



CLEARING A PATH

A PSYCHIATRIC SURVIVOR
ANTI-VIOLENCE FRAMEWORK

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JANUARY 2011

— First of a series of assaults against six vulnerable people living in Parkdale

FEBRUARY 2011: Hamilton police fatally shoot Andreas Chinnery

FORWARD

The heart of this report is a framework, an approach groups can use to engage in a response to violence against people with psychiatric disabilities in their communities. The psychiatric survivor anti-violence framework, as conceived by a working group of the Psychiatric Disability Anti-violence Coalition (PDAC), is intended to provide guidelines in which to respond to and address the various forms of violence experienced by persons with a psychiatric disability, in particular those who are further marginalized by race, gender, income, status, and disability.

Psychiatric survivor¹ history has long been shaped by community members' struggle for freedom from violence. Geoffrey Reaume, a psychiatric survivor historian, refers to the word 'survivor' as "chosen to show there was much pride in our history of surviving discrimination and abuse inside and outside the psychiatric system, in advocating for our rights and in our personal and collective accomplishments – that psychiatric survivors are much more than a diagnostic label." (Reaume, 2008. p. 2). As readers will discover, psychiatric survivors have developed many strategies not merely to cope with the effects of violence but to understand and prevent it. Regardless, this community continues to experience violence in many forms with appalling regularity.


PDAC has noted that achievements that might serve as a foundation for the community's advancement tend to become obscured. When psychiatric survivors collectively turn to their own resources and expertise to respond to incidents of violence, that work no longer appears to exist. In part, this is due to the ways in which activism primarily driven by poor community members has historically lacked

Community Meeting

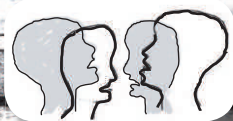
A community response to the recent violent assaults

This meeting is for residents of boarding homes and rooming houses in our community to join collectively for support and strategizing about the recent assaults in Parkdale.

Wed. March 23rd 2011
1:30 – 3:30 PM
 Parkdale Activity Recreation Centre (PARC)
 1499 Queen St W. (at Sorauren)



Media inquiries: Victor Willis (416) 537-2591 Ext. 242
 General inquiries: Lucy Costa (416) 538-8591 Ext. 3013
 In order to protect people's anonymity there is no tape-recording or filming at this meeting.



MARCH 2011

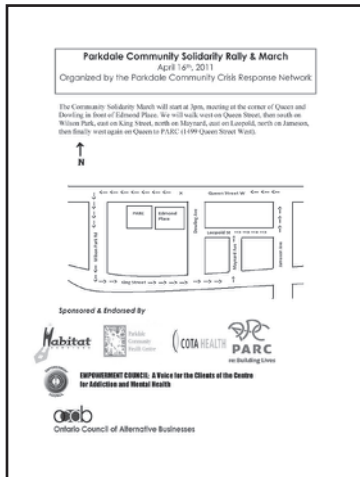
Community meeting about Parkdale assaults



PARKDALE SOLIDARITY MARCH, APRIL 2011

economic backing to mark and influence cultural capitol. Our own footsteps don't survive long enough to be retraced in the perilous landscapes of public policy or law. This must change if people with psychiatric disabilities are ever to live without fear, violence, and oppression.

Readers will note that this report does not place an emphasis on what must be done to staunch the violence. In part, this is because while many possible solutions have already been identified (sometimes repeatedly), policy-makers have not implemented many of these recommendations (see Kane, 2014; CBC, 2014). Furthermore, it would be ineffective to painstakingly craft foundations for a road that is constantly eroded by other forces: neglect, marginalization, and co-option by organizations with greater social capital. The intention of this report is to squarely position the voices of psychiatric survivors who have experienced violence at the centre of this discussion. It also provides guidelines that individuals, communities, and organizations can use to respond to and address violence experienced by persons with a psychiatric disability.



In order to understand what they are doing to perpetuate the status quo, and change, organizations must conduct a psychiatric survivor analysis. Until then, conditions for psychiatric survivors will not improve. Therefore, rather than mandating specific actions, this document will define how action could be conceived and carried out, and by whom. This is mirrored in the writing of this report, which focuses a great deal on how PDAC worked as well as on what it achieved.



APRIL 2011
Memorial for assault victim George Wass

APRIL 2011
Parkdale Solidarity March

PDAC envisions that the psychiatric survivor anti-violence framework will enable this work to be done meaningfully and sustainably. The challenge is that there is no 'one-size-fits-all' approach. This report will evolve principles and goals for the framework, while readers themselves will be responsible for delineating the terms that best address their particular situations.

For instance, it is important that psychiatric survivors understand violence as ongoing, and encompassing experiences shared by many diversely situated people with psychiatric disabilities, and therefore demand more 'action' from service providers, organizations and policy-makers and law.

PDAC extends this opportunity to move forward and deny the erasure of psychiatric survivors' expertise, knowledge, and achievements; with this report, readers will gain some appreciation of what these are, but PDAC has no desire to rebuild a road that, despite appearances, already exists. This is an invitation to prepare the way for new milestones to be achieved, and to reignite the movement toward revolution.

BACKGROUND

CONTEXT

From January 4 to April 5, 2011, an assailant wearing a black balaclava committed a string of violent assaults on people with psychiatric disabilities in Toronto's Parkdale neighbourhood. One of the victims was 62 year-old George Wass, who was attacked on the steps of his boarding house residence. Mr. Wass was taken to hospital, treated

JUNE 2011
Creation of PDAC

JUNE 2011
Ministry of Health announces divestment of the Psychiatric Patient
Advocacy Office (PPAO) to Canadian Mental Health Association – Ontario

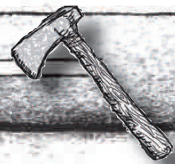


for broken ribs, facial cuts, and a black eye, and released the same day (Yang, 2011). Several days later, he collapsed at home and died. A post-mortem concluded his death had been caused by “blunt force trauma” (Donnelly, 2011). In all, six people were assaulted before a suspected perpetrator, himself a boarding house resident² in the area, was arrested in May (Rush, 2011).

Meanwhile, the conversation that had been unfolding in the community went beyond these assaults. People were talking about the ways other forms of violence, like discrimination, play out in institutions and social structures; for example, how psychiatric survivors experience illegal evictions due to government’s failure to invest in supportive affordable housing.

Coincidentally, an example of discrimination was occurring in the neighbouring city of Hamilton, as the city was attempting to prevent an eight-bed mental health facility for girls from relocating a few blocks over. (Coleman, n.d.) The debate became especially heated after a councillor employed some ugly rhetoric during a council meeting to describe patients. After months of legal challenges, and with support from the Ontario Human Rights Tribunal, the facility was eventually granted an exemption to the city’s “radial separation” by-law. However, the nature and tone of the dispute were disquieting to those who witnessed it (Coleman, n.d.).

Following the death of George Wass, a wide variety of people, including others who had been assaulted, felt the need to confront the violence they had witnessed. As a response to unanswered questions about why exactly Mr. Wass had died, as well as



JULY 2011

Changes to Ontario Special Diet Allowance

about the perpetrator and his mental health, holding yet another memorial or painting another mural would have been inadequate.

Instead, they came together in the summer of 2011 and formed the Psychiatric Disabilities Anti-violence Coalition. The purpose of this coalition was to engage in a meaningful conversation about how to address the issue of violence against persons with a psychiatric disability. We were a group of individuals with a vested interest in initiating a community dialogue, and in offering a critique of the stereotypes these public acts of violence had raised. This report documents that work.

ABOUT VIOLENCE AGAINST PEOPLE WITH PSYCHIATRIC DISABILITIES

Though the two instances described above are quite different from one another, both represent forms of violence against people with psychiatric disabilities. For the purposes of this report, ‘violence’ is defined as actions, words, attitudes, structures, or systems that cause physical or psychological harm to a vulnerable individual, or that cause such an individual to be placed in harm’s way (adapted from Fisher, Abdi, Ludin, Smith, Williams, & Williams, 2000). ‘Structural violence’ describes social structures – economic, political, legal, religious, and cultural – that put vulnerable individuals and populations in harm’s way (adapted from Gilligan, J., 1997 and Farmer, P.E., 2004 as cited in Farmer, Nizeye, Stulac, & Keshavjee, 2006). Violence against people with psychiatric disabilities occurs both through intended and unintended acts of violence and omission (Ontario Human Rights Commission [OHRC], 2012).

People with psychiatric disabilities face inordinate amounts of violence (Glied, 2013), from “daily micro-aggressions to deliberate overt harms, whether or not the harm was

“I want to talk about shame... Trauma is shaming... restraints are degrading. As some in institutions lose their sense of community, staff become security, they mistreat and push around clients... Shame shuts down people’s rights.”

COMMUNITY CONSULTATION
PARTICIPANT, 2015



AUGUST 2011

Death of Charles McGillavray in Toronto police custody

intended” (Costa, 2015). This violence is manifested in various forms; while some may appear more shocking, all undermine the dignity of people and create real harm. Acts dismissed by some as relatively insignificant, like certain kinds of ‘everyday’ discrimination, often form a pattern of subtle oppression that society has become adept at discounting (OHRC, 2012). People discriminated against in these ways often have no recourse through the usual complaint or legal procedures (Thornycroft & Asquith, 2015).

The literature about people with psychiatric disabilities leads to the inescapable conclusion that certain barriers persist for very many vulnerable community members, and further marginalize them (for example, see Urban Alliance on Race Relations, 2002; Early-Onset Illness and Mortality Working Group, 2011; OHRC, 2012; Federal-Provincial-Territorial Working Group on Mental Health, n.d.; Centre for Equality Rights in Accommodation, 2009). As an equity-seeking group, people with psychiatric disabilities experience various forms of violence: racism; poverty; homophobia and cissexism³; discrimination in employment and housing; verbal and physical assaults, including disablist violence (Thornycroft & Asquith, 2015); and institutional violence in the form of policing, the criminal justice system, and involuntary psychiatric confinement in response to distress. Together or in part, these can permeate a person’s life and are part of the matrix of oppression faced by many marginalized persons with psychiatric disabilities (OHRC, 2012).



THE FORMATION OF PDAC, ITS PURPOSE AND INITIATIVES

THE COALITION COMES TOGETHER

Though PDAC coalesced in response to the assaults targeting psychiatric survivors in Parkdale, we who joined the coalition had, from our various perspectives, witnessed a continuum of violence over the years. PDAC members were people with psychiatric disabilities, advocates, academics, representatives of community service agencies, community legal clinics, mental health organizations, and family and friends of people who had died as a result of violence⁴.

From our review of available literature and resources, we were aware that not much existing community knowledge had been systematically published. For example, the community's knowledge about where and how to get support during times of loss and violence is not available, meaning that people often have nowhere to turn to, given minimal resources and supports. Information about the pathways of violence and best practices for prevention strategies was lacking, and among that which had been published, first person narratives or lived experiences of people with psychiatric disabilities were underrepresented.

This was despite the fact that significant anti-violence organizing had been done by groups such as the Queen Street Patients' Council, Urban Alliance on Race Relations, Parkdale Anti-Violence Education Working Group (PAVE), ACT UP, Black CAP, Anti-Racist Action Toronto, No Force Coalition, and Ontario Coalition Against Poverty. (Organizations such as METRAC and Toronto Public Health have also made notable efforts to address violence beyond the psychiatric survivor community, but they fall

JANUARY 2012

Hamilton city council denies Carlton Hall request to relocate

outside the purview of this report). PDAC was born in the realization that despite this powerful history of resistance, community capacity to respond to and prevent violence had not significantly grown, and in fact had diminished with the rise of the non-profit sector.⁵

In light of this, PDAC's challenge from its inception was not only to evaluate what needed to be done to address violence and improve safety for people with psychiatric disabilities, but to do this in ways that would build sustainability. If the road to a safer community had already been built several times, it was time to consider why traces of it were so hard to find.

Under the rubric of the question, "How do we envision making change happen?" we identified specific needs, including, of course, being able to respond to and prevent violence. We also saw an opportunity to formalize the psychiatric survivor community's knowledge of anti-violence mobilizing, and at the same time, model for others how to work with individuals in this community.

To this end, PDAC held a number of group consultations with community members to access their knowledge and solutions for change, and, ultimately, to help us navigate the conversation about how violence happens and is experienced. The consultations were also in response to the commitment we had made to the community to find a way to mobilize their knowledge.

The funding we received from the City of Toronto's Access and Equity Community Grant program gave us the chance to formally document our dialogue with community



FEBRUARY 2012

Toronto police fatally shoot Michael Eligon

APRIL 2012

Never Again!: coalition of people who've had violent encounters with police

members, specifically psychiatric survivors. It also allowed us to make good on our intentions to capture and formalize the expertise within the community and amongst coalition members. An administrative group of three members worked on the grant application and the implementation of a work plan and provided administrative support and leadership. They were supported by a working group of PDAC members interested in bringing this work to fruition. (The larger coalition then evolved into a network that meets three times a year to share our work, strategies, and discuss emerging issues that are likely to be complex in nature.)

At the same time, PDAC sought to activate members of the psychiatric survivor community in light of the urgency surrounding the assaults on individuals in Parkdale. Additional public events that fostered discussion and dialogue among community members were held periodically in the following months. These events helped create some awareness and critical, politicized perspectives of the many ways that community members experience violence.

OUR APPROACH

PDAC recognized that in order to understand the current context of violence, it was important to attend to previous exchanges and historical interventions originating in the psychiatric survivor movement.

As a first step, we developed an analysis from inquest proceedings and other materials, such as media accounts of deaths of people with psychiatric disabilities by police. For example, PDAC member Jenna Reid analyzed 21 inquest reports, noting how people with psychiatric disabilities are talked about, the type of language



DECEMBER 2012

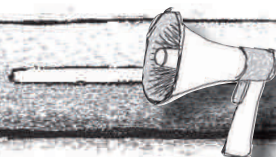
Ontario ends Community Start-up and Maintenance Benefit

used in describing incidents, and what kinds of details were included or excluded. Tracy Mack, another PDAC member, did a media analysis and cross reference check to analyze discrepancies in media portrayals of people shot by police. Ultimately, coalition members wove a snapshot of what the community already knew about violence against people with psychiatric disabilities.

We also synthesized the community dialogue that had been unfolding into a list of assumptions (see Appendix). Not only did this allow us to build on an already-established foundation and help establish sustainability, it honoured and validated earlier hard-won achievements. It gave us a shared place to begin our conversations during consultations.

The next step in this process of consciousness raising was a series of community consultations with participants who identified as having a mental health issue. These were designed and facilitated by the administrative group and a staff person hired to assist with outreach and co-facilitation. These consultations were strategically located in community-based organizations where people with a psychiatric or mental health disability might feel comfortable.

As previously noted, substantial data about the lives of people with psychiatric disabilities have been published, but the voices of psychiatric survivors — who have both confronted the violence directed at them and created anti-violence critiques — have been marginalized. Research led specifically by psychiatric survivors has been even more scarce or made invisible when other “leads” have been placed at the forefront. PDAC, using community consultations, conducted psychiatric survivor-led research⁶



MAY 2013

Rally and March to Stop Violence Against Women, in Regent Park

(Faulkner & Nicholls, 2003) facilitated in collaboration with our allies in the coalition. Together, our aim was to stimulate psychiatric survivors' own critical awareness of the broad ways violence impacts each others' lives and to re-invigorate stagnant conversations.

Throughout the active life of the coalition, we grappled with the question of how best to synthesize our ideas and research, and put it to use on behalf of people with psychiatric disabilities. Members of PDAC brought different perspectives to the work according to both their social, structural, and professional locations. Winding our way through many different views, reactions, and risks was a strengthening and clarifying process. Importantly, at times it was also a source of disagreement and creative tension.

As PDAC's work evolved, part of our effort was to continuously centre the voice and ethos of psychiatric survivor experiences within the work. To this end, we formed a small sub-committee of psychiatric survivors in order to tease out the threads of an emerging analysis, and to frame it within a survivor perspective. This initiated our work to create a psychiatric survivor anti-violence framework.

PDAC's position is that in order for substantial, lasting improvements to be made, the psychiatric survivor anti-violence framework must be acknowledged and integrated into the work of organizations that are based on equity-seeking structures and interested in anti-discrimination practices. This is work that can and should be led by the individuals who use organizational services and should draw from pre-existing literature in the field, include mentors and allies. It is also important to recognize the inter-



JUNE 2013

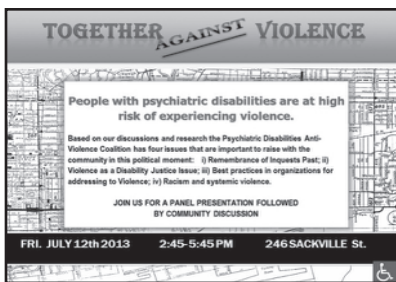
Hamilton police fatally shoot Steve Mesic

secting nature of violence in order to not only accept the complexity, but to find positive interventions and ways to work with perpetrators (especially if they themselves have a disability).

Whether actively or passively, intentionally or unintentionally, many organizations and institutions fail to address violence in the lives of people with a psychiatric disability, or those experiencing extreme emotional distress. A common example of this is when a service tries to address a client’s issue by making referrals to another service, which may be helpful or may cause further barriers. In light of numerous cutbacks to the public sector, this kind of measure on its own is not a viable option; moreover, it contributes to existing harms and inequities.

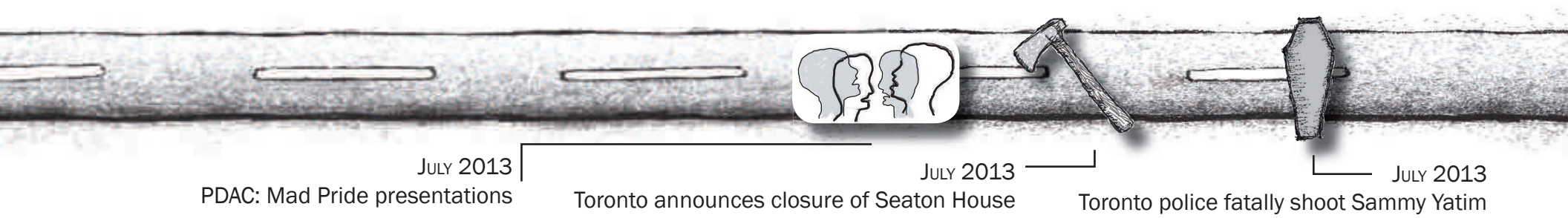
COMMUNITY MOBILIZATION

One of the hallmarks of PDAC has been our attachment to the community of psychiatric survivors. In fact, one of the events that led to the creation of PDAC was a community solidarity rally and march held in Parkdale on April 16, 2011.



PDAC organized three public events in addition to the community consultations. One was a meeting about policing and the psychiatric survivor community, which coincided with the annual 2012 Mad Pride Celebrations⁷. PDAC hosted a four panel member discussion:

1. REMEMBRANCE OF INQUESTS PAST – *According to our reading of inquests into police shootings in Ontario since 1997, 21 out of 32 people who were shot*



had psychiatric histories and/or were experiencing distress at the time of the shooting. (33 now including Andrew Loku and Jermaine Carby) (Reid, 2013)

2. *VIOLENCE IS A DISABILITY JUSTICE ISSUE – An exploration of how the Accessibility for Ontarians with Disabilities Act (AODA) and the UN Convention on the Rights of Persons with Disabilities (UNCRPD) should work for us in the struggle against poverty and violence (Landry, 2013).*
3. *KILLING US SOFTLY? – A critical look at the use of tasers and the implications of more police being armed with tasers. Police are also being trained to deal with consumer/survivors by watching videos about us. What will this mean? (Kanani, 2013)*
4. *R-E-S-P-E-C-T – A discussion exploring best practices for respectful interaction and non-violent intervention? Let's start to get a community-based working definition of how to engage with people in distress, so we can respond to the way police and hospital staff are being trained, and avoid escalating. (Gorman, 2013)*

The events were well attended and included a robust discussion from participants and assisted us to remain focused in our ongoing goal to keep conversations about violence alive.

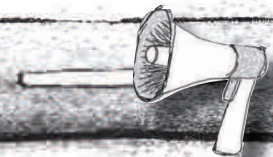
Similarly in July, 2015, following our consultations, we organized a community “report back” event during the week of Mad Pride. This event included presentations by Stitching a Social Safety Net, ARCH Disability Law Centre, ODSP Action Coalition,



NOVEMBER 2013
Toronto police fatally shoot Ian Pryce

DECEMBER 2013

Coroner's inquest into death of Ashley Smith: homicide



and PDAC members. A shared meal and art installations by PARC’s Making Room Collective were also part of the gathering. Several topics of conversation were prominent:

- To educate or not to educate? Education for police and the public has been provided for over 30 years without significant improvement for psychiatric survivors;
- Whether violence against people with psychiatric disabilities is a consequence of stigma or of discrimination?
- An anti-violence framework could serve as a “bill of rights” for how we should support each other, and a means of describing what’s missing from the world we want to live in.



To sum up, when psychiatric survivor communities experience violent events, they often respond emotionally, and struggle to mount a response that addresses the scope of the tragedy. PDAC’s work has been borne of a need to do more than paint yet another mural or attend another memorial. In addition to seeing all our gatherings as opportunities for encouraging critical self-awareness and engaging in critical dialogue, we have endeavored to use them to look back on the road so far and to contribute to the community’s next steps.



FEBRUARY 2014
 Coroner’s inquest into deaths of Sylvia Klibingaitis, Michael Eligon, and Reyald Jardine-Douglas: homicide

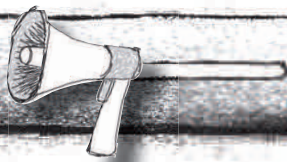
COMMUNITY CONSULTATIONS

PURPOSE OF THE CONSULTATIONS

From October 2014 to May 2015, PDAC hosted a series of consultations. These provided an opportunity to expand on and provide depth to the coalition's reflections and understanding, and at the same time to support this community to reassert its own learning.

RESEARCH APPROACH

The project used psychiatric survivor-led research that involved partners in the research process and recognized the unique strengths brought by each. Community-based participatory principles, such as promoting co-learning, attending to social inequalities, and disseminating findings guided the work throughout. From our ethical perspective, we were consulting with experts in the community⁸, whom we compensated for their contributions of time and knowledge. We wanted participants to know we understood the great value of their contribution and that we viewed them as experts, not token voices for a funder's report. It was also important to start the discussion by validating the importance of individual experiences, though we emphasized building on them by inviting participants to share strategies for change. We facilitated this by introducing the list of assumptions we had already prepared (see Appendix), while providing room for people to narrate their experiences of violence and the impacts on their rights and sense of self.



JULY 2014

“Police Encounters With People in Crisis”: Iacobucci report

“Most people don’t know their rights or how to say No. If you are not well, how can you even understand what that means? There are lots of things people don’t understand. If they are not well, they can’t speak up and have a voice.”

COMMUNITY CONSULTATION
PARTICIPANT, 2015

METHOD

We conducted a series of community consultations, each located in community-based organizations, after having distributed information through them about the purpose of the consultations and details about how people could participate.

The first consultation was a two-hour pilot; participants and facilitators explored the issue of violence with the group using a series of open-ended questions (see Appendix), and received feedback about the consultation method.

Based on the pilot, we chose to investigate six focal points of interest that had been raised by participants in relation to the overall topic of violence against people with psychiatric disabilities: women, trans people, immigrants/newcomers/people of colour, housing, institutions, and public space. Given the historic psychiatric pathologizing of these groups, it made sense to consult separately with them in order to better understand the specific ways in which violence is experienced bases on social location. However, during each group we acknowledged, and heard from community members, that experiences of violence are not tied to discrete social locations but that the nature of violence differs because of the unique ways that multiple social locations interact. In total, 67 community members contributed to a total of seven consultations (including the pilot).

WORKING WITH THE DATA

The small working group of PDAC members coded the community consultation transcripts, and identified common themes both within each group and across them. Quotes were pulled from each transcript and mapped out in order to continue discus-

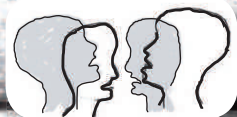
sion and analysis. Our work together was not to simply identify themes and patterns and, as detached scientific researchers, distancing ourselves from the implications of our work. Our goal was to pull together a clear analysis, to elaborate what we already knew, didn't know, and needed to know in order to foster change in the communities we respect and love.

To this end, after an intense process of refinement, our transcript working group synthesized the following eight considerations of how violence relates to the experiences of psychiatric survivors: 1) opportunities for naming the violence; 2) social discourses of violence; 3) alienation; 4) solidarity; 5) time; 6) space; 7) normalization; and 8) meaning-making.

1. **NAMING THE VIOLENCE** refers to community members' descriptions of forms and types of violence. Participants described many forms and types of violence that might be categorized as interpersonal, structural, and noted particularly significant structural violence as it occurred within, or in relation to, institutions. Participants gave examples of the ways in which health care experiences are experienced as a form of structural violence.
2. **DISCOURSES** – This theme refers to how community members used the language of specific discourses, such as patriarchy, to describe injustices and harm. Patriarchy was identified by some community members as responsible for the prevalence of interpersonal violence in the lives of women with psychiatric disabilities, as well as lack of public response to this form of gender oppression.



3. **ALIENATION** prevents community from successfully organizing against violence; it is a result of people being separated from each other by structural violence, and the experience of isolation and exclusion as a primary form of discrimination. This issue extends to why formal complaint processes are not utilized by people who have experienced violence, and the overall feeling that nobody is listening.
4. **SOLIDARITY** – Refers to descriptions of how people protect and/or stand up for each other, care for others by sharing information and support. Some community members stated that solidarity was important in their lives to help cope with violence; for others, the compulsive need to help others given pervasive levels of violence within community resulted in “burnout.”
5. **TIME** – Refers to experiences of being required to endlessly wait - for services, necessities and justice, for example. The impact of the preoccupation with ‘efficiency’ within the non-profit sector was described by community members as playing out in their lives in a variety of ways; including, for example, having to wait for an appointment when in crisis and not getting the time needed with professionals. This often resulted in people suffering dire consequences.
6. **SPACE** – Refers to descriptions of spaces as sites of violence and/or temporary reprieve from violence, and the reshaping of public and private spheres including the changes in character of neighborhoods through gentrification. Community members described the way ‘helping’ spaces, including hospitals and mental health agencies, are experienced as harmful because of discriminatory and dis-



FEBRUARY 2015
PDAC: community consultations

APRIL 2015
Salvation Army Hope men's shelter in downtown Toronto closes



missing interactions with professionals when seeking support. Exclusion from public space as a result of gentrification-related change was a common topic.

7. **NORMALIZATION** describes a phenomenon in which violence against people with psychiatric disabilities is seen as unremarkable and unworthy of being reported, “just the way it is.” This, in itself, is a form of violence that is taken for granted. Participants noted the insidiousness of normalization of violence; it occurs to some degree through the practices of our institutions, denying people the supports they require when they are victims of violence.
8. **MEANING-MAKING** – Refers to the way psychiatric survivors avail themselves of concepts to describe their experiences; for example, turning to references from mass media and culture. This also includes how service providers interpret what service users/clients say about their experiences.

THE SIGNIFICANCE OF THIS DATA

The importance of our findings isn’t tied to the question of novelty, indeed, as expected, people knew and confirmed many of the same kinds of transgressions, abuses, and neglect found in the existing reports and literature. PDAC didn’t embark on the community consultations as an attempt to unearth missing information. Rather, we addressed people’s need to come together; to have a voice, individually and collectively, on these issues; and to appreciate their own authority. This need was continually raised in our community gatherings. As one consultation participant observed, “Sometimes silence is violence.”

“Why is it, do we think, that women are experiencing more violence when they have a psychiatric matter, concern? ...You’re easier to mistreat and that person doesn’t get a consequence because when we’re not completely well we’re less able to look after ourselves, and speak out for ourselves.”

COMMUNITY CONSULTATION
PARTICIPANT, 2015

What became apparent from the community consultations was that:

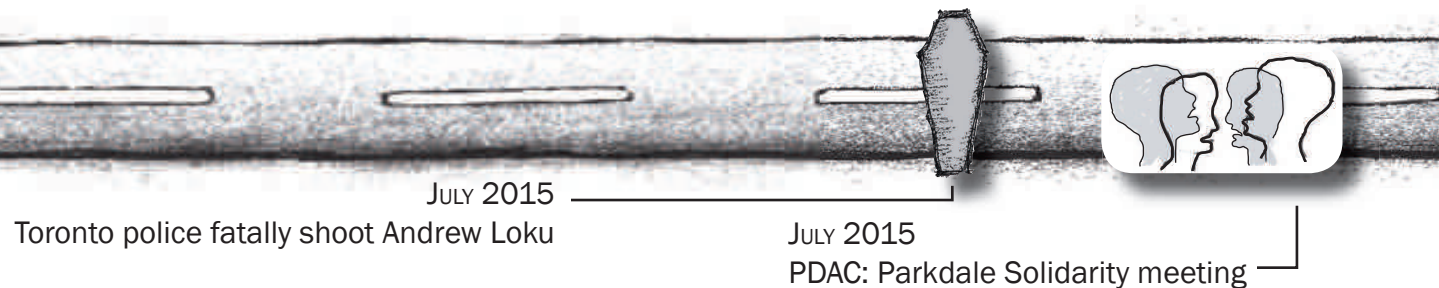
- This population is well-versed on the nature of the violence that permeates their lives;
- They recognize that a coordinated plan aimed at individual, systemic and structural levels is necessary to bring lasting improvements, and;
- Despite many years of sustained effort, their recommendations have largely been ignored and, as a consequence they continue to contend with the same forms of violence that has historically plagued the community;
- They recognize and respond to the need for mutual understanding and support within community. As a result of the community consultation process a group of women from the newcomers/people of colour group continue to meet every Friday to continue talking.

Recognizing this long-standing neglect, PDAC determined the consultations were not needed to build new paths of learning, but rather to delineate the stones of a road that has long existed.

WHERE TO NOW?

AT THIS JUNCTION, AT THIS TIME

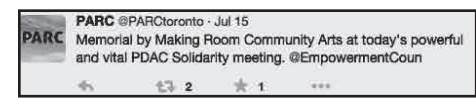
For the last three decades, psychiatric survivors have strived to articulate the nuanced ways their lives have been impacted and shaped by others' perceptions and prejudice. The literature about how psychiatric survivors have organized for change is extensive, locally and internationally.



Despite this history of activism and community organizing, there is an urgent need to address the pervasive lack of understanding about what people with psychiatric disabilities can contribute, and the years of activism and work they have already done. Because their expertise is not recognized as such, their meaningful participation in system planning, responses to crises, and accountability has been only marginal. More often than not, psychiatric survivor voices are relegated to ‘participatory’ models that are tokenistic at best; for example, when people are invited to participate in ways that assume their ‘disability identity’ will suffice to do political and social change work.

The barrier to change is not a lack of information about, or consultation with, psychiatric survivors. Neither is there a scarcity of insights based on various proceedings about how to move forward. At a Toronto conference called *Saving Lives: Alternatives to the Use of Force by Police*, it was pointed out several times that “the reports and recommendations from all the task forces and commissions that have reported over the last 20 years have, in essence, been buried” (Urban Alliance on Race Relations, 2002, p.19).

Therefore, the coalition concludes that if we are to collectively turn a corner in addressing the endemic violence experienced by people with psychiatric disabilities, future work must be premised on the use of a psychiatric survivor anti-violence framework. Without inclusivity at all levels, discrimination and stigma-bearing practices are perpetuated.



USING A PSYCHIATRIC SURVIVOR INFORMED ANTI-VIOLENCE FRAMEWORK

Lilith Finkler, a psychiatric survivor, introduced the term “psychiatric survivor analysis” to describe the importance of a theoretical framework to urban planning design. She argued that a psychiatric survivor analysis is one in which the impact of social and political processes on psychiatric survivors is considered central, rather than peripheral to, scholarly understanding.

We propose that a psychiatric survivor anti-violence framework sets guidelines to examine, analyze, and respond to violence in the community. Common principles should assist individuals, communities, organizations, and allies to work collectively to address violence against individuals/communities of people with psychiatric disabilities. They should also orient priorities for action, recognizing critical diversities in experiences of equity and social justice (e.g., race/racism, sexuality/heteronormativity/sanism).

In response to a crisis of violence, a psychiatric survivor anti-violence framework will:

1. EXAMINE

- Previous reports on similar incidents;
- Previous inquests and recommendations;
- Related reports; for example, poverty reports or equivalent social determinants of health work;
- Relevant legal jurisprudence and organizational or government policies;
- Previous research already done on similar issues or incidents.

2. ANALYZE

- Inquest and report recommendations (whether implemented or not);
- Questions of funding relevant to previous efforts;
- Who benefits from addressing or not addressing issues of violence;
- First person narratives and authorities in identified impacted communities;
- Impacts of violence beyond identity markers such as race, gender, disability, etc., towards analysis of how violence goes beyond categories and often includes the shifting of boundaries.

3. RESPOND

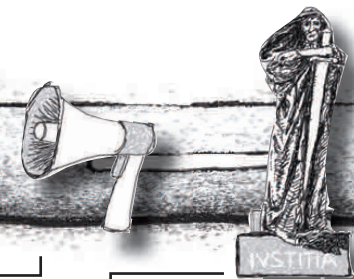
- Plan to build on what psychiatric survivors and researchers have written or stated in research literature and other materials;
- Assist and motivate organizations to develop and evaluate their psychiatric survivor anti-violence framework and implementation;
- Put forward and articulate consequences and implications of change for whom/what (i.e. organizations)

We invite further reflection and development of these elements of the framework, particularly through the actual experience of applying it. We can offer only guidelines for using this frame, given that each user will be faced with its (or his or her) own unique context and situation.

OCTOBER 2015
Ontario postpones changes to Employment Benefits

OCTOBER 2015

Trial of Sgt J. Forcillo in murder of Sammy Yatim begins



MOBILIZING RESPONSES AND ACTION

The coalition identified the following areas as priorities and goals for implementing a psychiatric survivor analysis to address violence against individuals with psychiatric disabilities. They include:

1. MEDIA RESPONSIBILITY

- Media responses to issues and incidents of violence must make the connection to broader issues (e.g., racism; service providers' preoccupation with 'efficiency') and take time to include them;
- Media must recognize that linking violence to individuals, and inattention to broader issues, is problematic and should avoid framing stories as singular, individual problems devoid of the political context;
- Must examine on an ongoing basis its prejudices and biases towards individuals with psychiatric disabilities, as well as question assumptions about who they consider to be "the experts" and their assumed neutrality.

2. TRANSPARENCY AND ACCOUNTABILITY

- Disclosures should include how much money has been spent in previous initiatives to resolve a recurring problem; e.g., who are recipients of salaries, programs, research funding, etc.?
- All efforts should be made to make transparent not only which previous attempts to address violence have worked, but which ones have failed, and why. This should also include details of funding and resources utilized;

- Use communication strategies that help restore the trust and confidence of vulnerable individuals;
- Engage in procedural truth telling, and commit to specific actions, goals, or responses.

WHAT REMAINS TO BE DONE AND BY WHOM

If the anti-violence organizing work already done by psychiatric survivors can be thought of as the paving stones of a road, it is no understatement to say that there are still many boulders standing in the way of future development. They've been there a long time. Psychiatric survivors' pressing needs — and indeed, their right — to safety and wellness demand that we use novel approaches to break them down.

Perhaps the first consideration is the need for policy-makers to accept what psychiatric survivors have already built and use this as a foundation for change. At the same time, they must acknowledge the biases which have led them to conclude that people with psychiatric disabilities are incapable of this kind of practical and intellectual leadership, and that their achievements are therefore non-existent. This form of discrimination is particularly widespread.

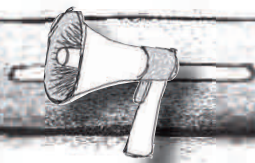
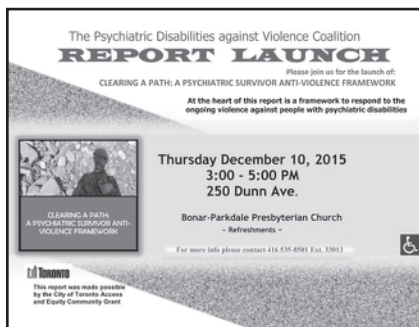
Familiar roadblocks such as lack of committed funding, organizational policy constraints, and apathy cannot be allowed to stand as unchallenged assumptions about "the way things are." Furthermore, systems that reinforce and perpetuate these roadblocks must also be confronted.



NOVEMBER 2015

Coroner announces inquest into the death of Ian Pryce

A psychiatric survivor-centred analysis is key to binding this work to a coherent and unifying structure. It is incumbent on any organization that interacts with psychiatric survivors or has an impact on their well being to develop their own analysis. PDAC submits the psychiatric survivor anti-violence framework as the tool to accomplish this, capable of doing heavy lifting to clear away obstructions, lay a foundation, and pave a safe and dignified future for the community.



DECEMBER 2015
PDAC: “Clearing a Path” report launch

**QUESTIONS FOR ORGANIZATIONS IMPLEMENTING
A PSYCHIATRIC SURVIVOR ANTI-VIOLENCE FRAMEWORK**

1. How well is your organization oriented to the problem of violence for people with psychiatric disabilities. What is the current knowledge of violence against people with psychiatric disabilities? What factors have shaped your understanding? How do you identify relevant sources of information?
2. What processes (networks, community relationships, etc.) are in place to be kept abreast of relevant sources of information and reports (e.g., inquest recommendations, poverty and social determinants of health reports, etc.)?
3. Why are you conducting the analysis? How will you use the analysis? (important as this will impact process) How do you support a psychiatric survivor-led process of analysis? How are people with psychiatric disabilities involved in analysis? What community relationships are required in order to ensure a survivor-led process?
4. How well do you integrate or link your analysis to existing sources of information (e.g., reports examined at the beginning under 'examine')? What does your analysis say about violence against individuals/communities of people with psychiatric disabilities that supports the existing sources of information?
5. Do you identify actions for change? Do you clearly indicate who is responsible for the identified actions for change?
6. Do you emphasize the need for ongoing psychiatric survivor-led change processes that duly recognize and compensate their knowledge, work already done, and ongoing contributions?
7. What are some strategies to incorporate a psychiatric survivor anti-violence framework into policy and initiatives such as risk management practices?
8. What are some strategies that you can develop in order to deal with workplace tensions and competing rights to ensure that you do not invalidate psychiatric survivor history, work and experiential knowledge?

APPENDIX
COMMUNITY CONSULTATION LIST OF ASSUMPTIONS AND QUESTIONS

PDAC HUMAN RIGHTS AND EQUITY PROJECT

A discussion about violence against people with psychiatric disabilities

Our general assumption about violence against people with psychiatric disabilities:

1. When we talk about violence, we are talking about physical assault and emotional harm, as well as systemic power relations that increases the risk of harm and assault.
2. People with psychiatric disabilities (PWPD) experience systemic discrimination, as outlined in the Ontario Human Rights Code (OHRC).
3. Because we believe that PWPD are exposed to the increased risk of harm and assault due to systemic discrimination, because as outlined in the Ontario Human Rights Code discrimination exists if there is harm, regardless of intention.
4. Violence against PWPD occurs both through intended and unintended acts of violence and through omission.
5. Toronto, similar to other North American cities, has a history of racist policing. Racialized people, especially Black and Indigenous communities, have been and continue to be targeted in specific ways.
6. The climate of racism and poor bashing exposes poor and/or racialized PWPD to a greater risk of harm and assault.
7. Gentrification exposes PWPD to a higher risk of harm and assault.
8. Police perpetrate violence against PWPD particularly racialized communities.
9. People with psychiatric disabilities experience higher rates of violence.

Assumptions relating specifically to women:

1. Women labelled with psychiatric disabilities may be more likely to have experienced gender-based including childhood sexual abuse, sexual assault and rape in adulthood, and intimate partner violence. These various forms of gender-based violence may be implicated in women's experience of major depression, anxiety, substance use, and posttraumatic stress and psychosis.
2. This suggests the likelihood of high rates of gender-based violence experiences among women labelled with psychiatric disabilities.
3. As indicated above, people with psychiatric disabilities including poor, racialized, and Aboriginal women likely experience greater risk of both direct and institutionalized harm and assault.
4. These experiences of direct and institutionalized harm and assault might include:
 - being given certain diagnoses (borderline personality disorder)
 - being forced in to hospital and criminal justice system (forensics)
 - being forced to take treatments (e.g., medications, ECT, birth control – Depo Provera)
 - access to, and the amount/level of, treatment received (over-medicated, multiple medications, no response to reported violence)
 - being mistreated by people working in community services and hospitals (not supporting first person accounts, not being included in decision-making)
 - physical, emotional, mental, financial, and sexual assault

Assumptions specifically relating to transgendered people

1. Transgendered people labelled with psychiatric disabilities may have been more likely to experience violence including transphobia, which may be implicated in experiences of major depression, anxiety, substance use, posttraumatic stress and self-harming behaviours.
2. Not getting access to resources required for social and medical transitioning because trans identity and/or expression is understood as a symptom of a psychiatric disorder.

3. mental health service providers not exploring the impact of experiences of transphobia and discrimination on mental health or problems in living.
4. Mental health care service providers not using one's chosen name and pronouns
5. Difficulty accessing mental health services because of discrepancies between health card identification and chosen name.
6. Being forced into hospital and criminal justice system (forensic).
7. Being deemed as not credible or believable, or as questionable, when reporting incidents of violence to police; having police question details of violence in relation to psychiatric label and medication and trans identity.
8. Being mistreated by people working in community health services and hospitals (not supporting first-person accounts, not being included in decision-making).
9. Physical, emotional, mental, financial and sexual assault.

Assumptions relating specifically to immigrants, newcomers, and people of colour

1. Migration often means having experienced multiple countries or temporary 'homes' including difficult locations such as refugee camps and hostels.
2. Precarious status or non-status individuals cannot access social services and health programs
3. Xenophobia, racism, and gender discrimination are often coupled with experiences of immigrating.
4. Many (if not most refugee claimants) have experienced trauma in the migration/immigration process, which is furthered by the trauma of relocating to a new country.
5. Language and cultural differences pose barriers in accessing social supports and adapting to communities.
6. Social isolation and loss of connection with family and friends
7. Navigating systemic processes to secure status, housing, health and educational supports can be fraught with barriers and experiences of discrimination.

8. People of colour are more likely to be targets of racist attitudes which deny experiences of mental health differences and can lead to acts of violence perpetrated
9. Precarious status or managing good emotional health while going through the immigration process where one's future is uncertain.
10. Discrimination based on status can factor in labelling, treatment options, and effective treatments and supports.

Assumptions specifically related to housing

1. Lack of affordable housing with appropriate supports in Toronto contributes to continued substandard housing options as well as ongoing violence.
2. Lack of affordable housing:
 - increases safety/security issues, and/or discrimination
 - forces people to stay in dangerous accommodations where they experience violence and/or discrimination
 - contributes to increased violence and evictions.
3. People labelled with psychiatric disabilities experience illegal evictions when landlords force them out of housing and do not file for a legal eviction through the housing tribunal.
4. People labelled with psychiatric disabilities face discrimination when trying to secure a private rental unit, especially those who are considered low-income/unemployed who are consumer/survivor of the mental health system:
 - experience discrimination when interviewing or applying for housing due to income status or mental health status
 - the power imbalance between landlords and tenants also contributes to more discrimination
5. People labelled with psychiatric disabilities need more supportive affordable housing options.

Assumptions related specifically to public space

1. Shelters, group homes, and supportive housing can be considered public space.
2. The privatization of public spaces exposes people labelled with psychiatric disabilities to a higher risk of harm and assault.
3. The remaking and gentrification of neighbourhoods exposes people labelled with psychiatric disabilities to a higher risk of harm and assault.
4. The increase in 'Not Criminally Responsible' (NCR) designations for minor offenses increases people labelled with psychiatric disabilities to a higher risk of institutional and police intervention.
5. The increase in discrimination based on immigration status/non-status exposes people labelled with psychiatric disabilities to a higher risk of labelling and further status complications
6. The reduction in community services that are safe spaces around status/non-status people exposes people labelled with psychiatric disabilities to greater risk of harm and assault.

Assumptions related specifically to institutions

Violence happens in institutions via:

1. Practices
 - coercion, security guards
 - physician orders are narrow and discriminatory
 - over-reliance on medications as a solution
 - lack of trauma-informed care
 - policies that guide questionable practices (e.g., covert medication, tobacco, search and seizure, urine testing);
 - crowding, seclusion, neglect

- Community Treatment Orders, including lack of information about rights and other matters
 - homophobia, sexism, racism, etc. in subtle forms
2. Law:
- bureaucratic barriers to access to justice; inaccessibility of legal process
 - law-breaking – not following or interpreting law as written (e.g., lack of following informed consent); liberty on hold when waiting to be transferred, etc.
 - clinical opinion in charts as opposed to fact writing (e.g., “She appeared aggressive”)
 - numerous deaths/inquests which are limited to coroner’s discretion
 - problems with the Consent and Capacity Board and the Ontario Review Board
3. Technology:
- documents and processes which govern clients are narrow and impact what clients may or may not be able to access
 - strict diagnostic categories and built-in assumptions with these categories
 - privacy breaches/concerns (e.g., information being shared with the wrong provider, etc.)
 - digital divide between those who can access technology and those who cannot
 - tools of various kinds for monitoring (e.g., hierarchy of who deserves care)
 - funding available for technology as opposed to individuals
4. Other:
- research practices; messaging that is PR/corporate-driven
 - as documented in the Ontario Human Rights Commission report, “Minds That Matter”
 - support for aging population lacking and more support needed
 - overemphasis on the brain to the exclusion of other research.

ENDNOTES

1. The term “psychiatric survivor,” as well as “consumer,” emerged from the ’80s onward and were used by individuals who had experiences in the psychiatric system, denoting a particular political identity to their relationship with psychiatric systems. However, over the last three decades, identity politics within the community has evolved; individuals now use numerous terms to reflect political and non-political relationships, and the intersection of identities to the psychiatric system(s). For the purposes of this report we use psychiatric survivor and psychiatric disability interchangeably. The latter particularly reflecting the entitlements allotted based on designation of ‘disability.’
2. In its analysis of these crimes, PDAC took pains to avoid demonizing the perpetrator, and rejected hyperbole like that used by the corporate news media (e.g., Toronto’s Sun dubbed the attacker, “the Parkdale Killer.” [Lem, 2011])
3. Cissexisms address discrimination for trans people that is similar to what is termed “heterosexism” for LGBQ people. Please see Eric Anthony Grollman (2012).
4. The Empowerment Council, Parkdale Community Legal Services, Parkdale Activity Recreation Centre, School of Disability Studies-Ryerson University, York University, Habitat Services, Toronto Public Health, and community activists have played prominent roles.
5. Though the non-profit sector had initially hoped to attend to issues of social injustice, given the evolution of funding structures, emphasis on “value for money” and “efficiency” has enabled the state to exert more control over what can and can not

be said about conditions of racism, poverty, and other forms of exclusion in communities.

6. “User- (or survivor-) led research is, essentially, research directed by, or led by, service users or survivors. What we mean by ‘user-led research’ is research in which service users get the opportunity to decide on the issues and questions to be looked at, as well as to design and carry out the research. ... Service users may not themselves be carrying out the research if they are active in steering it in some way, but they will be setting the agenda, designing the project and deciding on the questions and topics to be addressed by the research. Ideally service users will be interviewing people, since we believe that this can lead to better outcomes, but they can also be taking part in analyzing, writing up and disseminating the results.”

7. Mad Pride Day originated in Parkdale where people living in poverty demanded better living conditions and affordable housing. It has evolved into a public celebration where collaborative planning and activities celebrating creativity are central to creating a sense of strength and unity among psychiatric survivors. By coming together this sense of solidarity reinforces a shared identity and sense of community. Mad Pride is now celebrated in many countries around the world.

8. PDAC discussed at length the difference between the terms ‘consulting,’ ‘conducting focus groups’ and ‘interviewing participants.’ We decided to on ‘consultation’ in order to move away from the traditional ‘researcher’ and ‘subject’ positions; ‘consults,’ for us, implies more equality.

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