HEAD ON

—INTO THE EIGHTIES—

The psychiatric vocabulary and definition, which once seemed such a liberating instrument for modern man, have now woven a tight and strangling noose around the neck of the brain.

The expression "mental illness" as a convenient term of derogation, denigration, or thinly veiled attack, has thus become part of everyday life.

Mental illness now implies not ordinary sickness but obnoxious and socially deviant behaviour.

The diagnosis of psychosis is employed to justify the patient's forcible retention in the hospital, and also to legitimize punishing him in the name of therapy.

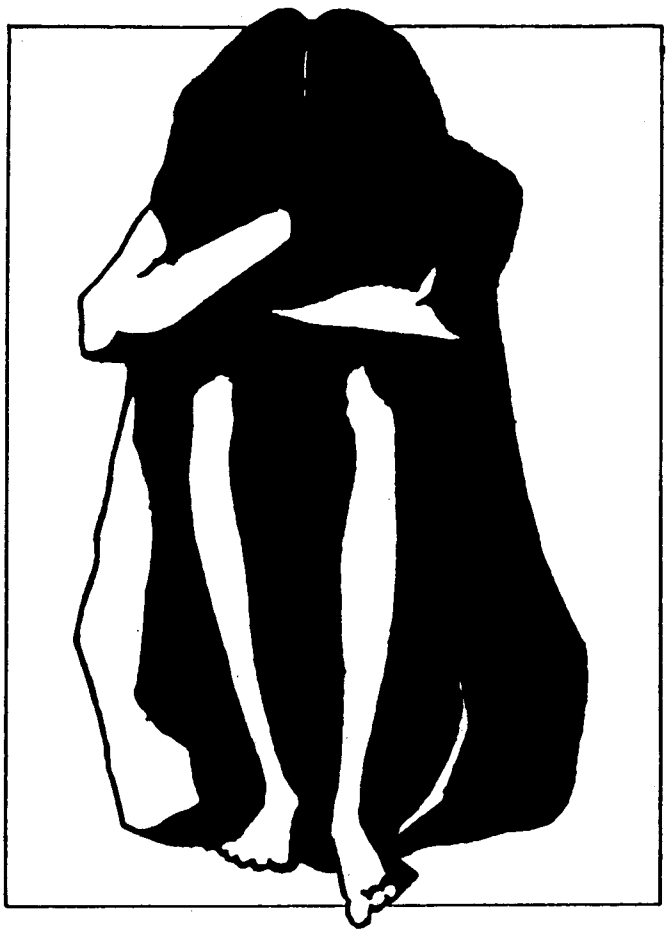
Throughout history, those in power have always sought to justify their control over the weak and oppressed by claiming to act in their interests. This was the slaveholder's attitude toward slaves, and the crusading Christians toward the heathen. Today the psychiatrist adopts a similar attitude toward the mental-hospital patient.

It is a fact that the vast majority of committed patients are members of the lower classes. Upper-class persons are virtually immune from this sort of social restraint. This point deserves emphasis.

It is pertinent to recall the case of Governor Earl Long of Louisiana. When his wife tried to commit him to a public mental hospital in his own state, he freed himself by dismissing the hospital superintendent.

—Thomas Szasz,
from *Law, Liberty and Psychiatry*

CONTENTS



PREFACE

This is an updated (and due to budget blues, condensed) edition of *Head On*, in which the Vancouver Mental Patients' Association Society moves, "head on", into the 1980's. Not the same MPA that began in 1971, nor even the same as it was when the first version of *Head On* was published in 1978. Developments over the years have warranted producing a more current representation of this very interesting organization.

Over the years MPA has grown and changed, as any vital organism does. Members have come and gone. The Association has adapted to changing economic and political currents, which recently have threatened the very existence of many grass-roots organizations that depend on government support.

Indeed, MPA has compromised some of its earlier radical ideals in order to be accountable to government, and some have cried "Co-optation!" It might also be said that any "alternative" that's been around for 12 years ceases to be an alternative. MPA's size works against the active involvement of *all* members, and thus exists less "self-help" ethic and more "service delivery".

Nevertheless MPA has continued for many years to provide housing and support for mental patients in the Vancouver area.

Individuals and groups regularly request information about MPA; some out of educational or professional interest and some because they want to start similar groups. It's not easy to establish and maintain a self-help collective but many groups all over the continent, in fact the world, are succeeding.

If this booklet helps anyone directly involved in mental patient advocacy work, or educates the "average" person about the cause, then its purpose will be fulfilled.

—the Editor

HISTORY

As a patient in a day-care program, Lanny Beckman experienced an alienation and powerlessness that led to a general lack of faith in organized mental health services. Specifically, Lanny and several fellow out-patients found their day-program inadequate since crises often arose on evenings and weekends when hospital staff were unavailable. Also it was against the rules for patients to have personal or even telephone contact with one another outside of the institution.

The suicides of two fellow patients, on weekends, prompted both a strong emotional response and the clandestine circulation of a patients' phone list. As time passed, the group found more real support from their informal network than from the therapy they received during hospital hours. They decided to try to find other people who were dissatisfied with established psychiatric treatment. With the help of others, notably Barry Coull, and a sympathetic newspaper columnist, an open meeting was publicized. More than 75 people turned up, and out of their collective discontent and desire to provide services for themselves, MPA was born.

One man offered the use of his house at low rent, and it was set up as a meeting place, 24-hour crisis center and 10 bed residence. A grant from the graduating class of the University of British Columbia and various donations took care of rent and furnishings initially. Funding was secured from the Company of Young Canadians for two nominal salaries, but much of the work was done by volunteers. Incorporation as a non-profit society with a consistution and 5 member board sped up the move to a more stable financial situation. The objectives of the Society were established as:

1) To assist in the rehabilitation and promote the welfare of mental patients and former mental patients,

2) To establish and operate social, vocational, recreational, residential and emergency facilities for the above purposes,

3) To acquire funds and other assistance for the above purposes, and

4) To print, publish and distribute literature for the above purposes.

Seeking out, applying for and renewing grants was a lot of hard work, but it paid off. MPA gradually established itself as a fiscally responsible, viable alternative to established facilities. Funding is a never-ending struggle, and MPA has rarely missed a chance to secure funds and initiate projects.

In 1971-72 grants were obtained from the CYC, Vancouver City Council, and a variety of sources including the Department of the Secretary of State, the Metropolitan Council of the United Church, the B.C. Telephone Company, and the Kinsman and Donner Foundations. MPA also started receiving part-time VOP (Vocational Opportunities Program) workers through a Ministry of Human Resources program to supplement the incomes of people on social assistance. A similar Community Involvement Program has also supplied many workers to help with cleaning, answering phones and other tasks, mainly at the Drop-in Center. City Council, who have been an ongoing source of support over the years, granted MPA surplus furnishings and bedding from a hotel that was being closed down. In December of 1971 a major break came with a grant of just over $36,000 from the Department of Manpower and Immigration Local Initiatives Program (LIP), which allowed the hiring of 12 Coordinators. This federal program was designed specifically to fund community-based, innovative social service projects. As Judi Chamberlin points out in her book *On Our Own*: "It is easier to gain approval for an alternative service if the deciding body is concerned with social services rather than specifically with mental health."

Humanistic, common sense principles aside, liberal federal funding policies and other

"political luck" had much to do with MPA's success. In 1972, shortly after MPA's inception, the New Democratic Party came to power provincially. As a party they officially supported local, progressive groups. In fact, in the Health Workshops at their Provincial Conference in 1971, the following resolutions were passed, with specific mention of MPA:

"THAT the NDP support:

a) self-help groups (eg. Mental Patients' Association) in the mental health field.

b) these groups to provide 24 hour, user-controlled centers (emergency, drop-in, social, etc.) that would extend but not encroach on existing services.

c) funding from government for these services."

"This is a group that's really being run by 'crazy' people. I mean, it just seems that if you put all those ingredients together ... you're just going to have a disaster on your hands in no time. It didn't happen that way. It all worked. There were continual crises and continual resolutions of these crises. I remember it as a very exciting time, a time of us really understanding that it's possible to put together an organization and a set of services that really are superior in a lot of ways to the existing services – a place where people really did feel some involvement. A whole lot of people came that had never had any sense of power in their lives before."

– Lanny Beckman

The Social Credit Party government, in power since 1975, has followed a policy of removing patients from costly institutional care and placing them back in the community. MPA's Residences clearly fit into this plan.

For the first few years various houses were rented. MPA was able to buy its first house in late 1972 with the assistance of the Canada Mortgage and Housing Corporation (CMHC). This meant not having to worry about rent increases or leases ending. There were perennial conflicts though, over licensing, and pressure from conservative groups resentful of having an unorthodox mental patients' group in their neighborhood. Licensing problems arose because of city bylaw restrictions differentiating between group use of residential premises, which required meeting stringent (and costly) fire and safety standards, and family use, which did not. In October of 1976, after three years of persistent work by MPA and other groups, City Council approved several recommendations of the Standing Committee on Community Services. They included: "THAT all Group Homes, Halfway Houses and related types of facilities be designated 'Community Residential Facilities' for civic by-law and administrative purposes ...

THAT Community Residential Facilities be permitted as a conditional use in all commercial and residential areas."

A condition that was not eliminated at that time was that groups had to give neighbors written notice of their intention to establish such facilities before doing so.

MPA's farm operated in two locations for nearly two years from August 1971 until July 1973. It is described more fully in this booklet under "Miscellaneous Ventures"; suffice it to say here that country life did not have the restorative affect on members that was hoped for. That and other problems led to the farm's demise.

In August 1973 MPA switched from LIP to LEAP funding. The Local Employment Assistance Project was under a branch of the federal government concerned with getting unemployed and "unemployable" people back into the job market. MPA's contract was renewable each year for up to three years.

In August 1974 the Office and Drop-in Center moved from cramped quarters in a house to spacious facilities in an older storefront/apartment block, also purchased through CMHC.

By agreement with CMHC the apartments in the block were to remain low-rent (part of CMHC's mandate is to provide for social housing), and they would be filled by attrition with MPA members. (The wheelchair-adapted suite built in 1978 can be an exception to the member rule.)

The new Drop-in offered a large lounge area, a kitchen, ping-pong and pool tables, TV room, crafts area, workshop, darkroom, a "quiet room" and office space. The darkroom, quiet room and pool table have been phased out over the years, the last because it attracted many teenagers who had no real interest in MPA. Wednesday suppers and Saturday breakfasts had to be discontinued in 1977 after someone complained to the City Health Department, and kitchen use was limited to serving coffee and tea.

In 1976 the General Meeting voted the Board of Directors out of existence (although they had been chosen rather arbitrarily very early on and existed only on paper anyways), and the Membership legally became the governing body of the organization.

When LEAP funding ran out in July 1976 MPA was told by the federal government to seek local sources of support. Ministry of Human Resources and civic grants were available to keep the Drop-in and Office activities going, but the Residence Program was a problem. The "global" LEAP funding had included the Co-ordinators' salaries and a small operating subsidy. Most operating costs were covered by the fees paid by residents, who paid the same amount whether employed or on welfare. When MPA requested continued funding on this basis, the provincial government instead proposed funding the houses at a "care hours per

day/per person", or per diem rate, as it funded private proprietary boarding homes. This proposal had several drawbacks, including:

– more complicated bookkeeping and reporting procedures.

– residents would not receive full welfare cheques, but a monthly "comfort allowance". Their rent and food money would be billed to MHR by the MPA Office. This arrangement would virtually eliminate residents' financial decision-making and money management abilities.

– employed residents, a valuable role model for others, would have to pay a much higher monthly fee or leave.

– length of stay would be limited.

– if the occupancy rate in the houses fell below 90% for 3 consecutive months, the per diem rate for the empty beds would be deducted retroactively for all 3 months. Since the Coordinators' salaries still had to be paid, MPA's surplus funds were considerably drained.

"Our principles have been damaged by the funding. The residents don't have the say in things that they used to. We have to keep lots of records that we didn't have to keep before. We used to just be able to budget the way a family does, but now it's more of a business-type thing. . . . What can you do with a twenty-five dollar a month 'comfort allowance'? . . . This way, it's just like being in a boarding home."

– Linda, a resident

The decision whether or not to accept the new funding was made by the residents. Initially they voted to reject it and to continue searching for a more suitable source. Appeals were made for outright funding to both the federal Department of Health and Welfare and the provincial Ministry of Health, but unsuccessfully. When no other source of funding could be found, the residents reluctantly voted to accept per diem funding rather than shut the houses down.

In the switchover a certain respect was shown MPA's self-help principles and a spirit of negotiation prevailed. However the problems of fitting an innovative service into a conventional bureaucratic framework were apparent, and compromises were made.

Currently the Residence Coordinators' salaries are paid by the Ministry of Health through the Long Term Care Program, but at a flat rate of approximately $12 per day per person (rather than on a "care-hours" basis). Food and maintenance money is billed to the MHR in arrears at the end of each month.

In September of 1983 MPA was told (without warning or negotiation) that the Drop-in Center would be funded by the Ministry of Health through the Greater Vancouver Mental Health Service, rather than through Human Resources. A 10% budget cut was imposed, retroactive to April, which in effect meant a 20% cut for the remainder of the fiscal year. This dealt a harsh blow to many aspects of MPA's operation. The activities, workshop, and other budgets were severely reduced. Honourarium shifts, which provided valuable job experience for members, were discontinued. MPA could no longer, at least in the forseeable future, even afford to serve coffee or juice in the Drop-in.

Financially MPA seemed to have reach its zenith. In recessionary times with its own cash reserves depleted, it would have to depend on the dedication and resourcefulness of its members to survive.

PHILOSOPHY

The Mental Patients' Association began as a result of the efforts of an ex-patient, Lanny Beckman, and a non-patient, Barry Coull, who were influenced by Marxist ideology and by the Radical Therapy Movement in North America. This movement does not represent a particular kind of therapy; rather it is a viewpoint which approaches emotional problems by determining the sources of oppression, exploitation and repression in our society. It is a current of thought which has always been recognized as legitimate at MPA because, while MPA is a place for mental patients to socialize, to find housing and to work, it is also a place where people can organize against the way our society produces and treats mental patients.

When MPA was founded in 1971, it was defined as a self-and-mutual help group for mental patients, though it has always been open to *anyone* going through difficult emotional times and to those interested in helping others. To reflect this sentiment, MPA in 1977 altered an objective in its constitution: "To assist in the rehabilitation and promote the welfare of mental patients, former mental patients and *potential* mental patients." MPA's members represent a complete spectrum of the emotionally oppressed, from native people to single parents, but the majority of individuals have experienced an exceptional kind of oppression — that which comes from being a patient in a mental hospital.

The definition of a mental patient (or ex-patient) became the subject of frequent debate in MPA's formative period. Finally the membership agreed on the following: someone who has been incarcerated either voluntarily or involuntarily in a mental institution. This definition has several important features: 1) it does not try to analyze mental illness (whether it exists or is just medical terminology), 2) it does say something about how society is organized (there may or may not be mental illness but there *are* mental hospitals), and 3) it recognizes confinement in a mental hospital as a special experience.

MPA was from the beginning dedicated to providing choices and power to ex-mental patients. Every aspect of the organization was based on the concepts of self-help and participatory democracy; becoming responsible for one's own life, learning the basic skills needed to survive, and helping others to do the same.

Mental institutions usually do not provide the counselling and support that people need. What they do provide is an education. The patient learns to be fearful and cautious, and to expose as little of himself as possible.

Incidents of mistreatment in the mental health system provide countless occasions for resistance. But patient advocacy is frustrating work. The system is designed to subdue and to prevent resistance or disruption. Problems arising from the power differential that the medical model assumes may be interpreted as problems of personality, and anyone undertaking a struggle for change must be prepared to be discredited, even abused.

Working within a group and building a community offered strength and a sense of belonging. The early days of MPA were characterized by enthusiasm and dedication. Day to day operations were chaotic; activities ranged from group meetings, crisis intervention, resource workshops, to providing a place to stay for those with nowhere to go. The first priorities were to deal with people's loneliness and emotional stress. Volunteer professionals offered seminars

on mental health problems, but were rejected as being patronizing and irrelevant to the true needs of members.

Only one cardinal rule prevailed: offer as much peer support as possible and never commit anyone to hospital. There was essentially no formal structure or planning for future growth. MPA had created a place where people could do pretty much as they wanted without conforming to a million rules. This in itself was an important stage in development. A series of events then unfolded which forced people to develop a more organized approach.

Early in 1971 two very disruptive people entered the scene practicing "attack therapy", which involved screaming and pushing other members around. The open nature of the association had allowed these people free hand to dominate the group, whose own distaste for rules and authority led them to believe that members should be free to do as they chose. Debate over this issue, and the matter of rules and their enforcement, raised a number of important questions. They were: How are decisions to be made? Who makes them? And who has the authority to carry them out? MPA had already adopted a system of participatory democracy but members were still relying heavily on leadership to make decisions. The "leaders", on the other hand, saw their responsibility as ensuring that the entire membership took part in decision-making so that no one filled the power vacuum by forcing his/her ideas on others. The matter was discussed at length and it was realized that the entire membership should be responsible for everything that went on, that authority must be the group's, and that the group was as important as the individual. With this understanding the following basic rules were instituted: 1) No violence, 2) No alcohol, 3) No non-prescription drugs, and 4) No disturbing the quiet enjoyment of others. Two more rules have since been added: 5) No disturbing the neighbours, and 6) No sexual or racial harassment. Further, the group voted to expel, or "ban", certain members who refused to conform to the few democratic rules. The membership was forced to realize that "MPA is not for everyone." Bans have always been a problem. Many feel that banning as a sanction just doesn't work, as evidenced by the fact that some people are repeatedly banned, for varying lengths of time, without seeming to learn or change as a result. Also, co-ordinators, stuck with the role of enforcing bans, are set up as authority figures. Ban appeals can be a very draining and disruptive portion of meetings, but no better way has been formulated to deal with rule-breakers.

MPA maintains a policy of not keeping long-term individual records on members, beyond utilization records for funding purposes. Doing so would imply a two-class system of those who keep track, and those who are kept track of. Also, to protect the privacy of members, no information about them is either gathered nor given without the consent of the individual.

In her book *On Our Own,* Judi Chamberlin briefly mentions complaints during her visit (in 1976) about a clique within MPA making decisions by themselves. She felt that MPA would have to grapple with this problem at some point. Those complaints no doubt helped to generate what was the most divisive controversy in MPA's history: the institution of a 50% ex-patient hiring policy. (The clique referred to was composed of non-patient Coordinators.) The ratio of patients to non-patients working at MPA has been a concern since the early years. It has been hard to pin down though, partly because the ratio changes with almost every election. Because of MPA's open membership policy, issues concerning mentalism (oppressive attitude or action, however subtle, toward mental patients) crop up occasionally and are exacerbated by the fact that the majority of Coordinators are non-patients. (They may therefore be seen as less in need of help, or more capable of giving it, than ex-patient members.) Because Coordinators are required to attend meetings, they may be in the majority at some meetings, and subject to suspicion of "block voting" on certain issues.

The long history of debate over the 50% ex-patient issue, detailed below, is an indication of its importance and of the difficulty MPA experienced in "grappling" with it. A problem solving conference held in 1974 made a recommendation to the General Meeting that 50% of MPA's Coordinators be ex-patients. It was defeated for two main reasons: first, that such a rigid policy might revoke members' freedom to vote for the candidate they felt was best suited for the job, and second, that many non-patient Coordinators had personal problems too, and should not be discriminated against because they weren't "certified".

The issue came up at a General Meeting in May 1977 and after much heated debate, was tabled indefinitely. But out-of-meeting discussion continued. It was almost two years later in March 1979 that it surfaced again; this time as a notice of motion that by a process of attrition, job vacancies would be filled by ex-patients. This motion was defeated in April of that year but a

committee was struck to discuss increasing the number of ex-patient workers. That committee came up with two motions: 1) that at the January 1980 elections, only 50% of the paid positions would be open to non-patients, but all positions would be open to ex-patients, and 2) that as of the January 1980 election, all Coordinators employed two years or more would be required to resign, and a maximum tenure would thereafter be set at two years (with re-application possible after one year's leave). These two motions passed but not without considerable hard feelings. Two distinct factions developed in the debate and much energy was consumed by internal politics. In July 1979, the two year tenure motion was rescinded but a motion to rescind the other was defeated; again with hot debate. In October that year, a committee was struck to deal with the logistics (i.e., which jobs would be open only to ex-patients since they didn't divide evenly), who would not be able to re-run for election, and just how the elections would be conducted.

At this point, another problem served to complicate and intensify matters. The group had to close the West 7th residence for renovations. A considerable amount of damage had been done to the house, in which a "laissez-faire" attitude had run rampant over preceding months. The residents were asked to leave and the employment of the two house Coordinators was terminated. (This situation spearheaded a drive for tighter job descriptions and increased accountability among Coordinators.) The West 7th affair caused more bad feelings, adding fuel to the 50% issue already at hand.

Finally, in December 1979, the ways and means committee threw up its collective hands, pronouncing the 50% resolution unworkable and the motion was rescinded. It was a long, hard lesson for MPA. Because there is no predetermined plan to fulfill and no executive to defend unsuccessful ideas, their success or failure is based only on whether or not they work.

MPA as an organization has neither a pro-psychiatry nor an anti-psychiatry stance, although it maintains an officially stated opposition to both ECT and psychosurgery. Opinions vary widely among members regarding psychiatrists and hospitals and the prevailing sentiment is "pro-choice". Although peer support is still the first response in dealing with distressed people, there has grown a tendency to encourage the seeking of professional help if all else fails. In fact, in recent years efforts have been made to cooperate more with local Care Teams and to dispel the opinions of some professionals that MPA is too unstructured. Although this might seem contrary to original MPA values, continued funding depends on a certain accountability and the survival of the residence program in particular depends on referrals from hospitals and other agencies.

The question of accountability to funding sources, etc. has had other effects on MPA. As the organization has grown into the largest comprehensive support service for mental patients in Canada, the responsibility involved has imbued an hierarchical importance on the job of Office Coordinator. While constitutionally every member has the right to run for any office, a process of requiring resumes and committee screening of job applicants was applied first to the Office Coordinator position, and then in varying degrees to Residence and DIC jobs. This was due partly to the need for accountability and partly to streamline the election process. (In high unemployment times, newspaper and employment office postings produce unwieldy lists of applicants.)

Participatory democracy isn't the most efficient system for running a large organization. The temptation to streamline and short-circuit the process always exists. Whatever compromises have been made over the years to various procedures and values, MPA remains a vital alternative to mainstream mental health care. Through all the difficulty of resolving internal conflicts and gathering outside support, it has continued to thrive and attract prospective members. There are a number of people drawn by the potential power inherent in collective action by patients but the majority come to MPA to find comfort and friendship. Realizing that everyone is not ready for the same amount of self-management at the same time, MPA designed a system that permits the maximum possible level of individual variation. Members are given responsibility for decisions regarding all aspects of their lives and the results have been seen as a noticeable decline in the number of people returning to hospital.

"The unique aspect of your service ... is that you don't provide a service to people, you work with people to enable them to serve themselves. Many aim for this goal in the helping professions but your group comes perhaps closer than most in accomplishing this aim."

— W. Dales, Social Worker, Riverview Hospital

HOW TO START

MPA was the vanguard of democratic mental patients' organizations in Canada. American liberation groups have been primarily involved in political work, as funding is not available to them to operate an extensive service component. MPA has been fortunate in receiving financial support from all levels of government for a wide range of programs, and encourages ex-patients in other places to organize themselves and to realize the possibilities.

On Our Own * is a book written by Judi Chamberlin, an ex-patient who spent years collecting information on patient-controlled alternatives. Her book is important to anyone involved in the mental patients' movement. She describes a number of methods in organizing self-help groups and political collectives, and she outlines the basic principles for developing an effective patient-run organization:

"A model for a good alternative service for ex-patients must include the following elements:

1. The service must provide help with needs as defined by the clients.
2. Participation in the service must be completely voluntary.
3. Clients must be able to choose to participate in some aspects of the service without being required to participate in others.
4. Help is provided by the clients of the service to one another and may also be provided by others selected by the clients. The ability to give help is seen as a human attribute and not something acquired by education or professional degree.
5. Overall direction of the service, including responsibility for financial and policy decisions, is in the hands of service recipients.
6. Clients of the service must determine whether participation is limited to ex-patients or is to be open to all. If an open policy is decided upon, special care must be taken that the non-patients do not act oppressively toward the ex-patients. In other words, such a service must be particularly sensitive to issues of mentalism.
7. The responsibility of the service is to the client, and not to relatives, treatment institutions, or the government. Information about the client must not be transmitted to any other party without the consent of the client, and such information must be available to the client."

An article, "Be The First Kid On Your Ward To Start A Mental Patients Organization," appeared in the July 1973 issue of *In A Nutshell*, in response to the many letters received from people who expressed interest in starting similar groups. People still request information on how MPA started and what they might do to organize, so the same article is reprinted here with some updating revisions:

Our early experience will probably be helpful to others, so let us review it briefly and draw from it some general principles that other groups can consider.

MPA began with a number of patients in a day hospital program. Organizing within a psychiatric progam is a good, though not essential, place to start. What is needed is several people, as few as two or three, who have some minimal organizing skills and who will make a commitment of at least three months work, slugging through all the set-backs, the apathy and the frustrations, no matter how large they are.

Once this tiny core group has formed, they should set out some concrete principles of philosophy and courses of action. The philosophy,

* This book can be obtained from: Press Gang Publishers, 603 Powell Street, Vancouver, B.C. Canada V6A 1H2

while it may not appear so at this stage, is crucial. It must embody policies of democratic participation which place the decision-making power in the group. This doesn't deny the importance of leadership (it is very important) but the group must know that it has the power to control its leaders and its fate.

It is in these very early stages when most groups flounder. In the face of crisis, there are great temptations to bureaucratize and to centralize the decision-making power. This lack of faith in the group often parallels the recruitment of professionals or indoctrination to an external philosophy, an act which is fatal to the group's growth.

MPA participated in the World Mental Health Conference in 1977 and was later invited to join the organization. At first the idea seemed appealing — it was a chance to have some influence on the direction of future conferences. After a lengthy discussion, the membership decided that it would not be in the best interests of a democratic ex-patients' groups to affiliate themselves with a professionally dominated organization. they chose instead to invite the World Mental Health Association to join MPA.

Ex-patients are naturally sympathetic to democratic structuring because mental hospitals are among the most authoritarian institutions in society. Collective power must be exercised even if it appears that this power is only ratifying the leaders' decisions. A time will come when their decisions will be challenged and democratic forms must be kept during the group's infancy so that the members' will can be enforced when it opposes that of the leaders. (It took MPA about three months before a motion didn't pass unanimously.)

If the group has to abandon the forms of democratic functioning in order to survive, it is probably better that it not survive. If the core group's ideas are good, the larger group will support them and should be encouraged to participate in as wide a range of decisions as possible. The more important the decision to be made the more important it is to involve the group.

The core group should also establish policies regarding the general purpose of the organization. The cardinal purpose must be to serve the interests of patients, not to help professionals do their work. It's crucial not to get sucked into the tailwind of professional organizations. The group must maintain a real autonomy and be prepared to fight on behalf of patients, whoever this brings them into conflict with.

Progressive professionals can be useful as resource people and your service should be coordinated with theirs. But under no circumstances should they be given formal power within the group. The idea is not to set up a small growth on the body of the professional establishment, but to create a real, independent alternative geared toward uncompromising struggle against the oppression suffered by patients.

When the core group is agreed on basic policies, two courses of action ought to be initiated. One, start seeking funds, and two, begin recruiting a larger membership. Funds are essential, whether they're from private donations or government grants, because people will respond to actual services and this invariably means finding a physical location, which costs money.

Paper organizations get nowhere — except on paper. The ideal physical structure is a house, just a plain ordinary residential house, or at least a secure place where the group can meet and not

be bothered by landlords or neighbours.

A good place to begin looking for funding is to find a fund-raising guide. These are usually available from regional government offices, but you may have to ask around.

In Canada, *The Canadian Directory to Foundations and Granting Agencies* (cost about $36.00) and other publications are available from The Canadian Center for Philanthropy, 185 Bay Street, Suite 504, Toronto, Ontario, M5J 1K6.

Most of the booklets will outline the various agencies that provide funding or grants, where to apply and what kinds of programs fit into their guidelines. (There may be separate guides for government and private foundations.)

Applications should be addressed to a specific person, if possible, and written in a clear and convincing manner promoting the quality of your ideas and strength of commitment. It may be necessary to slightly distort the facts about the nature of the service you intend to provide in order to meet all their criteria. For instance, if they are more likely to fund a job creation program emphasize the number of people you will employ. Also, play down any political objectives — most funding sources, especially government ones, do not want to finance organizations that are going to cause any disruptions. Letters of support are very helpful, especially if they point out the need of your service in the community. They are not difficult to obtain from other agencies and sympathetic professionals. Try to include a detailed budget and a comparative cost of similar services. A small grant is a good starting point and gives you the opportunity to prove that patient-run groups can be effective. Finally, beware of funding which threatens to endanger your autonomy. It is better to accept less money than to have too many strings attached.

The next step is to recruit members. It is ideal, though not necessary, to have some funding commitment beforehand. Probably the best way is to get in touch with a progressive columnist and have him or her do an article on your proposal, giving the background of the need for ex-patient groups. It should be easy to get the column done. As someone put it, "mental health is a sexy issue." The column should spell out the obvious need for such an organization and have interested people call the core group.

If your experience is like ours, you will be deluged with calls. Be prepared to talk for quite a while with each caller, convincing him or her that your idea is not a pipe dream. Also, be prepared to have the first general meeting within about 10 days of the appearance of the column. People's interest in ideas dissipates quickly.

The column should also ask for donations of furniture and money (though don't expect to get much), and should ask sympathetic landlords to contact you about renting a place. This is very important. Our first drop-in center was rented from an ex-patient who read the column and who turned out to be a great landlord. Most landlords would of course be totally resistant to renting you a house, so be sure that the one you find knows exactly what you want to do with it and supports your ideas. There are people like that around.

At the first general meeting, there should be plenty of time for people to express their ideas about the need for such an organization and to talk about their own experiences. Before this discussion gets too lengthy, however, attention should be turned to the immediate work to be done. A phoning committee should be set up to inform members about developments. If no meeting place has been found yet, a committee should be struck to look for one. Another committee can begin seeking donations of furniture, etc. Again, the core group should be involved in all these committees and should maintain contact with the members and be prepared to do the work if members' commitments prove too weak.

Of course, phone lists of members' numbers should be run off (there is always a handy information center that will give you use of their facilities) and circulated among all members. A lot of phone contact should be maintained during the early weeks. People are used to groups not getting off the ground, so the feasibility of the project has to be continually reinforced until it takes on its own reality.

There will probably be some sentiment at the meeting about electing a formal executive — president, secretary, etc. — and probably the core group will be nominated. This sentiment should be resisted. It is important not to develop hierarchies but to maintain a formal equality among all members. All of our elected people have had the same title (office coordinator, crafts coordinator, etc.), and received the same (subsistence) salary. (The two Phoenix coordinators became the exceptions to this rule in 1982, when their salaries were set at a higher level than other paid members.)

It is all too esy to develop a formal hierarchy in the early stages when there's not much commitment among the members (who really cares if there's a president or not?), but there will come a time when members care. By that time, if there is already a hierarchy, it may be too late to reverse the structure. So let the members live with the apprehension of not having a structured executive at

the beginning. This is also good because it leaves a lot of openings for new people to begin undertaking any of the work that has to be done.

Before the meeting ends, a time should be arranged for the next meeting and the phoning committee should notify all present, plus any new names acquired in the interval, just before the second meeting. Between the meetings, it is important for the core group (by this time hopefully expanded a few) to have accomplished some concrete goals. The main thing is getting a good location – this gives the group the physical reality that is essential. After that, don't be disillusioned if things go slowly. It took us six weeks to furnish the center. Expect some people to get tired of waiting and to quit. Don't let this shake your faith in the viability of the project. The word is perseverance. If you have enough of it, the group will eventually develop a momentum of its own.

These guidelines could go on endlessly, but let us wrap it up with a couple of additional points: first, more on the location, and second, on the setting up of rules.

We keep coming back to the finding of secure accommodation because without it the group has no actual base. The main thing is to avoid church basements or other locations controlled by institutions external to the group. The setting must be under the complete control of the membership, open whenever the membership wants, and used for whatever it wants. A good location is a corner lot because there are fewer adjacent neighbours. It's more important, however, to find a neighbourhood – usually working class – where neighbours are least likely to get uptight about the slightly unusual use.

This brings us to an absolutely fundamental point. DON'T go to the neighbours beforehand asking for their approval. This is only waving a red

flag in front of their noses. First, establish yourselves in the neighbourhood. Do this as fully as possible by endeavoring to keep all the activity inside the house. Everything possible must be done to avoid incurring the antagonism of neighbours. Once they see that you're not disrupting the community, they will naturally come to accept your presence and there will be no need to go to them formally to announce your existence. Deal with things as they come up.

Likewise, DON'T to to the city to get a license. Let them come to you on all matters. The house will be rented so it won't be in your name. Either the city will never know you're there, or like the neighbours, it will eventually recognize the value of your services and may turn a blind eye to any zoning regulations you may be violating. If they insist that you go through formal procedures, send your most responsible members to represent you.

The use of the house is somewhat more problematic. We began by combining three functions in one center: drop-in, crisis and residence. Needless to say, the place was a madhouse. However, we did survive the early months until we could establish our first residence so that the original center could be used only for social and crisis needs.

You should try within the first four months to set up a second house as a residence. Although ex-patients need a social center, housing is a much more fundamental need. If the group is going to provide real bread-and-butter services, it must eventually establish places for people to live.

Finally, let's consider setting and enforcing rules. While the tendency toward bureaucratization must be avoided at all costs, so should the opposite tendency: anarchism. Democracy doesn't mean having no rules. It means having them set and enforced by the group. There will be a good deal of chaos in the early stages and without some enforceable regulations, the group's existence will be threatened. This can happen through hassles with neighbours, minor scandals, etc.

We began with four cardinal rules: 1) No violence, 2) No alcohol, 3) No non-prescription drugs, and 4) No interfering with the quiet enjoyment of others. Two more rules were added in later years: 5) No disturbing the neighbours, and 6) No racial or sexual harassment.

Usually our group was very lenient — sometimes too lenient — in enforcing these rules. They were generally broken by someone who was very freaked-out and the group felt compassion and often declined to ban the person. At times this resulted in very serious problems. Occasionally the group's survival was threatened by the excesses of one or two people.

Since we had always been the people who had rules imposed on us by others, we didn't find it easy to see ourselves as the enforcers of rules. However, our enforcement was very different from "theirs" since ours was done democratically by the whole group. Of course, you will have to confront these issues as they arise in your own experience. But we suggest that you keep the number of rules to a minimum and that you do not shrink from enforcing them when the good of the whole group is threatened.

We hope that our experience and suggestions will be helpful. We very much want to aid any groups who are getting started. Please let us know how things are going and whether we can be of help. Good luck. Power to the patients.

— Lanny Beckman

PROCEDURES & STRUCTURE

The structure of MPA is essentially horizontal rather than vertical. There is virtually no hierarchy, no board of directors, no executive, no boss, and few restrictions regarding membership. One becomes a member by living in an MPA house, by coming to the DIC twice and attending a General Meeting, or by being elected as a Coordinator. Patients in psychiatric institutions may also automatically become members if they wish to.

Involvement with MPA means attending many meetings. The Residence Council Meeting on Monday morning takes place at each of the residences on a rotational basis. It is attended by office staff, Residence Coordinators, and occasionally residents, and deals with issues concerning the Residence Program. A Drop-In Center Meeting on Tuesday mornings takes care of DIC operations. The Business Meeting at noon on Tuesdays (except the first one in the month) includes reports from all areas of MPA and deals with expenditures of less than $100. The DIC, Business, and General Meetings all take place at the Drop-In Center. The General Meeting, held the first Wednesday evening of each month, handles expenses over $100, important issues, and policy decisions. The "7-Up" Meeting (so called because when initiated in 1982, it involved seven DIC workers) gathers at various locations informally to discuss Drop-In issues. There are also many committee meetings and General Elections every six months (in January and July). All meetings are open to anyone interested in contributing.

Two or more members can call a Special General Meeting for any purpose, but notice of the meeting, as with the Annual General Meeting, must be posted in all MPA facilities at least 7 days in advance. A quorum for General and Special Meetings is at least 10 members.

The General Meetings are the most widely attended because all important issues are reviewed and decided upon by the membership. The decision-making process is a pure form of participatory democracy; any member can make a suggestion, put forth a motion, express her/his opinion, and vote. Except in elections, voting is done by a show of hands. Roberts *Rules of Order* are followed (more or less) and the majority vote rules. A 2/3 majority is required to amend the Constitution and By-laws.

Although the democratic process can be slow and frustrating, it allows the maximum of information on and consideration of the issues. Also, members' confidence and self-esteem are restored by reliance on their own judgement.

All paid members stand for re-election every 6 months, excluding the Phoenix workers who are elected on a yearly basis. By-elections are held whenever a position becomes vacant in mid-term. Elections may be advertised via newspaper ads, government employment office listings, posters or word of mouth. The amount of publicity needed is determined by the group a minimum of 3 weeks before the election, and an Election Committee is formed to make the necessary preparations. Voting at elections is done by secret ballot, including absentee ballots cast by any member unable to attend the election.

Every ballot has placed on it the choice "none of the above." This practice was introduced in 1972 in order to ensure the maximum choice for voters. If none of the candidates seem suitable for the position and none-of-the-above gets a majority of votes, a new election is called and more candidates are sought.

In 1980 it was decided that in all elections

except honorariums and replacements, a 50% + 1 majority of the votes must be obtained to win. This rule often necessitates 2nd or 3rd ballots being run for the five Drop-in Coordinator positions, lengthening their election considerably. It was felt though, that simply taking the five people with the most votes on the first ballot was inadequate because people could win with much less than a majority of the total votes cast.

The physical structure of MPA breaks down roughly into three main components: the Office, the Drop-in Center (including workshop and outside activities), and the housing component (including the Residence Program, Phoenix and MPA West).

OFFICE

The Office operates out of a small section of the Drop-in Center. An Office Coordinator, a Housing/Office Coordinator, a Secretary, and part-time Bookkeeper handle operating expenses, communicate with government officials, answer in-coming mail and distribute information. The Office Coordinators are responsible for securing funding for MPA's programs, salaries and mortgage payments. They also do work that involves liaison between MPA and the community.

One of the harder aspects of their jobs, apart from working in a cramped and sometimes hectic environment, is to keep the membership informed and involved, and to avoid doing everything alone, while ensuring that everything gets done.

DROP-IN CENTRE

MPA's operating headquarters, activity center and social meeting place, the Drop-in Center, is located in Vancouver's Kitsilano neighbourhood, which has a history of tolerance of unconventional groups. The building blends in with other older structures in the area, and except for the flow of people in and out, remains fairly obscure.

Activity inside varies greatly. The day usually starts slowly, with early morning regulars sipping coffee, chatting, or reading magazines. Taped music or the radio can be listened to if everyone is agreeable. As the day progresses the office work begins, the phones start ringing, muffled noises from the workshop can be heard, people drift in and out, and things can get very busy. Members can watch T.V., play cards or board games (tournaments are frequently set up), there is a piano, and a ping-pong table gets heavy use.

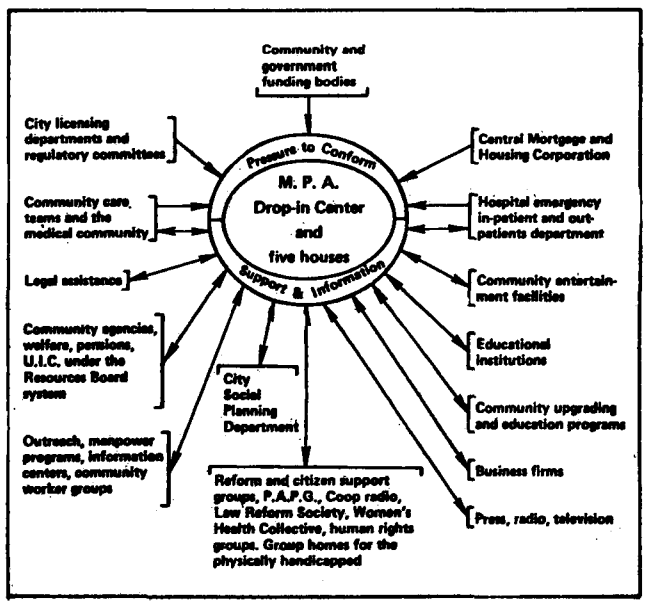
The five regular Coordinators, temporary grant and VIP workers, and volunteers all help keep the Drop-in open from 8:30 A.M. to 11:30 P.M. seven days a week.

With up to a hundred people using the DIC in a day, a certain amount of time must be spent dealing with rule infractions and personal conflicts between members. Sometimes conflicts can be diffused by mediation but if verbal or physical violence erupts, the Coordinator must call an Ad-hoc Meeting of everyone present to deal with it. Banning a person for a certain length of time or until the next regular meeting, is the group's only sanction. In order to appeal a ban a person must address a meeting and explain his/her behaviour.

The DIC is also the hub from which the Transportation Coordinator organizes outside activities. These include picnics, sporting events, visits to Riverview Hospital, swimming, bowling, or almost anything that enough members want to do.

Running a large and diverse center is difficult. The open-door policy and lack of consistent contact with many people make it harder to form the supportive relationships that occur in the houses. And as is all too often the case in any field, positive feedback is too infrequent.

Good times balance the hardships though; camping trips, movie nights, sing-alongs, and holiday parties and dinners are enjoyed by many. There is also the day-to-day satisfaction of seeing people inter-react positively, and of knowing that people need the Drop-in for many reasons; that for some, without the DIC there is only a dingy rooming house, hotel, or the street.



RESIDENCES

Mental hospital in-patient caseloads have been dropping steadily in British Columbia since the late sixties, with emphasis shifting toward treating people in the community. Mental health centers (Community Care Teams) have been set up for follow-up medical treatment, but they cannot provide other necessary support services that keep people out of hospital. The months immediately following discharge from hospital are very crucial for ex-patients, and a "revolving door syndrome" returns about 60% of patients again and again to hospital. Out of this knowledge came the first MPA residence, set up to encourage ex-patients to improve their living situation and change their outlook.

MPA now operates five residences for both men and women with a total of 46 beds. People learn about the residences by referral from hospitals or other social agencies, and by word of mouth. Applicants normally visit the house several times to acquaint themselves with current residents. They then come to a weekly house meeting to talk to the group, who then take a vote on the request for residency. This initial vote is for a trial period of two weeks or so. If, during the trial period, the new resident has abided by the rules and shown his/her willingness to contribute to the house, a vote is taken for residency on a permanent basis.

The house group also divides up cooking, shopping and housekeeping chores at their meeting, and deals with any issues that may have arisen during the week. If there are problems with a particular resident getting along, they are discussed too; people are given several warnings and ample time to change before expelling them is considered.

In hospital patients have had most decisions and personal care matters attended to for them, and they often become dependent, or "institutionalized". If needed, residents are assisted with basic life skills such as cooking, cleaning and money management, but are encouraged to become independent.

As well as setting individual house rules and deciding who will live with them (and who must leave), residents have a strong voice in who will work with them as Coordinators. At election time the house takes a vote on the candidates at their residence. The results are conveyed to the General Election Meeting as a recommendation, which is generally followed at the vote there. The two Coordinators per house do not live there and have no vote in housing meetings. They act primarily as friends and resource people, and are on call 24 hours a day, in case of crisis.

MPA residences offer degrees of support and responsibility not generally found elsewhere. A communal family atmosphere and peer pressure are important elements in the program. Each house has its own unique feeling, depending upon who works and lives there. When several people have lived together for some time, they formulate a "core group", which often makes decisions and handles crises on their own. As members of the core group move on, the feeling in the house changes and newer members must take on greater responsibility, a process which brings with it valuable learning experiences.

When people are helped through their low periods and encouraged to make personal changes, hospitals can become a last resort. The Residence Program's success is gauged by a dramatically lowered rate of return to hospital among residents.

MPA WEST

MPA West is a sub-divided house containing five self-contained suites, that was purchased through CMHC and the Provincial Department of Lands, Parks, and Housing in late 1981. It is located in a quiet residential part of Kitsilano near the beach. The rents on the five units are subsidized under Section 44 1(a) of the National Housing Act which provides housing for disabled individuals (whether physically or "mentally"). Tenants pay a rent equal to ¼ of their monthly income. MPA West is not "program housing". That is, the people who live there are not required to do anything except obey general rules of tenancy. MPA West has no Coordinators but does have an Advisory Committee composed of all of the tenants and three other MPA members. The Advisory Committee meets only when there is a need such as to fill a vacancy or deal with a specific problem.

PHOENIX

MPA opened its Phoenix apartment block in August 1982 after more than a year and a half of planning, negotiating, and waiting. It was MPA's first chance to design a program and a building from the ground up. Located on a small parcel of previously city-owned land in the Fairview Slopes area of Vancouver, it is dwarfed by large and expensive condominium developments. It contains ten studio and four one-bedroom suites (one of which houses the Building Manager), laundry facilities and a common area with kitchen.

If MPA's residences are half-way housing, then Phoenix could be called "¾-way" housing. While offering a more independent living situation with self-contained units, the program is more structured. The active pursuit of employment, educational or personal goals is a condition of residency; personal contracts to this end are established with tenants, and are periodically reviewed. The Phoenix program is more "formalized" because of funding requirements that it be distinctly different from existing ex-patient housing, and because of anticipated close scrutiny from a Provincial Government already cutting back health care programs.

The two Phoenix Coordinators, and the building manager, are hired similarly to the way that Residence Coordinators are, but on a yearly basis. A Phoenix Advisory Committee, composed of residents and other MPA members, interviews applicants to the program, and helps with any problems that the residents have trouble resolving at their regular weekly meetings.

As well as the MPA activities that all members can participate in, guest speakers are occasionally invited to talk to the Phoenix residents, or to conduct workshops on various topics.

The Phoenix program was designed to help people become fully independent and integrated into the community. Having just completed its first year of operation as of this writing, it has been successful in its goals and seems established as a viable effort.

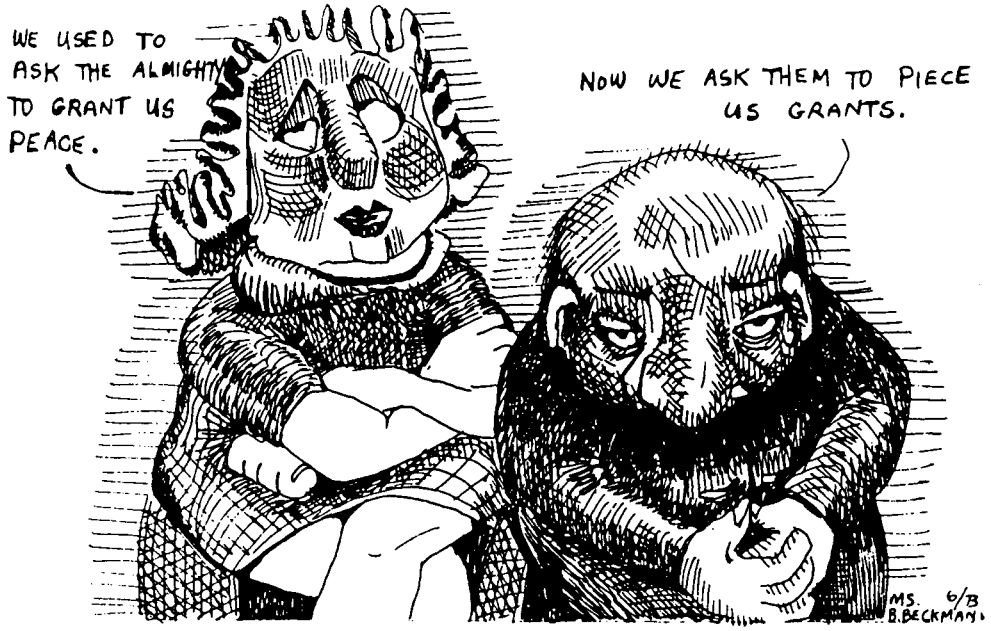
PHOENIX
A MENTAL PATIENTS' ASSOCIATION HOUSING PROJECT

"One late winter evening the police picked me up for crying on the street. That's all I was doing. Crying! They took me to the hospital, where I had to be cooperative, for fear they'd send me back to Riverview where I'd spent a good part of eleven years.

I wasn't crying because I was crazy. I was crying because the Christmas lights were so beautiful, and my life was so unbeautiful, with a physically abusive husband, a blind son, and no money of my own, you know?

In 1971 my husband beat me once too often — he even broke my glasses — but neither he nor the shrinks had quite broken my spirit. I had helped to start a new organization called the Mental Patients' Association and that night I fled to the MPA house and the people there put me to bed downstairs and finally I relaxed and went to sleep. The next day they sent me to Legal Aid to find out how I could leave my husband and keep my child. Thanks to MPA I never went home. And I didn't go back to Riverview. After seventeen hospitalizations and one hundred and twenty-eight electric shock treatments, I never want to go there again. You know?"

– Molly Dexall



LIVING IN AN MPA HOUSE

I wasn't talking to anyone or eating properly and found myself only going out to get drunk. I had had enough experience with the mental health establishment to know that they couldn't be of much help to me. They were too impersonal. Their advice never seemed relevant to my own situation.

I had lived in an MPA house three years before, and remembered the feeling of belonging. I knew the ropes and trusted some of the people there. I needed somebody to trust again — somebody who wouldn't fuck me over. I knew that at MPA I would be accepted at face value. People wouldn't try to make me over into what they thought I should be.

At the same time, being voted into an MPA house is a frightening experience. I was sure I wouldn't be accepted. I assumed other people would dislike me as much as I dislike myself. In spite of knowing what I did about MPA houses, I was angry at not being able to cope and having to put myself at the mercy of this group.

I wasn't fussy about doing cooking, cleaning or shopping. They became trade-offs in order to do something about the way I was relating to people — or failing to relate. In the long run, like it or not, I was forced to deal with the various people in the house.

When I first moved into an MPA house, I didn't believe the MPA rhetoric. I saw Coordinators as authority figures. I expected them to act like the staff of the hospital or the hospital's halfway house; giving orders, controlling life at the house and generally policing people's behaviour. Some people, when they first move in, ask permission from Coordinators to use the telephone, get something to eat, turn on the TV, etc. The habit of having all decisions made for you is hard to break. No one wants to risk doing anything wrong.

The first inkling I got that I could choose what I wanted to do was at house meetings where people really did get involved in making decisions.

Being a house Coordinator automatically means having power. I was lucky to have two Coordinators who wouldn't accept the power I tried to hand to them. I had to make up my own mind about everything.

It takes longer to see Coordinators as caring people. I had become used to the distant clinical professional approach to my problems. It came as welcome relief to find my Coordinators behaved like real people. It wasn't an us-and-them trip. It was all of us together. I lost some of my mistrust of people in general and was able to make some close relationships. I lived in the house for about ten months until I felt able to cope reasonably on my own.

Living in an MPA residence was a very important experience in my life. I learned to know myself better, to recognize some of my strengths and abilities, and am more confident about living independently.

— Pat Oram

MISCELLANEOUS VENTURES

The development of MPA has always been based on the membership having and making a myriad of choices. Trial and error isn't the most efficient system, and meetings are many and sometimes long. Errors in judgement tend to be less frequent though, because there are many people involved in critically evaluating each new idea or policy proposal. No one person has the power to decide what is best for the group. Often committees are struck to deal with specific issues but always with the understanding that they will report regularly to the General Membership. Committee recommendations may be met with anything from apathy to fierce disagreement. Although constitutionally each member is expected to "become involved to the best of his or her ability in the affairs of the society," this policy is not strictly enforced, and some members are happy to let the work fall on the same few shoulders. Others would like to contribute but find it hard; hospitals teach little of the concepts of cooperation and self-help, and to an insecure person taking on a task means leaving oneself open to failure. And finally, the people who *are* involved may be of many opinions. MPA's diverse membership rarely agrees totally on anything.

The majority rules, however, and many projects and activities have grown out of MPA over the years. Some endure, some fizzle and are reborn as needs or interests dictate. Most importantly they all serve as vehicles for expression, cooperation, and education among members.

THE FARM

The owners of a farm in Matsqui, about 25 miles outside Vancouver, were at MPA's first meeting in 1971. They offered their farm house and several acres of land to MPA rent free, if the members agreed to pay the taxes. No one had anticipated mounting such an ambitious project, but such a generous offer was hard to refuse. The membership voted to accept the proposal and thus was created the Foundation for the Understanding of Nervous and Neurotic Illness: the FUNNI farm.

Several people expressed interest in becoming residents at the farm and volunteers made arrangements for the move. It was decided to hire a Coordinator for the Farm, and the acquisition of an old van facilitated weekly visits from the city. A few months after people had settled in, the owner moved to Vernon and offered to sell the Farm to MPA. The deal fell through though, when the Canada Mortgage and Housing Corporation declared the building structurally unsound. The Farm Coordinator quit, but a new one found another farm in Whonnock, and the inexperienced back-to-the-landers made the move.

Problems developed there too though. Neighbors made complaints and local officials were unsympathetic. The Coordinator had talked the membership into buying 300 chickens, a few pigs and a cow in order to save food money. The chickens eventually died and people began to feel isolated. The Coordinator was also practicing Gestalt Therapy on his captive audience and did not attend meetings to keep MPA members in touch. The farm problem came up regularly at meetings and finally in June, 1973, members voted to close the farm down. It was replaced with a residence which thrived, surrounded by polluted air and a frantic urban pace.

WOMEN'S RESIDENCE

The establishment of a Women's Residence early in 1974 was linked to the broader issue of the position of women at MPA. Longtime member Portland Frank deals with the topic of sexism, both at MPA and in psychiatry, in the second edition of her *Anti-Psychiatry Bibliography*. It is a good analysis of the problem, and some of its ideas are presented here in condensed form.

The most harmful result of the lack of widespread political consciousness within MPA has been sexism. It strikes at individual members and at membership solidarity.

Psychiatry has helped sexism gain its stranglehold of mental patients with the myth that "mental health" comes from playing better sex roles. Women who buy this line accept their oppressed status, while men scramble for their manhood, which in a sexist society demands the oppression of women.

Sexism does not operate at the official, power structure level. MPA's participatory democracy provides everyone with equal decision-making power. In the residences sex does not determine one's duties; everyone shares equally in cooking, cleaning and other domestic operations. Rather, sexism assumes the same forms, both blatant and subtle, that it takes in society at large:

—coming on; treating women as sex objects rather than comrades,

—insults; women being interrupted at meetings and being subjected to sexist remarks,

—maid service demands being placed on women,

—male orientation in many houses and at the Drop-in, which results in a self-perpetuating overabundance of males,

—physical violence against women, which has been rare but has happened nevertheless.

It has been difficult to raise MPA's consciousness — both male and female — about these problems and to get people committed to dealing with them. Tolerance has been volunteered more readily than support and violent incidents have been too easily forgotten.

To deal with the problems brought on by sexism, MPA has tried three main things: an all-women's residence, a Violence Committee, and a Women's Committee.

The Women's Residence was set up in accordance with feminist principles by a small group of MPA women. It was designed to provide a relaxed, non-threatening environment and to help strengthen and increase the female membership. Unfortunately, the residence never maintained full occupancy, nor did it become the vanguard of feminism at MPA. This failure was due to some extent to a feminist consciousness never taking root among the residents. With a number of empty beds and a growing list of male applicants to the residence program, the membership voted to convert the house into a mixed residence late in 1975.

The Committee on Violence was formed in connection with MPA's self-evaluation conference of 1975. It was organized by a group of women who decided that it was time to challenge sexism directly. One proposal set forth was to define sexual advances against someone's wishes as violence, thereby making them punishable under the "No violence" rule. This sentiment was carried further later when a "No sexual or racial harassment" rule was instituted.

MPA's Women's Committee has had a sporadic existence since it began in 1974. The Committee was formed to bring women members together for dialogue and mutual support, and to increase feminist consiousness. Though never achieving wide scale participation it has been successful, and continues to meet when the need arises.

SUPPORT GROUPS, WORKSHOPS & COMMITTEES

When the membership feels that MPA is focussing too much on "programs", rules, and funding concerns, small groups are initiated to avoid isolation among members. The Alleviation Committee, for example, concerns itself with encouraging more participation from members at the DIC and raising awareness of their importance to MPA as a whole.

Any member in crisis who feels a need for help or direction can request a support group for themselves.

Workshops are conducted periodically to train members and coordinators in mental health related areas. They have included crisis training, first aid, drug information, assertiveness training, and workshops on the Mental Health Act. More socially oriented endeavors have included creative writing, dream analysis, yoga, and drama workshops.

In early years MPA had annual self-evaluation conferences to deal with general issues and to try to get a perspective on the association's direction. These conferences also provided oppor-

tunity for members to get to know each other better, away from the pressures of daily business. Yearly conferences no longer occur, but have been fragmented into smaller forums such as retreats for groups of coordinators, a Policy Committee formed in 1981, and informal discussions.

The Emergency Action Committee, formed in 1973, regroups occasionally to deal with specific problems, particularly if a Coordinator needs support or is not doing his/her job.

The Committee to Investigate Shock Treatment developed in 1975. Several months were spent reviewing research, investigating hospital practices and interviewing people who had received shock therapy. This committee recommended that MPA take a firm stand against shock treatment and that they support individuals who wish to refuse treatment.

In 1971 a committee was formed to establish a newspaper, which was called *In A Nutshell*. It took the form of mimeographed sheets until it was first printed in July of 1972. Most of the articles, graphics, and creative writing were, and still are, submitted by members and screened and edited by committee.

In A Nutshell was published on a quarterly basis for some time, but less frequently in recent years. It seems that volunteers willing to gather articles, edit, type, and do the layout, have become increasingly scarce. MPA isn't always able to pay someone to coordinate these activities, so the newspaper's publication has been sporadic. Nevertheless *In A Nutshell* has an international readership and is available on request, subscription by donation.

EDUCATIONAL SERVICES PROJECTS

Projects have been set up at MPA to increase public awareness about the association, its programs and philosophy. The first edition of *Head On* was produced under a Canada Works program, which also included the revitalization of *In A Nutshell*.

In late 1982 and through '83, Employment and Immigration Canada and the B.C. Ministry of Labour provided funding for work on a slide show on MPA, an issue of *In A Nutshell*, a pamphlet on the residence program, and other educational services. This work continued under another Ministry of Labour training program for disabled people, which allowed a person to work on this handbook and the newspaper (and two others to work at the drop-in centre).

RIV. EXTENSION

The MPA-run drop-in center on the grounds of Riverview Hospital first opened in 1973, staffed by volunteers. It offered a social center and a referral and information service for hospital patients. Workers also visited wards and opened up lines of communication between MPA and Riverview staff. The project has been a top priority for MPA, and was supported by various government make-work grants until the last one expired in 1980. At that time the drop-in was to be re-located elsewhere on the hospital grounds, but it never was. It re-opened in its original location in February 1983, following negotiations with hospital administration. The center is now open one day a week, utilizing the volunteer efforts of MPA coordinators and members. There are hopes for expansion in the future.

COURTWORKER PROJECT

MPA first became formally involved with the court system in 1979. An inquest was being held into the suicide of an MPA member who was being held in a Provincial Court Building cell. He had been held for several days without receiving the attention he needed as a psychiatric patient. Thereafter the number of people facing criminal charges who asked for help from the MPA office was kept track of. There were several per week.

During a two week trial period in April of 1979 MPA sent an interested member to the Provincial Court to check the court list each morning. She recognized about 15 names per week. From May until August she continued to collect data on psychiatric patients appearing before the courts. As the numbers were quite high, and growing, MPA decided to establish a Courtworker position for a trial six month period. The position was renewed in January and July of 1982 and again in January 1983. The value of the project was such that MPA paid the Courtworker's salary out of general funds when no outside support could be found.

The most common charges faced by psychiatric patients are theft under $200, food fraud (not paying a restaurant bill), failure to appear, breach of bail or probation, mischief and assault. Ironically, people have actually committed offences as a last-resort attempt to be hospitalized. However, health service cut-backs have resulted in less available hospital beds and shorter stays, and people "diverted" under the Mental Health Act to a psychiatric unit are likely to be released within a few days, or before they have recovered. In order to keep people who are "mentally ill" from reappearing on other charges, the Crown prefers to treat them as criminals, so diversion is being used less.

The jail doctor at the police station identifies an average of 2 mental patients per day. However, most people with psychiatric problems are not recognized and go through the system as part of the general population. In a 3 month period from April to June of 1983 MPA's Courtworker found an average of 15 ex-patients appearing per day, though each was not appearing for the first time on a particular charge.

The Courtworker attempts to interview each ex-patient who is either appearing for the first time or seems particularly troubled or confused. She offers various services: talking to lawyers, helping with Legal Aid applications, finding emergency shelter or long-term accommodation, arranging for Human Resources money, referrals to Mental Health Care Teams, phoning friends, family, or doctors, accompanying the accused to the Bail Supervisor's or the Probation Office, and generally doing whatever would be helpful. She also speaks on people's behalf in court.

MPA has been very excited about the Courtworker project and the service has been very much in demand. However, the membership realized early in 1983 that they could not afford to support the program beyond July of that year, and it was in danger of being discontinued. The City of Vancouver though, showed its support of MPA once again by granting $5,000 to extend the project another few months. At the time of this writing, further support is uncertain.

"To start with I kept telling them I was sane . . . They wouldn't believe me . . . They gave me this really heavy tranquilizer that made my body not respond to the commands my brain was giving it, and I really started to doubt my sanity at that point. Until I started palming my pills and found out that yes, it was the medication that was doing that, and I was still sane . . . There's a certain way to get out of the hospital. You've got to appear well, and to appear well means to think and act like they want you to. So you've got to do it slowly, because if you just say 'O.K. I've changed and I accept it all', they won't believe you. So you've got to let them think they win you over a little bit at a time."

— Patty Servant

MPA REACHING OUT

From the outset, MPA has advocated radical change in the mental health care delivery system. Broadly, the organization has addressed the oppression of mental patients by society and its agent, the psychiatrist, whether that oppression comes from myths perpetuated by misinformed and fearful citizens, or from mental health professionals unwilling to disturb the status quo or question the archaic laws and practices which govern the lives of mental patients.

Specifically, MPA has attacked B.C.'s mental health legislation, unfair and unlawful committal procedures, 'closed' investigations of alleged patient abuse, seclusion and treatment policies which, in practice, prove to be more punishment than therapy, community bias against patients in housing, employment and services, denial of medical information to patients, and lack of patient input into treatment plans.

MPA has utilized every means at its disposal, including the talents of many members, to demand change, to work with professionals to improve the lot of mental patients and to develop a model which provides alternatives to the purely medical approach.

PUBLICATIONS

MPA's newspaper, *In A Nutshell*, was initiated in the organization's first year and serves to keep members in touch, to criticize mental health policies and practices, and to publish members' ideas, poetry and opinions. MPA has also sponsored or contributed to the publication of other materials to promote appreciation of mental patients' perspectives:

1974 Madness Unmasked — (out of print) — poetry, prose and illustrations by MPA members.

1974 Anti-Psychiatry Bibliography and Resource Guide — by Kathy Frank; a comprehensive guide to literature, films and tapes.

1975 Women Look at Psychiatry — (out of print) — various authors, collected by an ex-MPA Reserch Coordinator under the Women's Publishing Project.

1977 Power Reversal and Self-Help — A New Concept of Mental Health in the Community — an MPA paper presented to the Banff International on Behavior Modification, March 21-26, 1976. Published in Behavioral Self-Management, Richard B. Stuart, ed.

1978 Head On — A Self-Help Model — first edition produced under a Canada Works employment project — Coordinator Bonnie Martin.

1979 The Anti-Psychiatry Bibliography and Resource Guide — second edition revised and expanded by (original author, now) K. Portland Frank. Available from Press Gang Publishers, 603 Powell Street, Vancouver, B.C.

PRESENTATIONS & CONFERENCES

1972 MPA's first report on the B.C. Mental Health Act, based on two years of research, resulted in a number of changes to the Act, the most significant being the establishment of review panels as an appeal procedure for committed patients. In 1977 MPA collaborated with Coast Foundation and a

lawyer to compile the best features of international legislation on mental health.

1973 MPA presented its first brief on crisis care in the community. MPA members were active participants in the Ad Hoc Committee on Community Resources for Persons with Emotional Difficulties.

1974 Workshop at the Canadian Mental Health Association (CMHA) provincial conference.

1975 Booth and workshop at the CMHA national conference.

1976 Workshop at the CMHA Ontario provincial conference in Oshawa.

1976 Presentation of an MPA video tape to the Banff International Conference on Behavior Modification.

1976 Presentation to the Williams Lake, B.C. CMHA

1976 Booth at Habitat.

1977 Booth and workshops at the World Federation on Mental Health Conference, UBC Campus.

1977 Tour to Penticton, Vernon, Trail — talks to interested citizen groups.

1977 Representation at the 5th Annual Conference on Human Rights and Oppression in Los Angeles, sponsored by NAPA.

1979 MPA delegate addressed the Third Conference on Developing Community Programs for the Psychologically Disabled, Baton Rouge, Louisiana.

1980 Delegate to the International Anti-Psychiatry Movement Conference, sponsored by the Bay Area Committee for Alternatives to Psychiatry.

1981 MPA rep toured Saskatchewan and gave talks on self-help, sponsored by CMHA (Sask. Division).

1983 Delegate attended a Mental Patients' Conference in Saskatoon, sponsored by By Ourselves.

MEDIA PRODUCTIONS

1971 CBC half-hour program on the beginnings of MPA.

1972 CBC program on MPA and issues concerning the mental patient.

1976 The National Film Board produced a film "The Mental Patients' Association." (Available by request from any NFB office.)

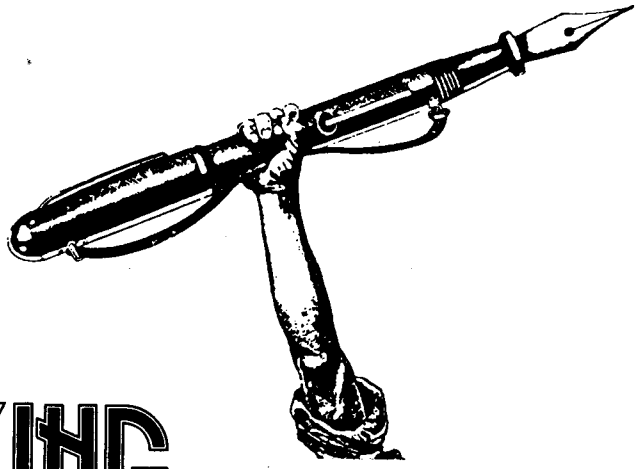
1976 MPA produced a forty-five minute video for presentation at the Banff International Conference on Behavior Modification.

1977 The national CBC program "Man Alive" produced a half-hour documentary on the MPA residence program.

1978 MPA produced a half-hour video designed to give feedback on treatment to hospital staff.

1978 MPA was invited to contribute to the Vancouver People's Law School production of four half-hour video tapes on "The Mental Patient and the Law."

1982 CBC "Fifth Estate" program on housing for mental patients examined MPA's program.



NETWORKING

AFRICA
Zimbabwe National Association
for Mental Health (ZIMHNAM)
P.O. Box A 196
Avondale, Harare
Zimbabwe

AUSTRALIA
Campaign Against Psychiatric
Injustice and Coercion
90 Elgin Street
Carlton 3053
Victoria, Australia

Union for Psychiatric Change
P.O. Box 153
Waverly, N.S.W.
Australia 2024

Pala Society/Louise Lawson Women's Collective
P.O. Box 153
Waverly, N.S.W.
Australia 2024

BELGIUM
Coordination International Reseau Alternative
A La Psychiatrie
ave. Louis Bertrand 39
Bruxelles, Belgium

Groupe Information Asile
c/o Yves-Luc Conreur
rue Langeveld 146
Bruxelles, Belgium 1180

S.P.U.I.T.
c/o Theo Peeters
Cogels-Osylei 67
2600 Antwerpen-Belchem Station, Belgium

CANADA
ALBERTA
Calgary Association of Self Help
1117 Macleod Trail S.E.
Calgary, Alberta

Southern Alberta Self Help Association (SASHA)
#205 Professional Building
740 - 4th Avenue S.
Lethbridge, Alberta T1J 0N9

BRITISH COLUMBIA
Mental Patients' Advocate Project
Riverview Hospital
500 Lougheed Highway
Port Coquitlam, B.C. V3C 1J0

Mental Patients' Association
2146 Yew Street
Vancouver, B.C. V6K 3G7

The Advocacy Group (TAG)
c/o Terry Gordon
CMHA B.C. Division
692 East 26th Avenue
Vancouver, B.C. V5V 2H7

MANITOBA
Last Boost Club
330 Edmonton Street
2nd Floor
Winnipeg, Manitoba

NEWFOUNDLAND
Newfoundland Association of
Psychiatric Patients
11 Church Hill Street
St. John's, Newfoundland A1C 3Z7

ONTARIO
On Our Own
P.O. Box 7251
Station A
Toronto, Ontario M5W 1X9

Psychiatric Association of Timmins (PAT)
c/o Florence Henderson
168 William Avenue, Box 953
S. Porcupine, Ontario P0N 1H0

RESIST
Box 1881
Guelph, Ontario N1H 7A1

Self-Esteem Through Independence (SETI)
c/o Brenda Ruddock
No. 2, Adelaide Street N
London, Ontario N6B 3J7

Society for the Preservation of the
Rights of the Emotionally Distraught (SPRED)
4927 Morrison
Niagara Falls, Ontario L2E 2C4

QUEBEC
Association Quebecoise Pour La Promotion
De La Sante
c/o Claude Labrie
5285 rue Aurele
St. Hubert, Quebec J3Y 2E8

Auto-Psy
45 St. Francois Est.
Quebec City, Quebec J1K 1Y4

Program for Alternative Lodging (PAL)
3694 Wellington, Verdun
Montreal, Quebec H4G 1V2

Solidarite-Psychiatrie Inc.
7401 rue St. Hubert
Montreal, Quebec H2R 2N4

SASKATCHEWAN
By Ourselves
1821 Scarth Street
Regina, Saskatchewan S4P 2G9

ENGLAND
Camden Mental Patients Union
c/o Mike Cardew
20a Camden Road
London NW1, England

Depressives Associated
c/o Mrs. Janet Stevenson
19 Merley Mays
Wimborne Minister
Dorset, BH21-1QN, England

Friends and Family of
Richard Campbell Committee
c/o 135a Lavender Hill
London SW 11, England

Hackney Mental Patients' Association
c/o The Secretary
101 Median Road
London E5, England

"Inquest": United Campaigns for Justice
Box 37, 136 Kingsland High Street
London E8-2N3, England

Matthew O'Hara Committee
c/o 177 Glenarm Road
London E5-0NB, England

Mental Patients' Action Group
c/o Joe Griffy
Second Chance
56 Dames Road, Forrest Gate
London E7-0DR, England

People Not Psychiatry
c/o Lawletter
90 Fawcett Estate
Clapton Common
London ES-9HX, England

PROMPT
c/o 11 Ottershaw House
Horsell Road, St. Paul's Cray
Kent, England

Protection for the Rights of
Patients at Rampton
University of Nottingham, Nottingham
Nottinghamshire, England

Winston Rose Action Campaign
c/o 25 Church Hill
London E17-3AB, England

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c/o Maurice Dumoulin
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Iceland

MEXICO
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Cuernevaca, Morelos
Mexico

NETHERLANDS
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Netherlands

Geh-ooit
Postbus 43097
Amsterdam
Netherlands

Wegloophuis Haarlem
Herensingel 7
Haarlem
Netherlands

Wegloophuis Amsterdam
Heizergracht 252
Amsterdam
Netherlands

Stitchting "Pandora"
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Amsterdam
Netherlands

Werkgroep Krankzinnigenwet
c/o above address

NEW ZEALAND
Campaign Against Psychiatric Atrocities
Box 6899
Auckland, New Zealand

Mental Patients Resistance
1 - 38 Cumberland Street
The Rocks, N.S.W., New Zealand 2000

SWITZERLAND
Association des Usagers de la Psychiatrie
22 rue Neuve du Molard
Geneva, Switzerland

Interessen Gemeinschaft Psychiatrie
Sektion Zurich
Postfach 104
8402 Winterthur, Switzerland

WEST GERMANY
Beschwerdezentrum Psychiatrie Bonn
Bornheimerstrasse 92
Bonn 53, W. Germany

Sozialistische Selbsthilfe Cologne
Liebigstrasse 25
5 Cologne 30, W. Germany

Sozialtherape Frankfurt
e.v. Egenolfstrasse 28
6000 Frankfurt/Main, W. Germany

UNITED STATES
ARIZONA
Advocates Coming Together (ACT)
c/o Arizona Dept. of Health Services
2500 E. Van Buren, R-30
Phoenix, AZ. 85008

CALIFORNIA
Bay Area Committee for Alternatives
to Psychiatry
944 Market Street, Room 701
San Francisco, CA. 94102

Center for Independent Living
2439 Telegraph Avenue
Berkeley, CA. 94704

Coalition to Stop Electroshock
P.O. Box 3301, S. Berkeley Station
Berkeley, CA. 94703

Liberation Information Center
#2, 2304 - 6th Street
Berkeley, CA. 94710

Madness Network News
P.O. Box 684
San Francisco, CA. 94101

Mental Health Consumer Concerns
2727 Alhambra Avenue, #2b
Martizez, CA. 94553

Network Against Psychiatric Assault
(NAPA) - Los Angeles
P.O. Box 5728
Santa Monica, CA. 90405

NAPA and Women Against Psychiatric Assault
2054 University Avenue, Room 406
Berkeley, CA. 94703

Patients' Rights Advocacy Services

2525 - 24th Street
San Francisco, CA. 95062

Psychiatric Inmates' Rights Collective
P.O. Box 299
Santa Cruz, CA. 95061

Terrap: Network for Agoraphobics
1010 Doyle Street
Menlo Park, CA. 94025

FLORIDA
Alternatives to Psychiatry Association
410 Dixie Highway, Unit 10
Lake Worth, FL. 33460

ILLINOIS
Fire and Rain
c/o Dan and Genie Burns
1157 W. Grace, Apt. 1 South
Chicago, IL. 60613

Alliance for the Mentally Ill of
Rock Island and Mercer Counties
P.O. Box 933
Rock Island, IL. 61201

Changes
5655 S. University Avenue
Chicago, IL. 60637

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Advocates for Freedom in Mental Health
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Kansas City, KA. 66103

Project Acceptance
P.O. Box 187
Lawrence, KA. 66044

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18 Williston Road
Brookline, MASS. 02146

Mental Patients' Liberation Front
P.O. Box 514
Cambridge, MASS. 02238

Project Liberation from Psychiatric Oppression
c/o Charles Hobbs
Indian Hill Road
Goroton, MASS. 01450

New Directions in Psychology
c/o State and Mind
P.O. Box 89
Somerville, MASS. 02144

On OUr Own Network
c/o Second Congregational Church
395 High Street
Holyoke, MASS. 01040

MARYLAND
On Our Own
c/o P. McCusker
3142A E. Joppa Road
Baltimore, MD. 21234

MICHIGAN
Oakland Patient Environmental Nexus
35 W. Huron, Suite 226
Pontiac, MI. 48058

F.O.C.U.S.
600 Cass S.E.
Grand Rapids, MI. 49503

Psychiatric Alternatives Alliance
32658 Menominee Ct.
Westland, MI. 48185

MINNESOTA
Mental Health Advocates Coalition
265 Fort Road
St. Paul, MN. 55102

Minnesota Association to Stop Psychiatry
and Psychlogy (MASPP)
P.O. Box 13027
Dinkytown Station
Minneapolis, MN. 55414

Project Overcome
1900 Hennepin Avenue
Minneapolis, MN. 55403

NEW YORK
Albany Mental Health Advocates
c/o Marin Lee Erwin
66 Judson Street
Albany, NY 12206

American Conference of Therapeutic
Selfhelp/Selfhealth
710 Lodi Street
Syracuse, NY 13203

Association for the Preservation of
Anti-Psychiatric Artifacts
P.O. Box 9
Bayside, NY 11361

Community Health Consumers' Group
c/o Peter Anderson
P.O. Box 372, University Station
Syracuse, NY 13210

Mental Patients' Alliance of
Central New York - Ithaca
P.O. Box 22
Brooktondale, NY 14117

Mental Patients' Alliance of
Central New York - Oswego
P.O. Box 1012
Oswego, NY 13126

Mental Patients' Alliance of
Central New York - Syracuse
P.O. Box 158
Syracuse, NY 13201

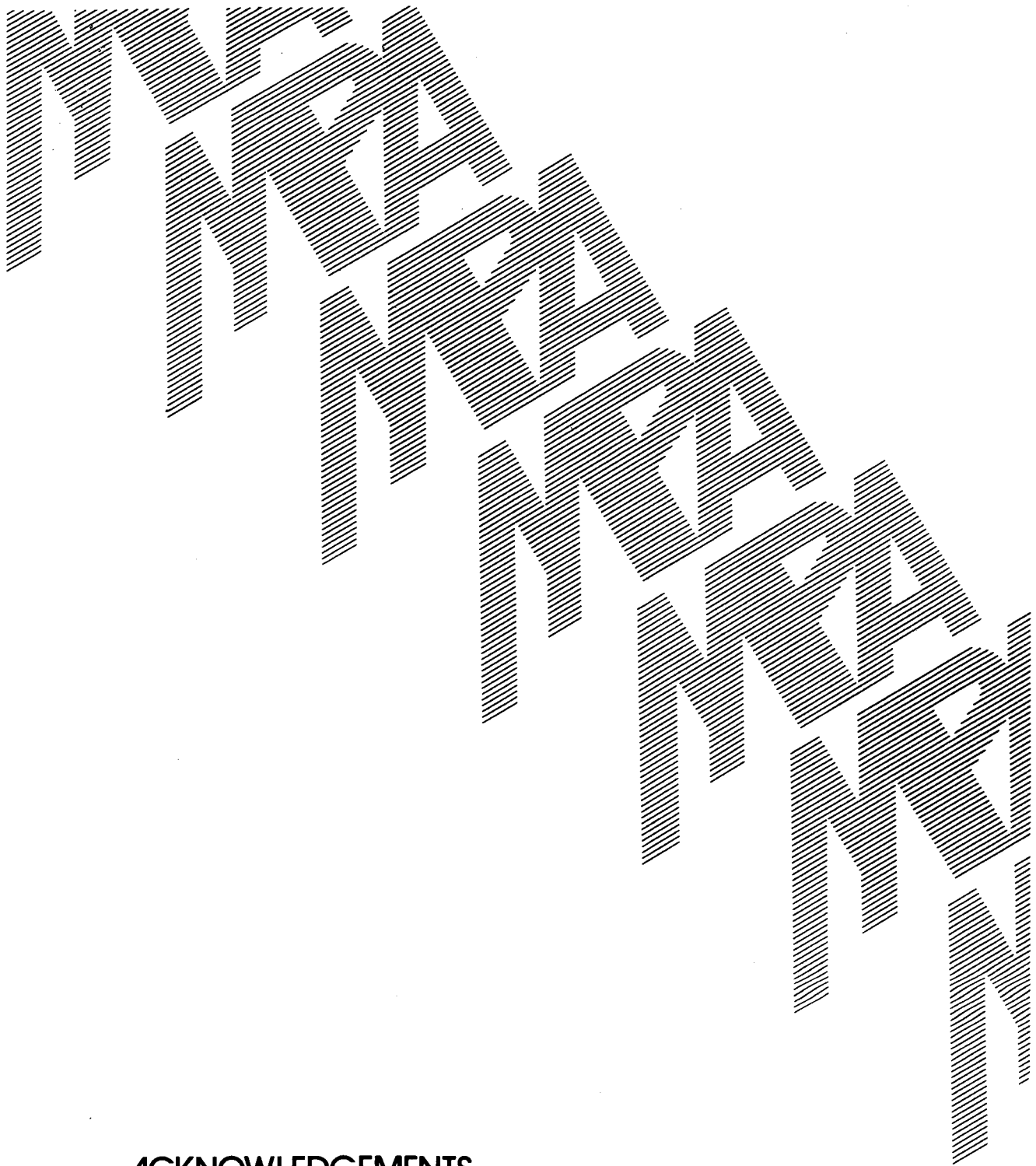
Project Release
P.O. Box 396, FDR Station
New York, NY 10022

OHIO
Patients' Rights Organization
1223 West 6th Street
Cleveland, Ohio 44113

PENNSYLVANIA
Alliance for the Liberation of Mental Patients
P.O. Box 30228
Philadelphia, PA. 19102

SOUTH DAKOTA
South Dakota Mental Health Advocacy Project
Box 618, 904S Phillips Avenue
Sioux Falls, SD. 47104

VERMONT
Vermont Liberation Organization
RD No. 1
Johnson, VT. 05656



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TO THE
BEGINNERS
OF THE UNIVERSE
KATHY FRANK

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