

Spotlight on Institutional Psychiatry

A one-time newsletter

Artwork by Ronda E. Richardson

**Citizens Respond to
a Report by the Community Legal Assistance Society
on Psychiatric Incarceration in British Columbia**

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Spotlight on Institutional Psychiatry is a one-time newsletter: a community response (direct and indirect) to *Operating in Darkness: BC's Mental Health Act Detention System*, a report issued by British Columbia's Community Legal Assistance Society (CLAS) in November 2017. To read the press release and report, please see http://www.clasbc.net/operating_in_darkness_bcsmentalhealthactdetentionsystem.

Who we are:

We are a small, loose-knit group of people who have been affected by psychiatry and feel strongly that CLAS's superb report should be distributed far and wide.

Irit Shimrat edited *Phoenix Rising: The Voice of the Psychiatrized* and, later, *The Networker* (newsletter of the West Coast Mental Health Network); co-founded and coordinated the Ontario Psychiatric Survivors' Alliance; and has spoken out against psychiatry at conferences and in various media. Her book *Call Me Crazy: Stories from the Mad Movement* was published in Vancouver in 1997.

Rob Wipond is an award-winning investigative journalist who has reported extensively on the mental health system. His writing has been published in popular magazines like *Focus* and *Adbusters* and in scientific journals and books, including *The BMJ* (*British Medical Journal*),

Radical Psychology, and *Mad Matters: A Critical Reader in Mad Studies*. Some of his work can be seen at www.robwipond.com.

Susan Davies is a writer and former philosophy teacher who thinks and cares deeply about the devastating effects of psychiatric "treatment" on the human body, mind and soul.

Nick Scardillo has for decades been a passionate, compassionate and dedicated antipsychiatry activist. His acting skills have been known to provide much-needed comic relief to fellow combatants in the war against psychiatric abuse.

Ron Carten is a Peer Navigator with the Canadian Mental Health Association. He has previously coordinated, and done other work with, the West Coast Mental Health Network, and has worked as a service provider in the social-housing and community-development sectors. His book *The AIMS Test, Mad Pride & Other Essays* was published in Vancouver in 2006.

Diana Girsdanskyy is a community activist who, though not herself a psychiatric survivor, has brought new life to our movement by inviting various speakers and workshop-leaders to Vancouver, both to demonstrate viable alternatives to psychiatry and to discuss the clash between "mental health care" and human rights.

Steven Epperson has been Parish Minister of the Unitarian Church of Vancouver since 2002. A beloved member of his family was seriously harmed by BC's mental health system.

Stuart Matthews is a freelance artist, photographer and designer. He designed *The Networker* (newsletter of the West Coast Mental Health Network) from 2009 to 2016.

Ronda E. Richardson is a Canadian artist and writer who seeks to bring awareness to the stories of those who, like herself, have been made invisible by psychiatric diagnosis and trauma. She is also a Hearing Voices Network facilitator. You can see her work at rondarichardson.net.

Who we are *not*:

No one involved with this publication has any association with the Citizens Commission on Human Rights (CCHR) or with any other group affiliated with the Church of Scientology.

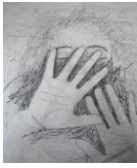
If psychiatry can't help us, what can?

- * The passage of time
- * Friends, family and/or support groups
- * Anyone who can listen to us calmly and compassionately when we are in extreme states
- * Music, art, dance, swimming, cycling, breathing techniques, yoga, tai chi, Feldenkrais, etc.
- * Medical marijuana, reflexology, acupressure, etc.
- * Good nutrition, decent housing and meaningful work (with no requirement of submitting to "mental health care" as a condition for being fed, housed or employed)
- * Political activism: Fighting for our rights, as long as we're not doing it alone

Note: The West Coast Mental Health Network, which is run entirely by psychiatric survivors, continues to exist despite the elimination of all funding by the Vancouver Coastal Health Authority (VCHA) in December 2013. Notably, VCHA has also cut paltry amounts of money previously allocated to other survivor-controlled initiatives, while adding millions to its budget for "tertiary care"; i.e., long-term psychiatric incarceration accompanied by (often forced) treatment. Please note that Canada has ratified the United Nations Convention on the Rights of Persons with Disabilities (CRPD) – a document that specifies and upholds the human rights of, among others, "persons with real or perceived psychosocial disabilities" (psychiatric survivors). VCHA is governed by BC's Ministry of Health – which, under the CRPD, is obliged to "closely consult with and actively involve persons with disabilities." That "active involvement" should include funding for independent organizations of disabled people, including those disabled by psychiatry. Thus, VCHA's funding cuts amount to discrimination based on disability. Perhaps the newly created Ministry of Mental Health and Addictions will require the restitution of funding to our province's user-run "mental health" organizations. We certainly hope that human-rights, justice, and health officials will be paying attention.

Comments or requests to join our e-mail list can be sent to: spotlightonpsychiatry@gmail.com

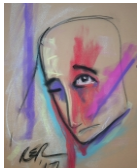
Contents



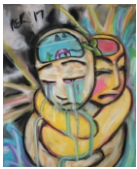
5 Introduction, by Rob Wipond



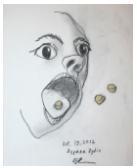
7 Darkness, Indeed, by Irit Shimrat



9 Good and Just Medicine, by Susan Davies



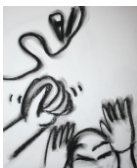
12 Psych Rights, by Ron Carten



13 Institutions and Treatments, by Nick Scardillo



15 Control Is Not Support, by Diana Girsdansky



17 A Meeting Gets Hijacked, by Steven Epperson



20 Quotable Quotes from the CLAS Report

Special thanks to Ronda E. Richardson for supplying all the artwork for this newsletter

Why is CLAS's report on institutional abuses being ignored?

Introduction

By Rob Wipond

It's been months since Vancouver's Community Legal Assistance Society (CLAS) released what is without doubt the most comprehensive and important investigative report on British Columbia's system for detaining people in psychiatric hospitals that has appeared in twenty years: *Operating in Darkness: BC's Mental Health Act Detention System*. What is significant about this ever-lengthening time lag is that it enables us to take stock of all of the mental-health-related organizations in BC – and indeed across Canada – that have not issued any statements about it, talked to the media, or so much as linked to the report from their own websites. Why haven't they?

To begin to answer that, it's necessary to understand what's in the CLAS report. Profoundly disturbing and damning, the report paints the picture of an unregulated, unaccountable and often abusive mental health system. Based on interviews with lawyers and pro-bono legal advocates who regularly represent people detained on BC psychiatric wards, the report details how citizens can be held with little justification, denied access to a lawyer, put in solitary confinement, physically restrained – and forcibly treated – essentially indefinitely. Meanwhile, virtually any aspect of their lives,

from their access to clothing to their right to have visitors, can be controlled in the interests of their “mental health.” Legal appeals occur before secretive tribunals (Review Panels), governed by no clear guidelines. And the frequency of psychiatric detentions and “extended leave” orders (whereby people can be forcibly treated in their own homes) has been rising dramatically – a general trend towards increased forced treatment that's mirrored nationally.

Operating in Darkness did get a smattering of news coverage across the country – most of it basically summarizing the key points from the accompanying press release – but within days public discussion largely evaporated. Yet there is still much to discuss. What do these legal and procedural problems mean in on-the-ground, human terms? How and why do people typically get certified? What is it really like to go through the experiences of incarceration and forced treatment in a Canadian psychiatric hospital? What does it feel like to be locked up and drugged, with no right of access to legal representation? What actually goes on during the secretive mental-health tribunal appeal processes in which people try to argue that they are sane enough to go free? Does any of this truly help the recipients of mental health care, or does it create many of the very problems it's supposed to eliminate – like fear of mental health treatments? If our laws need to change, how should they be changed? And finally and most importantly, why is virtually every major mental health organization in British Columbia and across Canada noticeably backing away from this unique opportunity to

generate more public discussion about these important issues? After all, most ordinary members of the public would understandably assume that mental health organizations must care deeply about these issues.

Unfortunately, this severe lack of public discussion pointedly demonstrates how most major mental health organizations in Canada do not actually care about or support the civil rights of psychiatric patients. And this is not news to anyone who has followed these issues closely over the years. Even as they claim to be trying to reduce “stigma,” most mental health organizations are run by mental health professionals and others who have long campaigned, behind the scenes, to support a regime of uncontested psychiatric power and control. This regime (often unquestioned by trusting members of the public who’ve never personally encountered this system up close) makes it easy to subject virtually anyone unfortunate enough to get labelled with a “mental disorder” to incarceration and forced treatment. And this is always paternalistically done “for their own good,” no matter how many times they may tell us our “help” is not helping them. In that sense, *Operating in Darkness* exposes a very dark and dangerous side to the dominant public message currently coming from many mental health organizations: that distressed children, teens, workers, seniors – in fact, anyone who is troubled – should always “seek help” at the nearest psychiatric hospital.

And all of this explains why the document that you’re reading now is so vital. If mental health organizations are not going to speak



up in support of the rights of psychiatric patients, who will? The answer is, everyone else. Everyone who has been through the experience. Everyone who has watched someone they care about pushed through the experience. Everyone who cares about basic human rights. And hopefully, this will help stir the much-needed broader public discussion about what forced psychiatric treatment is really like – and why we need much more robust civil-rights protections in our mental health system.

Involuntary psychiatric patients are prisoners

Darkness, Indeed

By Irit Shimrat

Every day, I see and talk with friends and strangers whose lives have been devastated by psychiatry. One friend no longer has the time or ability to reply to my emails because she is in a desperate struggle to have her Extended Leave order revoked. (“Extended Leave” is BC’s euphemism for outpatient committal, a form of psychiatric parole.) Under that order, she is required to take her “meds” every day in front of “Assertive Community Treatment” personnel. These “meds” leave her so debilitated that, last time we spoke on the phone, she said, “I’m phoning you now because in half an hour I will no longer have the use of my limbs.” Another friend, his intestines compromised by similar drugs (which he is legally obliged to take at the pharmacy every morning, observed by the pharmacist and by everyone else in the store), is only able to move his bowels about once a week, no matter how many laxatives he takes. As a result he lives with constant, excruciating pain. Another friend had to have most of her intestines removed for the same reason. Others have lost their careers, their homes, their children, their memories, their very will to live.

And when I say that I see strangers damaged by “mental health care,” I mean



that I recognize the signs of tardive dyskinesia (TD). When you see someone on the street moving stiffly, shuffling from foot to foot, constantly “chewing,” or with their tongue darting in and out of their mouth, or suffering from extreme twitches, tics and muscle spasms, that person probably has TD. This painful and debilitating neurological syndrome is commonly caused by the neuroleptics – literally, “nerve-seizing” – drugs that psychiatry inaccurately calls “antipsychotic medications.”

Neuroleptics can cause blood-vessel hemorrhage, osteoporosis, diabetes, organ damage, seizures, obesity, and many neurological disorders. Furthermore, decreased life expectancy is a known effect of long-term use of these and other psychiatric drugs.

And, speaking of other psychiatric drugs, what about the so-called antidepressants? Besides causing many physical problems, including heart attacks and strokes, these drugs are now well known to cause suicidal and homicidal impulses. Furthermore, an ever-increasing number of young people become “manic” due to antidepressant use, and are then diagnosed with “bipolar disorder” (or, depending on race, gender, class, etc., “schizophrenia”) and become lifelong mental patients.

Virtually all psychiatric drugs can cause cognitive and memory problems, anxiety, panic and “paranoia.” Then there is the horror of “withdrawal psychosis” – a surge of unusual thoughts, emotions and behaviour triggered by coming off the drugs too rapidly – which psychiatrists then blame on the underlying “disease” and use as a pretext for increased drugging.

CLAS’s *Operating in Darkness* report presented me with something I’ve never seen before: lawyers publicly admitting, en masse, that they are helpless to assist incarcerated psychiatric patients, and describing in detail the rights violations to which we are routinely subjected. The report does not demand the repeal of all mental health legislation as discriminatory. Yet its language illustrates the facts that “involuntary psychiatric patients” are prisoners – it consistently refers to us as detainees – and that how we are treated during psychiatric detention is an outrage.

Obviously, we psychiatric survivors have always known this. Some of us, who have not been utterly destroyed by “treatment,” have

been speaking, writing and making art about this for decades. And of course, everything we do or say in this regard is immediately dismissed by professionals as symptomatic of our so-called mental illnesses. But now that non-diagnosed lawyers are talking about what’s wrong with institutional psychiatry, the topic finally has the potential to be understood by the non-psychiatrized public.

Sad as it is that we psychiatric survivors can only expect outsiders to believe our stories of abuse within the system when someone in a position of relative power is telling those stories for us, I am greatly heartened by CLAS’s publication of this report, and hope that “patients,” politicians, practitioners and others will read it and be moved to stop accepting the status quo.

You can read the entire report at: clasbc.net/operating_in_darkness_bc_s_mental_health_act_detention_system.

However, if you do not have enough patience, time, or internet access – or a strong enough stomach – to read the whole thing, you will find on the final pages of this newsletter a few telling quotations, chosen by my esteemed friend and colleague Richard Ingram and I.

First, though, I hope that you will be both touched and educated, as I have been, by the following articles, written as direct or indirect responses to *Operating in Darkness*.

Psychiatrists prescribe drugs with devastating effects on the body

Good and Just Medicine

By Susan Davies

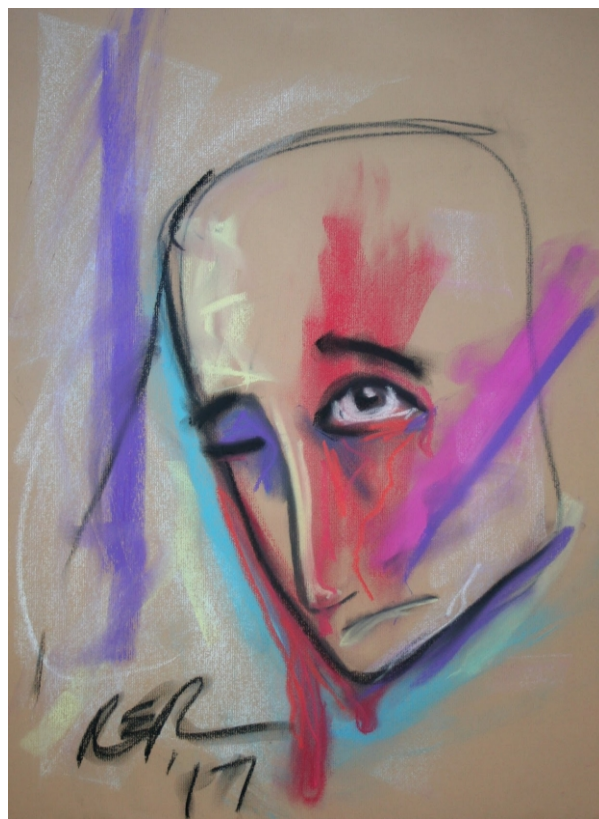
Are you taken in by big words? When you read one, written by someone in a position of authority – say, a medical doctor – do you assume that it denotes something not only credible, but also incredibly important? A downright scientific fact?

Don't rush to judgement.

Drapetomania is a diagnosis created to describe escaped slaves who had been recaptured. The name is derived from the Ancient Greek word *drapetos*, meaning “runaway slave.” *Mania* is Ancient Greek for madness. Today, “mania” can be defined as “an excessive enthusiasm or desire; an obsession.”

What was the standard treatment for slaves diagnosed with drapetomania? Severe whippings, to instill discipline; and amputation of the slave's big toes, to make running impossible. Obviously, it was the slaveholder – and not the suffering “patient” – who benefited. Today, the American Psychiatric Association (APA) boasts of its “treatments” for the supposed illnesses listed in its *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Ostensibly, this is all about promoting well-being and mental health. But is it, really?

“Schizophrenia” is a diagnosis that psychiatrists commonly give to people who



are socially and politically vulnerable, often due to poverty. In the US, this label is commonly bestowed upon African Americans. “Schizo” is derived from *skhizein* (Ancient Greek for “to split”); “phrenia” from *phrenos* (mind). In the service of the State, and at an exorbitant cost to taxpayers – and all at the expense of denying “patients” their basic human and constitutional rights – psychiatrists collect persons they deem as suffering from a “serious mental illness.” They do so with assistance from the courts and the police. Under the guise of medicine, this diagnosis actually serves to free society from being bothered by people who, while not dangerous, cause a nuisance with their “creative maladjustment” (to quote Martin Luther King).

Victims of psychiatry who are diagnosed as “schizophrenic” or “bipolar” are routinely prescribed “therapeutic dosages” of “antipsychotic medications.” They are forced to take these drugs after first being forcibly detained. And, because these human rights violations constitute standard medical protocol, victims cannot sue their perpetrators.

The term “antipsychotic medications” (used to describe substances that supposedly work to correct a condition of the soul) is a euphemism for neuroleptic (literally, “nerve-seizing”) drugs. These synthesized drugs are designed to block the flow of dopamine in the brain. Dopamine is a vital brain chemical. It is necessary for the executive functions of the frontal cortex. It is also what allows human beings to experience a sense of reward of any kind. Hence, dopamine is critical for the development of a sense of motivation, without which we cannot accomplish anything at all. Furthermore, dopamine is essential for the healthy functioning of the gastrointestinal system. (This is why “mental patients” who are forced to take dopamine-blockers chronically complain of debilitating constipation.)

But the greater, unanimous complaint is that the dopamine-blockers are lobotomizing. One cannot think. One does not feel like oneself. One can barely brush one’s teeth, take a shower, get dressed. Never mind being able to give consideration to a healthy diet, exercise, and finding meaningful work. And yet, the American Psychiatric Association – so dedicated to promoting the well-being and mental health, not just of America but of Canada and all the “civilized” world – increasingly promotes the use (by force, if necessary) of these drugs. Wherever there is Coca Cola or Pepsi, there is the APA, torturing

one lost soul after another under the guise of sound medical practice.

Why on earth would a psychiatrist prescribe a drug with devastating effects on the human body? The word “psychiatrist” is derived from *psyche* (soul) and *iatros* (healer). What special knowledge would a medical doctor have about caring for the soul? In order to learn how to effectively cope with and incorporate into my life the condition of my soul, I’d much rather consult with the peer professionals of the Hearing Voices Network than try to get help from a psychiatrist.

I propose that a new diagnosis be added to the *DSM*: Aphorismomania. *Aphorismos* means “definition.” And we’ve already covered “mania.” So, aphorismomania is “definition-madness.”

In its listing for aphorismomania, the *DSM* should include, at minimum, the following criterion: a medical doctor’s persistent and hazardous proclivity to join random nouns derived from Ancient Greek in order pass them off as medical terms, so as to “diagnose” hypothetical physiological abnormalities that do not exist, and for which there is no scientific evidence; in other words, non-evidence-based medicine.

Invariably, those suffering from this mental illness target people with socially and politically divergent experiences and behaviours (e.g., creativity) as victims, likely because they are sized up as easy prey, especially when poor.

Thus, those suffering from aphorismomania are inherently lazy and cowardly. Once they have “legally” captured and detained their victims, usually in solitary confinement, they inflict biological and psychological torture on them. They inject them with dopamine-blockers and inform them that they have no choice but to

comply. They suggest, as a means for “legal” recourse, a Review Panel, headed by a psychiatrist. At this panel, the treating psychiatrist will give key testimony regarding the “patient’s” fitness.

Psychiatrists justify their crimes against humanity as “necessary medical treatment” that will “prevent further deterioration of the brain.” This, despite the absolute lack of indication that there is any brain abnormality in the first place (as repeatedly admitted by the National Institute of Mental Health in the U.S.). When victims resist, it is documented in their medical records that “the patient” has no “insight” into her “illness.” These medical doctors are utterly oblivious to the irony of such statements.

Typically (my *DSM* entry might continue), aphorismomania sufferers display a schizotypal mindset, oblivious to their various conflicts of interest with pharmaceutical companies; oblivious to their gross violations of medical ethics as practised within medicine generally; oblivious to the gross harm and egregious neglect that they bestow upon their “patients”; uncaring about the betrayal of trust they daily commit against their victims, the victims’ families, and society at large.

It appears that this is often due to a predilection for making a lucrative income and sustaining the guild which permits it – the APA



– as well as the secure knowledge that they can continue to torture victims with impunity.

One recommended treatment is conviction for crimes against humanity, with a sentence of solitary confinement in a bare cell, with no human contact whatsoever, no medical care, and the minimal amount of food and water necessary to sustain life, in a maximum-security prison, for as many lifetimes as there were patients tortured under the perpetrator’s “care.”

What treatment might *you* prescribe?

There are so many barriers to fair and safe treatment

Psych Rights

By Ron Carten

The CLAS BC report *Operating in Darkness* is an instructive document. While it is legalistic and lengthy (over 170 pages), its qualitative research on topics such as psychiatric treatment, review panel procedures, the use of restraint and seclusion and other topics leads to solid recommendations in an easy-to-read format. A thorough read of the report is discouraging, because there are so many barriers to fair and safe treatment under current legislation. But if we are to improve mental health care in BC, we need to face up to the challenges outlined in this report.

One such challenge is that service providers must learn to work collaboratively with individuals living with real or perceived psychosocial disabilities. The report overview states: “Our mental health system now predominantly interacts with people with mental health problems in an adversarial way, by removing their rights to make decisions, rather than in a voluntary way that promotes autonomy and collaboration in the recovery process.”

It goes on to state: “Representatives reported many negative impacts of forced psychiatric treatment, including increased feelings of helplessness and fear, failure to involve individuals in an autonomous and collaborative recovery plan, adversarial relationships between individuals and mental health care professionals, and minimization and disregard of the expertise of individuals and their families and friends in reporting side effects and experiences with psychiatric treatment.” To me, the reluctance of

individuals to access our mental health system – to reach out – is another negative impact of forced psychiatric treatment.

The report, subtitled *BC’s Mental Health Act Detention System*, discusses the complex role of psychiatrists embedded within a system of health care and social control that requires of them more than just a working knowledge of mental illness: “[P]hysicians have not had sufficient legal training and view themselves only as health care providers, rather than administrative decision makers.” As a user of mental health services in this province, I sometimes wonder about this administrative aspect of the psychiatric profession.

My hope is that BC’s mental health system can be reformed, so that I can feel safe in accessing services. At present, I fear that trying to do so means risking the removal of the rights guaranteed to me under Canada’s Charter of Rights and Freedoms – because our provincial system does not uphold those rights. *Operating in Darkness* clearly defines those rights and describes how they can be better respected.

The report’s recommendations for measures of accountability and the production of scientific evidence illustrate why the title *Operating in Darkness* was chosen: “The Mental Health Review Board publishes no policies, guidelines, or decisions to guide review panel members in interpreting and applying the legal criteria in the *Mental Health Act*.” This lack of accessible documentation, among other failures of the current system, makes it difficult to study and improve the practice and administration of psychiatry.

Like many residents of BC, I would like to have support when I need it – support I can rely on. I am getting behind *Operating in Darkness* because I want my family, friends and fellow travellers to be treated with the same degree of respect enjoyed by all other Canadians when they seek medical care.

"Mental health care" is all about social control

Institutions and Treatments

By Nick Scardillo

Throughout the course of time, as a society, we have institutionalized mental patients and subjected them to various forms of mistreatment and abuse. Any reasonable, caring person would certainly agree that caging patients in an eight-by-ten-foot cell and subjecting them to the humiliations of psychological, verbal and physical abuse is not the answer. The million-dollar question is: Why, as a civilized society, do we fail to bring about desired changes?

Our elected officials do not realize how much room there is for improvement in "mental health care." It's all about maintaining social control: determining what kinds of behaviour are acceptable and what kinds are deemed abnormal, inappropriate, weird, strange, bizarre. But how is odd behaviour worse than bad behaviour? We do not track down, apprehend, lock up, and punish corrupt politicians who constantly implement arbitrary laws that only benefit the rich and, ultimately, stick it to the poor and other disadvantaged people. We never go after Wall Street brokers who have stolen working-class people's lives and deprived them of their life savings.

If this isn't two-tier justice, I don't know what is.

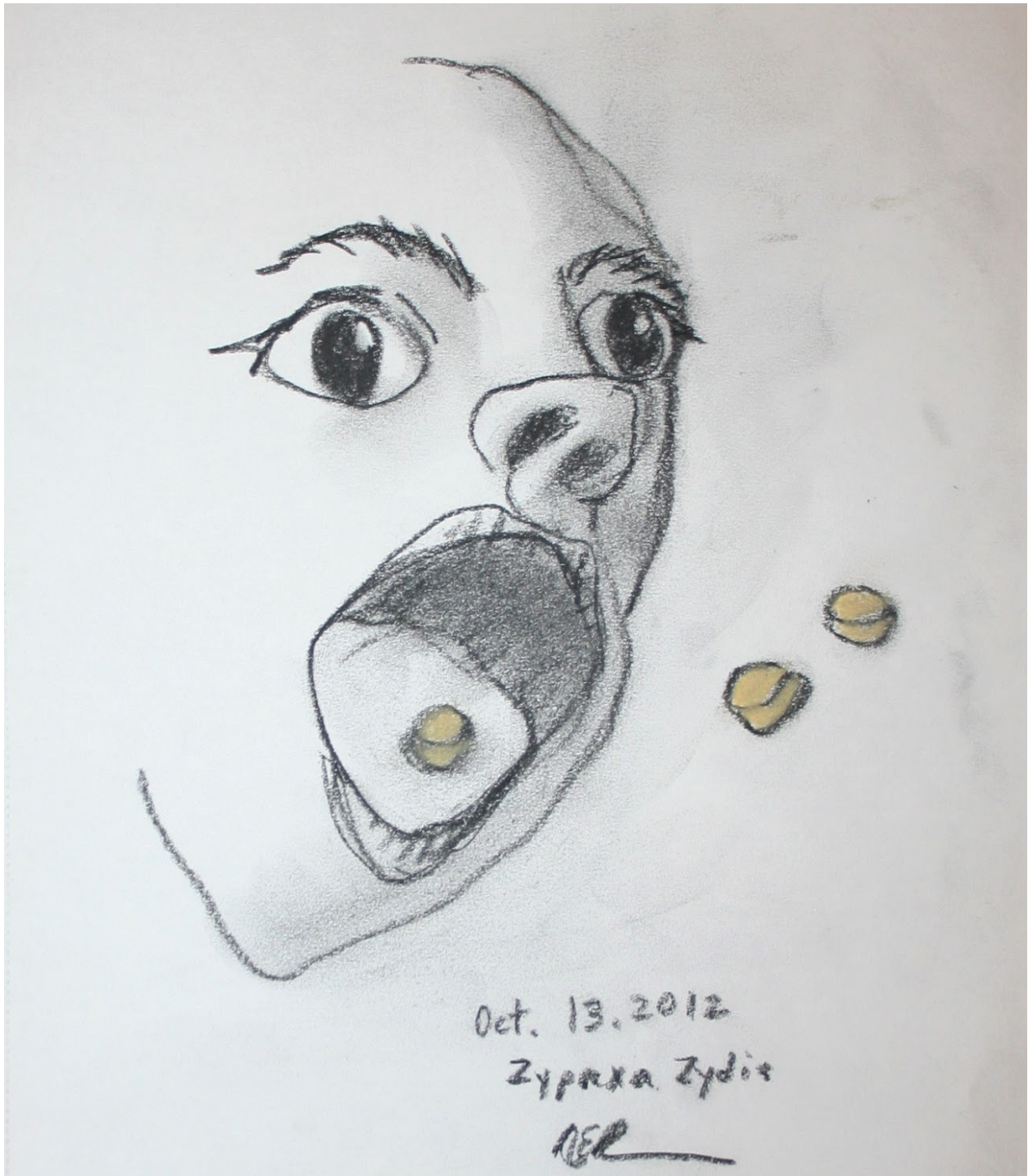
The history of asylums can be traced

back as far as fifth-century Jerusalem. Yet, even after all this time, "treatments" are regressive in nature. The people who administer and work on psychiatric wards do not treat patients with the respect, understanding and compassion that is due to us. French historian Michel Foucault condemned the use of institutionalized torture. Psychiatrist Franco Basaglia condemned his own profession for its abuses, citing torture and humiliation. Basaglia was very clear that such practices constitute cruel and unnecessary punishment.

Patients on psychiatric wards and in other "mental health" facilities are not rehabilitated. Rather, we are drugged into a stupor. Doctors, nurses and other staff basically just pump us with mind-altering, brain- and nerve-damaging drugs.

It is clear that the profession of psychiatry does not have its patients' best interests at heart. How can someone who has studied and trained as a medical doctor and sworn the Hippocratic Oath – to do no harm – end up doing the terrible kinds of damage that psychiatry inflicts on us? If the majority of society were better informed, they would find what goes on in the name of "mental health" absolutely untenable.

There are many alternatives to psychiatric wards and hospitals, such as safe houses for people in mental crisis or emotional distress. Just two examples are the Runaway House in Berlin (where people can go instead of, or to get away from, psychiatric facilities, and be cared for humanely) and Soteria Houses (safe houses where real, respectful, compassionate, drug-free help is offered), which have been



established in various parts of the world. In fact, Israel is now moving towards using Soteria Houses as a first-line treatment.

The cost of imprisoning people in psychiatric hospitals and wards is about a thousand dollars per day, per person.

I encourage and implore you to lobby your elected officials, in order to bring about progressive measures. As long as psychiatry continues to exist, its patients must be treated with the full measure of dignity and respect that we so clearly deserve.

The horror of being stripped, shackled, injected and isolated

Control Is Not Support

By Diana Girsdansky

I am a family member: a mother. In the mainstream media, and in pamphlets disseminated in all the waiting rooms of BC's "mental health" clinics, we repeatedly hear the passionate views of family members who are deeply concerned about the mental hygiene of their loved ones (especially their children). In their wish to protect their loved ones, many families gratefully accept the control psychiatry offers.

Unfortunately, this form of "protection" bypasses the legal standard of informed consent to which other branches of medicine are held. It often involves the use of forced and coercive medical treatment, backed up by police enforcement.

Throughout North America, the fear of persons labelled "mentally ill" is peddled by what some call the psychopharmaceutical complex, with the help of family lobby groups. Apparently, when one is in the business of fighting against the rights of individuals, it's all about family. The message that these groups repeat over and over again is that our "sick" offspring (don't call them crazy; that's stigmatizing), unless they are chemically incarcerated or physically restrained as needed, pose a threat to us, to the safety of others, and to themselves.

These fears are promoted with lots of money from those who manufacture and sell the chemicals; the government elected and pressured by the people selling the fear; and a booming industry that employs people to incarcerate, restrain, inject and electroshock people in extreme or unusual states.



In the CLAS report *Operating in Darkness: BC's Mental Health Act Detention System*, we learn that "while involuntary admissions have been steadily increasing over the last decade, the number of voluntary admissions has remained virtually unchanged."

The use of force has always been routine in psychiatric facilities. Yet forced "treatment" is by definition traumatic. It can flood the recipient with traumatic memories, not only of incidents of violence that may have caused the extreme state being "treated" in the first place, but also of previous forced psychiatric interventions. The horror of being "taken down," stripped, shackled, injected and isolated triggers the very chaos and loss of impulse control from which the person, or their family, is seeking relief.

Those who have been force-treated are everywhere. You surely know some of them. They are former students or teachers who have lost their

cognitive abilities; former musicians who no longer have fine motor control; former dancers who have put on disabling amounts of weight. “Patients” take up smoking, ingest copious amounts of caffeine – or even take street drugs – to alleviate the agitating or tranquillizing effects of the “medications” they are forced to take.

What I can’t understand is why all of the mothers – both the compliant moms wanting their kids locked up to ensure best behaviour and those who are more willing to take risks and help their kids to escape the system – can’t get together around the CLAS report. What mother wants her daughter to be stripped naked by male orderlies, which the report describes as a common procedure?!

How can a group like the BC Schizophrenia Society come out against this report? Is it possible that they simply don’t have the courage to read it? I wish they would. Then perhaps we could work together to raise our province to a level suited to the twenty-first century.

In *Operating in Darkness*, I read about the horrors that are standard practice in Vancouver General Hospital’s Psychiatric Assessment Unit. I know they are standard practice, because I have witnessed them myself, again and again, while visiting my incarcerated child and many other people, some of whom have become close friends.

It is terrible that I am so relieved to see these horrors detailed in the CLAS report – to see them finally described and substantiated by people who, because they are not personally involved, might actually be listened to.

When I’ve spoken of these practices in the past, people have thought I was exaggerating, or have not wanted to know. Or, worse, the procedures I describe are dismissed as necessary for “public safety.”

I know that this is not true.

There are many effective and compassionate responses to distress and to unusual or extreme states. The power we have handed over to the mental health industry, to psychiatry, to family members, to the police, to neighbours,

acquaintances and even passersby – power to incarcerate and forcibly “treat” individuals who are distressed, or whose behaviour distresses others – is a threat to our public safety and civil society.

Warning: If you are devastated by the death of a beloved mother, the miscarriage of a wanted pregnancy, the cancellation of your wedding by an adored fiancé – or, god forbid, all three of these events within a period of days – and take yourself to a BC hospital emergency department to get help, never refer to your existential misery by saying you feel like you want to die. If you arrive expecting a nice nurse to hold your hand through a dark night, you will be in for a surprise. If you “exhibit suicidal ideation” and refuse to take “antipsychotic medications” (neuroleptic drugs) in pill form, staff will likely strip you of your clothes and belongings, inject you with the drug, shackle you to a gurney and lock you into an isolation cell (and this is solitary confinement, even though they may call it a “quiet room” or “side room”).

If you have a job, you might miss work the next day (and for an indefinite number of days, depending on your compliance) without being able to warn your boss that you’re taking time off for sick leave. Why? Because, for your own benefit, you are now deemed diseased – “mentally ill” – and are receiving “treatment,” whether you want it or not, no matter how much it might debilitate you.

And if you bring a child who is in emotional trouble to the hospital for help, please know that this vulnerable young person, especially if they don’t want to be there, will likely be subjected to all the practices that I have described, and which are detailed in *Operating in Shadows* – practices that are seen by the industry as the gold standard of “first-line treatment.”

Far too many of us have learned through painful experience that to seek a medical solution for misery, whether our own misery or that of our loved ones, is a perilous endeavour.

Psychiatry's traumatic "treatments" can cause serious harm

A Meeting Gets Hijacked

By Steven Epperson

I am a member of the clergy, and minister to the Unitarian Church of Vancouver, a progressive religious congregation.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is a historic document that asserts and seeks to ensure the basic rights of disabled persons, including those with "real or perceived psychosocial disabilities." Signed and ratified by the Canadian government in 2010, the CRPD guarantees the right to be fully informed before consenting to treatment; the right to refuse treatment; the right not to be put in physical restraints or solitary confinement; and the right to supported decision-making. Unfortunately, citizens detained under British Columbia's Mental Health Act (MHA) are routinely denied these rights and subjected to an array of traumatic "treatments" that can cause serious harm.

In its November 2017 report *Operating in Darkness: BC's Mental Health Detention System*, BC's Community Legal Assistance Society (CLAS) exposes, in damning detail, the rights violations and chronic dysfunction that characterize our province's mental health system.

On the evening of Sunday, December 10, 2017, I opened our chapel to commemorate International Human Rights Day and the CRPD, and to mention the CLAS report,

which I see as an important step in the struggle for the human rights of persons with psychiatric diagnoses. My intention was to provide a safe place for those who had personally suffered under the BC MHA to speak their own truth, share their stories, and bear witness. I hoped that this could serve as a step towards healing some grievous and enduring wounds.

I welcomed those attending, spoke briefly about the CLAS report, and then invited people to come forward and tell their stories. Several individuals shared heartbreaking accounts of abuses they had experienced while detained under the MHA.

That was when the gathering took a disturbing turn: a group of audience members whom I did not know came up to the microphone, one after another, to attack the CLAS report (though it was not clear, based on their remarks, that they had actually read it), and to praise BC's Mental Health Act. In particular, they expressed gratitude for the power granted to psychiatrists to forcibly detain and "treat" patients. Their words directly negated the personal stories of psychiatric survivors – citizens who had attended specifically in order to be able to speak safely about what they had experienced at the hands of "mental health service providers" in our province.

In distress and disgust – and in one case, in tears – several psychiatric survivors stood up and walked out of the chapel.

I felt as though the meeting had been hijacked.

I later found out that the people who, in effect, took over our "Bear Witness" event were all members of a provincial advocacy



and lobby group that promotes forced psychiatric treatment.

I know something about cults. They are relatively small groups of people who excessively venerate and admire a particular person, text, or set of beliefs and practices. Cult members feel threatened by the outside world; they fear contamination by alternative ideas and ways of being. Cults create their own internally coherent world and expect adherence from believers.

In retrospect, thinking about what

happened at the church that evening, I realized that the behaviour I had observed on the part of this advocacy group reminded me of how religious cults operate. A small number of people attend a meeting to which they have not been invited. They sit close together, grouped around a leader, and avoid eye contact with other meeting participants. Then they stage a hostile takeover, in which speakers deny the reality of others' experiences and denigrate attempts to reframe and understand difficult, complex issues. They expound their own set views, seemingly oblivious to the pain they are causing to others in the room.

It is not surprising that this family advocacy organization receives significant funding from pharmaceutical companies that sell psychiatric drugs. What is Astonishing and deeply

disturbing, however, is the fact that they also receive taxpayers' money from the BC government.

It grieves me that I inadvertently subjected survivors of BC's "mental health" system to further pain and disappointment. They attended in good faith, expecting to bear witness in a safe place – literally a sanctuary – where they would be respectfully listened to and supported. I hope they will forgive me for not having been able to make it happen for them on that dark December night.



Devastating harm is inflicted on people incarcerated in institutions

Quotable Quotes from the CLAS Report

By Irit Shimrat

The experience of reading – or trying to read – CLAS's report *Operating in Darkness* brought up terrible feelings in most of my diagnosed friends. Not me. I was thrilled that the report documents brutal punishments such as physical restraints and solitary confinement used “for staff convenience,” and consistently uses the word “detainee” rather than “patient.” After all, so many of us have struggled to make families and friends understand what happened to us in the bin as torture.

Some of my friends, however, couldn't get through even a few pages of the report, so overcome were they by the rage, grief, despair or emotional paralysis brought on by the traumatic memories that CLAS's words evoked.

Later, when I started putting this newsletter together, I asked several people to write about their own experiences inside BC's “mental health” facilities. But few psychiatric survivors speak as easily as I do about their time “inside.” Most don't even want to think about that suffering, much less analyze and write about it. Too many of us grieve for friends who have died as a direct or indirect result of psychiatry. And we are painfully conscious of the devastating harm that continues to be inflicted upon countless innocent people incarcerated in psychiatric

facilities every day – that is happening to many thousands of citizens right now, as you hold these pages in your hands.

Tina Minkowitz is a human-rights lawyer and a survivor of psychiatric abuse, who contributed to developing the text of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Canada has signed and ratified the CRPD, which upholds the right of every person to refuse medical treatment or other services that they don't want, and to be recognized as having the right to make these decisions for themselves. Tina told me that – as interpreted by the UN committee that monitors implementation of the Convention – *the CRPD prohibits forced hospitalization and drugging*. It views these practices as instances of discrimination against “people with real or perceived psychosocial disabilities.” (It is thanks to Tina that the Convention contains these provisions that uphold the rights of psychiatric survivors.)

Tina recently came to Vancouver to talk about how BC mental health legislation contravenes the CRPD (<https://www.youtube.com/watch?v=psbaNLIZNMU&t=2s>). The next day, in a personal discussion about disclosure, Tina talked about “disability porn.” For psychiatric survivors, that's where your most personal devastating experiences are trotted out for other people to judge. Should they feel sorry for you? Did you get what you deserved? Can they use your story to feel good about themselves? (I would add, are they getting off on the idea of your naked, shackled body being penetrated, against your will, by a needle?)

In psychiatry, Tina reminded me, they don't allow us to keep anything private; they take our personal stuff and make it public in ways that aren't under our control. We are locked up and observed.

(I was reminded of the many times I've performed for the security camera after being thrown into the "quiet room" – i.e., solitary confinement cell – in the vain hope that, if I came up with the right series of sane-looking movements, they'd let me out of that hellhole faster. I always think that, and I'm always wrong, and I always forget. It doesn't help that the "antipsychotic" drug they inevitably shoot me up with, by brute force, makes me a thousand times crazier than when the police first bring me in. Like many psychiatric survivors, I have a paradoxical reaction to these drugs. And I always try to tell the emergency staff that, and they always assume I'm lying.)

So, when we tell our stories about psychiatric abuse, on whose terms are we making ourselves public?

Ronda E. Richardson, whose artwork appears throughout this newsletter, points out that when we try to rebuild our lives after psychiatry has torn them apart, the act of making our psychiatric histories public opens us up to whole new worlds of discrimination. Potential employers, landlords and friends are likely to use our honesty about our past as an excuse not to hire us, house us, or even give us the time of day.

Anything we say or do in regard to our psychiatric incarceration can be, and often is, mocked, debunked, or otherwise used against us. The idea that we have an obligation to tell our horror stories – to make ourselves that

vulnerable – in order to be believed, is something that, for many psychiatric survivors, is especially re-traumatizing, because it's similar to what psychiatry does.

Okay, here come the quotes. Brace yourself.

Many individuals diagnosed with mental disorders **leave BC** to live in other jurisdictions simply **to avoid our mental health system.**

... all detainees are **deemed to consent** to any form of psychiatric treatment ... [which may then] be **forcibly administered.**

[BC's] *Mental Health Act* ... [does] **not comply with the rights guaranteed by the *Charter* and the UN CRPD** [Convention on the Rights of Persons with Disabilities].

Some representatives had clients that had been **detained because they were homeless....**

... an individual who had been detained in an inpatient facility for seven years who was being **forcibly administered four high-dose psychotropic pharmaceutical agents simultaneously**, although the treating psychiatrist testified it had produced **no measurable impact on the mental health symptoms.**

... detainees ... can be put in seclusion (**solitary confinement** in a small, locked room), **tied to a bed** with 4-point or 5-point mechanical restraints (one strap is used for each limb and sometimes to



additionally restrain the head) ... **subject to physical force** by health care providers and private security guards ... and have their **clothes forcibly removed**. Detainees can also be subject to **chemical restraints**—psychotropic pharmaceutical agents which are **administered to control behaviour** rather than to provide therapeutic benefits.

... **seclusion** was often used as a **punishment** or **to ease the workload of staff** ...

Several respondents ... [who had been in jail] expressed that they had **fewer rights as an involuntary patient** than as prisoners and they would **prefer to be in jail**....

Detainees were told that they would **lose privileges** if they did not cooperate ... **such as access to clothes or the internet**.... Detainees were put in **4-point restraints** or put in **seclusion** as a **standard admission practice** in some wards.

... **staff have absolute control over where you go, what you wear, what and when you eat, when you bathe, when you sleep, what restraints you are placed in, whether you are placed in seclusion, and which psychiatric treatment you are administered.**

.... **individuals living in their own homes** in the community and going about their daily lives are **deprived of the right to make their own psychiatric treatment decisions.**

Some representatives ... reported that they had represented detainees who had been **forced to undergo Electroconvulsive Therapy.**

... **even if treating psychiatrists offered counselling**, many detainees would not feel comfortable speaking freely with them because of ... **the fear that anything they say could be documented and support prolonged detention or more forced psychiatric treatment.**

... **the failure of detaining facilities to provide adequate and timely disclosure** in the civil mental health context would be **completely unheard of and unacceptable in any other legal proceeding.**

... **it can be very difficult for detainees to access** the practical tools necessary to make a complaint, such as **a phone, a computer, or a pen and paper.** It is also difficult for someone ... **under the influence of psychotropic pharmaceutical agents, to sustain the focus necessary** to ... participate in the complaint process.

Mental Health Act detainees are in a position of powerlessness—**the mental health detention system has taken away their freedom, their bodily integrity, their right to make decisions, and in many circumstances, their voice.**

