**Open Season on Mental Patients - May 28 2022**

**By Irit Shimrat**

I named this talk “Open Season on Mental Patients.” But I could just as well have called it “Open Season on Humanity.” No one is safe from psychiatry’s project of medicalizing and treating just about every variation of human emotion and behaviour.

Especially in danger, as always, are those viewed with suspicion and contempt by the powerful, including Indigenous people; Black, brown, Asian and other people of colour; big, loud young men of any race; immigrants; refugees; people with physical disabilities; women and sexual minorities; old people; millennials; teenagers, even small children.

The particulars of psychiatric treatment – labelling, incarceration, solitary confinement, shackles, drugging, electroshock, and the less obvious violence inflicted on those leading silent, terrified lives under community treatment orders – cause a staggering amount of damage to far too many minds, bodies, and souls.

Media of all kinds are always screaming at us about the current “mental health crisis.” And there is, in fact, an ongoing crisis. But it’s not what they imply. Unbearable conditions of poverty, discrimination, abuse, neglect, and all the other ills that plague our society are driving more and more people into states of alienation, despair and insanity, which are then attributed to supposed medical conditions, to be treated with drugs.

Creating and maintaining an atmosphere of despair, anxiety and panic drives clicks, but that’s not all it does. It also facilitates the marketing of various means of individual and collective social control, from drugging away your own troublesome emotions to having troublesome humans shut up, shut down, and put away.

Psychiatry’s witting and unwitting minions – including police dealing with situations seen as being caused by mental illness – produce untold suffering through their oppression of some of our best, brightest and most sensitive citizens, and non-citizens too.

In British Columbia, where I live, police have literally broken into people’s homes – no warrant required – because some acquaintance has reported what they perceive as strange behaviour.

Not only physicians and family members, but friends, neighbours and even random passers-by can trigger legally sanctioned home invasions – which may end in incarceration and forced drugging, simply on the grounds that a person is deemed “incapable of appreciating her need for treatment.”

And way too many mental patients end up being *killed* by police. Predictably, the most common victims of such murders are poor, and many are Indigenous. I think of Chantel Moore, a First Nations woman who was just 26 years old when police officers entered her home to conduct something called a “wellness check,” in 2020, and ended up shooting her dead. And there have been many other such murders.

Wellness checks are just one example of the ferocious increase in psychiatry’s power to inflict forced or coerced treatment, not only in hospital but even in the community, where it is administered by Assertive Community Treatment (or ACT) Teams, under outpatient committal orders.

British Columbia boasts Canada’s most regressive mental health act. The criteria for involuntary admission include the stipulation that you require “care, supervision and control in, *or through*, a designated facility,” either in order to prevent your “substantial mental or physical deterioration,” or for your own protection or the protection of others.

These criteria are so vague and all-encompassing that, in essence, anyone can be locked up for anything. And, of course, once you’ve been made into a mental patient, any unusual behaviour, however harmless, is way more likely to trigger psychiatric interventions.

“Extended Leave” is my province’s ugly euphemism for outpatient committal. When you’re on Extended Leave, you are technically free. Legally, however, you’re still under hospital care. At any time, a warrant can be issued for your arrest and re-incarceration – or, as they put it, “recall to hospital.”

The state is, in essence, splitting persons. You’re at large in the community, but, at the same time, you’re legally detained.

You can’t run away. You can’t hide. You can’t go underground. Your only recourse is to leave British Columbia – and how could you afford that, and where would you go?

In effect, Extended Leave transforms the entire province, notably including your own home, into a designated facility.

And what if you *have* no home? The cops are empowered to show up at one emergency shelter after another, demanding the list of names of people staying there. If it’s winter, and you’re staying off the street so you don’t freeze to death, they can track you down.

When you are obliged to “attend” your ACT team, your schedule doesn’t matter. They set an appointment and then tell you about it. You either show up, or risk being “recalled.”

Extended Leave has been compared to prison parole. But parole is finite, whereas Extended Leave can last a lifetime. All it takes is for one doctor to sign a new form each time the previous one expires.

There’s nothing else like this in our society – this status of a human being who is not physically confined, but who can be re-incarcerated at any time, on the word of a physician – and even if she’s adhering to conditions.

Police officers, often undercover, are essential to ACT teams. Each team also includes at least one mental health professional and, sometimes, a peer, who provides personal support. But even if there is a peer, she is in a subordinate position, and unlikely to be able to alter the intended outcome of an intervention.

Friends who have been subjected to Extended Leave have been devastated by the intrusion, into their homes, of officials whose job it is to monitor their behaviour and ensure treatment compliance. And even if you *are* compliant, the team may visit (with no warning) to check up on you, or on the state of your home.

A messy apartment can be used as evidence that you’re “in danger of deterioration.” And, as always, the threat is much worse if you are not white, or not English-speaking, or not “ordinary”-looking, etc.

And then, if you’re *not* compliant – say, you’re not showing up for team appointments, or your blood tests show that you’re not taking your drugs – the team is legally allowed to enter your home by force, grab you, pull your pants down, and administer an intramuscular injection. (As those of us who have had been vaccinated against Covid know, there are other injectable muscles in the human body, but psychiatry prefers the gluteus maximus. It’s more humiliating.)

I know of people who are afraid to spend time in their own homes because this might happen to them.

And what about these drugs you can be made to take against your will?

The drugs most commonly administered by brute force are neuroleptics, also known as antipsychotics. Long-term use of neuroleptics can crush your dreams, your hopes, your desires, what you had thought was going to be your future. It can delete or diminish the self you knew. And virtually all neuroleptic use is long-term. What mental patient hasn’t been told she has to keep taking these drugs for the rest of her life?

And let me remind you of some of the short- and long-term physical effects of neuroleptics: akathisia; [dystonia](http://www.medterms.com/script/main/art.asp?articlekey=349); dyskinesia; dizziness; dehydration; constipation; sexual dysfunction; blood vessel hemorrhage; osteoporosis; diabetes; heart, kidney, liver, pancreas, abdominal, and other organ damage; neurological damage; seizures; obesity; parkinsonism; neuroleptic malignant syndrome; decreased life expectancy; sudden death.

As for cognitive effects, it’s very common for these drugs to cause withdrawal psychosis when you go off them. And they also commonly cause confusion; memory problems; problems with focus, concentration, and thinking; anxiety; distress; and “paranoia.”

Let’s talk about paranoia for a moment. The classic meme is of someone who mistakenly thinks they’re being followed or surveilled. But it should be recognized that mental patients often live under a terrifying level of actual surveillance.

My friend Fred once said to me, “As I get older, I realize, I’m not paranoid. The nice, kind nurse, is trying to get information from me. After she finishes sympathetically listening, she goes into the nursing station and writes everything down. When I try to get out, it’s all used against me.”

So, why does Fred keep getting locked up? For one thing, like me, he has some unusual ways of looking at the world, and doesn’t always hide that. Also like me, he sometimes gets so angry about injustice that he behaves in ways that upset people. As a white mental patient, I have been persecuted a little bit. But Fred, who is Indigenous, has been persecuted a lot – in his case, for failing to conform to white norms.

But what if normality is overrated?

And what if “bizarre” behaviour that causes discomfort or suffering to oneself or others is not, as psychiatry claims but has never been able to prove, the result of a chemical imbalance in your brain? What if your perceived craziness is actually a natural response to the craziness of the world we live in? And, what can we do for ourselves and each other, if and when we’re lucky enough to avoid, or escape, psychiatry?

Support systems and coping mechanisms are vital to this discussion – and these can be of use, not only to psychiatrized people, but also to those of those in danger of being psychiatrized. Which is, of course, absolutely everyone.

In my view, the number of so-called alternatives to psychiatry is infinite, because people keep coming up with new ones. Among the many that have worked well for me are:

* Traditional Chinese Medicine
* aromatherapy
* reflexology
* various breathing techniques
* Feldenkrais and other body-awareness and integrated movement disciplines
* physical activities, such as yoga, tai chi, bicycling, swimming and dancing
* singing
* listening to, or playing, music
* in general, being outdoors, even in the city
* writing, drawing – any creative activity; and, most importantly
* human contact, and the choice of who to have that contact with. And when, and where to have it.

Ah, choice. So essential to a livable life. And so unavailable when you seek, or are forced into, professional help at the hospital.

If you’re a good girl, you sign yourself in, go straight to the ward, take your pills, and obey all the rules.

But if, like me and so many others, you get hauled into the bin against your will and try to fight it, what you get is confinement in a tiny, concrete cell, with a steel toilet-and-sink apparatus in the corner that may or may not work, and a mattress that may or may not have a sheet on it.

By the time you get there, you’ve been stripped of all your clothing and made to put on one of those humiliating hospital gowns, open at the back. You have highly toxic drugs coursing through your veins, forcibly injected by a nurse, while orderlies held you down.

And then, if you’re even more like me, and happen to have a paradoxical reaction to these drugs, they will make you a million times crazier than you already were when the cops hauled you in.

Often, you are shackled to the mattress by means of physical restraints: straps holding you down by the wrists and ankles.

The lights, if they’ve been left on, are fluorescent and harsh. The door is locked.

In the seclusion cell, no one can hear you scream. Or, at least, no one’s going to respond.

You are left alone with your rage, terror and desolation.

The process of breaking your will has begun.

Once you’ve been made compliant enough to be released into the general population, there will, if you’re lucky, be physical and creative activities to punctuate the monotony of life on the ward. These will be framed as “therapy.”

But such activities, and all activities, are always so much more enjoyable when they’re *not* framed as therapy. After all, this idea that the underlying problem is a medical one remains unproven.

A nice experiment would be to offer a sampling of things known to help people feel better, and let you pick whatever appeals. A trusted friend, family member or advocate could be with you, to provide kind, gentle guidance and advice.

Mind you, when you’re “in a state,” you might be unable to choose items from a menu, even with assistance. So, it would be better to put a plan in place in advance – before problems arise.

But it can be hard even to envision common-sense prevention strategies and solutions in an atmosphere of fear and a near-universal belief in biomedical fixes for emotional, social and political problems.

It would help a lot if everyone learned about extreme emotional states early on. In my ideal world, elementary-school children would be taught to understand that bad things happen to everyone; that anyone might have a hard time coping; that some ways of coping look weird; and that difference can be greeted with curiosity, respect, and even appreciation, rather than fear or suspicion.

However, here in the real world, we can at least put an emphasis on meeting basic needs, such as good nutrition; decent housing, enough money to live on; meaningful work; and adequate health care – none of which should ever be tied to “mental health services.” I’m pretty sure that, if every person in Canada had unquestioned access to these essential human rights, the incidence of so-called mental illness would plummet.

A common-sense, empathic approach can go a long way.

I want to tell you briefly about VEEC: the Vancouver Emotional Emergency Centre. Way back in 1974, a group of former mental patients and their allies founded VEEC: a safe space where people in extreme states could stay for a few days or weeks and be accompanied while they went through whatever they were going through. No drugs, no force, no medical personnel. Just people helping people in whatever way was wanted.

Despite (or because of) its unprecedented success in keeping people out of hospital by helping them navigate emotional crises, the Centre lost its funding after only two years. It was just too much of a threat to the psychiatric establishment.

The late, great activist Judi Chamberlin stayed there, in the earliest days of her own activism, and was inspired to write *On Our Own: Patient-Controlled Alternatives to the Mental Health System*. By the time I moved to Vancouver, in 1993, it was hard to find anyone who even remembered VEEC. But I’ve never stopped thinking about it.

The point of getting support from other psychiatrized people, outside of the system, is not just that they won’t be alarmed by you, or that you can learn from and be inspired by their experiences. It’s also that the support is, or at least has the potential to become, mutual. You are not being “treated” or talked down to. The contact is genuine and natural, rather than being bound by “therapeutic” imperatives. No one in this picture needs to be fixed.

I can just about hear, in the far distance, the howls of people – not any of us here, I hope! – protesting the idea that those with “severe mental illness” or in a state of “psychosis” do not urgently need suppression and drug treatment.

Well …

Decades ago, Michael Cornwall – voice-hearer, activist and therapist, was working at a special ward in a California state hospital.

I met Michael at a Toronto conference called Psychosis 2.0. I was stunned to hear him say, “We didn’t use medication, or restraints. We knew we’d get punched, hit, kicked, physically assaulted. But other staff would come, and we’d securely hold the person, in a loving, gentle way. And, almost always, this would result in a real turning point in that person’s process.”

Another speaker at the conference, voice-hearer, researcher, author and counsellor Eleanor Longden, said, “I believe there is no greater honour, no greater privilege, than facilitating this process; than bearing witness, and reaching out, to voice-hearers; than sharing the burden of suffering, and holding the hope of recovery.”

These words made me think of my friend, mentor, and longtime lover, the late, great Chris Bearchell. Chris was a superb journalist; a passionate socialist humanist; and a brilliant and effective women’s and gay liberation activist.

Before she died, in 2007, she and I were planning to write a book together, called “Paid to Care,” about the problem with making a living from the provision of love and caring – which some practitioners claim to offer by way of therapy. Call me cynical, but I have to ask: When you’re making money from it, can it really be genuine love and caring that you’re providing?

In general, people set high stock by professional expertise. But in truth, each of us is the expert on her own self. And it’s not just psychiatrized people who can help each other. Anyone can get help from friends, relatives, and others – from almost any compassionate person whose perceptions have not been muddied by psychiatric, psychological or social-work training, or by the “cop mentality” that often develops in those who enter such professions, however good their original intentions.

I very much doubt that anything learned from psychology textbooks compares to what an ordinary grandmother understands about life, and has to offer by way of wisdom, kindness and support.

Our society includes more and more old people, retired people – people who can easily be made to feel useless. So many end up being *made* useless: shoved into so-called care homes, where they are often brutalized with restraints, tranquillizers and sometimes, incredibly, electroshock. And where, lately, far too many have been dying, alone and desperate, as Covid tears through entire facilities.

And yet, if such institutions didn’t need to exist – because, say, we lived in a society in which people took care of each other and elders were honoured – imagine how much they might have to offer to others who are, or are in danger of being, in psychiatric or other trouble.

And what about all the abused, neglected or abandoned children and teenagers currently being labelled and made to take harmful drugs? Surely these youngsters should have opportunities to get support from those oldsters, and vice versa, rather than everyone being expected to get professional help.

I want to return, briefly, to the subject of electroshock. ECT – so-called electroconvulsive therapy – is well known to cause permanent brain damage, with effects notably including permanent memory loss and severe cognitive deficits. Most members of the public believe that ECT went out of use decades ago. But in fact, its use is very much on the rise.

When I was young, shock was mainly used on people who were “unresponsive” to drug treatment and those diagnosed with “clinical depression.” Then, as now, many recipients of forced or coerced ECT were unruly women, and especially older women, and especially women of colour. But of course, men – and especially marginalized or “scary-looking” men – are often subjected to unwanted ECT as well.

And now, the scope of ECT is much broader, and notably includes children. According to the National Institutes of Health, in the United States: “The indications for electroconvulsive therapy in children and adolescents are similar to those in adults…. Multiple published reports demonstrate the safety and efficacy of ECT in pediatric patients with a wide range of psychopathology. ECT has also been successfully used in youth with autism and other neurodevelopmental disabilities…. However, resistance and stigma persist regarding the use of ECT in children and adolescents in both the professional and lay communities, creating barriers to pediatric ECT access. We argue that the use of ECT in children and adolescents is appropriate for specific clinical indications, and urge removal of impediments to ECT access in this population.”

There is sometimes the appearance of informed consent procedures being followed, as required by law. But who would ever consent to electroshock, or indeed to any psychiatric treatment or procedure, if all of the risks were actually divulged?

Over and over again, we are told, that mental illness is like diabetes and that antipsychotic drugs are, like insulin, necessary for saving lives. But, in fact, there are physical markers for diabetes and for every other real disease – but none for any “mental illness.” Not to mention that antipsychotics actually *cause* diabetes!

I know, or know of, way too many people who’ve had physical problems that were ignored, or not found, by medical professionals, due to a prior psychiatric diagnosis.

Years ago, Canadian artist and author Persimmon Blackbridge was diagnosed with depression, when she was actually suffering from a physical disorder called hypercalcemia.

But Persimmon had a psych history – so no one thought to look further. Shrinks decided she’d had a lifelong problem with “Bipolar 2.”

“I’m the world’s least manic person,” says Persimmon, “but they had to make my previous, non-depressed, times fit into their diagnosis somehow.”

For ten years, Persimmon took antidepressants. Meanwhile, her kidneys kept deteriorating. By the time she was finally correctly diagnosed, she’d become exhausted and dizzy. A doctor, checking for diabetes, happened also to check her kidney function, and discovered the whole mess. Persimmon ended up losing a kidney, completely unnecessarily.

And now I’m going to tell you my own story about real, versus fake, disease.

In the year 2000, I was diagnosed with cervical adenocarcinoma – an especially pernicious type of cancer. Had my tumour not been found in time – quite by chance – and had I not had emergency surgery to remove it, I would have died.

I had been locked up several times during the previous two years, after 18 years psychiatry-free. And whenever I get locked up, I spend a long time, afterwards, just lying in bed, feeling sorry for myself. So, there I am, pretty much unable to think about anything, except wishing I were dead. And then, all of a sudden, I find out I have cancer. And, instantly, all I want to do is survive!

I’ve always thought this was such a hoot – that the effects of being diagnosed with a fake disease, “bipolar disorder,” caused me to long for death, but being diagnosed with a real and potentially deadly disease made me fall in love with life.

Since then, I’ve developed an increasingly keen sense of what’s most important to me: helping others survive or avoid psychiatry and find better ways of living in the world.

Award-winning journalist Rob Wipond has written extensively about how well psychiatric treatment doesn’t work. (I urge you to check out his writing at robwipond.com). In an article published at alternet.org, Rob describes a Danish study which found that people who had visited a psych emergency room were *30 times as likely to kill themselves* as those who had not. And those who were actually admitted to a psych hospital were almost *50 times* as likely to kill themselves. The study quotes a psychiatrist who admits, “It is entirely plausible that the stigma and trauma inherent in psychiatric treatment, particularly when treatment is involuntary, might, in already vulnerable individuals, contribute to some suicides.”

Another of my favourite writers on psychiatry is UCLA professor, researcher and author [David Cohen](http://www.madinamerica.com/author/dcohen/). In his essay, “It’s the Coercion, Stupid!” at madinamerica.com (see madinamerica.com/2014/10/coercion-stupid), Cohen writes: “Since the beginning of psychiatry, the only constant in psychiatric treatment has been coercion. Psychiatry’s coercive function is what society most appreciates about it. Families and others can call upon police to restrain someone acting strangely, and have that person taken by force to a place run by psychiatrists. Without the shock and awe of a coercive medical discipline, the flimsy theories and continually-refuted hypotheses of physiological defects as causes of distress and misbehaviour would actually have to [account for] what ails people, what makes them tick, and how to help them overcome their problems. After decades of engaging in critical analysis of the psychiatric and other evidence, I conclude that there has *never* been good evidence to support psychiatric theories. Psychiatry’s top experts admit that they have found no biological markers for any mental disorder. Yet no one cares that 50 years of psychiatric research have failed to turn up a single scientific finding….”

Fortunately, amazing work is being done outside the system to promote better ways of dealing with extreme emotional states. This includes efforts supporting the implementation of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which prohibits forced psychiatry and upholds the equal rights of all people with real or perceived disabilities, including psychiatrized people.

I urge you to check out the campaign to support CRPD’s prohibition of commitment and forced treatment (absoluteprohibition.org), and also the Center for the Human Rights of Users and Survivors of Psychiatry (chrusp.org), and the World Network of Users and Survivors of Psychiatry (wnusp.org).

Also promoting many good ideas are MindFreedom International (mindfreedom.org), the Wildflower Alliance (wildfloweralliance.org) and, in Canada, the Coalition Against Psychiatric Assault, Our Voice/Notre Voix (ourvoice-notrevoix.com), Madness Canada (madnesscanada.com), Mad in Canada (madincanada.org), Health Justice (healthjustice.ca), SeeSpring ([seespringcoalition.org](mailto:info@seespringcoalition.org)) and the Mad Canada Shadow Report Group (madcanada.wixsite.com/shadowreport/report).

And don’t forget to ask Jim Gottstein about Soteria Houses!

I would also encourage you to check out some of the back issues of the Canadian national magazine, *Phoenix Rising: The Voice of the Psychiatrized*, which Jim has very kindly put up at Psychiatrized.org.

*Phoenix* *Rising* was founded in 1980 by Don Weitz and Carla McKague.

Don Weitz was a survivor of insulin-subcoma shock. He was also the great pioneer of Canadian antipsychiatry. Don was one of the angriest, kindest, most tireless, and most generous activists I’ve ever met. And it wasn’t just about psychiatry. Don never stopped fighting against all the different kinds of injustice and discrimination on which “Western civilization” is based.

We lost Don on September 1, 2021.

Carla McKague, who died in 2015 and was supported by Don to the end, was an electroshock survivor, author and, for decades, a ferocious advocate and mental health lawyer.

Both have written powerfully on issues related to psychiatric force and fraud. (You can read Don’s book, *Resistance Matters: An Antipsychiatry Activist Speaks Out*, at madinamerica.com.)

*Phoenix Rising* was published until 1990. It gave a voice to psychiatrized people who had never had their work published before, showcasing talents previously buried under the weight of shame and suffering.

I had the enormous good fortune of being hired by Don to edit *Phoenix* for its final four years. That work revolutionized my life, and helped me more than anything else in recovering from psychiatry. The hopeless, hurt, lonely, angry mess that was me – all that seemed to remain of my *self,* once the shrinks had got through with it – was transformed into a feisty defender of psychiatric survivors’ rights.

When I look back at *Phoenix Rising* now, I am wowed by its beauty and power. And this is not because of my competence as an editor, or the considerable skill of its designers.

Rather, it’s all about the contributors’ brilliance and the magazine’s uncompromising ethical stance.

What I have longed for, more than anything, ever since 1990 when it folded, is that the *Phoenix* should rise again.

And that is why I am so thrilled to tell you that this might actually happen, thanks to the Don Weitz Legacy Project!

December 10th, 2021, was Human Rights Day, and would have been Don’s 91st birthday. On that day, his children – my dear friend Lisa Weitz and her brother Mark – led an inspiring online celebration of Don’s life. One of the upshots of this event was a generous gift from a Canadian philanthropist, to start something new in Don’s memory.

And one of our hopes is to resurrect *Phoenix* *Rising* as a downloadable, printable online magazine. I can’t tell you how much I look forward to editing *Phoenix* again, if that’s what ends up happening. But I can tell you that Don Weitz would have loved this idea.

And, buoyed up by the opportunity to do good things in Don’s memory, I find myself daring to hope. Maybe there will come a day when the entire disease model of strangeness and distress has been made obsolete. When the idea of mental illness has faded from memory, because everyone knows that “otherness” and emotional intensity are not and never were medical issues, and that diversity and difference are at the very heart of what makes humanity wonderful.

Because, despite all the horrors of the 21st century, human beings are amazing creatures. We have the ability to come together with open minds, open hearts, and a will to make things better. And, when we do, we can find the power that systems have taken away from us – or that we never had in the first place. We can resurrect ancient ways, and create beautiful new ways, of dealing with problems of mind, soul, and heart. I think maybe we can change the world. At the very least, we can surely do a whole lot better than the mental health system.