EMPOWERMENT REPORT

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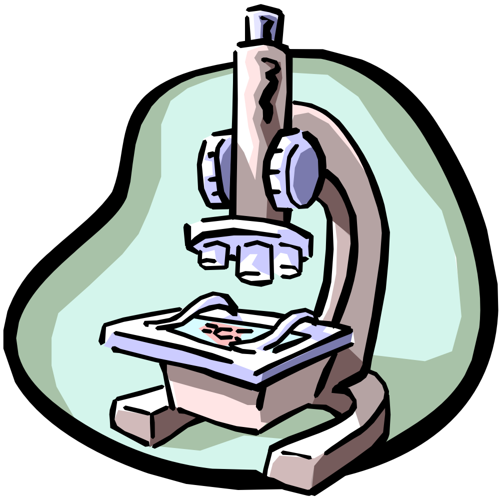
How to Use Science to Protect Yourself from “Science”

By Jennifer Chambers

Science is not generally seen as a friend of the people. People rarely say “Yay, the men in the white coats are here!” especially if one has ever been institutionalized. Most of us identify more with the lab rats than with the scientists.

But when done well, science can be a tool for liberation. The oppression of people is often justified by misinformation. Biased science has been used to justify inequality. For example, there have been many “scientific” theories that have stated in various ways, “These people have less because they are less”. This has been said about women, people with disabilities, people of various races and cultures, people with lower income, people considered mentally ill etc. Instead of questioning their assumptions, as good science requires, scientists have often accepted stereotypes as reality. Then instead of asking, “Is this true?” they ask, “What makes this true?” In this way, problems of society are often treated as defects in individuals, and the defects most often overly assumed to exist in individuals are located in our brains. *Because of this science has often been used to cover up the need for social change. If the problems stem from our own biology than there is no need to address the effects of poverty, racism or abuse on a person’s ability to achieve.*



But when science is done well, it can reveal beliefs that are rooted in prejudice, and it can weed out incorrect assumptions. Traditional (quantitative) science is really designed more to figure out what is not true than to find out what is true. The scientific method generally tries to establish the “cause” and the “effect”. Like detective work, it often proceeds by elimination. A scientific experiment tries to set up what is being studied so that all the other possible causes are controlled and only the one remains. This is the weak point of many scientific studies. Were there other influences or explanations that were not considered?

For example, say you are unhappy, and you are given pills and told this will eventually make you feel better. When you feel better weeks later did the pills cause it, or can you think of any other explanations?

Telling good science from bad is really just about being alert to other explanations for the results. Below I describe some of the flaws common to bad science.

TELLING GOOD SCIENCE FROM BAD

I. The Research Question:

Are there any biases or assumptions you can see in how the question was asked? Would asking it in a slightly different way get different results? For example: “What area of the brain causes depression?” Do you notice any assumptions?

a) It is assumed that the brain is the cause.

b) It is assumed that “depression” has a commonly understood meaning. Some diagnostic labels are so broad they lose meaning, so they cannot be validly measured. (I used to make fun of CAMH ads about depression: “Do you sleep too much? Do you not sleep enough? Do you eat too much? Do you not eat enough?” Apparently there was only a tiny little group of perfect sleepers and eaters who did not qualify as” depressed”.)

II. The Method of Testing the Question:

Does the method of study affect the results? Does the method create any biases that may explain the results?
How the study was done may affect the results more than anything else. Protect yourself by asking the right questions before accepting a treatment.

WHO was studied? How were they selected? Do the conclusions include people who are different than the people studied? How might different people change the results? *For example, if a study involved people who heard voices who volunteered to be brain scanned in exchange for money, the people studied may have been especially short of money. So one explanation for differences in the scans of people who hear voices and other brains could be nutrition.*

Were people compared with each other? Were they really equal?
For example, what if people were divided into volunteers who arrived early and volunteers who arrived late, and the early group got the medication and did better on the memory tests. Would the drug be the only way the groups were different? Perhaps the earlier people already had better memories?

Were they compared with themselves at different times? Was there anything else that might have affected them in that time other than the cause proposed*? For instance, were they more familiar with the test the second time around? Were they in a crisis that is now over?*

HOW were people studied?

Does the test measure what it says it measures?
For example, in the past scientists have based tests of "normal" women or men on answers given by stewardesses and men in the military. Can you see any biases that might result from using these people as a standard? Do you see any problems that could result from using self-report?

If the person being studied, or the person rating them know what is expected to happen, how could this effect what they do?
Sometimes the people being studied want to please the experimenter, or the reverse. The rater and experimenter may see only what they want or expect to see. (When neither the person being studied nor the person studying them knows what is supposed to happen and to whom, it is called a "double blind" study, a sign of a good experiment.)

III. The Interpretation of the Results:

Are there any other explanations for the results?

With the skills for evaluating science that you now have, you are better equipped to examine the science behind your treatment than most health care professionals.

If readers have questions about the scientific basis for particular treatments or diagnoses you may have received, please write and we can look at your questions in the next issue. As well, if you are interested in a class to better understand science, please contact me at jennifer_chambers@camh.net.

EC Membership Meeting

Thursday, February 3, 2011

Training Room A – 1001 Queen Street W.

5:30 p.m.

Guest Speaker – Dr. Catherine Zahn

Meet CAMH's CEO and hear about her plans for the hospital's future.

Refreshments Provided

$6.00 Transportation Subsidy Available

Community Treatment Orders:
Leash Law or Freedom from Hospital?
By Lucy Costa

What is a Community Treatment Order (CTO)?

Community Treatment Orders (CTOs) have been in effect since December 1, 2000. A Community Treatment Order (CTO) is a proposed plan of psychiatric treatment (mostly medications or set medical appointments usually to receive medication) and management of a person in the "community" (instead of the hospital). A psychiatrist develops the CTO "plan" with substitute decision maker(s) and/or an organization that will be part of the "management" team. Hopefully the client (consumer, psychiatric survivor) is also involved in the design of the plan so that it is in fact "client centred"!

What's happened since CTOs were introduced in Ontario?

Although presently it is difficult to assess accurate stats on the number of CTOs, the Psychiatric Patient Advocate Office (responsible for a majority of Schedule 1 facilities) has released information about the number of times that rights advice was offered. In 2001 there were approximately 108 CTOs (issued and renewed for which rights advice was offered). In 2009, rights advice was offered to 1092 new CTOs issued, with 1106 renewals of CTOs bringing the total number to approximately 2,198. A CTO coordination stats document from the CMHA states that from April 1, 2009 to March 31, 2010 three hundred CTOs were issued across 13 facilities (CAMH issued 73).

The budget for CTO service delivery is approximately $830,000, although this budget number does not necessarily reveal any additional funds for CTO delivery expenses that may be covered by other budgets - for example, within case management teams. We are also unsure if hospitals still apply for sessional funds related to CTOs in order to pay doctors. Hospitals were at one time able to apply for about $40,000 annually for this. A mandated review of CTOs was conducted in early 2005. Section 33.9 of the Mental Health Act requires the Ministry of Health review CTOs every five years. The first mandated review was scheduled to occur after the first three years of implementation (although the review was delayed both in getting started and in its final publication). The purpose of these reviews is to analyze the reasons that CTOs were or were not used and to assess their effectiveness. At this point in time, there is still no word about the next mandated review, which is now overdue.

Mental Heath Act Amendments in 2010

Recently, on May 18th 2010, the government made some legal amendments to the Mental Health Act and specifically to section 33.1(5) and section 33.3 (1) on CTOs. The prior version of section 33.1(5) required that a person on a CTO be offered rights advice (whether the offer was accepted by the person or not) as a necessary condition for the issuing of a CTO. Now, with the passing of the amended legislation, a psychiatrist is able to issue a CTO even if the person who uses psychiatric services or their substitute decision-maker has not spoken with a rights adviser to be informed about their rights. The psychiatrist can issue or renew a CTO without even talking to the person who is going to be subject of the CTO as long as; "best efforts" (language of the legislation) were made by the rights advisor to find the person. So a person can be made the subject of a CTO, and have no idea what a CTO is, or even that one has been issued in her/his case.

The second change relating to CTOs had to do with Form 47, an "Order for Examination" (used when a psychiatrist believes that a person on a CTO is failing to comply with their treatment order. This usually means that a person has not taken their medication as it's unlikely a Form 47 would be used if a person failed to show up for special programming). An "Order for Examination" (Form 47), gives the police the power (for up to 30 days) to locate the person, take him/her into custody, and return him/her to the issuing doctor. At that time, the doctor will decide whether to release the person on the same CTO, issue a new CTO, or admit the person to hospital. This section has been changed to make it clear that when a Form 47, an order for examination, is issued, it does not terminate the CTO. This means that there is possibly less opportunity for clients (consumers, psychiatric survivors) to oppose their CTO.

Focus Group on CTOs

The Empowerment Council will be holding a Focus group for individuals on a CTO in March of 2011. We have also been writing the government to request information about plans for the next overdue review. Finally, we would like to plan a public information forum to update the psychiatric survivor/consumer community on accurate statistics for and progression of CTOs over the last ten years. Please contact the Empowerment Council if you are on a CTO, or were on a CTO within the past 6 months and would like to participate in our focus group.

Tel: 416 535-8501 Ext. 3013

Stigma - *By Tucker Gordon*

Two things happened recently that got me thinking about stigma and addictions:

1) The first was the forming of the Anti-stigma committee of the Toronto Drug Strategy (TDS). It's creation came out of a report by the TDS on stigma and addictions.
2) The other was the Canadian Students for Sensible Drug Policy (CSSDP) conference, which I attended in November, where stigma was a topic in a few of the forums.

The Empowerment Council avoids the use of the term stigma because it can soft pedal situations of prejudice and discrimination, for which there is legal protection, while "stigma" may be seen as just unfortunate. The definition of the word can also imply that the person on the receiving end is flawed. People with issues with addiction or mental health require the same protections from prejudice and discrimination, as do other citizens.

Stigma has a few definitions. The World English Dictionary has the following: "a distinguishing mark of social disgrace - *the stigma of having been in prison*" while dictionary.com states: "a mark of disgrace or infamy, a stain or reproach, as on one's reputation". The goal of the TDS anti-stigma committee is to reduce the stigma amongst the general population concerning drug use or having a drug addiction. A recurring but slightly different theme at the CSSDP conference was stigma amongst those who use or have used drugs (across the entire spectrum, from use, to abuse, to addiction, to dependency). What this had me thinking about was how the TDS sub-committee is to achieve its goal, when people of similar experiences engage in the same kind of discriminatory behaviour with each other as the general population. For example:

- When we look down on someone and judge him or her for how they've consumed a drug, for injecting instead of snorting, or snorting instead of smoking.
- When we consider some drugs consumed to be a sign of worse behaviour than other drugs (I'm not talking about the different degrees of physical harm from drugs or the different levels of risk).
- When we say those with a gambling addiction don't have an addiction.
- When those who've chosen reducing consumption instead of abstinence are viewed as failures.
- When those who've chosen abstinence are not respected as those still using talk about the pleasure they feel they get from it, even when the person who's chosen abstinence has stated they're not comfortable hearing about it.

So, now that the EC will be sitting on the TDS anti-stigma committee, the question I've been pondering and would like to hear from you about, is this:

How can we ensure that while we work to reduce prejudice and discrimination about us from outsiders, we don't continue to routinely practice the same attitudes and behaviours amongst ourselves?

To join the EC, find our membership form online at www.empowermentcouncil.ca