RECOMMENDATIONS TO THE MENTAL HEALTH IMPLEMENTATION TASK FORCE (TORONTO/PEEL)

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Author's Comments, Disclaimers and Contact Information

In drafting this analysis I have drawn upon my nearly eighteen years' experience as a (not always willing) recipient of traditional 'mental health services', and my subsequent almost twenty years' involvement in a range of social justice-related issues, including the Psychiatric Survivor movement.

I have broken this document into a number of categories for you to consider, providing personal interpretations of the most pressing areas of concern under each category, and including a set of recommendations under each for possibly remedying these deficiencies. I have grouped these different categories into two main areas: ***General Policy*** and ***Services/Resource****s.*

I am not a 'mental health' professional. The opinions and recommendations contained in this document represent strictly my own individual point of view, and do not necessarily reflect those of any other individual or group.

I am presenting this set of opinions and recommendations in good faith for your consideration, and it is my hope that the Task Force members will respond in kind by giving due consideration to what this document is attempting to put across. I thank you for your time and attention.

Sincerely,

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RECOMMENDATIONS TO THE MENTAL HEALTH IMPLEMENTATION TASK FORCE (TORONTO/PEEL)

PART 1 - GENERAL POLICY

Preamble - Human Rights Protection

After an eleven-month period where nine Mental Health Implementation Task Forces have engaged in secret proceedings across Ontario, those of us who will be most directly affected by their recommendations are now being placed in a position of playing catch-up as a public consultation process gets underway.

This behavior by the Task Forces closely mirrors the actions and attitudes of the traditional psychiatric infrastructure, in which those most affected are generally the last to know of significant decisions concerning them, and who are typically barred from participating in decision-making but are frequently given no choice in terms of compliance.

This attitude itself more than anything else is an indicator of the drastic, and perhaps revolutionary, changes that are required in order to create a respectful system of caring which is rooted in community and is based on a strict adherence to and respect for basic human rights principles.

The existing system is predicated upon the (scientifically unproven) concept that emotional or mental crises result from actual physiological disorders, which are then generally responded to in a strictly medical context. It is also frequently (and mistakenly) assumed that such personal crises render someone incapable of acting appropriately in their own best interests, resulting in abrogation of choice or of the right to personal liberties and autonomy. In addition, recipients of psychiatric treatments are seldom advised of the potentially serious hazards associated with such interventions.

Recommendations: Before any other discussions on policy-related matters can proceed, a legally-binding Bill of Rights for ***all*** persons interacting with the 'mental health' system must be drafted and adopted, with direct participation from the psychiatric survivor community. This Bill of Rights needs to incorporate (but not be limited to) the recommendations included in the policy section of this document. Interim measures for rights protection including extensive use of Powers of Attorney for Personal Care need to be employed until more comprehensive rights protection policy can be implemented. Among 'mental health' professionals, strict adherence to the principle of informed consent must be maintained in their relationship with the people they claim to serve. It needs to be formally recognized that no matter how acutely distressed, people have both the ability and the right to make their personal wishes regarding care-related matters known, and to have these wishes respected without exception. Choices need to be expanded, with a range of resources not arising from the medical model being developed and offered for consideration by those who enter the system. An independent, twenty-four hour advocacy agency needs to be created and staffed by trained advocates from the psychiatric survivor community, with contact information for this agency being provided immediately to all persons upon their entering the system at any level.

Anti-Oppression, Stigma, The Law and Mental Health

Despite its claim of being merely another facet of health care, the existing 'mental health' system is tightly intertwined with law enforcement, the courts, the media and the educational system. As well, pre-existing systemic discriminations in the form of racism, misogyny, classism, homophobia and age-ism are greatly exacerbated within the system. Young people under the age of consent (sixteen years of age in Ontario) lack even the meager rights protection offered by the Mental Health Act, and are completely at the mercy of their legal guardians. Large numbers of school-aged children are routinely administered potent drugs which have not been approved for use in that age group, for the supposed 'treatment' of behavioral issues. Some other psychiatric procedures are also applied excessively to certain groups (for example, seventy per cent of electroshock 'treatments' are administered to women, with older women forming the fastest-growing subgroup). A disproportionate number of individuals entering the system are First Nations people or come from communities of color, and/or are recent immigrants and refugees. This reflects (among other things) the profound cultural insensitivity of a society and a medical protocol dominated by the ideology put forward by middle and upper-class white males. As well, psychiatric 'diagnoses' themselves evoke a profound, unjustified bigotry and fear from members of 'normal' society. The media exacerbates this problem of stigma with frequent sensationalist and out of context stories on 'mental health' issues or about people with a psychiatric history.

Recommendations: A comprehensive anti-oppression training protocol needs to be developed with direct participation from psychiatric survivors, communities of color, First Nations people, lesbian/gay/bisexual/transgendered people, recent immigrants/ refugees, women, seniors and youth. Once established, this training process needs to be made mandatory for ***all*** persons involved in 'mental health' service provision. Resources for people of differing cultures need to be tailored to the specific needs of, and staffed by, members of these cultural groups. A clear separation needs to be created between ‘mental health' resource provision and law enforcement, the courts and the education system, except in instances where non-coerced, informed consent has previously been obtained. In the interest of protecting medical confidentiality and preventing stereotyping, the media needs to be legally barred from reporting any information about the psychiatric histories of arrested suspects (including even the fact that someone may have a psychiatric history), and in court proceedings where the 'not criminally responsible' defense is used or other psychiatric testimony is presented, an appropriate publication ban on this specific information be applied. The credibility of psychiatric court testimony itself needs to be severely challenged. Protection under Canada's hate crimes laws needs to be extended to include psychiatric survivors. Any form of involuntary commitment (inpatient or outpatient) needs to be abolished. For-profit vested interests such as pharmaceutical corporations, along with the media and members of law enforcement agencies need to be legally barred from participation in policy decisions related to 'mental health' service provision.

The Medical Model and Peoples' Experiences With Trauma and Violence

The generally accepted belief among 'mental health' professionals nowadays is that most emotional, mental and social crises can be attributed to actual physiological disorders, with personal life experiences playing a minor role at most. The thing is, this supposed 'fact' ***has never been scientifically validated.*** What ***has*** been well-documented is that an extremely disproportionate number of individuals entering the system (perhaps more than nine out of ten) have experienced violence or other forms of trauma, including being victims of the various social inequities described on page 4. A survey conducted among patients at the Queen Street Mental Health Centre (now the Centre for Addiction and Mental Health) indicated that somewhere in the neighborhood of seventy-five per cent of female patients and more than a third of male patients have experienced sexual abuse. Other social pressures such as those imposed by homelessness or extreme poverty also have a profound influence on a person's state of mind.

Recommendations: The existing medical model of 'mental illness' needs to be replaced with a protocol which recognizes the importance of the role played by experience of oppression, violence or trauma in peoples' lives and responds accordingly, not by attempting to treat illusory 'mental illnesses' but by assisting people in healing from trauma, and/or by correcting injustices. Other cultures including First Nations communities already understand the value of this approach and need to play a leading role in developing broader policy in this area. Children (and adults) need to be thoroughly educated on what is (and isn't) acceptable behaviour of adults towards young people, and a policy developed to deal specifically with child abuse of any form, based upon the principle of zero-tolerance. All resources need to be sensitized to issues of class, gender, sexual identity, culture and age, as outlined on page 4 of this document. As is currently happening in the area of reproductive and related technologies, appropriate, strict guidelines for 'mental health' research need to be adopted and enforced. For-profit vested interests such as pharmaceutical corporations need to be legally barred from funding researchers, professional organizations or political lobbyists engaging in activities related to 'mental health' issues and policy.

Coercion and Force

The existing system is inherently coercive. Psychiatry is the only medical specialty which is legally empowered to routinely deprive people of their freedom and to treat them over their clear objections. This applies even to supposedly 'voluntary' users, who can see their status being subject to immediate change if they in any way arouse the suspicions of the attending shrink. 'Mental health' professionals routinely seek the assistance of the police in enforcing their decisions involving confinement or treatment of unwilling persons. Psychiatric survivors are among the very limited number of society's sectors whose lives are governed by specific discriminatory legislation - in this case the Mental Health Act. (Other groups in this category include First Nations people, and recent immigrants/refugees). It is the habit of many 'mental health' professionals to immediately resort to the most forceful measures available as soon as any crisis situation develops. These may include (but not be limited to) solitary confinement ('seclusion'), suspension of 'privileges' (read: denial of basic human rights), and forceful application of physical, mechanical or chemical restraints. In addition to being inherently dehumanizing, such practices can (and do) result in serious injury or even death.

Recommendations: All forms of coercion (including any form of involuntary committal and medical treatment of individuals without first obtaining their properly informed consent) need to be abolished. The Mental Health Act (including its recent amendments under 'Brian's Law') needs to be repealed and replaced with the Bill of Rights described on page 3. Amendments need to be made to the Health Care Consent Act to reflect an emphasis on rights protection and to close loopholes which may be potentially exploited by 'service providers', family members, etc. Workers in 'mental health'-related programs (and other residential facilities such as group homes or shelters) need to be trained in de-escalating potential crisis situations and calming distressed people without intervening physically. Before any 'medications' are prescribed the potential recipient needs to be provided with a clear description ***in writing*** of the substance's potential harmful effects, and appropriate medical supports need to be made available to persons who wish to safely withdraw from psychotropic drugs. Dehumanizing practices including use of physical, mechanical or chemical restraints, solitary confinement, or re-defining peoples' rights as 'privileges' to be arbitrarily granted or withheld at the discretion of staff, need to be outlawed. ***All*** serious injuries or deaths of 'clients' directly resulting from interaction with 'mental health' staff, shelter and custodial workers or the police need to be treated as potential criminal matters and investigated accordingly.

PART 2 - SERVICES/RESOURCES

Crisis Resolution

Traditionally, psychiatry and broader society alike have responded inappropriately toward people who openly display any form of emotional distress, express thoughts or ideas which violate societal standards of 'normalcy', present themselves to the world in an unusual manner or who make lifestyle choices which meet with the disapproval of others. Psychiatry often plays the role of an extra-legal parallel police force which deals with those behaviours which aren't considered criminal, but which others may find upsetting, disruptive or merely bothersome. As well, pseudo-medical psychiatric 'diagnoses' are commonly used as a form of 'victim-blaming', in order to deflect attention away from the true social causes of emotional or mental crises. It has been the tendency of the system to respond forcefully to what are considered 'disorderly' behaviors or forms of self-expression, which is an inherently destructive approach to take with someone who is already angry, frightened or otherwise in emotional pain for perfectly legitimate reasons. As well, emotional and behavioral issues of this kind lead to individuals becoming increasingly socially isolated, which further aggravates the situation.

Recommendations: A twenty-four hour 'warm line' staffed by psychiatric survivors needs to be established, and the contact information for this resource widely distributed. Associated with this resource a peer-based 'buddy system' can be created where people in distress are paired up with other survivors for the purpose of face to face mutual support on an 'as-needed' basis. A network of small, non-medical, hassle-free crisis centres staffed by psychiatric survivors needs to be established for use on a drop-in basis. Longer-term 'safe houses' modeled on that being developed by the ***Edmond Yu Safe House Project **** need to be created, to accommodate those individuals who have traditionally fared poorly in the existing shelter system.

Longer-term Community Supports

In the 1960's a process of 'de-institutionalization' commenced which saw large numbers of people being released from state or provincial facilities. The problem was that many of these people were long-term inmates whose sense of autonomy had been severely eroded through enforced dependency on an institution for all their physical, emotional and social needs. As well, no thought was given to availability of basic needs such as housing, food, employment/income support or community involvement, resulting in many people literally being released directly to the street, with nowhere to go, no fiscal resources and no friends or personal supports. Predictably, the result was large-scale homelessness, de-institutionalized people becoming entangled in the legal system, or themselves becoming the victims of exploitation and violence in disproportionate numbers. Recent neo-conservative policy changes have worsened this situation in many places The backlash of this well-intentioned but ill-conceived plan is being seen in the current trend towards the passage of coercive 'outpatient committal' laws in many parts of the United States and Canada, and in other parts of the world.

Recommendations: Basically, the institutions need to be closed altogether and replaced with accessible, user-defined, voluntary resources in the community. A 'pre-release' protocol needs to be developed for remaining inpatients in order to wean them from institutional dependency prior to permanent re-settlement in the community. A system of attendant care similar to that now available to persons with physical disabilities needs to be established to assist persons with those aspects of their day to day lives where they feel deficient or in need of additional support. Such attendant services need to be based on a non-authoritarian model, with those providing attendant services being legally barred from making binding decisions affecting someone's life without the person's consent. An extensive network of peer support groups needs to be established with facilitation from the psychiatric survivor and other oppressed communities. Social justice organizations can be approached for assistance in training peer facilitators, as many social movements have developed excellent tools for facilitation and aiding group process. An emphasis of all resources and services needs to be on developing a sense of community engagement and belonging for socially marginalized, lonely persons who are especially vulnerable to unwanted interventions under the existing system.

Other Resources – Housing, Employment/Income Support, Nutrition

In the summer of 1995, social assistance rates were slashed by 21.6 per cent in Ontario, with no subsequent increase occurring over the following six and a half years. This in itself has placed many people in the position of having to choose between paying rent, and feeding themselves and their children. As well, construction of new social housing was halted in the summer of 1995 and subsequent amendments to landlord/tenant legislation has streamlined the eviction process and sent rents soaring, especially in the Toronto region. Most of the new jobs being created nowadays are either part-time, or short-term 'contract' positions which offer little in terms of providing a stable source of income. Most 'normal' workplaces fall woefully short in terms of properly accommodating workers who struggle with emotional and mental issues. In addition to benefits being drastically reduced, social assistance has been rendered inaccessible to most people. The Family Benefits Act was replaced with the Ontario Disability Support Plan, a program for which is virtually impossible to qualify under the Provincial government's re-definition of what constitutes 'disability.' Despite their valiant efforts to cope with the consequences of this social avalanche, the resources provided by food banks and soup kitchens are terribly inadequate, in terms of both quantity and nutritional value.

Recommendations: The 21.6% cut to social assistance rates needs to be immediately rescinded, with all forms of income support being indexed retroactively to reflect the increase in cost of living since 1995. Criteria for receiving assistance need to be loosened to properly accommodate all those in need. Employment initiatives originating from within the psychiatric survivor community need to be expanded and fully supported. Requirements for properly accommodating special needs of workers with emotional and mental issues need to be established for 'normal' workplaces. A national affordable housing strategy needs to be created and implemented, using the ***Toronto Disaster Relief Committee's ****** 'One Per Cent Solution' model for funding. New housing needs to accommodate a diversity of individual needs and wishes, ranging from those who prefer to live alone, to those who desire a communal living situation. Personal supports need to be maintained as a separate thing from someone's housing situation and the right to housing must never hinge on compliance with a psychiatric 'treatment' regimen or other programs. Affordable, nutritious food programs such as that provided by ***Foodshare's 'Good Food Box' ******* program need to be greatly expanded. Other co-operative initiatives including community gardens and kitchens need to be developed – these have the added advantage of helping instill a sense of community and belonging in those who use these programs. Above all, entitlement to the basic necessities of life including secure decent housing, nutritious food, adequate income and meaningful community involvement needs to be legally established as a human right, and formally incorporated into the Bill of Rights described on Page 3.

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******* Details on ***Foodshare's 'Good Food Box'*** program can be viewed at
http://www.foodshare.net/gfbox.htm