

in a NUTSHELL

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WOMEN P. 3 & 6 AND MUCH MORE!!!!

in a nutshell

Mental Patients Association Newsletter

MONTHS WASTED

Citizen Participation Crushed

Council Forms
RESIDENTS
NO LONGER
MPA ORPHANS

Just over two years ago M.P.A. embarked on its program of establishing houses for its members and ex-mental patients. We now have five houses, one of which is the Women's Residence. Housing available in the community was totally unsuited to those wanting an economical, comfortable, pleasant place to live. It was unsuited to many who, in living alone, might become depressed and afraid. Boarding homes provided a rigid, sterile kind of atmosphere. Supervision tended to be punitive and uncompromising. Help for crisis situations was limited to telephone contact or nine-to-five agency service.

Very early we learned that finding houses for people, furnishing the house and then leaving the group to "get on with it" simply didn't work. People take varying amounts of time to learn to organize themselves or talk problems over and particularly to make decisions with a group. Crisis situations often need outside help.

We gradually developed an autonomous, democratic pattern for each house. The residents elected coordinators, decided how money should be spent, divided up the cooking and cleaning chores etc. The house meeting is the means to make these decisions and also the way to vote in new members, to help members with individual problems and to vote on measures to be taken when members break house rules.

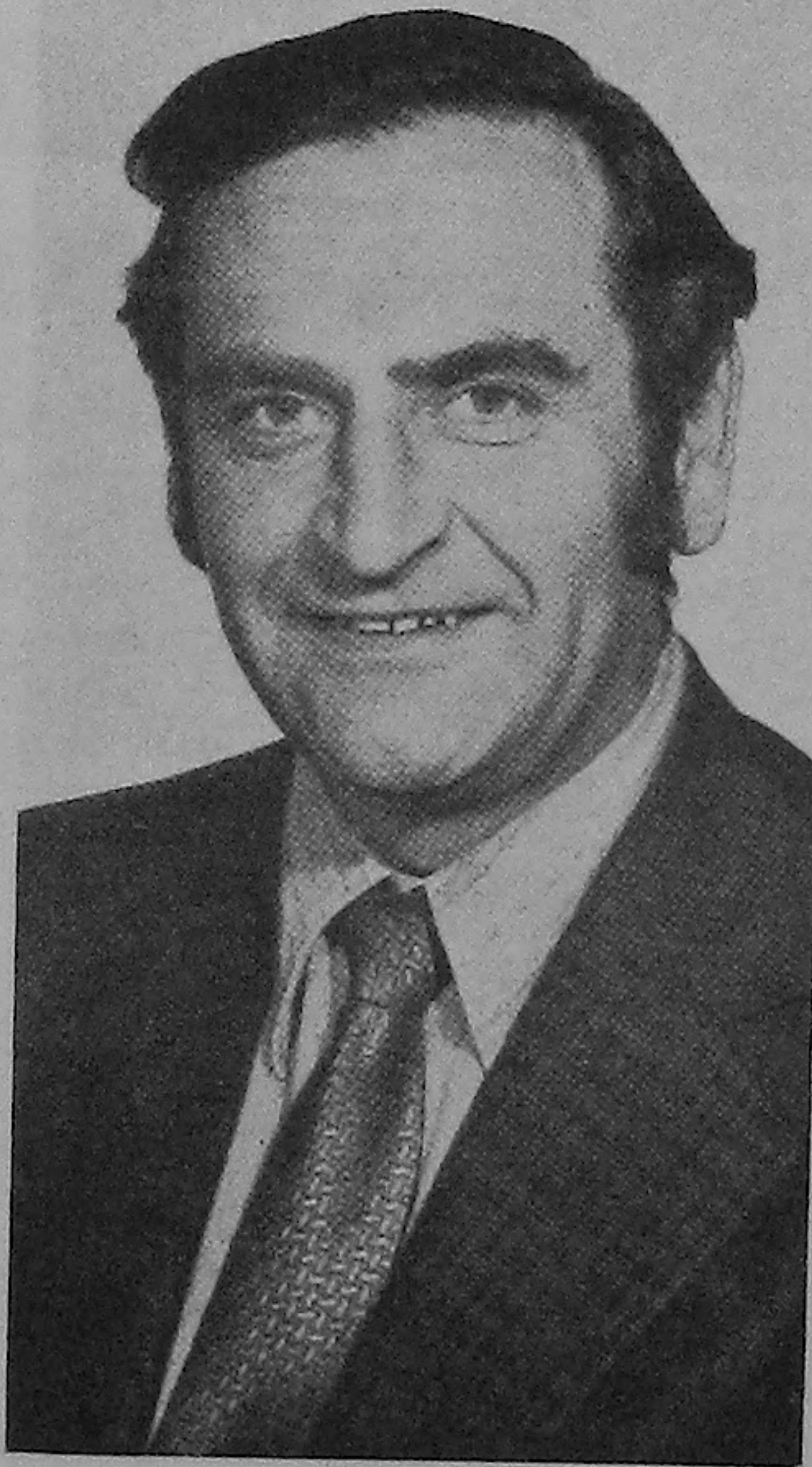
In all of our houses these rules are: 1) No alcohol; 2) No non-prescription drugs; 3) No physical violence.

The idea of residents running their own houses, having hiring and firing power of their coordinators has obvious benefits. It does allow people to learn from their own successes and mistakes. There is opportunity to learn how to manage money, organize house affairs and general activities of daily living. The drawbacks to autonomy have also become apparent. Making decisions is a tough business. It is sometimes easier just to let a coordinator take over and run things. People become used to this kind of thing in the hospital. It is a

see page 2 - RESIDENTS

At a closed meeting of the Metro Board of Health on November 21st, Dennis Cocke, Minister of Health, killed citizen involvement in the Greater Vancouver Mental Health Project. Cocke explained that citizens should not be involved in budget preparation or in the hiring of neighbourhood teams "as a matter of administrative principle." He further suggested that citizens not be permitted to form a majority on the Executive Committee of the project, and that their role be advisory only. He made it clear that the project is to be little more than a community bed-replacement service for Riverview Hospital, and will treat only "adult psychotics."

For the last nine months the Kitsilano Citizens Committee had operated on the assumption that



Health Minister Dennis Cocke killed citizen involvement in neighbourhood mental health scheme at a behind-closed-doors meeting Nov. 21.

they were to be major decision-makers in the formation of project policy within Kitsilano. In his proposal, "Plan for Vancouver," Dr John Cumming, originator of the project, stated that citizens were to have a major input in the formation of policy as it concerned the development of service in their neighbourhoods.

On that basis Kitsilano refused to accept the standardized budget for the project; instead they created a budget which reflected the particular needs of the community. Food, clothing, housing, child care, and crisis services were crucial factors in the budget; so was the emphasis on de-professionalizing the mental health teams and equalizing the salaries. Cocke's deputies chopped away at the body of the Kits budget until, heartless and mindless, it was acceptable to them.

The corpse of the Kits budget has now been approved and the project managers hope to hire a nuclear team of professionals by January 1st. But Strathcona, the West End, Mt Pleasant, and Kitsilano had set up citizen's personnel committees to hire for the project. Now all their months of efforts have been wasted as a result of Cocke's recent directives. Citizens are now advisors only, and whether their advice will be listened to is questionable.

What does this mean for Kitsilano? None of the social factors which contribute to "mental illness" will be considered. Only the most "chronic patients" will be served. It may even be necessary for the mental health teams to categorize people as "adult psychotics" in order to treat them. Thus the stigma of mental illness may be more widely distributed throughout the community by people who are ostensibly being hired to combat it.

As a treatment program for "chronic patients" the project seems doomed to failure. Community psychiatric nurses cannot hope to alleviate human suffering any more than institutional nurses. They can only hope to keep people out of hospital temporarily. The project also seems doomed as a bed-replacement program. How can they expect to keep people out of hospital for any length of time when there is no provision made for housing them in the community. The project is helping to establish more psych wards in local hospitals. "Bed-replacement" may become the replacement of Riverview beds with General Hospi-

See page 2 - WATCHDOG

Correction

The last issue of IN A NUTSHELL contained an error in the article, "How To Tell Schizophrenia From Normal Behaviour". Due to a mistake in layout, the column which read "Schizophrenia" should have read "Normal Behaviour" and the column which read "Normal Behaviour" should have read "Schizophrenia".

We apologize for any inconvenience this may have caused.

RESIDENTS GROUP

FROM PAGE 1

hard habit to break. It is easy to become comfortable in a house and not want to venture into the relative unknown of the M.P.A. drop-in center. Rivalries developed between houses around all sorts of activities. Residents rarely saw coordinators from the office, drop-in center or research areas. The residence program was seen by some as nothing but social service work.

We have learned from our experiences of the past two years. We found that house coordinators can become isolated and over-worked. This happened at the farm in Whonock where there was no support from the community for a self-help group. The distance from M.P.A. prevented the development of the kind of support coordinators and residents needed. We gave up the idea that fresh air and the country life had some magic curative effect.

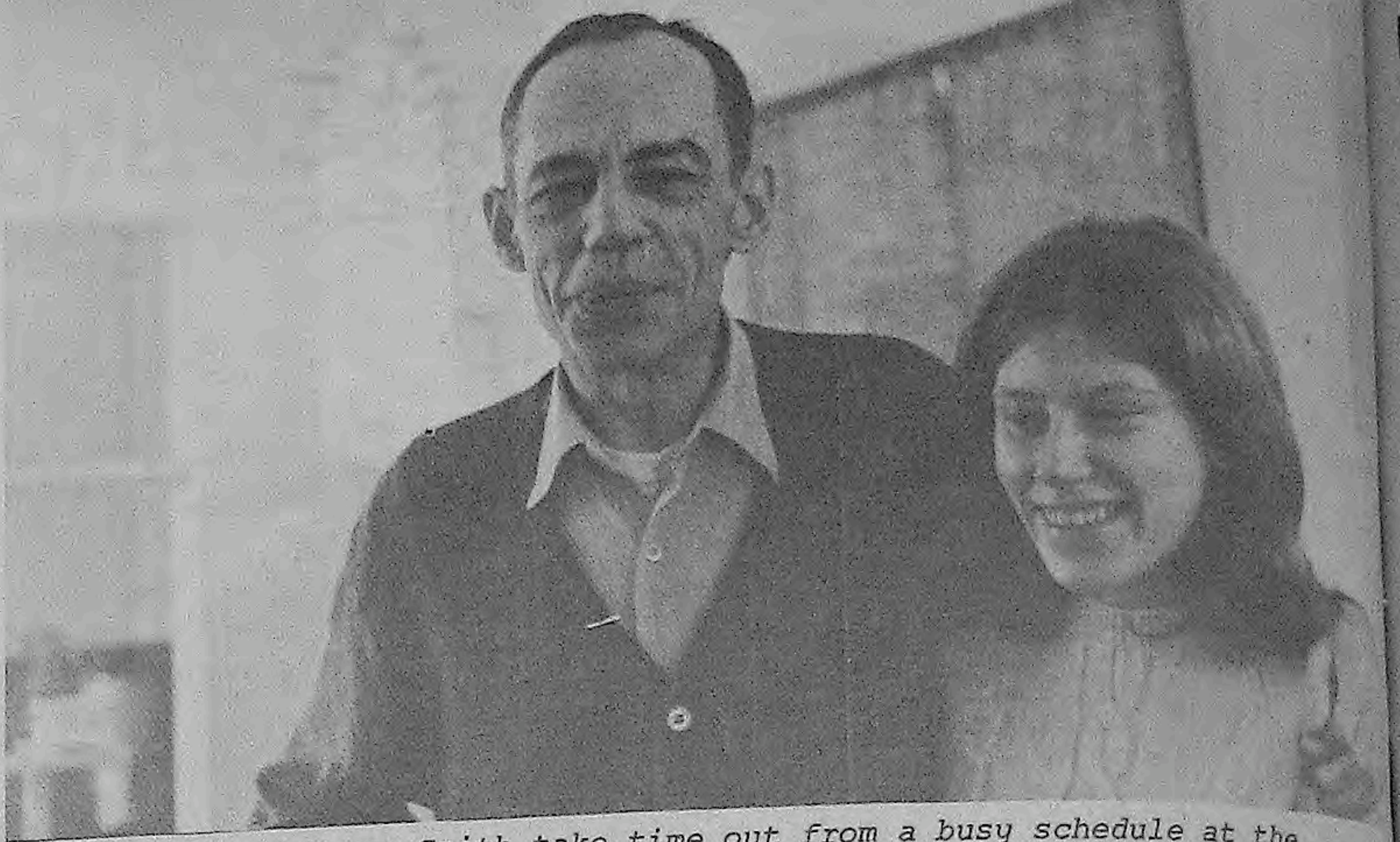


Here's Sandy and Ann-Marie ready to paint the Women's Residence ... red?

We also found that residents can feel abandoned right in the city. Our residence program is not simply the provision of facilities and a place to live. It is the development of a community. Up until recently this development has been achieved in each separate residence. House coordinators were not involved in other houses and some became isolated within the autonomous operation of their own house. M.P.A. found itself bailing houses out of situations that developed because we had not found a way to assist and help one another until things had gotten out of hand.

Problems

Another problem for individual houses was the introduction of new coordinators to the M.P.A. policies and programs. Orientation to community resources, help in special crisis situations, keeping books, were all areas where people were left to discover how to go about things as best they could.



Al Kuenzli and Nancy Smith take time out from a busy schedule at the West 3rd. Residence to pose for the camera...

We began looking at the various bookkeeping systems in operation and started questioning the value of autonomy in the houses. We discussed the responsibility that residents in the houses have to M.P.A. business. Out of these discussions has come the idea of a Residence Council. This council consists of all residence coordinators and any resident wishing to attend the weekly meeting. Problems concerning the houses are referred to the council for discussion and decision. In the short time we have been meeting, the Residence Council has set up a bookkeeping system and joint management of rent and utilities expenses. Pat Oram, one of our residents who is on V.O.P., will do the necessary accounting and will audit house books regularly. We have also listed the needs of each house for furniture and household supplies and have involved many of the residents in a donations drive to provide for these needs.

Major Benefit

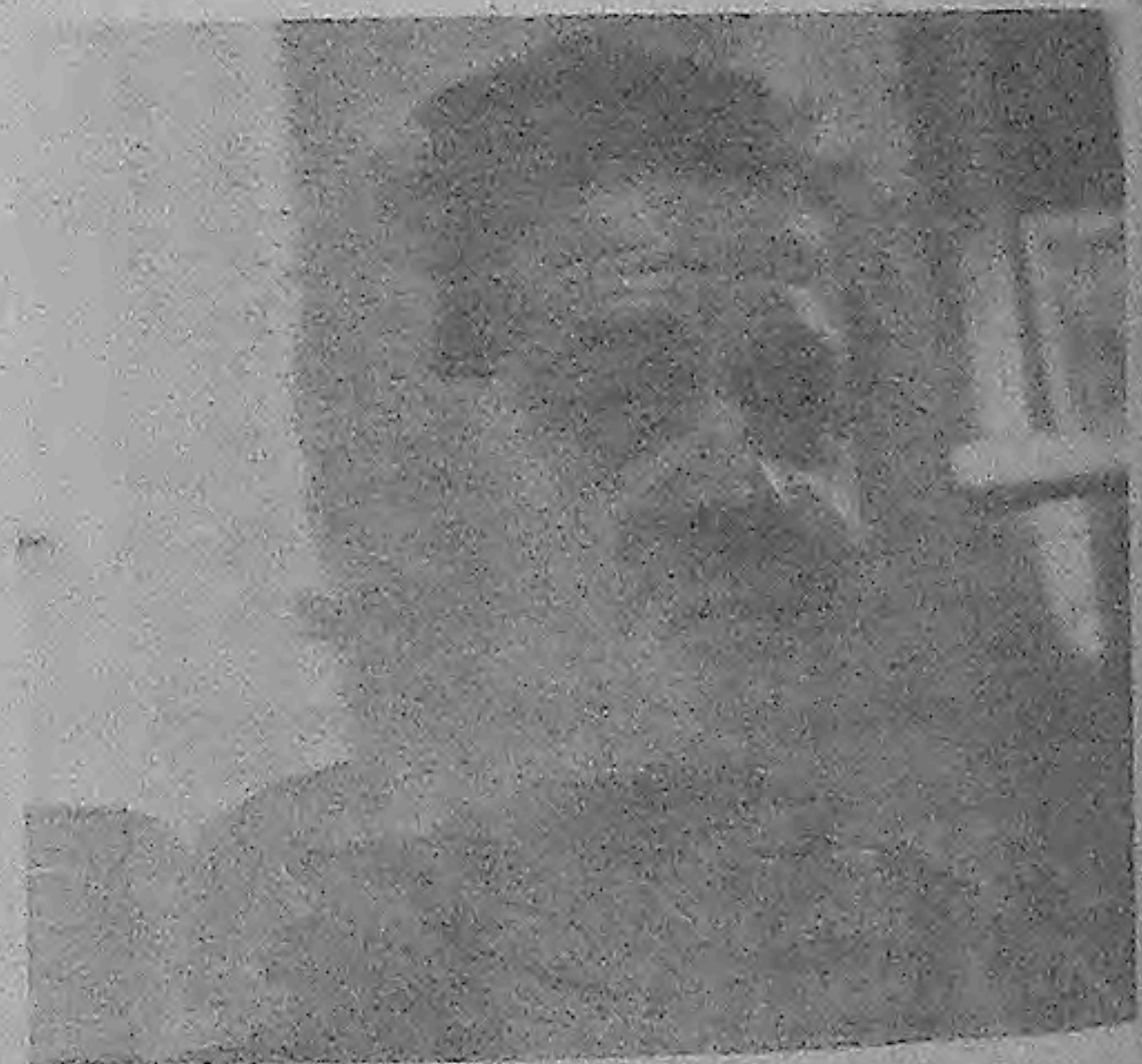
A major benefit to this group has been the practice of rotating meetings amongst the houses. This allows residents to participate and meet other coordinators. We can anticipate that by becoming involved with residence problems, members will gradually become interested in M.P.A. programs and make demands that these programs meet their needs or that new planning be developed to meet those needs.

Gaining Support

A further dividend from our meetings has been the creation of an avenue for discussing crisis situations, solving individual problems and gaining support and feedback concerning the ways we are handling house problems. This is the kind of workable solution which will prevent coordinators from feeling isolated and overworked. At the same time, residents can become involved in the broader M.P.A. view. The step into the community at large becomes possible.



Pat Oram takes on accounting



"Have you been a mental patient?" Monty's favorite question to prospective MPA workers.

WATCHDOG

FROM PAGE 1

tal beds. In effect, Riverview may be established in the community. Now that citizen participation has been crushed, the Kits Committee has realized that its energy was wasted in attempting to change the project. The Committee will now participate in the program as a watchdog over the team. At the same time, it will attempt to increase its internal education with an aim toward more political awareness and community activity. New directions are being considered. -Barry Coul

Mental Patients and the Law

IT'S BETTER TO BE CRIMINAL THAN CRAZY

Part 1

WHAT TO DO IN CASE OF ARREST

This is the first of a two-part series on legal issues affecting those who may be judged "mentally disordered." Part I deals with general information and guidelines on anyone (sane or insane) who is charged with an offense. Part II, to be printed in the next NUTSHELL, will go into considerable detail on the relationship between the Criminal Code and the Mental Health Act.

It's better to be criminal than crazy according to Sid Filkow, a lawyer who spoke to two gatherings of MPA members recently about what happens to those who freak out and end up in jail, and about how MPA can help their friends behind bars.

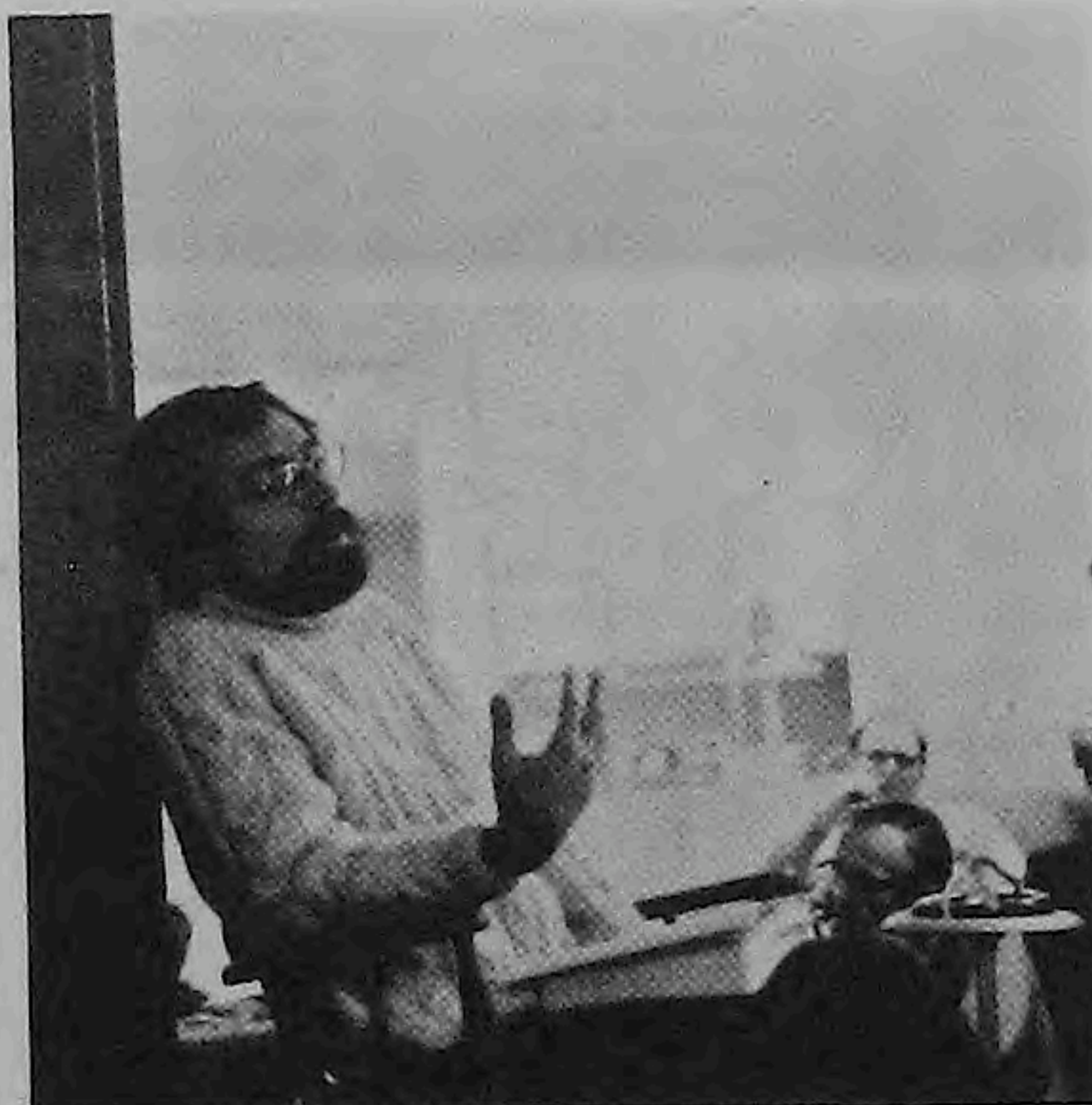
If you commit a minor offense such as shoplifting an insignificant item, and find yourself in the city jail, you can make one phone call. If you've got a lawyer, call him. If you haven't and don't know who to call, phone MPA and tell us where you are and what you're being held for. Hopefully the person who answers your call will be able to judge how freaked out you are and give you good advice. If you think you're in deep trouble, make out an application for legal aid. This should be done as soon as possible --when you're booked or before you appear in court the next morning. Legal aid is available to anyone without funds who requests it. During the day there is a Legal Aid Duty Counsel (lawyer) on the premises, and Salvation Army advice and help is available. Someone from Legal Aid or the Sally Ann will tell you what to do when you appear; what to expect when your name is called, etc.

Getting Bail

Cases are heard every weekday morning in Courtroom 2 at 312 Main Street. A number of things can happen to you when your case is heard. You can plead guilty, or be remanded to a further date to get a lawyer etc. When you appear you can ask for bail. You can a) be released on your own recognizance; b) be released on your signature plus that of a friend or relative with funds; c) be released on your signature and cash bail; or d) be refused bail and held in custody to appear at a future date not exceeding eight days.

The usual procedure for a minor offense, especially if it's a first one which is remanded for hearing at a later date, is that you will be released on your own recognizance, or in other words, you sign a form stating that you promise to appear on an appointed date for a court hearing into your offense. Naturally if you don't turn up in court when you're supposed to, a warrant is issued and you'll be picked up and locked up.

If you are refused bail on your own recognizance, you may be able to get bail by getting one or more "sureties" (friends with money) to guarantee your application for bail; which means that the person or persons, if more than one is required, promise to pay the amount of your bail if you don't show up on your trial date. This process doesn't involve the actual payment of cash; it's just a promise to pay. If your surety later decides you are not such a hot risk after all and decides to back out of serving as surety for bail, he can do so, and you will be picked up by the police. Until you're picked up the surety remains responsible and liable for the amount of the bail. It is MPA policy that we do not, as an organization, put up bail for members. If an MPA friend does it for you, that is his responsibility, not MPA's. Needless to say, once you're locked up, you should apply for legal aid right away because the procedures seem overwhelmingly complicated if you haven't been through the experience before.



Sid Filkow at MPA Legal Training Session

How to Intervene

Bail will be refused if a) the person is deemed to be likely to commit another crime and is considered dangerous to be at large; or b) the person is deemed unlikely to show up on his trial date. The onus is on the Crown--that is, the Prosecutor--to show cause why bail should not be allowed. Usually this will be because of the person's previous record or the serious nature of his crime. A person can appeal the refusal of bail, but this is a procedure which has to be taken to a higher court.

Sid suggested that knowledgeable MPA members should, as observers, become familiar with the procedures which go on in Courtroom 2 so that they can learn how and when to intervene on behalf of a friend in a helpful way. There are two aspects to a trial: 1) Did or did not the person commit the offense? 2) Why did he do it and what sentence

should he get?

Sometimes--and this has happened to several of our members -- the locked-up person will appear in court, be remanded (postponed) till the following week, be taken to Oakalla, be brought back to court the following week, be remanded again, and so on ad nauseam. We could help in such cases by making sure that the locked-up person does apply for legal help so that he isn't left in limbo for weeks. Or we could help in certain cases by appearing on behalf of the person on the stand as character witnesses, and explaining his/her circumstances, assuring the court that we feel the person is usually responsible and law-abiding, and that MPA could supply him/her with moral support during the rough times the person is going through. We could recommend that the charge or charges be dropped and the person released so that we can help him/her to get straightened out again. This implies responsibility on the part of MPA so that we would have to be sure of the cooperation of the person concerned.

Conditions

Many conditions can be attached to bail. In certain cases a person may be released on his own recognizance if, for example, he seeks voluntary admission to a psychiatric unit. Nevertheless, the judge may want to be shown that the person is going into an improved, helpful, therapeutic or supervised situation before he grants such a release.

Sometimes a conditional discharge is granted. Even though the person is found guilty, he is not convicted and sentenced. He may be released with probation. This happens when the judge considers the person is likely never to commit another crime.

So far we haven't said anything about the person in question being mentally disturbed at the time of his or her criminal act, or just being mentally disturbed and reported to the police. This complicates the picture, which up till now has not involved the Mental Health Act, but just the Criminal Code and routine civil committals to Oakalla.

In Part II (see next NUTSHELL) the topics of sanity and insanity, fitness to stand trial, Order-in-Council and many others will be discussed in detail.

WHAT?

May this seem what it is
May I understand what it is not,
And cradle that which it should be!

- Murray Sidenberg

SUICIDE...

Editorial

"The point is to live"

The thought of suicide is a great consolation: by means of it one gets through many a bad night.

- Friedrich Nietzsche

Suicide is a terrible thing. It is to be avoided at (almost) all costs.

In this issue we are printing several pieces on suicide, but we are somewhat apprehensive that the gloominess and starkness of the writing may push some suicidal people further in the direction of self-destruction. Our aim, of course, is the exact opposite of this.

Suicide is such a taboo topic that sometimes people give into the impulse largely because they are afraid to ask for help or to speak openly about their feelings (for fear of rejection, of being seen as "manipulative" etc.). One study found that suicide is the topic most commonly avoided by psychiatrists when it is raised by the patient. This is a mistake. It must be dealt with openly and honestly so as to prevent the ultimate act.

Suicidal impulses are almost invariably ambivalent. It is the "duty" of friends to intervene on the life-affirming side. Only in the most extreme situations, such as those involving terminal medical illnesses, can a case be made for supporting the person's wish to die.

The puristic argument of some civil libertarians--that killing oneself is a fundamental human freedom, not to be interfered with--is simply a false intellectual view of a basically emotional situation. You only have to have lost one friend through suicide to realize that calling suicide a form of

"freedom" is a pernicious distortion of language. Suicide is the ultimate expression of slavery.

It must, however, be recognized as a valid human expression and should not be rationalized by others via comforting clichés that suicide threats or attempts are "only a bid for attention," or "only a way of avoiding problems."

We are not advocating coercion as a form of suicide prevention. We are advocating warmth, concern and support; but that is putting it too simply. Before such feelings can operate, social agencies and institutions must be built within which people are encouraged to exercise them. As illustrated by the articles in this issue, these agencies do not yet exist.

While we are in the process of building, we must look suicide in the face--encounter our honest response to a friend's death. We must mourn and grieve and struggle to turn this powerful spring of feeling into an affirmation of life.

The French philosopher, Albert Camus, wrestled at great length with the problem of suicide. He begins an essay entitled "An Absurd Reasoning" with the following words:

"There is but one truly serious philosophical problem, and that is suicide. Judging whether life is or is not worth living amounts to answering the fundamental question of philosophy."

Fifty pages later, he concludes with the passage:

"By the mere activity of consciousness I transform into a rule of life what was an invitation to death--and I refuse suicide. . . The point is to live."

from prof's

Dear NUTSHELL,
Keep up the good work. I enjoy IN A NUTSHELL very much.

Vic Marshall
Assistant Professor
Department of Sociology
McMaster University
Hamilton, Ontario.

nutshell

IN A NUTSHELL is the official publication of the Mental Patients Association. It is produced entirely by psychotics, who believe that 2 plus 2 equals 5, and by neurotics, who believe that 2 plus 2 equals 4 (but don't like it). It is not produced by mental health bureaucrats, who believe that 2 plus 2 equals 5, but that it might equal 4 next year. If you understand these basic principles, come by and work for the paper at 1982 W. 6th Ave., Vancouver 9, B.C. Ph: 738-5177.

from trudeau

Dear Sir:
Thank you for your recent letter commenting on the coup which took place in Chile on September 11.

I appreciate and share your concern over the removal from office of a democratically elected government and the subsequent and tragic death of that country's president, Salvador Allende. I regret these events. When the Canadian government learned what had taken place in Chile, we sent a message of sympathy to the people of Chile and to the Allende family.

On September 29 the Canadian government extended formal diplomatic recognition to the present administration. Our reasons for taking this action were not based on support of any kind for the present government, but on the very real need for effective representation for those Canadians who found themselves in Chile during these events. As you may know, there

Prevention Centers Ineffective

According to at least two separate studies, suicide prevention centers have failed to reduce suicide rates. These centers, which in the U.S. have soared in number from only 4 in the late 1950's to more than 300 today, are also found in all major Canadian cities. If their effectiveness in Canada is anything like what it is in the States--and there is no reason to suspect otherwise--the results can only be called dismal.

In a report published in the *Journal of the American Medical Association*, Dr. David Lester concludes that, "There are no data to support the notion that suicide prevention centers have significantly reduced the suicide rate." He cites the following comparative findings for more than 40 major metropolitan areas in the U.S. Of the 17 cities which instituted suicide prevention centers during the span of the study, eight showed a decline in suicide rates and nine showed an increase. Of the 27 cities lacking centers, 14 witnessed a decrease in suicide rates and 13 an increase.

These negative findings are upheld in a study by Dr. Donald Light presented to the recent annual meeting of the Society for the Study of Social Problems. Sharply critical of the suicide prevention "movement," Light claimed that the leaders of the movement are less concerned with preventing suicide than with what he called "professional entrepreneurship," i.e., consolidating and expanding their domain of power. He made reference to one of the leaders who listed among the movement's achievements: 1) the publication of a suicide research journal; 2) the creation of a suicide prevention association; 3) the promotion of international conferences on suicide; and 4) to take the cake--coining of the term

LETTERS LETTERS

were a number of Canadians detained and questioned. It is extremely important that our embassy is able to help these and other people who require our government's assistance. Any help we can offer is of course only effective through the channels of diplomacy.

Our decision was carefully thought out. We would not have taken this step if we had not been satisfied that the present authorities are able to govern the country and are willing to fulfill Chile's international obligations.

I know I share your hope that democracy will be restored to that country very soon.

Yours sincerely,
P.E. Trudeau
Prime Minister

WE'RE AGAINST IT

"suicidology". Very professional indeed! The field no doubt subsumes the sub-disciplines of overdosology, wrist-slashingology etc. In a statement which must take the "Honest Confession of the Month Award," Light said, "Like a client coming to any other professional, the suicidal person expects the psychiatrist to have special expertise about the problem. In this he will be disappointed, because psychiatrists know relatively little about suicide."



It is not really surprising that suicide prevention centers have shown such a depressing record. In many respects, they combine the worst aspects of the professional approach. At the very point when the suicidal person most needs personal, human contact, almost all centers provide only contact by phone--perhaps the most alienating medium of communication.

Files are kept on all callers, a fact which in one way or another is surely conveyed to the client. Counsellors are strait-jacketed by a series of robot-like rules. For example, they are forbidden from swearing, and are explicitly instructed to adopt an "objective,"

uninvolved posture, even to the extent of being prohibited from disclosing their surname to the caller.

Like most services in the mental health field, suicide prevention centers represent just another half-way measure which functions as much to reinforce feelings of hopelessness as to alleviate them.

Pious platitudes notwithstanding, suicide will continue to be a major social problem until real programs of human intervention are widely instituted.

Vancouver— Suicide Capital of Canada

Vancouver is the suicide capital of the country. The city's suicide statistics show a ratio of almost 2 to 1 as compared with the national average.

The following table shows that Vancouver tops the suicide list relative to other major Canadian cities.

City	Suicide Rate Per 100,000
Vancouver	14.9
Toronto	13.5
Winnipeg	13.0
London, Ont.	10.7
Calgary	10.0
Quebec City	8.5
Windsor	7.9
Hamilton	7.7
Ottawa	7.2
Edmonton	7.1

It seems that older people take their own lives with greater frequency here than in other places in the country. The average age of suicides in the city is 32.5 years, or four years greater than the national average.

Suicide is most commonly committed by ingestion (poisoning or overdose). Fire-arms are the se-

cond most commonly used method. Vancouver has recorded 12.0% more jumping deaths than the rest of the province. This is presumably related to the numbers of tall buildings and bridges found locally.

The vast majority of suicide deaths and attempts take place at home. 79.2% of the attempts reported were in the home. Most of the people who attempt suicide are single men and married women. Women generally attempt suicide at an earlier age than men.

Japanese, Chinese and native people who live in Vancouver do not contribute significantly to the over-all suicide rate. Instances in these groups accounted for only 3.4% of the total in the years 1964 to 1965. Suicides do show a preponderance in poor or working-class areas of town.

Looking at the total grim picture an average of 75 people per year commit suicide in Vancouver (it must be remembered that this recorded number of deaths is only a small fraction of the actual number). Studies have shown that for every successful (!) suicide, there are approximately ten attempts. Vancouver General Hospital reported 760 cases of attempted suicide last year.

And some say we don't need crisis facilities here!

It is also interesting to note that 69% of all successful suicides in Vancouver for the years 1964-65 had no previous psychiatric history. Of the some 30.8% who did have psychiatric contact, 60% had this contact within six months of their deaths. An American study found that 50% of ex-mental patients who committed suicide did so within three months of discharge from hospital. (Draw Your Own Conclusions Department.)

Finally, what happens to people who attempt suicide? Recent reports show 42% were released to general practitioners; 14.4% were released to the care of a psychiatrist; 13.4% were hospitalized; 16.7% walked out on discharge; and two people died in emergency.

A bleak picture, badly in need of reform.

ing difficulties, however in the mean time we would appreciate receiving your newsletter if possible.

We praise your work.

Bob McArthur
Adjustment Into Society
Queen Street Mental Health Center
999 Queen Street West
Toronto, Ontario.

Gentlepeople,

Just finished reading your excellent (if slightly dated) write-up in last year's *Radical Therapist/Rough Times*. We were all really struck with your incredible accomplishments in the face of overriding oppression, the tremendous value of what you're doing, the guts, the energy (Ed. note: this is getting embarrassing), the power--it's work like yours that helps keep us going as well.

see pg 7 - LETTERS

LETTERS LETTERS

& from People

The Editors:

I want to thank you for sending us your newsletter. I was most pleased at the variety of topics discussed and was especially pleased to see the subject of Civil Liberties and Women's Rights highlighted in such an adept manner. I was also enlightened a little about an organization I hardly knew existed. Helping to keep us informed also helps reach the broader community.

Thank you.

Deborah Jossul
Assistant Coordinator
Crossroads Crisis Center
Upper Island Mental Health Society
Box 3286
Courtenay, B.C.

Dear People,

I discovered your newsletter for the first time this weekend at a citizens health conference. I work for a project titled *Adjustment Into Society* (I apologize for the ghastly name), at 999 Queen Street West in Toronto, i.e., Queen Street Mental Health Center.

Our project, which has been operating for approximately two years was originally designed to provide one-to-one support for persons as they were being discharged from the hospital. In the past year our focus has shifted toward developing programs for groups of people as well as aiming more directly at people in an "aftercare" situation.

Our accomplishments have been limited but in this province, due to the absence of all efforts to innovate in mental health, they stand unrivalled.

We may not exist for very much longer due to the proverbial fund-

DEMOCRATIC DAY CARE AT UBC

Judy, a therapist who works with an ongoing 15-20 member group situated in the Day Care House opposite Health Sciences Hospital (UBC), dropped in to MPA on November 21st to tell us about the Day Care Program.

She wanted to know about MPA and its resources, and wanted us to know that the Day Care program was a resource which MPA members should be aware of.

Initiated by Dr. F. Knobloch primarily for "neurotics", people in crisis, states of depression or anxiety, Day Care has been operating for several years, at first on a short-term basis on a Haney farm, then in Health Sciences Hospital, and since February at 2250 Wesbrook Crescent in a former fraternity house on the UBC campus.

The Day Care Group is democratically run by a patient-committee and is into intensive therapy, psychodrama, role-playing, psychogymnastics and constant self-evaluation, with the guidance of three therapists and Dr. Knobloch.

Members not only "run" the Group but also share in the upkeep of the house and grounds and have lunch in the house dining room. Hours are from 9-4 weekdays.

Prospective participants who are approved by a screening committee have to be approved by the group as well. Interviews for the 6-8 week program are held each Monday.

The primary purpose of the group is CHANGE. If you want to change into a more mature adult and get relief from symptoms; if you want to learn how to relate more closely to others; rid yourself of personality traits which you think make people hate you, or get Group help in working through a phase of depression or a personal crisis, maybe Day Care is for you.

A word of warning: Day Care is HEAVY, both physically and emotionally. You have to make a commitment to the Group to stay off drugs, alcohol and medication, and not attempt suicide while in Group. (Presumably when you've "graduated" you will no longer have the urge to self-destruct).

If you prove to the Group that you have worked hard to change, you can take part in a supportive aftercare group.

Judy is going to spread the word to her Group about MPA drop-in facilities and our residence program.

And in turn we're spreading the word about the availability of the unique Day Care program to anyone who feels he or she could benefit from this kind of therapy, under hospital coverage.

Whither (Wither) Support Groups?



With the growth of any community there are always people forgotten or lost in the shuffle. At one time M.P.A. consisted of a small group of people who knew each other fairly well. In its nearly three years of existence, M.P.A.'s membership has grown to well over two hundred. The sense of community shared by early members dissipated as the organization expanded.

The people most often overlooked are the "strong" who are seen as needing no support and the weak who are frequently shunned because of their heavy demands.

It was felt if small groups of people met regularly, friendships would form and people needing aid and support would get it.

This idea was discussed at the Annual M.P.A. Conference; a meeting

was held and seven groups formed. Some groups were self-selected while others formed more or less at random.

Of the original seven groups of approximately six members each, three are meeting regularly, two groups never really got started, one is floundering and one has yet to meet.

The emphasis of each group differs. Ours spends a majority of time discussing personal problems, other groups participate more in social activities, while the group which has yet to meet plans to have a religious orientation.

For the groups having most difficulty, the main problem seems to be a lack of strongly motivated people to give the groups momentum.

Co-ordinators (who are generally seen as "strong" people) have shown an unwillingness to join groups often believing them to be an added responsibility to an already crowded schedule. Groups comprised of people others view as "stronger" are unwilling to split up to give aid elsewhere, feeling a commitment to the original group and perhaps fearing to join a group which would not meet as many of their needs. Hopefully, people not as yet involved will be able to give suggestions or participate in starting new groups.

The problem common to all groups is uncertainty -- "Where will all this lead?" Seemingly, many people have given up too quickly, not giving themselves or the group idea a chance to be successful.

The support group concept has merit and potential. However, failing a greater commitment by more people the idea will help only a few, leaving the needs of many unfulfilled.

- David Beamish
- Ann-Marie Linklater

HOT BLEEP!

Any questions as to the viability of support groups at MPA were answered on the evening of Wednesday, November 28th. Support group 'D' ended its regular meeting that evening by joining hands together and jumping off the Lions Gate Bridge. The incident followed a public query by Support Groups Co-ordinator Lanny Beckman wondering if many of the groups would survive. "That's not what I meant," he said on hearing of the incident. Other reactions were mixed.

Gerry Walker was visibly shaken. "That's bleeping awful. Bleep, bleep, bleep."

Dick Betts, MPA Research Coordinator, was visibly shaking as he crawled from the Cecil pub. "The research group will look into it," he slurred, and set off for the

bridge. He was last seen at the wrong bridge.

DeeDee Smith said that she felt that Virgo rising in Capricorn probably had a lot to do with it. Both were unavailable for comment.

Other support groups said they admired group 'D' for the together way in which they had conducted their last activity, but the feeling shared by most was that they would probably stick to the more standard forms of activities.

"We'll probably just continue going out for drinks together and talking to one another," said Sandy Belanger.

"Support Group 'D' always did want to be different," said Dave Beamish. "Well they can go ahead and keep on doing it, but I don't think our group will want to follow in that direction."

California: weathervane for BC?

Slum Lords Take in Patients

By Elaine Elinson

Ms. Elinson is an editor of Pacific News Service who has traveled extensively in Asia where she wrote for several Asian publications. She has just completed a two-month investigative study of the changes in California's mental health care system.

Sitting on a hill overlooking a run-down section of San Francisco sits a two-story tan house. Inside, it is a railroad apartment, filled with long, dark, linoleum hallways. The heavy curtains are always drawn and, to a visitor, it has the dank, stuffy smell of a too much lived in place.

Six people who were formerly kept in California mental hospitals live on the first floor. They are crowded into three small bedrooms. Among them, they have a small living room (with a non-functional T.V.), and a small communal dining room where they are served TV dinners or other meals with a minimum of energy or expense.

They are encouraged not to go out ("The neighborhood is dangerous," they are told), given no professional care, and totally ignored throughout their long, uneventful days.

The second floor of the house is occupied by the landlady and her husband who make a sizable profit from the state by boarding and feeding these six ex-patients.

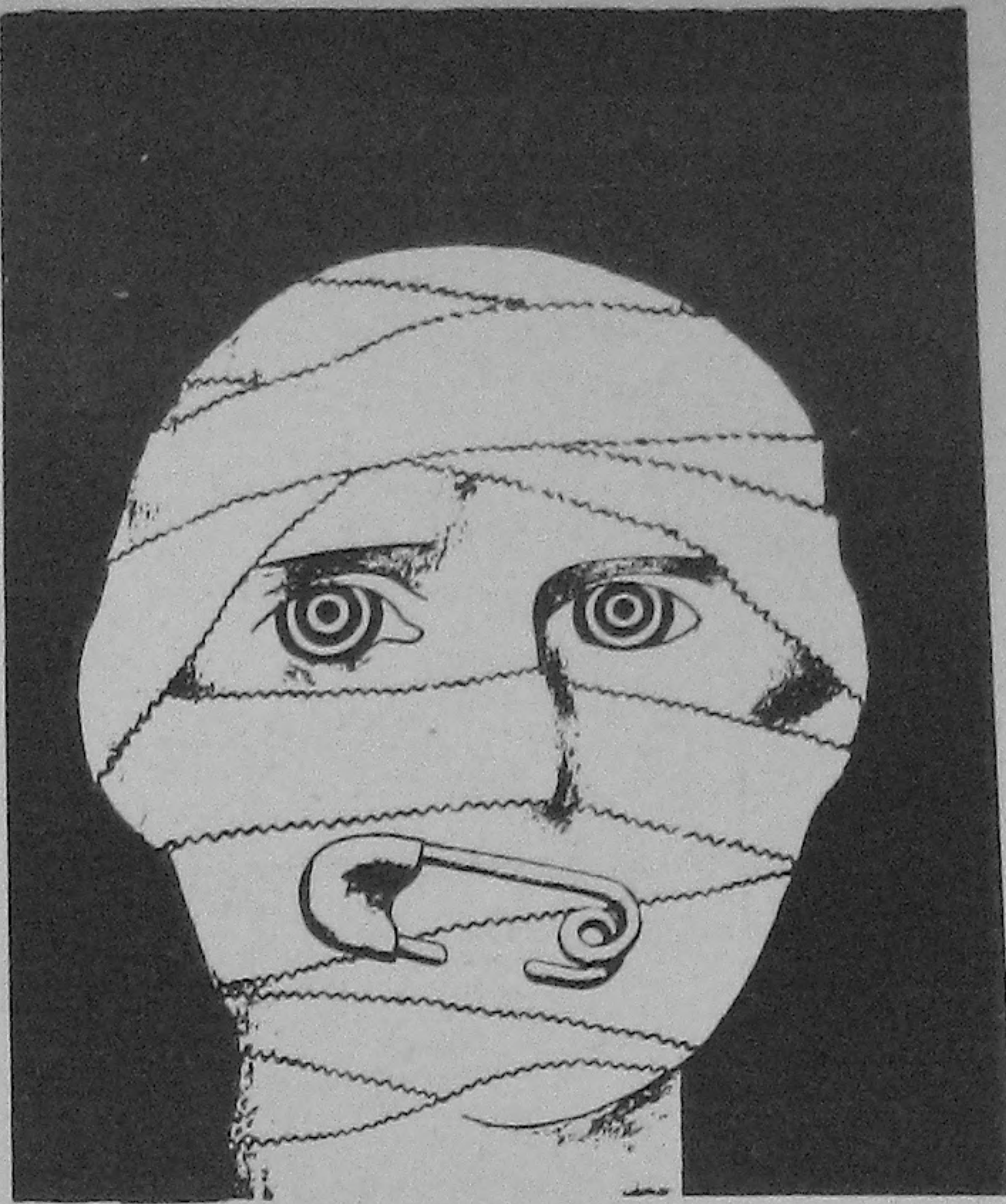
If everything goes according to plan, within the next ten years, all of California's mental patients will be transferred to facilities like this in their local communities, and California's sizable network of mental hospitals will be closed down forever.

"This is a new, enlightened approach to the problem of care for the mentally ill," says George Nelson, a spokesman for the State Department of Mental Hygiene. "The entire system in California will be directed towards the treatment of the mentally disturbed in the community. This is to prevent institutionalization or dependence on a hospital. It may be more difficult for an individual to be treated in this way, but in the long run it is better for him."

In line with the Community Health Services Act of 1969, the state will continue to provide 90 per cent of the mental health care funds, and the counties where the new facilities are located will have to provide the other 10 per cent. Recently, in a welter of positive statements about "community care" and "decentralization," the California State Department of Mental Hygiene disclosed a new stage in their plans. They will close eleven of the now-existing state hospitals for the mentally ill and leave open only two — one in northern and one in southern California — for the treatment and confinement of the criminally insane.

Already the state has closed three large hospitals, Mendocino, Modesto, and DeWitt near Auburn. The patient populations in several others have been cut severely. At Napa, for example, the population of patients has recently been cut by more than half.

Presently there is one major type of facility in California for the care of patients released by



the large institutions (aside from private hospitals); the board-and-care homes, and their number seems to be swelling as more and more patients are being pushed out of the state hospital system. One of the reasons for their rapid growth is that they are great money-making opportunities for landlords with a little space and time on their hands.

When patients are released from the hospitals, unable to work (which is the case with most of the recent ones), they are eligible for the State Aid to the Totally Disabled (ATD). They receive \$210.00 monthly. Out of this, \$175.00 goes directly to the board-and-care operator for room and board. This deprives the resident of any responsibility for his own financial affairs, and leaves him with only \$35.00 — hardly enough if the person wants to look for a job, go to school, or visit.

The cost of running such an establishment is minimal. "I used to rent the flat out to one family for \$125.00 a month," said one landlord, "now I have six patients at \$175.00 each."

These "homes" provide no recreational facilities, nor do they require that the residents go out during the day, or see a therapist. Only one of the five homes investigated had arrangements with an on-call psychiatrist. The others simply left the therapeutic treatment responsibility to a social worker who follows the patient upon release from the hospital or to emergency facilities at local hospitals.

Generally, the homes are even more desolate than the hospitals from where the patients came. In one home, three elderly women residents were confined in a small, dark room. One woman was on her bed, playing solitaire. "She never gets off her bed," said the landlady, "she just gets up for meals and then right back to bed." Another was babbling to the wall, recalling past, more pleasant memories. The third was still in her nightgown, though it was early afternoon, and listening to a transistor radio. A fourth woman was pacing the narrow, ill-lit corridor, while a fifth was loudly complaining about her.

"None of them ever go out," the landlady said, "they just stay inside all day." As in most of the homes, the doors are locked at nine o'clock and the residents do not have keys.

Though there has been a recent bill passed in the legislature to license the homes, this has not yet been put in practice. "Lack of time," says George Nelson. At present, the board-and-care homes hold no license at all. The only requirement is that they pass the inspection of the local fire department.

Although state officials speak of the new board-and-care programs as an attempt to return health care to the community level, critics see it mainly as a possible model for future nationwide cost-cutting in mental health care services.

As yet, the California mental health budget has not decreased, but this will certainly change radically over the next decade. Now money, which previously went directly to the care and well-being of hospitalized patients, is being spent to create a bureaucracy of professionals and administrators in each of the county programs.

Once that bureaucracy is functioning, enormous cuts in funds can be expected as the whole state mental hospital system is dismantled. Whatever the intentions, cost-reduction may be the only final product as the "community facilities" become no more than small businesses which make a profit off mentally disabled and offer little or nothing in return.

As one local psychiatrist put it, "It's as if the Reagan administration just threw up its hands and looked to the dollar signs. What they're actually doing is planning to dump the patients on the community without providing adequate funds or follow-up therapy for their care."

LETTERS

FROM PG 5

SOURCE is a radical political collective currently engaged in researching and writing a series of organizers' catalogs ranging from housing to education to ecology. We're now working on Volume III, Health Care, due to be published this spring. It will include resources and groups attacking existing health systems in this country or working to build up new ones to serve the people, ranging in sections from occupational health to women's health to community health to 3rd world and so on. Mental health (whatever that is) will be part of each of the other sections. I must admit, we are pretty much at a loss as to how to deal with it. We can't pretend to know anything at all about that mystified concept, and there's so much trash around that tacks names and models and stuff on it all, wraps it up and tucks it away, neat and clean. Obviously bullshit.

We'd like to get some current

info from you folks to include in the patients rights section of the catalog. Although you are in Canada, your type of program is very much the type of model we want to include in that section, to give other organizers an idea of what they can aim for.

We greatly welcome any suggestions, ideas, general input etc., and also just having contact with you. Your work is incredibly exciting to us. Keep it up! Hope to hear from you soon.

Penny Rosenwasser
SOURCE
P.O. Box 21066
Washington, D.C. 20009

Greetings,

My husband and I enjoy IN A NUTSHELL, or should I say it really holds our interest; much news re governmental inaction is not for enjoying! You are doing a splendid job, really reaching out to people far beyond a small geographical area. Keep it up.

I always pass our copy of your magazine on to someone else I feel it may benefit, or mail it to someone.

Enclosed is a small donation.
God bless you all.

Jan Kaija
Niagara-on-the-Lake, Ontario.

Dear NUTSHELL,

Very interesting! Good and easy to read. Are there subscription costs to be met. Please let us know. (Ed. note: only if you're rich.) Please have Ellen Frank and Tom Sandborn, who wrote in about starting a crisis hostel in Vol. 2, No. 7 of IN A NUTSHELL, get in touch with Ann McGorigan, Executive Director of the Association of B.C. Hostels, 728 Homer St., phone 688-7791. She is a good resource.

Thanks.

Pat Deakin
Gyro Youth Center Drop-In Program
c/o Echo Center
1001 Wallace Street
Port Alberni, B.C.

i've done it myself
again,
clenched my teeth and fist
as soft tears rolled--
not a sound
from me you heard,
except a gasp,
to know i'm still alone and strong,
and much too weak
to not do it all myself.

what's the hurry?

what's the hurry,
rushing headlong thru life,
stopping only long enough
to start it all up again.

what's the hurry,
dashing headstrong into strife,
making peace only so
you can get to fight again.

when you've finally won the race,
got to where you're going,
panting, out of breath,
someone's holding out his arms...
death.

:: my first reaction to fritz perls
was that he set himself up as a
god. fritz perls' first reac-
tion to me was that i set myself
up as a god.

:: i saw lots of faults in fritz.
he saw me seeing lots of faults
in him.

:: at first, i didn't let in much
of what he said to me, especial-
ly when he told me i didn't let
anything in, because i already
thought i knew it all.

:: i noticed how harsh he was with
me and others, how unrelenting &
unyielding. he helped me to see
how i was that way with myself &
others.

:: i found him unreasonable. he
showed me that i tried to reason
out everything.

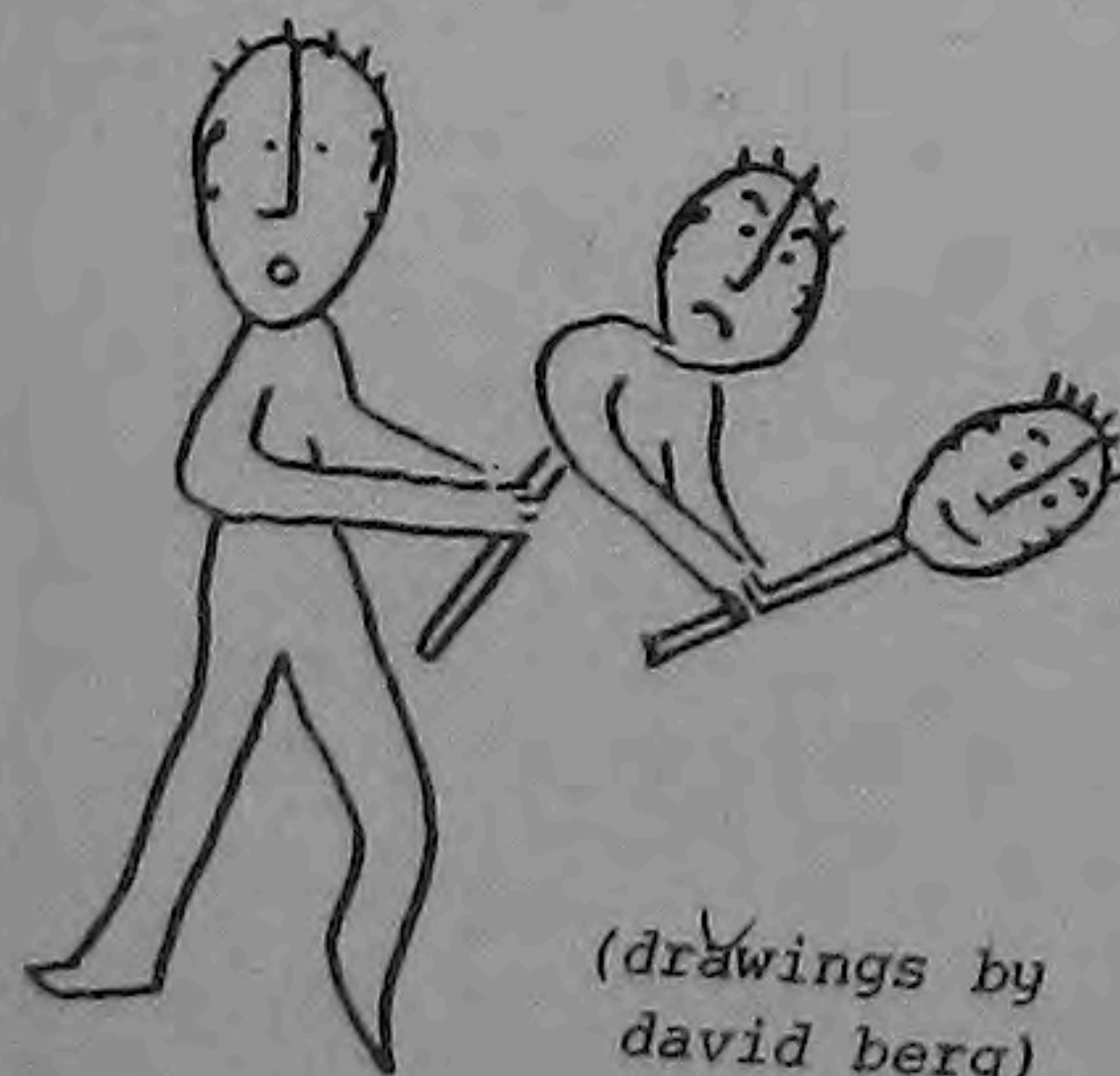
:: i found him childish at times.
he showed me the disapproving
parent in myself.

:: i found him astonishingly in-
sightful. he helped me see how
i discounted my own insights as
'crazy' or 'foolish' or too 'far
out'.

:: i felt that he demanded that we
all bow down to him: he showed
me how i expected him to bow
down to me.

:: he told me i gave a perfect imi-
tation of natural behaviour. it
took me a year to discover what
he meant, and the truth in it.

:: he told me i was like an ovum,
fighting off the sperm that
would fertilize it--i didn't let
that in, of course. except,
somehow, out of the thousands he
sent my way, one got through,
and now i have something growing
inside me.



(drawings by
david berg)

:: i often feel that i can give my
attention to the difficulties of
others only because i share
their difficulties. each time i
work with someone else i am wor-
king on something in myself. if
i do not take time to see how
what i give to them applies to
me as well, i am wasting my
time.

WHITE GESTALT

excerpts from a book

where are we?

oh where are we,
you and i,
clowning around in dead earnest
ever missing our grip on the
flying trapeze.

oh where am i
far off, gone,
in search of a sun that never shone
no way to lighten your darkening
eve.

oh where are you,
lost and afraid,
crouched in a corner, beginning
to fade,
haunting the shadows, filling
with gloom.

oh where are we,
you and i,
drifting, drifting
apart.



I THINK, THEREFORE I AM NEUROTIC.

:: last night i worked with someone
who complained of having no mo-
tivation. as he talked, i felt
how dry his words and speech
were. i asked him to identify
with and play a dried up river
bed. he felt drier. then i
asked him to be the desert. i
asked him to identify with a
cactus he had placed in the de-
sert, hoping he would discover
moisture there, but his cactus
was empty and hollow inside. he
felt his hollowness and said,
"it's all dead"; i asked him to
say instead, "i'm all dead," and
then he broke down crying, and
water flowed into all that dry-
ness.

:: some people have a great desire
to be unique--it is quite com-
mon.
a very few recognize that they
share a common humanity--that is
unique.

:: a friend pointed out to me that
i have a great many sayings; how
many listenings did i have? i
heard that.

you ask me to be honest with you
i say i won't
and so i am.

you ask me if i lie
i say i don't
and so i do

we deceive each other
and so,
what else is new?

i feel weary, weary of words, weary
of answer, weary of slipping away
to the next occasion to slip away.
"he who fights and runs away, lives
to fight another day." who wants
to live "to fight another day"? i
have a sore temptation to ask,
"what can i do?", a kind of wail,
or lament.
i do what i do, i slip away. i am
becoming more aware of when and how
i do it, and i am feeling my dissa-
tisfaction more keenly. that is e-
nough.

david: but surely there's something
i can do to cease this constant
slipping away.

therapist: you are probably so good
at it, you would slip away from any
attempt i or you made to stop you.
let yourself be, if you slip away,
don't play the side of those who
would have you pinned down. iden-
tify more with the part of you that
feels the NEED to slip away. have
some sympathy for him.

david: i am the part that slips
away. i am afraid what you will
do with me if you catch me. you'll
hit me or hurt me in some way.

hurt: david, i'm your hurt. i'm
you as a child, beaten & bullied,
i'm the cries that didn't bring re-
lief. i'm your sensitive feelings
that got injured over & over again.
i'm your young hopes & dreams,
crushed and stowed away. i'm your

poor dad,
you never could hit me enough
to make me stop crying--
you had to give up
comforting me with your blows
if only once, instead
you'd thought to wipe my tears,
listen to my tears,
you might have pruned the hate
i've nourished all these years

you say i never let you close
always whined for mother
hmmm, perhaps you're right
ah, yours the CRIME
mine the oversight!

:: gestalt group process is
me, like theater. we have
gedy, we have comedy and we
lots of melodrama.

:: the aim of gestalt process
not so much cure or riddance,
flexibility.

:: although self-reliance is a
of gestalt, it is well to re-
alize that some people's indepen-
dence is a propped-up and
tressed structure--that they are
almost incapable of asking for
what they need.

On The Death Of A David Berg

Dead, David is dead. Dead and
gone, all of him, his massive body,
6 foot 5, well-proportioned. I re-
member the way he sauntered into
the room where we waited to begin
therapy; his brilliance, his ener-
gy!

His enormous body, hung by a
rope in the stairwell, his neck
broken, arms dangling at his side,
head slumped on his chest. His
massive body gone, not even dead
and present, but gone, cremated.

The ashes of his body filled a
small golden box which sat on a
board in the snow, waiting to be
lowered into the earth. His hair,
nails and bones and of course his
flesh--which i had held, not just
held, but clung to--the horizontal
line in his chin, burnt to ashes.

He stood on a chair on the land-
ing to fasten the rope to the ceil-
ing. Perhaps he screwed a hook in-
to the wood. If he did, there
would be a hole there now, for she
--who found him hanging while she
carried the newborn baby upstairs--
must have climbed up later that
Thursday or the next day to remove
the hook.

mad energy, i'm your i-don't-care.
i feel like i'm so much of you, and
you try to make me so little.

david: you're hurting me now, an
ache, a sinking feeling, such a
sense of loss. god, there's so
much pain in the way, how can i get
you back?

hurt: i am the pain, you mustn't
feel i'm in the way, let me come
up.

david: i'm crying now and i don't
know why. you're bubbling up in
little sobs & jerks; i'm still a-
fraid there's so much of you.

hurt: no, you're afraid of the emp-
ty place i'll leave when you let me
out, you've held me inside and at
bay for so long. have some faith
that there's more than pain that
can come and fill you again.

david: my faith is such a small
flicker, scarcely enough to light
the vast dark places i have inside.

hurt: you've made a start...i'm
coming home at last.

What did she do with the baby? bear
She must have reacted automatically
--run downstairs, placed the baby in
the basinet, grabbed a knife from the
kitchen, leaned over the banister
and cut through the cord, causing
his body to fall, the banister
against the stairs below. She must
have run down, removed the rope
from around his neck, and whispered
or screamed or both, "David, please
be alive." And then she dashed
to the phone to call the police.
The police, ambulance, a friend
Eventually an ambulance must have
come, and the men in their
short blue jackets rushed to where
the body was.

(Could she have moved him down
the stairs to the landing below?
Or when she cut him down, did he
body slide and bounce down the
stairs? Did she place a pillow be-
neath his head? Was there blood
Did the bone stick through his
skin? There must have been a
nounced rope burn around the
of his neck.)

God, how awful. I vacillate
toward and away from the most
cise details. I enter them to

:: one can learn to distinguish be-
tween demands that arise from
need, and those that arise from
from the individual's unwilling-
ness to do something for him-
self. always encourage the ex-
pression of need.

:: most of us suffer from delusion
of one kind or another. quite
often we suffer from delusion
of MEDIOCRITY. at the first
chance, we shoot down our hopes
and ambitions. the only kind of
ambitions we will conceive of
those so far beyond our grasp
that we have a sure way of
courageing ourselves. we are
quick to join with our imagi-
nary detractors. we scare our-
selves with labels like 'conceited',
'pretentious', 'out of touch'
with reality.

:: the fear of being ridiculous
foolish is what stops us from
being great.

BLACK GESTALT

book by david berg

i sometimes encourage people to have delusions of GRANDEUR. what is the harm? we suffer from delusions anyway, why not have enjoyable ones.

confluence: a flowing together & merging of two otherwise disparate things. couples often will be in confluence, unwilling to have different tastes and honest differences of opinion. we often try to be in confluence with authority, and authority usually demands confluence.

in many cases of someone's being blocked, it is because they subscribe to: better to do nothing than to do something wrong. REVERSE: better to do something wrong than to be dead.

a dangerous fallacy: to believe that how something is when it is suppressed inside us is how it will be when released. the caged bird will peck your finger, a freed bird may feed from your hand; a caged lion is apathetic and disdainful, freed he is lively and supremely confident.

Dear, Distant Friend

1938-1973

dearable, less terrifying, for i am explaining. Why? did he step on a chair and then the banister and then place the rope around his neck? Did he stand, balanced precariously on the banister, waiting for his body to drop? Was there ambivalence? Or was it just the chair, the banister jump--1,2,3. Had he conquered ambivalence? Was this an act of taking responsibility for his suicidal feelings? Had they had a fight just beforehand? Had he asked her to stay home? Had she said, "David, I must go out. Come with me." Had she betrayed her excitement and impatience with him? Was she too at the end of her rope?

i really don't believe in death. you can't hang yourself to death. you could hurt your neck and cut your breathing off for a moment, but then you would instinctively reach up, grasp the rope, raise your body, loosen the noose, slip over your head and let go, falling onto the stairs below, perhaps spraining your ankle. You couldn't transform a real live sensitive body into a pile of ashes in

is this really me?
i do not recognize myself
is this really me
not recognizing myself.

i think i am, when i am not;
when i am not i think
when i do not think, i am
(i think i am
i think i'm not
i think
i think
an awful lot)

i don't see myself at all
in the mirror on the wall
i just see someone
not seeing himself at all

:: we run the risk of losing face
only to the extent that we put
one on.

:: being-at-a-loss is the most valuable experience one can arrive at: it is the labour pains before birth.

a few hours. No one would permit it.

It was permitted. He is gone. He must have been so hard on himself, unyielding, insistent on being responsibly suicidal.

He had talked with us about suicide. He had risen at 5 one morning while she slept. He dressed and drove to the edge of a cliff; stood there in the dark fall morning, dimly perceiving the creek below. His legs grew tremulous and weak. It was cold. He returned to the car and drove home. She was still asleep, their baby almost full-grown inside her. I thought it was a good sign.

Oh, David, I did have dreams for us.

I will try my very hardest not to follow you. I have experience on my side, seven years of adjusting to the meaningless pain. I wanted to teach you how to live an unbearable life. I did not try hard enough. Will you help me not to follow you, dear David?

- Lanny Beckman

sweet unreasonableness. tight head, temples, rage somewhere inside. hide & seek game with my anger, holding on, letting go, poof. i go away by myself, up drawbridge, kill the world by annihilating myself. god, do i hate! sometimes i feel like i despise everybody and everything, and this makes me want to cry. good to pound the keys.

i need someone to talk to, though i don't know what i want from them. not advice, not sympathy--i don't know what i want. i want to feel the way i feel now, isolated, alone, angry, insane, frustrated, pent-up!

what do i want anyone for? because i can't be alone! why else? i need some people watching, like every good caged animal does...cage yourself, invite some onlookers, and you have a zoo, a few tricks, a few peanuts.

how much longer am i going to keep swallowing my anger? who the fuck cares whether i'm reasonable or unreasonable--let's agree right now that i'm insane & dangerous & harmful etc. etc. o.k., that's the worst.

where is my hurt? i don't feel any hurt, just anger. hurt, injury, pain, poor david, where the hell are you? if i'm going to go around like a wounded animal in rage, i at least want to feel my fucking wounds! right now i'm more like a vindictive machine camouflaged as a do-gooder. swallow, swallow, swallow...a thousand swallows do not make a spring.

how can i go anywhere if i feel trapped there after a short time? i must be carrying my cage around with me. have cage, will travel, let me feel trapped with you. trapped inside my old head.

:: the petty thing to do about a petty feeling you have is to hide it from others so they won't think you're petty.

:: something to keep in mind: nothing is such that thinking can't make you think it's so!

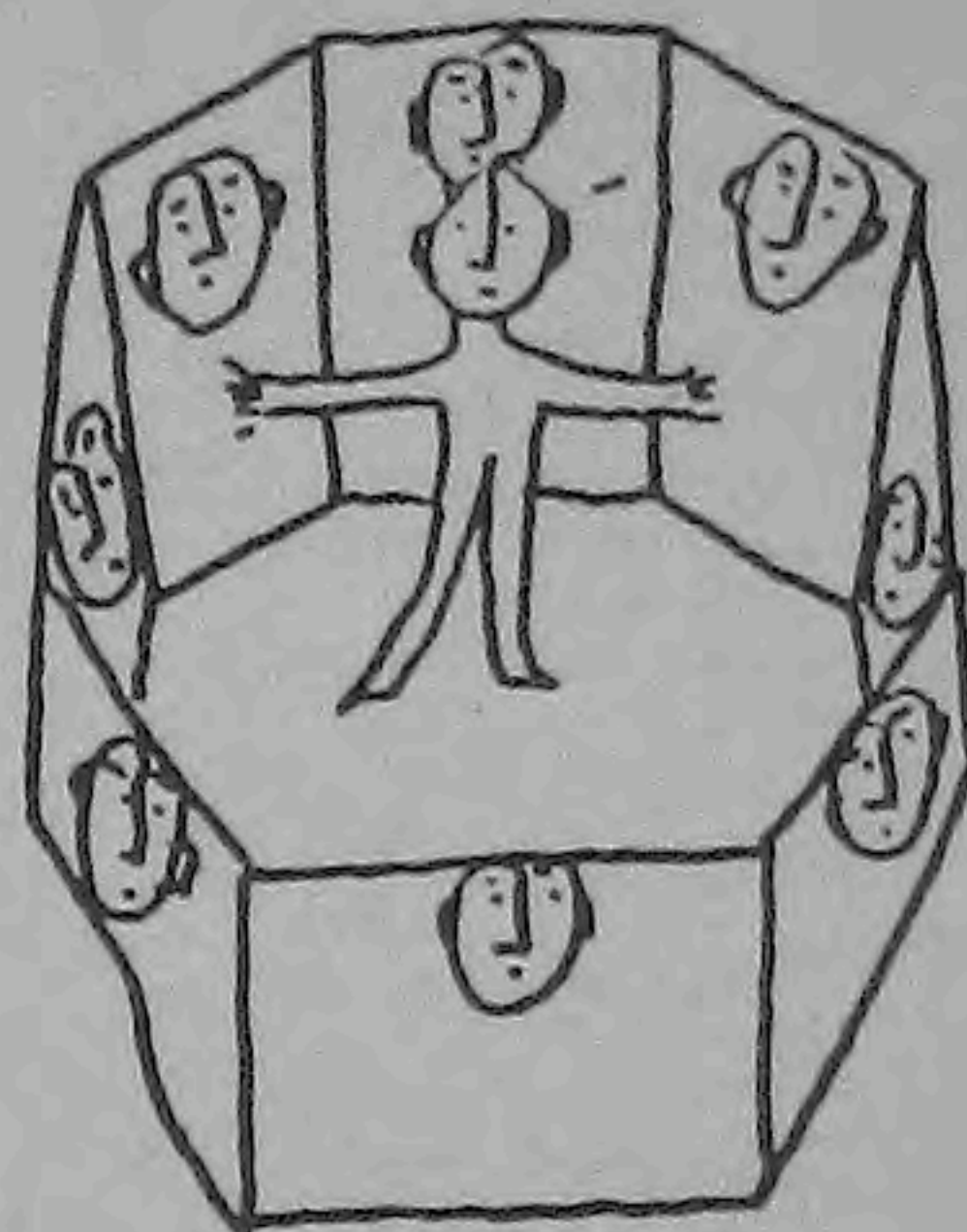
:: pride is a horse that each of us keeps at hand, so that we can climb onto our high horse and ride away from what is here.

:: perls quoting nietzsche: pride & memory had a quarrel. memory said it was thus. pride said no, it could not have been. memory bowed and agreed, no it could not have been.

:: often we take a genuine feeling and turn it into a performance for a purpose, thereby never really contacting the feeling. i've lost someone i loved deeply; i make the rounds of moaning and groaning, a great performance that has replaced my real sense of loss: i feel safer acting grieved for you than feeling my own grief.

:: if someone feels distant from the rest of the group, ask them to withdraw further and to take you along by describing where they are going & what is happening. don't ask them to come out, ask them to invite you in.

spit and shit before they go are our very own, once they're out they seem to take a rather ugly tone! strange to say it's just that way with all that we disown: my disgust to see in you the lust that was my own: my disdain to see in you the pain i will not own.



everything is aware process, if everything is anything.

:: when we are judging ourselves selfish, we are doing so as a SELFISH judge. self-judgment is hypocritical.

i hate to end this book so impersonally. marie suggested that i could say goodbye to it.

book, i find it hard to say goodbye to you. you're like my child, & i'm sending you out into the world; i don't want to, i want to keep you home and over-protect you. that's a cruel, cynical hard world out there, how will you ever manage?

"mother would have me in her womb, warm, eternal life

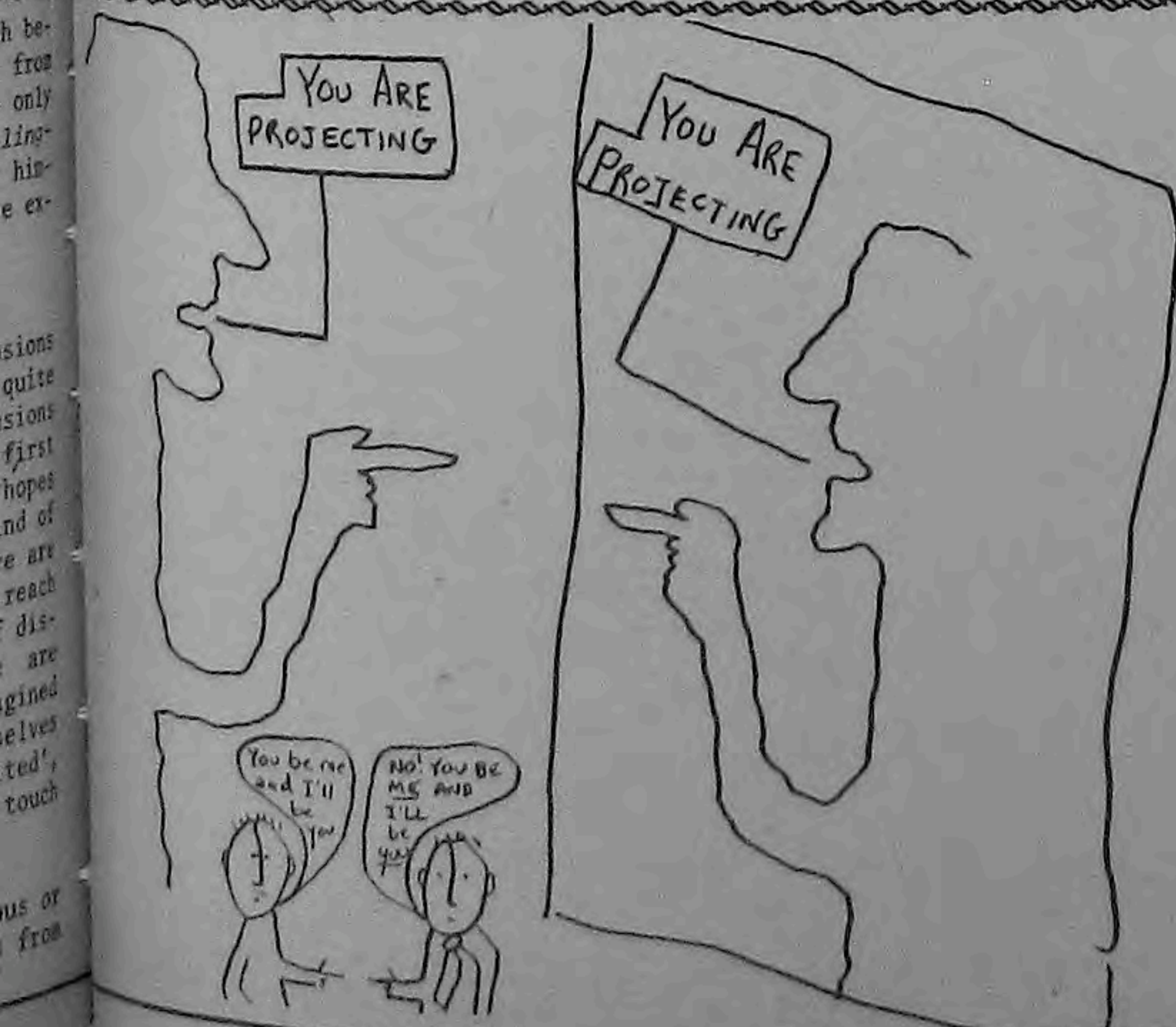
father would have me leave too soon a world filled with strife"

oh, all the things i've said in you, book, apply to me. it's so easy to say wise things, and so hard to live wisely. i keep getting this image of a young child going off to school or kindergarten on his own for the first time. am i inventing it? can i admit i'm sensitive and tentative without mocking myself? just a kid, the world's so big, i'm so small...i feel very small right now.

how can i look after you, book, i can scarcely look after myself, muddle after muddle. still, if i can believe myself, i want to feel this way right now, i want to feel like a sensitive pre-schooler, vulnerable and hungering for a tender word and touch. yeh, i like the way i feel right now, very soft, very warm, disarmed. book, how is it i've never learned the tough lessons in life? who can i blame? only me, i've sheltered myself, still do. well, i won't make the same mistake with you, little love, enough pampering. and now i'm my mother, who always felt she grew up too late in life, unprepared, trying to toughen little david up so the same mistake won't happen. the same mistake always happens just because i try and avoid it.

so, book, i'll commend you to the world. i won't shove you out & demand you be big right away. take your time, time to grow, feel your way, and remember, yours is the same painful journey we all have to make. oh, i hate to let you go. i'm a mother, and you are my son, and i feel at such a loss that there's nothing i can do to make life easier for you. there is nothing, it's time, i guess, you learned to make life easier for yourself.

goodbye little book.
goodbye little david.



What psychiatric drugs can do for you

Haldol[®] (haloperidol)

Adverse Reactions: **CNS Effects:** Extrapyramidal Reactions—Neuromuscular (extrapyramidal) reactions have been reported frequently, often during the first few days of treatment. Generally they involve Parkinson-like symptoms which usually were mild to moderately severe and reversible. Other types of neuromuscular reactions (motor restlessness, dystonia, akathisia, hyperreflexia, opisthotonos, oculogyric crises) have been reported far less frequently, but were often more severe. Severe extrapyramidal reactions have been reported at relatively low doses. Generally extrapyramidal symptoms are dose-related since they occur at relatively high doses and disappear or become less severe when the dose is reduced. Administration of anti-Parkinson drugs may be required for control of such reactions. Persistent extrapyramidal reactions have been reported and the drug may have to be discontinued in such cases. **Persistent Tardive Dyskinesia**—Tardive dyskinesia may appear during long-term therapy or after therapy has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. The symptoms are persistent and in some patients appear irreversible. There is no known effective treatment. All antipsychotic agents should be discontinued. The syndrome may be masked by reinstitution of drug, increasing dosage, or switching to a different antipsychotic agent. **Other CNS Effects**—Insomnia, restlessness, anxiety, euphoria, agitation, drowsiness, depression, lethargy, headache, confusion, vertigo, grand mal seizures, and exacerbation of psychotic symptoms including hallucinations. **Cardiovascular Effects:** Tachycardia and hypotension. **Hematologic Effects:** Reports have appeared of mild and usually transient leukopenia and leukocytosis, minimal decreases in red blood cell counts, anemia, or a tendency toward lymphomonocytosis. Agranulocytosis has rarely been reported and then only in association with other medication. **Liver Effects:** Impaired liver function and/or jaundice have been reported, although a causal relationship has not been established. **Dermatologic Reactions:** Maculopapular and acneiform skin reactions and isolated cases of photosensitivity and loss of hair. **Endocrine Disorders:** Lactation, breast engorgement, mastalgia, menstrual irregularities, gynecomastia, impotence, increased libido, hyperglycemia and hypoglycemia. **Gastrointestinal Effects:** Anorexia, constipation, diarrhea, hypersalivation, dyspepsia, nausea and vomiting. **Autonomic Reactions:** Dry mouth, blurred vision, urinary retention and diaphoresis. **Respiratory Effects:** Laryngospasm, bronchospasm and increased depth of respiration. Complete dosage information available in insert which accompanies each package (or on request).

Librium[®] (chlordiazepoxide HCl)

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium[®] Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs[®] Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

DEPROL[®]

ADVERSE REACTIONS: Nausea, dry mouth, other g.i. symptoms, syncope; one case each of severe nervousness and loss of power of concentration.

Benactyzine hydrochloride. Benactyzine hydrochloride alone, particularly in high dosage, may produce dizziness, thought-blocking, sense of depersonalization, aggravation of anxiety, disturbance of sleep patterns, subjective feeling of muscle relaxation. Anticholinergic effects: blurred vision, dryness of mouth, failure of visual accommodation. Other: gastric distress, allergic response, ataxia, euphoria.

Meprobamate. **Central Nervous System:** Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

Gastrointestinal: Nausea, vomiting, diarrhea. **Cardiovascular:** Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case).

Allergic or Idiosyncratic: Usually after 1-4 doses. Milder reactions: itchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and mepro-

Tofranil-PM[®] imipramine pamoate

Adverse Reactions Note: Although the listing which follows includes a few adverse reactions which have not been reported with this specific drug, the pharmacological similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when imipramine is administered. **Cardiovascular:** Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke, falls. **Psychiatric:** Confusional states (especially in the elderly) with hallucinations, disorientation, delusions; anxiety, restlessness, agitation; insomnia and nightmares; hypomania; exacerbation of psychosis.

Neurological: Numbness, tingling, paresthesias of extremities; incoordination, ataxia, tremors; peripheral neuropathy; extrapyramidal symptoms; seizures, alterations in EEG patterns; tinnitus.

Anticholinergic: Dry mouth, and, rarely, associated sublingual adenitis; blurred vision, disturbances of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilation of the urinary tract.

Allergic: Skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight); edema (general or of face and tongue); drug fever; cross-sensitivity with desipramine.

Hematologic: Bone marrow depression including agranulocytosis; eosinophilia; purpura; thrombocytopenia. Leukocyte and differential counts should be performed in any patient who develops fever and sore throat during therapy; the drug should be discontinued if there is evidence of pathological neutrophil depression.

Gastrointestinal: Nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: Gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: Jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: Though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache and malaise.

Vivactil[®]

Adverse Reactions: **Note:** Included in this listing are a few adverse reactions which have not been reported with this specific drug. However, the pharmacologic similarities among the tricyclic antidepressant drugs require that each of the reactions be considered when protriptyline HCl is administered. Protriptyline HCl is more likely to aggravate agitation and anxiety and produce cardiovascular reactions such as tachycardia and hypotension. **Cardiovascular:** hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: confusional states (especially in the elderly) with hallucinations, disorientation, delusions, anxiety, restlessness, agitation; insomnia, panic, and nightmares, hypomania; exacerbation of psychosis.

Neurological: numbness, tingling, and paresthesias of extremities; incoordination, ataxia, tremors, peripheral neuropathy; extrapyramidal symptoms; seizures; alteration in EEG patterns, tinnitus.

Anticholinergic: dry mouth and rarely associated sublingual adenitis; blurred vision, disturbance of accommodation, mydriasis; constipation, paralytic ileus; urinary retention, delayed micturition, dilatation of the urinary tract.

Allergic: skin rash, petechiae, urticaria, itching, photosensitization (avoid excessive exposure to sunlight), edema (general, or of face and tongue), drug fever.

Hematologic: bone marrow depression; agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia.

Gastrointestinal: nausea and vomiting, anorexia, epigastric distress, diarrhea, peculiar taste, stomatitis, abdominal cramps, black tongue.

Endocrine: gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido, impotence; testicular swelling; elevation or depression of blood sugar levels.

Other: jaundice (simulating obstructive); altered liver function; weight gain or loss; perspiration; flushing; urinary frequency, nocturia; drowsiness, dizziness, weakness and fatigue; headache; parotid swelling; alopecia.

Withdrawal Symptoms: though not indicative of addiction, abrupt cessation of treatment after prolonged therapy may produce nausea, headache, and malaise.

Ritalin[®] (methylphenidate)

ADVERSE REACTIONS

Nervousness and insomnia are the most common adverse reactions but are usually controlled by reducing dosage and omitting the drug in the afternoon or evening. Other reactions include: hypersensitivity (including skin rash, urticaria, fever, arthralgia, exfoliative dermatitis, erythema multiforme with histopathological findings of necrotizing vasculitis, and thrombocytopenic purpura); anorexia; nausea; dizziness; palpitations; headache; dyskinesia; drowsiness; blood

Serax[®] (oxazepam)

Adverse Reactions: Therapy-interrupting side effects are rare. Transient mild drowsiness is common initially, persistent, reduce dosage. Dizziness, vertigo and headache have also occurred infrequently; syncope, rarely. Mild paradoxical reactions (excitement, stimulation of affect) are reported in psychiatric patients. Minor diffuse rashes (morbilliform, urticarial and maculopapular) are rare. Nausea, lethargy, edema, slurred speech, tremor and altered libido are rare and generally controllable by dosage reduction. Although rare, leukopenia and hepatic dysfunction including jaundice have been reported during therapy. Periodic blood counts and liver function tests are advised. Ataxia, reported rarely, does not appear related to dose or age. These side reactions, noted with related compounds, are not yet reported: paradoxical excitation with severe rage reactions, hallucinations, menstrual irregularities, change in EEG pattern, blood dyscrasias (including agranulocytosis), blurred vision, diplopia, incontinence, stupor, disorientation, fever and euphoria.

CHLOR-PZ.

Adverse Reactions: Drowsiness, cholestatic jaundice, agranulocytosis, eosinophilia, leukopenia, hemolytic anemia, thrombocytopenic purpura and pancytopenia; postural hypotension, tachycardia, faintness, dizziness and, occasionally, a shock-like condition; reversal of epinephrine effects; EKG changes including blunting of T waves and prolonged Q-T interval; neuromuscular (extrapyramidal) reactions: pseudoparkinsonism, motor restlessness, dystonias, persistent dyskinesia, tardive dyskinesia, hyperreflexia in the newborn; psychotic symptoms: catatonic-like states; cerebral edema; convulsive seizures; abnormality of the cerebrospinal fluid proteins; urticarial reactions, photosensitivity, exfoliative dermatitis, contact dermatitis; asthma, laryngeal edema, angioedema, anaphylactoid reactions; lactation and breast engorgement (in females on large doses); false positive pregnancy tests, amenorrhea, infertility; gynecomastia; changes in libido in males; hypercholesterolemia; dry mouth, nasal congestion, constipation, adynamic ileus, miosis, mydriasis, hyperpyrexia; increased appetite and weight; urinary retention, peripheral edema; after prolonged substantial doses, skin pigmentation, epithelial keratopathy, lenticular and corneal deposits and pigmentary retinopathy, visual impairment. **Note:** Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported, but no causal relationship has been established.

Uranxene

ADVERSE REACTIONS: This side effect most frequently reported was drowsiness. Less commonly reported (in descending order of occurrence) were: dizziness, various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. Other side effects included insomnia, transient skin rashes, fatigue, ataxia, genito-urinary complaints, irritability, diplopia, depression and slurred speech.

There have been reports of abnormal liver and kidney function tests and of decrease in hematocrit.

Decrease in systolic blood pressure has been observed.

Miltown[®] (meprobamate)

Adverse Reactions: **Central Nervous System:** Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity.

Gastrointestinal: Nausea, vomiting, diarrhea.

Cardiovascular: Palpitations, tachycardia, various forms of arrhythmia, transient ECG changes, syncope; also, hypotensive crises (including one fatal case).

Allergic or Idiosyncratic: Usually after 1-4 doses. Milder reactions: itchy, urticarial, or erythematous maculopapular rash (generalized or confined to groin). Others: leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross reaction to carisoprodol, and cross sensitivity between meprobamate/mebutamate and meprobamate/bromal. More severe, rare hypersensitivity: hyperpyrexia, edema, angioneurotic edema, bronchospasm, oliguria, anuria, anaphylaxis, erythema multiforme, exfoliative dermatitis, stomatitis, proctitis, Stevens-Johnson syndrome; bullous dermatitis (one fatal case after meprobamate plus prednisolone). Stop drug, treat symptomatically (e.g., possible use of epinephrine, antihistamines, and in severe cases corticosteroids).

In the small print of each of their ads, drug companies are required by law to list the side effects of their highly promoted products. The above are reproduced verbatim from their ads.

STAR ★ BELLY

Like any other day, the birds started chirping, young couples folded their blankets after spending the night on Kitsilano beach, sleepy eyed working people slept their way to bus stops and city noises began to noise. It was a sunny summer morning and I was looking forward to spending the day sleeping and daydreaming on the grassy slope leading to Kits pool. After roping off a small area and putting up a sign saying:

KEEP OFF THIS AREA
PRIVATE PROPERTY
TRESPASS AND I'LL KILL YOU
I promptly fell asleep.



My mind became fully conscious again when I felt someone shaking me. I opened my eyes to discover a huge, bearded man of swarthy complexion bending over me. When he realized I was awake, he began to shout over and over, "At last I have found you, my son, my son." I was shocked, to say the least, and after listening to his paroxysm for a few minutes, I sat up and said "Take off, you huge bearded man of swarthy complexion." The bearded man said to me, "Please let me explain. I know you don't understand." I stood up and told him to go ahead because he certainly owed me an explanation. For the sake of brevity, I will just give an outline of what he said, for as he spoke he broke down crying and it took him over half an hour to tell the following incredible story.

His name was Abdul, a mid-easterner of 75 years of age. He had been a humble nomad for most of his life. He had married a very pretty girl whose father was well off, having invented a large, involved piece of equipment for removing the humps from camels. With the large dowry (by mid-east standards) they had bought a new tent and settled down by an oasis. After a year, a son was born--pretty healthy except for a lot of sand between his toes. They had true married bliss and would often thank the High Power for giving them happiness beyond their wildest dreams. It wasn't until the boy was two years of age that they noticed that the child had a large birthmark in the shape of a star situated on his belly. They were very proud of the son and would display the child's star-marked belly to complete strangers, so proud they were.

Disaster struck suddenly, as so many disasters do, when a group of drunken Canadian tourists invaded their humble tent and stole the child. They were completely grief-stricken for over two days, and then completely forgot about the incident. Time went on (as it so often will). Abdul and his wife became fabulously rich.

They started by renting half their tent out to tent-dwellers, expanding their wealth by buying more and more tents. They rented to more and more tent-dwellers until they became millionaires. They immigrated to Canada, applied for and received an L.I.P. grant and settled down in Kitsilano in a two-room cold water suite.

One night while watching a Cowboys and Arabs movie on TV, his wife jumped up excitedly and exclaimed in a stammering voice (she was drunk), "Abdul, remember the baby we once had, the one the Canadian tourists stole?" Abdul had to think hard before the vagueness of the past registered in his fig-dry mind. "Yes, what about it?"

"Well" replied his wife, "wouldn't it be nice if we could find

him?"

"Of course," said Abdul, "why didn't I think of it?"

The next day Abdul began looking for his star-bellied son, knowing that he would be grown-up by this time and not easy to locate. He looked in the phone book under star-bellied people, to no avail. There was no such listing. It was only by chance that he had wandered down to Kitsilano beach.

As he stood there, motionless, awaiting my comment, I said, "What the hell has this got to do with me?" He didn't immediately reply, but instead reached down behind him and picked up a large suitcase that I hadn't noticed before. He silently opened it to display stack after stack of thousand dollar bills. I stood speechless. He bowed from the waist and said, "There is over five million dollars here my star-bellied son, and it's all yours." With that he turned and walked away.

I just couldn't comprehend what had happened. I must have stood stock-still for a good half-hour in bafflement. Suddenly I felt a slight twinge on my belly, and looking down, I discovered a small star-fish clinging to my lovely



belly. I quickly brushed it off, and being honest, went looking for the huge bearded man named Abdul. It was to no avail, as he had vanished. I am still looking for either him or a star-bellied man so I can return the money to its rightful owner. If you have knowledge of either one of them, don't call me. I'll call you.

- Stan Mailey

Thank God Someone Still

Has a Sense of Moral Priorities

Kids fight, and steal each other's clothes, and all this must be lived with, but swearing and certain obnoxious behaviours are simply not tolerated, although they have been tried to the limit of the staff's endurance.

From an article in the October, 1973, Mental Health Branch Newsletter on a therapeutic program for "emotionally disadvantaged" youth.

Heightened View

Mt. Baker, suspended as a pubic triangle
past Fraser Valley fog
and strike-stopped tankers on the river
after an easy rock-clambering of hungry people eager to taste
their German sandwiches and warm canned juice.

On all sides from Mt. Seymour
we can see strikes: Island ferries,
wheat-carrying railroads, millworkers.
How easy to stop the monster when we
no longer dissociate ourselves from its reality.

Feel our energy! Our bodies are warm and warned against incursions
from sexual bosses and factory bosses
and failed positions of no-trust.

- Phil Brown
for my comrades in Vancouver

I Wish I Could Remember Their Names

It's impossible to forget. And, of course, there are certain things that bring back vivid memories--

Practically any song popular in the summer of 1966. There was always a slightly out-of-tune radio blaring the top ten, usually in competition with the T.V. on the opposite side of the dayroom.

The word "ladies" used as a command, to herd us around--to the cafeteria, to the backyard, back to the ward. I used to wonder if there wasn't some term that would sound less demeaning, but the tone would have made any word as ugly.

Or keys, clipped to a belt. Those keys were a symbol, as official as a badge, of status, of power, of the ability of the wearer to leave at any time. I used to wish they would hide them away in their pockets, but, of course, symbols of power are to be used, and enjoyed.

For years, each time I tried to express the pain to anyone, to people I thought were my friends, I was told not to be bitter. And I supposed they were right, and I tried not to be bitter. If I was supposedly "normal" the best way was to be like all the other normals. And if they thought mental hospitals were places where sick people went for help, then I'd better appear to think it too. In those days, when my only instinct was to hide, I never would have considered another ex-patient for a friend.

Only after I learned to accept my identity as a mental patient was I able to remember two people I met while in hospital, who gave me two of the best pieces of advice I ever received.

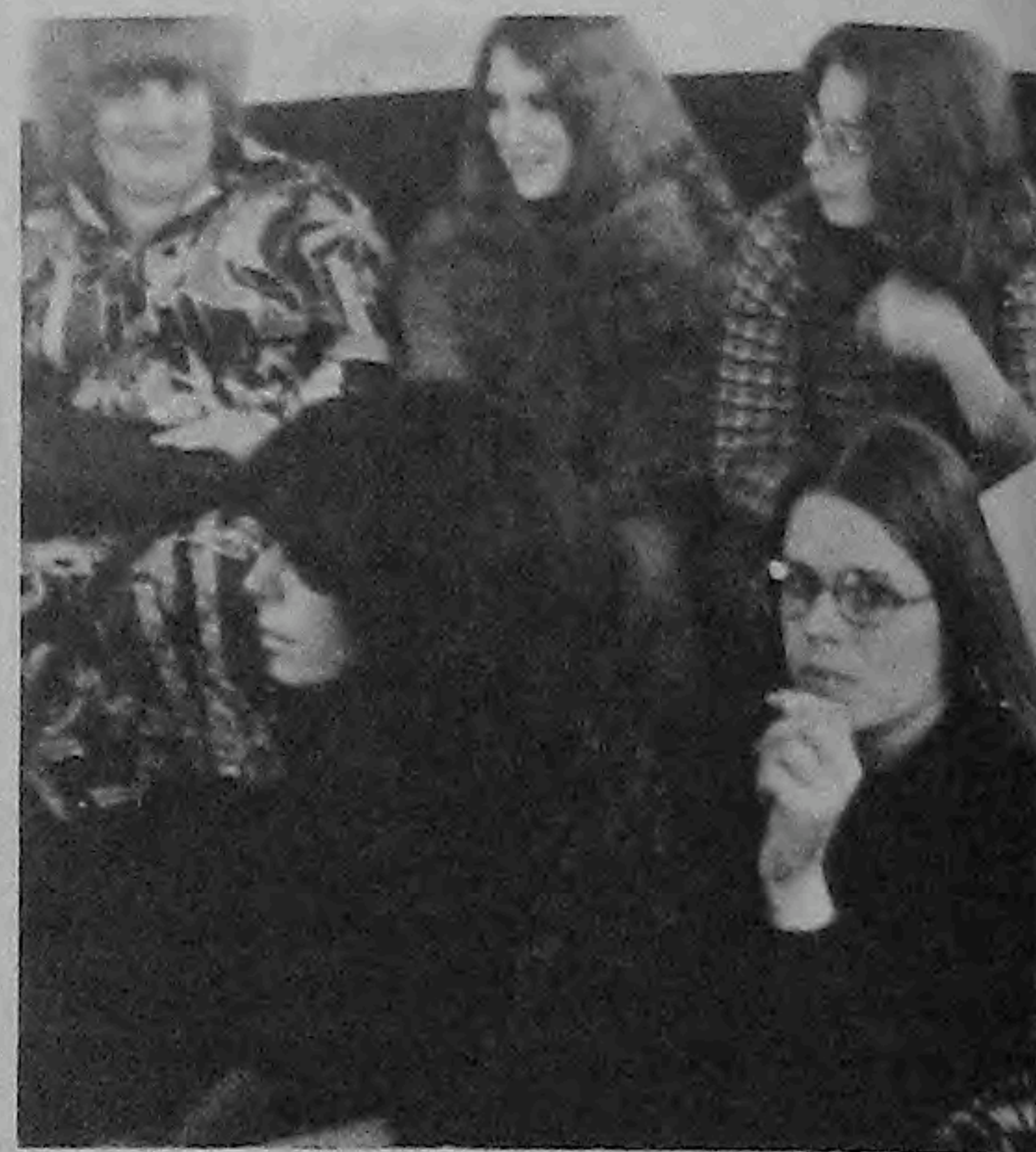
The first came shortly after I was admitted to a new hospital and was immediately taken off all medication. Over the preceding few months, all varieties of tranquilizers, anti-depressants, mood elevators and all the rest had been tried on me, with little effect that I could see. Now, it was decided to "evaluate" me without any drugs, which at least sounded sensible. The only thing I couldn't understand, over the next day or so was why I felt so awful--chills, cramps, a crawling feeling all over my skin. The staff said nothing, and finally another patient explained that I had become addicted to my medication, and was experiencing withdrawal. At least, with that explanation, the pain had a name.

The second occurred at still another hospital, a state hospital, the end of the line. Frightened and alone, a few hours after admission, I sank down on one of the hard dayroom chairs. Over the last few hours, I had had my clothes taken away, had been subjected to a humiliating search, and had been issued a huge and faded cotton dress with the name of the hospital stamped on the back. Feeling lost

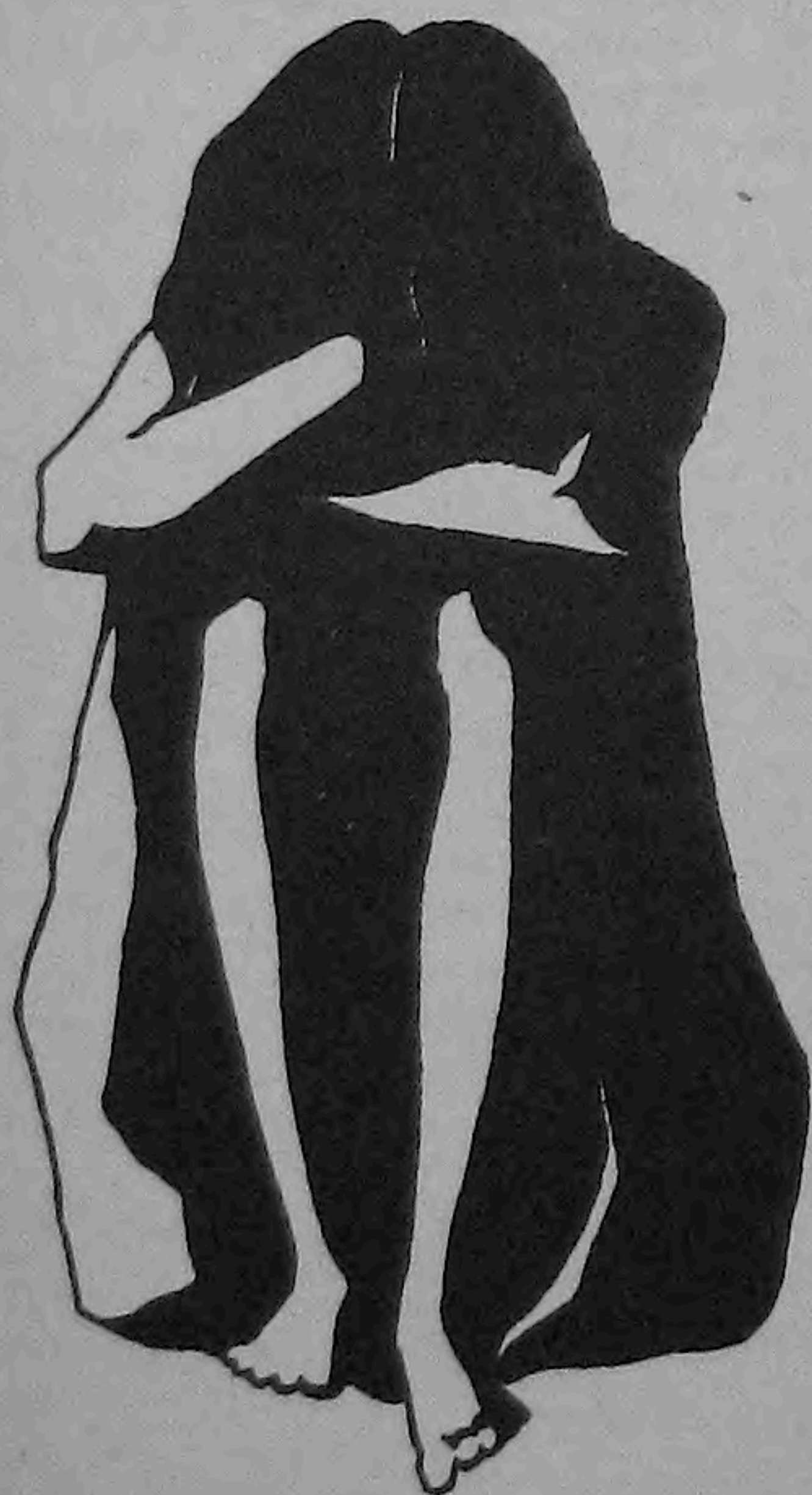
and abandoned, I drew up my knees to my chest, buried my face and started to cry quietly. Another patient approached, leaned down beside me, and whispered, "Don't do that; they'll think you're depressed." It was a lesson in survival. Immediately I straightened up and hid any trace of tears. After that I was careful to cry only alone in my room in the middle of the night, quietly.

Those two people should have been my friends. How I wish I could remember their names.

- Judi Chamberlin



Author Judi Chamberlin (top right) and MPA friends, Ursula (top left), Doreen (top center), Eve-Lynne (bottom left) and Jane (bottom right).



More recently, I have learned to be myself, instead of being "normal." It's a long process, still continuing. Now I seek out others who have been mental patients too, as friends and as people to learn from. Following the paths of normalcy meant fitting into a mold, and denying anything in myself outside that pattern. That mental-patients could be friends, supportive of one another, was an idea I was unwilling to face for years.

The NUTSHELL is looking for short items from other publications to be used as fillers. Readers are invited to clip out and send to us items in the mental health field--articles, cartoons, graphics etc.--

particularly humorous ones which point out the follies and horrors of psychiatry.

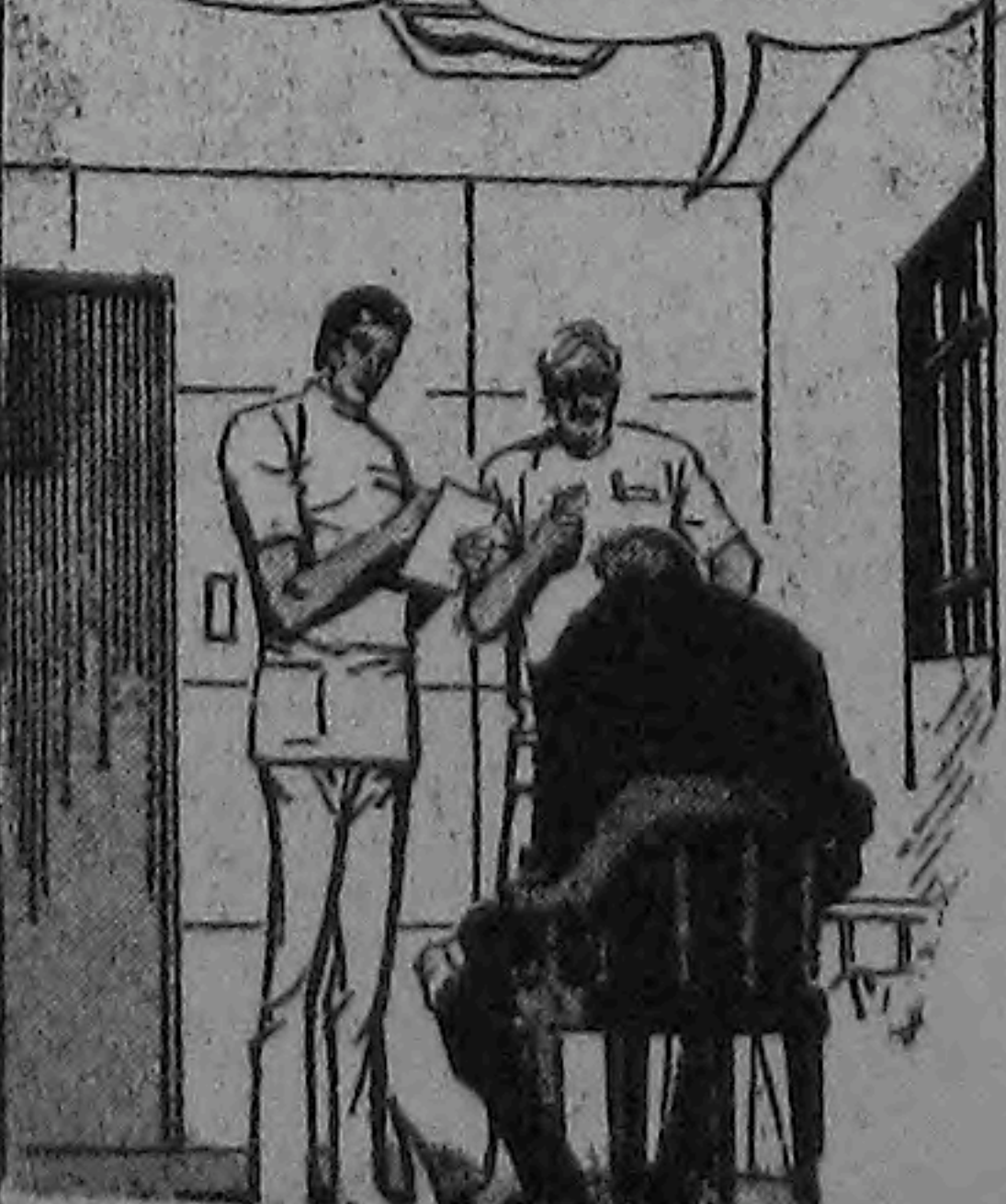
Ten cents will be awarded to those whose items are printed; 15¢ to those whose are not.

PRIZES

Psychiatric Diagnosis of the Month

THE CAPTAIN TOOK ME TO THE HOSPITAL, WHERE PSYCHIATRISTS INTERVIEWED ME...

IT'LL TAKE TIME, BUT THERE'S A GOOD CHANCE WE CAN GET YOU BACK TO NORMAL... IF WE CAN GET YOU OVER YOUR TERRIBLE GUILT AND INFERIORITY COMPLEX.



Gulp! Tranquillizer tops aspirins as poison

-Headline in the Vancouver Sun, 8/2/73

FOR

At last, a cure for hiccups!

THORAZINE tablets, concentrate, injection, and syrup, and Thorazine Spanules, all marketed by Smith Kline and French Laboratories, have been reclassified from probably effective to effective by FDA for the control of the manifestations of the manic phase of manic depressive illness, and for the relief of intractable hiccups, "based upon reevaluation of the drug and review of new data submitted," it was reported in the July 27 Federal Register.

Psychiatric News, 10/3/73

FILLERS

SANTA'S HELPERS

DAVIE, Fla. (AP) — Little Jody Dietrich will get a vital heart operation thanks to a \$2,000 donation from a group calling itself the "Broward County Marijuana Dealers Association."

- Portland Oregonian, 11/30/73

Drink Slowly the Cup of Life

It was a cold winter evening close to spring, but after the bitter winter it seemed almost mild. Prairie people know the faint, first feel of spring. They feel it in their bones, the slow thaw of their blood, the faint scent of grass and trees and flowers that are to come. If you breathe real deep you can almost smell the wheat even though the snow is so high that a child can bury himself in it, standing up. The cold burns and toughens the skin. Fingers and toes are numb almost on contact. The hard-packed snow starts to feel a little different underfoot about March or April and people begin to notice each other again as they walk along. In the middle of winter nobody sees anything else outside but the sharp, raw cold. In the middle of winter they concentrate on getting from one place to another as quickly as possible. In the spring they open their eyes to the world about them again.

On this night Leila went with her father to the church to hear the lecture he wanted so badly to attend. She and her mother felt he should go even though they knew it would be a tax on his strength. His heart had given out and he was dying. Year by year he grew weaker and weaker and they did everything they could to help him in these last days, months -- doubtfully, years.

In the church he listened raptly, his eyes half closed, intent, his face ashen and damp with weakness. She couldn't listen herself. She watched him and thought about his determination to live life out to the end. He was an idealist--a man of high morals and keen intellect. He had a small general store in the little town and he was known throughout the area as a generous, kind man of sound judgment, and was greatly respected. During the Depression he had told his customers he would not send bills and dun them, but when the war started and everyone had money again they had all paid him off in full. Nothing seemed to dissuade him from the idea of the fundamental rightness of the world and the people in it.

The illness had cut him down in the prime of life but he refused to relinquish his business. In addition to Nellie in the office and Archie who did the deliveries, he took on a young man named Larry who he hoped would eventually take over the load and act as manager so he could retire.

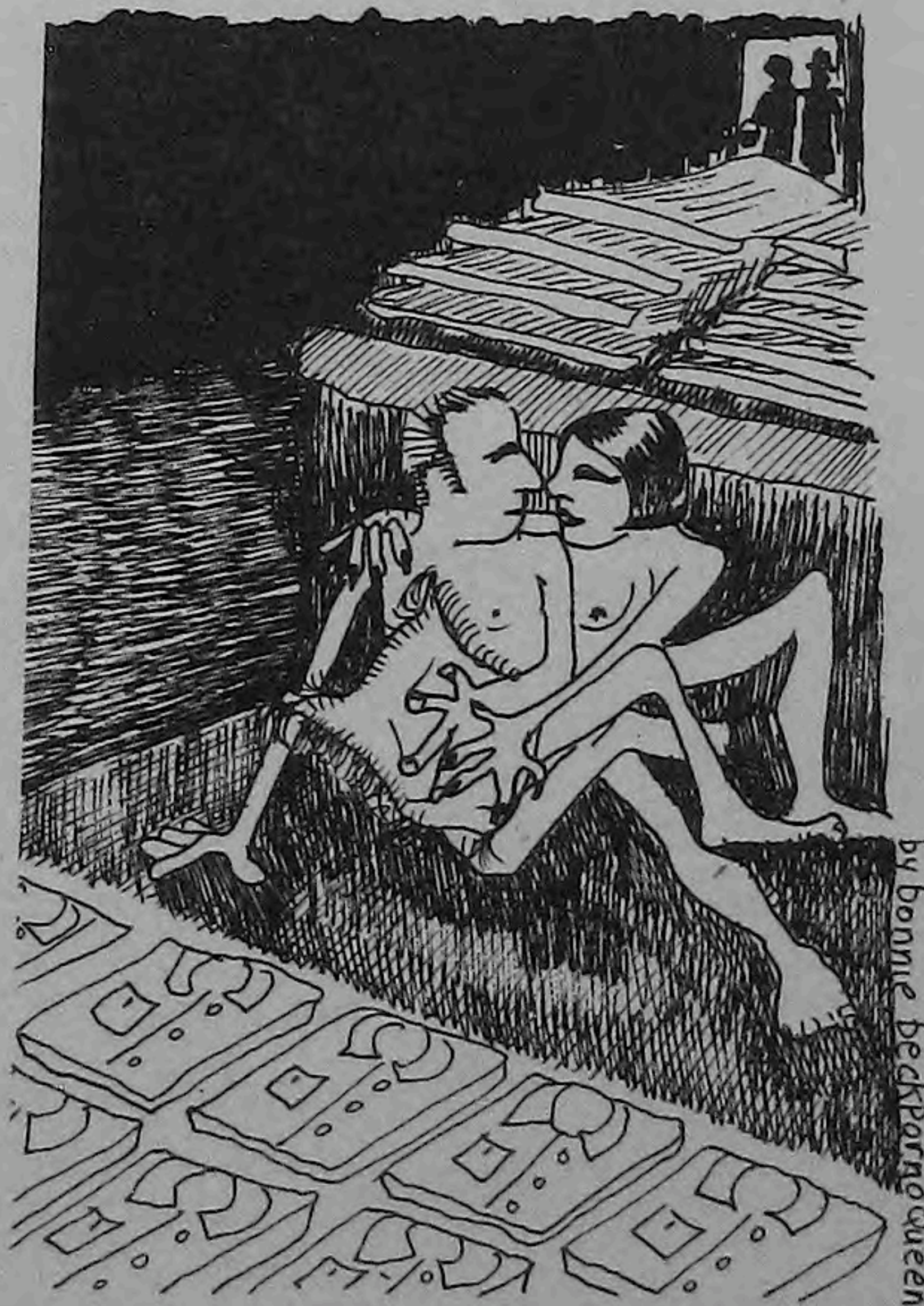
Larry came from a good family. He was very bright, conscientious and respectful. After he had been in the store six months, he had been given a key and now Dad only went to the store for three or four hours a day.

Leila was not happy with the set-up. She didn't like or trust

Larry. She was particularly protective of her father because she had once made him suffer so. All through her childhood he had been ambitious for her and she had always, sub-consciously and sometimes consciously, resented it. Just when he expected the most of her, it was her habit to disappoint him but he never gave up. He always expected the best. He loved her and in her strange, twisted way she loved him too--deeply. Later she left home and lived in the city and worked in an office and wrote very seldom and never came to visit. She met a lot of different kinds of people. Somehow she learned that she was wrong and began to write more often. It was not soon enough for him to enjoy it in good health.

The first heart attack felled him to the state of semi-invalid and she came home to be with him. She felt that recompense was impossible, but she wanted to help to stretch out his days more peacefully so he would know she understood finally. Without telling him, she wanted him to know she loved him and was with him in every way she could be to the last. Dear Father!

Leila thought of these things as she watched him enjoy the lecture. He loved to think and loved the things that made him think.



After the lecture he sat for a while, drained. It took so little. "Leila," he said, "what did you think of his ideas on totalitarianism?"

"Excellent," she replied.

"I'm a little tired," he said. "I'll go you a couple of games of gin rummy when we get home and then I'll go to bed. Tomorrow we'll talk about the lecture. I want to think about it. We better stop at the store on the way home; I forgot my glasses in the office."

They slowly walked the block to



the store, arm in arm.

He unlocked the door and walked down the aisle to the office in the back. She lingered, looking around her. The store looked so different in the dark. Suddenly there was a sound. It came from over near the blankets.

"Please God!" she said, "Nothing to frighten Dad!"

Her father turned the light on in the office but the rest of the store was still in darkness. She stepped closer to the blankets and could see more clearly in the dark. It...it was...Larry! Naked! And a woman! They were lying on a blanket on the floor and they were naked! With one hand Larry held a fancy pillow over his private parts. The other hand was lifted in a fist and he was shaking it at her. The girl was cringing and hiding her face.

In a split second her mind took it all in and she went into action. She moved quickly to the other side of the store, away from the blankets, and raising her voice but talking calmly she said, "What I didn't like was his manner of speaking."

Coming out of the office and looking at her, her father said, "His personality was a little offensive, but there's no doubt about it, he knew what he was talking about."

Speaking quietly and holding his eyes and attention, she took him gently down the aisle of the store and out into the cold brisk air and safety.

Matching her footsteps to his, she held his arm warmly and firmly and walked him falteringly home, her face lit up with a great depth of feeling.

Later they sat in his den by the open fire and played rummy. They could hear Mom making tea and toast in the kitchen.

"Gin!" he cried.

"Oh, nuts to you Dad!" she said. "You always win!"

Now, lying on the white sand beach of a distant land and closing her eyes to the blazing sun, far from her birthplace, she remembered that her father had been dead for twenty years today. And yet she could still remember the frozen wheat smell of that night. She could still hear her father's voice ringing out "Gin!"

- Molly Dexall

GENERAL MEETING ELECTS 23

More than 70 people turned out to vote at the MPA General Election on December 5th. They elected the following lucky (?) people to serve as coordinators for the next six months.

Drop-in
Allan Barker, Dave Beamish, Jane Blackstock, Len Lorimer, Phil Pelzman and Gerry Walker

Transportation
Barry Birch

Research
Lanny Beckman and Dick Betts

Office (administrative)
Barry Coull, Stan Persky and Patty Servant

Office (secretarial)
Jane Mullens

Residences
Brian McManus and DeeDee Smith (West 11th)
Al Kuenzli and Nancy Smith (West 3rd)
Pat Lagos and Fran Phillips (East 21st)
Helen Palmer and Tessa Stewart (East 4th)
Judi Chamberlin and Ann-Marie Linklater (West 12th)

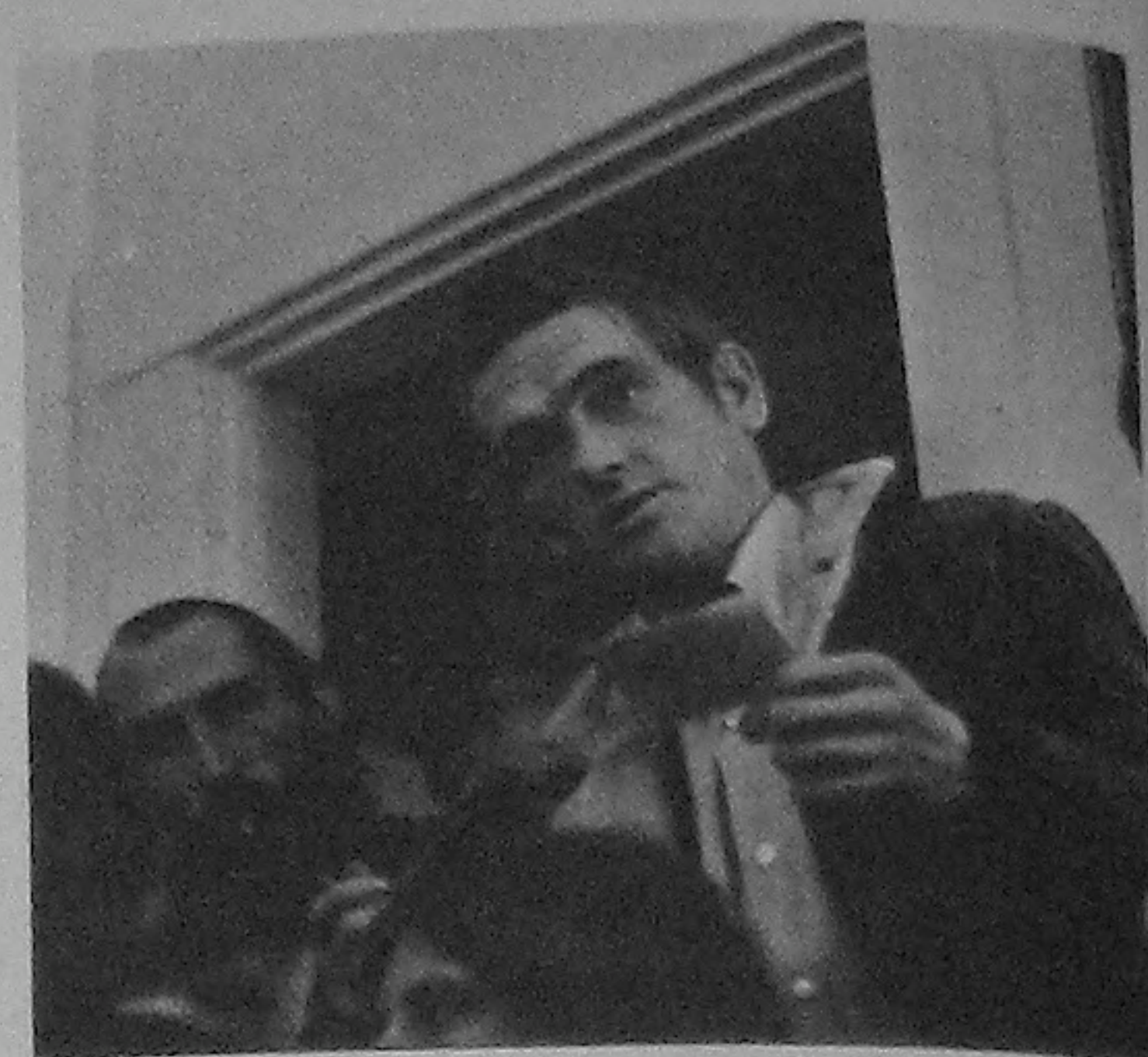
MY KIND OF PEOPLE

I turn and see people
who are normal
and I know I am not
I ask why I am uncomfortable
the answer is simple, I had
to be with my kind of people
I sit and I am glad
because the ones around me
are the same as me
What can I say except thanks
to those who are different
I know we understand
each other

-Francis Mackenzie

DON'T THROW IT AWAY!

The MPA Xmas Planning Committee would appreciate donations of Xmas decorations for trees and houses. We can also use any other items you can spare. If you can help out, please contact the drop-in center at 738-5177 or Molly at 731-0890. Thanks.



(l.) Billy and (r.) Francis Mackenzie

DILLENNIUM
or Maharaj Ghee

Ghee Maharaj you're a mirage
A car without a garage
A volley almost, not even a barrage
Medium rare - no message
Peddle elsewhere your flowerless
powerless corsage
Christ you are not - overpriced
you are
Mill greist - you'd just as soon
kill Christ.
Your fruits are over-ripe
and rotten
Your truths are tripe
and easily forgotten
What the hell is a 1000 years
of peace
Or 1/1000th as compared to
a million more of war
Or
the way things were before
or war without cease

- Billy Basquette-baal

TWO POEMS

My dad
broke the statue;
the chisel slipped,
the hammer
broke off the cock.

The old man
kneels in grief
with the piece in his hands.
He had tried
to attach it
again

many times.
"I'm sorry,"
he says,
"for the things
I didn't do
as well
as I could've."

My father stole my cock from me.
He did it with a look.
He tried to put it back

many, many times.
His eyes almost teared.
He said to me, "There were things
I could have done better."

The night he died,
I said "Good night,"
& he smiled sweetly.
Such little things:

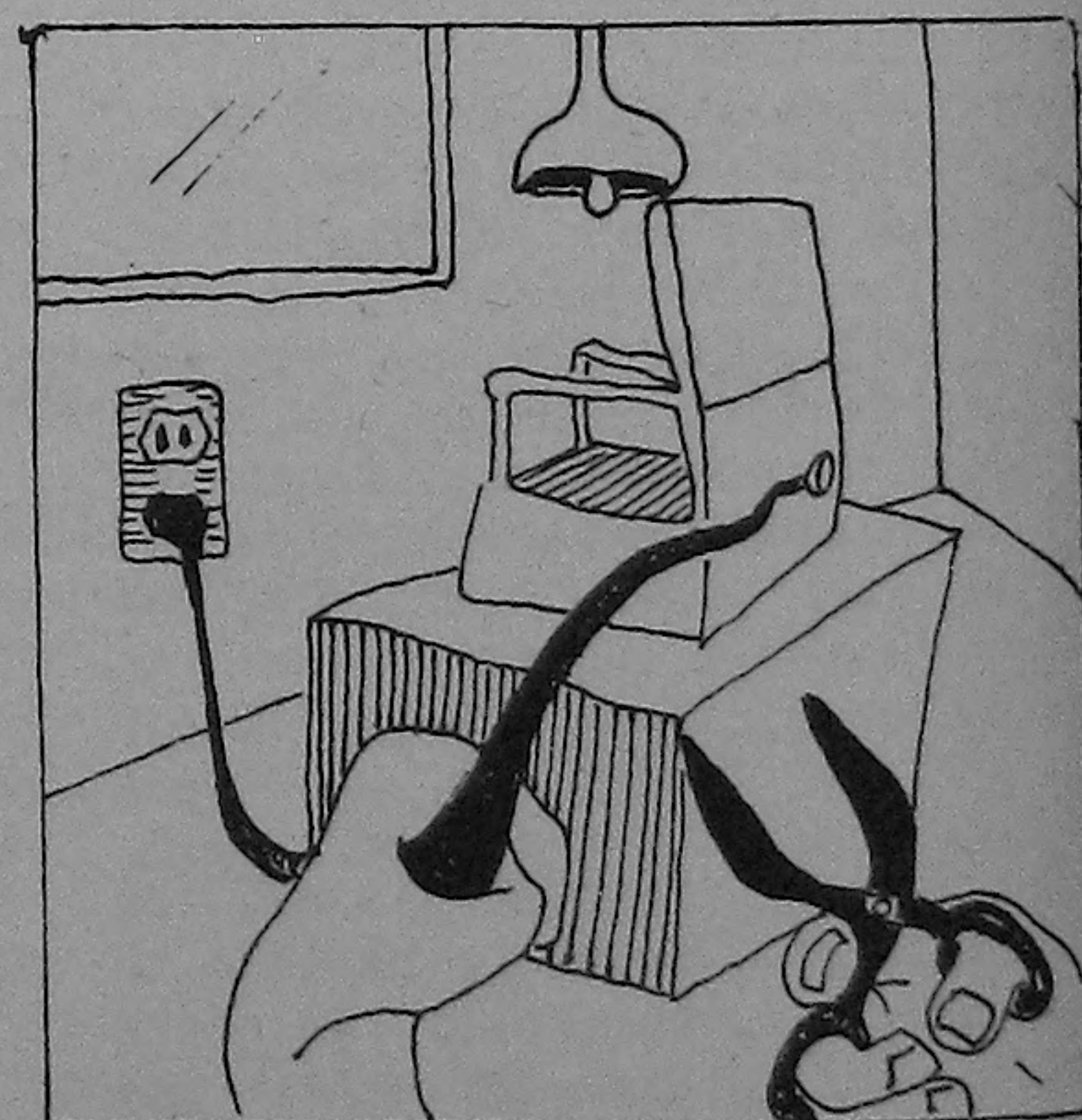
a look, a word, a smile.
And all this while
I have used this stick,
this weapon,
to replace the loss.

Now I know it is not
a sexual organ,
and I lay it down.

- George Stanley

Patients Won't Suffer From Energy Crisis

Dr. Edgar Hinckledorf, Director Of Riverslough Mental Hospital, today denied rumours that Premier Barrett had ordered him to conserve electrical energy through the abolition of electroshock therapy.



hurray for individuality!

No two depressed patients are exactly alike...

from an ad for the
anti-depressant, Elavil

DIRECTORY

FREE MEDICAL

Pine Street Clinic	738-6622
East End Clinic	872-2511
Reach (Medical)	254-1354
KCHCS Clinic	731-6929
Gastown Clinic	685-2744
Abortion Referral	873-3984

736-8471

688-7133

V.D. Control 874-2331

City Health Unit 736-9844

Gordon House

(V.D. & Birth) 683-2554

684-4191

Women's Self Help Clinic 873-3984

RECREATION & COUNSELING

Coast Foundations 879-2363

DRUG FREAK-OUTS

The House (soft)	732-3301
Safer - VGH OPD	876-3211

EMERGENCY

Fire & Inhalator	34-1234
Free Ambulance (police)	683-1122
Crisis Center	733-4111

HOSPITALS

Vancouver General	876-3211
Health Sciences (UBC)	228-3731
Riverview	521-1911
St. Pauls	682-2344
Lions Gate	988-3131

DENTAL

UBC Fac. Dentistry	228-2112
Gordon House (free)	683-2554
Reach	253-0232
Health Dept - Loc. 3	738-9844
Emergency Dental (8 to midnight)	738-9844

HELP

Crisis Center	733-4111
KCHCS	736-9971
NOW	736-7376
Comity Info Center	736-3661
Cross Reach	732-3245
KIND	733-4144
Kits Info Center	736-3431
Woman's Place	872-1824
FISH	299-4824
	922-1311
Dial-A-Dietician	687-6439

COMMUNITY MENTAL HEALTH CENTERS

West End Ment. Hlth.	681-8723
Burnaby Ment. Hlth. Ctr.	434-4247
Riverview Out-Patients	872-0211
New West M.H. Center	526-1601

LEGAL HELP

Legal Aid Society	687-1831
Legal Assist. Society	872-0271
Van. Legal Referral	689-5629
Emergency	733-2065

WELFARE

UCWIC	731-0131
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LODGING

Youth Referral Cntr.	681-7205
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FEED-IN

4:30 Daily - Free Tribal Village Hostel 199 W. 6th Ave.	874-9009
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LANGUAGE PROBLEMS

Language Aid	688-5016
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PHYSICAL HANDICAPS

Handicapped Resources	261-7281
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MPA RESIDENCES

369 E. 21st Ave.	874-9422
1754 W. 11th Ave.	732-8222
1656 E. 4th Ave.	253-6996
1838 W. 3rd Ave.	733-5733
2620 W. 12th Ave.	738-3616

MPA DROP-IN CENTER

1982 W. 6th Ave.	738-5177
	738-1422

AND

Status of Women	736-3746
Birth Control Info	261-9821
Alcoholics Anonymous	688-1716
Methadone Rx	872-8311
Narcotics Addiction Foundation	736-6746
Salvation Army Detox	688-7796
Van. Women's Hlth. Ctlv.	873-3984
Van. Tenants Council	872-0296
Van. City Rental Grievance Board	873-7325
Single Parent Group	738-4652
Single Parent Co-op	434-3703
Single Mothers Co-op	683-2531

ACTIVITIES

REGULAR WEEKLY ACTIVITIES

Monday

Noon: Drop-in center meeting

Tuesday

Noon: Business meeting
7:30 p.m.: Religious discussion

Wednesday

6:00 p.m.: Free pot-luck supper

Thursday

1:00 p.m.: Riverview visit (meet
at drop-in center)

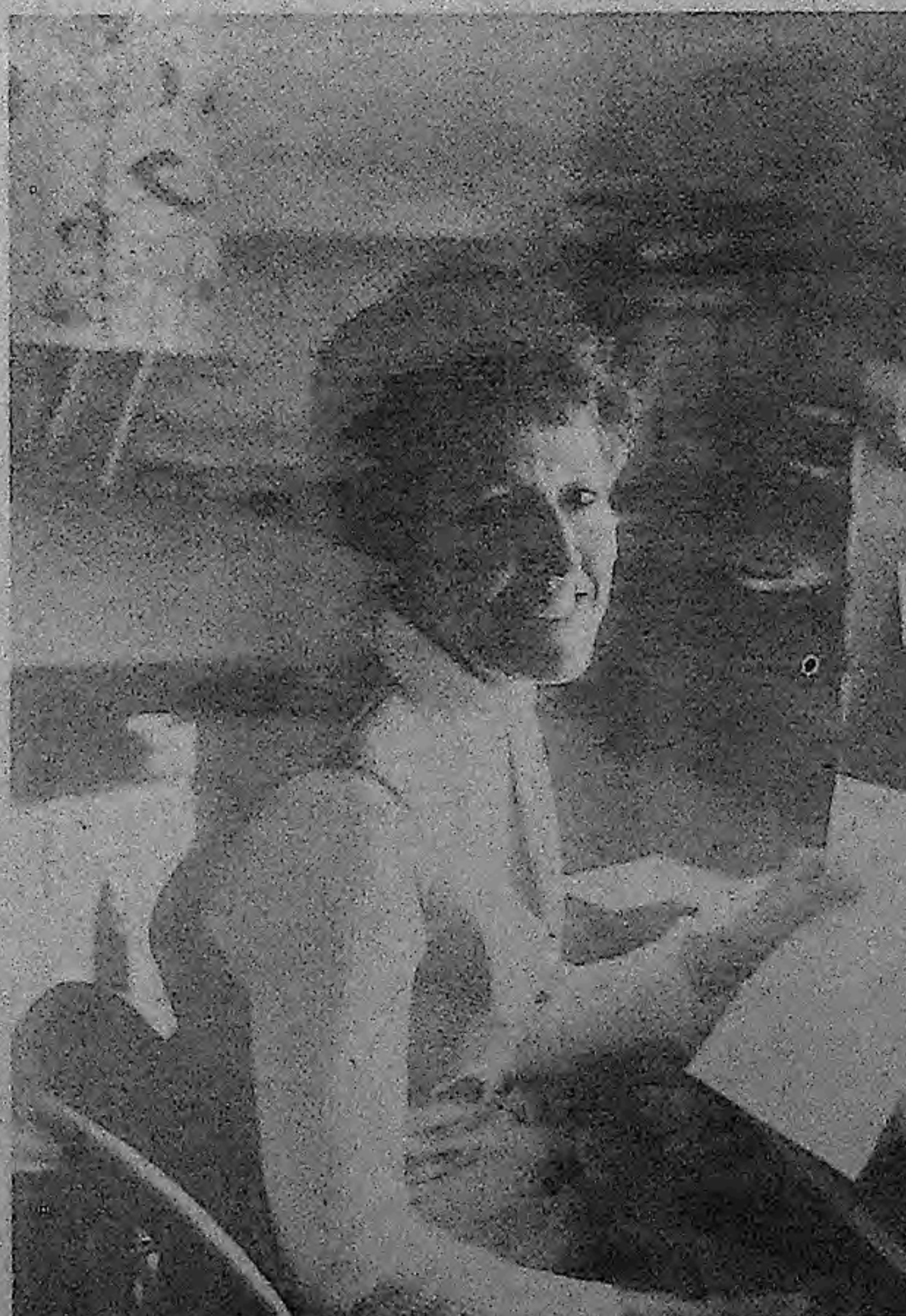
Friday

11:00 a.m.: MPA Residence Coun-
cil meeting (held at a dif-
ferent residence each week;
phone the drop-in for loca-
tion)

Saturday

11:00 a.m.: Free breakfast
1:00 p.m.: Special outing (each
week the MPA van travels to a
different spot in the Lower
Mainland -- wherever members
who join the activity decide;
children, especially, find
this activity enjoyable)

REGULAR UNSCHEDULED GROUP

Women's Committee Rap Group (phone
the drop-in for the time of
the next meeting)

Jane Mullens at work in the office

SPECIAL ACTIVITIES

Sun. Dec. 23, 6 p.m.: Christmas
carolling and hayride or
sleighrideChristmas day, Dec. 25, 5:30 p.m.:
Christmas dinner (free)Fri. Dec. 28, 7:30 p.m.: Dance at
Kitsilano United Church, 2490
West 2nd Ave.New Years Eve, Mon. Dec. 31: bring
in the New Year with MPA at
the drop-in centerWed. Jan. 2: Roller-skating party
(meet at the drop-in at 6:30;
we will be skating at the New
Stardust in Richmond from
7:30 to 10:30)Wed. Jan. 9, 7:30 p.m.: General
Meetingp.s. Join a support group, a group
of about six people that become ex-
tra special friends and get togeth-
er usually once a week for discus-
sion, fun, coffee and general sup-
port. Phone the drop-in for de-
tails if you are interested in form-
ing or becoming part of a support
group.NOTE: Unless otherwise noted, all
activities occur in or start from
the drop-in center, 1982 W. 6th
Ave. There are many special acti-
vities not listed here because most
of them are planned only a week in
advance at the Monday Drop-in Cen-
ter meeting. For details, call the
drop-in at 738-5177 or 738-1422
anytime, or better still, come to
the Monday drop-in meeting and help
plan or suggest activities.

ACTIVITIES ☹️

REGULAR WEEKLY ACTIVITIES

Sunday

Noon: Writers' Group

Monday

Noon: Drop-in Center Meeting

Tuesday

Noon: Business Meeting

7:30 p.m.: Religious Discussion

Wednesday

Noon: Men-Women's Rap Group

6 p.m.: Pot-luck supper

Thursday

1 p.m.: Riverview Visit

Friday

1 p.m.: Women's Com. Rap Group

Saturday

11 a.m.: Breakfast

1 p.m.: Outing

SPECIAL ACTIVITIES

Wed. Nov. 7, 2 p.m.: Day-care Mtg.

Wed. Nov. 14, 7:30 p.m.: General Meeting

Fri. Nov. 16th, 8 p.m.: Support Group Meeting for all interested in joining a group.

Wed. Dec. 5, 7:30 p.m.: General Election Meeting

NOTE: All the above activities occur in or start from the drop-in center, 1982 West 6th Avenue. There are many special activities not listed here because most of them are planned only a few days in advance. For details, call the drop-in center any time at 738-5177 or 738-1422.

business booming

IF THINGS KEEP IMPROVING
AT THIS RATE...
THE SITUATION WILL
SOON BE HOPELESS!

TWENTY-FIVE years and \$4.3 billion later, just exactly what has the National Institute of Mental Health accomplished?

The question was posed and answered at the 50th anniversary of the American Orthopsychiatric Association by NIMH Director Bertram S. Brown.

"We have made great strides in the care of the mentally ill," Dr. Brown told the presidential session.

"In 1946 less than one million people had a contact with a mental health professional in hospital, clinic, or office. By mid or late fifties, this number had doubled to two million, and by 1971 this had doubled again to four million people; approximately 2 percent of the population received some form of psychiatric or mental health care every year, and the number and percentage are continuing to rise.

- *Psychiatric News*, 7/15/73

Psychiatric Diagnosis of the Month

