PROPOSALS FOR REFORM IN THE AREA OF MENTAL HEALTH CARE

IN BRITISH COLUMBIA

A Brief submitted to the Commission of Enquiry into Mental Health in British Columbia

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Introduction:

I

This brief concerns the state of mental health in B.C. at the present time. The material contained within is taken from two main sources, the practical experiences of the Mental Patients Association in its two years of community organizing and the setting up of services for people who have faced hospitalization, and from statistical material gained from several months research into the existing mental health system. This brief reflects no acute separation of those two sources since the organizational praxis of MPA is firmly grounded in the existing health care system and the social, political and economic conditions upon which that system is based. Many of the proposals and changes we envision come from our experience. Others are arrived at by critical assessment of the prevailing facts, practices and attitudes which keep the present mental health system operating. What follows may be seen as a narrative embodying a critique of what presently exists in the area of mental health and proposals for change to effectively alleviate the hardship and misery many people face in their lives today, inside and outside the confines of mental hospitalization.

II

When people think of mental health and its attendants of "mental illness" and mental hospitalization or psychiatric institutionalization they usually see it as something existing "out there" or away from their collective realities. Yet it should be pointed out that British Columbia's expectations for per capita hospitalization rates is 28.34% for men and 24.14% for women, or roughly, one out of four.[1] One out of four people can reasonably expect to be placed in a mental health facility one or more times during his or her life. In other words, attitudes which see physical health as an area needing more attention than mental health are profoundly mistaken. We see people's problems in living as potentially more serious than physical health problems.

Without at this point advancing any hypothesis on the causes or effects of these problems in living we can note that the social situation is creating problems that it can in no way begin to solve. Unless fundamental changes are made in the province's care, treatment of and attitudes towards people labelled as "mentally ill" the problems present institutions are facing (and which this commission of enquiry is being called upon to correct, or to suggest corrections for) will only grow in number and severity.

III

The Mental Patients Association operates primarily in the Greater Vancouver area. Thus our paradigm, not unfairly we think, for the ills and evils of the present mental health system is Riverview Hospital which is located about 20 miles outside of the city and which services the whole province. The majority of people in Riverview come from the Vancouver area.

There are some fairly well-known facts about Riverview Hospital which tell much of what it stands for in the system of mental health care in the province. In 1970 the in-patient population of Riverview averaged out to 3,514 persons.[2] Of those persons 2,217 were committed by medical certificates and legal procedures.[3] Out of the total in-patient population 66% were put in against their will by another person for all sorts of reasons. The recidivist rate for the hospital in 1970 was 2,137 persons out of 3,514 or 61%.[4]

Two comments are in order right away. First, most people who receive psychiatric care in Riverview do not choose to do so themselves. Rather they are forced to "receive care" in a climate they would probably not ordinarily choose. In other words people who are "certified" as being "mentally ill" are locked up and held prisoner in a large institution. Most levels of humanitarianism would deplore this brutal fact. Second, the majority of people who"receive care" in Riverview seem to find

this "care" unsatisfactory as the rate of recidivism already shows. On a general level, 61% of those who are placed in Riverview either by their own choosing or by medical certificate go back at least once more either on a voluntary (informal) or involuntary (formal) basis. These comments lead into two areas of theoretical and practical interest: the nature of the care provided by the mental health care system in B.C. and the nature of "mental illness" in the aegis of which the present practices are justified and carried out.

IV

The concept of "mental illness" has been the key concept in the practice of psychiatry and psychotherapy. The validity of this concept had gone unchallenged since the turn of the century. Now increasing numbers of psychiatrists and social scientists are beginning to lay the groundwork for a solid critique of the whole notion of "mental illness" and the accompanying categories of psychiatric diagnoses. Thomas J. Scheff points out in a paper entitled "Schizophrenia as Ideology" that "...the concepts of mental illness in general - and schizophrenia in particular - are not neutral, value-free, scientifically precise terms but, for the most part, the leading edge of an ideology embedded in the historical and cultural present of the white middle class of Western societies".[5] Rather than a series of medical categories "mental illness" and psychiatric diagnosis represent the type-casting of culturally normative behaviour. Influenza is influenza the world over. Schizophrenia is obviously not since the"schizophrenic" is treated very differently in India than in Canada. To put a gloss on Scheff's beautifully precise phrase one could explain that as society places more demands on the individuals within the social setting the more those individuals are expected to conform to predetermined (social and cultural) standards of behaviour. So if a housewife decided she no longer wanted to be a housewife and her husband felt she should, her refusal might be condemned as "sick" behaviour. The state could then

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see to it that her behaviour be changed back into the behaviour of a housewife regardless of her choice in the matter. This might involve hospitalization where it is very doubtful that her wishes and aspirations would be respected or encouraged. Somewhere along the line a psychiatrist would place a diagnositc label on her particular form of revolt.

This example could be amplified by direct use of case studies but the point has been made. "Mental illness" cannot be said to reflect medico-scientific knowledge. Nor can mental health care. These two sets of categories and praxes can only be seen as a "scientifically"justified attempt to promote some public order to which criminal proceedings cannot apply. Mental health care as it is presently conceived is by definition repressive. This leads back to the point at the end of section III on the nature of "mental health care".

"Today, treatment and care of the mentally disordered within the community is accepted in the same manner as is treatment and care of those who are physically disabled".[6] This, the concluding sentence of a government report, reflects the problems in mental health care better than anything we could say. It uses the myth of "mental illness" as its rationale and, by stretching the point beyond all conceivable recognition, posits a sameness between health care in general and mental health care which is blatantly untrue. No one, except a psychiatric case, is committed to a general hospital against his or her will. The re-admission rate to a general hospital for the same physical complaint is nowhere near 61%. If 61% of people who had appendicitis had to go back for the same thing there would be a full-scale investigation into the hospital's competencey to treat the sick. Yet the figure has been accepted with equanimity for Riverview. In 1970, 77% of the people placed in Rivewview were there for over a year as of December 31st. It is doubtful that Vancouver General Hospital could make such a claim. On the statistical level alone the claim that mental health care is like any other form of health care is false. Equally false

good

is the claim that it should be carried on in the same manner. On the human level such assumptions are dangerous.

It has been our experience in the Mental Patients Association that people's emotional problems (seen by psychiatrists and mental health professionals as "mental illness" are in fact problems in living. If a person has been unemployed, lost his family or suffered some other kind of social upset, the degrading ritual of hospitalization is hardly ever beneficial. Most of the testimony gained from people who have been labelled "mentally ill" is that the experience of hospitalization produced bad effects rather than help. The labels themselves produce a stigma which makes it difficult for a person to live freely and confidently. It complicates what is usually already an untenable social or economic position, that of being poor or on welfare with no apparent way out. Other sections of this brief will deal more fully with the relationships between social and economic pressures and problems in living or mental breakdown. Many of our recommendations inextricably link these facts together since our experience in MPA has forced us to deal with emotional crisis on a level which includes welfare, legal rights and a host of other problems common to the poor. In the majority of cases this kind of approach is necessary. The majority of people who find themselves in mental hospitals or large, public psychiatric institutions are working-class and poor.[7] Case studies have substantiated this fact. Middle and upper class people generally receive private care or "plusher" treatment in expensive private homes and therapy.

When it comes to dealing with problems of working people or the poor, private therapy is irrelevant and the large institution (we feel it is axiomatic that poor people wind up in large institutions) is harmful or at least inadequate. The psychiatrist who earns between $35,000 - $50,000 per year cannot relate to a person whose income is $102 per month. The class gap is simply too wide. Nor can a person on welfare or a worker afford a psychiatrist unless he or she takes "pot-luck" on a medical referral. On the other hand the large institutions are failing in their stated aim

of "cure" for the "mentally ill".

V

We have outlined some of the problems we see the mental health system facing in British Columbia. We have done so in polemical fashion not only because the situation is growing more serious every day but because those who have been labelled "mentally ill" in modern society have suffered greatly in the hands of their persecutors and even their "helpers". The point made above will be returned to and amplified in what follows. We hope we will be listened to and, most important, we hope action will be taken. The Mental Patients Association hopes to be a part of that action.

MPA

I

The Mental Patients Association has been operating for approximately two years. In this period it has grown from a small group of people who felt existing services for ex-patients and people with emotional problems were inadequate to a membership of about 500 people. Of that number about 150 are more or less active members and recent tallies show that about 75 people a week use the Drop-In Centre, the focal point of MPA's activities. In addition to the Drop-In Centre MPA operates two in-town residences (a third is being planned) and a farm in Whonnock, B.C. The residences and the farm have a capacity for about 30 people and are full at the time of this writing. All of these services will be described in more detail along with funding and staff, but first a discussion of MPA's theoretical underpinnings, why it exists and what it hopes to achieve in the future.

II

MPA is a self-help group dedicated to serving people with experiences in hos-

pital and people whose problems in living have become too great for them to handle themselves. In other words most, but not all, of the membership have had the experience of being mental patients. What made organization possible amongst mental patients?

There are essentially two reasons for this. First in the macro-political sense, the sixties saw the emergence in North America of community groups whose generally stated (collective) aim was to provide services, help and organization to oppressed groups within the society. Blacks, Chicanos, women, poor whites, and native peoples in the U.S. and Canada began organizing by themselves for themselves. In all cases the organizational base seemed clear, the ghettoes, barrios and certain neighbourhoods in town. These areas provided the micro-political area or geography for an organizational thrust of some sort. Although conditions were a bit different in Canada than in the U.S., forms of community political organizing did grow here as well especially in Vancouver with youth groups, native people's groups and women's groups. Thus there was a general climate for organizing and a fair bit of material and resources to draw on for support.

MPA's micro-basis consisted of the fact that there exists an "invisible community" of people who have been made mental patients. Through the high recidivist rate in hospitals and day hospital programmes people saw each other regularly while under care of one sort or another. Certain links and friendships were established which broke down after people left an institution. There were reasons for this. Society places a stigma on people whom it has summarily banished from the community under the sentence of "being mentally ill". This stigma carries over and keeps apart people who have established ties amongst each other. This process in turn leaves people who have been in hospital isolated and alone to deal with their problems - often with painful and disastrous results. Connections begun in hospital had to be maintained. Here is a statement from one of the founders of MPA which amplifies the above points.

The experience related took place in a day hospital.

> "Our decision to form MPA - to extend these connections and make them visible - grew out of an experience which every patient has experienced. One of our fellow patients killed himself. Following the weekend break, during which time the day hospital was closed and we were all 'on our own', we congregated for the Monday morning meeting. The head shrink solemnly announced that he had some bad news. 'Gordon Kinnon' he said, 'suicided over the weekend.'
>
> This was the third such announcement I had heard in my few months as a patient. Again I was filled with feelings of shock and rage that such things continue to happen.
>
> The news of Gordon Kinnon had an especially grotesque overtone that made it press in all the more closely. There were at the time two Gordons at the hospital and since most of us did not know each other's last names, our eyes darted around the group to see which Gordon as alive and which dead. The reaction happened instantaneously and somehow made each of us more aware of our common vulnerability to dead Gordon's fate.
>
> Some of us cried. Someone kicked a chair across the room. We talked for a long while. There were self-recriminations. 'If only I had called him over the weekend'. Uncomprehending grief: 'Why didn't you prevent it? That's your job.'
>
> What we all knew was that the death was preventable and the we could have prevented it. He didn't have to be alone in the city.
>
> Eventually someone suggested that we run off a patients' phone list. Each of us received one and soon most copies were tattered from use. Not long afterwards we decided to begin an organization through which we would maintain our contacts and involve other patients and ex-patients".[8]

The result was the Mental Patients Association inadvertently formed by Gordon Kinnon in the same unwitting way that Fraulein Anno O. pointed the way to psychoanalysis. MPA's initial premise was to prevent needless suicide and hurt through people's being alone with their problems and suffering. In an organizational way it sought to link people together, people whose common experience it was to have been a mental patient.

At present there is no other such organization in Canada or the U.S. More-

over there exists no comparable service either through a community group or professional or state service. Nor have such matters been considered by professional or state services. MPA's success with federal government grants seems to bear this claim out. Proposals such as the Hastings and Cumming Reports offer no real alternatives to what exists presently to off-set the human misery which comes from individual isolation in society. We will deal in more detail later with the substance of these reports and their inadequacies and go on now to say more about MPA itself which, to be sure, has its own shortcomings and gaps.

III

MPA has grown along democratic community lines. The people who govern MPA are the members themselves, through vote and discussion at general meetings. The residences are controlled by the people who live in them. The most "therapeutic" thing MPA does is to allow people to control their own living and activities environment. This is extremely important and, we insist, necessary in almost any form of mental health facility. For the most soul-killing "fact" that has been impressed into the heads of mental patients is "You are mentally ill and cannot be responsible for yourself or look after yourself". The wide-spread practice of involuntary commitment attests to this and legitimizes it in the minds of psychiatrists and mental health workers.

The fact is, and MPA by its very existence proves this, the vast majority of mental patients and ex-mental patients can make decisions for themselves and collectively determine the immediate direction of their lives. Matters such as employment and social standing are clearly beyond their control but they are so for the majority of people in society. We feel that the present treatment of people in hospital as people who cannot decide for themselves what is best for them is grossly unfair, unjust and misguided. True there are people in MPA who are temporarily too depressed or anxious to take very much control over their lives. Most

can be brought back in through group help and solidarity. Where we fail in some instances, the failure can always be traced back to organizational deficiencies and not to the individual concerned. For example, at the moment MPA lacks a comprehensive crisis program to deal with people whose lives have crashed out from underneath them and who often need intensive help and care until they get back together again. We feel too, that if people in hospital appear "sick" and helpless it is as much an effect of institutionalization and the practices of the hospital itself as any "psychosis".

Just as the existential psychiatry of R.D. Laing, David Cooper et al is "anti-psychiatric" in its rejection of standard psychiatric practices and treatment MPA can be said to be "ant-psychotherapeutic". The demonstration has been to our satisfaction that the most effective form of therapy is the collective creation of an environment whereby people can live and work together taking part in activities which are freely chosen and not forced upon people. We realize that this is not for everyone, that it appeals mainly to people under thirty years of age. People over thirty and into middle-age do take part in MPA activities but we are still weak in this area. We have no clear-cut solution to the problem but we are presently trying to devise programs which will be attractive and stimulating to people over thirty years of age.

IV

As stated previously, MPA has a Drop-In Centre, two city residences and a farm. We present a brief description of each and what its activities and areas of concern are.

The Drop-In Centre: is the focal point of MPA's activities. The Drop-In houses the offices of MPA, a crafts program, is where meetings take place and where a modest crisis program operates. It will soon contain library facilities with material on the mental health field and books for reading enjoyment. The Drop-

In Centre is the place of contact for most of the membership. It is open 24 hours a day with a coordinator on duty from 4 p.m. to 12 a.m. every day. The office maintains contact with the government, persons interested in MPA and other patients' groups in North America. Activities such as song nights, pot-luck dinners and discussion groups are carried on in the Drop-In Centre.

The residences: are communal houses where people from hospital situations live and share the running of the houses together. Decisions concerning the houses are made by the residents themselves. They decide in house meetings who will live in the house after meeting with a prospective resident. There is no fixed limit for a stay in residences and residents pay $75.00 per month room and board, an amount sufficient to meet the rent costs and affordable for a person on social assistance. One residence is located in the east end of Vancouver and the other in the Kitsilano area.

The farm: is located near Whonnock, B.C. With MPA money it purchased 300 chickens which in turn have produced more chickens for consumption and for egg-laying. The farm has other live-stock in the form of cows and calves. A residence program has recently begun with cooperation from various social workers in the Greater Vancouver area. The farm also has good relations with the near-by community. At present the farm is full to capacity with residents and more space is being developed. The farm maintains contact with the rest of MPA through regular city-to-farm visits organized from the Drop-In Centre.

To organize programs, insure organizational continuity and administer certain areas MPA employs 19 paid coordinators. These coordinators are elected by the membership in a secret ballot at a general meeting or a specially called election. This amounts to a group hiring process. The coordinators are paid on funds provided by the federal government's Local Initiatives Program (15 salaries), the Company of Young Canadians (3 salaries) and the B.C. Government (1 salary).

The coordinators are hired to work in areas, incoporating as many of the

membership as possible into the work. Many members work on the Vancouver Opportunities Program welfare subsidy scheme thereby getting some financial remuneration for a certain number of hours worked. The main areas of work are the Drop-In Centre, the residences, the farm, office, research, membership, activities, newsletter and newspaper, community relations, and transportation. One or more coordinators are assigned to work in each area. There is not the space here to go into these areas singly and in detail but taken together they form the bulk of MPA's organizational work.

V.

In summary MPA is a community service dedicated to meeting the needs of mental patients and ex-patients. That it has been successful in its own scope of operations is apparent by the large numbers of people who use its services and take part in activities. Our future activities will involve improving the areas in which we are weakest. These areas have already been mentioned. We propose MPA as a serious model of a partial alternative to the existing mental health program and one which could work well in the framework of a broader progressive mental health system.

New Directions In Mental Health?

I

It is hard to find a person in the mental health profession these days who will argue that a centralized system of care and treatment is good or even desirable. Most agree that a system involving decentralization is needed. In principle MPA agrees but proposals which hide behind the magic work "decentralized" often reflect little or no substantive change in thinking about a whole range of concepts and practices: mental illness, health care, treatment, the role of the professional, psychiatric labels, the role of extra-professional groups, etc.

strips of band-aid

In fact community-based health care proposals oftem simply attempt to eliminate the awesomeness of a huge hospital in favour of more, smaller hospitals. And, proposals of this sort frequently do not negate the large hospital altogether but see it as a last resort for "chronic cases". The Cumming "lily-pad model" is an example of this.

II

In the preceding section of this brief we pointed out how a community-based service to patients and ex-patients could meet many of the needs of those groups without a strong reliance on professionals. At least two briefs, recently published and dealing with health care and mental health care, minimize the role non-professional groups could play. The "Report of the Community Health Care Project to the Conference of Health Ministers" otherwise known as the Hastings Report and the Cumming Proposal both see the valid work done in the field as being professional. Both reports stress decentralization and team-work without substantively attacking or altering attitudes towards health care. The Hastings Report does out-line a broad enough scheme for health care in general to make some more basic changes possible despite its strong professional bias. For example it admits that "It has been recognized for some time that many health problems have a psycho-social and economic component and that many psycho-social and economic problems have a health component".[9] At the same time the report goes on to recommend the combination of medical and social work services rather than a broad community-based program for the alleviation of economic and psycho-social problems.[10] In other words it falls into the main error of professionalization; that skilled professionals from many different fields are best equipped to deal with social, political and economic problems.

This is a supposition we can only see as arrogant and patronizing. Community groups in self-help projects have been officially ignored by professionals in related areas. Health care systems in which those who use them are seen as people who might have a say in how they are run rather than simply as receivers of services are virtually unheard of. Yet people would agree that the social life of a community depends for its quality on the amount of in-put individual members of the community can have. Still, people have no say at all in a service as vital as health. At this point people are seen only as recipients of health care, rather like consumers in a super-market who have no control over the price of goods or even the selection of the goods which are stocked. In other words members of the community are alienated both from the community itself and from the services they might receive within that community.

While arguments for scientific expertise might be relevant vis-a-vis the knowledge of what is wrong with a person physically (still no argument why lay people should not participate in many levels of health care planning and the determination of community needs) an entirely different rationality is called for in the consideration of mental health needs. Psychiatry has been wedded to medicine so that the two are inextricably bound up but:

> "...there are certain natural-scientific principles which have been imported without qualification by some workers into the field of the sciences of persons (or anthropological sciences) and have been proclaimed as desiderata if not first essentials or preconditions of any study that would call itself scientific. This tendency has led to endless methodological confusion and repeated attempts to prove things in terms in which 'proof' is an a priori impossibility in this field".[11] *(emphasis ours)*

The importation here is the linkage of problems in living (psychiatric disturbances) to the medical science of disease. The confusion results in statements such as "mental illness is an illness like any other". Our point simply is this. Mental health has marked differences from other forms of health care. Even presently this is the case although many would dispute this. There

is nothing that can properly be called a "disease of the mind". "The expression 'mental illness' is a metaphor that we have come to mistake for a fact".[12] Medicine's place in its dominion over people with problems in living is highly questionable. Our conclusion from all this is the emphasis in the future should be placed not upon streamlining professional services but on finding ways to de-professionalize mental health care and our notions of it so as to put it in its proper social perspective and to allow the community, especially those who are having or have experienced severe problems in living, both social and economic, to have more control and influence on what is happening in this area. If these suggestions sound totally 'idealistic' it is because they have never been seriously considered by professionals let alone tried. Our previous discussion of MPA was an attempt to introduce people to an experiment with just these ideas put into practice.

III

The above criticisms apply particularly to the second of the two reports mentioned, the Cumming Report. Its author proposes city-wide coordinated health teams composed entirely of professionals who, from certain bases in the city, would provide for many needs related to mental health. One of the aims of such a strategy is to partially eliminate in-patient forms of care and to significantly de-populate larger mental institutions. We support these aims so far as they go. It is significant that the Report does not allow for the eventual closure of places like Riverview. We feel, for a variety of reasons -- many already stated, that large institutions must be abolished in any truly progressive policy. But as we have already stated "de-centralizing" existing facilities is not enough. Along with de-centralization we would propose community-control of facilities along with de-professionalization. The Cumming proposal tries to minimize these last two alternatives.

Community groups are viewed as consulting mechanisms only. Nowhere is it clearly indicated that they will have a role even approaching that of psychiatrists, psychologists, nurses and social workers. In other words the services are still removed from people through professionalism. Indeed some pretty serious decisions affecting certain people's lives will be made by professionals. In stating the criteria for whether or not a person will be served by the proposed system the report states, "The most common reason for non-acceptance will be that the person is not ~~rich~~ sick enough".[13] The report further says, "We state as a premise that treatment for mental illness should be humane, <u>as effective as our knowledge permits</u>, and readily available with a minimum of environmental dislocation".[14] *(emphasis ours)*. Again, a small group of people will be making decisions for a larger group.

We could go on finding sentences in the report to substantiate our criticisms. The important points have been made. To sum up, the over-all tone of "A Plan for Vancouver" is that it is too pre-determined: that people with problems in living will be codified as to the service they'll receive; in other words, it strikes one as a ready-made health care scheme when perhaps more flexible and less structured approaches are needed. For in any pre-determined system valuable human experiences are lost. A pre-determined system can under-cut the possibility of a creative path chosen and carried out by the person who "receives services" from such a system.

<u>By Way of Conclusion</u>

I

This brief has dealt with several critical points on the practices and attitudes of the present mental health care system in the province, its misconceptions and failures, certain proposals for the future made by professionals (the Hastings and Cummings Reports) and an out-line of the scope and activities

of MPA as a possible alternative to much of what presently passes for mental health* care in the province.

The scope and activities of MPA could be summed up thusly: human happiness, growth and well-being can best be achieved through people taking part collectively in structuring and shaping their own lives, living situations and destinies. Psychiatry, by placing a person in the position of "patient" or "client", destroys the possibility of an alternative path or direction for human fulfilment.

Mental health systems at present are dedicated to a psychiatric medical perspective and, as a consequence, hinder human development. The fact that the majority of people in modern-day mental hospitals are locked up bears us out on this point. The fact that these people have no legal rights to speak of once they are locked up and the power rests with a few other people to decide how they will behave and when they will leave shows what a soul-killing experience "mental health care" can be.[15] It should be the explicit task of any new system of mental health care to redress the aspects of total control now exercised by psychiatirc agencies over people's lives. De-centralization is a step in the right direction in terms of the structure a new system might take but it is only a step. The people in the community and, especially, those effected by the services should have a major say in their development and implementation. In the case of MPA it was just those people who founded it. Professionals did not play and have not played any part in it.

II

To propose a model for mental health care is not easy. There exists a large system primarily funded by government sources which stands in the way of change. However, any new system (we have no doubt there will be some changes in the future) should take into account the points stressed in the brief. In point form these are:

1. De-professionalization - allowing patients, ex-patients and lay persons who have experience in dealing with people with problems in living to take a major share of the responsibility in running new systems.

2. Community and user control - let the facilities express the wants and needs of the surrounding community and let the community run them through lay boards of directors. Professionals might be viewed as consultants instead of the other way around.

3. Creation of micro-communities - the best care or therapeutic setting would be a community-within-a-community where patients gain control over their own lives by planning their own living situations and running them. There is plenty of room here for people to advise on and coordinate or initiate programs (as in MPA).

4. Integration with other community settings - a micro-community will always have the opportunity to cooperate and work with other groups in the city. This would alleviate any possibilities of a community of people who are overcoming their problems to become insular.

These are our specific proposals. With planning and coordination they can be implemented in any new mental health system. They are points presented in germinal form because we realize that no one can fully plan and implement a complete system. It will have to grow.

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* We have used the term "mental health" repeatedly in this brief because it is generally known what is meant by it. One could safely say, however, that "mental health" is perhaps a misnomer and the real issue is human happiness, freedom and growth.

FOOTNOTES TO BRIEF

1 B.C. Mental Health Branch, 1970 Statistical Report, page 14

2 Ibid

3 Ibid

4 Ibid

5 "Schizophrenia as Ideology", Thomas J. Scheff from Schizophrenia Bulletin, Fall 1970, page 15

6 A Summary of the Growth and Development of Mental Health Facilities and Services in British Columbia, 1850-1970; Mental Health Branch, Department of Health Services and Hospital Insurance, April 1972, page 25

7 Hollingshead and Redlick

8 Rough Times, Vol. 3, #2; November 1972

9 C.M.A. Journal, August 19, 1972, Volume 107, page 365

10 Ibid

11 David Cooper, Psychiatry and Anti-psychiatry, Paladin Books, 1970, page 17

12 Thomas Szasz, Ideology and Insanity Anchor-Doubleday, 1970, page 23

13 Dr. John Cumming, "A Plan for Vancouver", page 6

14 Ibid, page 3

15 G. Thomas Szasz, Law, Liberty and Psychiatry, Collier Books, 1968