Act* because they lacked the authority to aid Mullins. Thus, the judge ruled their assistance to be negligent, indeed violent (*Mullins v. Levy*). Obviously, abuse is acceptable for those too crazed to know better. After seven costly years in court, Mullins was awarded \$15,000.

## Pharmaceutical Lobbying and Intervenors

The Schizophrenia Society of British Columbia was allowed to act as an 'intervenor' in the *Mullins* case, that is, as a third party with pertinent additional information. The Schizophrenia Society, which has local, provincial and a national branch, has intervened in several cases across Canada, a lone social voice adding to those of psychiatrists, attendants, hospital administrators, and in *Mullins* the provincial government. Often seen as the voice of all families of the 'mentally ill', or even the 'ill' themselves, Schizophrenia Societies (formerly called Friends of Schizophrenics) advocate for more chemical treatment, pharmaceutical research, and stronger legal mechanisms to enforce treatments. They argue such interventions save lives, and should not be restricted to moments when the person is *dangerous*. First, committal criteria should be expanded so that a person can receive treatment when they begin to *mentally deteriorate*. The law should not tie the hand of the psychiatrist until the person has become a threat, which the Societies see as a major problem within contemporary practices, though psychiatrists have broad powers of professional discretion in these determinations. According to these advocates, violence in the family dwelling is a common occurrence. During such emergencies, it is difficult to prove to authorities that their loved one has become dangerous. In response to these sorts of concerns, Brian's Law made it unnecessary for police in Ontario to witness destructive behaviour before apprehending someone under the *Mental Health Act*.

British Columbia statutes provide an important contrast to Ontario statutes highlighting key controversies in psychiatry. Ontario's mental health legislation was changed to include the right to choose or refuse treatment in 1967. As I discovered in British Columbia, treatment can still be imposed without consent whether the person's status is voluntary or involuntary (a principle reserved for other areas of medicine in B.C.). Despite this radical change to Ontario's law in 1967, physicians were surprised when they discovered the shift twelve years later during another redrafting of the *Act*, and they lobbied vociferously to have the provisions revoked (Simmons, 1990). This speaks to the ways in which reforms in psychiatric law are not enforced. In theory, an Ontario physician must inform a psychiatric inmate or her 'Substitute Decision Maker' as to the nature and reason for a proposed treatment, its risks and benefits, and any alternatives. Rights are monitored, not enforced, by the Psychiatric Patients Advocate Office, which was funded 'at arm's length' from the Ministry of Health in 1983. This body came into existence soon after the Alvioni inquest, in which a 19-year old man's death

due to 'overdrugging' at the Queen Street Mental Health Centre in Toronto was declared 'therapeutic misadventure' by a coroner (Simmons, 1990). While British Columbia's psychiatric laws do not provide for consent, Ontario consent rules are not systematically enforced.

### **The Insight and Capacity to Consent to Treatment**

In the landmark case, *Starson v. Swayze* ([2003] 1 S.C.R. 722. 2003 SCC 32) the Supreme Court of Canada ruled that Professor Scott Starson had the right to refuse treatment. Starson is a physicist who became 'psychotic', was incarcerated and was later transferred to Penetanguishene Mental Health Centre's maximum-security Oak Ridge facility, for uttering death threats to a doctor and fellow tenants. Accordingly, he went from the civil psychiatric system to the criminal or 'forensic' psychiatric system when found 'not criminally responsible', yet the legal rules regarding forced treatment in that system are essentially the same. Despite his difficult situation, Starson represented himself in the proceedings, with the support of lawyer Anita Szegeti. The case brought to light the seeming ease with which psychiatrists could impose treatment based on an inmate's refusal to comply. It also provides an excellent view on psychiatric law in Canada and the notion of *capacity*.

In the judgement, three competing values were identified regarding forcible treatment: the inmate's 'autonomy', everyone's 'right to treatment', and an overarching duty to 'public safety'. This medico-legal constellation assumes the biological explanation of some behaviour as 'illness' requiring 'treatment'. A person may not be chemically treated against his will (that is legal assault) unless the state deems the person a threat to society, or the self. I will leave aside the questionable right of the state to incarcerate people who want suicide (see Odette, 1995), or to impose treatment rather than incarcerate alone; in the *Starson* case the court recognized the inmate was no longer a risk to others or himself. However, psychiatric law explicitly provides for forced treatment even when there is no dangerousness. The purported responsibility of the state to protect its 'mentally ill' citizens (through *parens patrie law* or *paternal law*) is crystallized in a movement for *therapeutic jurisprudence* or *justice* (Caulfield *et al*, 2002). Under this view, constitutional rights are actually conferred through treatment (O'Reilly, 1998). This has been called the 'right to treatment' argument, a counterstrike to autonomy rights established in the 1970s (Perlin, 2000; Caulfield, Downie & Flood, 2002). In theory, the 'seriously and persistently mentally ill' should, by chemical management of their symptoms, recover their reason and conduct themselves

accordingly within society; responsibility confers rights. The 'ill' may then re-find acceptance and opportunity, but failing that, the Court generally assumes treatment "can improve functioning and alleviate suffering" (*Starson v. Swayze*, at para. 9). Though psychotherapy may be preferable, it would never be useful as a restraint. Drugging is a forcible intervention for remedying unwanted behaviours. Thus, chemicals shown to inhibit neurochemical processes that may generally be involved with 'madness' have become ensconced in jurisprudence in spite of our autonomy rights.

Under the 'therapeutic' paradigm, drugs can be legally forced on someone, *dangerous* or not, when she loses legal *capacity* to make her own treatment decisions (Bay, 2003). Moreover, the law allows for the treating physician herself to decide whether the inmate is capable with respect to her own treatment. First, the person must be informed of her 'diagnosis', the 'treatment' and its associated 'risks and benefits', and whatever 'alternatives' are available. The legal test for capacity used by the psychiatrists is an inmate's ability to *understand* her own 'symptoms' and the 'treatment' suggested, as well as her ability to *appreciate* the consequences of deciding or not deciding on such treatment. The test is not whether the person can repeat specific terms or, at least since the *Starson* decision, agree with the psychiatrist's terminology or 'diagnosis'. Rather, the psychiatrist must decide whether the person is able to see that some 'condition' affects her, and that a 'treatment' decision will affect her; she must not base her 'treatment' decision on a 'delusion' (*Starson v. Swayze*, at para. 18). This suggests that a person must accept that she still has a problem (in herself, not with others) and that some form of chemical intervention would be a responsible choice. The demonstrability of psychiatry is not as important, perhaps, as the inmate's willingness to accede to control. Nevertheless, the nature of the problem and the resulting solution are medically prescribed. All that remains is the question of the inmate's reasonableness in seeing this. What happens if the inmate understands and appreciates this dilemma in the way the psychiatrist presents it, but still rejects treatment?

The psychiatrist and the Consent and Capacity Board decided Professor Starson was *incapable* with respect to treatment because he did not *understand* and *appreciate* his condition and the choice before him. This is not surprising. Psychiatrists have defined 'psychotic disorders' like 'schizophrenia' and 'bipolar affective disorder' as 'delusional' or losing touch with reality, interfering with a person's understanding and appreciation for risk. This phenomenon is also called 'lack of *insight*'. Psychiatrists forcibly treat people regularly and believe they do so with the best interests and health of the person in mind.

In an attempt to 'stabilize' their allegedly imbalanced brain chemistry, the inmate is treated so they might later realize their predicament and volunteer to *comply* with treatment. However, the patient might later find that the drugs do not work or he may detest their negative effects. The psychiatrist is legally discouraged but not prevented from judging such concerns a product of the illness itself; any emotional reaction to this judgement may be entered into the 'cycle of evidence'. The risk of mistreatment and 'misdiagnosis' are considered theoretically, but are ultimately weighed against risk by the treating psychiatrist. Since *Starson*, at least, the law attempts to protect inmates from clinicians identifying *incapacity* with an inmate's acceptance of specific psychiatric 'diagnoses'.

Starson's *capacity* was upheld by the Supreme Court and his reasons for rejecting treatment were supported, especially because the tribunal, which bore the onus of proof in finding the inmate incapable, brought scant evidence of incapacity. The Court strongly noted the risks that Starson faced in treatment:

Professor Starson stated that the medication's normalizing effect "would be worse than death for me, because I have always considered normal to be a term so boring it would be like death". The evidence indicates that the dulling effects of medication transformed Professor Starson "into a struggling-to-think 'drunk'", a result that precluded him from pursuing scientific research. Professor Starson stated unequivocally that every drug he had previously tried had hampered his thinking (*Starson v. Swayze*, at para. 102).

Thus, incapacity is, in theory, not to be equated with the rejection of 'illness' but demonstrated by the psychiatrist through compelling information, or by a psychiatric tribunal, which is generally made up of a psychiatrist, a lawyer and a layperson.

### **The Consent and Capacity Board**

The psychiatric system extends to inmates the right to *challenge* (the word 'appeal' is reserved for the Courts) psychiatric determinations such as *involuntary status* (for detention in a facility) and *incapacity* (for imposed treatments). The history of how these determinations became 'safeguarded' or regulated by tribunals is beyond the scope of this research, but until 1967 in Ontario, two psychiatrists could 'certify' (declare insane), then 'commit' (incarcerate), someone the court ordered or police forced into 'examination' without any review. 'Dangerousness' was not a criterion until the law was changed, in great part thanks to the Canadian Mental Health Association (formerly the Canadian National Committee on Mental Hygiene, a eugenics organization). After 1967, one psychiatrist could make the determination to incarcerate without the need of court

sanction, but a dissatisfied person could have a 'hearing' at a psychiatric 'review board', without the right to appeal to the courts (Simmons, 1990).

Hospital 'review boards' acted without oversight and when committal procedures were separated in the law from forced treatment procedures in 1992, these patronage nests were reformed into a legally functional body, now named the *Consent and Capacity Board*. This legal distinction between imposed treatment and detention did not change the criteria by which people could be force treated or detained, however. A person had to be an 'imminent' danger to self or others and believed 'mentally ill' as of 1967, but 'imminence' could be interpreted to mean 'within months' according to a former chair of the Consent and Capacity Board (Bay, 2003). Upon release, clinical 'discharge' plans and agreements are made with inmates, often functioning in the same way as CTOs, but without legal force. Before CTOs, there was already a three-month 'leave of absence' section in the *Mental Health Act* (Sec. 27). As we shall see, the Board has heard few challenges to CTOs.

### **Mental Health Act Forms and Criteria for CTO**

1979. North Bay, Ontario.

The ['deprivation'] therapy was to continue for 6 weeks, but in the fifth week, a concerned union steward went to check, observed the man in a little side room like a naked animal in a kennel. No one spoke to him. No amenities in the bare cell. A pail to urinate in, newspapers to shit on. Five weeks [in that cell]! When the steward was noticed by a doctor, the result was a quick decision to release the man, bathe, shave and clothe him. A consent document for the treatment was signed— the day after his release. (Marshall, 1982:14).

Legal texts allow us to see the workings of institutions. The *Mental Health Act* provides psychiatrists with powers to detain, restrain, and treat. These powers are exercised by use of *Mental Health Act* forms, such as to assign inmates a status under the *Act*. For example, a psychiatrist must check boxes and write descriptions on a 'Form 1', 'Application by Physician for Psychiatric Assessment', to explain her 'belief' that a person should be 'assessed' under detention for 72 hours (though this is not called 'involuntary' status). She simultaneously signs a 'Form 42', which is delivered to the inmate indicating that the person's right to counsel and the indicated reasons for detention. After this period, a psychiatrist may sign a 'Form 3', which denotes a period of *involuntary* commitment lasting two weeks or less. A 'Form 30' is also provided to the inmate to indicate reasons for detention, the right to counsel, and that a 'rights advisor' consultation will occur. It also says the person can fill out a 'Form 16' in order to challenge the psychiatrist's decision at the Consent and Capacity Board. This menagerie

of forms and procedures adds to the problem of consent for people who might have dared hope for deliverance from stress. Advocates spend most of their time explaining these processes.

A Community Treatment Order is issued using a 'Form 45', signed by a psychiatrist who indicates reasons for the order, and also signed by the inmate or her Substitute Decision Maker. The required 'community treatment plan' is developed and distributed with the Form 45 to everyone on the 'treatment plan'. A 'Form 46' is also given to the inmate indicating her right to challenge the decision at the Board.

Each form provides check boxes noting the standard reasons a person may be detained under the *Mental Health Act*. A psychiatrist can detain someone if she falls under one of two areas:

(Part A). The *Mental Health Act* allows a psychiatrist to detain someone if she believes the person a) attempted, attempts, threatened or threatens to cause bodily harm or self-harm, or b) behaved or behaves "violently", even if only as perceived by someone else, or c) shows inability to care for herself because she is "apparently suffering from mental disorder of a nature or quality that likely will result in" serious harm or impairment (*Mental Health Act*, subsection 15.1). The last of these three requirements is most broad, and is all that is necessary for a psychiatrist to renew a form and detain the person longer. The 'nature or quality' of the illness does not mean the 'kind' of diagnosis, but the 'seriousness' of the illness. A physician may judge what part of someone's behaviour is 'illness' or judge the 'seriousness' of illness involved. As such, Part A is the 'dangerousness' category. Most critics agree this text leaves a great deal of room for determinations borne of inaccuracy, decontextualization, dehumanization, and exploitation. For example, a man named "R.R." in tribunal documents became so angry at his psychiatrist's calling the police to apprehend him, under circumstances the psychiatrist later regretted, that R.R. demolished a nursing station; the psychiatrist declared his actions were not related to his illness and 'discharged' him promptly (*R.R.*). This seemingly contradictory outcome explains the way in which perception and competing interests, such as convenience, may come into play in psychiatric determinations, even with legal oversight.

(Part B). New criteria allow the psychiatrist to commit a person if he believes she a) has been treated in the past and improved as a result, b) may, as in the past, because of her illness, "suffer substantial mental deterioration" or physical deterioration or physical impairment, and c) is also incapable to *consent to treatment*. I have arranged



the criteria in b) to emphasize the newly-added and broadest criterion, *substantial mental deterioration*.

The Community Treatment Order applies to people who fit the designations above, plus a few more. The person must have had two 'hospitalizations', or one lasting more than 29 days on a single occasion, in the last three years. Yet, the CTO is encouraged to prevent 'chronic' readmission to hospitals (33.1(3)) and relieve the 'revolving door patient'. The CTO is supposed to be offered as a treatment by the psychiatrist, and the person is then to be provided with a Rights Advisor. However, if the person is deemed incapable (perhaps by use of "Part B"), a Substitute Decision Maker will be found or appointed to decide on the CTO matter for her and will also be provided with 'rights advice'. A CTO candidate must also be deemed by the psychiatrist to require psychiatric care and supervision while living in the community, and be able to 'comply' with the treatment plan. Services in the treatment plan must be available in the community. The 'community treatment plan' may include any conceivable treatment or appointment, and may assign monitoring and information-sharing tasks to the person's family, community members, and agencies beyond the facility, usually a 'case manager' or Assertive Community Treatment team.

### **Substitute Decision Makers and Families**

The role of families has expanded under Brian's Law legislation. First, they are recognized legally as playing a role in treatment when listed in a "community treatment plan", making them quasi-professional 'health care service providers' whereas in the past the designation 'caregiver' was used to praise work done freely. Whereas professionals operate under a code of detachment deigning accountability, families now mix intimacy with their new role of 'service provider'. During government consultations by invitation only, families became as concerned as professionals regarding their exposed liability while performing institutional functions in a less controlled situ.

Families are the first route open to psychiatrists who need someone to consent to treatments rejected by an inmate, unless the inmate has previously chosen someone to act as a *Power of Attorney* to handle such decisions. Family members, in the *Health Care Consent Act's* prescribed order of relation to the inmate, will be asked to be a 'Substitute Decision Maker'. If someone cannot be found or no one accepts the responsibility, a doctor can always rely on the Public Guardian and Trustee, a government office (that can also control an inmate's estate if they are deemed 'incapable to manage property'). Only the physician's judgement regarding the family's motives will

provide a check to the potential for conflict of interest, a problem mentioned by the psychiatrist who participated in this study.

In this research several participants discussed the role of families in the CTO arrangement. It was noted that in some instances, doctors had overridden a person's Substitute Decision Maker (SDM) when they did not agree the inmate needed treatment. The participant psychiatrist in this study, however, welcomed the family's involvement as a check against psychiatric authority. She noted that inmates often felt betrayed by families who accepted a CTO on their behalf. She had seen families that tried to use an inmate's status for monetary gain, though this was very rare. A survivor participant explained that a CTO inmate's father enjoyed long phone conversations with the inmate's doctor, whereas the inmate had virtually none, and imparted minutia, and false 'facts', about the inmate. However, this participant also expressed sympathy for families, saying they experienced loss whether or not they consented to an inmate's drugging because the inmate would never be the same either way.

### **Assertive Community Treatment Teams**

The 'Program of Assertive Community Treatment' ('PACT', usually shortened to 'ACT') is a 'community psychiatry' model or 'service', where treatment interventions are performed beyond the institution. The ACT model grew out of Madison, Wisconsin, in the early 1970s, and practiced a sort of protean 'psychosocial rehabilitation' that became popular in the 1980s and 90s (Jacobson, 2004). Today, the model has proliferated throughout the U.S., and very recently, it would seem, in Ontario. Assertive Community Treatment is no longer homogenous or based on the old model. One study found that an urban ACT Team performed no better than an 'out-patient' hospital 'day program' in attending to primary needs for 'out-patients', such as housing and employment (Nieves, 2000). Critics of ACT cite the expense of such "million dollar" teams working with only "about 80 clients", as one participant said. Rudy, a participant in my research, described the structure of ACT Teams: "Generally, all they have is a psychiatrist, nurse, often a social worker and occupational therapist. Some employ what they call peer specialists or peer support workers."

Another participant, himself an ACT 'peer support worker' admitted many ACT teams, like most psychiatric workers, focused on 'medication compliance' at the expense of other objectives, and said "[some] ACT team[s], for some reason do [not] have a consumer [or peer support worker], which they should according to the 'Ontario ACT Standards'." (see also, White, Whelan, Barnes & Baskerville, 2003). Some peer support

workers on ACT Teams attempt to show ACT professionals the possibilities of working beyond medical parameters. He saw an improvement in his team's capacity to connect with community services after his arrival, including with scarce 'consumer/survivor initiatives' or agencies. He said about ten percent of the people 'followed' by his ACT Team were under Community Treatment Orders, and that almost all of these had middle class families, an issue we will turn to later.

### **CTO Research**

Given the scope of this investigation, I can only provide a brief and therefore incomplete review of the CTO literature. There is a lot of work regarding professionals' 'ambivalence' in imposing CTOs (Dawson, Romans, Gibbs, & Ratter, 2003; Levy, 1994; Geller, 1986). Professionals started considering CTOs in the 1970s, as the project of 'deinstitutionalization' failed. Some raised the issue of whether CTOs truly constituted the "least restrictive alternative" to physical institutionalization (Switzky & Miller, 1978; Miller, 1982). In the 1990s, when CTOs became more popular through psychopharmaceutical campaigning in the U.S., issues of "reciprocity" (availability of services) took the fore for opponents to CTOs (Eastman, 1994), as well as the question of whether coercion despoiled 'therapeutic relationships' (Dennis & Monahan, 1996). It is from such considerations about CTOs that researchers began attempting to evaluate their effects. However, such research was and still is framed as the quest for "efficacy", which belies an institutional set of objectives including drugging.

The literature on the 'effectiveness' of CTOs is somewhat unsatisfying for both proponents and opponents. The nature of success and its desirability provides much ground for disagreement. The literature continually takes up the purposes of 'outpatient committal', including: decreased 'rehospitalization', increased drug 'compliance', 'quality of life' (usually the obtaining of housing or employment), and decreased arrests or violence. Such seemingly improvements may be related to 'compliance' rather than reduced 'symptoms', as the coercion literature suggests (Dennis & Monahan, 1996). Some CTO studies address 'symptom management' or 'perception of coercion' (Steadman *et al*, 2001; Swartz, *et al*, 2004). The oft-quoted RAND study (Ridgely *et al*, 2001) cites four problems with studying CTOs: selection bias (people who resist institutionalization may 'respond' to a variety of interventions), unclear target population (who is a 'revolving door patient?'), unclear operationalization of outpatient commitment (the what and how of CTO 'treatments' vary widely), and unmeasured variability in forms of treatment. The RAND evidentiary review (not a literature review) claims that the

alternatives to CTOs are community interventions and housing, which do not constitute a legal alternative and exist with or without CTOs. That study found no conclusive evidence that CTOs 'work', though in one study from North Carolina, it was found that the longer CTOs were imposed, the more likely inmates would remain on treatments. Critics would say that psychoactive chemicals may overwhelm inmates' resistance to drugging over time so this finding is not surprising.

The CTO efficacy research is weighed down by political and social questions and debates. Monahan (1996) explains that psychiatrists cannot predict violence, especially by people not yet diagnosed like the man involved in the killing that led to 'Laura's Law' in California. CTOs cannot prevent such violence like the Brian Smith episode here in Ontario; moreover, desperate people seeking intervention will be turned away, like Herbert Cheung who pushed a woman into a Toronto subway on September 26, 1997. Such logical problems with CTOs are rejected as 'philosophical' griping, and proponents proceed to seek statistical support for CTO 'efficacy'. According to critics, efficiency in enforcing drugs may sometimes even result in dangerous behaviour. The issues have led to much controversy, and newer legislation, like Laura's Law, is bogged down by provisions that appear to make it unworkable. Many U.S. states are less often using CTOs because they are inconvenient to professionals (Appelbaum, 2005). Appelbaum reported New York's 'Kendra's Law' recently passed a test of constitutionality because it did not directly force treatment. As such, he argued that the law was not coercive.

In 2005, a study emerged from New York State appraising Kendra's Law and found that 'involuntary outpatient committal' increased compliance with chemical treatments and use of psychiatric programs; predictably, there was also a reduction in aggression and 'hospitalization'. Non-Hispanic blacks were disproportionately represented in the data. Though hailed as a breakthrough success by the Treatment Advocacy Center (2005), Paul Appelbaum (2005) cautioned that 'improvement' ratings were made by 'case managers' who may be biased. He said a longitudinal study needs to be done to confirm long-term 'improvement', and that the study had no control group. Yet, since those who accept the medical model are more likely to see chemicalization as improvement, bias may be pervasive in efficacy studies. Chemicalization is assumed the discreet causal element in positive outcomes for inmates, while life changes, identity, and relationships lose ground as explanations to a notion of selfhood as brain function.

### **Amongst the Free and Untreated**

2005. I tried at a party to explain in summary sentences what this thesis was about. It is "people's experience of a new psychiatric legal requirement to take their medication outside the hospital." What? "It's kind of like parole for psychiatric patients. It's very new." No. That can't be right, says a woman who is on 'medications'. "Why hasn't anyone heard of that?" asks a man. "They must be violent!" says another. "No, anyone who's deemed ill," I say. There is common disbelief; the public perceives "patients' rights" as so entrenched that homeless people are left incoherent and agitated, allowed to bother businesspeople on city sidewalks. Someone steps through the door, and though interest has piqued and they want to know more, the party boogies on.

In so-called polite society, there is a pervasive aversion to human affairs that go awry, agonize us, shake our belief in reason, threaten poverty. People fear loss of self-control and 'madness' almost as much as death, perhaps more. Even psychiatrists claim their science is 'stigmatized' by 'mental illness'. Anything having to do with 'madness' is contemptible, disreputable, crazy-making, zany, spooky, so people have a resistance to becoming informed about institutional abuse. Government pronouncements on spending or 'reform' are taken as indicative of imminent improvement. Examples of institutional abuse are routinely dismissed as 'delusion', exaggeration, even romanticism. At best, such complaints are seen as misguided liberalism from people who don't know real social problems. If people have heard of opposition to drugging, they often think it a religious conviction or Scientology. "Well have you ever tried dealing with a crazy person?" asks a politically astute socialist breezily. Even those who take Prozac despise less 'together' crazies. A narrow escape with an irredeemably cantankerous screamer (caricatured as the cat-throwing lady in *The Simpsons*) is taken as proof for the neurological cause of all 'behaviour'. And of course, most psychiatric inmates hate each other and themselves for being society's fools, silenced as they are. Talking openly about psychiatric oppression requires familiarity with dismissive audiences of all kinds.

Who at this party would know that electroshock is more popular now than it was in the 1970s, especially for women, and the elderly (Funk, 1998)? Would they see the sale of psychiatric pharmaceuticals to pre-school children as a problem with paternalistic help rather than simple profit mongering? Would anyone suspect that 'laser' lobotomies are being performed today (Mashour, Walker & Martuza, 2005; <http://www.psychosurgery.org>)? Would they be surprised that implants have been

developed to continuously deliver chemicals and electric impulses to the brain (Siegal *et al*, 2002; Spencer, 2005), or that animals on route to slaughterhouses are given 'anti-psychotics' to calm them (Canadian Food Inspection Agency, 2004:38)? What would they think of President George W. Bush's plan to test all students and workers in U.S. schools using 'mental health screening' (Lenzer, 2004)?

Despite these psychiatric advances, governments continuously attempt reforms that address the re-integration of 'the seriously mentally ill' into society. The Ontario government announced it would reckon 'these people' in its policies: the "Heseltine Report" in 1983, the "Graham Report" in 1988, "Putting People First" in 1993, "Making it Happen" in 1999, which was followed up with Brian's Law and the CTO (Canadian Mental Health Association, n.d.). Reform has been a repetitive and superfluous process spanning decades, culminating in the most recent Mental Health Implementation Task Force Report (see Queen Street Outreach Society, 2002b), ignored by the present government. McCubbin (1998) says there can never be reform because power, interests and economics are simply one-sided in the arena of psychiatry.

### **Institutionalization: Diagnosis, Treatment and Education**

1993. I would like to explore how 'psychiatric medications' work. After an intramuscular injection of the older chemical haldoperidol, I was administered the newer 'atypical anti-psychotic' drug loxapine, in liquid form while two professionals watched. I was being initiated into a cycling of chemistry. Contrary to decades of psychiatric education, as shown in a major recent study, the newer 'atypical antipsychotics' are no more 'safe and effective' than the old drugs (Lieberman *et al*, 2005). I raised no fuss; the door was locked. No one was talking about drugs. Forgetting the benevolent betrayal of being swarmed and tied down without cause, the injection itself made quite an impact on sleeping patterns, muscle response, body functions, and consciousness itself, but it would take days before I would distinguish the effects of 'treatment' from the general experience of shock. Mostly I remember waking with the worst thirst imaginable. I salivated at first, but soon my mouth would become perpetually dry, my gums would thus expand and bleed, my jaw would look wider to me in the mirror, and my skin would break out in places it never had. I wondered how bad it would get.

The experience of being 'given treatments' on a locked hospital ward was for me little different than receiving orders to eat or sleep. It was simply done by schedule; consent to treatment is not necessary in British Columbia (i.e., not required), and in my experience treatment was not discussed except in instructional terms. When I asked

how a person might leave, a nurse raised her brows with bemusement and said, “Wow, you move fast.” Earnestly and with utmost delicacy, I asked for resolution to this egomaniacal trifle. I was ricocheted along a well-trained crew who informed me I had to wait for a ‘psychological assessment’. Indeed, I was on the Psychological Assessment Unit, a fact which would later be used to test my ability to think clearly: ‘where are you today’? This is the stuff of medical tests. The requirements for my release were difficult to obtain during several convivial chats with these new caregivers. For example, the assessment might possibly be conducted by Dr. X, but nothing was scheduled, or it might take place 24 hours hence, or it would have to wait for three physicians to decide.

While I waited and hoped for release, the ‘medication’ and the locked ward started to take effect. The veteran inmates around me did not interact, did nothing but sit and pace, as if jailed. The environment was hospital-clean and bright. There was a subdued fear however. No one wanted to speak. Later, a psychological test was administered to me, which was like doing a multiple-choice exam as a condition of attending my own wedding. Out there, a whole life awaited: in here, the long drudgery of life on a form. I looked at the assessment. I drew a line down the middle, and a second line to bisect it laterally. Soon the sheet was a conceptual well of gravity. Right on time, my partner arrived and, thankfully, convinced me to fill out a new sheet by following the rules. With her help, I answered the questions effecting a plausible sanity, which is part of the reason I was given the non-specific diagnosis of ‘psychosis (not otherwise specified)’ I think. In nosological terms, that’s like hitting the goal post. My naive hope of being deemed sane and released evaporated. Two weeks later, feeling just a tad dispirited by all this, I admitted to feeling blue, and blamed the rain. My doctor consequently blamed my brain, informing me this clue was used to diagnose my ‘psychosis’ as derived from ‘affect’ (i.e., feeling). Even in Nazi Germany, fewer affective ‘psychotics’ (‘manic depressives’ and ‘depressives’) were forcibly euthanized than ‘schizophrenics’ (Friedlander, 2001), perhaps because an emotional basis for ‘psychosis’ seems ‘less biological’. My primary nurse confided that ‘bipolar affective disorder’ was easier to ‘treat’. “In this century,” she confided, “we call you mentally ill. But sometimes I look at these people and wonder if we’re just turning them into zombies.” I appreciated her candor, but I dared not agree under the circumstances. I had already been baited during my admission.

In a single month, I was successfully institutionalized. Seeing myself as ‘medically ill’ and in need of life saving drugs, I longed to be normal, to rejoin the living.

## Chemobotomy

Two family members made the grim journey west to retrieve me in Vancouver. They negotiated my release to Ontario by the following month. Before I left, my doctor slipped in a passive aggressive insult and said he would have liked to keep me a month or two longer. He may have been surly because I had talked about a double helix in a discussion regarding my 'delusions'. He had corrected me saying, "Well, I've heard of the helix, but not 'a double helix'." Again, I dared not disagree under the circumstances. Playing the game, I escaped being transferred to the back ward hospital, Riverview, and a sealed fate on Vancouver's Eastside upon 'discharge' (Chambers, 1993). I only had to agree to take drugs and see a psychiatrist if I went quietly with my family. Toronto beckoned. I acceded.

By the time I acclimatized to Toronto again, I realized I was no longer the same person. Despite the overwhelming experience of incarceration, I was more radically transformed by loxapine. I realized the greater dilemma of my new life was the drug. Breggin (1994) describes the chemical action involved with neuroleptic chemicalization:

How do [neuroleptic drugs] 'work'? It is well known that these drugs suppress dopamine neurotransmission in the brain, directly impairing the function of the basal ganglia and the emotion-regulating limbic system and frontal lobes and indirectly impairing the reticular activating system as well. The overall impact is a chemical lobotomy—literally so, since frontal lobe function is suppressed. The patient becomes de-energized or de-enervated [sic]. Will or volition is crushed, and passivity and docility are induced. The patient complains less and becomes more manageable. Despite the claims made for symptom cure, multiple clinical studies document a non-specific emotional flattening or blunting effect.

The cyclical use of drugs occurs when the effects resemble 'illness'. The institutional response is to drug the 'mental illness-like' effects as non-illness effects, as well as other kinds of effects like nervous tics.

Growing evidence indicates that these drugs produce tardive psychoses that are irreversible and more severe than the patients' prior problems. In children, permanent behavioral or mental disorders frequently develop as a result of the drugs.... Many patients find themselves unable to stop taking the drugs, suggesting that we should consider them as addictive.

•••

[We found that] long-term neuroleptic patients were developing a largely irreversible, untreatable neurological disorder, tardive dyskinesia (Crane, 1973). The disease, even its mild forms, is often disfiguring, with involuntary movements of the face, mouth or tongue.

These effects are so common that they are often mistaken for 'illness symptoms'.

Breggin's next criticism is echoed in personal accounts by many psychiatric survivors.



There is no significant body of research to prove that neuroleptics have any specific effect on psychotic symptoms, such as hallucinations and delusions. To the contrary, these remain rather resistant to the drugs. The neuroleptics mainly suppress aggression, rebelliousness, and spontaneous activity in general. This is why they are effective whenever and wherever social control is at a premium, such as in mental hospitals, nursing homes, prisons, institutions for persons with developmental disabilities, children's facilities and public clinics, as well as in Russian and Cuban psychiatric political prisons. Their widespread use for social control in such a wide variety of people and institutions makes the claim that they are specific for schizophrenia ridiculous.

Breggin has won several court judgements against pharmaceutical drug companies, one in Canada, on behalf of people who were damaged by neuroleptic 'side effects'.

Since 2003, Mrs. Jones has been completely disabled by a variety of motor abnormalities associated with tardive dyskinesia. In addition to the spasms of her neck, her shoulders twist severely and she has facial and abdominal spasms. Her vocal cords are impaired, producing an abnormal tone of voice. She is weakened and cannot carry out tasks requiring coordination or strength. She suffers from chronic pain. Humiliation over her appearance has caused her to be socially isolated. (Breggin, 2005)

As long as neuroleptics are considered 'safe and effective', psychiatric workers can be said to be following ethical and safe clinical guidelines and are thus protected by psychiatric law. However, tardive strikes about 5% of people treated each year, and another 5% of treated people each year after, leading Breggin to suggest 40-50% of everyone treated has the disease. A cycle of chemistry is firmly entrenched when: inmates need the drug to mask its effects; people discover the effects of tardive diseases after going off the drugs. Tardives are rarely discussed, especially tardive psychoses, which are diagnosed as underlying illness (though psychiatrists often report disclosure: Kleinman & Schachter, 2000). Though there is little research on the latter, Breggin suggests how 'psychosis' or 'madness' can be achieved through biological intervention. Though some would conclude madness is biological, this would be a premature conclusion in light of no consistent results or a 'model psychosis', which the CIA tried unsuccessfully to induce and study by using LSD (Lee & Shlain, 1985). Without the guidance of biological markers affixed to behaviours, madness continues to elude medical explication (Greenman, 2004). Nevertheless psychiatric workers press on. As inmates with tardives get older, their bodies adapt to increasingly higher neuroleptic dosages, ramping the cycle of chemistry higher. A friend three times my age in a psychiatric survivor group with me was on a dose three times higher than mine and showed convulsing and other extreme effects of tardive.

Whitaker's *Mad in America* (2001) shows how such treatments came to be seen as 'antipsychotics'. He gives an excellent overview of studies that show the impact of these drugs on the brain and in the lives of inmates (2001:175-193). He describes how the brain's frontal lobes shrink, while other areas grow larger, spurting new nerves in search for the blocked neurochemical called dopamine. He explains how blocking dopamine produces the symptoms of Parkinson's Disease, such as slowed movements, which psychiatrists in the 1950s saw as 'therapeutic'. As a result, 'psychosis' was declared to occur because of an overabundance of dopamine that only neuroleptics could 'balance': the chemical imbalance theory (2001:161-5).

Psychiatry claimed these drugs could make prison-like institutions obsolete. Whitaker (2001) quotes former inmate Janet Gotkin, who gave official testimony in 1975 calling drugs a prison (quoted in the sixth chapter). Whitaker explains how motor movement is impaired by drugs blocking dopamine pathways in the nigrostriatal system (2001:162-3). This seizure of nerves physically limits movement. He describes a second dopamine pathway called the mesolimbic system, the seat of emotional response, which fuels apprehension (or 'paranoia') which is necessary to self-defense. Thus feelings are muted and will is controlled, "an effect that has made the drugs useful in veterinary medicine for taming animals" (2001:163) and exceeds the method of jailing the body. Finally, a third dopamine pathway called the mesocortical system is blocked which serves to sever the communication between the frontal lobe, which is the seat of thinking and decision making, and the older, 'emotion-regulating' limbic system (2001:163-4). This dislocation of feelings and will from thinking processes, which I recall in a narrative below, leads to a disturbing disruption in the ability to know or communicate feelings, intentions and needs. Jails merely disallow or prevent communication between inmates and others. Chemical incarceration impedes motion, agency, and communication at a far more fundamental level than bars and walls.

People should be able to elect these 'treatments' if fully informed. But can we elect forced drugging or coerced drugging in which there is only nominal 'consent'? Can we 'choose' somatic imprisonment? A recent neuroleptic study showed that 75% of participants, all 'diagnosed patients', discontinued their 'newer atypical antipsychotics' (Lieberman *et al*, 2005), a strong indicator of what people would choose. The reliance on force to provide remedies elucidates the prison-like effects of the major tranquilizers.

So much of what we were suffering from was overlooked. The context of our lives were largely ignored. The professionals who worked with us had studied the science of physical objects, not human science....

But no one asked for our stories. Instead they thought our biographies as schizophrenics had already been written nearly a century before by Kraepelin and Bleuler [the former 'discovered' 'dementia praecox', the latter called it 'the schizophrenias' at the turn of the 20<sup>th</sup> century and declared such people incurable].

We were told to take medications that made us slur and shake, that robbed our youthful bodies of energy and made us walk stiff like zombies. We were told that if we stayed on these medications for the rest of our lives we could perhaps maintain some semblance of a life. They kept telling us that these medications were good for us and yet we could feel the high dose neuroleptics transforming us into empty vessels. We felt like will-less souls or the walking dead as the numbing indifference and drug induced apathy took hold. At such high dosages, neuroleptics radically diminished our personhood and sense of self.

We found ourselves undergoing that dehumanizing transformation from being a person to being an illness: 'a schizophrenic', 'a multiple', 'a bi-polar'. Our personhood and sense of self continued to atrophy as we were coached by professionals to learn to say, 'I am a schizophrenic'; 'I am a bi-polar'; 'I am a multiple'. And each time we repeated this dehumanizing litany our sense of being a person was diminished as 'the disease' loomed as an all powerful 'It', a wholly Other entity, an 'in-itself' that we were taught we were powerless over.

Professionals said we were making progress because we learned to equate our very selves with our illness. They said it was progress because we learned to say 'I am a schizophrenic'.

But we felt no progress in this. We felt time was standing still. The self we had been seemed to fade farther and farther away, like a dream that belonged to somebody else. The future seemed bleak and empty and promised nothing but more suffering. And the present became an endless succession of moments marked by the next cigarette and the next. (Deegan, 1992)

### **Confinement from Within**

The body is fully restrained by imposed chemicalization. My physical capacities were drained. Movements were terse, limited, far less fluid. My body shook, spasmed, and sputtered under the new regimen in my central nervous system. Psychiatrists commonly 'treat' spasms with an 'anti-parkinsonian' agent, like benztropine (brand name Cogentin). The minor tranquilizer, lorazipam (trademark, Ativan), was used to help inmates sleep. Drugging was imposed without discussion. Psychiatry seems gentle, kind, and helpful as it dispenses drugs over the unspoken threat of 'mechanical' (physical) restraint. My psychiatrist said, 'It will take a few weeks before you experience the benefits of the medication, and the side effects will soon go away'. The effects did decrease slightly, but I also had developed better ways of hiding them. This became a sort of work in itself, the work of the psychiatric inmate unseen by others.

You can't sit still. Your muscles feel pulled from all sides by some invisible hand. You rock yourself to subdue a nervous energy coming not from you somehow, but it

does not work. Your heart seems to beat stronger, your breath is shallow. Sleep becomes a mission after the Ativan is discontinued. You can't retain your bladder and it interrupts much needed sleep. Sex is no longer a fascination, whatsoever. Scientifically you attempt masturbation, and even though you achieve orgasm, you don't seem to feel it. Pleasure is distracted. All feelings and phenomena seem distracted in your consciousness. You fight the urge to do less and less.

Now, for a short interval you seem alert. A plan occurs to you between the skipping record of your thoughts. You write it down before the rest of the endless day comes to wash it away. You stare emptily into rooms, but not out of windows because the sun is too bright. You move slowly when you walk; you would never think to run: you are a prisoner within yourself. You still believe what you want to believe (the 'delusions', your thoughts, are still there but your restlessness distracts you). Everything means less and less because you don't feel it long enough, if at all. You can speak and listen, but it's bland, empty; any emphasis is an extra effort. You read but do not retain or associate it to anything. You forget what you read after a paragraph or two, and start again. You have odd chills, pains and itches. Your body is doing things it has never done before.

Then, your roommate tries your medication at half your dose. He is 5 feet 10 inches tall, 170 pounds, a drinker and smoker. He returns in one hour saying he can't stay awake. He wakes up 36 hours later, somewhat lost [anonymous, personal communication, October 20, 2005]. He 'goes off his medication' immediately.

### **Separation without Walls**

Simple conversation. You wonder aloud about talking to your doctor. You're going to need your brain back to obtain work. Your family, unlike most, is supportive of your leaving 'the system'. They remember you as a bright, buoyant person, someone who joked. You start planning on working, but within twenty minutes, and with such simple ideas, your attention wanders to something else. You walk the street spending your daily allotment on a falafel. You are never noticed on the street and you avoid being noticed. Weeks pass and nothing changes including your halting determination to get off the drugs. A psychologist friend says you cannot be forced to take them, yet your hospital education says otherwise. You remember your doctor's word, 'relapse'. You never want to relapse, to be taken back into a hospital and be treated forcibly. Not only would you have failed as the 'lowly mental patient', but there would be proof that the diagnosis was correct. At least for now you fantasize that, against the doctor's odds, you will live a somewhat normal life some day. Others are cheery about this prospect.

One day your partner arrives and says she must leave you. You know this is bad, but you struggle to feel it. You try to remember what you had, the competing problems, the private contentions, happy memories. A sense of your life together briefly skirts your mind like a glance at a movie preview. None of the storyline is left. You search for feelings with which to respond. You wish you had some command over this blankness. You concern yourself with the immediate task of rolling socks just washed. She stares at you. Tasks make much more sense. Sensing that she is waiting for a response, you apologize. "I wish I knew what to say," seems appropriate. Your face shows undead calm. Your lover starts crying uncontrollably, and you feel compelled to stay 'grounded', not to 'stress' yourself, as the professionals taught you. But you empathize with her. She is like a stranger who has dropped a bag of vegetables. You say, "I wish there was something to do... but..." It's not that you don't care. It's just that there is nothing you can feel. But how can you explain that? How can you say, 'Honey, it's just that I'm not allowed to be a person, otherwise I'd have something to offer. You might try explaining this to my doctor. He might reduce the dosage.' You simply cannot say.

Later you report the break up to your family, but you have no feeling to attach to this, so they do not express any feeling after the initial, 'What?!'. Another simple conversation lasting less than five minutes. Your life has shrunk before your eyes; you gaze with psychiatric detachment. Your family sees that you are not in distress and asks if you are okay, but you 'present' vacuity, which appears very much like male stoicism. They go back to discussions in which there *is* emotion, even riotous emotion later in the evening. You try to join in, speaking slowly or haltingly when trying to think fast, but no one laughs at a joke you make. It's not that you're a sad figure, or too 'mad'. It's not that they dislike the new you. You simply cannot interact with them in a meaningful way. You lack the creativity and personality to make a connection with someone because of a physical block on your brain's processes. The distance between you becomes consistent and accepted, eventually unspoken, then irrelevant. You wish you could explain your lack, but what you lack is you. You learn to accept that you cannot be more exciting, excited, connected with people. You wish you could compel, convince, entertain. You are isolated from society, from the people closest to you. People wonder why you don't get your life back on track, just shape up, get off the drugs if that's what you want, start your life again. That would require more executive control than you have; you are being controlled from within. No one seems to notice. A perfect prison.

## Chemical Institutionalization

Today, 'compassion' is used by the state, it is not felt by individuals. One can kill with compassion! (Jull, 1997).

'They can't get inside you,' she had said. But they could get inside you.... 'Under the spreading chestnut tree, I sold you and you sold me—' (Orwell, *Nineteen Eighty-Four*).

Throughout modern patriarchal history, the triad of: declaring madness without contest, incarcerating without trial, and forcing unwanted 'tranquility', has often occurred to authorities and others who might benefit. Any part of this triad may become central to mental institutionalization. But in this thesis, I argue that the simple rotation of the triad is not progress towards humane treatment or away from sanism.

A participant or two in this study have called outpatient committal practices an "institution without walls". The Community Treatment Order extends institutions and their practices beyond physical facilities, making for a new urban geography (Montagu, 2001). The resulting effect is a legal shrinking of the 'private sphere.' The 'community treatment plan' is a legally binding document that enforces observation, monitoring, therapies and chemical treatments, enforced by clinics or mobile treatment teams and others in the 'community', most conveniently the family. The purpose of this plan is to protect public safety and increase the inmate's adherence to chemical treatment; the state presents the CTO not as an acceptable extension of psychiatric power, as some psychiatrists have done (O'Reilly, 2004), but as a less restrictive choice for the inmate. An inmate may now choose home over locked hospital ward, or their family may choose it for her. She may be monitored or supervised by families as per the CTO treatment plan, and have 'service providers' deliver chemical treatments directly, as several participants have observed. A long-institutionalized inmate can, with agreement from the Public Guardian and Trustee be relocated to a rooming house that functions for her like a psychiatric facility, and seldom with a better view. One participant said this was happening to a 90-year old man who had spent decades in a psychiatric facility, and whom I know personally. He refused to leave a place he had become so accustomed to, she told me, but his CTO discharge was imminent. The sight of an inmate's rocking back and forth in a sweltering rooming house, afraid of wandering outside to be confronted in his state, is common in the sort of residence he was being transferred to.

The CTO functions to establish institutional practices beyond the physical plant, bringing legally mandated coercion to the 'private' sphere. How has this become possible? If we move our orientation of analysis from the physical site to the 'treatment plan', as the CTO provides, we see the function of chemicals as a restraint where at one time professional supervision and walls were necessary. Chemicalization makes detention less necessary and the mechanics of institutionalization become invisible. We may speak of a chemical institutionalization process supported by intermittent visits to psychiatric sites. This practice has evolved since the mass exodus from 'mental hospitals' in the 1960s. But only in the last decade have we seen the state move to impose institutional legal powers beyond the asylum, especially in the U.S. The life of the 'discharged' inmate may then be more easily monitored and controlled.

To be vacant, trespassed, and simultaneously stuffed, overwhelmed: these are difficult experiences to express, let alone capture in coercion surveys. Through decolonization (Smith, 1999), people who have been somnolized and dispirited may re-find meanings and subjectivities. We may recover the self that is not compartmentalized, reconfigured, elaborated, psychologized, psychiatrized: institutionalized.

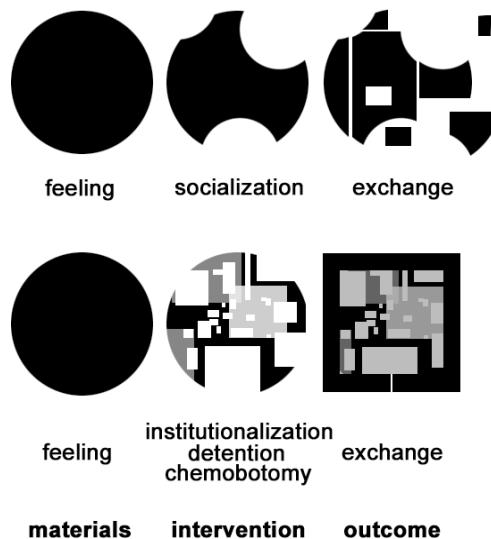


Fig. 4. 'Madness' can be conceptualized as part of a range of feeling we are all born with, which in patriarchal societies may be crafted and often broken and made into behaviours for economic exchange (see Vaughn, 2004). Specialized functions of state and industry allow for a more radically organized process of socialization: institutionalization. The product of institutionalization is not the socialized entrepreneur, but an economized, serviceable chemical form which is exchangeable by others.

Erving Goffman's seminal work on mid-twentieth century mental institutionalization provides a modern sociological model of what he calls "the resocialization chamber" of "total institutions" (1961:163, 203). Goffman exhibited in detail barbarisms that occurred in the last days before fiscal and pharmacological 'deinstitutionalization'. He was not antipsychiatry. He believed institutions would always be demanded by families, professionals and governments, and the clinical 'tinkering trade' he critiqued would always prevail, if only to "stay somewhat the hand of the attendant" (1961:383). In the historical literature on institutions, doctors have remarked (rather disingenuously) that their wards were not nearly as violent as the public believed. However, they rarely decried abuses by institutional employees (Dwyer, 1987:23). American institutions of the 19<sup>th</sup> century were a move from custodial "almshouses" or "poorhouses" (with rooms sometimes smaller than those in rooming houses today) to hospitals refitted with iron shackles and unheated basement cells. Before such luxuries, American towns dealt with the emotionally distressed through a 'welfare' scheme; the 'mad' were sometimes provided for, but more generally abused, or sold for labour, or sent away to other towns (Anonymous, 1982:111-2). Relocation is still used by professionals today, as Victor explains: "In [this city] for example, if a client can't fit in anywhere or can't maintain housing, they send him to [the] hospital [in a city 100 km away]." The wealthy were put in mad houses where 'physic' (or 'medicine') was force-fed to them with a 'bulluck's horn' (or ox's horn), a pre-Enlightenment method of drugging that lends a rare but revealing view on the modern practices (Belcher, 1997:131). Many of the complaints made hundreds of years ago ring true today.

Goffman's asylums are not long-past, violent forerunners to the contemporary 'mental health center'. They have postmodern equivalencies, and the methods used then are used today. The CTO extends them. Goffman says total institutions, such as prisons and religious convents, manage groups by surveillance, restriction of movement, social distance (quarantine). They are "a social hybrid, part residential community, part formal organization... forcing houses for changing persons; each is a natural experiment on what can be done to the self" (Goffman, 1961:9-12). Thus, they achieve through surveillance and several other methods a *restriction of movement and association*. But whereas "disculturation" in a prison-like environment incapacitated inmates' ability to live outside physical sites over long periods, chemicals can now make inmates more receptive to psychiatric training and more dependent on others in much shorter periods (1961:13). The loss of one's full name (1961:18) still occurs as the 'client' is hidden from



'stigmatizing' view, keeping the mocked and the tormentor apart (see also, Reaume, 2000b). Most importantly, we see this sequestering in the tribunal documents quoted in this research, a supposed protection of the inmate's privacy. Similarly, participants repeatedly say CTOs hide inmates from view of other inmates, survivors, and advocates. While rights advice is provided at the time that a doctor is considering the imposition of a CTO (not when signing), the patient may likely have little other contact with advocates after the CTO is signed. As such, inmates' 'privacy', or closeting say CTO critics, is overdetermined today.

Goffman says the inmate is "stripped of his usual appearance... thus suffering a personal defacement" (Goffman, 1961:20). Whether by old neuroleptics that make her tremble or new neuroleptics that cause rapid weight changes, or the physical defacement brought on by hunger, diseases, and other lacks born of insufficient care, this method of institutionalization continues also. "Disfigurement" was seen as a physical violation caused by persistent violence, possibly less visible than defacement (1961:21), yet interestingly, Goffman did not list electroshock 'treatments' among such disfigurements. He left the purposes of 'treatment' in relation to institutionalization open question. Of course, we may assume electroshock is essentially a burning of brain matter as the principle of electrical resistance provides (Alper, 1948), and continues to be practiced today, sometimes accepted voluntarily (if one can properly volunteer for this procedure under institutional pressures or under the mystification of 'electroconvulsive therapy' education). Beatings and abuses are still known to occur, on and off the principal institutional site, including at the hands of some psychiatric workers (e.g., Lopez, 2005). It is said that statistically, inmates are more often victims of violence than violent themselves (Wahl, 1995). "Physical indignities" (Goffman, 1961:22), such as being made to lie prostrate in silence, certainly occurs today even with the delivery of an injection under a CTO. Verbal slights and insults, such as talking about an inmate as though she were not present, or rudely dismissing her feelings, or asking embarrassing 'diagnostic' questions such as, "Do you know what room we are in right now?", still occurs in psychiatric settings including the home of a CTO inmate (1961:23). This practice is remarkably resilient, probably because the person is quite subdued on neuroleptics and defiance is unexpected, but also because any reaction can be applied to the 'cycling of evidence'. So the work of the 'mental patient', which is to read well the moods and desires of her keepers, is certainly still necessary on and off site. "In total institutions, staying out of trouble is likely to require persistent conscious effort. The

inmate may forego certain levels of sociability with his fellows to avoid possible incidents.” In the case of CTOs, relationships with family or professionals may be altogether focused on ‘managing illness’. Psychiatric workers in this study said inmates work extremely hard to avoid attention and to ‘stay out of trouble’.

### **The Cycling of Evidence**

Goffman also describes methods that violate ‘self-feeling’; “the boundary that the individual places between his being and the environment is invaded and the embodiments of self profaned” (1961:23). If detention and restriction of contact can profane the self, somnolence and enervation will pollute it obtaining more than the same effect. The self may enter a period of ‘non-self’. Whereas bars and walls are phenomena to be seen and resisted by inmates, drug soma and hibernation wipe away phenomena. Goffman mentions “discreditable facts”, collected in a case file, to embarrass the inmate, and enlist the support of her next of kin to psychiatric management (1961: pp. 24, 156, 307). As Dorothy Smith has explained, these practices certainly continue (1990b; also Burstow *et al*, 2005). As Smith demonstrates, the ‘patient’s clinical record’ is a primary method of decontextualizing and objectifying ‘behaviours’ reported using supposedly neutral medical narratives and professional protocols. The inmate’s daily life may thus be offered up into the relations of ruling. This allows for the legal management of individuals despite the possibility of varying or opposed ‘stories’ regarding the events in question. Goffman also says, “the inmate’s reaction to his own situation is collapsed back into the situation itself”, meaning one’s ‘desperate’ acts of resistance are ‘fed back’ to them as proof they should be detained (Goffman, 1961:37). Any agitation is psychiatric. A feedback loop is established. Certainly, this cycling of evidence continues today. The passing of CTO legislation was itself an example of evidence cycling on a sociological scale: isolating choice actions by a few individuals to discredit a whole population as threatening public safety (Mallan, 2000; Blizzard, 2000; Corrigan *et al*, 2005).

Psychiatric workers also use the clinical file to discredit the inmate and uphold the biological basis of her incarceration, a ‘cycle of biology’. Biological disorder demands immediate physical action: institutionalization and treatment. Biological explanations for inmate behaviour or even self-reports is known to predispose other people, including psychiatric workers, to viewing the inmate as uncontrollable and violent (Read & Haslam, 2004). When institutional workers discharge the inmate, especially if on a CTO, into a ‘treatment’-oriented home, her family begins to use ‘discreditable facts’ as other

workers do. Discrediting facts multiply as more embarrassments are logged and recounted by workers and family. The inmate may also become involved in this practice, weaving the evidence of her lack into her self-concept. The self is putrefied. Goffman says inmates may always be 'readmitted' given their psychiatric 'history' (Goffman, 1961:167). Yet, to outsiders, the inmate's responses may appear reasonable, innocuous or trivial. In a clinical setting or life, the inmate cannot escape the cycling of evidence, a case file full of events that would normally be ignored by friends who would themselves exhibit other kinds of embarrassing behaviours. Has Western culture infused into its language the same sort of clinical terminology, psychologisms like 'passive aggressive' and 'denial', so that the public has a taste of being managed this way?

Goffman discusses several other methods of institutionalization. The physically incarcerated inmate is never alone, with "bars for walls" exposing him (1961:25). By contrast, the drugged CTO inmate sees no more bars. She is exposed as a psychiatric inmate by the effects of the drugs, if people will notice, but at the same time her CTO 'status' is hidden from view. The prison is invisible both to her and her allies. Goffman rarely mentions 'medications', which in the institutional context of the late 1950s would have been forced (1961:28). But then, he also does not mention lobotomies or electric shock explicitly. He may have felt that 'treatments' were not an important part of institutionalization, or that they were taboo subjects. Like clinicians, he may have seen a composed and predictable individual as improved, especially as many inmates would seek 'improvement' if only to be released. As an advocate, I found drug-somnolent people spoke few ills about their captors, less about the cognitive effects of their 'medication', and almost never of its subjective effects. Goffman also discusses the inmate losing control over who sees him as a 'patient' (1961:28). She is vulnerable to spot searches (1961:29). These issues are no different for on-site inmates and CTO inmates today. As a minor example, under the *Mental Health Act*, inmate's mail can be intercepted. And now as in Goffman's era, the inmate can still be ignored even as they ask for food, or call out in an emergency (1961:45). The inmate can still be humiliated into asking for minor items like razors, or for major needs as well (1961:41). The cycling of evidence turns all interactions into institutional exchanges. The individual becomes a serviceable form for others to exchange, a slavery according to Szasz (2002).

Some aspects of Goffman's model apply differently in a CTO context. CTOs were heralded as preventing or limiting institutionalization in a physical site for certain individuals, a fate purportedly worse than chemicalization or 'obliged' treatment alone.

Goffman speaks of “desegregation”, being forced to share accommodations with people, ‘the other’, which might not happen under a CTO as the inmate may not be placed in a boarding home but rather in a middle class family home. “Privilege systems” (Goffman, 1961:48) or “indulgences” (p. 283), whereby inmates are granted 10-minute breaks for cigarettes, or highly supervised group outings off hospital grounds (e.g., to the local shops, as I recall), may have been the inspiration for the CTO itself. Similarly, what Goffman calls less-supervised “free places” (p. 230) have been expanded, but monitored spaces now include the private domicile. The ‘smart home’ electronic surveillance system for ‘people with schizophrenia’ is considered in Stip and Rialle (2005). The “buddy system” (Goffman, 1961:279) may sometimes no longer be applicable if a CTO inmate lives alone, yet may be yearned for by those without other supports. Goffman uses the term “mortification” (pp. 34-5) to describe being forced to watch brutality performed on other inmates. This method of institutionalization is still used in hospitals today, such as when a ‘Code White’ is announced and orderlies run to subdue an inmate while others watch. But this does not necessarily work to subdue inmates, as Goffman says. I was appalled when I saw a teenage girl chased and dragged screaming into an isolation room (by two men). I was incensed when an older Asian inmate admitted to me that he did not know what to do now that shock was ‘suggested’ to prevent his ‘condition’ from worsening. I think the use of “mortification” only encourages rebellion, which can be managed on site, but spreads by word of mouth off site, as it has even since Goffman’s *Asylums*.

Finally, inmate “performance” under workers’ expectations is the same in chemical incarceration as in institutional facilities. Goffman’s work considers the making of the “mental patient”, tracking the plight of the “pre-patient” (1961:131) who must enter and survive an absurd series of expectations. Some of these demand that the inmate abide by “conditions of imminent exposure and wide fluctuation in [her] regard, [pride, or honour] with little control over the granting of this regard...” (p. 164-5). Today, the inmate must still perceive immediately the expectations of power handlers (p. 120). The self must be easily changed for the institutionalized person to perform to her keeper’s expectations. She may have to discard or puppet selfhood to comply with extreme but ostensibly benign programs of erasure. For some, the ‘illness’ becomes the repository of negative facts, inferences, and meanings; but for others, this cutting away of the self into ‘ill’ and acceptable parts is impossible. Inmate use of institutional language (p. 97), such as diagnostic categories and psychologisms for mockery or self-mastery, can threaten

workers' social distance. Workers may label such forms of resistance as 'intellectualism' and 'denial'. Again these practices continue.

Table 2: List of institutionalization's methods and potential routes of resistance by psychiatric inmates.

| <i>Institutionalization</i>             | <i>Resistance</i>                               |
|---|---|
| certification (medical arrest)          | question, challenge, second opinion             |
| commitment (medical incarceration)      | reticence, feign, appeal                        |
| treatment (chemical incarceration)      | non-compliance, self-medication                 |
| Restraint, isolation (physical control) | defacement, violence, dissociation, self-injury |
| illness education (indoctrination)      | parrot, challenge, research, publish            |

This is not an exhaustive review of Goffman's many important examples of methods used to alter the self in total institutions. It is by no means a full demonstration of the kinds of personal violations of selfhood that continue to occur. Goffman's work is helpful to me here because it suggests how interpersonal indignities and mechanical methods of restriction blend with 'treatment' itself, into the project of institutionalizing identities and bodies. Mental institutions can orient their practices to somatic treatments primarily and while retaining depots for committing, seizing and tranquilizing a person for initial psychiatric education. Chemical institutionalization is merely a reorientation of practices that were mastered in the physical plant. Thus, many of the practices of power inherent to the older modern or even Victorian institutions can conceivably be transferred to the private domicile. Of course, the CTO may not be the first or only transfer of institutional power into the home, for as Goffman tells us institutional workers hope to enlist the family in their work as soon as the inmate is 'admitted'. Their work consists of several methods and practices.

Most important to psychiatric education is the cycling of evidence, the 'discreditable facts', that will prove to everyone including the inmate that her 'behaviour' is imbalanced by her biology. This serves to sever her private narrative and identity from her actions and to serve them up as 'behaviours' and 'impulses' through bureaucratic reports into the relations of ruling. Examples of this can be seen in participant's accounts, such as when Danielle, the psychiatrist, explained that an inmate could not attribute his improvement to treatment even though the treatment coincided perfectly with his improvement. She relied on a biological explanation to account for his incredulity: his 'lack of insight into his illness' (cycling of biology). This is not a complex education, and CTO families may certainly have more practice in this practice of power

now that they too may bear the responsibilities of workers under a 'community treatment plan'.

Other methods of institutionalization will serve to support this self-fulfilling methodology. Almost any discomfort caused as a result of a CTO treatment plan will either be quietly anticipated and accepted by the inmate, in which case all is as it should be, or rejected, in which case an institutional response can be brought to bear. Surveillance and monitoring by family and neighbours, disfigurements such as tardive causing exposure to others, the closeting of decreased mental agility due to drugging, all of these may ensure the inmate has no reason to resist institutionalization. Whereas in Goffman's day, disculturation and desegregation were important tools, and though they may still occur in boarding home environments, our culture has become more heterogenous. Disorientation and somnolization will achieve the same results and more. Insults, slights and the 'profaned self' that the inmate must endure will seem to be welcomed by the inmate as she performs the task of staying out from underfoot and begging for minor needs. Some workers or family members may forget that if they do not take advantage of the inmate's position, others have or will leading to inmate passivity and fearfulness which participants in this research often reported. In vulnerability, the inmate is bound to experience some form of violation over time, if this has not already occurred during the on-site initiation. All these irritations and dislocations will only serve to encourage the inmate to rebel, whereupon by the nature of cyclical practices of power including biologizing and psychologizing, and drugging the errant 'behaviour', the institutional program is secured again. Rampancy has been the hallmark of psychiatric confinement, and it does not change as a result of moving the locus of control from the psychiatric facility to the psychiatric body. The restriction of movement and association is completed through chemical institutionalization.

## Dreams of Escape

As described above, chemical institutionalization affords ways to manage greater numbers of people in society without expensive physical plants. Chemical imprisonment makes possible inmate education and management with less supervision across institutions, which participants call ‘the system’, a ‘transinstitutional’ network (see, Maidment, 2005). This research has benefited from the perceptions of workers who understand difficulties as they are experienced by people in marginalized groups likely to fall into psychiatric or other institutions. Frequently psychiatric involvement is imposed on racial minorities, women, the poor, members of the gay, lesbian, bisexual and trans communities, people with physical and non-psychiatric mental disabilities, people in the ‘criminal justice’ system, the elderly and others. Youth are no exception.

Tyler (housing worker): I’ve seen cases where people are entering the system at a young age, and it doesn’t take very long for them to start acting like the people that have been there for ten years,

Kim (peer worker): Yeah, the role that they’ve been expected–

Tyler: you know, and pretty soon they’re in that hopeless category, and they’re getting treated the same as those other people that are–

CTOs become *effective* in the management of inmates when they do not adopt institutional identities and behaviours, the ‘unmanageables’.

June (legal worker): The groups of kids that are high risk are usually kids that end up in front of a psychiatrist because of a behaviour-related problem, or because of a suicidal, um,

Erick: ‘Phase’?

June: Or something, yes. And the suicidal one is where a lot of people end up in the system.... I see this happening all the time where I’m getting calls from colleagues and parents and stuff, where the young person is distressed– and I’ll say child, because, you know what, you really are a child when you think, physically, about the medication they’re putting in their bodies, because they’re still growing, and they’re coming in at what the medical model says is ‘high susceptibility’ for a mental illness– at 16 to 24, right? Because, at 16 they are offered... they don’t keep them in the pediatrics ward. They go up where the adults are. So the behaviour and the culture gets learned very quickly, about how to survive there. All that it takes is for me to be depressed, because I might be thinking about, you know, same sex thoughts, or I might think my mother really sucks because she won’t let me do this, or I’m an Indian who doesn’t want to have to wear dresses to school, and I’m in a culture that doesn’t support me. I don’t fit in with my peers; I’m getting drunk all the time, so my parents are really pissed at me. They think I need a psychiatrist. I’m depressed, and I say one day, to somebody I trust, that I feel like killing myself. That suicidal language is a ‘reaching out’ language, but the medical model confines you very quickly, and I think once you’re in there... that could be it. Because a lot of people give up....

June has described practices of power in which unmanageables are entered into a 'cycling of chemistry' early in life, and their need of assistance is entered into the 'cycling of evidence'. Workers drive the process of institutionalization, fueling it with human need.

June: I worked with homeless youth and men and women who are in the criminal justice system and coming out. And so, part of what I saw with the young people— I worked a lot, I had no special training or anything, but I worked a lot with the youth— that had mental health issues: predominantly they were young men, and their issues were coming up after being incarcerated— and the trend I started to notice was most of them spent time in segregation, and most of them had taken psychiatric drugs against their will. And they were completely different. Like many of them I'd known since they were fourteen, cause they used to do 'youth employment', and they had kind of traveled around and stayed in touch with me. And now I see them in the neighbourhood because that's where I used to refer [send] them to, cause it has cheap housing, and some of [these kids] are just vacant. And I remember when I was there, that everybody in the front line doing the service providing work felt, without discussion, that it was in the best interests of clients to be medicated. Now I didn't really have a critique. I was just, in general, against any kind of medication. You know, people having to take those options. But, I did think at some points, 'Now this person would be better off with somebody making sure that they're safe', you know? 'Cause he's walking around the streets, and you know he's getting into trouble cause he's exposing himself,' things like that.

Youth are forcibly treated and isolated resulting in increased manageability. However, the above example shows poor drug 'efficacy' in which 'symptoms' are not 'managed'. Because drugging is seen as being in the 'best interest' of the 'client', chemical institutionalization emerges on a mass scale. June said institutional drugging prevents workers adopting simpler solutions.

June (legal worker): But then I ran a group for six weeks, twelve weeks, and then it was so successful he [a supervisor] wouldn't let me run it again. And the group was for young people who were immigrants and refugees, who had experienced some kind of economic or political violence in their country, and what came out of that was we made sure people had food. Not like sandwiches, but like rice and wheat and vegetables, because they weren't eating properly. Many were Muslim, and stuff. Their bodies could not physically adapt to the food. So, I had the Health Centre, Shout Health Clinic, working with me, and they're like on the forefront of mental health and stuff, but there were a couple of nurses in there who did kind of grass roots [beyond medical] work, so the clients would always go there for whatever they needed. But we never forced them to take treatment. We never forced them to see psychiatrists, because we found, if they were eating (we gave them two TTC tickets, and let them stay with us all day, because they were being kicked out of the shelters during the day), that they would be more stable the next day, and then the next day. The ones that kept going into the doctors and getting the shots and stuff— cause nurses used to give the shots before CTOs were in place— they were always more likely to be in and out of the system. So there was that mentality, 'Don't question. It's better.' And if you're a front line service provider with no political analysis, or no education, cause



they're not giving it to you in that field, right? (they just want you to hurry up, hurry up, and produce), it's very easy to buy into it. It's very easy to be brainwashed into believing it's in the best interests of the client, cause the client gets situated as problematic when they're not medicated. Everything is about 'they're not medicated'.

Refugees from other countries find themselves under CTOs. Their only way out of a horrifying past and into Canada is through psychiatric institutionalization. Like Rudy's friend, who dreams of escape, some refugees wish to flee Canada.

June: I've had [a few] people on CTOs. Some are immigration related. The CTO has prevented them from being able to leave the country. They want to be deported, because they've been in the mental health system— I'm not sure if you [speaking to Kim in the focus group] see that a lot... but people that are held against their will in the mental health system who are on a refugee application want to leave. So part of what I do is [start by] trying to talk to refugee applicants about what's going on with them, cause most of them are experiencing— and I have a case this week— 'post traumatic stress'. His father died horrifically in March. They've just diagnosed him as 'schizophrenic'. The problem with that is that it might make him "medically inadmissible" [to Canada]. So I was talking to him about like his options and he thought going to the hospital might be a good option. And I'm like, "If you're really concerned about your freedom, and if you're concerned about this thing that they call 'schizophrenia', what you're going to read in a book is that it's permanent and it's not curable unless you take medication". And I said, "But the reality is, your dad died, you know?" [His father was murdered and he was forced to witness the murder].

A CTO imposed on refugees acts as an *abuse* by preventing them from leaving the 'system' and thus the country that once promised freedom from harm.

June: So if there is something going on like depression, grief, trauma, it escalates, and gets worse and worse and worse 'til they're [refugee claimants] put in the system against their will. At that point, they're probably feeling most like delusional stuff from the trauma they come from— this country is pretty like delusional itself— language issues, all these things. And then you're being told by this doctor, you're going to get hit up with this drug, which is going to give you serious side effects, and you cannot leave the hospital. So then you tell the doctor, 'I want to leave the country, call my lawyer.' They're like, 'we can't deport you cause you're being held here against your will'. Somebody in prison, they can make arrangements to deport them after their term or to just return them to the country. We're finding that many of the refugee claimants [under psychiatry] are not being given that option. And I don't really know how to help in that situation.

Again, we see people in correctional institutions have more rights than psychiatric prisoners. In psychiatry, there is no finite term of 'treatment' on which to base a release. The desire to escape a jurisdiction in which CTOs are imposed is a salient example of how the relations of ruling are experienced similarly by persons of different cultures.

This brings up several comparisons that have been made in the psychiatric survivor literature (from historical texts and contemporary times) about psychiatric institutions not conferring basic rights afforded to other prisoners. Elizabeth Packard, a well-known U.S. psychiatric inmate and reformer of the late 1800s, said that psychiatric inmates often had less provisions than many slaves (in Geller & Harris, 1994:58-85). Nevertheless, the interlocking of oppressions allowed black psychiatric inmates and criminal psychiatric inmates far fewer provisions than other psychiatric inmates.

June: So, they [refugees on CTOs wishing to flee Canada] can't do anything, but then they don't have any money to leave, right? But the thing that concerns me the most is that you've come from a god-awful situation and you've come here, and you want to leave this god-awful situation for the one which, politically and economically and violence-wise, is probably worse. But the fact that people are perceiving our mental health system as a form of torture that's worse than the one they escaped should concern people.

The inmate's experience from the vantage point of a so-called 'developing' nation illustrates the dehumanizing effect of losing one's identity and full consciousness under 'treatments' imposed by CTOs. For some, this is more tragic than experiences of brutality abroad.

### **Gender Under CTOs**

Women have been outspoken not only about their abuse in psychiatric institutions, but also about their experiences of 'madness' and abuse (Grobe, 1995; Geller & Harris, 1994; Wood, 1994). Again, they claim to be afforded fewer 'privileges' than male inmates are in the psychiatric and criminal justice systems alike. Participants spoke of how institutions of various types intersect.

June (peer worker): And now prisons are no different than psychiatric institutions. Especially since they're rehauling our forensic system.

Kim (peer worker): M-hm.

June: But with young people—

Erick: How do you mean, do you mean that they medicate prisoners now more generally?

June: Well you're going to go— if you're out in the street, or if you're a problem, you're going to go to one of two places. Depends how the cop feels. They either go to local hospital's emergency where the cop might wait for 12 hours— I highly doubt it! Or, you're going to be shoved off into jail and be put into 'mental health diversion court' [a judicial program that tries to redirect 'mentally ill' people charged with minor offenses from jail into the psychiatric system]. Either way, whatever institution you end up in, it's likely you're going to be forcibly treated.

So, aside from that I work with women that are incarcerated, and I can't tell you how awful in the last five years (we're a half-way house where I work)— and I work with women that are in crisis, and so we advocate for women— I can't

tell you how many hard medications these women are coming out of prison with! And when you read up on them, the side effects are just horrible. But since they've been in prison, their tolerance level's increasing, they get a different doctor out here who just increases the medication, and all of that is just to keep them quiet.

And 'superjails' are not delivering appropriate mental health services. People involved in the criminal justice system are jumping on the mental health band wagon, with no infrastructure to understand mental health and their client community. So you can see how it happens....

Some women face several biological-deterministic beliefs about their 'mental illness' (Caplan, 1995) which impacts *identity*. Danielle provided an example in which bodily changes can be understood as psychiatric problems, an example of 'cycling of biology'.

Danielle (psychiatrist): There's a woman, when we first took her on, she had an illness for several years, maybe 15, 20 years, and for whatever reason the course of the illness changed— schizophrenia— so it became less treatable, less responsive to meds. You know that happens: the illness changes over time. Women going through menopause sometimes become less treatment responsive. Anyway. It changed. So she went from being someone who could live fairly independently, had children, had hospitalizations now and again, to someone who's chronically homeless and chronically very psychotic.

E: With her children still in the community?

D: Oh, no, no, they were apprehended.

In terms of *identity*, we see a slippage in this narrative between an illness "less responsive" to treatment and a "less treatment responsive" inmate, a distortion caused by cycling of biology: identity is inadvertently collapsed into biology.

Danielle: So by the time we met her I think she'd been homeless for about 5 years. You know every once in a while when she posed a public threat or whatever, she'd be hauled off by police to hospital, treated for a month or two and released, 'til she deteriorated to the point that it started all over again, you know, a few months later. So we took her on, very, very psychotic woman, very bright, and very, very spunky. Like she just would not accept psychiatry at the time. So we followed her for a year or two with no change in pattern of illness, and she has this brother, very respectful. Like in anything, not all families are the same, right. He understood her illness, very respectful of her, but wanted to make sure the system could deliver the best of what it had to offer her.

This is a good example of how *identity* is cleaved into "spunky"/person and 'psychotic'/illness: which of these is responsible for the inmate's rejection of psychiatry? Is rebellion borne of biological error, and merely sustained by independence? Cycling of biology creates such distortions; identity becomes incidental. The family member and psychiatrist, two well meaning persons, accept the idea that this inmate may be confrontational because of biology, so their goal remains clear.

Danielle: So in discussions with him [the inmate's brother], we put her on a CTO. I think we just did the 6<sup>th</sup> or 7<sup>th</sup> renewal; I think she's been on a CTO for about 3 years. And the CTO, what it's done for her? She's still psychotic, she's still has a lot of problems, but she's housed, and for [non-medical] circumstances I won't go into, she's got way more money now.... So she's got more money and more money's always good when you're in poverty. And the most important thing for me is the woman's not cured or treated by any stretch of the imagination but she's able to connect with the staff where she's living, and she's able to connect with the team members, which she never could before because she could never have any kind of conversation. So now, even though it's [sic] quite psychotic and disjointed, she's not alone in her psychosis. So it's not that same condemned level of isolation that she had before....

The inmate's decreased functioning due to drugging will make her amenable to conversation, whatever the quality of this conversation, yet this is a global, not specific, action of the drug on the brain. The cycling of chemistry is well in place here, a self-fulfilling function of *chemical institutionalization*.

So, my point being, every time I renew [the CTO], and every time we have a Review Board [hearing], and every time she fights it— she never accepted this— I have to know, you know (her treatment responsiveness is not great), I need to know or have some increased probability that I'm doing the right thing. Her brother's a thoughtful person too, and he thinks about it every time if he's doing the right thing. So I guess it decreases my unilateral power to have family members— you know if you have the PG&T, the Office of the Public Guardian and Trustee, I mean, you know, they'll do whatever the doctor wants, right? Because objectively, these people meet the criteria [of imposing a CTO] so clearly, there's nothing to discuss, but if there's family members who really know the person, and you know they know that the person wants to be autonomous, but at what price, and are really weighing the pros and cons, I feel a lot better as a clinician that I'm not making these decisions by myself.

Both individuals involved in determining the inmate's CTO '*status*' are well-meaning to be sure, and not naively so. They are trying to 'fix' a problem for which chemical institutionalization seems the only available option, yet they do so based on social relationships sustained above the inmate's social and legal position. The family-psychiatrist relation allows the determinations secured through shared legal decision making powers to withstand ethical scrutiny. They attempt a negotiation of power that will balance family intimacy with medical authority, merging folk sense with medical-legal intervention.

The role of gender comes into play when we contrast the views of the psychiatrist participant regarding a female CTO inmate and a male CTO inmate, both of whom clearly did not wish to be under CTOs. In Danielle's interview, she spoke of the female inmate as "spunky", but here she refers to a male inmate in much stronger terms.

Danielle: That's right, there's a man who again had an illness, not that long actually, ten years or so, complicated by substance abuse, although that wasn't so great, but he just tends to pop whatever is around like Tylenol or whatever, and would take high doses of tranquilizers and then stop all of a sudden and have withdrawal and seizures. So, there's lots of reasons why he would meet the criteria [of a CTO]. When we first met him it was the same thing, like: revolving door in and out of hospital, wouldn't maintain housing because he would get paranoid, he had this whole paranoid system that would evolve, and he'd get paranoid about the people where he was living, so he'd have to move. He couldn't even be in a shelter because the paranoid delusion system would take over the shelter. So he'd have to be on the street like under bridges and stuff. Anyway, he's sort of an Ayn Rand kind of guy, like rugged individualist, good at getting what he needs, but he connected to the team as well as he would connect to any health care professional. Never accepted psychiatry. But we had a connection. So after a couple of years, and this is where I felt somewhat ambivalent, but after a couple of years, when the in-patient doctors [at the hospital], after seeing him 4 or 5 times a year, started talking CTOs of course. And I talked to his sister, though she didn't want to be Substitute Decision Maker cause she didn't want to strain the relationship, so the PG&T provided substitute consent. I went with a trial of the CTO. I think it lasted for a year in total. But this guy, and, you know, good for him, got himself a good lawyer, and [went] to [the Ontario Court of Appeal] and [the CTO] was thrown out, on a technicality, nothing to do with the substance of the CTO. I could have re-issued a CTO but I haven't.... [H]e presented himself to emerge twice and had brief hospitalization because he was feeling depressed and suicidal which he never did before, and that was it. But he was miserable. Very, very miserable. So we basically gave it a year, so he didn't have so much of the psychotic symptoms, but he did feel extremely dysphoric [sad], had a lot of side effects to the needle, wouldn't take oral meds. He was just miserable.

This is another example of the Public Guardian & Trustee and families conveying psychiatric decisions to psychiatrists by fiat, having no psychiatric expertise. Compared to a CTO-resistant female, the male CTO inmate is seen as a "rugged individualist" who "never accepted psychiatry". While the female inmate may not have demonstrated her opposition with suicidal acts, she too was a rugged individualist and rejected psychiatry. Only the male escapes the CTO, revealing the possibility of *abuse* through gender bias, which both men and women carry in patriarchal society, including professionals. The female inmate has had her CTO renewed indefinitely, despite her vocal opposition. Yet the male's vocal opposition is set in emotional relief in Danielle's interview:

Erick: What did he say?

Danielle: Well just that he feels awful, and he would never go to the psychiatric system unless he was desperate.... He's not that much at risk of self harm or harm to others really. I mean he's at risk out of self-neglect, but he did seem miserable, and he has a lot of side effects cause in the injectable medication you only get the old antipsychotics that come with neurological side effects [as do the new ones (Lieberman *et al*, 2005)]. He had that restlessness

and that parkinsonism [shakiness, akathisia], even though he was on a very low dose. So yeah, high side effect burden, yet his voices and paranoid system wasn't as obvious for sure, but the guy was mostly miserable. But he was housed and his hospitalization rate was decreased, so if you just looked at housing and the hospitalization rate, it would be deemed a success, but in terms of his personal quality of life, he was no better. In fact, I'd say he was suffering more.

I should note that negative effects of neuroleptics do not depend on the amount, but on each individual's reaction making them difficult to quantify. Danielle also shows that the CTO's *efficacy* based on the inmate's use of services is not necessarily indicative of 'positive outcome'. The question remains whether this inmate's negative experience was addressed because he was male.

Danielle: [H]e never ever forgave me for that CTO, and basically we've lost contact with him and now he's chronically psychotic and homeless and I've discharged him from our service hoping he would engage with other services. So anyway that's an example of a prototype that I hold in my mind about people you wouldn't put on CTOs and I think there the lesson for me was the gradient between the treated and the untreated wasn't great enough and there was no appreciable change in his quality of life that was important to him. He would rather die than be on a CTO. He's a rugged individual. He does not want to be controlled. He wants to do everything on his own terms. Personally I have no problem with someone like that going to hospital 4 times a year for two weeks and then the rest of the time, he does the best he can. Personally I have no problem with that. So the reason I issued the CTO was to see if it would make a difference to him.

Notably, Danielle saw a reduced level of 'treatment success' when the inmate's rights were denied, while other psychiatrists would separate the two issues. As a psychiatric worker, Danielle has tried to help this person as best she could, but limited options seem available to psychiatrists. The CTO is a powerful new mechanism that establishes institutional practices beyond the physical plant.

### **Choice and the "Harness"**

A common question asked is why are so many resources spent on options vested in drugging like the CTO? Why not provide affordable housing, personal supports, flexible and dignified employment, advocacy services? Psychiatric industry workers call these 'alternative' *services*, which few people would dismiss out of hand, but they remain quite unsupported. Some may suggest that these supports would be rejected by inmates 'too far gone to care', yet psychiatric survivors 'who've been there' have consistently called for such supports (e.g., Queen Street Outreach Society, 2002b). This imbalance may simply be a product of structural and economic forces in or beyond

the psychiatric industry (McCubbin, 1998), or it may be a problem of an underlying custodial-institutional default of imprisonment. When all else fails, detain.

Some inmates elect services invested in drugging as their only recourse, as do psychiatric workers on behalf of inmates. Yet, I was able to find only one example of a person who wanted to be under a Community Treatment Order *per se*. He told people assembled at a public forum on CTOs that without drugs he would surely become violent and end up in a maximum security prison because of prior crimes. Assuming correctional detention is a societal response to crime, not just a ‘therapeutic’ detention that people can avoid with a CTO, these orders enable someone to avoid other forms of incarceration. This fact suggests again that CTOs should be considered a *status* under medical-legal law. Yet it seemed most people resented, rejected, hated being on CTOs. I asked the participant psychiatrist if anyone she knew accepted CTOs.

Danielle: No, none of them do. [laughs] None of them do. But the one who comes closest to accepting me, [the woman discussed above], she likes me, I’m her “hero”, quote, unquote– say that at the review board!– but she hates that medication. So what do I do for her? And for her it’s very much a question of it blunts her feelings. And she’s a very good artist and it just kills her drawing. So what I do is I just use the CTO as a bit of a harness for her. So she’ll skip doses once or twice a week and then we just raise the scepter of the CTO and she gets back on, so it gives her a bit of breathing room. And prior to being on a CTO she’d been off– we’d known her for at least 2 - 3 years, and no matter how many meetings we’d have with her individually, any time you tried to bilaterally negotiate medication reduction or whatever, it would just go off and she would just do things unilaterally and stop her medication every single time. So the CTO kind of is a bit of a structure where I can then have some influence and help her to get back on her meds. But she has the room to get off the meds to feel her feelings a bit. It’s like an elastic structure kind of. She’s the only person I would say doesn’t fight. All the others are completely against it. So I end up going to a lot of review boards. You know, where they contest it.

Again, Danielle’s view was that this inmate was opposed to the CTO, but was not fighting it. She also suggested the CTO is an “elastic structure” which is an apt metaphor for legalized chemical detention. Most importantly, this example shows how ‘care’ and ‘custody’ intersect. Psychiatric survivors decried CTOs as “Leash Laws” in 2000 and were dismissed, yet here is the same metaphor being used to demonstrate exactly how control is achieved, relaxed, and reasserted. The inmate plays the game, as survivors say, until she feels a lessening of her chemical bonds. Any hope of getting out of the *chemical institution* is grabbed at desperately. An inmate who is offered some leeway, even a retractable “harness”, will vault for freedom. This physical need for relief from

toxicity is seen as a flight to fantasy, a desire for 'madness'. Yet, it is well known that drugs do not curb 'fantasy' itself.

The inmate tries to escape drugging, but under the cycling of chemistry, she finds herself chemically and socially dependent and thus contained, repeatedly. The CTO as a legal mechanism acts as an additional advantage for the psychiatrist in 'bilateral negotiations' between inmate and prescribing authority. It is obvious the inmate bears no personal hostility, may truly like psychiatric workers as individuals, who happen to exercise power over her. Why should it matter whether they show her respect or not? Her needs are moot in relation to the requirements of the psychiatric industry that employs them. While the inmate may retain some dignity, aspects of her *identity*, her power to think, feel, and create are brushed aside by crude 'treatments'.

Moderate voices between psychiatrists and inmates attempt to rationalize and shift the locus of power to allow for 'alternative' services like 'psychosocial rehabilitation', even 'recovery' services, which challenge the present belief in 'mental illness' as 'incurable'.

Victor (ACT peer worker): But I might say there might be one case of this person I mentioned that we see every day, that [the CTO] just gets renewed. Is it out of convenience? The client has— is not saying "I don't want to be on a CTO"— there's just— each time it comes up it seems to get renewed, and it's been renewed since I was there. It's been years. So you wonder where is it going to go? Is it serving a purpose? Is it doing anything? Is it effective? I think with CTOs [either] you're preventing this person from doing something 'really bad' or you're doing it for 'their own good' kind of, those are the two things [possible]. It's like, they're not... You make them take their medication or they're going to be [forced to do so] in the hospital. But what's the person learning from that? I mean they're going to get discharged and then it starts all over again. I mean, it's hard sometimes. CTOs, to me, are effective with some people; with other people they're not. I think the people that they're used on are generally people that aren't in the frame of mind to say no, or have the resources to fight them.

Victor is saying that CTOs seem to *postpone* 'rehospitalization' rather than prevent it if an inmate continues to resist drugging. This criticism of the CTO attacks the assumptions of CTO *efficacy*: success, even simple 'compliance', cannot be forever extended through coercion alone. This suggests that the CTO is more than coercion or chemical restraint if it is imposed indefinitely. It may be seen as a detention, an ongoing use of force. Coercion and persuasion would then merely account for the methods used to put someone under a CTO, while force would describe the CTO mechanism itself. This would leave it more open to challenges of its *constitutionality*.



## Drugging Control and Technology

Technologies are more concrete and governable than social and interpersonal interventions. Under the relations of ruling, the language of technology is utilized in the hope of operationalizing a concrete and accountable program of physical intervention. Even if strictly social interventions, which may still be sanist or destructive, are welcomed by inmates the priorities of the psychiatric industry are to ensure imprisonment as the foundational element of intervention. If all else fails, detain.

Danielle (ACT psychiatrist): Now, for people who aren't on [being 'treated' by] an ACT team, what the literature has shown, and before I started CTOs I read all the literature that was available at the time, you know in other countries, etc., is that the CTO is more to make the system come together and be responsible for the patient than for the patient [herself], if you know what I mean? It's more a System Cohesion Order. That way you've got a fixed point of responsibility and you've got people built in around the person written into the CTO.

Unlike a facility, in which treatment and detention are separated in law, the CTO attempts to bind them again, for the purpose of service 'system' integrity. Thus, the logic of detention becomes a methodology to ensure *service* delivery, whether individuals' basic needs are met. That suggests a recent strengthening of institutional and custodial values, not their dissipation by way of facility closures or restructuring.

While some inmates learn to abide drugging as their bodies become inured to toxins, others resist drugging altogether and become eligible for CTOs. I wondered whether inmates objected to the CTO as a mechanism in itself, or to the CTO as a drug regimen, a drug treatment, a mode of drug delivery. In other words, did inmates resist drugging or the CTO?

Erick: But was it the CTO that he objected to? Or the treatment *per se*, or I guess that's all the same in a sense?

Danielle (psychiatrist): No he doesn't like the treatment, but no he doesn't like the external control [either]. He just does not— he wants to run his own show. And you know, I can appreciate that.

...

Danielle: ... it's so hard to untangle the CTO versus choice over medication. Well no there are a few though [that] the CTO in and of itself is objectionable to them, not their medication, if that makes any sense.... They're enmeshed because if you didn't mind the medication you wouldn't be on the [CTO] medication anyways.

The CTO is not necessarily imposed if an inmate is 'non-compliant', yet might be even if she is 'compliant'.

Erick: How does he feel about his medication?

Rudy (peer worker): Fine with it.

E: He's obviously concerned about the delivery?

R: Absolutely, it's the delivery, not the medication. It's how it's delivered. He's saying, "I don't want an injection," he's saying, "I want to take medication, and orally." And they're saying no....

E: So for the most part in talking to him everything has been positive in terms of medication. He hasn't felt some of the debilitating side effects or the difficulties with thinking?

R: I think he's managed with the side effects that happen. He's never said anything to me about that it was not tolerable to him.

E: In this situation, this person really had most difficulty with the police driving him from his apartment for 45 minutes to get an injection.

R: Right. They inject him, then they drive him back.

Thus, participants suggested independently that CTOs are objectionable to inmates as a sort of involuntary *status*, not as a treatment mode.

There are inmates not on CTOs that reject drugs, and Danielle said their resolve may soften over time. Critics would again say that the drugs, or institutionalization, make them more amenable to drugging.

Erick: So others [not on CTOs], they accept the medication?

Danielle (ACT psychiatrist): Or they don't! You know we talk— [laughs] I don't mind people being off medication. Sometimes they do sometimes they don't. It changes right? You know for the first few years they fight us all the way, then after a while they go through certain consequences, they might start making different decisions. It changes over time or life circumstances, whatever. It's a good question. That lack of friction you described [in which some people accept treatments without reservation]? I'd say maximum: maybe 40% of our case load. Because the people who end up with our [ACT] teams— the medication does come with a lot of cons for them, that's one issue.

Though some inmates accept drugs, they may demand control over how drugs are delivered into their bodies: method (oral versus injection), dosage, and regularity. In the context of medical-legal arrangements, such demands for control over drugging constitute an attempt at negotiation for inmate *rights*, not just 'treatment decisions'.

Victor: The CTO wasn't effective... he was discharged from hospital six months ago and the medication had such drastic effects on his body, side effects like a lot of stiffness, it was just not a good thing. So the psychiatrist said, "You know what? We'll let him not take medication, and there's no need for him to have a CTO, so we'll take the CTO off." We're still seeing him as a client twice a week, and it seems to work out better. He's having symptoms but he's able to live and do his own thing; he has his routines. He's quite well known in the community, and it works out well that way.

Victor's comment suggests *efficacy* studies of deserted CTOs may bear some interest.

Victor: I mean CTOs, when you look at it, you can't compare it with anything else in society. It's almost like you're on parole. It's basically a form of parole but you haven't committed a crime; you're being forced to— it's almost like you're being

punished for mental health and not taking your medication and being hospitalized. Well, why not look at another way of making the person better. I think sometimes CTOs are an 'out'; it's like they don't know what else to do with the person.

Again, the logic of 'illness' results in custody and detention, whether in a facility or under a CTO. Inmate *status*, legally recognized or not, is ever-present whatever the 'therapeutic' aims may be.

Kim (peer worker): and then on another practical level, it's like sort of isolating people cause they do have to stay home and wait around for... their worker if they're going to come to the house and give them their drugs, and also, I think it's kind of impacted the quality of support, dialogue, or whatever people were getting from workers. I, for example, worked at a [regular] health centre, where somebody was on a CTO, and that meant that this person would come in, at whatever times, get their needle, and then leave, and that is sad to me.

Erick: And that's *since* they've been on a CTO? Whereas before, they might have talked [more], is that what you mean?

Kim: I think that it's actually a new relationship, you know what I mean?

Erick: Okay, that reporting relationship.

Kim: Yeah, cause you go to your doctor when you're not feeling well, and you have like a discussion, like my arm hurts or my elbow hurts and stuff. But that was just like, I'm going in and getting my needle, like that's something altogether different.

Tyler: It just makes your visit routine. It has nothing to do with—

Kim: Yeah, and what is that moment!? [incredulous laugh] Whereas before if you're having a discussion with your doctor, it's sort of like doing— I mean granted, it's never been good, like it's fifteen minutes, but you do talk together about whatever, but now, that's just, you know, roll up your sleeve, get your shot, then you leave. I think that needs to be examined very carefully, like, what the hell is that?

Erick: And you're saying that that's a CTO phenomenon, right?

Kim: That's a CTO phenomenon, and the image that comes to me is like army, military, control.

Erick: Okay. So, generally, that population is being, even more, steered into a kind of a reporting relationship?

Kim: Yeah, yeah.

Erick: where they go and they get—

June: Probation.

Kim: Yeah.

June: Pee in a cup. They'll talk to you as to how you are. Just pee in the cup, and they'll call you back, and tell you [that] you have to pee again.

## **Coercion Literature**

Some participants initially felt that the CTO was not so important to psychiatric oppression, merely a poorly devised mechanism that was so complicated workers would rarely bother to use it.

Tyler (housing worker): ...cause there's other ways to, you know, coerce people into doing things– there's a lot of inertia there, there's certain ways that things have worked for a long time.

Coercion is a term that seems to convey a practice that is less severe than physical force, such as holding someone down while delivering an injection or electroshock, but more severe than providing such treatments on request. There is some controversy, however. Can electroshock not be seen as a violence in itself, and by that logic, destructive drug regimens? Can people freely elect such measures even if they know they are destructive, or can the ever-present possibility of psychiatric detention in a facility mean that there is always a level of duress?

When psychiatry uses force (to detain and/or treat, if detention and 'treatment' are not a force in themselves), it is usually on the pretext that a person will become violent. Leaving aside our inability to predict violence (Monahan, 1996) and the lack of a statistical association between violence and 'madness', some behaviours may be understood to emerge directly as a result of cyclical practices of power. A person may become 'agitated' or violent because of umbrage at being labeled, or having their intentions interpreted medically rather than personally, or as a result of brain damage or toxicity preventing them from controlling aggression. Are such problems born of interventions considered in coercion studies?

The 'problem' of what 'causes' human behaviour, especially violence, is often framed in abstract debates of: 'illness' versus 'society'. Coercion is examined in countless ways, from Szasz's radical concepts of pharmacracy and psychiatric slavery (2004), to 'progressive' critiques of psychiatry's 'medical model' (e.g., Leifer, 2001; Allen, 1999; Caplan & Caplan, 2001) to not so critical studies of perceived coercion by 'people with severe mental illness', 'patients' and 'consumers' (e.g., Elbogen, Swanson, & Swartz, 2003; Canvin, Bartlett, & Pinfold, 2002; Farabee, Shen & Sanchez, 2002; Iversen, Hoyer, Sexton & Gronli, 2002; Borum *et al*, 1999; Nicholson, Ekenstam & Norwood, 1996). Some coercion studies deal with CTO provisions specifically (Greenberg, Mazar, Brom, & Barer, 2005). Some studies question whether the perception of coercion is based on real events (Lidz *et al*, 1998; Poulsen & Engberg, 2001), yet no agreement seems possible on such basic questions as whether involuntary status leads to a perception of coercion. Some researchers seem to be suggesting that if detention were delivered 'respectfully', people would not perceive any imposition. But coercion could still exist. We might ask someone in jail if she felt imposed

upon, and she might explain in detail how her captors meant well, how horrible she was, but why should we assume that she isn't simply reflecting her captors' expectations?

Many studies assume there is a way to transcend a coercive situation, using interview or survey, to find out whether coercion indeed exists. A good example, after having read Linda Smith's work on decolonization and research (1999), is a study called "Maori experience of community treatment orders" (Gibbs *et al*, 2004). This small New Zealand study suggests that CTOs were considered helpful by Maoris in increasing patient safety and family or community (*whanau*) security. It was noted however that CTOs imposed drawbacks, "particularly concerning medication and restrictions on choices", and "reconciling [indigenous] traditional beliefs with the medical model of mental illness." A critical study would have attempted to resolve the contradiction that a practice seems to offer "security" while confounding a traditional way of life. This would require seeing psychiatry as doing more than 'health care'. Nevertheless, the question of whether there is coercion in psychiatry, and whether psychiatry is at root a coercion, seems to be growing in the literature. Survivors and qualitative researchers have recently entered the arena (from New Zealand, O'Hagan, 2003), and some are quite aware of psychiatric racism against Maoris (Johnstone & Read, 2000).

Qualitative research attempts to name and describe the practices seen as coercive rather than to prove that they are coercive. Questions related to inducement, authority, and persuasion come into play (Wertheimer, 1993). Generally coercion is conceived as an alternative to force or violence. Diamond, in Dennis and Monahan (1996:51-72), says coercion is common practice in 'community treatment' of any kind, especially with the homeless, ranging from "friendly persuasion" to "interpersonal pressure" to "control of resources" to the "use of force". Monahan *et al* find that 'perceptions' of coercion decrease when concern and respect are used to perform psychiatric functions (1996:13-26). In the same edition, Hiday finds CTOs feel coercive when 'services' did not meet people's needs (pp. 29-47). Diamond says coercion is inevitable if workers reinforce dependency while simultaneously encouraging independence (pp. 51-72). Susser & Roche show that "tolerant" approaches are discussed openly in clinical practices but not coercion, which is described as "setting limits", a term that may conjure images of voluntary psychotherapy (pp. 73-84). "Deception", "enticement", and the "extraction of concession" are discussed by Lopez as uses of persuasion in coercive practices (pp. 85-92). Withholding crucial information, and threat of withdrawal of services, benefits and basic needs like housing are

discussed as coercion, which supports what participants discussed in this study. Professional sense of “moral rightness” to coerce, and consequently “angst and ambivalence”, were identified by Hopper as themes of study (pp. 197-219).

Dennis and Monahan (1996) provide a comprehensive account of coercion, but fail to establish the place of destructive medical practices in the scheme, perhaps because treatment is not conceived as having aims beyond ‘therapy’. Directly coerced or not, surreptitiously put into food or not (Ahern, 2005; Psychiatric Patient Advocate Office, 2005), drug treatment bears physical effects that may be seen as coercions if they serve a purpose to restrain or detain for long periods. The question of damaging brains is not only an issue of ‘treatment success’ or ethics. As we have already considered, neuroleptics can be addictive and were adopted because they caused dysfunctions that were held to be ‘therapeutic’ by psychiatrists. The study of coercion must include destructiveness of ‘treatment’ and duress under the ever-present possibility of detention if we are to understand people’s experiences in psychiatry.

### **Coercion and Acquiescence**

Participants in my focus group reported some of the same mechanics of coercion as revealed in the coercion literature. These augment and explain the ways in which treatment *abuse* occurs.

Tyler (housing worker): I had a problem with the fact that they [the local ACT Team] keep, uh, ‘coordinating’ their clients to the same places, so they’re kind of ghettoizing them, right? They’re setting up in one boarding home so it’s convenient for the ACT team to go out and visit them.

Kim (peer worker): Right.

Tyler: Whether it’s appropriate for that person to be in that home is less important than the accessibility for the workers.

June (legal worker): Goes back to making it easier for staff.

Tyler: Yeah. Definitely.

All participants reported a concern with convenience driving practical decisions and medical determinations regardless of an inmate’s needs. *Abuses* involved relocating ‘clients’ where they wished not to be, even land owners (who have no medical-legal authority) demanding that tenants be drugged before being given housing. Some have access to inmates’ medical files.

Tyler (housing worker): Cause you know, where I work they deal with for-profit housing, and landlords, they don’t have much of a political analysis about anything. They just want their rent money, right?

Kim (peer worker): And they ask if people are on their drugs, right?

Tyler: And they want compliance, and they almost always– I can't think of one case otherwise– they assume that compliance with medication means that the tenant will remain in good standing–

June (legal worker): Your organization outreaches to private landlords to house people with mental health issues?

Tyler: Um, we have contracts with private landlords, so we get a *per diem* [per day] subsidy for a tenant there, but the landlord is the owner operator, the person that accepts or rejects tenants.

June: We get tons of tenant problems mostly when people are going through a state of crisis. We've been fighting it by saying 'duty to accommodate'. So we've been using that kind of accessibility language, but they eventually get the tenants out, eventually....

Erick: So you're saying landlords look for compliance, and then maybe even encourage–

Kim: There's some landlords that won't accept tenants unless they're on drugs.

Tyler: Yeah, exactly.

June: It's a violation of their human rights.

Kim: But somehow there's that whole piece–

June: [separate conversation]–tied into the system– if they come through you [your housing organization] it's different cause they're identified already to the landlord cause they're a client of your organization.

Tyler: That's right. But the landlords have access to the client's information from files.

June: How? Oh, with you guys.

Tyler: With us. So they'll ask what kind of support they have.

June: What about personal privacy laws under the *Personal Health Information [Protection] Act*?

Tyler: They sign a consent form–

June: The client?

Tyler: Yeah.

June: Whoo–

Kim: Yeah, the whole housing piece is fucked up, royally.

Many instances of coercion, rights abuse, and service failure occur because the inmate does not challenge her psychiatric workers. Within the psychiatric system there is a tendency to attribute this passivity to the inmate's personality. The cycle of evidence suggests there is a psychological or medical reason the person has entered the psychiatric system yet also the reason they cannot move beyond it. This engenders further *abuse*. Tyler discussed some inmates' unquestioning acceptance of medical decisions.

Tyler (housing worker): I think they [people on CTOs] believe, sincerely, that their doctor is working in their best interests. And they might also believe that they have to do what that doctor says, whether on a Community Treatment Order or not. They wouldn't even conceive of the fact that maybe, in fact, 'I should get a second opinion', or [they] couldn't get a second opinion, right? They just assume that one doctor's as good as the next, and what they say is– their word is gold.

Yet, passivity may be based on 'systemic barriers' to self-assertion. I would attribute this problem not to a lack of rights, which surely exists, but to the framework of institutionalization, especially *chemical institutionalization*.

Over many years, anyone may accept or adapt to oppression. To a certain degree, we all accept some level of coercion in our lives. *Chemical institutionalization* is rationalized as conferring selfhood through treatment, with some risks and setbacks, making it a medical necessity rather than an unconstitutional detention. This argument suggests an ethical duty to impose a treatment that may 'work' according to some observers, or fail dramatically according to others.

Erick: You were also talking about their resistance to the notion that they are ill, their resistance to psychiatry and so on. Your motivation, in all of that of course, is to help them to reconnect with society and help them get better, right?

Danielle: Well [slight pause], how do I rationalize it for myself? I guess to me the goal of so-called treatment is to increase people's real true choices. It's paradoxical, I know. So I guess that's how I rationalize it for me, that they just have more true choices. So like that man I described; when he's treated he has more choices. He decides which college he goes to, he decides where he's going to live, he decides how much contact he's going to have with his father. When he's ill, he has no choice. He's constantly in hospital, his father talks for him because he can't speak for himself, and the police are all over him. Even though he won't agree with what I just said— he'll agree, but he won't make any connection to meds or CTOs. But, from my standpoint they have more true real choices. To me, that's the objective. I can give you another example of a CTO I abandoned. I don't know if that would help.

E: — I just want to continue this question because I'm trying to understand— you said, you know, these "so-called" treatments, and you've talked about the possibility that these treatments don't always work as well as they're intended to, but generally I think the idea is they confer more choice, more social choice in other words, more capacity for the person to enter society, and to deal with society, really. If he's going to school rather than just being spoken for in an institution, obviously he's going to be reconnecting with soci— like when you say true choice, is that what you mean?

D: That's what I mean, and if someone were to say to me, 'I'd rather be psychotic,' then I'd say, 'Fine, then that's your choice.' But when they're treated, the ones I'm talking about, they say they prefer the treated state even though they don't attribute it to treatment.

So while 'psychosis' may be appreciated, though hardly sponsored, by psychiatric workers who understand 'it' through psychiatric texts, 'treatment' and its risks are generally recommended (if not demanded). Drugging is understood to be successful precisely when an inmate relents and accepts 'the benefits of treatment'.

The hope of forced or coerced treatment is that the inmate may come to understand and appreciate its benefits, and 'enjoy a normal life' again. The psychiatric



experiment with her body and personhood (which is believed absent in 'madness' anyway), may help the inmate take control over difficult feelings almost immediately. Leaving aside the question of how often this happens (as often as placebo, say critics), why it happens, and whether it will last, let us assume that 'treatments' as destructive as electroshock do bring some people 'to their senses' and help them reject whatever experiences occurred while 'mad'. This does not solve the debate about *efficacy*; the question remains, will the treatments not cause problems over time, and should they be imposed on everyone without knowing what harm may come? The psychiatric answer to this question is usually, 'We must weigh the benefits and risks'. It would be good to know precisely what these are.

### The Right to be ‘Sound’ or ‘Mad’

One of the risks commonly used to champion forced or coerced treatment is the ‘mad’ person may lose her ability to function in society, and violent or not, she may cause harm to herself comparable to that of the ‘treatments’. Some forced treatment advocates even say this is inevitable (Torrey, 1987). Psychiatric survivors do not necessarily fault ‘consumers’ or people who fear such risks and accept treatments they may know to be destructive.

Carmen (peer worker): Because when he is taking medication he actually paints and draws and tries to— he’s learning animation programs on the computer and, so when he’s really engaged in his intense thinking process, like actual production is zero, which is fine because I’m sure he’s informing himself as to how he’s going to proceed creatively. That’s fine with me. But I’m saying for all intents and purposes, for the external observer who’s not around mad people all the time, it looks— so now you’ve got a guy who’s lost lots of weight, he’s dressed in rags in the middle of winter, he’s filthy dirty, he’s yelling all the time, he’s lost his apartment, so as far as things go on the...

Erick: I can see what you’re saying. Anyone who doesn’t know him that well—

C: Who feels like they should do something, do something, do something, cause it looks like he needs something done— but at the same time I appreciate what [this person is] saying as well, that these are the best moments of his life.

E: And he literally says that.

C: Yeah, except the unfortunate thing is he ends up in jail! [laughs] So can you have a best moment of your life in jail? Probably spiritually, and internally you can, right? I’m just not sure how to measure these things.

Psychiatric survivors have had difficulty defending what pharmaceutical lobbyists deride as ‘the *right* to mental illness’. Madness has few apologists. If society were more accepting, perhaps someone could be ‘mad’ without interference or risk. But can we properly say people have a right to be forcibly detained or treated? I asked Carmen how inmates decide to accept involuntary drugging.

Carmen: Well I don’t know that it’s any different than anything else that people have to reconcile themselves to. If I want to have a kid I have to give up my job, or whatever. Some people have really difficult decisions to have to make in their lives, right? If I want to keep this job, I have to hide the fact that I’m gay and deny my partner and whatever. Those are all very difficult trade offs that people make. And this [drugging] is for me a very difficult trade off, but I guess it’s like anybody who has to live with that. Some people can and some people can’t. The resentment, the anger, the rage, you know? Some people don’t have a problem with it at all. They’re willing to comply with medication and they’ll say, ‘if I go off my medication my father will put me in a hospital.’ They do it willingly.

Leaving aside for a moment the level of choice available to an inmate in contrast with a worker, Carmen suggests that sacrifices are made if a person feels life without drugging would be too painful. Yet it seems a person must choose to accede to drug treatment and the possibility of imposition of treatment if they wish to get by in society. In other words, one's *identity* is at odds with being safe in our society.

'Mad' identity does not always mean rejecting help. Certain feelings, 'mad' or not, 'sound' or not, are too overwhelming. We seek wise counsel, or the miracles of technology, but find instead the usual operations of power, force, and scarcity.

June (legal worker): Cause you can be incompetent and be forced to take services, but if you're competent enough to say you need services, you're booted out the door, right, even though you're exhibiting crisis. So I think in general how mental health laws apply really depends on who is applying the law.

As such, June reported that 'emotional trauma', 'acute psychosis', 'violent or suicidal desires' are simply not enough to obtain *services*. They may be too scarce, so who is getting them? June said that 'incapacity' tends to confer services, possibly because psychiatric workers see 'incapacity', however it is determined, as 'real need', real 'madness'. This suggests a paradox: a person must resist services, possibly as a result of someone trying to impose them, in order to obtain services. As such, the 'right to treatment' might be rephrased, 'the right to forcible treatment'.

In the following comments, Kim reported how imposed treatment is sustained using cyclical practices of power, so that once *chemical institutionalization* is engaged, the inmate needs someone who is not trapped in the system to account and advocate for her.

Kim (peer worker): [In advocacy] I generally say [to someone who is misinformed about their rights as an inmate], 'Oh, actually, you know that's not okay, you have rights.' I'll say the second time, 'That's— do you know that's a rights violation?' And then, they'll call me up, "Can you help me with something? I've been lowering my medication and I'm supposed to be taking 20 [milligrams]. I've been taking, um, 15. I have to go tell my doctor. I'm really afraid they're going to freak. I'm really afraid they're going to put me back in the hospital." This person just got out after 20 years [in a physical institution]. I go to the shrink appointment, and— this was like actually beautiful! This person said to me, "Okay I'm going to go to the doctor and I'll do the talking, and then I'll say everything, and then we'll see what happens, and then if you want to talk you can talk." I thought that was brilliant. I thought that was so strong that that person could do that? Say what they needed, and then we went—

Erick: Usually they don't suggest such things?

Kim: Not everybody's that... sometimes people are just confused and they don't know how to bring me in [as the advocate], but I just thought it was

brilliant that this person said, "I will do the talking," and then— I just thought that was what we want: for people to self-advocate in that way, for themselves.

And so I went, and they had [put] this person with some shrink, and the social worker was there too, [and the inmate was saying] that he had lowered his drugs to fifteen.... 'Kay, so he's lowered his serious drug from 20 to 15, saying "I just wanted to tell you, I-I-I I've done this." And they were like [screaming]! "WHAT!?" [group laughs] They totally were like, "Why didn't you tell us!? You need to tell us! You need to communicate with us [so] we'll communicate with you! Why didn't you tell us!" And I said, "—

June: "He IS communicating!" [all laugh]

Kim: "He actually is, in fact, communicating with you." And it becomes really overwhelming with the power dynamics of that scenario. This person actually had brought this up before, and they said "No. We'll talk about it later." And they had a whole bunch of reasons why they wanted to talk about it later, but he needed to do it now, cause it was like interfering with his thinking....

Through Kim's statement, we see a different view, the inmate's view, of the negotiation. It illustrates a common situation of rebuff and indifference that inmates face even when they ask for important things. A non-inmate, often a worker, is required as a sort of witness for the inmate, and guarantor for the workers, in order to ground any negotiation. Also, the advocate confers much needed moral support. Advocacy becomes quite complex in psychiatric arrangements. It takes immense courage to face a hopeless situation, which is what many inmates perceive their communications with the psychiatric system to be. I have not forgotten my fear at 'leaving' the psychiatrist, that last step off his concrete stare.

### **Cold Turkey, Cold Comfort**

Some never leave psychiatry. Not because they do not muster the courage; survivors are most courageous when they have situated themselves at last. Drugging and the cycling of chemistry is more difficult to overcome for many inmates than shedding medically determined identities. Increasing dose prescriptions and multiple drugging is common, as psychiatrists attempt to make up for a rising tolerance to neuroleptic toxicity or try changing drugs that are not working. I asked Danielle what chance inmates had of getting off drugs in general.

Erick: I suppose when they go off meds they go off cold turkey.

Danielle (psychiatrist): Yeah, absolutely.

E: Have you ever tried to take someone down off medication slowly?

D: Yeah, oh yeah.

E: Has that been successful?

D: You mean ongoing? Nothing successful; eventually symptoms will resume and then we'll have to get them back on. There's quite a few like that.

E: So even though they've been dropped slowly, symptoms will resume?

D: Yeah just because the nature of the people— you see we end up seeing people who've had many, many psychotic episodes. So by then it's very predictable; they'll get psychotic again. So we have quite a few, I mean we let them get quite ill, like we try really hard to preserve patient autonomy.

It must be quite distressing to inmates to find after several attempts and some maturation that they simply cannot let go of the 'treatment', unbeknownst to them because they are addicted to it. It may be especially frustrating if they have resolved themselves to staying grounded, to 'sanity', despite the lack of support and status they would need to do so. *Chemical institutionalization* works to prevent escapes, while attempting to provide 'symptom management'.

The invisible escapees in society like me, meanwhile, do not usually parade their 'recovery' without drugs. Jonathan Nash, portrayed in the movie *A Beautiful Mind*, did not take drugs (though the movie script was changed to make it appear that he always did). He eventually just became 'disillusioned with his illusions' (Richter, 2003).

Danielle (ACT psychiatrist): For me the big ethical dilemma is, the reason people don't take medication is, because the medications aren't particularly effective and do not appreciably change their quality of life in a way they can— I'm sure if medications were more effective I don't think CTOs would be a big issue.

Danielle considered the issue of rights and forcing or imposing drugs as bound by the best possible 'technological' solution to a complex social dilemma. In psychiatry, the restoration of an inmate's insight into her illness is the most important problem, demanding forcible treatment. Grave problems with drug *efficacy* cannot dislodge psychiatry from its pursuit of 'mental health'. For most psychiatric workers, 'mad' identity is but 'illness', a fool's gold.

Carmen (peer worker): I don't know if it's a reaction to going off the medication or what that is— and it's not my job to figure it out.... He had a job for 10 years and he quit and he just takes off into his own flight there that he says on the inside he doesn't feel bad at all. But on the outside he looks really distressed, [losing] his apartment, punching people in the head cause they piss him off or whatever, and he stops bathing or showering for months on end. His clothes turn literally into rags, like he wears exactly the same clothes all the time, right, and then winter comes and he's wearing the same clothes, no coat no gloves, you know, and arguing all the time, talking all the time, but it's not just like 'talking to himself' talking to himself. It seems like he's in distress because he's saying, "No, no, no!" and like trying to protect himself in the things that he's saying, right? And he loses tons of weight.

The most common response to this man's problem is to restore his insight by imposing drugs. We may never know if his drug is exactly what is causing his distress. *Chemical institutionalization* and a cycling of chemistry are supported by a lack of drug effect

research and a lack of discussion about these issues. The work of psychiatry is not to deal with tardive but with 'mental illness'.

### **Consumption and Survival**

One of the problems with reversing the trend further and further towards *chemical institutionalization* and medicalizing identity is that drugging people seems to work from the view of people not on the drugs. Even if the person is suffering somewhat, it is reasoned, at least they are not 'agitated' or 'deteriorating'.

Carmen: Well I don't think that they're angry that the medication didn't work. I think that they're angry because everyone presumes it does work.

E: While they're going through the throes of withdrawal, while their energy levels are being dropped, everybody else is saying—

C: This is a positive outcome. When they're medicated everybody else is saying this is working and thinks it's a positive outcome and I think that's where the angry part comes in because they're seeing the exact opposite.

Carmen has reported an issue that vexes those who would demand control over their bodies. What appears to others like improvement is to them a destruction of the body and mind. Yet even this *abuse* is tolerated by inmates if only to make peace with others.

Erick: So that's good. That means [the man who paints while on medication has] got a little bit more creative capacity, as well as a managed routine, whatever, that nobody will jump on him for, is that right?

Carmen: M-hm.... Well, I wouldn't say— like he would think that the best medication is no medication. But he also would tell you that he has to take enough to keep everybody off his back, essentially is what he's told me. And that's how he's framed it to me. Like, "I just have to take enough to keep everybody off my back, so I don't do any of the things that, you know, I get in trouble for." Which is, if you read the *Ottawa Citizen*, an article yesterday or today, where Scott Starson says the same thing.

E: Really?

C: Yeah, "I realize that if I want to do my [physics] work, I have to comply. I have to do what they say."

Even after Starson won in the Supreme Court, was told he could refuse drugging, there is no detoxification program he can use, no avail from his regenerative inmate *status*. He is not simply locked in a room or cell. Starson is a chemicalized inmate who must go back to Penetanguishene and forsake his identity, his creativity, his brain, his body and 'play the game' of the mental patient: hope for release from indefinite detention. I asked Martina (also Kim), who works in a psychiatric 'hospital' whether she knew people who were happy with their treatment.

Martina (peer worker, also Kim): I think that whole thing is a myth, the "happy consumer". The person that is unhappy with their life and goes into the psych system, that comes out and they feel happy and healthy, I think that's a myth. It's

one that different people participate in, on different levels. But people aren't happy. Even the happy consumer isn't happy; they go to things where there's critical discussion. They wouldn't go if they were so happy. Maybe some of them don't, maybe [they are just] sitting at home in front of their TV. We're talking about people who have made a decision to take drugs that have been suggested to them. They have a right to do that as long as they've had a full discussion about it. It's their body, they can do whatever they want.

E: You're saying they're not completely happy?

M: There's tons of people that complain all the time about their drugs.

E: Even though they'd never think to go off them?

M: I think some don't but a lot of people do. If they were supported or there was more availability of other choices, people totally would come off their drugs. People don't come off their drugs because they're afraid and it's a lot of work to challenge the structures that are in place. But I know that people are not happy with their drugs. I meet people every day who complain about their drugs. Some people accept drugs, but others don't, that's the piece not being discussed openly.

### **Consenting to Force**

The so-called right of 'informed consent' is another aspect of *chemical institutionalization* that must be interrogated. Consent comes to psychiatry from the general medical system where incapacity is often based on unconsciousness. Consent rules are being applied to the institutional context as though paternalistic detention powers in psychiatry are easily checked. There is a disconnection between what people live as 'madness' and the demands of medical capacity, but clinical capacity tests are not physical tests. This creates problems not only in the kinds of 'services' available to people, but the kinds of 'treatments' operationalized. To be truly informed before acceding to psychiatry one might need to consider the history of the institution as a form of detention, the history of eugenics as a means to 'cure', the history of paternal law deferring to medicine, the economics of drug manufacturing, the contested veracity of psychiatry's scientific claims, the sociological literature on psychiatric epidemiology. But most importantly, to be informed would mean to know all this before one becomes an inmate trapped in cyclical practices of power. Once involved in psychiatry, consent depends on a psychiatrist's capacity test, which rests on sanist presumptions about distress and experience, something 'mad' people would consider meaningless as much as their captors see 'mad' experience as meaningless.

Martina: It's hard because drugs have been used for altering states of mind forever. I'm becoming less and less anti-drug in general because if people want drugs for whatever reason, whether it's to reach more spiritual places or to curb the demons for a night or two, I understand reality is a hard thing to contend with all the time so people want to take drugs. I think the issue of the business of drug selling, buying, manufacturing, imposing, makes it more difficult. To find out who

wants what, when— self-medicating has been happening for a long time; if someone's got too much shit going on in their head and they want a break, I get that. It's just different if a salesman comes to your door and sells it to you like a vacuum or something. Then it would make me doubt myself, make me think there are things there that may not be there.... I think the jokesters and magicians have overtaken the natural witches and wise people. The balance is out.

Danielle gave her perspective regarding this issue in terms of technology, a technique of blocking neurotransmitter receptor sites. Unlike many of her colleagues, she is somewhat critical of imposing drugs that an inmate has tried but cannot abide.

Danielle (ACT psychiatrist): Everything we've offered him is not— I guess that's it: he's experienced all the options and that's what he's quote unquote "choosing", I mean you can argue whether he's competent or not, but when you've been to the limit of what medical technology has to offer you it becomes kind of moot. Like, this is the person that you're dealing with. You can't talk about some hypothetical person, another brain. This is the person you're dealing with; this is the limit of our technology.

Here is an interesting conceptualization of the inmate as a person. The chooser, though incapable by psychiatric standards, is still a chooser, albeit if she has tried them first. Critics would charge that even short-term exposure leaves the inmate open to reactions that could keep her involved with psychiatry for years to come. If an inmate is forcibly treated and develops or complains of problems that make her incapable to consent, is it an *abuse* to continue drugging her while she vocally refuses the drug? And after several months, is it ethical or mere concealment to keep the inmate on the drug so she will not experience the additional burden of withdrawal or tardive diseases?

I asked Danielle about CTO inmates who do not realize they are under a CTO.

Erick: In one case I had someone say, 'you know a lot of them don't even know they're on a CTO'. And I said what do you mean. And they said, 'well often they're not informed that they are'. And I said 'well how can that be, because they have to sign something,' you know, and they said 'well when they come to me, they often don't know what their legal status is.' Now I'm wondering whether that's because of their cognitive ability—

Danielle: Yeah—

E: Or what that might be, but—

D: That's very odd. The only thing I can think of is like a sub-population of people who are either developmentally handicapped and have a psychotic illness, or because of the seriousness of their illness they have a lot of cognitive deficits and they're just very, very immersed, very passive, very— the scenario I'm thinking of in my mind is that they're living with the family, and the family is agreeing to it and it doesn't really change much. But certainly all my clients know they're on a CTO and they never let me forget it!

E: [laughs] Wow, right.



D: The only person— the one I told you who's at very high risk, the person who is developmentally handicapped— he knows he's on a CTO. I mean I don't think he can explain to you what a CTO is. He just knows if he gets into trouble the police pick him up and bring him into hospital. He knows. No, they know. And the other thing that strikes me as odd is that they get rights advice, right? So that's why I'm saying it must be a population that's very cognitively impaired.

E: M-hm.

D: Plus their mind is overmedicated, or something, cause you know [then] they have no awareness.

The issue of consent is central to this thesis. I was drugged before I was seen by a sort of rights advisor (a social worker), at least one or two weeks later. Many people who are supposed to be given information with which to base a decision on treatment are instead 'treated', as though they do not understand or care for information. A distressed person is seen as a sort of biological mess. Perhaps a lack of *services* to choose from makes consultation redundant. Consider June's description of how CTO plans are constructed, which put into question the notion of consent.

Erick: So, you're saying then that until somebody is really a problem and gets pulled back in [to a facility by force] and gets put on a CTO, they're not finding the services that they might want?

June (legal worker): It usually involves 911, the police, or somebody in the community taking them in on a Form 2 [*Mental Health Act* Form to detain signed by a Justice of the Peace].

Erick: Okay. And you're also saying that usually psychiatrists and social workers, almost, not single handedly, but—

June: Draft the [CTO] agreement.

Erick: They draft the agreement.

June: Especially if somebody is in a hospital because they're considered to be delusional or whatever— they don't actually wait until they're competent enough to agree [before planning a CTO], right?

Erick: Okay.

June: Cause part of it might be they want to forcibly treat them, and they want to treat them cause they're named incapable to make a decision, but at the same time they're supposed to agree to a CTO?

June was asking if someone can conceivably give consent to a CTO. Leaving aside for a moment the issues of environmental duress and procedural bias against the inmate, might there be a problem observable in the legal construction of consent for a CTO? If the inmate is deemed incapable while incarcerated, someone else can decide whether she will be able to live in the community under a CTO. The psychiatrist can always go this route, and critics would argue the inmate's consent is therefore token, perhaps allowed as a deceptive exercise in 'trust' building, another *abuse*. However, if the institutional capacity to physically force drugs is what keeps her compliant, the inmate is

not actually capable to consent. Any artificial capacity conferred by a drug can fail due to environmental pressures over time, given the drug has no specific action (because there are no specific mechanisms of physical disease). Nevertheless, note how the CTO is being used as a proxy to 'hospital' force, an extension of force, in this hypothetical demonstration. Perhaps the CTO is more than a 'legalized coercion'. The CTO makes available the force used by the facility to ensure her compliance; to assume she is capable as a result is to mistake consumption of drugs with compliance, neuronal seizure with capacity, and compliance with 'insight' about one's condition.

I asked Danielle about consenting to a CTO and how this was possible.

Erick: ... the CTO legislation calls for them choosing to be on a CTO.

Danielle (psychiatrist): Yeah, well that's just a twist. You know, that's just to make it more palatable to the public. They talk about it being voluntary or something?

E: Right.

D: Yeah, well that's just nonsense. You know, the way they get around that is that you can put capable people on a CTO, and I've talked to a lot of clinicians about this, people who do that. I don't understand it. I see no need for it.

Danielle's statement reminds us that in real life, a capable inmate (capable but having involuntary *status*, as is possible in Ontario), can be 'persuaded' under custody to accept a CTO if she is not deemed incapable. As such, while a person is involuntary but supposedly capable, she may choose a CTO under what critics would call duress.

Danielle: If I have a capable person, what I do is I just engage— I mean it has absolutely no legal grounds whatsoever— but we just have a conversation and I ask them to engage in treatment for a year, you know, even if they don't like it, and we sign like a simple little contract, and that's it. And that's just to formalize it; they have a copy of what they've committed to, and it works a lot. I don't need to go through all this paperwork to do that.

I've asked many clinicians who use the voluntary CTOs to explain the function of it and the only argument I've seen is people who don't have an ongoing relationship with the person, like they've just met them as an in-patient and the person knows that when they get ill it gets really bad really quickly, I don't know, so, I guess, just to help them stay on their meds for 6 months they release them on a voluntary CTO.

Duress and coercion outside of facilities may occur through the management of information if the relationship bears an imbalance of power (Lopez, 1996).

Danielle: And even if they do [reject a CTO while capable], because you know there's all kinds of reasons— nobody likes taking their medication every day. If you have an ongoing relationship with the person you can kind of work around

that. You can, you know, have discussions about it, and they trust your judgement, and then you become a repository of their history, even though they'd like to kind of lose it, like you would remind them of what it was like when they reduced the dose previously. Like, it becomes, in the context of a relationship, much easier to manage.

Danielle was suggesting persuasion (within a coercive context) makes it unnecessary to impose a legal agreement to work with a psychiatrist. Can inmates be persuaded to give up basic *constitutional* rights?

Danielle: The other thing about a voluntary CTO is it's impossible to renew it after six months.

Erick: Why is that?

D: Because the criteria to renew it is that you have to be certifiable at the time of renewal.... If your symptoms are under control then you're not certifiable under what's called "Box A" criteria, where you're a danger to self or others, or imminent risk of immanent physical impairment or mental deterioration. But there's a "Box B" to the Form 1 where, for chronically incapable patients, as soon as they stop their medication, their Substitute Decision Maker can agree to have them brought to hospital because there's been a repeated cycle of them going off their meds and being hospitalized.

In that case, an involuntary CTO becomes available to the psychiatrist. These (Box B) rules closely resemble the logic I considered in consenting to CTOs above. The drug is said to artificially prop up the inmate's capacity. While this is hypothetically possible, we might ask what drives the inmate to discontinue her drugging? If her 'illness' is under control, she should never go off the drugs. Or, if environmental factors contribute to her forgetting her dose for a day, we should expect the amount still in her body should get her through for a day (or weeks). What is causing the discontinuation? Perhaps stress leads her to get careless about her compliance. Now we may ask again if this was a decision she made due to life itself, rather than 'stress'. Is the supposed cause of any decision *identity* or illness?

### **Insight and Capacity in Perception and Literature**

Erick: I'm just wondering if in your experience with "in-patients" you've seen that lack of the understanding of rights, the understanding of where they're at, 'agency'-wise.

Kim (peer worker): It's epidemic and it's not only... just generally people in the hospital, even people connected to the community are overmedicated, and so that affects people's physical ability to do stuff and navigate [the 'system']. Even when, beyond that, you have people who are quite strong and serious about wanting information, or wanting something, there's something not right. It's an overwhelming learned helplessness, and feeling like they cannot— they don't know how to problem-solve? Like, there's somebody that came into the office on Thursday or Wednesday, and we had a whole conversation, cause this is someone who lives in the community and is ticked off cause they have to come

to the hospital every day, and yet has psychiatrists saying, "Why do you have to do that? You're voluntary. You don't have to come to your shrink appointments." [But he tells me], "But I have my programs." And I'm like, "What are your programs? Do you want to go to your programs? Like creative crafts and recreation, whatever?" And he's like, "No, not really, cause I have them where I live as well." [laughs] And they had no sense that they could actually say, "No, just no." They don't have to come to the hospital at all.

An aspect of *chemical institutionalization* is the prevalence of passivity and a hope that pleasing authorities will obtain release, which can be attributed to learned behaviours. Because 'psychotics' in psychiatric facilities are drugged, however, this helplessness or lack of will may be one of the many negative effects neuroleptics are known to induce. A person may be understandably less willing to trust herself in dealing with decisions if she is unable remember problems or articulate concerns. No matter how much is known about drugging and its effects, the oft-repeated idea that inmates are cognitively affected by 'mental illness' such as a 'negative symptoms' of 'schizophrenia' instead of observable drug effects belies a problem with consent. The ability to understand and appreciate choices (that may seem restricted under CTOs) is of course connected to the capacity to consent.

Danielle: So yeah, coming back to voluntary CTOs, they can only last 6 months anyway. I would never do a voluntary CTO. I don't understand the purpose of it other than to make it look less coercive than it is. The true application is when people are chronically incapable with a Substitute Decision Maker, otherwise you wouldn't need a CTO.

Erick: I think I understand what you mean, because by then the person's become capable and they normally wouldn't if capable go off their medication?

D: That's right.

...

Victor (ACT peer): The only thing is that most clients who are on CTOs have poor insight into their illness. They might either have some insight, like 'I have schizophrenia' but might say it's caused by something else, or we have some that don't even admit they have schizophrenia. 'I don't have schizophrenia.' I've said to them, 'I have mental illness; I take medication.' They'll say to me, 'Well you might have mental illness but I don't.' So I find because most of our clients have schizophrenia, the ones on CTOs, their insight's not that great. But that's not the reason to be on a CTO necessarily, on its own, but the reason most of them are on CTOs is because they wouldn't take their medication and would end up in the hospital.

However, the only way to suspend their *rights*, to incarcerate them without criminal charges, is to show that they are not aware their actions are disordered, driven by an illness. They must lack 'insight'.

Danielle (psychiatrist): ...some people like the two examples I gave you, they're still not capable when they're treated.

E: Oh I see, so the treatment doesn't– [...necessarily always work]

D: Well, do you know, what we call insight? They still don't have insight. What I mean is they never accept a psychiatric explanation of their experience, where they don't even remember or acknowledge the experience occurred, the experience being of psychosis. They see it as a spiritual happening, or they completely deny it happens at all, or– I don't know, they just don't buy psychiatry– which is fine with me. The problem is when they behave the way they do, they end up in the psychiatric syst–

Danielle has introduced us to a key aspect of consent and likewise the use of coercion and force. 'Insight' is a foundation of the consent test and helps in determining whether to incarcerate. It rests on the notion that a psychiatric explanation for an inmate's experience or *identity* is scientifically correct and philosophically superior. Scientific scales are being developed to test insight quantitatively (Beck et al, 2004). Philosophers have entered the debate on 'insight' by proposing a "Wittgensteinian approach" that involves interpersonal frameworks, yet embrace biological rather than sociological conclusions (Gillett, 1994). However, some researchers question whether the concept of insight is useful or meaningful in potentially alienating situations (McCabe & Quayle, 2002). Capacity as a medical-legal construction has been thoroughly deconstructed by Secker (2001).

### **The Management of Ontology**

*Identity* relates to one's ontological view, one's understanding of 'reality'. Philosophers like Mary Walsh (1997) explore the possibilities of an ontology that can be 'performed'. The 'mad' inmate is experiencing; madness may be achieved. Something quite unexpected but 'real' is occurring. Upon incarceration, she may refuse to speak of her reality as a psychiatric event. Words may not describe it. She may not be using the same rules to pattern her thinking as she uses to co-exist in sanist society. She only accepted these rules when she was a child. For her, the full body could be a voice. This is not 'madness', this is reality.

Danielle (psychiatrist): Well just that he feels awful, and he would never go to the psychiatric system unless he was desperate.

The psychiatrist seeks agreement using rules established in childhood, whether they be logic, diction, grammar, definitions, forward causality, any ontological assumption or operation that 'madness' might suspend. Thus, the disagreement between psychiatrist and inmate is not about 'perception' but 'reality'. Perhaps it is the intensity with which the inmate professes her reality that others construe as a threat or

challenge (to their 'real' reality). In educated circles, in a postmodern cultural scene, this sort of contest is seen as trivial, outmoded. In 'total institutions', rules of relation are at play engendering cyclical practices of power which inform *abuse*, so 'reality' is contented bitterly.

Danielle: He would rather die than be on a CTO. He's a rugged individual, He does not want to be controlled. He wants to do everything on his own terms.

The sanist's 'real' world is a medical-scientific world in which all phenomena can be understood (pending research), regardless of whatever 'postmodern worldviews' exist 'in' that world. Individuals clinging to a personal construction of their experience, which they might call their 'sanity' or 'reality', are thrust into a contest of wills, a rather serious political or socio-political struggle, as Laing once suggested (1961). This is to them a *constitutional* right. They may be willing to stake whatever 'rational' people stake on their 'worldview': credibility, assets, friendships, life. Conscience demands risk, something 'sound' people take for granted in agreement with others occupying common sanist ground.

To the psychiatrist, this is all confabulation. The will to 'be' impedes 'treatment'. The inmate is said to lack psychiatric 'insight', the proverbial path back to reality.

Danielle: I mean it's not that the patient— a patient like that would rather go to jail than end up in a psychiatric hospital. I have no problem with that (well, I do have a problem with that) but in this society, you're going to end up in front of a psychiatrist. That's what's going to happen. It's just the way it works. So, you know, either you play ball with me or [short pause]. Most people can, actually. It's kind of 'agree to disagree'.

In any psychiatric relation, inmates will be advised, even by other inmates and survivors, to 'play the game', 'agree to disagree', and appear to accept psychiatric determinations over their sense of identity. The rules of the 'game' are simple. The door is locked; consultation is conjectural. This coercion into 'treatment' may seem to the inmate a violation of civil and human *rights*. *Consent* comes with *insight*, which is supposed to come with *compliance*, which is ensured with *coercion*. Thus, 'realities' are managed.

Victor: I find lots in mental health that the[ir] focus for clients is compliance. 'Did this person take their medication?' 'Yes,' and they check it off then move to the next client. That shouldn't be the focus of our clients. Their focus should be on: how are they doing? What things do they want to do? I'm not saying we only focus on compliance, but sometimes it gets to that point where people just want to know if they're [simply] doing okay. I think a lot of mental health teams tend to focus a lot on crisis, and they like to stabilize people.

Victor suggests the interpersonal should be primary in helping individuals that sanists call 'mad'. Survivors help each other back away from chemical institutionalization, whereas psychiatric workers often hope to bring a person 'back to reality' through coercive methods. Victor's analysis suggests that ACT Teams and psychiatric professionals value their medical expertise over their interpersonal knowledge; they are trained as clinicians. Even if a psychiatric worker is not medically trained or oriented, they defer to medical-legal rules at all times and the interpersonal issues, especially power issues, become secondary no matter how important. The training of professionals is technical, making them available to supervision and accountability measures, improving service *efficacy*. Accounting for their work is a management of production, risks, 'crisis', which becomes a management of 'illness'. As identity is involved in 'illness', the 'person' is also managed.

Victor (ACT peer worker): It's almost as if you're trying to force... you're forcing insight on, into them. You know you can't force someone to have insight into their illness.

Victor's statement suggests imposing reality does not make the inmate truly 'sound', truly 'capable', under psychiatric rules. If insight could be gained by drugging, either we would have the proof of it in large studies, or we should stay force until we found such a drug. Such an ideal drug, which could conceivably redesign *identity*, or reconstruct rather than simply disable will, would have far greater implications. To speak of psychiatry as a 'control' as critics do is to give it more credit than it presently deserves, though Szasz (2004) is no doubt speaking of a more crude kind of control. To imagine perfectly managed brain functions for the aim of coordinating attitudes and behaviours in the quest for 'mental health' seems absurd to me. Such 'mind control technologies' would not likely be sold over the counter, if they could ever be possible, but administered by aircraft or satellite.

### **Violence as Illness, a Futile Resistance in Psychiatry**

In the previous section, I suggested ‘mad’ people may insist they have a constitutional right to a way of being which is not structured on sanist rules. Upon psychiatric involvement, which is organized by extralocal rules of relation (Smith, 1990a), an inmate may resist coercion or force, often applied using cycling practices of power that ramp up the division and conflict between her and her ‘caregivers’. This may conceivably lead to violence or an aggressive stand in life generally. Many of the following examples of violence come from records of the psychiatric tribunal, the Consent and Capacity Board. They bear the unmistakable flare that psychiatric workers develop in the cycling of evidence about inmates’ ‘behaviours’ and identities.

From within psychiatry we might ask, ‘Does lack of insight increase the risk of violence?’ Victor described stalking, threats, and minor physical force as possible when someone is confused. He also felt, however, that much of it is perceptual:

Victor: (peer worker): ...someone else’s interpretation, and you wonder what it could be. I’ve heard of cases where someone is being forced to take medication cause they took their finger and made a sign of pointing a gun at someone, you know? Like that’s like giving someone the finger, you know?

This is a common complaint from survivors, that an angry person who is incarcerated and becomes confused may understandably threaten a well-meaning professional with the power to further coerce them. ‘Care’ represents a threat. The conflict cycles up unnecessarily, but it is not attributed to coercion but rather biology. During my time as an advocate at Queen Street Mental Health Centre, reports of people ending up in ‘forensic’ psychiatry units for such things as slapping a doctor were common. The ‘forensic’ psychiatric system, commonly conceived as locking away the ‘criminally insane’, is more profoundly hidden away in society than the ‘civil’ psychiatric institution. Its inmates are imprisoned indefinitely, often for minor offenses like theft (R. Pritchard, personal communication, November 10, 2005). While violence should not be tolerated, psychiatric workers should consider how care, punishment, and reprisal are interwoven in contexts of control. These environments make otherwise rational workers take up imbalanced power practices, however ‘soundly’ rationalized, as the very medium of their work.

Before the passage of ‘Brian’s Law’, some hoped that the criteria for imposition of a Community Treatment Order would be restricted to ‘violent’ individuals, even if this designation is questionable. However, in the three Canadian jurisdictions using CTOs,



that has not been the case. Orders can be applied to anyone who is at risk of harm or 'mental deterioration' under the *Mental Health Act*.

I searched online for the most salient example of violence or negligent acts by CTO inmates in decision statements published by the Consent and Capacity Board.

R.J.A. is a 43 year old, single man, who resides in supervised housing when not in hospital. R.J.A. has had multiple contacts with the mental health system since the 1970's and has faced numerous criminal charges and convictions since the 1970's as well, many of which involve assault, forcible confinement and harm to others. He has had an ongoing relationship with CAMH-Queen [facility] since 2003. His criminal record is considered, to a large degree, to be a result of his mental disorder. R.J.A. suffers from chronic unremitting schizophrenia. (R.J.A.)

The Board leaves much to interpretation. This decision statement neglects to provide any indication of the seriousness of R.J.A.'s assaults. As Dorothy Smith contends (1990b), psychiatric files mystify the events that lead to determinations and descriptions about an inmate. The linkage between R.J.A.'s violent temperament and the psychiatric determinations in this report are dithered. This CTO was predictably upheld.

A female CTO inmate was said to be a danger to herself, but again, obfuscation in the psychiatric report prevents an examination of other explanations, such as the impact of drugs in her life. The following record also exhibits a curt solemnity that contrasts starkly with R.G.J.K.L.'s self-explanations, giving her identity a farcical air. Note the level of detail given to her self-descriptions. The text fails to account for the reactions of others to her evocative declarations. Did anyone laugh, smile, agree patronizingly, or beg for clarification?

Ms. R.G.J.K.L. was 46 years old. In introducing herself at the hearing, she said that she was the son of God, both male and female. When asked where she was born, she said the Kingdom of God. She also told the panel that she was a social worker on leave of absence, and a lawyer, namely Johnny Cochrane, working on her Bar. She said that she was very bright at school and had won Nobel prizes all over the world. For many years, Ms. R.G.J.K.L. had been receiving ODSP benefits. She lived alone in a subsidized apartment. (R.G.J.K.L.)

Using the gaze of psychiatric solemnity, the Board dismisses R.G.J.K.L.'s candor outright and the cold facts of her solitude are left to the end of this narrative for effect. This is a common sanist rhetorical device: 'get a load of this, but look, how sad, in the end'. This construction swats at R.G.J.K.L.'s imperious intent, creative meanings, performed ideas, and multiple subjectivities. Any of these might inform us in regard to R.G.J.K.L.'s understanding of her needs and interests, but the Board is driving for a medical conclusion. "Ms. R.G.J.K.L. was using charcoal and lighter fluid to light a fire

inside her oven, both for cooking and to heat the apartment” (R.G.J.K.L.). We are led to assume her oven was operational though I have known individuals in poverty without such amenities. As we know little of R.G.J.K.L.’s life, we cannot offer competing explanations for the Board’s next sentence, “She explained that the Bible instructed her to do this, and insisted that it worked very well and caused no problem whatsoever.” (R.G.J.K.L.). The glib humour that emphasizes the last clause defies a search for contextual issues other than ‘illness’, and any personal beliefs are rejected off hand. Explanations for this action could include poverty and its related anxieties, resigned desperation, or overwhelming confusion; all of these explanations depend upon empathy.

Self-defense is also seen as impossible when you have been labeled ‘deluded’, and the problem of danger to inmates as a result of their perceived social status is ignored as an explanation for their behaviour. In this example, beliefs are assiduously described in a banal stare of the case file genre, again pretending evidentiary import.

He believed that he designed all the computers in Canada. He also believed that he owned numerous vegetable gardens. He thought that his family owned the apartment building in which he resides. He believed that strangers from New York *banged on his door to harass him. He indicated that he would cut these people with his knife.* He also thought that the police who apprehended him were not real police in the domestic police force, but rather those from England. He felt they came to get him because they had heard that he was doing very well. He thought that he fathered children all over the world. Finally, he believed there was nothing wrong with him, and that he should be able to go home. (my italics, S.H.M.)

Spliced into the psychiatric evidence are clues, which I have italicized, regarding a possible reason for S.H.M.’s actions. These seem immaterial as the Board cycles through the usual litany of ‘unsound’ beliefs, with a predictable tendency to appeal to the imagination in describing violence or threat. This narrative drowns the possibility of a survivor’s fear and discrimination against survivors. It pursues the demonstration of S.H.M.’s ‘madness’ in support of a psychiatric determination of ‘mental illness’. The rules and rationale for psychiatric intervention must be defended rhetorically, with beliefs as legal evidence, however well each case is weighed under using the scale of ‘illness’.

Violence by the psychiatrized, though estimated to be rare over decades of research (Monahan & Hood, 1978; Steadman *et al*, 1998), is used to excuse oppression of survivors in social and medical-legal contexts. This final trump explains the *raison d’être* of psychiatry and incarceration, and allows for a social abandonment of the institutionalized to a system that not only uses and abuses, but also sometimes inflames

inmates' violence, as in the well-publicized case of Herbert Cheung. As governments begin to accept the possibility that drugs have a role in teen violent rampages and suicides, the issue of how many crimes are in fact precipitated by treatments makes the prevention of psychiatric 'dangerousness' a matter of expedience. A person's beliefs and experiences, far from being respected as personal or cultural matters, are amplified and blamed for any danger. Even professionals, such as those on the Board, who know that the psychiatrized are more likely victims of crime or abuse tend to equate their identities and subjectivities with violence. This may simply be a process of conceiving them as biologically disordered (Read & Haslam, 2004). As a whole, psychiatric professionals do not publicly defend their 'clients' when the media or government lashes out at them, equating 'mental illness' with 'dangerousness'.

### **More Painful Injections**

Psychiatric tribunals have been known to decide in favour of a psychiatrist in more than 90% of cases (Chambers, 2003). An inmate may challenge their involuntary status, and a doctor will show, by use of psychiatric case files, that the requirements for her 'committal' were met in "clear, cogent and compelling" ways. This phrase is utilized often at the Consent and Capacity Board to authorize psychiatrists' decisions. The following is representative of such evidence: "At the time V.S. was described as exhibiting extremely paranoid ideas. He believed his various medications were poisoned. He had been spending all his time in bed, but could not sleep." (V.S.). The Board is not of the opinion that V.S.'s drugs are toxic. Nor do they believe that V.S.'s electroshock 'treatments' could be a contributing factor in his problems: "In hospital, V.S. received 12 ECT treatments, his mood became brighter and he improved." (V.S.). Again, improvement is declared without mention of brain injury, which is known to result in 'aphasia' (or euphoria as occurs with serious head injury). Though VS rejected drugging, "Dr. Illivitsky believed that V.S. has shown no resistance to his anti-psychotic medication because he felt obligated to comply with the CTO. Injections are given to V.S. by a nurse in his residence." (V.S.). In other words, there is no question about V.S.'s rejection of drugging, let alone his privacy under a treatment order.

The Board does admit CTOs weigh heavily on a person's rights, but evidently the need for medical attention is paramount:

A CTO is a significant infringement on a person's liberty, autonomy, and right to self-determination. Although it does not restrict freedom of movement in the same way or to the same extent as involuntary detention, it nonetheless imposes substantial restrictions on a person's inherent right to live as he or she chooses,

e.g., by requiring attendance at medical appointments and/or the taking of medication. For that reason, the *Mental Health Act* contains a number of important procedural and substantive safeguards, such as the requirement that a person for whom a CTO is being prepared receive advice and information about his or her legal rights. (*D.B.*)

As I have suggested, these safeguards are not easily conferred in coercive arrangements, especially not through chemical incarceration. The Board hears challenges to psychiatric determinations, but of the 24 CTO decisions I found published online, the CTO was revoked in six cases, and four of these revocations were based on minor technical problems.

Table 3: Published Consent and Capacity Board Decisions revoking a Community Treatment Order in Ontario with Date and Reason.

| <b>CTO Revoked</b>    | <b>Date</b> | <b>Reason</b>                             |
|-----------------------|-------------|---|
| <i>W.</i> , Ottawa    | 2005 06     | Missing signature                         |
| <i>Q.S.</i> , Ottawa  | 2005 03     | <i>2 incarcerations but 7 years apart</i> |
| <i>E.B.</i> , Ottawa  | 2004 12     | CTO already cancelled                     |
| <i>R.R.</i> , Toronto | 2004 09     | <i>Accepted his illness, drugs</i>        |
| <i>L.F.</i> , Guelph  | 2003 10     | Missing signature                         |
| <i>D.B.</i> , Toronto | 2003 05     | Board not available on time               |

The most successful of these challenges was brought before the Board by *R.R.*, mentioned above, who was seen as capable to reject his order because he had accepted his diagnosis and was still accepting treatment. *R.R.*'s destroying a nursing station was deemed unrelated to his 'illness' by his psychiatrist, and *R.R.* was discharged. This may have influenced the Board's decision. However, the *R.R.* case shows the lengths to which a survivor has to demonstrate acceptance of psychiatric explanations for his behaviour in order to control his fate.

*R.R.* worked and dutifully took drugs for seven years when he started experiencing serious negative bodily effects. His psychiatrist's attempt to administer another drug resulted in further complications like 'akathisia' (restlessness, nervous tremors). He became violent and was incarcerated five times in the next five years. Only when he 'assaulted' a nurse (there is no clear record of what happened) was he put on a CTO. He accepted the conditions of his order so he could avoid the police, he stated. However, because *R.R.*'s treatment consisted of repeated intramuscular injections that made it painful for him to walk (though this was barely mentioned in the Board's decision), he hoped to reduce and ultimately stop the drugging. The Board again adopted psychiatric explanations in understanding the problems *R.R.* faced. The

possibility of complications from drugs leading to R.R.'s behaviour, though medically possible, was overlooked. Despite all this, R.R. 'presented' the appropriate attitude.

R.R. did not have to give us direct evidence concerning his belief that he was capable. However, he did and the panel accepted that evidence as clear, cogent and compelling. R.R.'s ability to recognize that he suffered mental illness and that medication had helped him was important and relevant to making a treatment decision. We were also satisfied that R.R. was able at the Hearing to appreciate the reasonably foreseeable consequences of making or not making a treatment decision. As a result, R.R. has the right to take risks and to be wrong in his decisions (*R.R.*).

In this rare decision, the Board favoured R.R.'s autonomy rights by dismissing a psychiatrist's belief that R.R. had no 'insight' because he could not describe his diagnosis to the psychiatrist's satisfaction. Also, R.R.'s maverick belief that he could slowly discontinue medications and get better "on his own" was accepted, defying psychiatric sense. Definitive reasons are not given. It is not unimportant that, R.R.'s lawyer, Anita Szegeti, was involved in the *Starson* case. R.R. also received extensive help from Sound Times, a local survivor-run support service with an empowerment orientation (*R.R.*). This case is however extremely rare. The resources necessary to support R.R. in gaining control over his 'treatment' and life are not available to the large majority of inmates.

### **Supporting Self-Empowerment versus Rehabilitating Selfhood**

There are reasons not to force compliance in the absence of 'insight' or 'consent'. The process of establishing a social function or 'presentation' (Goffman, 1961) after or even during 'mad' transformations requires various supports. Often, material support is needed. A wealthy person who behaves irresponsibly may find the world still attends to her needs. Those without resources may find the experience results in a social brutalization, in homelessness and undeserved force. Someone who needs escape may need support, but not necessarily from 'services' wielding psychological or psychiatric knowledge. Psychiatry fashions a response to 'mental illness', but not to poverty, brain damage, or institutional abuse. The moral support catalyzed by 'recovery'-oriented workers, survivors, and others with a clear understanding of social and phenomenological issues faced by inmates is ignored or glossed over by the psychiatric industry. Yet inmates who are seen as 'psychotic' can still manage.

Erick: So even though [this inmate who was allowed to go off his drugs and taken off a CTO] has these delusions, he's able to function?

Victor (ACT peer): He's able to maintain his housing and we check in with them [his housing workers] to see how he's doing. If they have any concern they can reach us.

As Victor suggested, survivors are beginning to realize that the fictions of psychiatry, in which a 'medicated' inmate is restored to 'health', do not always hold. 'Recovery' may actually depend on a lack of psychiatric, especially drug, intervention such as the CTO bestows, at least if these interventions hinder consciousness. Many workers question the impracticality of only addressing human problems with medical management.

Tyler (housing worker): Well, just in how, we were saying that, it's all about compliance with taking medication. So where does that leave, you know, discovery, or trying things differently, you know?

•••

Danielle (psychiatrist): they can't stand the mental straitjacket. They just can't take it anymore. And it becomes a whole issue of 'what is self?' Like what is your experience of your self? And if you have no sense of your emotions, what is that? I don't know.

The Community Treatment Order is an escalation of this impractical motive to manage distress by *chemical institutionalization*. Again, chemical management may hinder recovery.

Erick: A lot of people say that if they're on treatment, they'll be able to do more [voluntary] therapies. But what you're saying is that because they've had choice withdrawn or taken away, they don't feel as open to other things?

Victor: Oh yeah, it affects the relationship. I have clients that I work with and I have good relationships with them. I have goals and I'm trying to help them with things. I just find, in my opinion, with clients who are on a CTO that we don't generally work with them on these kinds of things. It's not a good relationship for us. It's hard. I think other clients that aren't on CTOs, and they're taking medication and they're living their lives, they have a lot more choice, whereas people who are on CTOs seem to be, you know, really— it really is stigmatizing, right? No matter what anyone says, it's stigmatizing for someone.

Psychosocial rehabilitation posits a need for an alliance between the therapist and her subject. The reform-oriented objective of 'recovery' goes further and seeks to support the inmate in self-empowerment, as called for in survivor manifests of the 1970s and embraced in very recent survivor research (Clay, 2004). Psychiatric workers have only now breached the widely accepted concept of 'incurability' in psychiatry, especially the most elusive psychiatric 'disease' of 'non-affective psychosis' called 'schizophrenia'. One can only wonder what survivors might achieve together. They have established housing, employment and significant relationships with and without government resources.

Victor: Well I think on a CTO it's hard to recover [laughter] if you know anything about recovery. It's all about having choices. It's all about hope on something other than medication. If you're working with someone who's being forced to take medication, they don't generally want to work with you. It's not really a good thing. We still try to do things with some clients, focus on other things. We continue to— I think our [ACT] team's quite good that way – we always offer help with things, or to talk about goals and other things. But I think it does affect how that person's going to recover.

Leaving aside how institutions adapt 'grassroots' or interpersonal responses to 'madness', one of the arguments against CTOs in 2000 was the notion that a 'continuum' of supports should be put in place instead of CTOs. To proponents who saw the CTO as a necessary compulsion for those who did not submit to psychiatry outside of detention centres, this seemed a false argument. Government could more easily demonstrate a response to increasing needs and demands with 'get tough' legislation.

Erick: What kinds of alternatives could [have been] possible without changing the legislation? I believe the CMHA was talking about a 'continuum of care'. What sorts of ideas would they have proposed?

Rudy (peer worker): Well I think they've argued for a long time for many years if not decades, and what the CMHA has talked about, was put a much greater emphasis on supporting people, getting them adequate housing, adequate income, setting up a foundation that allows a person to experience a community at a level that isn't survival, striving to meet basic needs. I mean that's certainly very important. I think the other piece of it is types of mental health community services. There needs to be much more opportunity and options. Are you familiar with the Gerstein Centre in Toronto?

Erick: Yes.

R: That's an example of a type of alternative approach where a person who's experiencing some emotional or mental distress can go [usually 'depression', not 'psychosis']. There's some limitations on that service, but it's an excellent service. Or there are peer support homes— I've done a lot of research into what's offered in the States, what's called peer support homes or safe houses, non-medically oriented where people with mental illness can go and be supported and work through the issues they experience outside the medical model with a lot of success and a lot lower costs. I think in this province, the services are so narrowly defined and provided. There's just such limited types of services. Basically you crash and your options are: the hospital. There isn't much else.

There is still a lot of resistance to notions of 'the sick leading the sick', or interpersonal rather than technological supports.

Danielle (psychiatrist): The only option is that personal choice and personal autonomy [might] trump [treatment].... Like it's for sure that they're going to get ill again and they're going to be hospitalized by police intervention. It's just a matter of when. Is it 3 months, 6 months, 9 months? No there is nothing but medication that would alter that, other than you know just changing your values a bit. And like for the guy who I abandoned [took off] the CTO, it doesn't bother me

particularly that he does things on his own terms and that he goes into hospital and he can't take it anymore, stays as long as he wants, and leaves, and starts all over again. It doesn't particularly bother me.

For Danielle, failing to impose technological treatment is a primary issue. The hypothetical outcome Danielle described here is underwritten by medical and coercive practices. The practice of attributing behaviour to errant biology rather than to drugging specifically informs how the 'rotating door' outcome occurs.

What may seem success to survivors, such as emotional buoyancy, or far less often 'madness' itself, is not greatly valued by the 'mentally fit'. Radical selfhood or mere survival of the self under somnolization is difficult while negotiating society's enlightenment expectations for a liberal, self-mastered 'client'. Yet survivors helping each other have slowly begun to show others the possibilities of self-recovery, and how to escape social erasure. This is still a risky endeavour in sanist society.

June (legal worker): I also teach people's rights, so when they're done a session with me, they know what the criteria for being confined is, and then they match their personal situation to that knowledge they now have acquired. So it does create a lot more fear. Maybe if I didn't do that– but that's something major right, if I didn't do that... I think that the consequences– and because I disseminate information that survivors have written and produced, I think it does impact other people, how they feel about the system.

Professionals also need information on navigating 'alternative services' as these are usually hidden in a network of dominant 'services' that support drugging.

Victor (ACT Team peer): I'd have to say, and I don't know if I'm tooting my own horn, but, since I've started working there it [the ACT team] seems to have changed quite a bit I think. We also have new staff too who share my viewpoint as well since I've started. We focus more on recovery and having links to groups in the community. When I first started there weren't a lot of links to places in the community. People didn't know what was available for our clients in the community.

The ultimate 'alternative' may simply be identifying *with* mad people, in solidarity.

Martina (peer worker): I'm saying that when people in power say they're on board with wanting to share power and be more equal, I think that's lip service. I think the actual work, the actual sweat, they don't want to do that. In fact, it's not just that it's sweaty. It's uncomfortable. You have to give something up. And you have to deal with messiness. It's dealing with messiness, the messiness of humanity, if you're not going to coerce somebody or lock them up for doing something or whatever. You're going to have to deal with somebody who doesn't completely fit into some socially created compartment of normalcy.

Erick: What does that look like?

M: That means, for example, they call thousands of times, and they say things that don't make sense. It gets annoying. It gets tiresome. It's not in pace



with— it's a different pace— the step of capitalism for sure, some nationalist creation of progress. That's why I think people who are 'different' are different.

Then there's a whole other dialogue about people who commit crime, and I think those two things have gotten merged together and it's really confusing to try to sort that out.

E: How have you dealt with that messiness?

M: It's not always comfortable for me either, I recognize that. That's where it partially comes from, recognizing that it's not always easy, it's not always comfortable, it takes up my time. It prevents me from doing maybe something else I would rather do. It prevents me from taking time to inflate my ego in ways that one can living in this culture. But, I think for me I try to balance out both. I need time to do my own thing and do things that are going to inflate my ego or perception of myself (i.e., go to school or engage with people who have very quick-witted kinds of discussions). But I also really value the messiness and I value where that goes. That's why I really get pissed off when people say to me, 'Wow you do really great work. It's so rewarding. You must feel really great.' And when they say that it takes away—

E: What do they mean by that?

M: They're calling me some Mother Theresa, right? They're saying that it's 'rewarding' in that I'm doing something that's going to better the capitalist society, which in fact I'm not necessarily on board with. But, I hold both worlds equally on par. One's a bit more chaotic and one's a bit more organized.

### **The mess...**

Martina's conception of an orderly, logocentric, egotistical, nationalist, capitalist progress rests in stark contrast with her sense of messiness. Messiness lies beneath a skin of propriety and power, on the streets of urban centres and psychiatric facilities, under the fastidious reach of progress. Treatment cannot control messiness. Messiness, like strangeness, is a resistance, a solidarity with no emblem.

Carmen (peer worker): There's are people that are moving around all the time. I'm not saying that they don't have relationships. They do. Very strong relationships. However, they don't come by that as easy as you stepping over to your next door neighbour for coffee.

Erick: They're strong relationships?

C: Friendships that go back years. Lots of times there's lots of reunions that take place at [our organization] because somebody was in the hospital for 6 months with somebody but then 15 years later they're at [our organization] and then that person walks through the door at [our organization] like, 'Hey I haven't seen this guy since we were in [the hospital] together!' I mean people manage to keep track of each other, but for a lot of people it's difficult. There's a lot of chaos.

E: What do they share?

C: They go over to each other's place for dinner. They do all of those things too, right? But it's just not as— their lives get disrupted more often. For middle class [people], they'll get divorced and that's a big disruption in their life, and everybody changes and they have to change their friends. But for people who are really marginalized, and I don't think this is necessarily true of just consumers and survivors, there's a lot of disruption, so it's very hard for them to have those long standing social wrangles. Some do, but my observation, and it's

only my observation, is that a lot of people don't because their friends are moving around all the time. Then they get pissed off and, you know, then they decide to go back home to Peterborough, or they decide Vancouver's better, or— there's a lot of travelling and coming and going.

E: You'd mentioned the disruptions, the travellings—

C: and moving, because they're always in crappy housing. So they're always ready to move to a better place.

E: Can you describe "crappy" housing.

C: Well like they're in a boarding house where they're sharing a room with one other person and maybe they don't like the person and people come and go, and they don't really have any say over what person they're sharing a room with. They're in an apartment—

E: What's it look like this room?

C: Well I've seen different ones. They're generally rooms, a little smaller than this one that we're in [10' x 10'], there's a couple beds in there, they have a cupboard to put their stuff in, some are better than others, some are terrible, some are clean.

The mess under coercion attempts to organize itself and stands to be co-opted.

Survivors have agonized over the problem of professionalization since the 1970s. The 'consumer/survivor' movement is in the process of attempting local, national and international forms of organized to support 'mad' people. Governments are slow to respond.

Rudy (peer worker): I sat on a [regional] Mental Health [Implementation] Task Force a couple years ago. It was going to look at reforming the whole mental health system [in Ontario]. The Conservatives initiated it. It sat, did nothing. Then the Liberals came in and looked at the priorities of it, the recommendations were strongly around consumer initiatives [but also housing and medical model services]. There was a number of recommendations identified. When the Liberals came in and implemented, all of a sudden these consumer initiatives just weren't the priority. They're not even on the table right now. It was all about crisis and crisis management, and medical... expanding what 'is', and the ACT teams.

E: Why wouldn't they? Consumer/survivor initiatives are one of the things that people elect to go to when they're in trouble [see Trainor *et al*, 1997]. Why wouldn't they pay much attention to that in budget talks?

R: There's no political power. I don't think the consumer movement— there is no movement first of all in my opinion.

Were it not for survivors, the elite determinations of coercion would be impervious to interrogation from mere 'patients', however allies may try to defend inmates beyond their reach. In the legislated review of CTOs mentioned earlier, a lead investigator drove round the province holding private interviews with CTO inmates and focus groups of survivors and consumers without transcriptions or consent documents. One participant described reactions to a CTO reviewer at one of the local consultation meetings.

(Peer worker): They [those attending] felt almost unanimously that it [the CTO] made them second class citizens, is what they told him.... One of their concerns was most people have had the experience of adverse effects to medications while they've been forcibly medicated within the institutions. They had a lot of concerns about that, what if you're on a medication and it doesn't work? And then we talked earlier in the conversation about what working looks like to the person outside and working looks like to the person who's taking it. So a lot of concerns about that. They couldn't— it's the conundrum that we're all stuck in: they wanted to know if this is a health issue, then why don't you scoop fat people up off the street and forcibly starve them, or take heroin addicts and force them into methadone, or if you've had 2 or 3 drunk driving convictions why aren't you forced medicated with Antabuse or one of the other— so you don't force any kind of health treatment on any other kind of health problem which can have just as disastrous effects. A drunk person behind the wheel of a car... On the other hand then if you're saying no, it's not just a health problem, then they felt it got into the political realm and so now you're talking about a form of social control.

E: So they were concerned then. These are people who are majorly threatened by poverty, they're in difficult straits, but they were concerned about his description of CTOs. They saw it as a further violation of their rights.

C: Yeah and they didn't know why he was trying to sell them on all the services that you'd get. I mean obviously they asked why can't you get those services anyway? Like why do I have to have my rights taken away to get housing?

Participants and survivors believe the CTO is a failed concept and experiment insofar as 'treatment' is concerned. It may fail as a chemical restraint, however problematic restraint may be, though the literature continues to suggest that control is achieved through CTOs (O'Brien & Farrell, 2005). A legislated review of CTOs is predicted to uphold the belief that CTOs are effective, necessary and humane.

### **Legislated Review of CTOs**

Rudy: I'll be curious to see Michael Bay's report. I don't expect to see anything dramatic come out of it.

Often in my research, I found a listlessness about the topic of CTOs, a kind of hangover from the legislative battles of 2000. The review of CTOs, which was called for in the legislation that introduced them, is perceived as a familiar operation of the relations of ruling. Such a perception is partly held because the Ministry of Health, which implements Brian's Law, is also reviewing it. Also, major researchers in the review once sat on the psychiatric tribunal, which also oversaw the implementation of Brian's Law. The legislated review of CTOs is predicted by opponents to 'improve' the CTO mechanism by making it less vulnerable to constitutional challenge. The review becomes one of the

practices of power in which survivors are silenced, and in which professionals are at pains to show treatment is not linked to force.

The CTO review was to be completed by 2003, but was started in 2004. The report has yet to be approved or released by the Ministry of Health. The review team appointed by the Ministry included clinicians who imposed CTOs in their practice. These psychiatric professionals soon resigned in a small tempest of controversy (Community Treatment Orders: Ontario Legislated Review, 2004). However, the Minister of Health supports former members of the Consent and Capacity Board conducting the review, one of whom resigned his position on the Board just as the review process began (The Right Honorable Mr. George Smitherman, personal communication, 2005).

The review process illustrates the present state of psychiatric law reform in Ontario. The people hired to investigate the supposed 'efficacy' of Brian's Law have also implemented it, in the same way that family members who elect CTOs on behalf of inmates implement the orders. Such fine arrangements led one CTO proponent to bay majestic in the *Canadian Journal of Psychiatry*, "Why Are Community Treatment Orders Controversial?" (O'Reilly, 2004). I agree. There is no apparent controversy. There is simply the matter of managing controversy.

## Summary and Conclusions

I have used interpretive inquiry to consider Ontario's adoption of the Community Treatment Order, a legal mechanism mandating psychiatric treatment for inmates exiting psychiatric facilities. The CTO is presented by authorities to be a preventative and less restrictive alternative to repeated detentions in psychiatric facilities for people who continually refuse to 'comply' with their prescribed 'treatment'. Authorities argue that inmates are protected by a 'rights advice' process, a legal right to 'consent' to a CTO 'treatment plan' and the right to challenge a CTO decision at a psychiatric tribunal. I have explained 'Substitute Decision Makers' making psychiatric 'treatment' decisions whenever a person is deemed 'incapable to consent' by a psychiatrist. I have provided some background information on the emergence of 'treatment order' legislation as it arose in the U.S. especially through the efforts of lobbyists who believe in the safety and efficacy of psychiatric drugs, and as a way to prevent violence and 'deterioration' while someone is deemed 'ill'. I have provided some information about the implementation of CTOs, especially through 'Assertive Community Treatment' teams, which are perceived by participants as expensive extensions of psychiatric institutional practice. I have also informed this exploration with a description of the sort of procedural forms used, and the determinations made in order to impose CTOs. I have provided some information on legal texts: the *Mullins* case in British Columbia, and the *Starson* case at the Supreme Court of Canada. The latter greatly informs how people are determined 'incapable to consent' to 'treatments', an issue that is central to this thesis. Further to these texts, I have used decisions of the Consent and Capacity Board (which is funded 'at arm's length' by the Ministry of Health), to illustrate how psychiatrists' determinations are authorized through the narratives presented in case file accounts. I have suggested this process of authentication permeated the Ministry's legislated review of CTOs, which is being led by lawyers who have been on the Board.

Inmates' narratives of self-perception being relatively rare, I used some of my own experiences to shed light on what happens when identity is not only ignored in ordinary practices of 'diagnosis, treatment and psychiatric education', but demolished by the use of detention, restraint and seclusion that precedes those activities. The *Mullins* case was used to show such practices of force are common, indiscriminate, and often bear no legal safeguards such as information about rights when they are needed.

Whereas personal experiences, labeled 'madness' in folk culture, and 'mental illness' in psychiatry, are avoided, shunned and dismissed, I have introduced psychiatric survivor writings and efforts to redress 'sanism', that is, chauvinism against inmates and so-called 'mad' people. I have argued that 'psychotic' processes (not 'states' as in a materialist psychological narratives) are in some cases *achieved* rather than only passively suffered or induced through conflict or torture. I suggest this helps to distinguish between 'mad' experience, which seems bizarre because of its abandonment of communicative rules, and emotional distress, aggression, or violence. Whatever economic and political reasons belie occurrences of distress, violence, and society's 'sanist' responses towards 'madness', such as dismissal, exploitation, and abuse, I was interested in how society constructed legal rules that result in the use of force and coercion in 'care' facilities and through psychiatric interventions.

I was interested in the CTO as my focus because it drew issues of force and detention apart from confinement in facilities. The CTO is an opportunity to clarify violation of privacy, the use of detention, brain damaging 'treatment', and the notion of 'consent' under paternalistic coercion. To begin this exploration, I identified ways in which inmates' lives are affected by psychiatric practices of power. I identified three ways in which a sort of 'feedback loop' occurs which increases the pitch of coercion using self-fulfilling cycles. Briefly, these include the use of decontextualized 'psychiatric evidence' regarding an inmate's presumed instability, the explanatory 'biological theory' for inmate 'behaviour' as fixed and 'chronic' in textbooks, and the loop of 'altered chemistry' in which 'treatments' physically precipitate diagnosable behaviours. This thesis identified numerous examples of these. These 'cycles' were very useful in deconstructing distortions that might otherwise bog exploration. They were also useful in separating issues specific to Community Treatment Orders, which participants explored in detail through several interviews and a focus group. I also investigated the psychiatric and academic literature on 'mandated treatment' beyond facilities, including work on 'coercion', especially by Dennis & Monahan (1996). This look at the literature would not have been complete without the sociological foundation of Erving Goffman, whose *Asylums* (1961) provided the inspiration for a sort of historical comparison of practices of mental institutionalization. The work of Dorothy Smith was instructive in elaborating the ways in which authorized knowledge and practices operationalize institutional relations. Of course the work of survivors like Janet Gotkin (with Paul Gotkin, 1975), Judi Chamberlain (1978) and Mary O'Hagan (1993) supported my understanding of power

practices in relation to the work I have done with the psychiatric survivor movement. This exploration would not have been complete without a critique of 'psychiatric medications', specifically the neuroleptics or major tranquilizers (new or old) once named 'chemical lobotomies' by psychiatrists. My personal experience of these was the most frightening aspect of my psychiatrization, and informed the basis of this work: that drugging begets distress and more drugging, which is what CTOs are touted to address. Though psychiatric drugs create iatrogenic diseases that mask damage to the nervous system and prevent some inmates from withdrawing, even some who become violent, I do not believe tardive diseases should be treated with the very drugs that cause tardive diseases.

This thesis owes much to the reports and insights of participants. They demystified CTOs for me, as I hope this thesis helps to do for those who have searched for information on the CTO since the passage of Brian's Law in 2000. Using their perceptions of CTO inmate experiences, I sought to make visible how the CTO is not necessarily less restrictive than detention and that the treatments it imposes can be considered a detention within their bodies. This is not only because the CTO brings institutional operations and determinations into the private sphere beyond facilities, making it easy for psychiatrists to 'leash' inmates far from drugging depots, and making families a legal part of the institutional structure, but also because it is a 'treatment' mode that is a legal chemical seizure of the brain and body. I have argued, using Whitaker's and Breggin's work especially, but also survivors' experiences, that neuroleptics act to retard motor control, incapacitate feeling and will, and ultimately sever one's capacity to conceptualize and communicate feelings and thoughts to others. This incapacitation, like imprisonment, restricts movement and association with others. I call this a chemical incarceration *within* the body, and suggest that long term uses of these drugs is a chemical institutionalization, especially as they cause toxicity and damage that can make it impossible to discontinue usage. This form of institutionalization is legally mandated outside facilities for the first time with the passage of CTO mechanisms. Such mechanisms are now in widespread use throughout the West, and their merits are evidently argued on the basis of whether they work to impose 'treatments' (or ensure 'treatment compliance') beyond sites of incarceration. I argue that CTOs cannot be said to be useful or successful if they work to somnolize inmates for a reduction in expensive hospital use, eradicate feelings or consciousness in order to prevent aggression, and ensure inmate compliance in order to recommend inmates for

housing and other basic needs. The CTO is not definable as less restrictive, but in fact clarifies how 'treatment' is itself restrictive, how it leads to broken wills and identities, making it possible for inmates and others to ignore abuses and exploitation.

Participants discussed the **abuses** they have witnessed under CTO rules, including: relocating 'inconvenient' inmates, managing costs, failing to provide 'rights advice' information, arbitrarily imposing CTOs on inmates with existing supports (especially so-called 'schizophrenics'), preemptively imposing CTOs rather than using them as a last resort, preventing refugees from fleeing Canada's 'mental health system', imposing CTOs more restrictively on women and other marginalized groups, and more. Participants offered ways in which CTOs seemed to lack **efficacy** in establishing: 'reduced symptoms', 'treatment compliance', continued 'service delivery' and 'integration', help for 'homeless' people, reduced use of police and other resources, 'positive outcomes' as seen by inmates— in fact virtually none of the CTO inmates known to my participants wanted to be on CTOs. One participant said, lest they be used indefinitely, CTOs merely *postponed* 'rehospitalization'. Two participants spoke of improved outcomes upon *ceasing* CTO use, which may inform the 'efficacy' researcher. I have argued here that CTOs should be seen as an involuntary **status** under the law, rather than as simply a 'treatment' with 'consent' rules attached to them.

Participants spoke of inmates unable to get 'off' CTOs, who objected to the CTO rather than its embedded treatment, or were stuck in parole-like reporting arrangements, and one who used it to avoid detention in a (non-psychiatric) maximum security correctional facility. These examples suggest there is an involuntary aspect to CTOs. I have argued CTOs should be considered an involuntary legal status. To argue this I hypothesized an 'incapable' inmate, arguably made 'capable' only by forced drugging in a facility, thus allowed to decide upon her own release. Yet only on a treatment order that ensured her continued compliance. This seemed to suggest she had no capacity except through an artificial 'perpetual motion machine' of capacity. She was neither capable in the first place because capacity was 'forced' in the facility, nor 'capable' off-site because only the CTO, arguably less restrictive, kept her capable. If she were truly 'capable' as understood in psychiatry, she would not need force or 'coercion' to decide on treatment.

Participants said **rights** were also abused, such as by the general lack of information about CTOs shared by inmates and workers. Participants reported that: many inmates were not aware they were under CTOs, there was little time to give proper



'rights advice', advocates didn't ask or know who was on CTOs making CTO inmates more difficult to help or inform, few CTO inmates were challenging orders at the tribunal, and inmates often could not control the method of delivery of drugs under CTOs. I have argued that CTOs violated **constitutional** rights insofar as they were imposed on people for defending their identities and interpretations of experience, and erasing their consciousness by chemical means, making it impossible for them to enjoy Canadian Charter rights. CTOs were found to expose people to cruel, addictive chemical 'treatments' which operated like a somatic incarceration, and could be imposed indefinitely.

This thesis configures such perceptions of CTOs into a view of the psychiatric operations of power as enabling a **chemical institutionalization**, which supercedes, strengthens and expands prior methodologies bound to physical institutions. Many of the ways in which chemicalization interfered with inmate **identity** and assisted in imposing psychiatric education and bodily incapacitation were explored through participants accounts which elucidated experiences of: iatrogenic diseases, toxic and withdrawal reactions, tardive diseases masked by drugs, addiction (to psychopharmaceuticals), stupor or decreased energy labelled 'improvement', inmate passivity and fearfulness produced by drugs and education, and inmate 'invisibility' before psychiatric workers. These 'side effects' of an institutional program based on biological explanations of behaviour as diseased and only manageable (not curable) by major tranquilizers, as the participant psychiatrist suggested, were perceived to fundamentally affect being, including 'mad' identity of course. Participants related institutionalization directly to inmate feelings of: rage, distrust, self-denial, lost esteem, dependence, despondency and immobility, lack of creativity, lack of feeling, lack of safety in society, lack of agency, and self-'splitting' (into healthy and ill selves). Beneath the institutionalized self there were signs of: strident independence, inquisitiveness, creativity, realism, reason, empathy, spirituality, sexuality, zest and esprit, and of course any aspects of subjectivity known to 'sound' individuals. These perceptions were compared to the perceptions in Goffman's *Asylums* (1961), in which I argued that many of the same techniques and methods used to alter a person's self in total physical institutions was operant in chemical institutionalization, including: detention, demobilization, social segregation, physical abuse, monitoring, disculturation, disorientation, disfigurement, indignities, insult, making inmates beg for needs, profaned and performed selfhoods, closeting,

cycles of evidence, and privilege systems. The last of these seemed the conceptual origin of the CTO mechanism.

With incarceration and drugging comes a suppression of self. With CTOs comes a new method of ordering the self. Institutionalization brings a psychological pressure to identify with the oppressor. This dynamic is well described in literature on interpersonal or political conflict as a form of abuse, with terms such as: 'hazing', 'capture-bonding', 'Stockholm syndrome', 'double bind' and 'brainwashing'. This process can seldom occur without restricting a person's movement or association with others. That can be achieved by any physical process, including chemicalization. The process of institutionalization can therefore be achieved through 'treatment' alone, if it can be enforced, coerced, monitored, enhanced, or asserted. Forced drugging, legalized off site by CTOs, can be argued to do what asylums have done for decades: restrict movement and free association.

There is not enough medical or empirical evidence to suggest 'madness' is illness, nor that drugging is 'therapeutic'. The fact that some people do accept psychiatric drugs to prevent 'madness', or what is associated with it, violence and strangeness, cannot be used as an argument for coercing drugs on anyone else. Many people who have voluntarily accepted psychiatric drugs do not consider forced drugging when they defend drugs, and seldom suspect consent occurs under duress. They are often seen as spokespersons for others who accept and even master their strange experiences (without drugs). Strange experiences need not be defined and defended. There are also many ways other than drugging to fit into or keep up with sanist society. When a person does not feel brain damage as a result of drugging, or electroshock, that does not mean the person's brain is not damaged, or that others should be forced to accept these procedures to avert social conflict or despair. This damage may ironically account for improved relations between that person and others. But when drugging is imposed, we follow a subtractive, destructive theory of social 'health', in which one person's consciousness, identity, or some of their brain, must be sacrificed to help her achieve what is seen by others as a proper sense of self in social relations.

Even if 'illness' were philosophically and medically tied to behaviour and mood, even if there were a link between 'madness' and violence, why should the law provide for a system of incarceration in which rights are only granted arbitrarily? Goffman said we are forever stuck with institutionalization, but we might consider that society does not impose imprisonment, parole, restraints, or even treatments on people who act

irrationally because of an underlying or accompanying physical illness. While any use of imprisonment is disputable, imprisonment in facilities for crimes in which someone is unable to rationally explain intent is preferable to drug imprisonment of consciousness and self for some psychiatric survivors. (Several survivors I know who spent time in correctional facilities have said psychiatric detention was worse). I would suggest the latter is a more 'total' institutionalization, to which Goffman alluded, because identity is modified physically through drugs. As such, if imprisonment is imposed as a 'treatment', there can be no consent. And forgetting for a moment the psychiatrist's power, or weak legal protections, why should people be detained for their thoughts alone?

Survivors in the past have imagined the possibility of a society in which radical experiences could be freed of deterministic labels and impositions. While it has been argued that survivors are less defended than other marginalized groups and subjectivities for various reasons, I propose that we have much in common with them, with 'sane' people, surely 'madness' itself.

A boy would only listen to his 'inner' voices, never to others who counselled him in survival amongst outer voices and bodies. They reasoned with him that he would either do this until he died, or was killed, or killed himself, or he would be imprisoned for some crime. He responded that an outer death was fine in the company of his voices. They were most alarmed and imprisoned him. They believed an inner death was fine in respite of his voices. Under their power, he doubted himself. He reasoned that he would be here, in what they called his golden cage, until he died, was killed, or killed himself.

Nothing was really different. He would be someone else, split from his voices, like the outer voices and bodies who counseled him in survival, who ignored their inner voices.

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