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IN A NUTSHELL.

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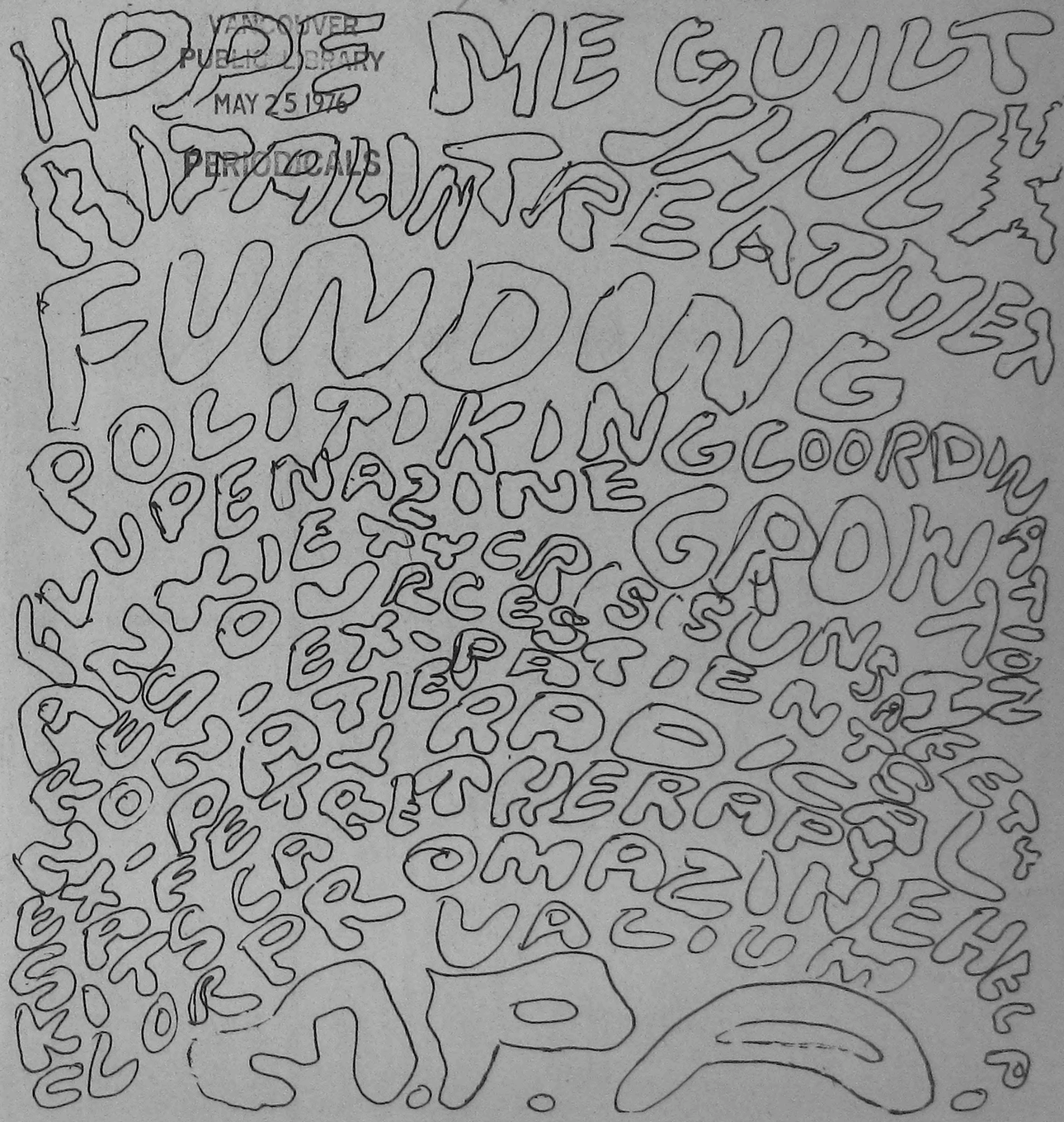

MENTAL PATIENTS ASSOCIATION NEWSLETTER
2146 Yew St. Vancouver, B.C. 738-5177

IN A NUTSHELL

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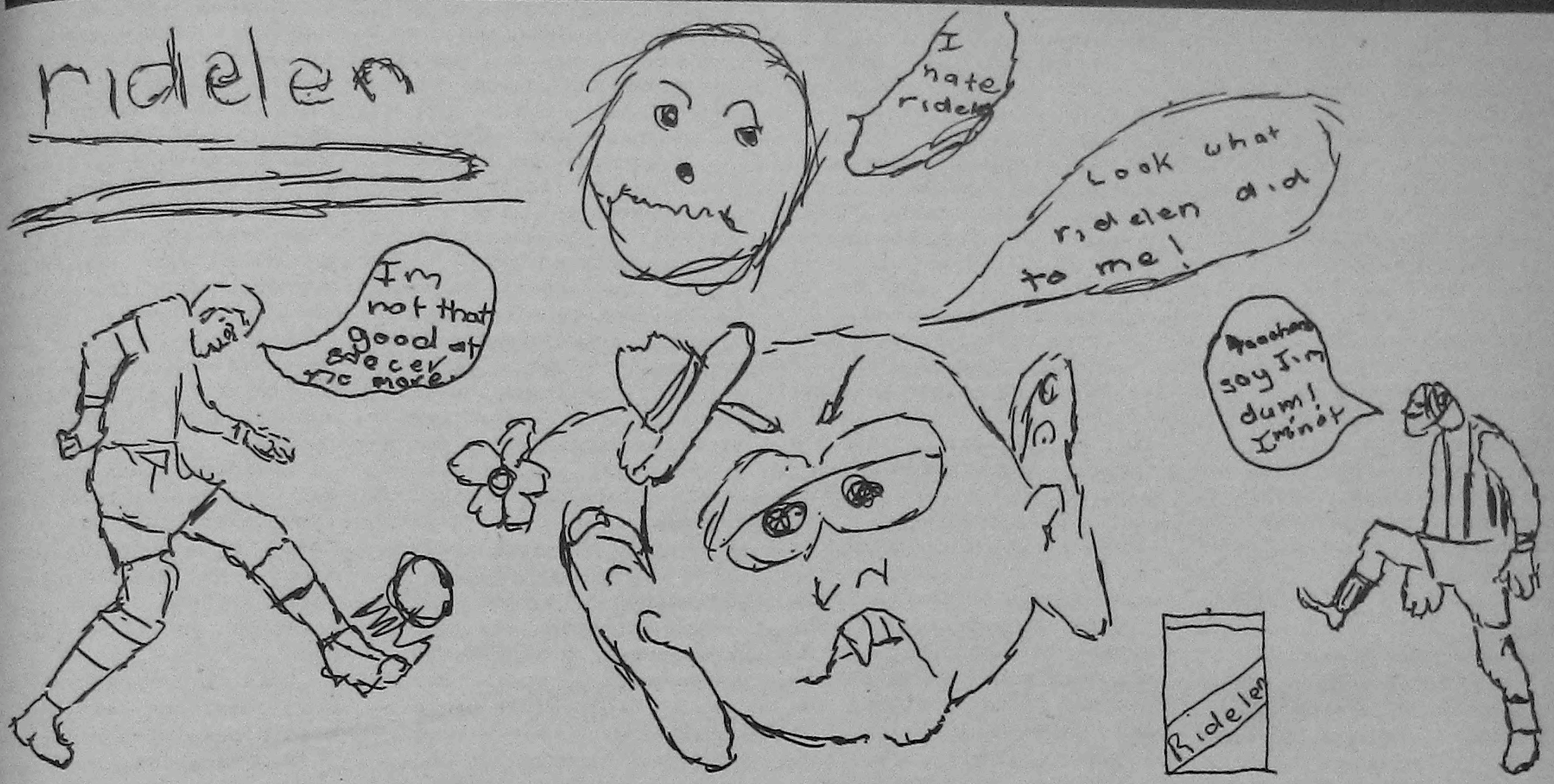


LEGAL SPEED FOR KIDS

The "authorities" cannot agree on the meaning of the term "hyperactivity" let alone on what causes it and how it should be treated.

One group of professionals takes hyperactivity to mean the same thing as hyperkinesis. Hyperkinesis, a term originally used in Britain referred to the condition of an individual with demonstrable brain or central nervous system impairment who showed signs of hyperactivity and learning problems.

Now how does this group come to regard hyperkinesis being the same as hyperactivity? They believe that all hyperactivity is caused by brain damage or central nervous system impairment This belief seems to be based on the conclusions of two research studies - in the 1930's by Kahn and Cohen, and in the 1950's by Strauss Lehtinen and Kephart). Both studies looked at individuals with demonstrable brain damage who also had hyperactivity symptoms and learning problems and concluded that since these individuals with known organic damage had symptoms of hyperactivity, then ALL INDIVIDUALS WITH SYMPTOMS OF HYPERACTIVITY HAVE BRAIN DAMAGE OR NERVOUS SYSTEM IMPAIRMENT, WHETHER OR NOT ANYONE CAN FIND IT.

Such circular reasoning has been heavily criticized for being unscientific. This same group of professionals recommends the use of stimulant drugs for treatment of hyperactivity, which means the daily management of the individual's hyperactive behaviour, for no real "cure" exists.

An opposing group of professionals believes that hyperactivity is a collection of symptoms with a variety of underlying causes - from an anxiety-producing environment to a chemical imbalance in the body. They believe that only in rare instances is hyperactive behaviour a result of brain damage or nervous system impairment (hyperkinesis, or minimal brain dysfunction), but that generally these symptoms - lack of concentration, short attention span, restlessness, temper tantrums and other behaviour found offensive by people - are created by treatable causes and that the use of stimulant drugs such as amphetamines or METHYLPHENIDATE HYDROCHLORIDE (RITALIN) IS TO BE AVOIDED.

TREATMENT OF HYPERACTIVITY

The method of treating children with the symptoms of hyperactivity depends upon what the person in charge of administering the treatment thinks about "hyperactivity". If the therapist thinks that hyperactivity is synonymous with hyperkinesis then the usual treatment is stimulant drugs. If on the other hand the therapist believes that only a tiny fraction of those children sent to him are true hyper-kinetics, and the majority of children are showing "overactivity" and "behaviour" disorders for other reasons he will treat these other contributing factors.

Sydney Walker III, head of the Southern California Neuropsychiatric Institute writes in Psychology Today (Dec. 1974) that he has never used stimulant drugs in treating children with "hyperactivity". He says that if symptoms of hyperactivity cannot be explained either by neurological disease or the detrimental effects of the child's social life in the family or at school then perhaps they can be caused by other treatable factors that influence the central nervous system. Here is a list of causes he had found that created symptoms of hyperactivity in children - calcium deficiency; abnormal level of glucose in the blook; poor blood oxygenation due to circulatory abnormalities; lead poisoning; carbon monoxide poisoning; mixed brain dominance, a condition creating dyslexia, a reading problem; hunger; pin worms; even uncomfortable underwear causing restlessness and inattentiveness

He also goes on to say that he thinks the use of amphetamines and ritalin is a "disastrous fad" and that these drugs are used to "subdue" children.

Benjamin Feingold of the Kaiser-Permenante Medical Centre in San Francisco claims to have successfully treated 50% of a group of hyperactive children with a special diet free of artificial flavourings and food colourings. This finding is currently being tested with further independent research but preliminary findings suggest that food additives and artificial flavourings somehow play a role in helping to create symptoms of hyperactivity.

P. Susan Stephenson, head

of Child Psychiatry, Department of Psychiatry, University of British Columbia, writes in the Canadian Medical Association Journal (Oct. 18, 1975), "...hyperkinesis or hyperactivity, cannot be considered a disease or syndrome, but is in fact a symptom, with a variety of underlying causes and appropriate treatment approaches."

"Hyperactive" children she has seen while working in a diagnostic centre appear to include the following: (I quote) --

1) The normal 2 to 3 year old child, who has the high activity level common to this developmental phase.

2) The retarded child with a mental age of 2 or 3 years

3) The child with a constitutionally high activity level, particularly when the child's activity level is not that expected by the parents, teachers or other important adults.

4) The child whose normal activity is restricted at home or in the classroom.

5) The child who is bored or frustrated in school.

6) The child with the "no-breakfast syndrome". This is common in some parts of Vancouver, where children who receive no breakfast are restless and inattentive in school. The more experienced teachers are well aware of this problem and some take extra supplies of food to school.

7) The "unsocialized" child who may be from a socially disadvantaged, chaotic and disorganized family, in which the children have not been taught to curb impulses delay gratification or control behaviour.

8) The anxious child. Restlessness and inattention are manifestations of anxiety in children, which may stem from a number of causes or be transferred from parent to child.

9) The autistic child, who is frequently hyperactive.

10) The "true hyperkinetic child", as described in British studies. The child exhibits continuous, non-goal directed motion in all situations. These children are rare in my opinion.

11) The child with an unusual cause of hyperactivity such as hyperthyroidism, lead poisoning or de Lange's syndrome. (end of quote)

BEHAVIOUR DISORDERS

There is no doubt that a large number of children do show behaviour that is negative and disruptive - throwing of temper tantrums, low frustration level, etc. If this is not due to a neurological or nervous system disorder then what causes such behaviour? It is a known fact that disruptive family situations, inconsistent and inappropriate child-raising methods, cramped living spaces and high level anxiety environments do cause children to sometimes behave in a manner found inappropriate by others. Attention should be given to changing these negative environments.

We should keep in mind that there are "observer variables" that make a crucial difference in the diagnosing of who is hyperactive and who is not. In one research study (Kenny) it was found that trained observers could agree about the diagnosis in determining hyperactivity in only 13 of 100 consecutive referrals.

Schools play a major role in labelling children hyperactive. This seems to be due to the fact that those symptoms associated with hyperactivity - excess movement, disruptibility, are found to be intolerable in most rigid classroom settings- Where individualized, supportive interaction is needed to deal with these behaviour problems in children, we find instead, in many cases that the parents of the children are told they have a hyperactive child that should be taken to the family doctor and appropriate medication should be obtained to treat the offensive behaviour. Some parents seem to be fighting back from this intimidation. There is a lawsuit pending before the California courts where a group of parents are bringing suit against the school authorities who refused to admit their children into the classroom unless the children took medication to treat their "hyperactivity" problem. This brings us to the issue of chemotherapy or treatment by drugs.

CHEMOTHERAPY

Many children who have been diagnosed as "hyperactive" are taking stimulant drugs - ritalin (methylphenidate) and amphetamines.

These drugs have an effect that makes this form of treatment probably the most popular one in dealing with "hyperactive" symptoms. These drugs, in a way that is not completely understood subdue motor activity and are thought to increase the ability to do repetitive tasks in some individual children.

It has been charged that this medication is used to subdue and control children in rigid environments (like the classroom) where there is little tolerance for any behaviour different from the accepted norm.

The two main criticisms of the use of these stimulants is that they mask the symptoms of "hyperactivity" and do not treat the cause in the great majority of children diagnosed as "hyperactive". Secondly, and most importantly, there is no conclusive evidence of their safety.

In the case of amphetamines, they are regarded by almost all authorities as a potential health hazard. Remember the slogan "Speed Kills"? The U.S. Food and Drug Administration in 1972, declared that amphetamines, "because of their significant potential for dependence and abuse should be used with extreme care". The F.D.A. requires a warning label that cautions physicians to prescribe the drugs sparingly - for obesity. There is no similar warning required for their use in treating hyperactive children.

The Canadian Dept. of National Health and Welfare recognized the potential hazards of certain drugs - amphetamines being one of them - and attempted to control their use by requiring, in January, 1973, that physicians use these drugs on certain disorders only - "hyperkinetic disorders in children" being one of them - and required that the physicians inform the department by mail, of the physician's name, patient's name, address, age and sex, and if the treatment was to last longer than 30 days, a consulting physician's confirmation of diagnosis and treatment plan was necessary and this information was to be mailed to the Department as well. However, the controls on restricting the use of the drugs appeared to work too well for in March of 1974 all doctors were informed that "information indicates there has been a marked reduction in the use of these drugs. As a result of this it was felt that controls over them could be relaxed"...

And now what about ritalin, the most commonly used drug to treat "hyperactivity" in children? In the Compendium of Pharmaceutical Specialties, a reference book listing all the approved medications used by physicians we find this:

"Methylphenidate (brand name ritalin) is not recommended for severe depression except in hospital under close supervision". And "chronically abusive use may lead to marked tolerance and psychic dependence with varying degrees of abnormal behaviour. Careful supervision is required during drug withdrawal since severe depression as well as the effects of chronic overactivity can be unmasked".

And under the section "Adverse effects: Nervousness or insomnia...hypersensitivity reactions, anorexia, nausea, dizziness, palpitations, headache, dyskinesia (loss of cerebellar functions resulting in involuntary body movements) drowsiness, skin rash. Rarely, blood pressure and pulse changes, both up and down may occur, tachycardia (rapid heart rate) may be observed more frequently in children than in adults. A few instances of angina and cardiac arrhythmia have occurred (irregular heart beat). Abdominal pain and weight loss during prolonged therapy have been reported and may occur more frequently in children...Overt psychotic behaviour and psychic dependence in emotionally unstable persons have occurred rarely with chronic overdosage."

Overdosage, it goes on to say can lead to vomiting, convulsions that may be followed by a coma, hallucinations, delirium, hypertension, dryness of the mucous membrane and 13 more effects.

This certainly raises a few questions as to the healthiness of the drug.

Research is now coming out that indicates that ritalin and other stimulants such as dextroamphetamine may retard growth and weight gain over long periods of use. This may happen because a side effect of these drugs is a loss of appetite and so the body cannot get the proper nutrition to grow and the drugs may decrease the secretion of growth hormone. (D. Safer in the New England Journal of Medicine, Aug. 3, 1972).

How many doctors prescribing ritalin inform the parent, who brought the child in because of discipline problems, that the drug their child is going to take has many adverse side effects, one of which is the possible retardation of growth?

As for the credibility of the CIBA-Geigy Company, who manufacture the drug ritalin read what they say about hyperactivity in a pamphlet entitled: "The hyperkinetic child: What can parents do to help?" - on page 7 - "It seems likely that he (the hyperkinetic child) may always be somewhat more restless, impulsive and so forth but these qualities, which give him so much trouble in school, may have advantages in adult life. An abundance of energy, a desire for action, an outgoing attitude towards people, and an ability to make up one's mind quickly are real assets in some walks of life". This begs the question - then why should we give him medication?

What contributes to the easy acceptance of chemotherapy on children? We

have been led to believe that controlling the symptoms of a malady is as good as curing the cause. We believe in drugs; we are a society of pill poppers. The Lambert study in California showed that parents of "hyperactive" children are likely to be drug takers themselves; 60% of these parents took tranquillizers.

Besides the public believing in drugs, the pharmaceutical industry believes in drugs. After all it is their business. CIBA-Geigy Company, the makers of ritalin, had sales of $30 million on ritalin alone, in 1974. However, many drugs have been introduced as a cure only to be withdrawn as their adverse effects became publicized (including heroin, a brand name of Bayer Pharmaceutical of Germany who sold it as the cure for morphine addiction).

Thirdly, the majority of the medical profession believes in drugs. They have come to rely to a great extent on information supplied by the drug companies on how to treat disorders. Moreover, prescribing medication is an efficient way to treat the maximum number of patients.

CONCLUSIONS

A large number of professionals who deal with children erroneously believe the term "hyperactivity" implies some sort of nervous system impairment or damage.

Hyperactivity is not a "disease" but a number of various symptoms, which are related to various causes - a very small percentage of which are due to nervous system damage. The majority of causes are unhealthy physical and emotional environments.

A huge number of children are labelled "hyperactive" by medical professionals, school professionals, and other adults dealing with children. It appears one of the major labellers of children into the category of "hyperactive" is the school system. These large numbers of children, whose behaviour is found intolerable in most school settings are then drugged into passivity with the rationale that the children are better able to perform schoolwork, which is only true in an unknown amount of cases. Instead of providing more tolerant supportive individual attention to children with unacceptable behaviour in the classroom, these children are drugged with potentially harmful medication.

It has been charged that the huge numbers of children labelled hyperactive (from 5% to 28% of the public school population) would have been labelled mischievous before the advent of chemotherapy. This is hotly denied by some people as was demonstrated when a member of MPA attended a Vancouver Association of Children with Learning Disabilities Meeting which was dealing with the topic of "hyperactivity" When he suggested to the assembly that children now labelled "hyperactive" would have been called mischievous before the prior term became well known, he was soundly booed by the large audience made up of teachers, other professionals, and parents of "hyperactive" children.

Adult society seems dependent on drugs to control unacceptable behaviour in children by labelling them "hyperactive". It is difficult to know how many children are regarded as hyperactive in Canada and Vancouver. MPA has written to both the National Dept. of Health and Welfare and the Vancouver School Board to get this information but several months have passed with still no word.

The most dangerous aspect of using chemotherapy on hyperactive children is the question of safety. Ritalin has a multitude of adverse effects on the mind and body and there is a serious question of their influence on children's growth. Amphetamines, the other stimulant used in chemotherapy for hyperactivity is a recognized potentially dangerous drug whose use is being restricted on adults, but no such restrictions exist on their use on children labelled hyperactive.

by Victor Nowicki

ELECTROSHOCK DAMAGES THE BRAIN?

"Since I recieved shock treatment my memory has been horrendous. I cannot retain anything I read and I have trouble remembering things that I learn in conversation."

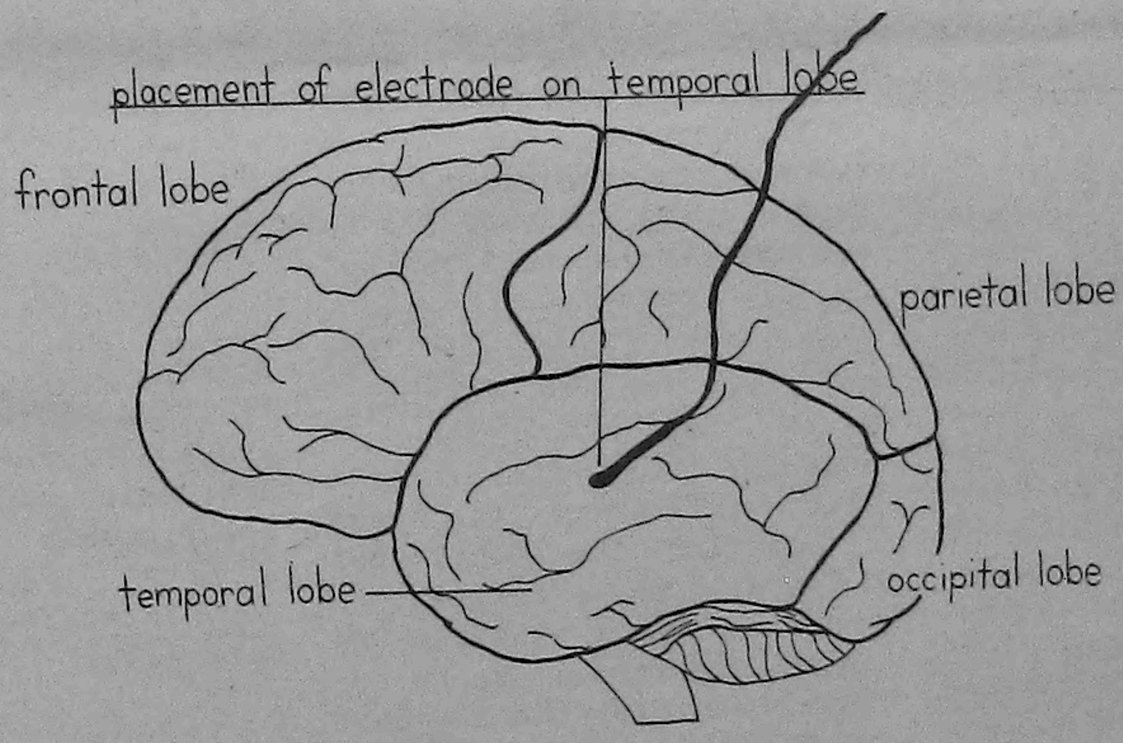
"I knew I had a Husband and three small children someplace. I could picture them but couldn't form any mental image of where they were."

"Sometimes I find it difficult to work out simple problems, especially at work. Thank goodness most of my fellow workers are very understanding of my problems. But why must I go through life with this handicap?"

The above statements are samples collected from people who have recieved shock treatments. What are the long term effects of electroshock and how do they influence a person's life?

Research done by the Committee to Investigate Shock Treatment indicates that E.C.T. creates brain damage, permanent memory loss or memory impairment. There is evidence that E.C.T. destroys brain ribonucleic acid (a memory molecule) and inhibits protein synthesis.

Electroshock consists of applying 70 to 175 volts of electricity for 1/10 to 1½ seconds to the most complex and least understood organ of the human body, the brain. E.C.T. has been shown to cause physical damage to the brain. This entails haemorrhaging, cell destruction, lesions, and circalatory disturbances. While conducting autopsies on experimental animals subjected to electroshock, Fedatov and Fortnov found evidence of pinpoint[1] haemorrhages in the brain tissue. Circulation of blood within the brain is disturbed[2] and the blood-brain barrier is impaired by a weakening of the vessel membranes.[3,4] In frontal and temporal lobes, devastation can occur.[5] Nerve cells may shrink and degenerate, leaving ghost cells or empty shells.[6] Two recent studies by Templar and Goldman[8] scoring perceptual-motor abilities of patients who had recieved an average of 50 shock treatments, led the authors to conclude that "The E.C.T. patients' inferior Bender-Gestalt performance does suggest that E.C.T. causes permanent brain damage.



Human Brain seen from left side

The most common complaints from people who have recieved shock treatments are memory loss and memory impairment. The research has demonstrated two types of memory damage: a loss of memory for events that took place before E.C.T. (memory loss) and a lessening of one's ability to acquire new memories (long-term memory impairment).

MEMORY LOSS

It has become common knowledge that E.C.T. can produce memory loss for experiences that occur before treatment. This memory loss also called retrograde amnesia, is not necessarily a temporary effect. It can continue for years after treatment. Irving Janis (1950) found that "...a series of electrically induced convulsions as administered in standard psychiatric practice, produces retroactive amnesia which persist after the usual recovery period of several weeks, during which the obvious impairments observed during the treatment period clear up."[9] The memory loss is indiscriminate; that is, good memories are lost as well as unpleasant ones.[10] The patient has trouble recalling names, places, people, personal life history, and has memory gaps in sequential events.

It is not necessary to have a convulsion or siezure

to experience memory loss. Even mild stimulation of the brain can produce disastrous results. Administering E.C.T. at a low voltage guarantees no safety. "Under some conditions the stimulation appears to produce retrograde amnesia (RA) at intensities that are below the seizure thresholds. These findings are important since they suggest that RA may be produced by subtle alterations in brain activity." 11

E.C.T. even administered at low voltage can produce memory loss. The amnesia can affect any aspect of recall, good, neutral, and bad. "Although some investigators have reported finding that the memory impairment is only temporary, most studies investigating this problem have found that RA is permanent...Overall, there is very little evidence to support the view that E.C.T. produces only temporary RA." 12

LONG TERM MEMORY IMPAIRMENT

The lessening of a person's ability to acquire new memories following shock treatment has only recently been studied adequately.[13] For years the studies on memory impairment have yeild -ed contradictory results. Recent studies of retention (long term memory) show that retention of material is impaired following shock treatment.[14] Moreover, the effect on retention abilities is cumulative, increasing with the number of shock treatments received.[15]

A study by Squire and Miller 16, involving mental patients and a control group assessed the ability of patients receiving shock treatment to retain newly-learned material for thirty minutes and twenty-four hours. In a discussion of the results of their findings, the authors state: "ECT patients did far worse on twenty-four hour retention tests, whereas patients not recieving ECT performed about the same on these two tests....Moreover, after the fourth treatment patients were less able to retain material for twenty-four hours than after the first treatment, indicating that the effects of ECT on twenty-four hour retention were somewhat cumulative.[17] Dornbush et al 18 and Williams 19 have also shown long term memory impairment following shock treatment.

These studies clear up much of the confusion in the research regarding memory impairment and shock treatment. They are also consistent with temporal lobe lobectomy studies which show that patients who have had damage to this part of the brain are markedly impaired in tests of retention but not for short-term recall.[20] This further suggests that memory impairment may be the result of brain damage.

RIBO-NUCLEIC ACID

When a patient submits to electroshock, physical damage is done to the brain. One of the many destructive results is the breakdown of ribo-nucleic acid (RNA). RNA protein is found in the nucleus of every cell. It is of fundamental importance in the synthesis of more complex protein molecules. It acts as a template and selectively allows the combination of other molecules in a special order.

McConnell's[21] experiments have established solid support for the thesis that RNA brain cells have a special significance in relation to learning and retention. McConnell and his assistants conducted experiments on planaria, which are species of worms. One group of worms was taught to respond to certain stimuli . These " educated " worms were ground up and fed to a group of "cannibal" planaria worms The cannibals learned the same response much faster than a comparable group of planaria who had not eaten the educated worms.

Further, when RNA was extracted from the ground educated worms and then fed to the cannibals, they learned the new trick faster than a comparable group which had not been fed RNA. This suggests that RNA is the substance within the planaria which influenced the speed of learning. The theory that McConnell was attempting to prove is that somehow RNA codes and stores memory for the behavioral changes that occur when something is learned. Some of the proofs for this theory from previous experiments are the following;

1) there are changes in the RNA of a rat's brain when it learns something,
2) substances which inhibit protein synthesis also inhibit remembering,and
3) some substances which speed up protein synthesis facilitate remembering.

Many research studies indicate that externally induced convulsions, including ECT, cause a breakdown of the nuclear material, RNA. Speigal et al 22found this to be true by studying the brain fluid of 30 dogs subjected to ECT. Another experiment done on monkeys by Ferraro 23 et al concludes that reversible and irreversible chemical & structural changes in brain cells cause alterations of mental processes in people undergoing treatment. Earlier, Mihailov 24 et al (1958) and Noah(1962) 25 showed that following ECT there is a decrease in the total brain content of RNA, a result confirmed by Essman(1972).26This suggests that ECT causes substantial breakdown of RNA in the brain cells. It also suggests that memory loss and impairment is directly related to the breakdown of RNA in the nucleus of the brain cells caused by the passage of electrical current in ECT

In conclusion ,it seems apparant from the studies on planaria that RNA has a distinct function in learning which is necessarily related to memory. This relates to ECT inasmuch as ECT appears to destroy RNA and interferes with learning and memory. The breakdown of RNA probably plays a significant role in permanent memory loss and impairment . The path taken by the electrical current in ECT is a destructive one, lessining the totality of the individual and his potential.

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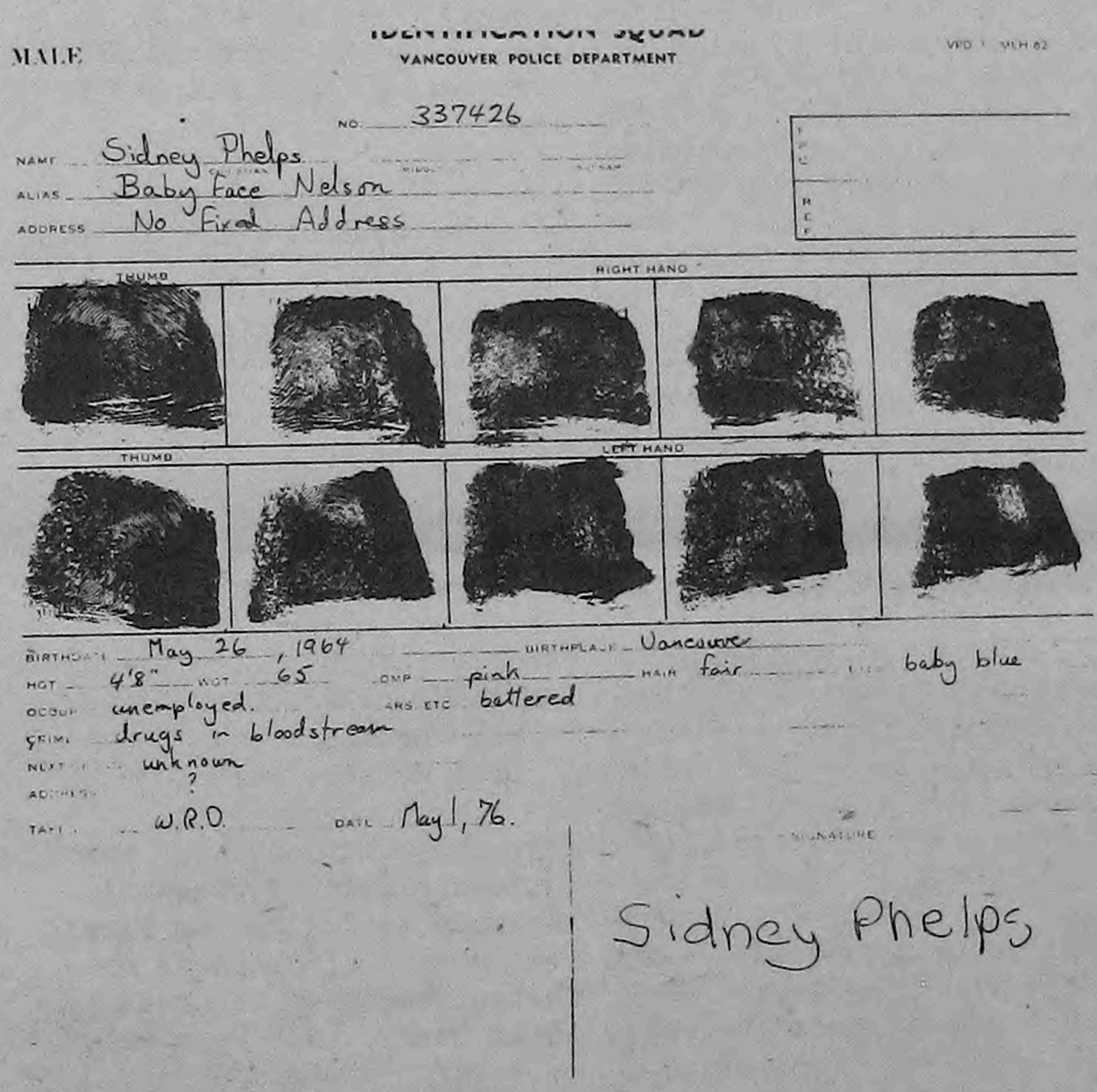
JUVENILES MUGGED BY POLICE IN PUBLIC SAFETY BUILDING

D. Martin

Two single parents from Vancouver South have written letters to the Vancouver Resources Board claiming that threats were made to bully them into bringing their children in for finger printing and having mug shots taken.

Tom Dixon, Deputy Chief of police, has stated that the children were charged before they were fingerprinted. Yet the parents claim that on April 11th, when they were told to bring their children in, there was no mention that they were charged with an offence. One parent agreed to the fingerprinting because she felt she had no alternative but to comply. The second parent refused after talking to her social worker, her son's youth worker and a policeman of the identification department who told her that she was not compelled to have her child finger printed. Her eleven year old son was picked up and fingerprinted two weeks later. As of April 27th the date of their letters neither parent has been informed of charges against her children.

The parents have claimed that they have been harassed and intimidated by the police. In her letter to the VRB, the mother who refused to bring in her child April 11th tells how she was bullied a few days later. Her letter states: "I met the same policeman a few days later and he told me I'd better bring him down or he'd come and take him and that this would embarass me in front of my neighbours. He told me that my social worker and the policeman downtown had been raked over the coals for the information they had given me."



The Vancouver Resources Board has asked lawyer David Mossop to investigate the legality of fingerprinting practices and will invite Superintendent of Child Welfare Vic Belnap and Superintendent of Police Tom Herdman to a VRB public meeting to discuss the issue. It is hoped that the VRB will attempt to stop the practice of fingerprinting children.

There is considerable controversy as to whether or not police have the right to fingerprint children even if they have been charged. The B.C. Civil Liberties Association feels that the fingerprinting of juveniles is illegal unless the child is raised to adult court. However Deputy Chief of Police Tom Dixon states that police are within their rights to fingerprint juvenile offenders under provisions of the Federal Identification of Criminals Act which states that juvenile offenders are to be treated the same as adults as to their identification.

The central concern of these parents is, however, that they were harassed and intimidated by the police who fingerprinted and took mug shots of their children, while not informing them of charges against their child. It is hoped that VRB investigation of the issue of fingerprinting juveniles will include a specific investigation of all children who have been previously fingerprinted by the police to determine both the legality of fingerprinting juveniles and also whether or not police have been finger printing children before they have been charged.

Also it is important to have information on how many children have been fingerprinted, what happens to the child's prints once they're taken, and whether or not there is a clear procedure for removal of a child's prints when the juvenile reaches legal age or if the child is found not guilty of the charge. Putting aside the legal issue, is it wise to fingerprint and mug shot children at all?

FREE LAW

The Vancouver People's Law School offers free lectures on the law to the public. One of the subjects offered explains the laws relating to mental patients in the province.

A detailed booklet is available on the material covered in the course and can be obtained for 50¢ from the School. To obtain a copy call 681-7532 or write to #610 - 207 West Hastings Street.

The booklet explains the laws concerning civil admissions, criminal detentions and committees appointed under the Patients Estate Act.

Under civil admissions, the booklet examines the laws relating to both voluntary and involuntary admissions under the Mental Health Act. It also discusses apprehensions by the police under the Mental Health Act and the rights of the patient as provided by the Mental Health Act. The discharge of voluntary patients is also explained, including an explanation of review panels.

The section on criminal detentions explains the procedure of remand for psychiatric observation to determine fitness to stand trial, and committal by order-in-council if the accused is found unfit. The discharge of order-in-council patients is also explained.

Finally, the booklet explains the appointment of a committee under the Patients Estate Act to act for a person who is found incapable of managing his affairs. In addition to explaining the powers of a committee, the booklet explains how a patient can retain or regain control of his affairs.

For more information, contact the Vancouver People's Law School to order the booklet or to obtain the summer schedule of free lectures on law. The subjects offered this summer are: immigration procedure, welfare rights, landlord and tenant, small claims court procedure, aboriginal land claims, co-operative housing, consumer law, legal research, labour law, women and the law, civil liberties and environmental law.

LETTERS

Dear MPA:

I would like to thank you for the copy of the Nutshell featuring shock therapy. I think it was put together with genius and am sending a dollar towards its publication.

Also I would like to submit to the editor that I for one feel just as deeply concerned about tranquillizers and their possible addictive nature as I do about shock.

I do not feel myself or at all well when taking tranquillizers.

I feel it is cruelly hard to feel dull, dizzy and unable to reason properly, careless, sloppy in my appearance and fatter than is normal, as I do when on this medication.

But most important I feel drugged and every time I have tried to be withdrawn from the sedation I have shown unmistakeable symptoms of addiction to them.

I am a practising Christian and as well as the physical discomfort of taking tranquillizers over a long period of time I feel spiritually derelict for being forced to take them.

When without them I am myself and can really think responsibly.

When on them I feel as though I've been slugged into accepting lack of justice and an inadequate life style and illnesses that could be treated easily.

Yours truly,
Mary (Molly) Ransford.

Dear MPA:

Most people who have spent time in a psychiatric ward never broke any laws. This fact employers must understand.

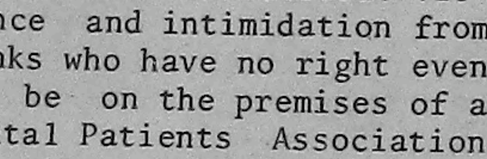
There is so much unemployment now and MPA could send a newsletter to employers. We'll get some feedback and maybe, just maybe, progress.

In these times, employers are very fussy about who they hire and they should know some hard facts. For example, can a reference be given by a psychiatrist to an employer? Does a social worker always know nothing about a patient's employment history? Does a Riverview psychiatrist do anything about finding work for patients?

There are many questions to be asked and exchanges of ideas to be developed.

I've been looking for a job for about a year now and I'm getting pretty down and beginning to wonder just where an ex-patient stands when looking for a job!

Ron Andrews



Dear MPA Liberals,-

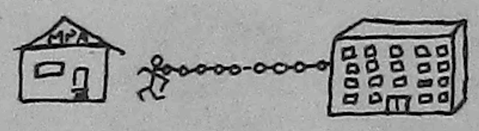
Perhaps you can help me resolve a deep emotional problem I've had for some time now. This emotional problem is so severe, it manifests itself physically, as an extreme pain in the ass.

Let me explain the circumstances which aggravate / cause my affliction and you might be of some help. You see, I have a number of friends who work and play at a social centre in Kitsilano. Now these friends find their ordinary jobs quite demanding enough, both emotionally and physically, but it seems lately they have been subjected to considerable violence and intimidation from punks who have no right even to be on the premises of a Mental Patients Association drop-in centre. Yes indeed MPA stands for love, brother hood, people helping people- and all that, but it was never intended to deal with any and every individual's fuck-ups. Even if MPA had the people power, the resources and the firm desire to help all kinds of people get their shit together, the space and time limitations of a small drop-in centre alone would demand that some people be turned away. (Remember, MPA is not the only life raft in the ocean.) Therefore, priorities must be set, and in my opinion preference ought to be given to ex-mental patients, with the second priority going to people who genuinely want to contribute something positive, however small, or who really need and benefit from e relationships offered at 'A. People who wander in f the street to play pool, atch tv and drink coffee ust because it's a convenent place to hang out ought o be tolerated, in my opinion, but at the first sign of any negative trips, e.g. throwing coffee cups through windows, their asses ought to be trucked out the door damned fast, but not before some payment for damages is arranged.

If people wish to stand and die on the beautiful principle of total acceptance for all, let's try and help the poor boy with his problem, then so be it. An enviable attitude for a utopian society. But when you hesitate to impose the harsh penalty of a ban on someone, please consider the damage to the silent and easily intimidated people YOU are causing. It's very easy for someone of size and strength to be loving and forgiving about intimidating people, not so easy for many others.

I hope this argument doesn't fall on deaf ears but if it does I hope that you liberals will remember your solemn principles and thus not judge me harshly when my problem gets out of hand. My problem? Well, lately I've been having these terribly violent fantasies about storming into the drop-in and bouncing a few punks off the walls. My fantasies include blood, broken glass and much property damage. If I should someday lose control and something terrible like this were to happen, please don't ban me, as I live on a poverty income (UIC) and have many problems and frustrations to deal with in my life.

yours sincerely,
Kevin Topalian.



Dear MPA:

I would like to suggest a way to help those of your residents who require rehospitalization and who so often are just a short time at VGH and discharged unchanged to your houses.

From working with some of you I have observed that the most frequent occasion your residents require rehospitalization is during the first few weeks after their discharge from hospital and initial entry into your houses. This happens especially with persons who have been frequently hospitalized before they have ever come to you.

I advise you to much more frequently make use of the extended leave provision - ask for extended leave for perhaps three months when you are unsure of the likelihood of a person adjusting in the first crucial weeks. This request could be made by one of you to the person's doctor at Riverview prior to the person's discharge. The person who is on extended leave status is able to be taken DIRECTLY back to Riverview after his doctor has been informed of the situation, without a lengthy waiting period, often the same day.

Yours truly,
Barney Eades,
Psychiatrist.
Mount Pleasant Community Care Team.

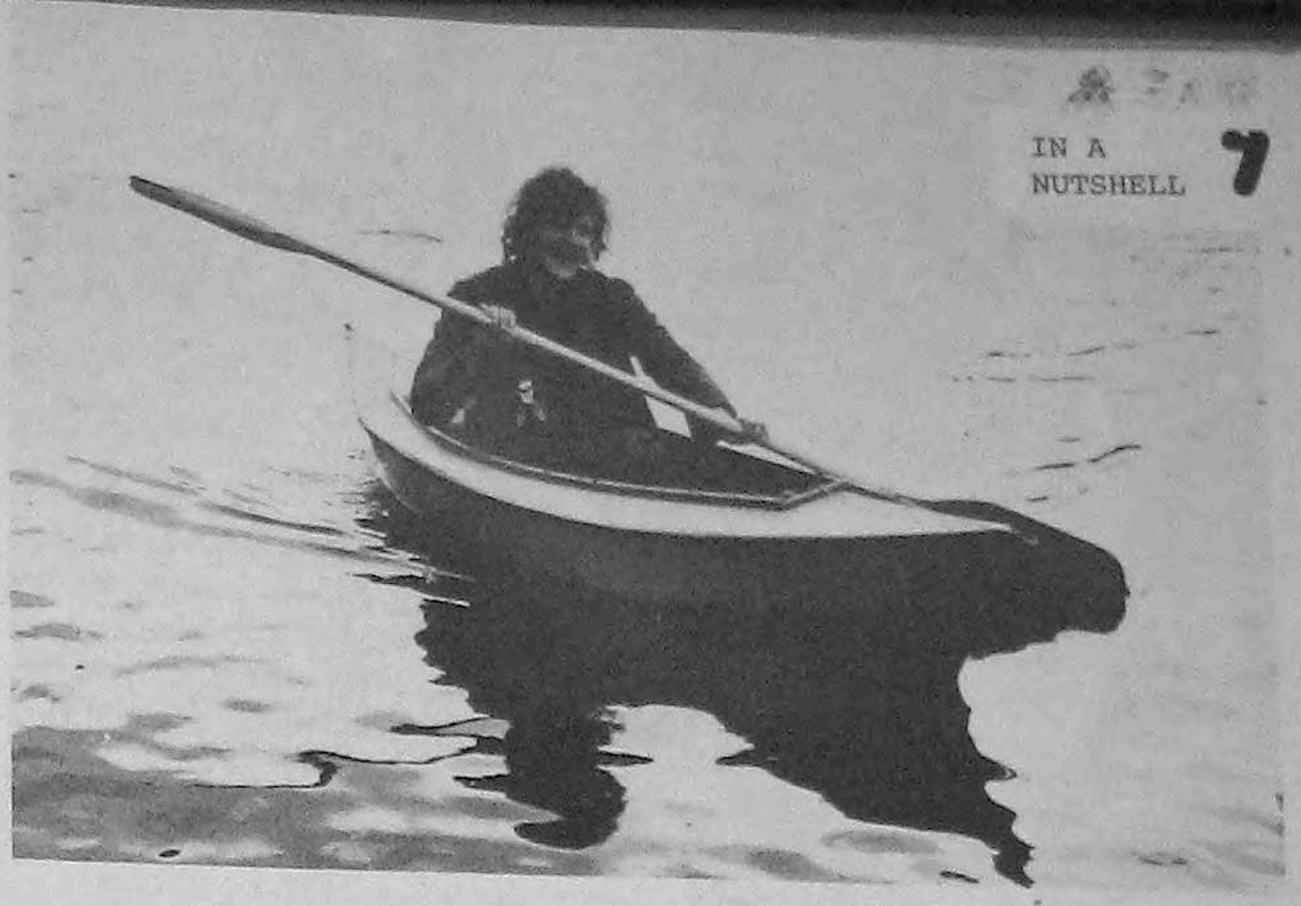
Once again at MPA, we found ourselves discussing violence. This time, using a different approach, we decided to share information on how individuals deal with violent situations. The idea itself was a good one but we did not come close to any solutions. We can console ourselves with the fact that other organizations have probably not done any better than we have. There is a tendency to pass the buck, and it is eventually reflected on the street and at MPA. We don't have any more answers, but we somehow end up with more of the problem.

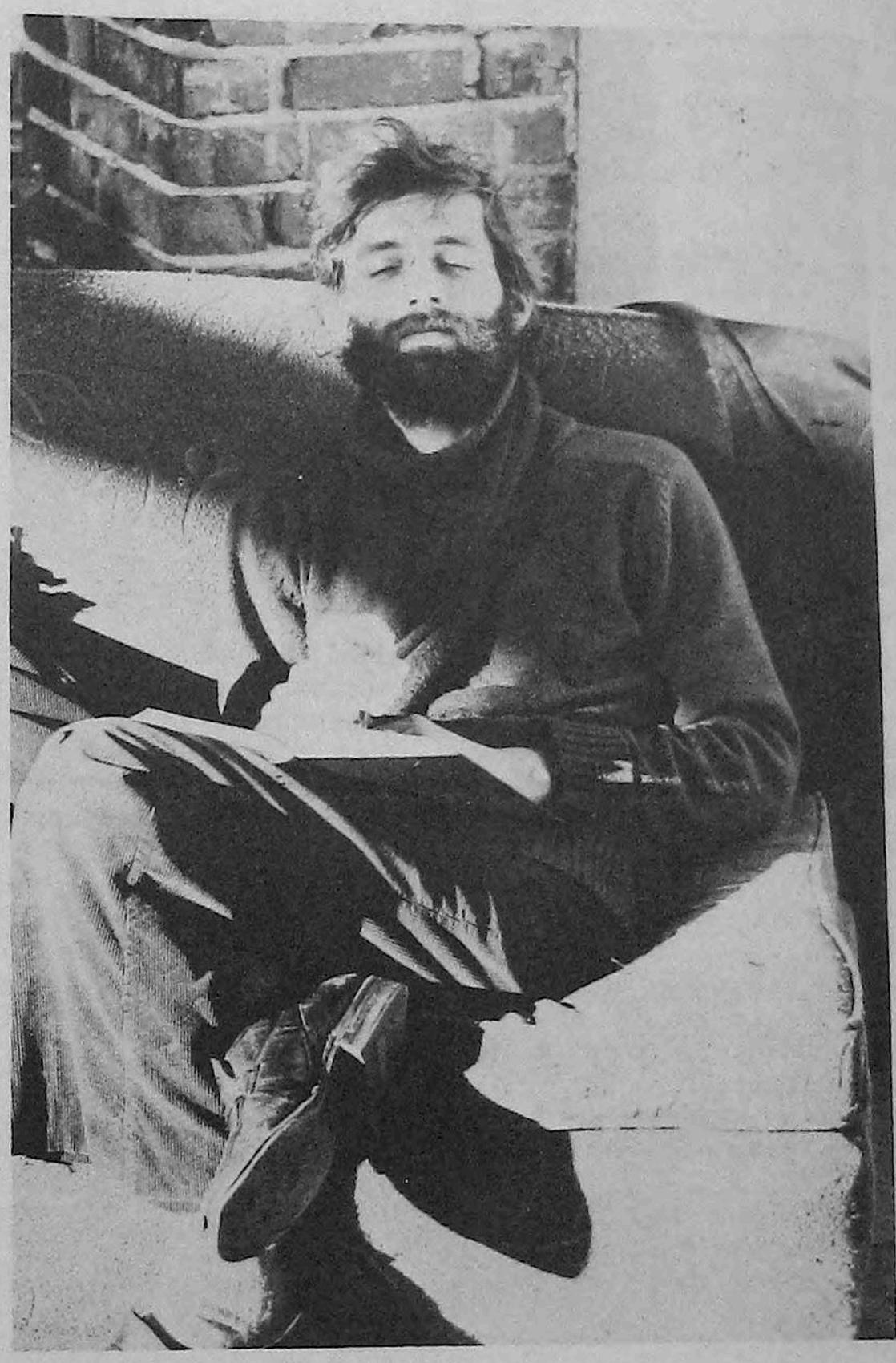
MPA has for some time been used as an unloading place by other community services. If someone is unmanageable or unhouseable, MPA is the last resort. In return, what we frequently experience are closed doors when trying to place or get help for someone in crisis. The problem here is obvious. Internally, it is a little more subtle.

There is a constant flow of new people into MPA. Education must therefore remain a priority if members are to be informed and involved. I've always felt that the most effective thing we do is to encourage people to stand up for themselves, to speak out and not accept being walked over. Many members (both paid and unpaid) have made dramatic changes. Our decision-making process provides the situation for members to gradually become less intimidated about voicing their opinions without group pressure. Communication methods are learned by observing other people.

The type of atmosphere that we project is our first impression. Individuals feel out what their limits are and decide whether or not they want to return. For some people, MPA might be the place to express their own aggression. We seem to be accepting it in one form or another. At meetings we often insult, interrupt, and generally degrade each other. In short, mutual respect does not always stand out as the prevalent factor. If you happen to be easily intimidated, the aggression sometimes reflected is frightening. MPA, by nature, has been aggressive. Some aggression is necessary in order to communicate on an individual basis. In the houses and in the drop-in, the environment is a learning experience. How people are treated is how they will respond.

Bonnie Martin





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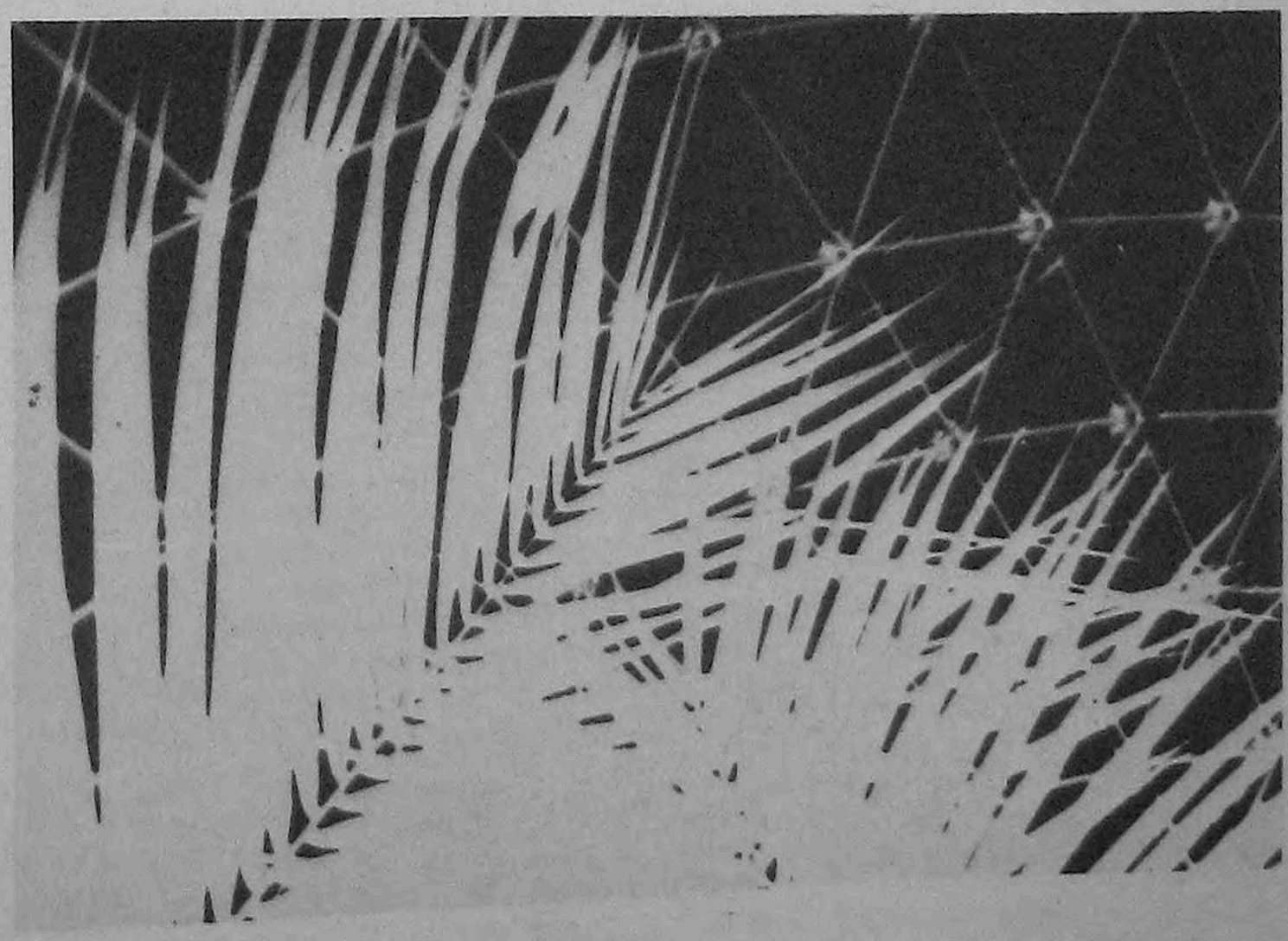


HABITAT

The United Nations Conference on Human Settlements
Vancouver 1976

Habitat deals with how people live. Increasingly, people are living in urban communities, creating new pressures on the human environment. Our human settlements are becoming very large very quickly. A world of problems faces mankind in our cities, towns and communities: food... water supply... shelter... energy.. work... transport... population pressure... pollution... aesthetic environment... protection... recreation...

PUBLIC PARTICIPATION

"How does HABITAT affect me?" "How can I be involved?"

HABITAT is an official United Nations Conference so in the broad sense, through our Government representatives, we are all involved. But of course this does seem a bit remote from our workaday lives and it must be recognized that only officials can speak at the UN Conference itself, with little or no facility for specators.

But... At the February 22 meeting of the Mental Patients Association the following resolution was passed unanimously: "THAT M.P.A. request demonstration space at Habitat Forum."

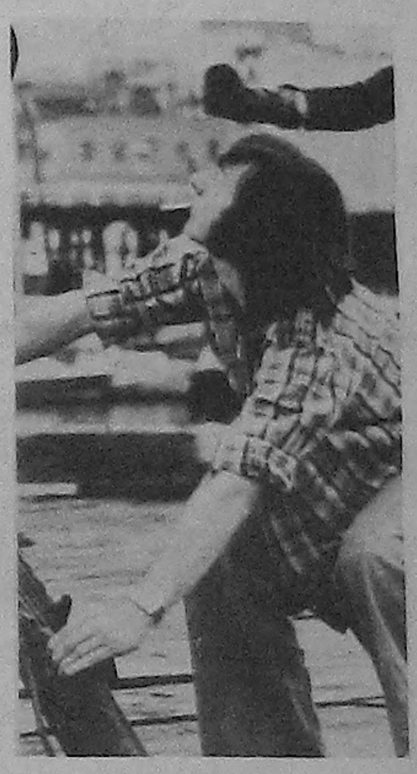
As mental patients and ex-patients comprise a significant percentage of world population and potential mental patients comprise our entire population, we feel that the environmental needs of consumers of mental health services must be brought to public discussions at Habitat Forum.

On May 27, 1976 — four days before the UN HABITAT Conference begins — non-government organizations will gather at Vancouver's outlying Jericho Beach for an 'alternative' or 'counter' conference known as HABITAT FORUM.

We are pleased to inform you that we have now available exhibit and seminar space sufficient for our own group, as well as the involvement of other groups, in a large tent specifically built for such needs.

As well, we have available a "democracy machine" for supplying immediate electronic feedback by and to participants during discussions or while viewing presentations in and around the tent.

As M.P.A. operates with a participatory democracy model, the democracy machine might supply a needed input and output (as well as a neutral chairperson-guiding mechanism) for persons participating in our "partici-tent".



Representative vs. Democracy ?

Some of the main issues that any group must come to terms with are:-

* how decisions are to be made?
* who is to make them?
* who has the authority to carry them out?

Erving Goffman, a sociologist who made a survey of mental hospitals, concluded that they have the following features:-

a) All aspects of life are conducted in the same place and under a single authority

b) There is little or no room for private activity. All inmates are treated alike and are required to do the same things together.

c) There is strict schedule of daily activities which do not arise from the inmates' interests or wishes but are imposed from above.

d) The contents of the various enforced activities are brought together as parts of a single overall plan designed to fulfill the official aims of the institution.

It is my impression that most MPA members do not like having their activities dictated as they are in mental hospitals. People come to MPA in an attempt to build an alternative to the authoritarian atmosphere in these institutions.

If people want dictatorial rules about when they must get up and go to bed, about signing in and out, about when they can have visitors, the hospital is the place they can find rules galore.

DEMOCRACY

I am quite sure that the large majority of members want MPA to follow democratic principles. Democracy is a concept that almost everyone agrees with. I do. I associate it with concepts like Motherhood and Apple Pie. And democracy, too, is a word we ofter endorse unthinkingly, without really knowing what we mean by it.

REPRESENTATIVE DEMOCRACY is the type we have in Canada and is really the only type we have experienced. According to this system, we elect people to represent us in government. They do the day to day work of running the country; they do not consult us about decisions. This system differs from dictatorship because if we dont like the decisions our representatives have made during their term in office, we can vote them out at the next election.

We have been conditioned into thinking of politics as being something that has nothing to do with our daily lives. Its just a kind of entertainment show that rolls around every few years But politics ought to be about procedures for involving everyone in making decisions that do affect the details of our daily lives, in schools, factories, offices, neighbourhoods, mental hospitals, etc..

We think of this as a pipe dream. However, Representative Democracy has removed us all so far from the levers of power that we are resigned to thinking the only role we can play in politics is putting an X on a ballot and getting drunk while we watch the election returns on TV.

We're fed up with and intimidated by politics because we know we have no real, active role to play in the political process. And noone is going to give us that role until we decide we are going to have it.

We feel so powerless that we may believe the rationalization that the only way to run a huge nation is to elect people to represent us This rationalization is false however.

And not only nations, but most small groups the size of MPA use Representative Democracy. The membership elects Co-ordinators who mess things up while everyone else bides their time until the next election.

"It (Habitat) is a process as much as an event and one that will profoundly affect each of us."

The MPA way : Democratic participation

PARTICIPATORY DEMOCRACY means that everyone who wants to, can participate in decisions making. I believe MPA has been using and should use this system. The power should be exercised by the membership, not the executive. MPA's executive has less power than in any other group that I know of. Participatory Democracy is slower and sloppier than Representative Democracy, but is in every other way better. The membership of MPA should be responsible for everything that goes on. Authority must be the group's, not the executive's If you have complaints or suggestions you must attend the meetings and raise them. Talk to other members; try to convince them of your point of view. Dont be afraid of raising unpopular ideas. The general membership has the final say on how things are to be run.

The level of democratic participation in MPA is very high, but it could be higher. Too many people still want to delegate authority to others.

We rationalize our irresponsibility as the need for efficiency. How else can things be run? The answer is up to us. Things are not being run efficiently now. If efficiency means creating conditions of human happiness, the system of Representative Democracy is highly inefficient. We all know this from personal experience.

The trouble is that we have been conditioned politically to want to be children, to have parent figures make our decisions for us. We want to be represented by others so we dont have to be responsible for making our own decisions.

The issue of leadership comes up again and again. In Democracy, leaders exercise authority and power. They co-ordinate, organize, make suggestions. If members dont want to follow these suggestions, they are free not to. If MPA's leaders give orders the way hospital staff does, we are no different from a hospital. Setting up a few ex-patients to play doctor and nurse is no way to create a real alternative to the hospital structure.

Leadership

The most responsible leadership entails making sure that the entire group participates in decision making.

There are not many groups run by the active participation of the members. If MPA is going to serve any useful function it will only be through the democratic participation of everyone.

Dear Editor:

The Mental Patients Assc. is currently seeking community input into our activit - ies at HABITAT FORUM.

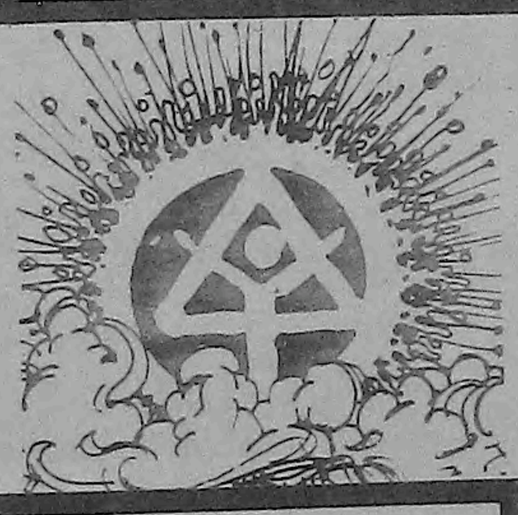
The working title of our discussions is " Authority Reversal and an Enriched Enviornment - a New Concept in Community Living - as Opposed to Institutionalizat-ion."

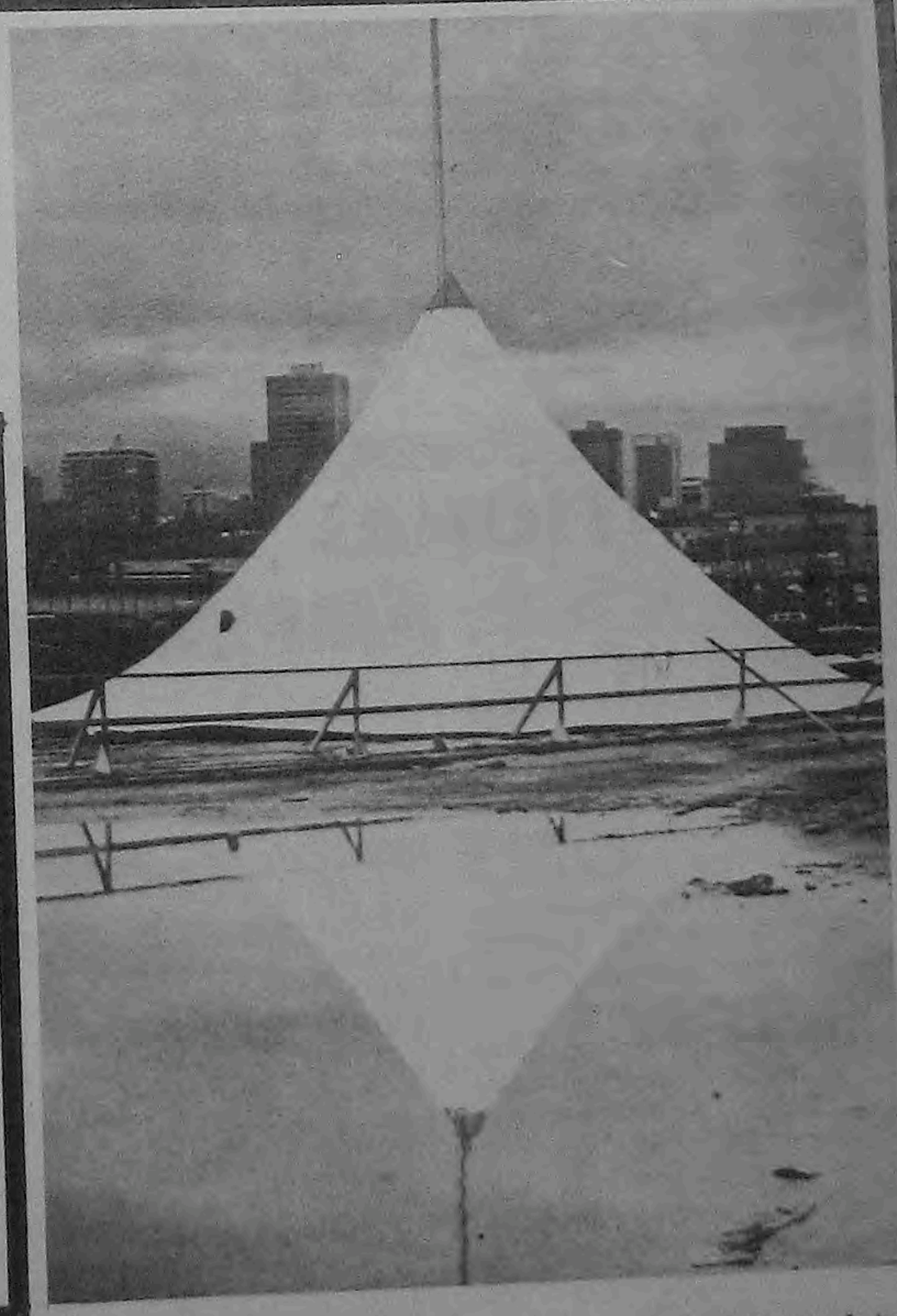
People's experiences with institutional life (schools, hospitals, prisons, bureaucracies, etc.) and solutions to problems that institutional life breeds, will all be welcome inputs into our discussions.

We are particularly interested in other's experiences with authority reversal using participatory (direct) democracy, and enriched enviornments (where in problem solving (self-help) capabilities are available).

I am very willing indeed that your Association should contribute in some way to the Workshop on the Practice of Participation and I enclose a note setting out the preliminary arrangements that I am trying to make.

I wonder if you would be willing to submit a brief statement of not more than 1000 words, as suggested in the note, indicating the points that you would like to have raised at the Workshop. It would be very helpful to me if you would, and I wonder if I could suggest that you broaden your interests to include the interests of deprived and disabled minorities in general, rather than just mental patients. I realise this may be rather a tall order, but I am sure you will appreciate the point of my request.





At the May 5th General Meeting of the Mental Patients Association the following resolution was passed unanimously:

> "THAT Mental Patients Association direct participation in the World Federation for Mental Health seminar on 'Mental Health in Prisons' at the Habitat Forum be investigated and strongly encouraged."

Members of the Mental Patients Association have direct experience and expertise in the subjects of mental health, prisons, and their combination (forensic psychiatric hospitals).

Our group's support for the de-institutionalization of recipients of the aforementioned services has proven itself to be so remarkably successful that to overlook our positive solutions within the seminar's discussion would "be a crime".

With a typical recitevism rate of between 60%-90% for both mental hospitals and prisons, we would suggest a "solutions oriented" seminar is in order. The Mental Patients Association may have that needed solutions orientation.

Hoping that M.P.A. isn't "locked out" of this very important seminar, we wish you well in your preparations for Habitat.

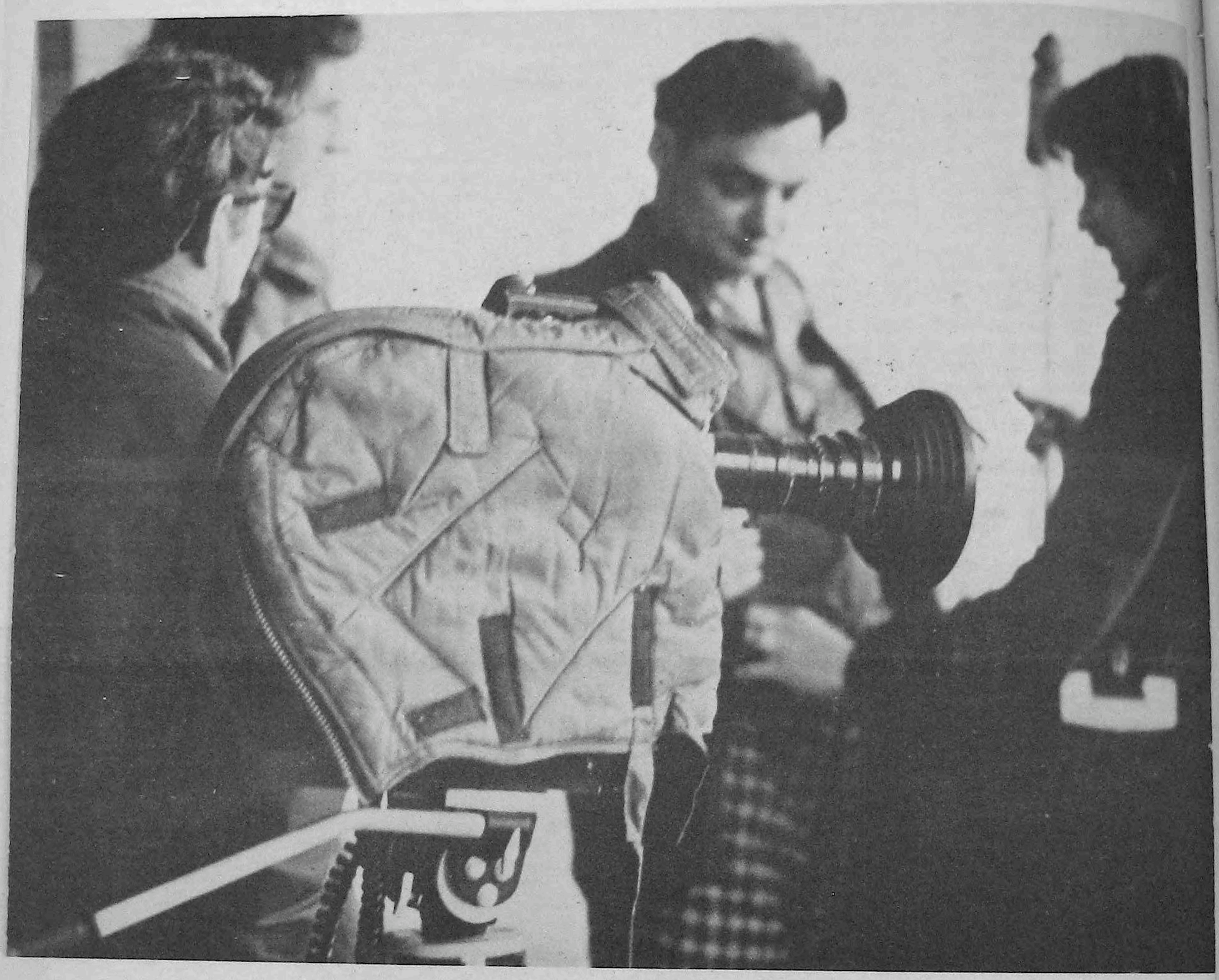
FOOTNOTE

The membership of the Mental Patients Association is pleased to accept your offer to coordinate the use of a large tent at the Habitat Forum site during the Habitat Conference.

IN A NUTSHELL 10

NFB EXPOSED!

Essondale, B.C. Special to In A Nutshell: Camera crew from the National Film Board documents the release of an M.P.A. member.



ADDITIONAL AMPERAGE

Why is Electro Shock Treatment still so widely used?

For many months, myself and others have investigated this wide spread use of Shock Treatment in British Columbia. Our findings have been terrifying.(1)

Even as I write this article people are being slated for tomorrow's temporary cure for their depression.

The increased demands made in this form of treatment, i.e., memory loss and respiratory or circulatory system failure are valid enough reasons to stop and re-evaluate the effectiveness of Shock Treatment.(2)

Who really has the right and wisdom to administer this style of treatment?

Certainly not the appointed heads of psychiatry in our institutions.

As I walk through the streets of Vancouver, talking with those individuals whose trust is great in our mental institutions, they are amazed and horrified that Shock Treatment still exists.

When I talk with individuals who have had Shock Treatment the fear and haunting memories of this treatment still lingers, even many years after their last treatment.

Need an individual who is suffering from depression be subjected to this memory of a temporary cure?

Have our psychiatrists ceased to further their research into the effects of Shock Treatment?

The Mental Patient's Association's Committee to Investigate Shock Treatment hasn't stopped their research. Our files are readily available to the public at any time. What is the availability of the research files done by psychiatrists who generously administer a temporary cure for depression?

Can't Shock Treatment be readily available for those who wish it, and left aside for those who wish not to take the memory of its pain and hardship through the journey of life?

Do restrictive measures have to be taken to see that only those who sincerely want Shock Treatment recieve it.

Are our Psychiatrists so insensitive , they do not hear the cry of many who wish not to share an experience in Shock Treatment?

When does this insensitive way of treating an individual in a depression end, and the care for one person for another begin?

I too am vulnerable to this style of treatment; I too am scared of it.

Lawrence

A member of M.P.A.'s Committee to Investigate Shock Treatment.

MICHAELLA

And she called, Oh mother I am sinking so sinking and her mother said well tomorow we could go sailing... and she said, Oh please I am so sickly so sick and there are flies all around me. And her mother said well it might not rain tomorow so don't take your umbrella to school.

And in the night her daughter drifted away from her and turned into a bird that flew out the window of the bathroom into the starry night that was black.

Empty stomachs rolled on in the morning and ever after in the white. Her mother turned yellow and became very grimacing. Later on in the day she was reeking and green with laughter.

Sharon Ryan

POST-PARTUM DEPRESSION

Barb Pryce-Jones

On October 28, 1974, my son Gabriel was born. The delivery was a long one. But with the help of the Lamaze method of natural childbirth and self hypnosis we came through it all beautifully.

Two days after Gabriel's arrival I began to feel very down. I felt no connection with my baby; he was totally foreign to me. This made me feel very guilty. Where was that maternal instinct? How could I possibly not like, much less love him?

I kept these feelings to myself hoping they would go away. I tried rooming-in with my new baby but sent him back after two hours. I was terrified of him. I rationalized that my depressed state was caused by my own inadequacies as a woman and now as a mother. The guilt grew and grew. I became more and more depressed and dreaded the day when I would leave the hospital and be completely on my own with Gabriel.

We live on a mountain far from the madding crowd but at this time the prospect of going home to that kind of isolation - a long hike from our cabin to the road - did not seem so ideal.

What happened after I left the security of the hospital was, I think, not necessarily a normal example of the course that "post partum depression" may always take.

When I was on my own I quickly realized how weak I was. It seemed that Gabriel only slept an hour at a time. I felt I would never sleep through the night again. Exhaustion takes many forms and in my case my appetite began to fall off. This was very bad for the baby as well as myself as I was breast feeding. Gabriel developed a bad case of diarrhea. My milk was not nourishing enough and the anxiety I was feeling was turning the milk bad.

I went to my doctor who immediately took me off feeding Gabriel and put me on valium. I was very upset because I had made a point of reading up on breast feeding and had prided myself on my ability to at least carry that off with ease. Up to this time no mention of post partum depression had been made. Perhaps my doctor, the hospital staff, my mother, and everyone else assumed that I knew all about it and what was wrong with me. Well I didn't. I had always believed that what I thought of as post-partum depression was a phenomenon which lasted a few days.

My self-esteem plummeted. I felt there was no way out. Every small problem became magnified a thousand times. The possibility that I would ever be normal again seemed hopeless and certainly my freedom was gone forever.

I began to devise ways of leaving Ted and Gabriel, of running away somewhere, anywhere. I wished that someone would come and take the baby, put him up for adoption or anything. All I wanted was to sleep for a long long time and wake up to my life being the way it was before Gabriel was born. The weight of responsibility to this tiny creature was intolerable and the guilt now became so intense that I could hardly hold my own baby.

Finally my nervous system took over and precipitated an epileptic seizure. This was the first time I had ever had one. Such seizures are very similar in effect to electroshock therapy and I was left stunned for about six weeks. No-one explained to me - neither my neurologist, nor my family doctor, the repercussions of such an attack. My memory became terrible and my thinking very vague and slow. I was convinced I was going crazy. I don't think I was depressed anymore; I wasn't anything; I barely knew my own name.

I realize now that post-partum depression is both physiological and psychological and is something that does in time rectify itself. The hormone changes after a birth are incredible and of course manifest themselves in some visible form. But nonetheless it is very real and threatening, and if, as in my case, left untreated, can leave very real scars.

The trapped, isolated feelings that having a new baby generates are normal. However I was brought up to believe that motherhood is Everything. It is the essence of selflessness and saintliness and something to be attained at all cost. I didn't feel any of these feelings - so I considered myself a failure.

In my case everyone assumed that I was more knowledgeable than I was. The hospital staff could have informed me. My doctor should have told me what was happening. I was taken off breast feeding and put on drugs, but no-one explained why. Everyone was very kind to me, but that in itself was terrifying because I didn't know how to deal with something I couldn't understand. Looking back I don't know how I ever escaped ending up in a mental hospital, as so many women do in the same circumstances.

After two or three months I began to feel human again. My husband was the essence of Job himself throughout this whole ordeal. Being new at this game himself he did not know what was going on, but he learned quickly to cope with the baby if not with me. I'm sure he was experiencing some of the same feelings I did but he was better able to turn his attention to Gabriel's needs

Today Gabriel is a joy. Ted and I are secure in our relationship and in our new design as a family. Looking back on our shaky beginnings I consider it a miracle that we survived the nightmare of those months, which needn't have been such a nightmare if only someone had told us about post-partum depression and how we could best deal with it.

MPA RESIDENCE PROGRAM

IN MEMORIAM

ASHES TO ASHES, DUST TO DUST - IF THE FEDS DON'T FUND US THE PROVINCIALS MUST.

An open letter to Mr. McClelland and Mr. Vander Zalm re M.P.A. the highly effective grassroots organization - blessed by all but funded by none:

What does it take to obtain funding for a program which has been recognized throughout the city of Vancouver as well as across the country as a unique and outstanding alternative in community housing for ex-mental patients?

The Vancouver Mental Patients Association finds itself in the unenviable position of looking for $200,000 in funding at a time when the federal government is chopping its excess fat (thus no longer being in a position to fund M.P.A. as it has in the past) and the provincial government is still feeling vindictive toward programs which Liberal or N.D.P. governments have supported. M.P.A. now stands in this political crossfire. Our survival with our philosophy of self-help and power reversal intact is questionable.

Mr. McClelland was heard on C.B.C.'s Ombudsman program across Canada only a month ago praising "the B.C. Mental Patients Association."

He assured Canadians that mental patients in B.C. with the advocacy of M.P.A. need never worry about losing their rights or finding themselves undefended in hospital or legal situations. High praise indeed for a group of ex-patients who are seen by many in society as being unable to make really important decisions in their lives.

Mr. Porteous (Mr. McClelland's deputy minister) wrote M.P.A. a marvellous letter of recommendation regarding the high quality and excellence of the residence program. However the Health Department could not find the necessary dollars to keep the residence program alive and well. People discharged from hospital as being unable to function on their own and requiring continuing follow-up from the community mental health teams are now said to be the responsibility solely of the Human Resources Department.

Mr. McClelland could find nothing in his budget to support the M.P.A. program he so highly recommended.

The Health Department has been reducing its institutional costs by reducing the number of patients admitted and the length of stay in mental hospitals. Where are those would-be mental patients? They are in the community - many remaining in Vancouver because there are few back-up services through out the Province and few enough in Vancouver itself. Yet little of the money saved by the Health Department has found its way to supportive community housing facilities.

The money is being used alright. "Venture" no doubt with twenty-four hour proffessional staffing takes a large bite. But just try to get someone from the community, even if they are patients of the community care teams, into Venture when the need arises (very annoying when you learn that half the beds are empty but the staff don't feel the person to be suitable). Apparently only intimidated submissive people or those who are "no trouble" are considered appropriate.

No doubt another large bite is financing the latest extension of various kinds of acute hospital beds. Ah yes! empire building must go on whether or not people have safe and decent places to stay in the community.

We now have a situation-where the Health Department says that once discharged the ex-mental patient becomes the responsibility of the Human Resources Department. Unfortunately, the Human Resources Department has only managed to come up with two thirds of the funds needed to operate the Drop-In Centre and zilch for the residence program. Well so much for Mr. McClelland's assurance to B. C. mental patients that their needs are well taken care of. The number of referrals to M.P.A. increases every day and M.P.A. assures everybody that the organization will be able to attend to two thirds of their needs but if supportive housing is needed you will have to find it yourself.

To the many professionals WORKING in the community who have phoned and expressed concern for our programs all we can ask is that you express your feelings directly to the Minister of Health Mr. McClelland and to the Minister of Human Resources Mr. Vander Zalm. Who knows? They may even start to talk cost-sharing with one another.

M.P.A. has never been in the habit of sitting about hoping that funds will drop into our laps. We have sent proposals to all levels of government. We have approached various foundations and individuals who have been most helpful with goods and services but are unable to provide these until they are assured we have basic funding. Our inquiry to Margaret Trudeau as to whether she knew any influential people who might be of help to us was politely answered but was unproductive. We did no better with our letter to the Pope.

M.P.A. has been investigating alternative funding for the residences by applying for Personal Care Homes funding. When we discussed this method of raising money our members felt that there are so many rules and regulations which would disallow freedom of choice that M.P.A would become just another institutional extension of an already ineffective system. As it now stands only those people now on welfare would be eligible to apply to M.P.A. houses. Any person with other forms of income, wanting to start work while remaining in a supportive house, etc., would be disallowed or would have such sanctions applied that living in an M.P.A. house would become untenable ... a large number of our current residents would have to leave their homes. Much cooperative work has been done by the department to make this form of funding more palatable but the fact remains that although the money is available there are severe limitations to the usefulness of this type of funding to an organization such as M.P.A.

In the first place this route for funding is the bureaucrats' dream of putting a muzzle on M.P.A.'s big mouth. Criticism, when it comes from recipients -of-service who are receiving government subsidies, does not sit well with the higher echelons of management. Some of the lower echelons don't take too kindly to critical analysis either.

A more serious drawback to Personal Care Home funding, as far as it concerns the lives of M.P.A. people, is that it provides no inspiration. Under this program a person would have to be crazy to work. As well the penalty of having the larger part of any money earned returned to the Department will force people to try living on their own long before they really feel ready.

A further problem and one which M.P.A. people were quick to notice is the enormous administrative costs of application, reports and the necessary checking to see that rules and regulations are being followed.

The marginally operating person and those people with problems in living cannot be helped in the community unless there is safe and supportive help for them. Part of that type of housing is being supplied by M.P.A. at an approximate cost per year of $100,000. The supportive programs and Drop-In Centre will cost a further $100,000. This is a bare bones budget which depends on salaries remaining at $610 per month for each coordinator. Our reputation for accountability has never been in question. We have submitted to federal, provincial and civic audits.

Our request to the Provincial Government Departments of Health and Human Resources is that they get together a cost-sharing agreement that would provide a basic budget for M.P.A. as already submitted to both departments. M.P.A. is providing a much needed service to a group of people who have been neglected, abused and forgotten for long enough.

- Frances Phillips

PASS THE BUCK, PLEASE

THE SCIENTIFIC METHOD FOR FINDING FUNDING FOR AN ORGANIZATION SUCH AS M.P.A. BY AUGUST AT THE LATEST.

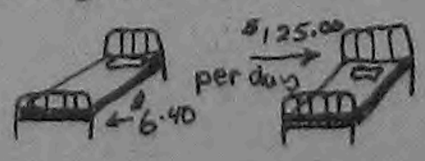
PROBLEM: As above.

APPARATUS: A non-profit society. Affirmative motions from General, Business, Residence Council, Drop-In, Office and Special Funding meetings.

MATERIALS: 2 or 3 telephones, at least one with a direct line to Victoria. Pens and a lot of paper. A calculator with new batteries. 1 overworked secretary complete with typewriter. 2 or 3 enthusiastic office coordinators with no objection to working 20 hours a day.

METHOD: a) Start with obvious funding sources such as the Pope, J. Paul Getty, Howard Hughes' aunt, Margaret Trudeau, Lord Thomson of Fleet. When impassioned pleas go unanswered, send night letters. When night letters are ignored, try telephone calls. When all possible approaches are spurned turn to less obvious sources.

b) Send lengthy funding proposal to national Department of Health and Welfare. When refused, send funding proposal to provincial departments directly concerned with funding of vitally needed community support and housing services for the exmentally ill, such as the Department of Health (Mental Health Branch or its equivalent); Department of Housing, Department of Human Resources. Wait for refusals from Ministers concerned (usually two weeks), or acknowledgment that the proposal has been handed down to lesser mortals within the departments, (usually three weeks, then silence). Follow up with phone calls to Ministers, Deputy Ministers, Associate Deputy Ministers, Executive Assistants, Secretaries, and Janitors. Ministers will in all cases be unavailable until after the spring session (July?). Deputies and Associates will be out-of-town-till-next-week (usually in Terrace, Cranbrook, Cassiar or Fort Nelson. Try to cultivate Associate Ministers' secretaries by sending them singing telegrams of the M.P.A. anthem. Send flowers each time they promise to arrange appointments. When no further reply has been received for two weeks try again, explaining that MPA houses accommodate ex-patients at $6.40 per day whereas psychiatric hospital beds cost up to $125 per day. Show possible saving of $118.60 per day in bold type, and include invitations to free Wednesday night dinner at the Drop-In Centre for any politician or senior civil servant who can be persuaded to visit the wilds of Vancouver when returning to Victoria from regular official business in major centres like Fort Nelson. This routine should occupy April and May. If none of the above procedures produces positive responses try c)

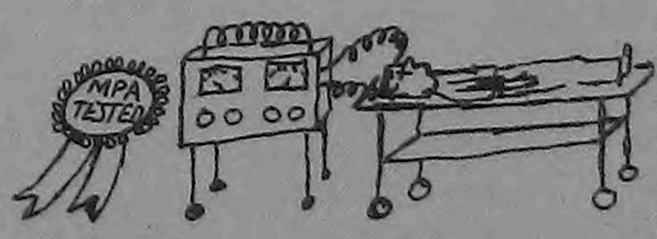


c) Prepare Personalized Partial Funding proposals for small investors, minor philanthropists, local head offices of Foundations, and Significant Others. Partial Funding Proposals should be geared realistically to what-the-traffic-will-bear. Using the calculator, with new batteries, determine a reasonable percentage of the Drop-In Centre or Residence Program budgets and submit to largest funding body available, e.g. City Hall.

Do not exceed $20,000 - $30,000. Beyond this amount smaller funding bodies seem to suspect that proposals are padded. The advantage of pursuing this type of funding from local agencies is that communication by normal means, i.e. mail, telephone, personal visit, is usually possible.

When enough partial proposals are in circulation to ensure that the total budget (could) be met, turn attention to MPA's bookeeper and secretary who may by this time be exhibiting symptoms of severe anxiety and/or depression directly related to situational causes such as the prospect of preparing monthly reports for up to 20 funding bodies. Pay particular attention to funding-paranoia on the part of the membership, which can be expected to mount as the August deadline nears. Understandable fears should be allayed by lengthy discussion and close examination of correspondence and long-distance telephone bills, at all General and Business meetings. Unreasonable fears should be referred to community care teams.

d) When all international, federal, provincial, and local funding sources have been exhausted, with negative results, turn to Unusual or Radical methods of funding. These methods should involve the entire membership including those presently freaked-out who may have the best Unusual solutions. Suggestions to date include:



i. Selling of MPA Seal of Approval: $1,000 annually to institutions; $100 to individual psychiatrists; $50 to other mental health personnel and probation service personnel. A suggestion that the MPA Seal of Approval be sold to drug companies was rejected.

ii. M.P.A. Province-Wide lottery: $1 per ticket. Draw to be scheduled for July 31st, 1976.
1st prize: 1 month vacation for two in beautiful Health Sciences Hospital, including group therapy and sauna.
2nd prize: 5 days for two in Vancouver General Hospital Psychiatric Assessment Unit. Room service. Colour t.v.
3rd prize: An exciting weekend for two in St. Pauls Emergency. Neighbouring trolleys with clean sheets. Screens for privacy. Ipecac on request.

iii. Not actually a money-making proposition, iii. - concerns mass application for voluntary hospital admission of all MPA employees, house residents, and Drop-In Centre habitues, to publicize the possible result of an inability to fund MPA. Use will be made of the Mental Health Act, Section 11, Right of Treatment. Those

who are not genuinely freaked-out or noticeably anxious will be requested to act as crazy as possible. Discontinuation of medication is advised at least two weeks in advance of requested hospital admission. Those not on medication should try haloperidol or chlorpromazine at least 2 hours prior to admission to simulate mental illness.

OBSERVATIONS: A rise in hospital re-admission rates of MPA office staff from stress-related causes may be observed by June. This can be expected to alter upwards the usual city-wide hospital re-admission rate of 60%. A parallel rise in local unemployment rates, and social assistance and UIC applications will be observed subsequent to August 1st.
Other observations may be referred to the Research Department, while it lasts.

CONCLUSIONS: a) The only sensible conclusion to which we can come is that the provincial departments of Health and Human Resources should be gratified to share the obligation of funding an acutely needed support service like MPA, at a time when more and more mental patients are being discharged into the community MPA supplies the major share of Vancouver's supportive alternate housing for ex-patients and the largest activity - pre-employment - counselling - advocacy-service for ex-patients in Canada.

b) If all else fails, fire the office coordinators and begin again at GO. If $200 can be collected, divulge the funding source. Play money not acceptable.

A large linocut, 30" x 24", done in 1975 by the artist. (An example of more conventional work)

USEFUL

Functional-Mobile
Wood Sculpture No.

001~2~74

Function: stool and chair
Mobile Function: Changeover, stool to chair, chair to stool, changeover time 3 seconds.
Number of Moving Parts: 3
2 wood constructs; 1 steel rod.
Possible Future Development:
The artist plans to develop this sculpture design as a studio stool-chair with its present height of 27 inches, and with the addition of cushions. Also a 23 inch stool-chair-high-chair is planned for household use. Since commonly used kitchen stools are 23 inches high, and children's high chairs are also 23 inches high, this is a natural development for this design concept. The high-chair top structure will, of course, be removeable for separate storage. The stool-chair-high-chair, if built, will be an example of 3 function design.

Functional-Mobile
Wood Sculpture No.

002~74

Function: lounge reading chair
Mobile Function: Body support construct reclines
Number of moving parts: 4
2 wood constructs
2 metal circle washers
Possible Future Development:
The crescent structure of the body support section of this sculpture permits experiment with any "contour" of body support panelling.

For this first generation model a body support contour with a superior head rest was devised which supports the head in the ideal position for reading, even when this "chair" is in its furthest back-tilt position. The arms do not tilt and may thus be used for coffee-mug and ash-tray rests. The circular indentations used for mug rests are intended to compliment aesthetically the functional wood pivot-circles which are visible on the sides of this sculpture. This design concept can be used to make a chair which will "balance-tilt" recline all the way to a body horizontal position. Such a tilting to horizontal chair might be useful in airports for in-clothes sleeping between flights.

Functional-Mobile
Wood Sculpture No.

003~76

Function: lounge chair
Mobile Function: folds to 6" width. Time to fold or open 3 seconds. Sculpture is free standing in folded position. Number of moving parts: 4.
1 canvas cover with cushion attached. 1 catchbar, 2 wood constructs, (one of the wood constructs has a steel pivot rod rigidly attached.)
Possible Future Development:
The artist believes this wood sculpture is the most exciting in the double zero series. It was cut entirely from one sheet of 3/4" - 4 x 8 foot plywood with the grain aligned as desired. There are no non-plywood wood parts and 3/4 " ply is the only thickness used.

The strength of the structure was tested by having a 255 lb. man sit in it. He was then given a 50 lb. bag of moulding plaster to hold in his lap. The laminated plywood did not pop or crack when this test was made.

This sculpture can be used as a lounge chair which can be folded and stood flush against a wall to make more space for dancing in a living-room area, or folded and moved in the trunk of a large car.

ART

THE DOUBLE ZERO FUNCTIONAL MOBILE WOOD SCULPTURE SERIES

General information:

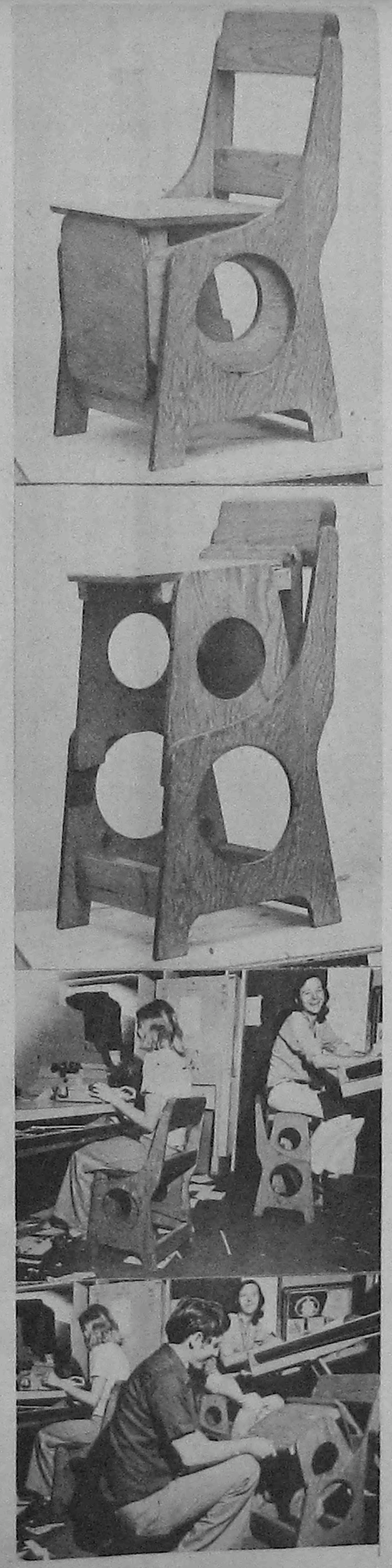
Wood sculptures in this series are intended, by the artist, to have the following three characteristics: aesthetic beauty, useful function, and a mobile part or parts, contributing to both beauty and function.

There is also a fourth intended characteristic which is less easy to define. The double zero series is intended to include only original artwork of a generative nature. By this is meant that the functional design characteristic of the series should be original and have the potential of giving rise to further derivative useful designs. This generative potential will be discussed concerning each wood sculpture separately.

The number notation of these wood sculptures is an attempt at a system to indicate design development. I am numbering the wood sculptures in order of their completion after the digits 00. Thus the first sculpture completed is 001, the second sculpture completed 002, etc. The two 0 places will be used to indicate the number of design changes in future designs developed from the original. Thus generative design 002 with two changes would be design development 202.

The completion number is followed by a dash and a function number (for multifunctional designs only), thus sculpture 001 which serves two functions is numbered 001-2. A final dash is followed always by the two digits of the year the sculpture or design development was completed. In this way the full number of the first wood sculpture is 001-2-74.

You can derive similar information about each of the other wood sculptures from its number.



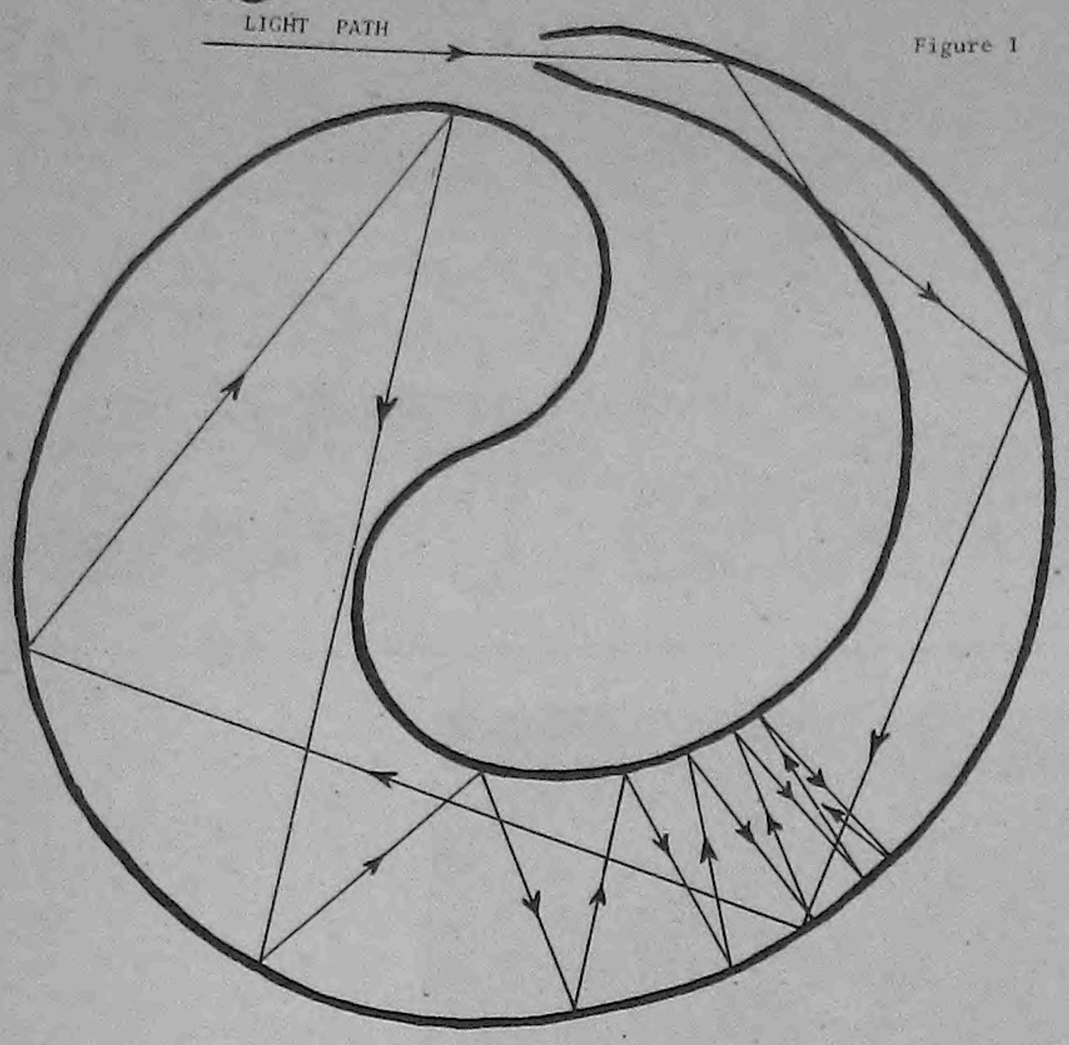


Figure 1

Cross Section Diagram of RC Radiation Trap

The device is a tapered tube, open at the small end and closed at the large end, with a smooth mirror surface on the inside. The tube is bent in an almost complete circle. Thus the cross section forms a bent wedge which reflects crisscrossing radiation (light) towards the closed large end. The bend ensures that crisscrossing will occur.

For heat collection the closed end of the tube need not be a reflective surface, but all the inside tapering surface of the radiation trap should be as reflective as possible.

The steeper tapering at the extreme small end is to make absolutely sure that light cannot be reflected out. It may not be neccessary in actual use.

On the other hand if this length of bent wedge is not long enough to be completely effective as a radiation trap it may be extended into a helical shape with an overall "conch shell" pattern.

RADIATION TRAP

A DEVICE FOR TRAPPING ALL THE HEAT ENERGY OF VISIBLE LIGHT?

In 1963 the author was interested in designing a "box" which would "trap" by reflection all light which entered it. It would be possible for light to shine into such a "box". Once in the "box", however, light would be reflected in a criss-cross manner only. Because of the basic law of angular reflection (as per high school physics) light could never be reflected back out of the "box".

The solution to this design problem occurred to me while I was riding in a streetcar in Toronto in 1963 See diagram 1 for design and explanation.

The name for this device would naturally be "reflective radiation trap" or more colloquially "light bottle". I have looked in encyclopedias for entries for this device under any name I could think of and have been unable to find it. Also I have discussed it with several people who have taken university physics. None of them had ever seen the design before. Also there seems to be no doubt that the reflective "trapping" of radiation would occur with the design as described.

On this basis there is a possibility that the design is original with me. If so I can name it and I would like to call it the R C Radiation Trap. Why? What does R C stand for?
Well it can stand for:
1) reflective criss-cross radiation trap
2) regular cut ying-yang radiation trap
3) Royal Canadian radiation trap
4) reverse cornucopia radiation trap

You can pick the one you like best. Now for some speculative discussion. This device was first discussed seriously with an honours physics student. The author was mostly interested in the function of increasing radiation density. The student pointed out that radiation density would not increase by a very large multiple inside a light bottle because all mirrors are imperfect and the best mirrors reflect something like 99% of the light shining on them - the 1% being absorbed by the mirror surface. Thus he explained that light would merely reflect until the inefficiency of the mirror allowed it to become absorbed in the mirror walls. He presumed that the energy of the light would then probably escape in the form of heat.

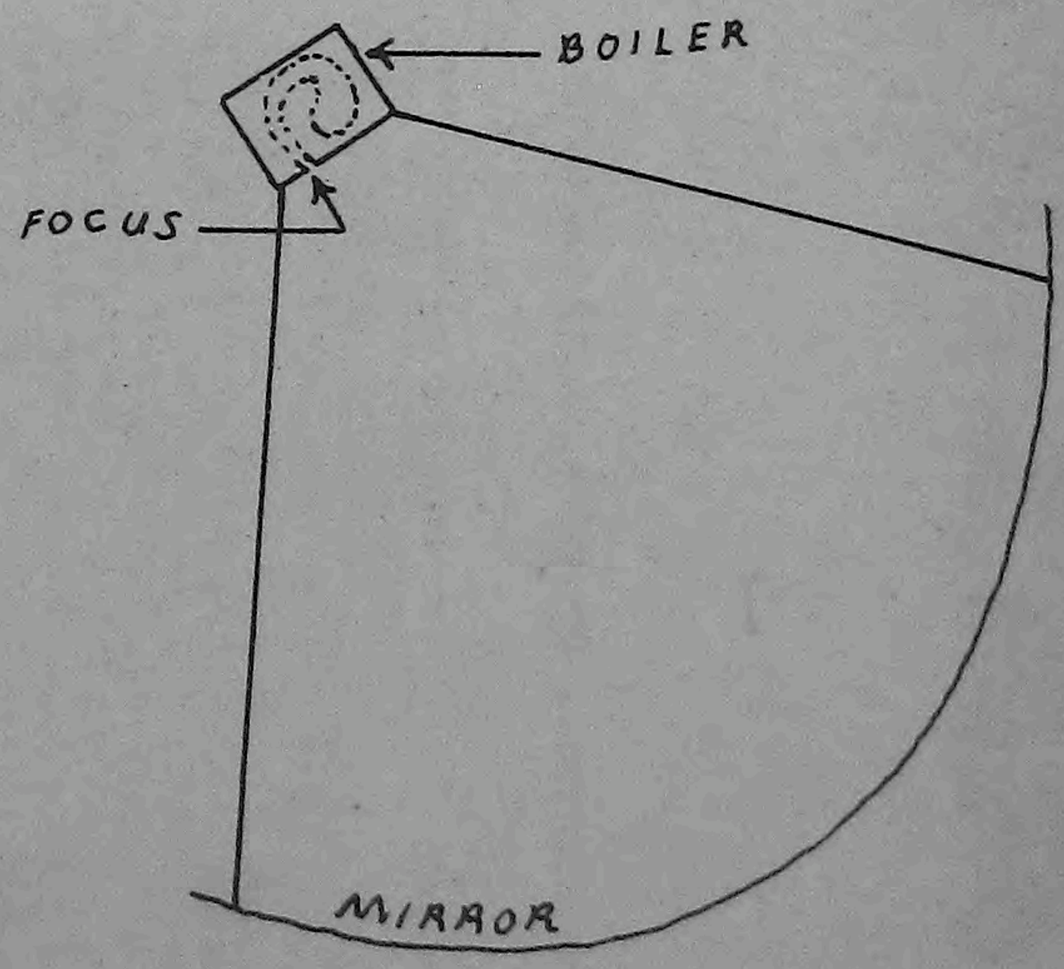
I agree with the above reasoning and I hope it is correct. If it is correct the R C radiation trap can function as a transducer, converting visible light into heat. Heat can always be used to make steam for mechanical energy.

Anyway the guesswork I would like to propose as the main point of this article is simply the following statement: the R C radiation trap may be an efficient collector for heat energy from solar radiation.

I will advance three reasons why the "light bottle" might be valuable for solar heat power plants.
1) It is a device from which heat is radiated from the Interior. This means that it can be surrounded by a boiler containing water or other heat collecting liquid, so that all the heat must radiate Out through the liquid. This should give an increase in efficiency as compared to direct forms of sunlight on the outside of a boiler where some light is reflected rather than absorbed and the outer skin rather than the inner centre of the boiler is heated.
2) Black is the colour that absorbs radiation but any black object will reflect some light. This reflection is a loss of heat energy in the light and since hot objects turn "bright" rather than remaining black this loss would tend to occur in direct radiation heated systems. The efficiency of focusing light into an R C radiation trap (and collecting the heat on the way out) should be much greater than that of focusing directly on an absorbing "black" boiler.
3) The transformation of at least some percentage of other types of radiation into heat in the R C radiation trap (it could have many different reflective layers like an onion) should make the R C radiation trap more efficient than other radiation heat energy collectors.

Anyway, if no-one else will build one, and I live long enough and have the facilities, I will some day. The opening in a light bottle, constituting as it does a "one-way radiation portal" should be "perfectly black". Perhaps a small light bottle would make an interesting art object. A large one might give rise to a shadow free omni-directional light environment inside. I wouldn't want to go into it if the opening were facing direct Saharan sunlight however.

Figure 2

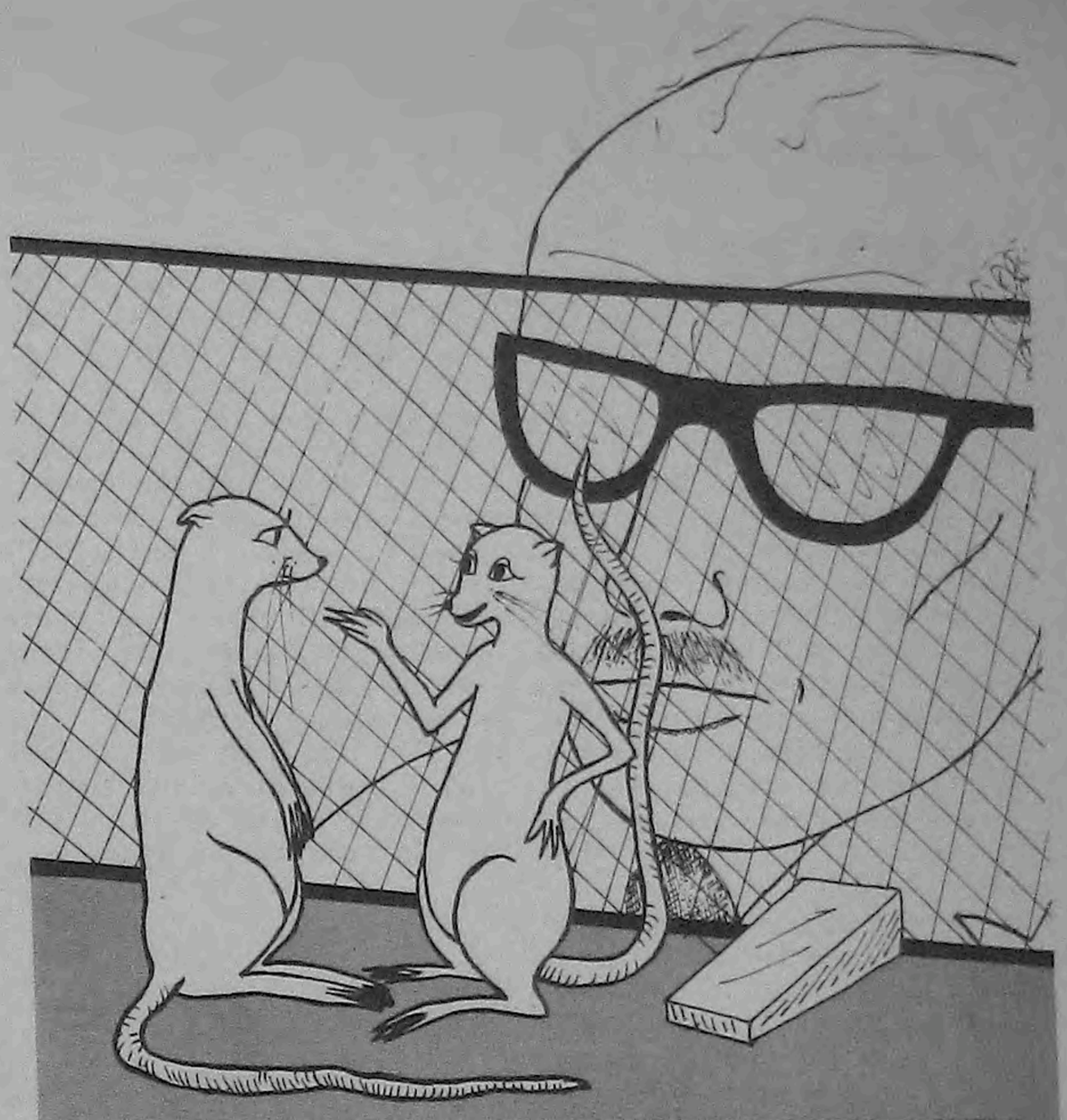


SOLAR STEAM PRODUCTION UNIT?

Radiation trap is shown inside the small boiler mounted at focal point of large parabolic mirror pointed at the sun. A converging lens could be used to direct light into the trap.

Question : Could a suitable number of such units, linked both for alignment and steam production, and built to optimum scale, constitute a viable "hot desert" solar-electric power plant?

MPA AT BANFF 8



Have I ever got this guy conditioned! Every time I press the lever he gives me a piece of cheese.

"People are more likely to make lasting changes to the extent that they see themselves as the agents of change". This was the wrap-up statement by Richard Stuart at the conclusion of the 8th Banff Conference on Behaviour Modification, March 21st - 25th (and is what we have been saying for 5 years that self-help works).

M.P.A. and the Women's Health Collective were both represented at the conference - the first time that "self-help" groups have been invited to make presentations at this prestigious international meeting of leading professionals, covering behaviour modification methods of dealing with such problems as obesity, alcoholism, smoking, anxiety, etc.

Behaviour modification, for those who haven't been exposed to it, includes such methods as sensory deprivation, i.e. Patty Hearst 's brain-washing while imprisoned in a closet; aversion therapy, which would be exemplified by an alcoholic receiving an electric shock whenever he lifts a drink; TM methods of reducing anxiety and promoting relaxation; biofeedback as a self-monitoring system, and so on.

In its simplest form behaviour mod slaps you when you're naughty and rewards you when you're good to the end that you'll be "good" all the time. Whether you do this to yourself or someone else does it to you is a matter of circumstance: the mother toilet training an infant; the nurse giving out tokens on a behaviour mod ward; the individual trying to quit smoking, or cure himself of agoraphobia. Only the techniques of bringing about behaviour change differ.

M.P.A.'s presentation at the conference was a well-received 45 minute video-tape of M.P.A. members explaining how our brand of participatory democracy and self-help works to assist ex-mental patients in becoming responsible for their own lives by making positive changes in the way they relate to others and positive decisions concerning themselves.

Probably the most valuable part of the conference for M.P.A. was the opportunity to meet a variety of mental health professionals from all over the U.S. and Canada and to tell them about our organization, our houses, and our influence in the community in upholding the rights of mental patients. Fran made an impact that many psychologists and psychiatrists won't soon forget.

M.P.A.'s video-tape told our story of group and environmental support in achieving self-help, but somehow, despite the amazingly clear air of Banff, the self-management / self- help issue became befogged in professionalese. Only through considerable intellectual effort were we able to sift through the behaviour mod jargon - paradigms, parameters, desensitization, coping skills, hierarchy construction, precurrent acting stimuli, covert operants as opposed to cognition, deviant-controlling systems, probablistic models, modifying sets, concentral validation, core-cognitive or affective processes, ideation, self-actualization, antecedent situations, and, would you believe, social epidemiology and environmental re-engineering - to figure out just what the speakers were talking about.

Once we established that they were, generally speaking, talking about behaviour, Fran was able to make the point that self-control/ self-management as perceived by behaviour modification proponents is a far cry from self-help, which means GROUP support - like A.A., or MPA- and not isolated individual iniative in surmounting behaviour problems. Having established that premise, she went on to even greater triumphs - skiing the Banff Springs Hotel golf course at her first try on cross-country skis.

Many people, by the way, expressed interest in obtaining our video-tape and in learning more about M.P.A and particularly our resident-run housing program, which is apparently unique on this continent because of our philosophy of power reversal in which the M.P.A. "staff" are wholly accountable to, and take direction from, the residents for whom they work. We have had the video-tape copied and it will now be available for rent to interested groups or individuals.

The conference location at the Banff Centre is designed to accommodate ardent ski buffs, who spent every free moment taking advantage of the spectacular scenery and the ski slopes. Daily buses ran to Sunshine Village near Banff where ski rentals were reasonable, blizzard conditions just right for the adventurous, ski runs in beautiful shape for both downhill and cross-country skiing, and the Lodge available for those who just wanted to listen to music, talk to friends and drink a lot of hot cider, or whatever.

After a few drinks at the heady altitude of Sunshine Village (7500' and up), one was able to imitate the peculiar gait used by downhill skiiers when out of their natural element - a slow motion glide necessitated by their ten pound solid plastic ski boots.

Reta McKay, the Women's Health Collective presenter, who works at the Strathcona Community Care Team, was a great companion on the ski slopes and at Banff Centre where conventioneers shared excellent food, rooms, booze and ski stories.

We may never be invited back, judging from the varied reactions to Reta's tape (a 15 minute documentary of a diaphragm fitting) and our tape, with Lloyd Howarth's amazing cure of a man with 55 personalities who recovered to the point that he was able TO EMPTY AN ASHTRAY but we left the conference with the distinct feeling that Banff 8 would never forget us.

Jackie.

WOMEN AND MENTAL HEALTH

The main treatments available in psychiatric facilities are psychiatric drugs which cause mood alterations and electroconvulsive therapy which causes memory loss and a temporary lifting of depression. These facts indicate that women's behavior is manipulated in isolation from the social context in which they find themselves.

Psychiatrists could serve women better by making them aware of social conditions instead of merely adjusting their behavior to function within prescribed roles.

Male psychiatrists by far outnumber female ones in BC. If a woman breaks down, most likely she will discuss her problems with a male psychiatrist.

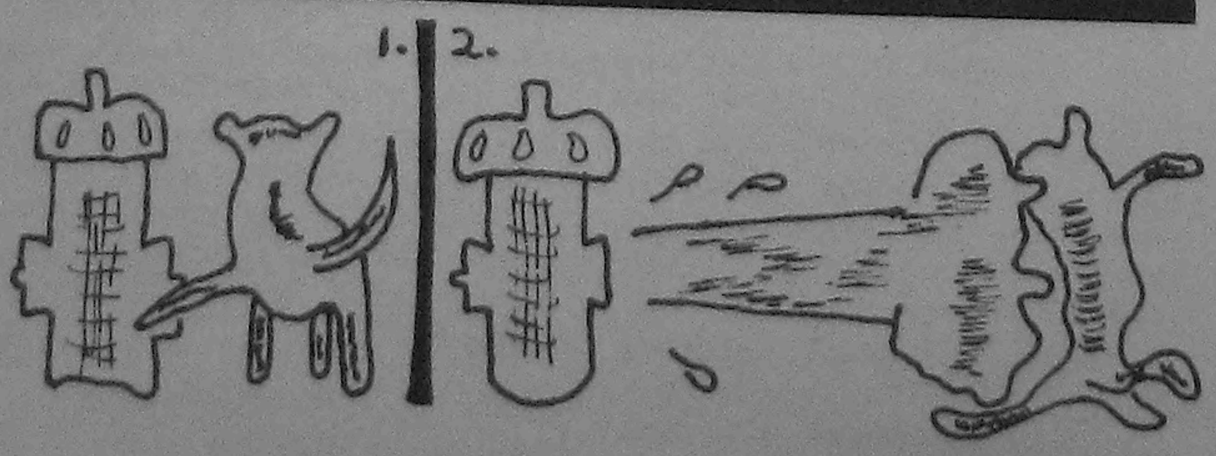
Statistics gathered by the Committee to Investigate Shock Treatment consistently indicate that more women receive this form of treatment than men. In fact, it is a standard treatment for women who experience severe depression during menopause.

Single mothers face a stressful situation in raising their children alone. This is amplified by the fear that if a mother breaks down she may lose her children and then have to prove herself worthy to get them back.

The following recommendations are made:

1. That homemakers be made available to women who need a break from their families in order to prevent a breakdown, and to women who are undergoing a breakdown without the woman's ability as a mother being called into question.
2. That forced treatment wit drugs and shock treatment be discontinued in BC psychiatric facilities.
3. That women not be discriminated against in custody hearings on the basis of previous psychiatric treatment or sexual orientation.
4. That an interdisciplinary committee be formed by the Depts. of Health & Human Resources to investigate the safety and effectiveness of electroconvulsive treatment.
5. That the provincial Dept. of Human Resources assume financial responsibility for and reallocate funds to VEEC.
6. That treatment facilities be established in each community for women in need of support and-or treatment, based on the established viable model of the Vancouver Emotional Emergency Centre, which provided a safe, comfortable, drug-free residential facility where women's problems were listen-ed to by non-sexist paraprofessional workers.
7. That funds be reallocated to Transition House for women and their children who are in need of a temporary residential facility.
8. That informed consent forms must be signed before any and each type of treatment is administered in a psychiatric facility, informing women of the full range of possible side effects.
9. That before a woman is admitted to a psychiatric facility, close scrutiny be given to why she is being admitted and by whom, and that alternatives to hospitalization be discussed (eg., women's groups, psychotherapy with non-sexist therapists.
10. That female psychiatrists or para-professional workers be available to women who are being admitted to psychiatric facilities.
11. That all psychiatrists be required to take a course in sex-role stereotyping.

Cathy Kidd



ARBUTUS WORK INCENTIVE SOCIETY

In the fall of 1975 people working in the community mental health field approached MPA about starting a workshop for physically and emotionally handicapped persons. As it happened, MPA had been throwing around the idea of a sheltered workshop for some time so we were certainly ready when approached. We met with all the interested people and discussed what we thought a workshop should be. Ideas for work evolved such as: jiffy print, woodworking, building assistive devices for the physically handicapped, building boats, and assembling picture frames. We have recently received a proposal for candle-making. We all agreed that the workshop could serve the needs of handicapped people in a way not being adequately fulfilled at present by other services. We also all agreed that there is a huge gap in long-term, ongoing vocationally rehabilitative services. The people we saw as being served would be both long-term or permanent placements and shorter work-training placements, depending on the needs of the person involved.

From the beginning we envisioned the workshop would be one where community participation would be high especially the handicapped community. We thought of the workshop being in Kitsilano and serving the physically, emotionally and mentally handicapped.

From these beginnings we expanded the original concept of a Kitsilano Workshop into a broader-based concept of a Work Incentive Society. As a result we became incorporated as the "Arbutus Work Incentive Society". The following are the objectives of the Society:

To establish and operate rehabilitation workshops and vocationally-focussed activity centres.

To develop, initiate and foster employment opportunities for the emotionally and physically disabled.

To educate the general public re the occupational and vocational needs of physically and emotionally disabled persons.

To maintain, through provision of opportunity for work with dignity, the self-respect of emotionally and physically disabled persons.

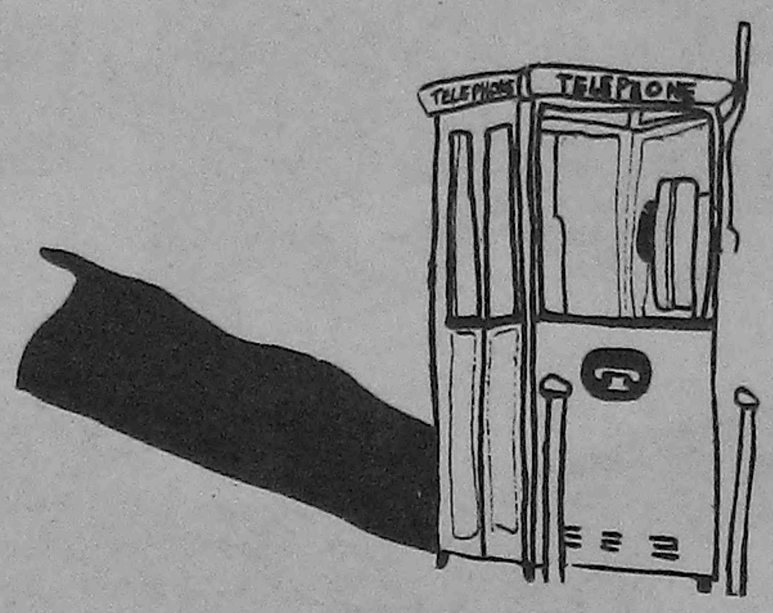
To facilitate, through the provision of employment opportunities, the integration and acceptance of the emotionally and physically disabled as members of the community.

To ensure that the rights of the emotionally and physically disabled are upheld in all vocational and occupational circumstances, and in particular that those served by the Society participate in the direction of its affairs.

To encourage and support other groups, agencies and Societies interested in pursuing the above or similar objects.

What have we done to make the Society's objectives a reality?

1) We submitted a proposal for a Kits Workshop to the now defunct Kits Community Resources Board who responded with great enthusiasm.
2) We conferred with L. Propas of the Howe St. Canada Manpower office. We obtained the promise of a staff person one day a week supplied by the Orenda Manpower Outreach office.
3) We met with Mr. Cornish, Canada Manpower Industrial Training Program Consultant.
4) We submitted a proposal to the Vancouver Foundation for funds, and were rejected.
5) We submitted a proposal to the Vancouver Resources Board for two salaries and got approval in principle.
6) To raise funds we will be selling chocolates, and would like volunteers.
7) We will be holding a car wash (tentative date May 8), and expect volunteers.
8) We have picked a space for the Workshop and now need money for rent.
9) M.P.A. has loaned the Society $100 to help meet the rent.
10) Orenda has given the Society $125 to help meet the rent.
11) Two community agencies have each donated part-time staff to the Society.



MPA Drop In Centre	2146 Yew St.	738-5177
		738-1422
Riverview Office	Local 538	521-1911

MPA Residences

2021 E. 8 Ave.	255-5312
1754 W. 11 Ave.	732-8222
1656 E. 4 Ave.	253-6996
2805 W. 7 Ave.	733-5733
2756 W. 10 Ave.	738-5177

Legal Help

Legal Aid Society	687-1831
Legal Assistance Society	872-0271

Drop In Centres

Coast Foundation	876 E. 18 Ave.	879-2363
MPA	2146 Yew St.	738-5177
Vancouver Activity Centre (CMHA)	2207 W. Broadway	732-5022

CHEAP PLACES TO STAY

JERICHO YOUTH HOSTEL ($10 MEMBERSHIP / $2 PER NIGHT / 4 NIGHT STAY)
FT. DISCOVERY &N.W. MARINE 224-3208

YWCA	580 BURRARD $9.00	683-0281
YMCA	955 BURRARD $8.00	681-0221

PLACES TO EAT CHEAP, GOOD FOOD NR. MPA

GLADYS SNACK BAR 4 AVE NR. YEW
MINNIE VERNS 10 AVE. NR. YEW
(6 AM - 3 PM)
RICE BOWL, CHINEESE FOOD
BROADWAY & MAIN

HOSTEL BEDS (FREE)

CATHOLIC CHARITIES	150 ROBSON	683-0281
LOOKOUT	90 ALEXANDER	687-9126
CENTRAL CITY MISSION	233 ABBOTT	681-3348
VRB NIGHT LINE (IF HOSTELS FULL)		733-8111
CRISIS CENTRE	1946 W. BROADWAY (CRISIS ONLY)	733-4111
ST. FRANCIS HOTEL (WOMEN) CORDOVA & SEYMOUR.	DAYS:	681-1920
	NIGHTS:	733-8111
CATHERINE BOOTH HOME (WOMEN) 1190 WOLFE		731-7320
CITY CENTRE YOUTH RESOURCES 52 WATER		688-2565
TRIBAL VILLAGE (TEENAGERS)		874-9009

PLACES TO EAT FREE

HARBOR LIGHTS (SALVATION ARMY)
119 E. CORDOVA 11:30 AM/ 8 PM
DOWNTOWM COMUNITY HEALTH SOCIETY
373 E. CORDOVA / SOUP AT NOON
MPA 2146 YEW ST. WED: DINNER
SAT: BREAKFAST
KITS HOUSE THUR: DINNER

FREE MEDICAL

PINE STREET CLINIC	1985 W. 4	736-2391
V.D. CLINIC (VGH)	828 W. 10	874-2331
REACH	1144 COMMERCIAL	254-1354
VANCOUVER WOMENS HEALTH COLLECTIVE	1520 W. 6	736-6696
DOWNTOWN COMMUNITY HEALTH SOCIETY	373 E. CORDOVA	685-2744

EMERGENCY

VANCCOUVER CITY ONLY	911
FIRE & INHALATOR	34-1234
POLICE/ POLICE AMBULANCE	665-2211
AMBULANCE	872-5151

HOSPITALS

VANCOUVER GENERAL	876-3211
ST. PAULS	682-2344
HEALTH SCIENCES UBC	228-2344
RIVERVIEW	521-1911
LIONS GATE	988-3131
BURNABY MENTAL HEALTH CENTRE	434-4247

CRISIS LINES

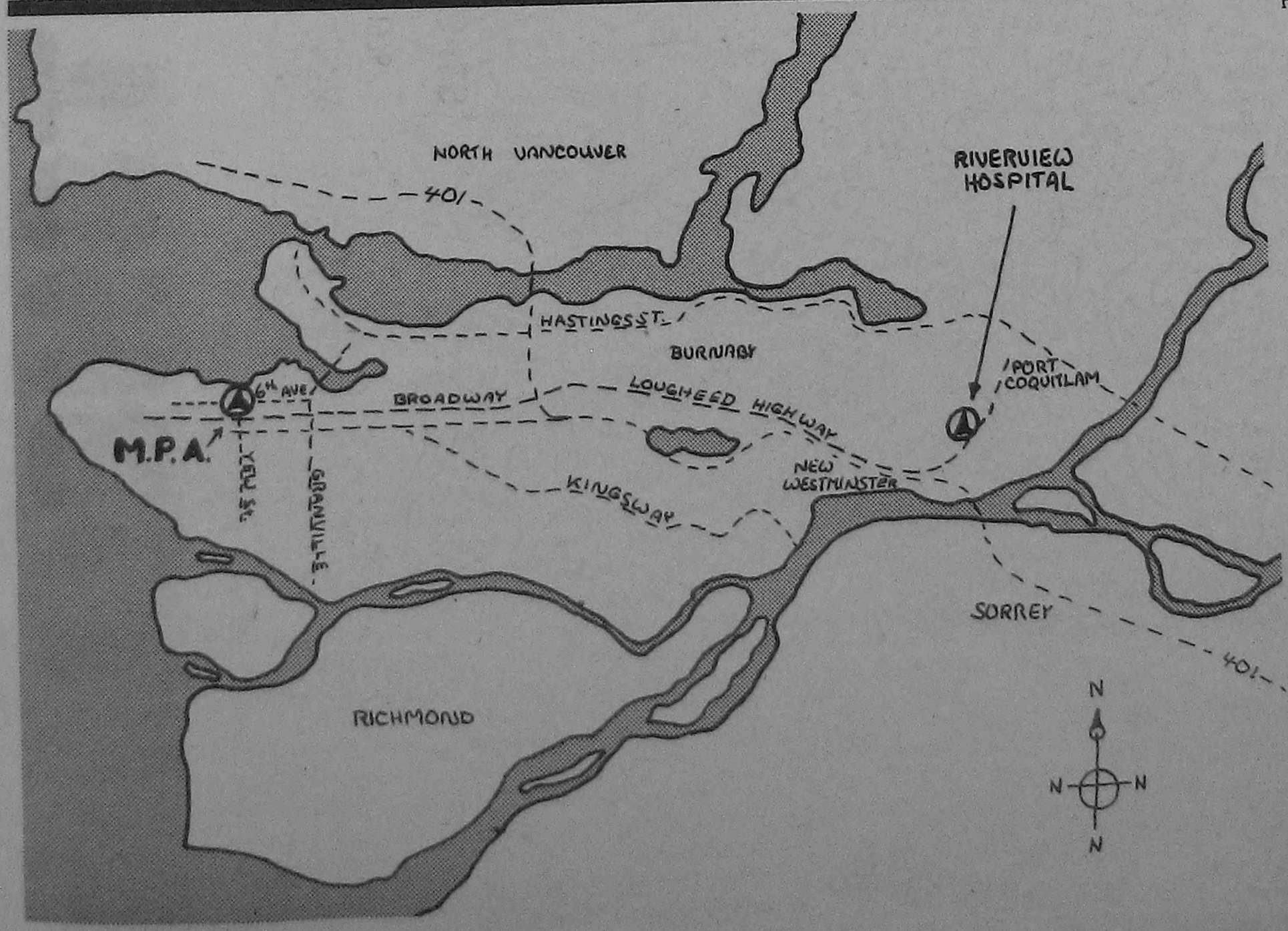
CRISIS CENTRE	733-4111
NOW (YOUTH LINE)	733-4115
CHIMO (RICHMOND)	273-8701
LIFELINE (COQUITLAM)	526-4444
MPA	738-5177

FREE DENTAL

VANCOUVER GENERAL HOSPITAL 9-12 WEEKDAYS	876-3211
EMERGENCY DENTAL 6PM- MIDNIGHT	874-9848
REACH 144 COMERCIAL	254-1354

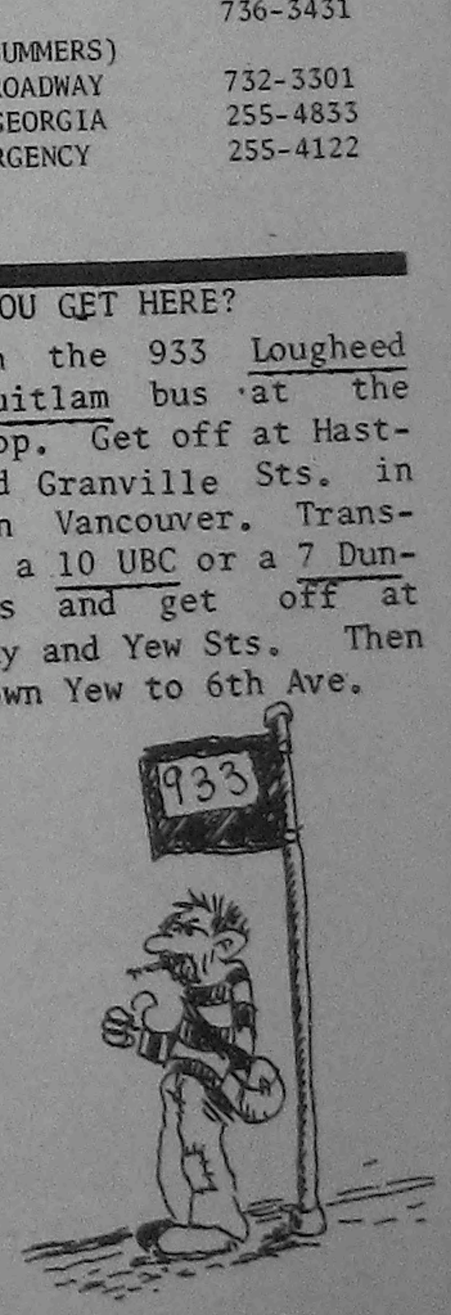
OTHER USEFUL SERVICES

KITS INFORMATION CENTRE 2741 W. 4 AVE.	736-3431
THE HOUSE (SOFT DRUG BUMMERS)	
2ND FLOOR 820 W. BROADWAY	732-3301
CONNECTION 1348 E. GEORGIA	255-4833
24 HR. EMERGENCY	255-4122



HOW DO YOU GET HERE?

Catch the 933 Lougheed Pt. Coquitlam bus at the Tuck Shop. Get off at Hastings and Granville Sts. in downtown Vancouver. Transfer to a 10 UBC or a 7 Dunbar bus and get off at Broadway and Yew Sts. Then walk down Yew to 6th Ave.



HOW MUCH DOES IT COST?

Buy a 50¢ bus pass on Sunday and you can travel on it all day. At other times fare is 25¢ from 10-3 every day and after 7 every night. It's 40¢ other times.