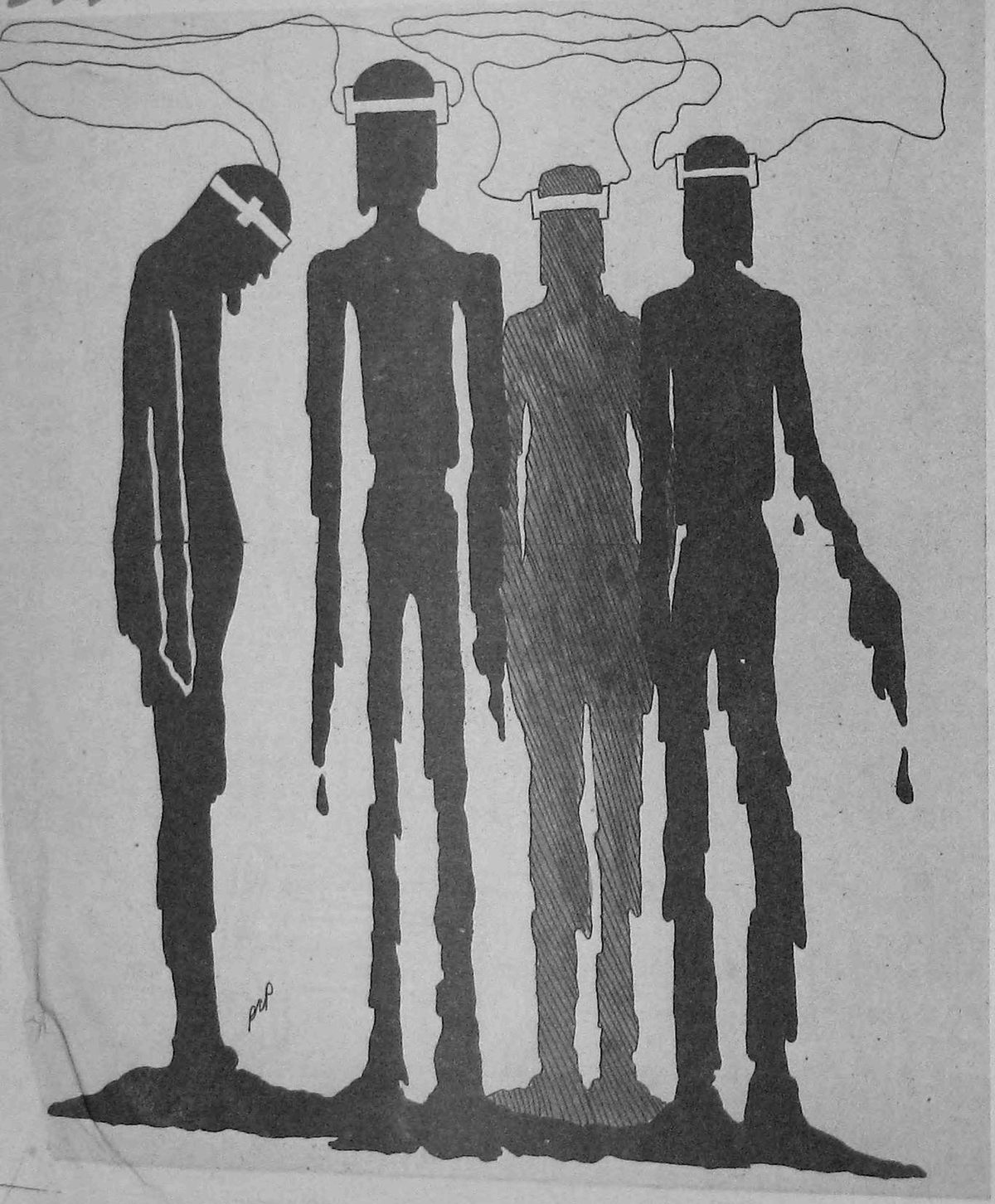
SHOCK



in a nutshell

MENTAL PATIENTS ASSOCIATION NEWSLETTER
VOL. 4, NO. 1. FEB. 1976
special springtime and shock issue

in a nutshell

MENTAL PATIENTS ASSOCIATION NEWSLETTER FEBRUARY 1976

E.C.T.: is it Effective and Safe?

One of the priorities of the MPA Committee to Investigate Shock Treatment has been to gather research information of scientific validity on shock treatment. The two issues which we are primarily investigating in this particular report are: 1) the alleged effectiveness of shock treatment, and 2) the alleged safeness of shock treatment.

1) The alleged effectiveness of shock treatment.

In psychology and psychiatry there is a simple procedure for demonstrating that a treatment is effective: it is called the controlled, double-blind study. Such a study requires that a group of persons of a similar diagnosis be divided into two groups. One group receives the treatment being investigated while the other group receives a simulated treatment. The term "blind" refers to the fact that the person evaluating the research must not know which individuals have received the treatment being investigated and which the simulated treatment.

In order to prove with scientific authority that shock treatment is an effective treatment it is necessary to conduct such a controlled double-blind study which could control all possible extraneous factors which could influence any change in behaviour. Every time a person receives shock treatment there are many factors which could influence behavioural change other than the ECT. The fear of the treatment, for example, could easily persuade an ECT' recipient to modify his behaviour in order to avoid the pain and terror and be released from the hospital.

A second factor which could account for any changes in behaviour is known in scientific terminology as the placebo-effect. Here, the individual reasons that since the doctor or relative recommended the treatment, and has faith in the treatment, the person convinces himself that yes, indeed, he does feel better. The possible relevance of the placebo-effect is shown by the recent failure of a shock machine in London which was used for two years with no actual electricity flowing from the machine.

Treatments went on with no-one, either patients or doctors, noticing that the machine wasn't working.

A third factor is the amnesia induced by ECT. If the shock treatment erases the memories which make the person feel unhappy or ill, then it could be the amnesia which is affecting the behavioural change. Memory loss or amnesia can be induced in ways other than through ECT and could be the crucial variable which affects a behavioural change.

The MPA committee has so far been unable to find controlled studies to separate out these various factors. Dr. John Friedberg in a paper titled Electro-Convulsive Therapy dated March 20, 1975 states that it is probably impossible for a controlled double-blind study to be done on ECT "since the damaging effects of ECT are so striking that there is no way the evaluators could not know which patients had received ECT."

A frequently heard argument concerning the effectiveness of ECT is that it prevents suicide in cases of severe depression. We have been unable to find any sta-

tistics to prove this claim. In fact, numerous people within MPA have told us that they feel that the opposite is the case. That some persons who have experienced ECT were so terrified of having further treatments, that when they became ill again they committed suicide rather than return to an institution where they could be forced to undergo more shock treatments.

In view of the fact that the MPA Committee to Investigate Shock Treatment has failed to produce even one study which scientifically proves the effectiveness of ECT, we request from the medical and psychiatric professions in B.C. that they come forward with such studies which are necessary to justify the widespread use of this treatment. We feel, moreover, that 38 years of experimenting and over 3,500 experimental studies ought to be sufficient to prove one's case.

2) The alleged safeness of shock treatment.

A second consideration is the issue of the safeness of shock treatment. Leon Epstein of the Langley Porter Neuropsychiatric Institute has stated that ECT is now "safer than aspirin". (3) Although few psychiatrists would state such an extreme position, most do in fact view shock treatment as a relatively safe treatment. This in fact is not the case. The history of shock treatment has shown that the advocates of shock treatment show little concern for the bodies or minds of the mentally ill. Before the advent of anectine, a muscle relaxing drug, there was a long history of broken bones, broken teeth, and spinal injuries. One study reported spine fractures in 30% of the patients treated, (4)

Anectine and anesthetics carry a risk of their own. Quoting a letter from W. McFarlane, M.D. assistant - executive director of Riverview, in a letter to MPA dated December 10, 1975, "There were 2 deaths associated with ECT; one occurred approximately 5 years ago and one more recently. Both were associated with cardiac arrest, and therefore, may have been associated with the anesthesia." (#5). The death rate for patients receiving ECT runs nearly 1 in 1000 patients treated, with one fifth of these deaths being due to brain damage. (#6)

Neuropathologic studies have consistently shown severe brain damage in association with ECT. The Russian professors Portnov and Fedotov accept the evidence of brain damage without question. "ECT involves gross interference in bodily functions, and entails pinpoint hemorrages in the brain tissue." (#7) Bernard Alpers who did an extensive review of the literature on brain changes associated with ECT states numerous human case studies: to quote just one: "The patient, a man, 57 years old, received 13 ECT treatments and died one half hour following the last treatment.....In the frontal and temporal lobes (of the brain) were small areas of devastation, entirely devoid of ganglion cells and containing some ghost cells..... diffuse degeneration of the nerve cells in the cortex was present consisting chiefly of shrinkage and sclerosis of the cells..." (#8)

Another devastating effect of ECT is memory loss. Janis, in a study involving 19 subjects and a control group concluded, "All of the ECT patients, as of approximately four weeks following the termination of treatment, exhibited clear-cut instances of retroactive amnesia....such failures occurred so infrequently among the 11 patients in the control group as to be almost negligible." (#9) Miriam Geller in an extensive review of 500 studies on ECT found everyone dealing with learning ability showed impairment, not one showed improvement. (#10)

In another study by Gomer Goldman and Templer which tested patients 15 years after shock treatment found dramatic deficits in learning and memory abilities leading the authors to conclude that the data "sug - gests ECT causes irreversible brain damage." (#11)

Also, recent studies by Dunn and Wilson (#12) on the biochemical effects of ECT suggests that ECT has an effect on brain RNA molecules and protein synthesis, the effect being to destroy molecules in the brain which are responsible for memory storage.

The effects of ECT on the heart and endocrine systems are also well documented. Quoting John Friedberg (#13) in this regard: "Cardiovascular effects are profound. A massive vagal discharge results in bradycardia and hypotension with diminished cerebral blood flow, quickly followed by a compensatory tachycardia and hypertension (#14) EKG changes of one sort of another occurred in 98 out of 100 patients in one study. (#15) The stress on a diseased heart may be excessive and many ECT deaths have resulted from cardiovascular collapse. (#16) "The endocrine system is also affected by ECT(#17) The thyroid gland has been shown to increase its output with increased appetite and obesity sometimes following ECT (#18) Biologic rhythms of body temperature are disrupted, presumably via an effect on the hypothalamus. (#19)

"Also, there is some evidence to suggest that ECT can produce a permanent epileptic disorder in a previously healthy individual. (#20). ★

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Special credit to John Friedberg, M.D. for his article Electro-convulsive Therapy, March 20, 1975 and to Wade Hudson of the Network against Psychiatric Assault, San Francisco, for his article Shock Treatment Testimony, S.F.M.H.A.B. Inquiry, 1/20/'74. Copies available from MPA, 2146 Yew St. Vancouver.

mpa in a nutshell

Following the Canadian Mental Health Association Conference in November 1975 in which M.P.A. participated to a small degree, we received a lot of requests for information about how we got started as an organization. People in Winnipeg, Halifax, St. Johns, and Williams Lake have expressed interest in starting their own "M.P.A.".

We decided to prepare a do-it-yourself kit for would-be organizers but the pressure of other work has prevented us from getting this done, so perhaps a bare outline via the Nutshell pages will suffice for now.

1. Way back when, Lanny Beckman, hospital day-care patient, realized the need for a grass roots mental patients organization. He contacted a Vancouver Sun columnist who wrote a column outlining the need and informing ex-patient readers of a place and time to meet. 85 people came to the first meeting.

2. We drew up a constitution and became incorporated in March, 1971. Lanny searched out funding sources by writing letters to private foundations, the city, provincial and federal governments, to request money for salaries. A member donated his house at a minimum rent. We used the house as a drop-in centre, crisis phone line and crash pad until we outgrew it and rented a bigger house.

3. We eventually received salaries from O.F.Y., C.Y.C. and L.I.P.; opened two more houses as ex-patient residences and rented a farm. The farm experiment didn't work but the houses did - with 2 salaried coordinators per house.

4. We run the organization as a participatory democracy - as opposed to the representative democracy we're used to outside M.P.A. - with a 3 weekly General Meeting (for policy decisions) and a weekly Business Meeting (for day-to-day operation). All members paid or unpaid have an equal say in all matters and vote on all decisions.

5. We acquired 3 more houses, bought a new drop-in centre (all through Central Mortgage and Housing Corporation), got involved in citizen advocacy and mental patients rights, a publishing project, research into legislation, publication of a bi-monthly newsletter, participation in conferences, speaking before university and secondary school audiences, defending rights of other oppressed minorities.

We opened an information office in the provincial mental hospital where we help people find housing, make new friends and introduce people to M.P.A.'s resources.

6. Because our three year L.E.A.P. funding runs out next July we are presently working on new funding arrangements for 23 salaries and operating expenses. ★

a suggestion to the minister of human resources

Furniture and lamps made at the Mental Patients Association Workshop at 2146 Yew Street by ex-mental patients and welfare recipients: You can see that we can produce. We need an effective sales outlet and more workshop facilities for more people to use.

The Minister of Human Resources overlooks the fact that mass unemployment is a defect of our economic system, not a defect of people.

If Mr. Vander Zalm really wants welfare recipients to work he should support programs which will give welfare recipients access to facilities to make articles of value for sale.

Such programs must allow welfare recipients to keep some profits from the sale of any articles which they make and which are sold, (perhaps up to $200.) In this way, welfare recipients can become motivated and develop skills to become employed, perhaps self-employed.

We propose opening a sales outlet(s) for personally crafted goods, such as swag lamps, furniture and artwork and such things of value as people working with initiative and a workshop can produce. This sales outlet should be used exclusively for the sale of work of ex-mental patients, welfare recipients, people with health handicaps, and perhaps, other disadvantaged low income groups. With such programs people otherwise unemployed can contribute goods of beauty and genuine value to the community.

This proposal could possibly tie in with the Kitsilano Sheltered Workshop proposal recently endorsed by the Kitsilano Community Resources Board. ★

RESIDENCE PROGRAM - A History of Residents at the Mental Patients Association: January, 1974 5

These statistics were compiled by residence coordinators from each house and a strong effort was [illegible] as similar in structure as possible. Variations do occur however because of the difference in i[illegible]le.

For the purpose of determining individual's "State on Departure" we set up some basic guidelines [illegible] are as follows: 1) Deteriorated 2) Hospitalized 3) Unimproved 4) Slightly improved 5) Improved 6) [illegible]oved 7) Smashing success.

Dashes are used to indicate that information is unknown.

We hoped that these statistics would show similarities and a success rate, which they have done, in all five residences. We feel this is due to our common operating philosophies and the nature of our program.
Results were tabulated for individual houses and collectively based on the attached tables. They are as follows:

Residence	No. of Residents	Average Stay	Employed	*Hospitalized	Returned to Community	Showed Improvement
West 7	23	5 months	6 / 27%	3 / 13%	8 / 30%	16 / 70%
West 10	27	5 months	7 / 26%	1 / 4%	13 / 52%	20 / 74%
West 11	29	4.8 months	9 / 31%	3 / 10%	12 / 42%	21 / 72%
East 8	21	8.5 months	9 / 43%	4 / 14%	8 / 38%	15 / 72%
East 4	29	7 months	9 / 31%	2 / 7%	15 / 55%	23 / 79%
Totals	129	6 months	40/ 31%	13/ 10%	56 / 43%	95 / 74%

* The category for re-entry to hospital does not include those residents who went in and out of hospital for a few days only.

WORKING TOGETHER

Sgt. G.S. Howland
TEAM POLICE

J Karpoof
C.R.B. manager

Cpl. C.L. Turncliffe
TEAM POLICE

COMMUNITY RESOURCE BOARD INFORMATION SHARING PROPOSAL.

Plan bared to give police welfare files

By ROBERT SARTI

A plan to give police access to confidential files of welfare recipients and other social welfare "clients" has been quietly developed by police in co-operation with community resource board officials.

The information-sharing arrangement, which would go into effect initially in the Vancouver South community resource board area, is being sharply criticized by some community groups as discriminatory against the poor.

"Something like this would never get past first base if the proposal was to look into the files of private psychiatrists who have only middle-class patients," said Kevin Topalian, a researcher for the Mental Patients Association.

"This will completely erode the basis of trust between the client and the social worker. Who in hell is going to tell a worker anything personal when the next day it could be in the hands of the police?"

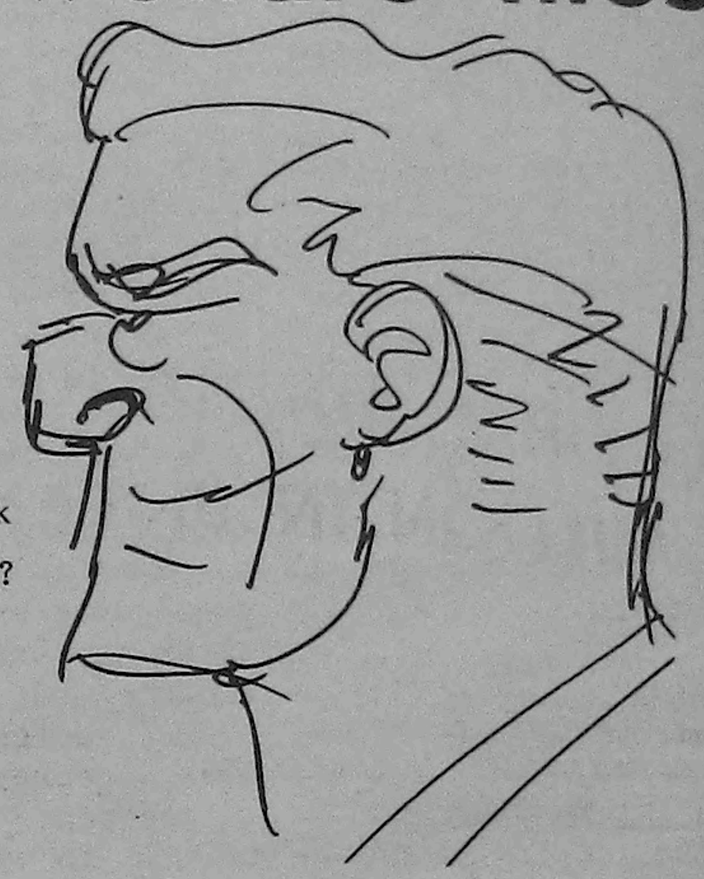
Topalian noted that a somewhat similar information-sharing scheme involving juvenile offenders was scrapped four years ago after "public outrage over the threat to civil liberties."

The proposal, which is detailed in a memo from the provincially-funded Police and Community Service Project to CRB officials, provides that certain types of information can be provided to police by a social worker even against the expressed wishes of the client.

This information includes whether the client is receiving some kind of welfare service and problems relating to his or her family and living situation. The proposal says such disclosures would be exceptions to the general rule that such information would not be shared without client consent.

As well, social workers would be expected to volunteer information on suspected client involvement in illegal activities involving public safety and on whether the client presents any threat to public safety because of quirks in personality.

Other information that would be shared routinely with the police, without checking first with the client, would be whether the individual is a CRB client or not, and what data there is on his or her name, address and telephone number.



Pssst. Wanna look at a welfare file?

Police and C.R.B. Information-Sharing

C.R.B. information

Police purpose	Known to us	Statistical Information	Service Information	Family Information
warrant/charge	✓	✓	X	X
investigation	✓	✓	X	X
C.R.B. feedback	✓	✓	✓	X
case conference	✓	✓	X *	X *
surveillance	X	X	X	X

* - if client consent is not forthcoming, this may still be shared with police but always with client knowledge.
✓- information will be shared without client consent
X- information will not be shared without client consent
*- in situations where the client is not able to authorize information-sharing, worker discretion may be used.

Storm raised at plan to give data to police

The opposition was spearheaded by the Mental Patients Association (MPA) which said "there are vital moral and ethical problems involved which make this issue everyone's business.

"The issue of confidentiality is incredibly important," the group's brief said. "If a client cannot regard his worker with a sense of trust that anything said will be held in strictest confidence, then the whole basis of their relationship is nullified.

"If this policy becomes common practice, you might as well give social workers badges and guns, because they're going to have to go out looking for their clientele."

A narcotics halfway house worker said: "If our information was open to the cops we wouldn't have any clients."

The board agreed to an MPA motion imposing a moratorium on information-sharing and recommending further discussion.

Board manager Jim Karpoff said the proposal was needed for police and social workers to work together in solving individual's problems. The proposal notes that 80 per cent of police calls involve non-criminal matters.

Reg Danson, past president of the civil liberties association, said a desire to help "is not a good enough excuse for endangering citizens by giving information to various agencies, information which could damage them."

Diversion: Keep 'em out of jail and in the ghetto where they belong. db

MOTION:

THAT the M.P.A. opposes the proposed new information-sharing policy developed by the Police & Community Services Project on the grounds that their interpretation of the confidentiality regulations of the social assistance act far exceeds the explicit limitations in the present regulations. We demand a moratorium on information sharing of any kind except in compliance with the present regulations. We do recognize that important problems exist in police-social agency relations, and we recommend that discussion and debate be initiated by local C.R.B.s throughout the province. The issues involved should be the number one priority and any future policy must include the broadest spectrum of input, especially that of social assistance clients.

What's New

HOSPITAL PATIENT DENIED VOTE

COMOX

Mental health association critic ejected from reception

A member of the Mental Patients Association was ejected from a news media reception sponsored by the Canadian Mental Health Association Wednesday night after he sharply criticized the CMHA for ignoring the "consumers" of mental health services.

The MPA member, Denis Blue, told about two dozen assembled CMHA officials from across Canada that they should be visiting Riverview hospital instead of staging media events in plush locations such as the Hotel Vancouver.

Vancouver lawyer Gowan Guest, who is chairman of the CMHA annual convention being held here today through Saturday, said the food and drinks at the reception were being paid for by drug companies.

Guest told Blue his remarks were out of order and disruptive, but Blue persisted in his contention that CMHA was primarily oriented toward government agencies, voluntary groups and business and professional organizations.

"To work on behalf of troubled people, you need input from troubled people," said Blue.

"You need input from MPA, which is a consumer organization."

Guest then told Blue, "Please leave, this is my room."

When Blue made no move to leave, Guest grabbed him and pushed him out the door.

Later, Guest went out into the hall and invited Blue back in.

drug officials kill off

Invading crazy ants bug islanders

is mental illness a plot?

"What would happen," the visitor asked if all those inmates got together and ganged up on the guards?"

The superintendent just laughed. "No chance of that happening," he assured the visitor. "Lunatics never unite."

Mrs. ELIZABETH I. HIEBERT
RR 2,
Mission

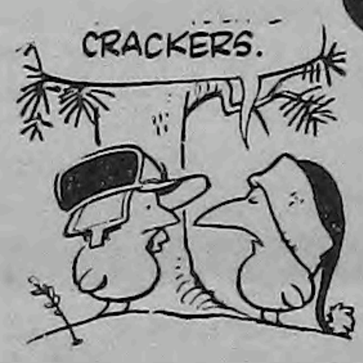
join **lunacy**

DRUG FIRM ADMITS PAYING $1.3 MILLION IN BRIBES

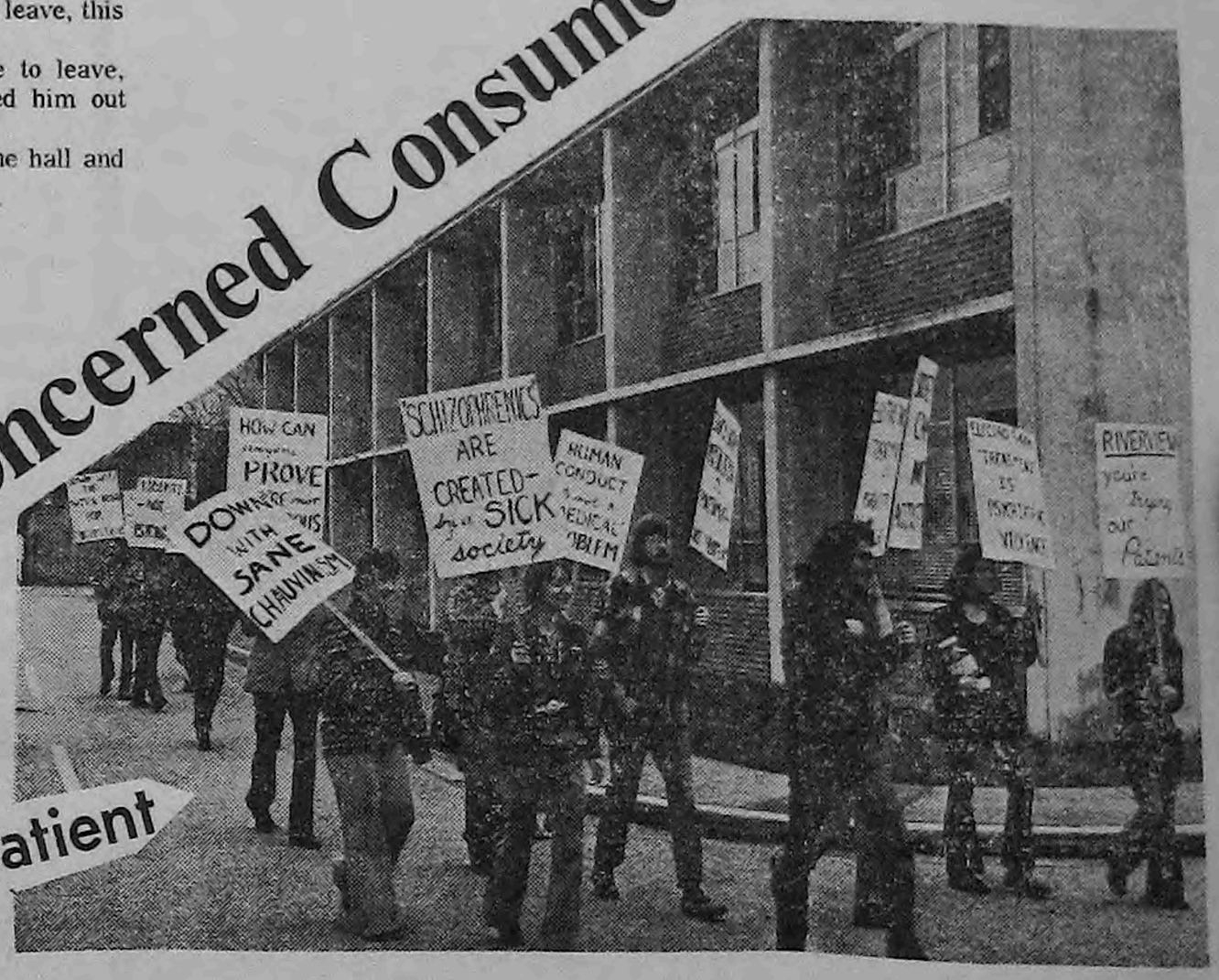
OAKLAND, Calif. — Early in September, parents of 17 schoolchildren in Taft, Calif., filed suit against the local school district, its senior administrators and the school physician, charging them with "coercing children into taking a psychoactive drug commonly referred to as Ritalin as a condition of attending public school."

The parents said they had been told that their children were "hyperactive," that teachers "could not control" their behavior, and that if the parents did not consent to medication — generally two pills daily, five days a week — their children would be taken out of regular classes.

The suit also charges that as a consequence of the drugging, often prescribed without any medical examination, the children suffered from headaches, nosebleeds, stomach aches, loss of appetite, insomnia, nightmares, crying jags and a number of other ailments.



Concerned Consumers search for patient



Mental disorders 'caused by chemicals'

It's readin', writin' and druggin'

Probe

Hard to pick out dangerous types

Protest at Riverview Hospital

WASHINGTON (AP) — Walk down any city street. Look at the faces. Who is disturbed? Who is dangerous?

What of the man on the elevator with the sullen face? What of the woman, mumbling to herself? What of the young man pushing through the crowd fairly trembling with rage? Which person walking by carries a gun? Which suitcase loaded on a plane carries a bomb?

Who is disturbed? Who is dangerous?

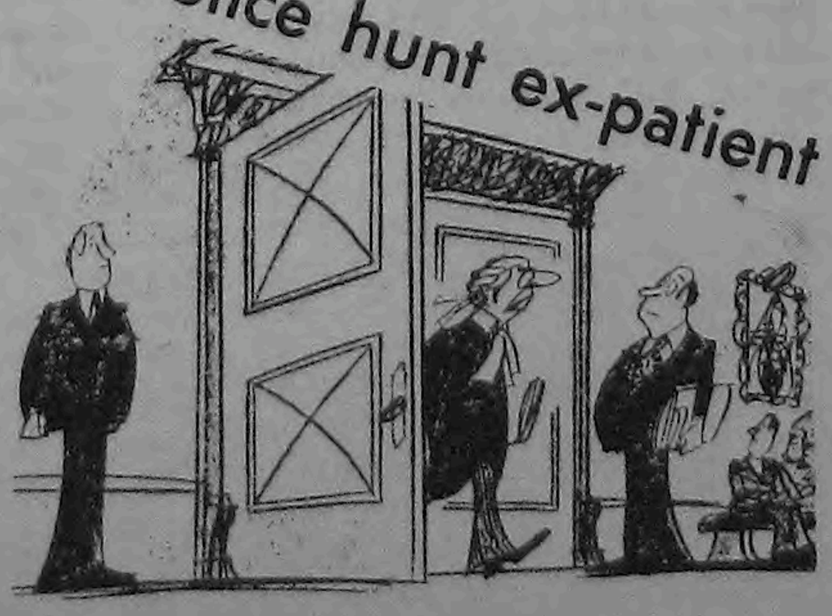
Look at the montage of faces. Pick the assassin.

The psychiatrists who talk of the concept of "dangerousness" may look at the subject from [illegible] perspectives

data

NANAIMO — A provincial court judge here has asked Crown prosecutor Jack Gibson to investigate the reason for a three-month delay in release of a man from the Riverview hospital at Essondale.

Police hunt ex-patient



"*Six* ruddy medical experts and they can't even agree on whether the *judge* is sane!"

Patients' group criticizes criminal insanity bill

By TIM PADMORE

Legislation before parliament that would allow persons charged with minor offences to be committed to an institution for the criminally insane is regressive and unnecessary, the Mental Patients' Association charged Tuesday.

Telegrams attacking provisions of Bill C71, which makes a number of amendments to the Criminal Code, have been sent to Solicitor-General Warren Allmand, the head of the law reform commission, Tanner Elton, and B.C. Attorney-General Garde Gardom, said MPA spokesman Jackie Hooper.

MPA legal advisor Sid Filkow said in an interview: "It's not necessary to invoke these extraordinary measures for ordinary offences. We're talking about people who are nuisances, not people who are a danger."

The bill, which received first reading last July, is now at the report stage and still is open to amendment.

It adds clauses to the section on summary offenses providing for a "trial of issue" to determine if an accused is mentally fit to stand trial on the charge.

The trial of issue proceeds according to the rules for indictable offences and can result in an order from the lieutenant-governor to commit the person to an institute for the criminally insane.

Summary offences are usually minor for example, public mischief or creating a disturbance — while indictable offences include such crimes as robbery and murder.

"A person could face indefinite incarceration . . . for shouting in the street," said Filkow, adding that "creating a disturbance" is one of the commonest offences committed by unbalanced persons.

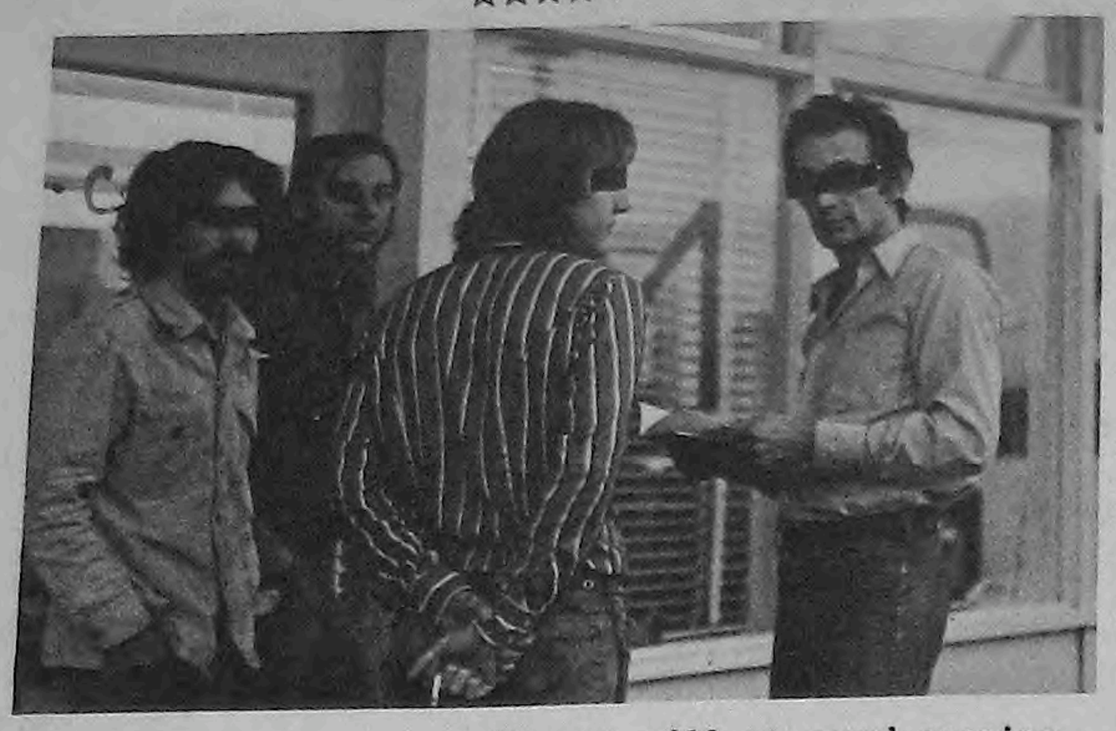
The lawyer said the proposed amendments, buried deep in the 63-page bill, came to his attention by chance, and he urged that the bill be changed.

Lawyer Norm Einarsson, a director of the B.C. Civil Liberties Association, also was surprised when he learned of the new provisions.

"It's a travesty that, for an offence you don't even have to go to jail for, you can be incarcerated indefinitely," he said.

He said the association has been opposed to the present criminal code because of another provision, that accused persons can be detained at the discretion of the judge for up to 30 days for psychiatric "observation." The 30-day detention period would be retained under the bill.

☆☆☆☆



Throngs mill at grand opening...

mpa's new d.i.c.

Several months back a group of people at MPA had the idea of setting up an MPA chapter at Riverview. We discussed the idea with Sydney Baird(the co-ordinator of volunteers) and she was supportive of the idea. Finally in November we were given the permission and the space to open a drop-in at Riverview.

The location is central, right beside the Tuck Shop, which makes it easily accessible to the patients who have ground"privleges". The first groups of people to go and open up took several posters, which they posted on the wards, telling people where we were and inviting them to come and drop in. The first couple of weeks we didn't get many people coming in and we were only open one day a week. But now that we are open Wednsday, Thursday , and Friday and more people know about us , we are getting approximately 30 people a day dropping in.

Some people have been wanting information about housing, review panels,legal aid and MPA.For a lot of people it seems to be a safe place to come and relax and rap with people.

There seems to be a variety of expectations and ideas from people in MPA as to what should be happening at Riverview. They think that there is nothing really valuable happening. But I see it as a slow growing process.

Eventually I think we would all like to see the patients themselves making decisions as to what they want to have happen.

Hopefully, with our help and support,it will happen.

Raven Mad.

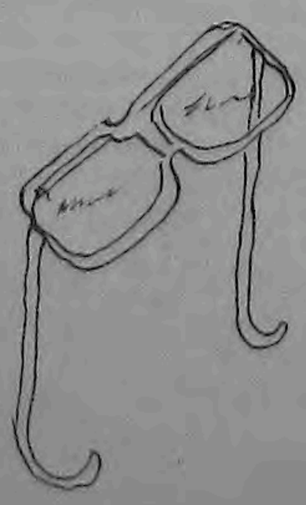
SOCIAL
ASSISTANCE
INFORMATION SHARING

Feb. 26, 1976 7 p. m.

at the M. P. A. Drop in

with resource people
from th Kits Community
Resource Board

This is your first issue of 1976. It is also the first issue since last October, 1975, due to the mail strike, and to MPA psychotics who cheerfully insist that January follows October. The neurotics know perfectly well that November follows October but they worried so much about Chirstmas and about being late for publication that they weren't capble of putting pen to paper until a few weeks ago. The behaviour probiems, sobering up after the holiday, said, 'that we could publish when we damn well please anyway'.



SUMMARY

Thought patterns disturbed, barbaric torture, terrifying, are all real experiences described in statements recieved by Mental Patients Association's Committee to Investigate Shock Treatment.

The loss of memory (whether permerent or temporary) is evident in all statements that have been received by our committee.

In many of the cases (explained to us), shock treatment had been forced upon them with little, if any idea of what to expect. A psychiatric nurse tells us that "I frequently encounter overt and covert threat of shock, if a patient doesn't "smarten-up".

Many have expressed the feeling that shock treatment was of no help:

1. "It is my belief that I could have been helped by some other manner of treatments perhaps with just ordinary "rap sessions" with a doctor at the time."
2. "I consider shock treatment to be a torture unfit for living things."
3. "It is barbaric and will someday be regarded with the aborrence with which we now regard the burning of witches."
4. "It's in the same class with beating a child for his own good.
5. "Fear of my hair dryer, simply because it is electrical and touches my head."
6. "They look like zombies as they were being led to a table set up with toast and coffee for them."
7. "you feel burnt out"
8. "It made hell seem like a health spa."

These quotes and more, paint the terrifying experience that is shared by many on the use of shock treatment.

Shock treatment has proven time and time again, that it doesn't cure a sincerely depressed person, but only temporarily alieviates the thought that induced said depressed state.

In other words, it can create more damage to one's mind and social existence, than to help restore one's mental health for a happier life.

ALTERNATIVE TO ECT

Many doctors claim that they use ECT as a last resort when patients fail to respond to other treatments, such as chemotherapy. It seems the element of time is a great consideration of psychiatrists; un-desirable behaviours and depression must be eliminated fast. Why should this be so? Perhaps what a depressed person needs most is time to relax and recover. If we remove the pressure of time, some long range alternatives to ECT will emerge.

If country communities could be set up, people with emotional problems could leave their environments of pressure and go to a community which has a relaxed atmosphere and time to unwind. Instead of the usual doctor-patient encounters, there could be an emphasis on group counselling. Each group would be composed of different kinds of people, different age groups, paraprofessionals, and perhaps a representative of the psychiatric community. People would be given an opportunity to relate to each other and to share support, responsibility, and experiences Each person would act according to his ability at the time.

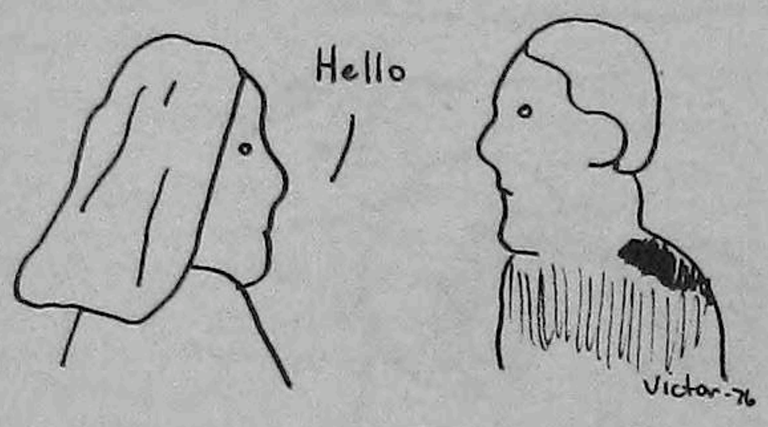
Hobbies and sports could be cultivated there. I am not referring to occupational therapy, but to activities that can be continued after individuals leave the community. Some of these are gardening, growing indoor plants, film -making, drama, mechanics, skiing, etc. If a person took an interest in gardening, for example, an arrangement could be made for him to have a small square of land in the city for that purpose when he returns home.

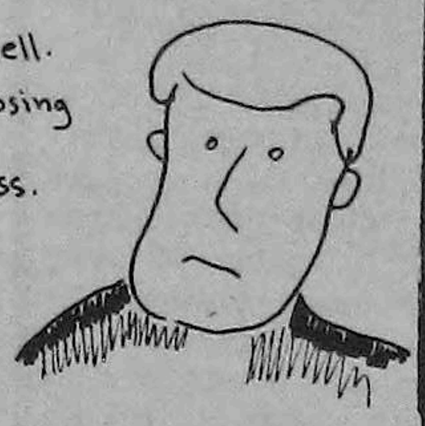
Survival courses could be another feature. These would include topics such as cooking, driving, grooming and how to gain access to various organizations. Health in general cannot be overlooked. (I feel one of the main drawbacks of mental institutions is their gross inconsideration of the human body.) There should be a heavy emphasis on proper diet and exercise; this could include yoga, meditation, dancing, hiking, swimming, camping and many other activities. Entertainment should be plentiful and enjoyable with lots of relaxed get-togethers and parties, involving as much participation as possible.

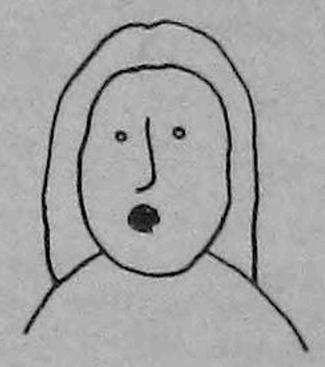
I think this is economically feasible since a great deal of money is already being spent to treat patients in hospitals. If people can stop to relax and leave their pressures behind for awhile, their anxieties will lessen. If they have never been able to relate to others, they should be given the opportunity to learn. Leaving a bad environment and going to a pleasant one is a solid beginning to mental health and to the exclusion of such treatments as ECT.

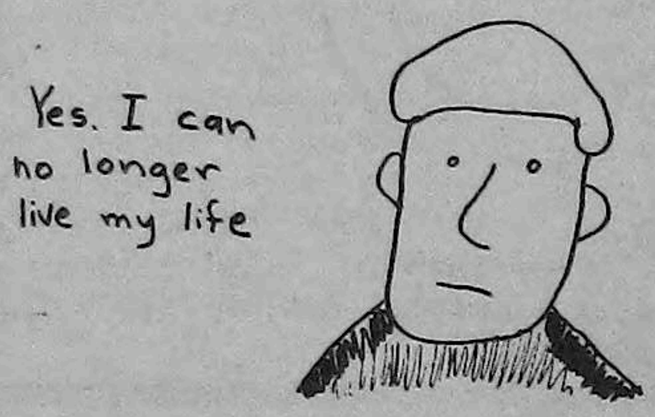
- Ruth and Phil Prefontaine

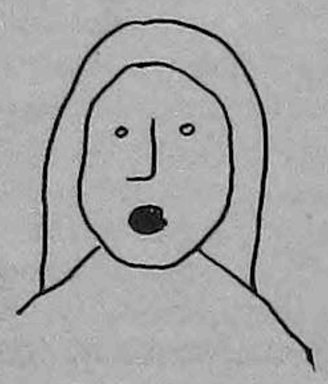
COMIC PAGE

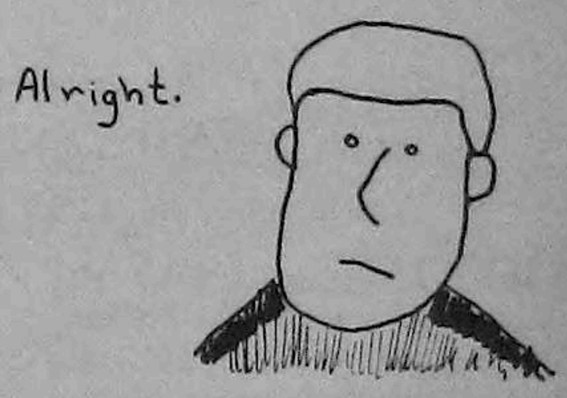








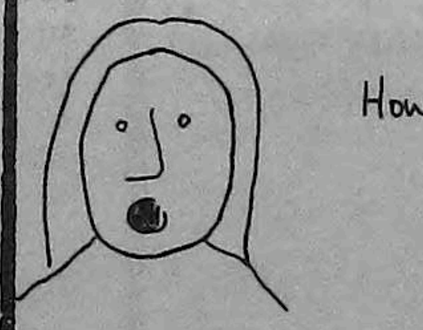


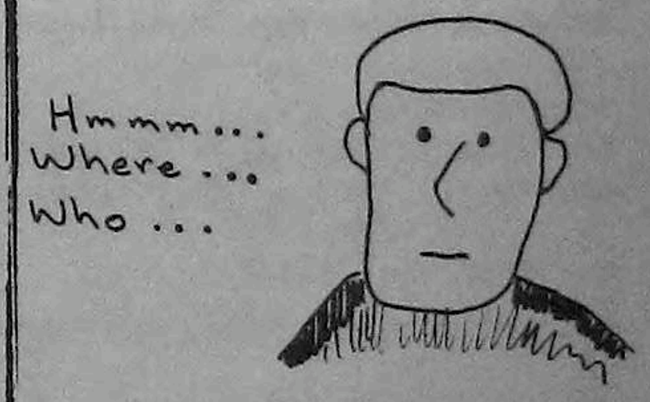


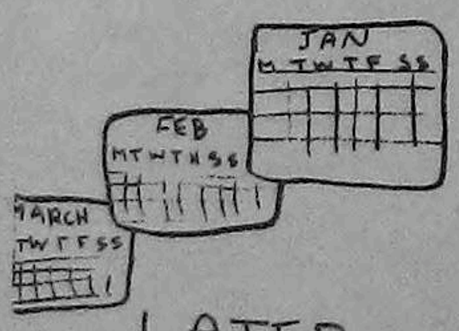
LESSON # 1002

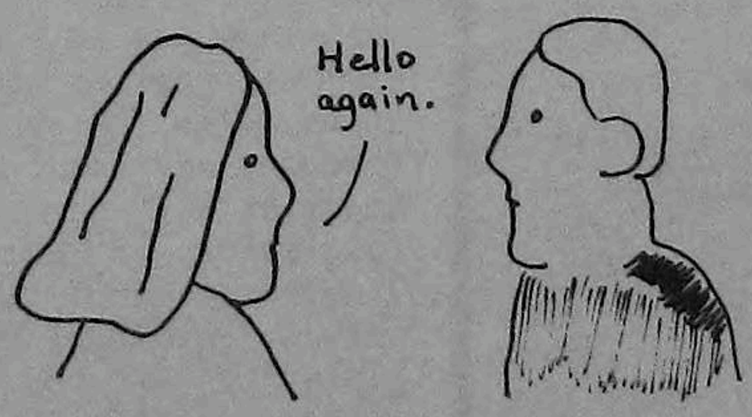
Electric Shock Treatment:

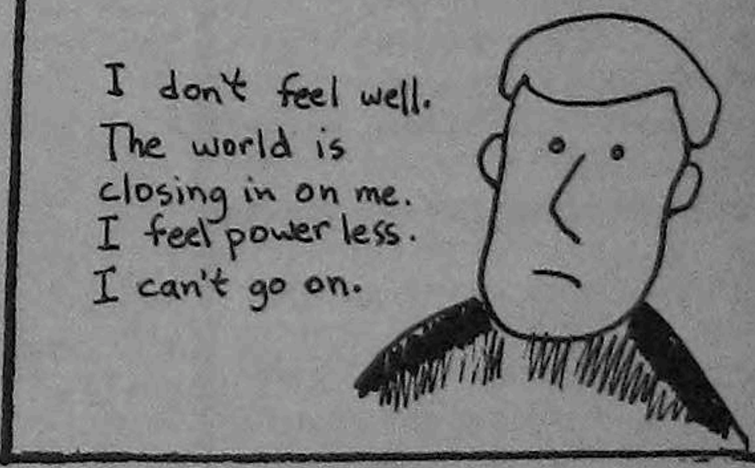
- Apply graphite jelly to shock points. Give general anesthetic and muscle relaxant.
- Apply 70 to 175 volts of electricity to the brain.
- This will cause convulsions and coma resulting in Amnesia.











SCHOOL DAYS

The Residence Programme

MPA houses are doing a better job than we dared to imagine. Only 10% of the resident population returned to hospital last year, which is an excellent record compared to other programs we have read about. Not counted were brief rehospitalizations like an overnight or several day's stay. Hospital readmission statistics were based on those whose hospitalization caused them to give up residence in an MPA house.

The readmission rate was much higher for people who went from the community into hospital: 64% of those who were admitted to Health Sciences Hospital in 1974 were readmissions. 63.7% at Riverview were repeaters in 1974; 61.9% in 1975.

Cost per day of hospital beds continues to climb. Health Sciences is now $101.65; St Pauls is $121.20 and Vancouver General is $124.50 per day.

By way of comparison we worked out the daily operating expenses of MPA houses and found that the cost is $9.01 per person. When the house income of $90 per resident per month is subtracted the per diem rate is $6.40. Not counting coordinators' salaries the rate is only .85 per day.

The conclusion that we hope Health Minister McClelland and Human Resources Minister Vander Zalm draw from these figures is that MPA houses are saving the provincial government a large sum of money. And this is the argument MPA is using in trying to obtain funding when L.E.A.P. funds run out next July. It's also the basis upon which we are trying to expand our residence program through the Ad Hoc Committee proposal, to include two more houses and four more residence coordinator's salaries

BEFORE:

AFTER:

STARS

by Oscar, M.P.A.
(mental patient astrologer)

Your horoscope for Feb. 30, 1976.

Aries: rip-off activities are favoured. Caution, however, must be maintained. Pickpockets working the same street have a very good chance of picking each other's pockets. Do not be unduly alarmed should this occur, as outlook is also favourable for strangers meeting and exchanging I.D.

Taurus: if you are a coordinator, avoid morning shifts. Crises are liable to occur at 11:10 a.m. precisely. At this time, take a valium and stay in bed. Members (in the absence of a coordinator) should protect themselves by maintaining a high level of disorganization.

Gemini: be prepared for collective hallucinations. Imaginary unicorns, hallucinatory giraffes and a hypothetical Minister of Human Resources may emerge from the storage cupboard. Do not be perturbed. Any such apparitions will dissolve in MPA coffee.

Virgo: The welfare of lovers is in jeopardy. Be prepared for frustration. Mercury occludes Venus, with the result that Venus suffers from slight mercury poisoning. Virgos will tend to have headaches. Check your supply of aspirin. Restrict your attention to hobbies.

Capricorn: This will be a dull day. Your planets have gone to collect their welfare cheques. Forecast: may be sunny or cloudy, with a chance of rain or snow. Advice: hang in there, baby.

Taurus: be extremely cautious. Jupiter falls out of the Big Dipper making this whole time period dangerous. Precipitate action may end your world. Generals should avoid military action since history shows that all battles fought under these planetary conditions have been lost by both sides.

Post Script: Missing signs could not be included since Oscar is a Taurus, and he engaged in precipitate action before completing his forecasts. He is now hospitalized. ★

Scientology?

At the recent Canadian Mental Health Association Conference held in Vancouver in October, a number of delegates questioned MPA members about our affiliation with Scientology. We were not the only group which made our presence felt at that conference. We decided picketing was an ineffectual way of making our views known. The Scientologists, however, did not. Ray Rockl Chairman of the Citizen's Commission on Human Rights (another group affiliated with Scientology) headed the picketing of the CMHA Conference. After the demonstration delegates from the conference began asking our members to explain our association with Scientology. We said then and repeat now that the Vancouver Mental Patients Association is not now nor has it ever been affiliated with Scientology or with the Committee on Institutional Psychiatry (sponsored by the Church of Scientology).

Last year, it came to our attention that in a pamphlet put out by the Committee on Institutional Psychiatry, the name of MPA appeared on their list of Advisory Board members. We took the matter to our membership. Our members cited a number of instances where they were approached while walking on Vancouver streets and persuaded to go to the Scientology Centre. We discussed the curt dismissals and disinterest shown our members when they questioned the organization. We finally decided, by democratic vote, that the publication of the MPA name on a list of Advisory Board members was an unethical act. We directed the Church of Scientology to remove our name from any Board they may have put us on and further informed them that our group did not wish to associate itself in any way with the Church of Scientology or its affiliates.

It does not come as any surprise to many of us that the Scientology group is continuing to use its high-handed methods to exploit the members of MPA. Our members have reaffirmed their disassociation from Scientology. We have no desire to contribute to the support of L. Ron Hubbard (Mr. Scientology) in the manner to which he has obviously become accustomed.

Fran Phillips ★

A Review:

"BELIEVE WHAT YOU LIKE"

By C. H. Rolph, Andre Deutsch Ltd., 1973.

In this book, Mr. Rolph examines (as his sub-title indicates) "What happened between the Scientologists and the National Association for Mental Health". The NAMH (as, for the sake of brevity, I shall henceforth refer to it) is a society in Britain in the same vein as the Canadian Mental Health Association, but with much more power. At one time it provided the only training course given in Britain for the teaching of the retarded. It runs group homes for people described variously as "mentally confused old ladies" and "very disturbed young offenders" - and for a tribe of people of various shadings in between. The NAMH has engaged actively, over the last few years, in decrying conditions that have been discovered in some British mental hospitals, in demanding that a Hospitals Commissioner or "Hospitals Ombudsman" be set up to investigate complaints from patients, relatives of patients, and other interested people concerned about mental hospitals and hospital staff.

The membership of the NAMH consists of (to quote one of its members) "psychologists, psycho-analysts, psychiatrists, social workers, psychiatric nurses, medical officers of health, justices of the peace, religious nursing sisters, school teachers, and perhaps most important, persons who are or have been mentally ill". (I might add that the consumers - the mentally ill - seem to have little to do with the running of the organization.) The same commentator goes on to point out that the NAMH deliberately seeks for diversity among its members in their viewpoints toward mental health. In support of this he mentions that the group "has been addressed by psychiatrists as widely divergent in their view as Dr. William Sargent, the advocate of pre-frontal leucotomy, and Dr. R.D.Laing..." The NAMH would regard the domination of their organization by any one strongly opinionated group, however well-intentioned, as a disaster.

So much for the NAMH. What then is the Church of Scientology? After reading Mr. Rolph's description of it I am still not sure, and nor, I think, is he. Apparently (many Scientologists refute this) the idea of a new "church" sprang up in 1948, when a group of science fiction writers including Lafayette Ron Hubbard met in New York and tossed around the idea of creating a religion embodying, probably, some of their own published fantasies. But the Church of Scientology was not born until 1953, under Hubbard's direction. In the meantime (1951) he had published Dianetics, the Modern Science of Mental Health. Insofar as any sense at all can be made from the excerpts given from this book, it seems that each man has a Thetan (roughly meaning "spirit") which may be as old as the universe, and which may have been damaged over the course of the centuries by means of mental image pictures called engrams. These engrams have to be erased before the subject is "clear" (equivalent, perhaps, to "saved" in the more extreme Christian sects?) (Engrams are hypothetical memory traces, which have yet to be proven to exist, yet the Church of Scientology claims to know how to erase them.)

To be "clear" means to have completely erased the subconscious; to have brought out and forgotten every unconscious thought in one's mind - a pretty fair undertaking. In order to become "clear", one is examined by means of an E-meter, a device described by Rolph as a pair of objects resembling soup-cans, attached to an electric current. By undergoing a course of such training (I believe, at some considerable expense) the subject arrives at a state of supreme mental and physical well-being, and maximum efficiency.

At this point I hope you are willing to give up any further attempt to understand the inner workings of Scientology, because I have had quite enough of the subject. In any case, somebody must have been able to make sense out of Dianetics, since, by 1967, Scientology had become so rampant in the United Kingdom that the problem this "church" presented was debated in Parliament. The main result of this debate was that foreign nationals seeking to enter Great Britain to study Scientology were henceforth to be refused entry permits.

The Scientologists' reaction was vitriolic. They began publishing broadsides accusing their opponents of having committed unnamed crimes which would be exposed, saying that their phones were tapped and that Scotland Yard officers were following them about, describing the Ministry of Health as a "cult", and making claims such as the following: "A psychiatrist kills a young girl for sexual kicks, murders a dozen patients with an ice-pick, castrates a hundred men. And they give him another million appropriation..." Shortly after this, Scientology founded a group called the Campaign Against Psychiatric Atrocities, which took most of its ammunition from the writings of Dr. Thomas Szasz. At the same time while all this was going on, Scientology was disavowing any claim to treat mental illness (or indeed, illness of any sort) probably to avoid legal measures that might have been taken had the "church" made such claims.

As this review is becoming long and unwieldy, I am going to skip over the sections of BELIEVE WHAT YOU LIKE which describe various lawsuits laid by Scientology and also investigations made of their activities in Australia and New Zealand. On to the great battle with the NAMH.

Hostilities opened with a demand on the part of Scientologists to meet with the NAMH Council of Management, and the appearance of bands of demonstrators outside the NAMH offices. Then in October, 1969, there was a sudden influx of new members to the NAMH (membership to which can be obtained simply by paying a two guinea fee) so that the Association found itself with 302 new members within a space of two months. Some of these members were known Scientologists, who at once began nominating some of their group for high office in the NAMH. It appeared likely that at the Annual General Meeting, the Scientology "members" would outnumber their opponents, and, in effect, take control of the NAMH.

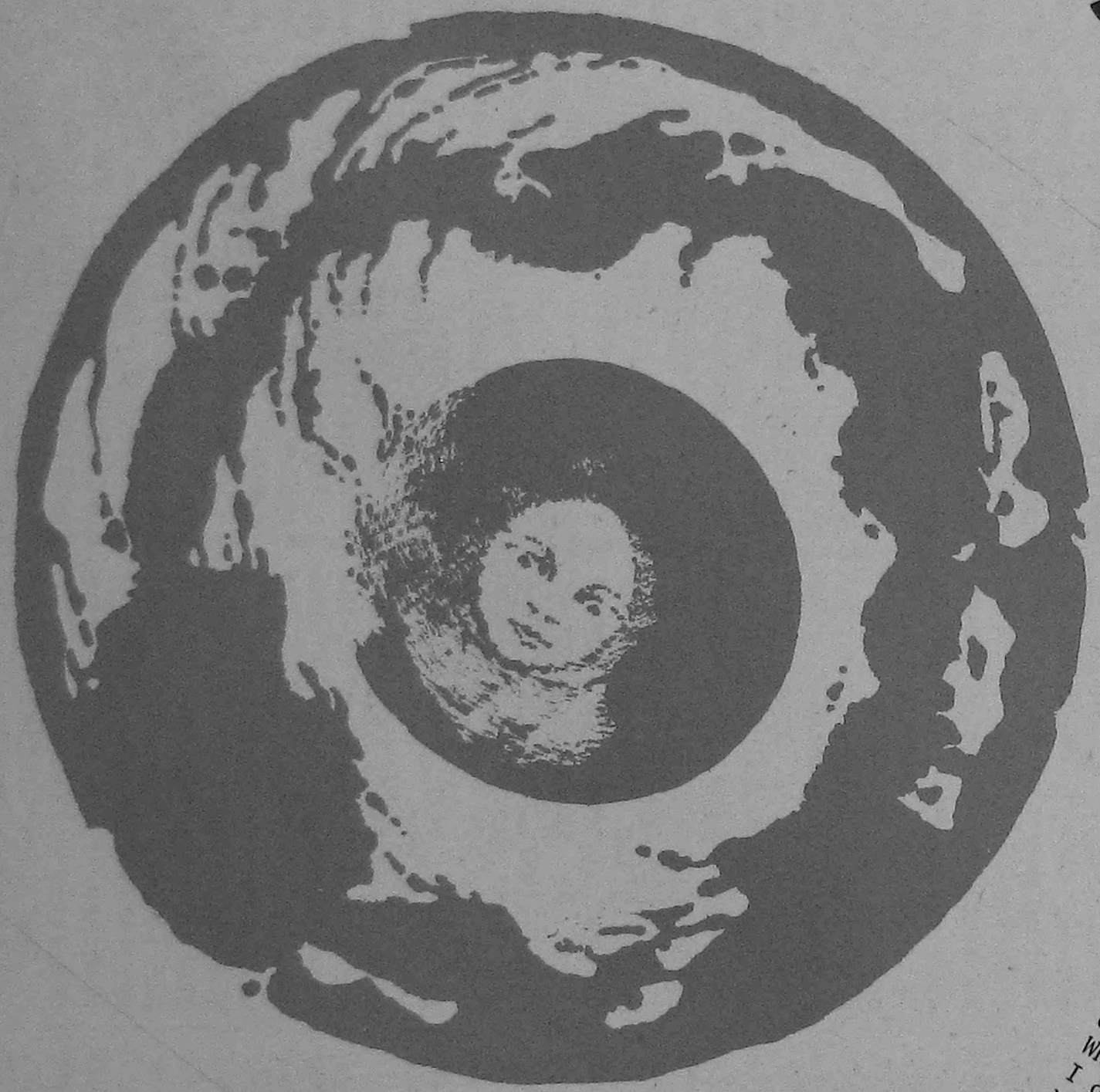
The NAMH called on all 302 members to resign; the Scientologists in turn applied for, and got, a court injunction restraining the NAMH from holding its Annual Meeting until it had been decided whether or not the dismissal of the new members were valid. In March, 1970, a legal action began between the expelled members and the NAMH. The arguments and counter-arguments that ensued are too complicated to report (I might even say, to understand, unless one happens to be a lawyer) but the point of interest that struck me was that the Scientologists' lawyer, in support of Scientology's claim that psychiatrists are murderers, torturers and runners of death camps, read excerpts from some of the books which certain members of MPA think contain the best criticism available of psychiatry: Laing's Politics of Experience, Erving Goffman's Asylums, and some words of wisdom from Szasz. This is not to say that, for example, Laing is responsible for the fact that a "fringe" religious group has found it expedient to adopt some of his ideas. It does, however, suggest that writings in anti-psychiatry, as well as those in psychiatry, should be carefully examined for dangerous and harmful implications.

When the judgment was given, it was found to be in favour of the NAMH, largely on technical grounds - that is, the judge felt that the NAMH had acted within its rights, but declined to comment on the charges and counter-charges made between psychiatrists and Scientologists. This dramatic conflict faded out "not with a bang but a whimper" on the 25th of February, 1971, when during an annual conference of the NAMH, members were prevented from listening to a scheduled planned tape-recording by the sudden resounding of another such recording from the press gallery: the recording of a violent attack on shock treatment. The apparatus used for the press-gallery recording was confiscated by the NAMH, who found it "a useful addition to office equipment". David Gaiman, the Scientologist who had made the recording, said he was "delighted it served its purpose and interrupted the proceedings". So everyone was pleased.

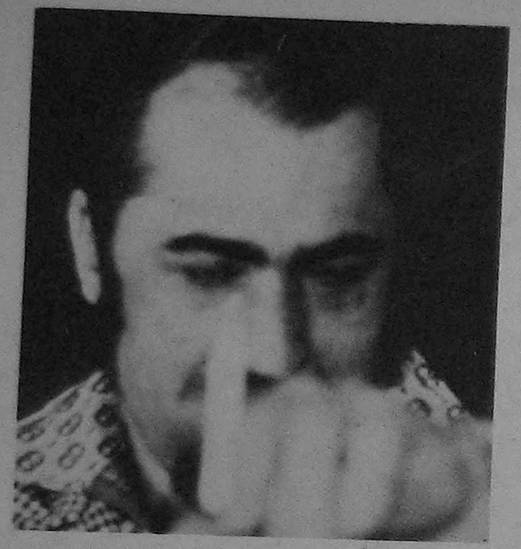
Mr. Rolph, in BELIEVE WHAT YOU LIKE, approached his subject from a position of detached amusement, therefore it is impossible to say what he thinks of the various claims made against psychiatrists by Scientologists and vice versa. My own feeling is that Scientology is a particularly dangerous group because, while some of their pronouncements are obviously nonsense (not to mention self-contradictory), others have more than a grain of truth in them. These claims against shock treatment and, particularly, lobotomy have backing from far more reputable sources, and it is easy to see how the Church of Scientology has made itself known, among people who do not read or think carefully, as a genuine opponent of "psychiatric atrocity". If Scientology is a joke, it is a pretty dangerous one. And most unfortunately, exploitive of the legitimate and pressing issues of mental patients to further the ends of their own organizations. Let the buyer beware.

Cathy Batten

molly starpin



I'm sure you must be Acorn. the mother Starpin,
Have you met our mad old brood, anything else, I am making
Molly to all she sees... before Acorn, them high and white against the
This morning, I am making mountains. inside
sky, all covered with snow. I am making the sun shine on them.
Now I am making slow in circles, I am making silence.
Do you see? very deep-
Hands moving them is the silence,
All around you too.
How long have you been here, Acorn? in the first place?
How did you get this way time I was having with
my life, and they said I should come in here for rest
and observation... I told them about the strange
Yes, this is the place to come in here for rest
and observation...
Good this is the place to come for observation-
But almost as good as a tower is.
Tell me, what are your observations so far?
No, its just the perfect place for making mountains, silence, and such.
the staff- they that observe me... the doctors,
And does it matter? they are forming an opinion on
Yes, of course... my condition.
But what do you make of them? or I might say, what do
you make them out to be? you make things inside on your own,
I mean I'm sure you make things you know. I want to, but
in spite of what they seem. I never trusted out there
I really don't trust them you know.
they're too much like the ones
in my life.
And in here you are alone...close to death. Of course,
She smiles at me. its all been done so
Don't you love to be alone... many times, and isn't it good to send the world back
to itself?
Back to itself?
Wherever it comes from, you know- back to wherever it
comes from.
Just leave me free whenever I wish, to sit here making
mountains... thinking of nothing to say.
Molly silent. Moving on the ceiling. Smiling.
Streaks of light.
Are you a witch, Molly?
Am I then?
They say you think you're a witch. That's why you're
in here...
A witch is it?
What do they think is wicked in this body? Born and
died the same. Who calls this Molly in my mind?
Who would call it Witch?
I don't understand...
You do - of course. You have a nasty habit, Acorn,
like a bad cold caught from them to say what is
can not be found. Your eyes say things,you know.
Don't worry... They say you once lived in the mountains, Mol'
- is that true?
Here I live with mountains - I lived th
them, yes...
looking across th
children come and go aro
you're the only one for no
Children?
Yes... coming as yo
You mean they we
Because of me
among th
floore
Ch



Sitting here, weary of all these silly games;
It was definitely much better last summer.
Why do you make up your own rules?
No-one else can play without,
Changing to suit your whimsically,
Distorted sense of reality.
But I refuse to give in.
I am not a toy to be manipulated.
So what if I don't get mad,
Outside is different, I keep it all inside.
Is there no reprieve, such ceaseless agony.
Is This what its ending means.

D.D. Rempel

WHY I DON'T SHOW THE WAY I FEEL TO YOU.

GROUND TO GROUND

Small rooms latch my mind.
Rooms that fill my heart are dim
But the ones that fill my teeth
are the ones that are not in the
right place.

Sherlock Lewis.
Riverview.

HARVESTER

Who will reap this rain
falling about the roof-tops red and grey
now the sun a long time
come again
out in March
the rains
down and to him
who holds the promise
captive summer, or spring
in these tears
a fruition denied
(mainly)
but savoured
anyhow
sowing space
by YOUR senses.

Geoffrey Button

QUIETLY

time howls and seasons roar
pounding savage around the door
of my lone soul

quietly i break inside
and watch chances
gone and near
shatter
unborn in fear

One hear
was all it was.
They don't count
the bullets
striking death.

One heart was
all it was.

Bullets are candy
and
one heart
was all it was.

Now I bleed
unseen; two hearts
was all it was.

Parents, sister, friends.
Many hearts
was all it was.

And bullets are candy.
And children
love candy
and games.

Bang! Bang! You're dead.

You won!

And Jesus
was a criminal.

Petra Graves.

LEGEND OF THE WOMAN AT THE MENTAL INSTITUTION BUS STOP.

Beside the Great South Road, near Auckland,
In a dream or maybe nightmare,
Sits a woman at a bus stop.
She has sat there every day
For thirty years the legend says.

In a dream or maybe nightmare
With a sandwich lunch she sits,
Feeding swallows when she's lonely,
Blessing blossoms in the springtime.

In a dream or maybe nightmare
She's been waiting for her lover,
Hands may shiver in the winter,
Sweat may blind her in the summer,
Miracles have been recorded,
Governments have come and crumbled
As she sits and prays to see
Her soldier lover coming for her.

Malcolm Crockett

COORDINATOR'S LAMENT

I'm not allowed to run the train
The whistle I can't blow
I'm not allowed to say how far
The railroad cars can go
I'm not allowed to shoot off steam
Nor even clang the bell
But let it jump the goddam track
Then see who catches hell.

- stolen from a bulletin board.

AFTERLIFE

You can find me in the sunrise
sitting alone with two beers
i wear tiny skulls around my neck
they are all of my friends
they talk argue among themselves
only i can hear them
there is the ocean outside
and it is raining
wind cuts thru the trees
an endless noise of cars
a girl sits down
skulls eye her
they need another lady
i buy a beer
and say nothing
for a long time
now we're in a chamber
beneath the water
we walk toward the forest
at the end of the corridor
each door slamming simultaneously
she weeps around my throat
and the skulls jeer

Gordon Williams

IN MEMORY OF A FRIEND,
MARY STEINHAUSER...

I'll meet you again
where the trellis
meets the roses.

When the wheat
stops fluttering
in my eyes,
I'll meet you again.

When the sunlight
stops bathing trees,
and the butterfly
hides its wings,
I'll meet you again.

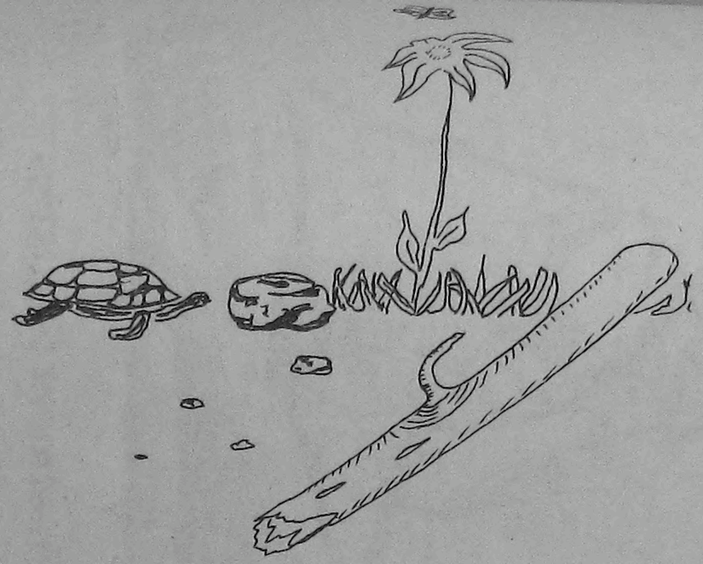
As a hiker
kicking stones
down lanes, I'll
look up suddenly
and meet you again.

Petra Graves.

YOU CAME HERE

You came here.
You lay quietly beside me.
You hurt; I knew that.
I watched you -
I had never seen such stillness,
Such real suffering.
I cared.
I hurt for you.
We talked quietly through that night.
Morning came uneventfully.
We slept.
I awoke first, I remember.
I lay there watching you breathe.
And I knew.
You finally awoke.
I was so shy -
Still I moved closer to you -
I touched you.
I waited.
You didn't respond at all
I wondered about that.
How long was it exactly?
Three days; I imagine.
Three days - no response - No sign you knew.
Finally I told you.
It was time.
I knew it would not change
anything -
I told you anyway
Finally you went.
As quietly as you came.
How long will it hurt?
I don't know. But I'm strong!
If only you had been strong
too -
Strong enough to be honest.

Judy Clements.



CREATION

As we wonder in the spectrum of life
Through the stairways beyond
We spread ourselves through, the
blossoming love there is
As in and out of along
All about us doth unfurl
beneath our feet the world
As the plants that we harvest
And the wheats that do grow
And we are taught what we reap
is that of what we sow.
And with the variety of spices
of life
Leading away from the man made strife
That they say of creation
and what does everything mean
There is a purpose for each and every thing
As you hear the pulse of the heartbeat
that surely doth ring
All around us life flows on
Until we believe it has gone
For really it hasn't it goes beyond
With forest green trees and white bark of birch
Where many a bird has had his perch.
With a wise owl sitting around
yet not making a sound.

Jeff Angel

SONGS IN THE NIGHT

Standing naked before the night
I shout my songs to the sea
But the waves rise in contempt
And crash upon my words

Time crawls from the foam
And laughs in my face

ATALANTA

electro-convulsive "therapy"

What is Shock Treatment?

Ugo Cerletti administered the first electrically induced convulsion in April, 1938 to a prisoner delivered into his care by the police. Cerletti had neither the permission of any authorities nor the permission of the prisoner himself to perform the experiment and he proceeded to administer a second shock despite the prisoner's clear statement "Not a second one, it will kill!"

Cerletti himself is reported to have remarked, "When I saw the patient's reaction, I thought to myself: this ought to be abolished. Ever since I have looked forward to the time when another treatment would replace shock treatment."

Thirty=eight years later this form of treatment is still widely used. Statistics from Riverview show that 3,982 shock treatments were delivered to patients at Riverview during 1974. This is only a small percentage of the total number of shock treatments given in Vancouver for all of 1974 since many depressed patients are treated in the general hospitals (eg. Lions Gate, VGH, Health Sciences, etc.)

Everyday people in Vancouver receive ECT for treatment of depression (especially involutional melancholia, this refers to depression experienced by a woman experiencing menopause), catatonic schizophrenia, manic - depressive psychosis, suicidal tendencies, lack of insight, agitation, refusal to eat or talk, delusions, crying spells, apathy, stupor, negativism (refusal to cooperate) and hostility are all characteristics which suggest to many psychiatrists that ECT may be in order.

METHOD

The technique of administration of electroshock therapy at Riverview goes something like this. The person is not allowed to eat or drink anything for 4 hours before ECT. During this period tranquillizers or sedatives may be used to reduce the subject's fears and "resistance to treatment".

Graphite jelly, applied to the two areas of the head where the electrodes are to be placed, increases conductivity and prevents burns. A fast-acting intravenously injected anaesthetic renders the subject unconscious.

Then succinylcholine, a muscle relaxant derived from curare (the poison used on the tips of poison darts) is administered to reduce the risk of bone dislocations and fractures. It causes almost complete paralysis, so that the subject's breathing must be assisted artificially.

The psychiatrist presses the button and anywhere from 70 to 170 volts are delivered across the temples. A current of up to one ampere passes first through the temporal lobes. The energy consumed is equal to that of a 100 watt bulb flashed for one second. If the convul sion threshold is reached a Grand Mal seizure ensues.

This may be repeated as many as one thousand times, although the usual course of treatment is between five and fifteen. The convulsion consists of a transient apnea followed by tonic stiffening and succeeded, in turn, by clonic shaking and a variable period of generalized depression, disorientation and confusion.

Amnesia, with respect to memory before treatment and memory after treatment, persist indefinitely.

Other possible side effects include headache, dizziness, muscle ache, nausea, and vomiting, fear, panic, combativeness and physical weakness.

The side effects are the manifestations of severe and abrupt stress.

The stress on a diseased heart may be excessive and many ECT deaths have resulted from cardiovascular collapse.

These are the most obvious side effects. Less easily observable effects include damage to the tissue of the brain, increased secretion of the thyroid glands and disruption of the biologic rhythms of body temperature.

The more subtle effects of shock treatment on the psyche and mind, are illustrated in the following exerpt about Ernest Hemmingway.

In December of 1960, Hemingway underwent a course of eleven treatments at the Mayo Clinic in Rochester, Minnesota. Three months later, he was back for another series. A. E. Hotchner writes "Ernest was even more infuriated with these treatments than the previous ones, registering even bitterer complaints about how his momory was wrecked and how he was ruined as a writer, and putting the blame for all this on the Mayo doctors, who had finally acceded to his demands: that they stop giving him the ECT's". Hotchner quotes Hemingway: "What these doctors don't know is about writers and such things as remorse and contrition and what they do to them. What is the sense of ruining my head and erasing my memory, which is my capital, and putting me out of business. It was a brilliant cure, but we lost the patient. It's a bum turn Hotch, terrible..." One month after the second series of ECT, Ernest Hemingway committed suicide. ★

Shock Treatment Statistics

During the last three months the M.P.A. Committee to Investigate Shock Treatment has been visiting with various psychiatrists at the major hospitals in Vancouver These visits have served a dual purpose of finding out each hospital's policy regarding ECT and also to gather pertinent statistics from each.

We compiled a series of questions which were given to each psychiatrist we visited and this article is based on their answers to these questions. As of this writing we have gotten replies from Dr. McFarlane at Riverview Hospital and Dr. Margetts, Head of the Dept. of Psychiatry at V.G.H. I will go down the list of our questions and the doctor's answers one by one.

Our first questions were on the number of admissions compared to the numbers receiving ECT, and a breakdown of their sex and age.

We received much more complete figures from Dr. McFarlane. The number of admissions to Riverview has decreased in the last five years from a total of 3300 to a projected total of 1797 in 1975. Each year the number of males admitted has outnumbered the females from 88 in 1970 to 524 in 1974. Surprisingly though, the number of females receiving ECT has always been running quite a bit higher than for males. Figures from Centre Lawn Unit show this ranges from 940 more female recipients in 1966 to 184 in 1969.

Both doctors made the point that the use of ECT has decreased over the last 10 years due to the use of psychotropic drugs. But at Riverview for the two years we have complete figures, 1973, there were 2830 shock treatments given and in 1974

COND. P. 15

this rose to 2982. I personally do not see a drastic drop in the number of ECTs given and in some units this figure has actually risen (e.g., Crease Clinic administered 766 ECT in 1973 and then gave 1033 in 1974).

Dr. Margetts told us that at VGH there were 1304 ECTs given in 1970 (or as he prefers to call them electroencephalotherapy. (personal note: a wolf in sheep's clothing is still a wolf) and this number decreased to 776 in 1974. But he fails to include how many patients these were given to, whether they were male or female or the total admissions to the hospital. We do know that there were 1576 admissions in 1974 but what about 1970? Has the percentage really dropped?

Our next question asked each doctor if there had been any complications from ECT in the past 5 years.

Dr. McFarlane told us of the usual side effects that occur. Headache occurs fairly frequently. Confusion occurs, more often with older patients, but is related to the number and frequency of ECT. He had no record of any fractures or dislocations in the last 5 years which he attributes to the anaesthia and muscle relaxants. But he does have records of two deaths which have occurred, one approximately 5 years ago, and the other more recently. Both were associated with cardiac arrest which he says might be attributed to the anaesthesia. Dr. Margetts told us that no complications had been reported to him as he was Head of the Department. He failed to tell us if there was another doctor in his department these would be reported to if any occurred.

Our next question was-did any people receive ECT involuntarily.

Both exclaimed that no patient in their hospitals had received ECT without proper consent, as defined in the Mental Health Act, had been given. They are talking of the little blue slip of paper one signs when one goes into a hospital giving the institution the right to use any form of treatment or diagnostic procedure on the patient which the superintendent deems necessary.

Our next question was what kind of follow-up program is used with people after their ECT.

Both said there is no specific or general follow-up program as it would be set up specifically for each individual by the individual doctors.

Our next question - the average number of treatments per patient.

At the Crease Unit it is currently 4 treatments per patient. At VGH the average number is 8, but some receive 3 or 4 while others get as many as 25.

What are the situations and indications for ECT to be diagnosed?

Dr. McFarlane states that the chief indication is indigenous depression. Dr. Margetts calls it deep depressive illness. Both say anti-depressive medication would usually be tried first but that would depend on whether the patient could be suicidal. Other conditions would be schizophrenia and neurosis, But Dr. McFarlane points out this is usually if there is a depressive element and has not responded to other treatment.

Is it used in conjunction with specific drug treatment?

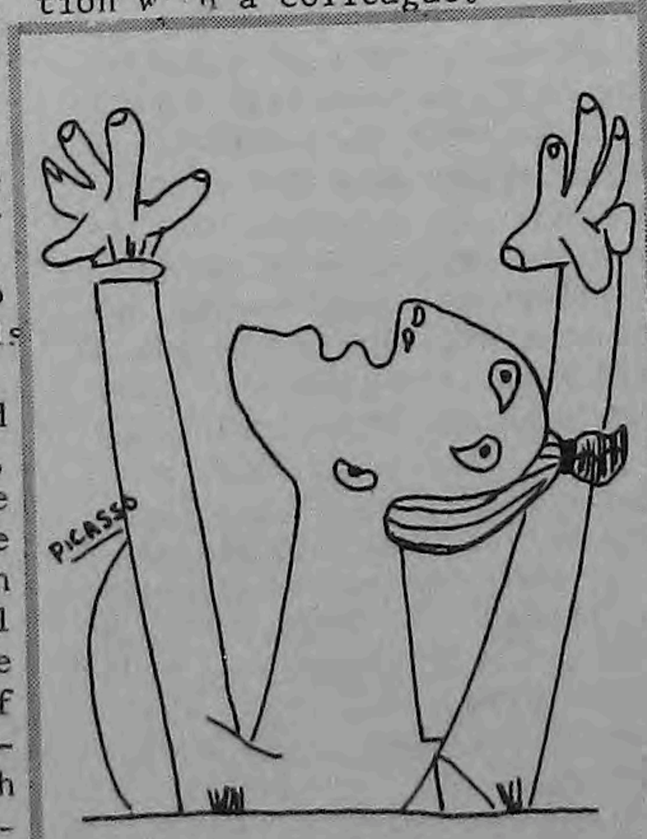
Yes, usually the patient is on some medication.

What are the statistics of recovery and relapse?

Dr. McFarlane said he did not have any specific readmission rates for ECT treated patients. Dr. Margetts also said he had no specific figures but he would guess it is no more than 10%. He felt if there were relapses it was probably due to an insufficient number of treatments in the first place. If more rather than too few are given then this will minimize relapse.

Our final question was - is there any control on the number of previous ECTs?

Dr. Margetts could not interpret this question. Dr. McFarlane said that the attending physician has the responsibility for use and number of ECT. If there is a danger of physical risk they do require a consultation with a colleague. ★



Voice of Shock

To think I have
Thought of myself
As magnanimous
In my decision to take
Your right to yourself
And as much of you
As I want.

Phil Prefontaine

Alternatives to Shock Treatment

It is very difficult to be around a person in pain especially emotional pain. Relatives and friends of a person undergoing a breakdown feel a need to act on the person's behalf by removing them from the household because they are being too disturbing or by giving doctors freedom to treat the patient.

Doctors use shock treatment as a "quick cure" which quite successfully eliminates the symptoms of a depression. In this "cure", the responsibility for what happens to the patient is taken completely out of her hands. Often the doctor makes the decision that shock treatment is the cure, he communicates this to the family, and they both undertake to convince the patient that it would be good for her.

In the past couple of months, I've talked to a lot of people who've received shock treatment. I asked all of them what might have helped them at the time that they freaked out or became depressed. Many said they needed someone to talk to.

A psychiatrist at St. Paul's hospital who does not use shock treatment said that he spends time developing a caring trusting relationship with the person. He feels that this is more effective on a long-term basis, than shock treatment.

It takes time and patience to come to an understanding of one's own behaviour. Depression and freakouts are understandable reactions to events in the outside world or in a person's inner world. Shock treatment eliminates the possibility of understanding by making a person forget or become confused about the events prior to treatment.

Other people felt that they needed a rest from the pressure of the responsibilities in their daily lives. In order to do that in a mental institution a person loses all power, including what is done to her body.

Consider the possibility of a person giving up responsibility for basic life support things like food preparation, maintaining a shelter and clothing, but being encouraged and helped to take responsibility for their own actions and their own learning about themselves.

This would amount to a place where a person could feel safe and could give up responsibility for taking care of themselves physically for a while without giving up all of their power. It is humiliating and degrading to be treated without your knowledge and without any recollection of what happened.

The basic elements of what many people seem to need when they are very depressed or upset seems to be a safe, comfortable place to be where they will be physically cared for, and contact with people who can help the person come to some understanding of what is happening to them emotionally and give support and validation.

The Vancouver Emotional Emergency Centre has existed for the past two years and has provided just such an environment. I have worked there for a year and am aware that it is a viable alternative to other psychiatric facilities.

Shock treatment has been justified by statements that it prevents suicides, that if a person didn't receive shock treatment they would starve themselves, or wear themselves out or otherwise damage their bodies.

For two reasons, I feel this is not valid. Firstly, suicide attempts are announcements that a person is not getting what they need out of life. A natural response to that would seem to be exploring with a person why they feel that way in context of a warm supportive relationship. Secondly, there is as much evidence to show that people commit suicide after shock treatments, because of the humiliation of having received shock treatments or fear of receiving more, than there is evidence to show that it prevents suicides.

I want to stress the need for more humane forms of treatment than the now extremely widespread use of shock treatment. ★

THE LAW

The Mental Health Act of British Columbia states that the consent to treatment forms (for shock treatment or any other treatment) for an involuntary patient, may be signed by the Director of the institution (i.e., the treatment may be performed without the patients consent).

On the other hand a person who voluntarily admits themselves, must sign a consent to treatment form before they will be admitted to the hospital, thus legally giving up their right to refuse treatment.

In neither case do you legally have the right to refuse treatment. There is no special consent to treatment form for ECT. One form is signed which applies to all forms of treatment that a psychiatric patient could potentially receive in the institution. ★

SELECTED ATROCITIES

NUTS AND VOLTS FROM THE E.C.T. MAIL BAG

DEAR EDITOR

Every day many people in Vancouver receive electroshock therapy for treatment of depression (especially involutional melancholia), catatonic schizophrenia, manic-depressive psychosis.

Suicidal tendencies, lack of insight, agitation, refusal to eat or talk, delusions, crying spells, apathy, stupor, negativism (refusal to co-operate) and hostility are all characteristics which suggest to many psychiatrists that EST may be in order.

During the month of September, 187 treatments were administered at Riverview Hospital alone. The majority of shock treatments are administered to the patients in psychiatric wards of the general hospitals (Vancouver General Hospital, Lion's Gate Hospital, Health Sciences, etc.).

The technique of administration of electroshock therapy at Riverview goes something like this.

The person is not allowed to eat or drink anything for four hours before EST. During this period tranquillizers or sedatives may be used to reduce the subject's fear and "resistance to treatment".

Graphite jelly, applied to the two areas of the head where the electrodes are to be placed, increases conductivity and prevents burns. A fast-acting intravenously-injected anaesthetic renders the subject unconscious in moments.

Then succinylcholine, a muscle relaxant, is administered to reduce the risk of bone dislocations and fractures. It causes almost complete paralysis, including respiratory paralysis, so that the subject's breathing must be assisted artificially.

The psychiatrist presses a button which releases 70 to 175 volts of electricity for one-tenth to 1½ seconds. The electricity penetrates the skull into the brain. This induces a convulsion, the movements of which are modified by the muscle relaxants. The convulsion is followed by a coma lasting several minutes.

Upon reviving, the subject experiences some of the following: headache, dizziness, muscle ache, nausea and vomiting, confusion, disorientation ("where am I", "who am I"), fear, panic and combativeness, physical weakness and memory loss.

The nature, extent, and duration of EST-induced amnesia have always been a controversial subject. The Committee to Investigate Shock Treatment is a group of people working out of Mental Patients Association. We are going to hospitals to talk to psychiatrists and reading material written about shock treatments.

More importantly, we want to collect reports written by people who have received shock treatments because we feel that these are the people most able to report the ongoing side effects of shock treatment.

If any reader has received shock treatment or knows someone who has received shock treatment, and would be willing to share this experience either verbally or in writing, please contact the Mental Patients Association, Committee to Investigate Shock Treatment, 2146 Yew, phone 738-5177 or 738-1422.

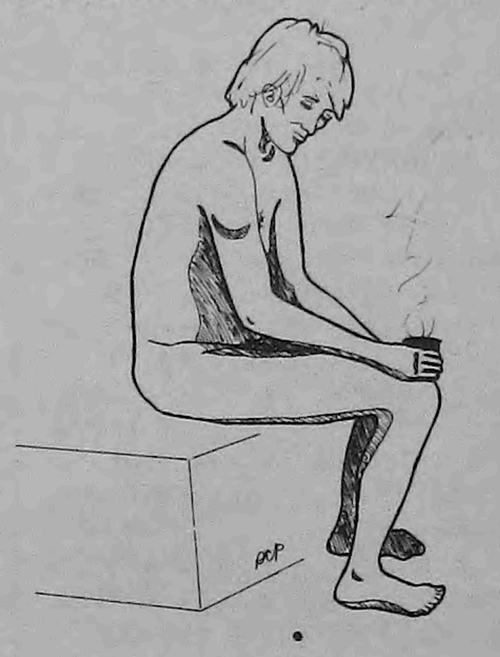
LAWRENCE BELFRAGE
KATHY KIDD
(MPA's Committee to Investigate Shock Treatment)

TO WHOM IT MAY CONCERN:

I am presently 42 years old. About sixteen years ago I was hospitalized in another Canadian city, although I had committed no crime, I was placed in a psychiatric ward where I was subjected to repeated shock treatments. Incidentally, I was not rendered unconscious prior to the treatments, as your article suggests is the practice today. I found the experience extremely painful and disorienting, and threatened one of the doctors who was administering the shock treatments with a law suit. His reply: "Why don't you?" I have never felt as physically strong since receiving the treatments as I was before receiving them.

After giving the matter considerable thought, I have come to the conclusion that the psychology of administering shock treatments is basically one of guilt and punishment----a punishment which takes the form of a ritualistic near-killing and in some instances leads to actual death, as is well known. (I have also experienced insulin shock treatments, against my will, and the doctors had to suspend the procedure when I didn't awaken from an insulin-induced coma for several hours.) The patient feels guilty and is punished by being symbolically slain. We have not basically advanced from the middle ages, where such methods as water torture were used. (Of the two, I would prefer water torture.) The fact that psychiatrists admit they do not know how electroshock works is tantamount to an admission of the truth of what I am saying. Believe me, it is barbaric, and will someday be regarded with the abhorrence with which we now regard the burning of witches. While I am on the subject, I would like to add that I was once instrumental in saving someone from having a lobotomy performed on that person, and she is now leading a normal life.

I am a professional man, and for obvious reasons I do not wish to reveal my name.



When I look back at my experiences in a Mental Institution and the different forms of treatment especially ECT I am filled with fear of ever having to be subjected again to the cold and callous manner in which the staff treated myself and other patients. I certainly would never return voluntarily, my first experience with ECT was very terrifying. I had just been admitted to the institution and after a few days had started to talk to a couple of patients. One girl I had been talking to was having ECT treatments, the first time I had seen her and the other patients who were having ECT I felt numb with fear, as I watched them come back looking white-faced and staggering, some being physically supported by staff, they looked like zombies as they were being led to a table set up with toast and coffee for them.

I tried talking to this girl after the treatment and she did not recognize me at all. A short time after seeing this I was painting my nails one night and a nurse seen me and told me to take the nail polish off because I was having ECT in the morning. I was told nothing of this until then and was terrified. I stayed awake all night and the next morning was taken into a dorm, half of the dorm was partitioned with white sheets and I heard some short strange noise, a nurse gave me a shot in the arm, she said it was to dry up my saliva.

I started screaming loudly I wanted to see the doctor and finally the nurse contacted my doctor. I was let out of the dorm shaking all over and was taken back again by another nurse who wouldn't believe that I was to see the doctor first. It was soon straightened out to my relief when I seen the doctor he told me not to take it as a threat but if I did not participate in occupational therapy I would have to have ECT. I was discharged shortly after.

A few years later I was in the hospital again. This time I was forced to have ECT. I was terrified and was dragged by the nurses down the hallway to a room - the hall door was locked behind me and I was put into a bed with my head at the foot. The sheets were folded back to expose my feet. I thought all sorts of terrible things. I saw a machine being wheeled in and I completely panicked. I was held down by male and female nurses as the doctor forced a needle into my arm.

I had six of these treatments the first time, the second series of six I had on another ward and the fear had increased. I was led up to another ward with other patients. We were all lined up in single file in beds one by one. A bed was dragged behind a curtain until it was my turn. I was pulled into a brightly iit room and given a shot. After each treatment I awoke very confused and with a severe headache, and, supported by a nurse, I was led back to my ward. I begged the doctor not to give me anymore and he would not listen. At the time I was epileptic but did not know I was - I was told what I had was "panic attacks". The panic attacks have now progressed - into Grand Mal seizures - and I cannot help but think I was lucky these treatments did not kill me.

After I left the hospital I found a couple of letters written to me by an ex-

patient who had left my ward. She wrote me these letters while I was still in the hospital. The letters were ones you would receive from someone who you would know well - I have no memory of her at all , and at a few different times when I was out I was approached by people that said they had been with me in the hospital. They were total strangers to me and yet they knew me well enough. I have an extremely poor memory now. These blank spots in my life have made me afraid of seeing people I THINK I know because I really don't know whether I know them from hospital or have met them elsewhere. It has been very embarrassing for me to explain to some people I had no memory of them or to explain to someone I vaguely recognize.

Based on my experiences of having ECT, being given no explanation why I was having it and the lack of concern about my fears, my poor memory and the blank spots, I certainly feel it did not do anything good for me but rather the opposite. I do not advocate this inhumane "treatment".

Sharon Mae Douglas

When Miss Callaghan had discovered enough symptoms, I was sent to the Bellevue children's psychiatric ward, to be officially diagnosed and to be made an experimental animal for Dr. Bender. I was one of the first children to be "treated" with electric shock. I was six years old.

I gave up that little boy for dead thirty years ago, but now he's come back to life, kicking and struggling. I won't go to the shock treatment, I won't! It took three attendants to hold me. At first Dr. Bender herself threw the switch but later when I was no longer an interesting case my tormentor was different each time.

Ted Chabisinski

Dear Mr. Belfrage;

Back in 1965 I recieved 16 shock treatments. They had considered me violent because one thing led to another and I had given my husband a punch in the mouth. I tell you this because my husband had the treatment stopped after 16 because he felt I was more violent. The truth is I'm not violent and after some talk, the doctors didn't wonder that I struck out at my husband.

I found, along with my mates at the hospital, that I was terrified of the shock treatment. A lot of it too was the feeling after. Your head burned, you felt burnt out. Your mouth felt burnt out and dry. You couldn't think and you felt groggy like your head and body weighed a ton.

I don't know how long it lasted but at one point everything went black. I found myself sitting at the table in the ward and realized everything was black and I couldn't see and then gradually the room and things in it came into focus.

I got so I would run and drink water and I'd yell, 'I took a drink of water.' They carted me off to shock anyway. When I found it did no good I stopped for fear they'd accidently kill me with the water in me.

The thing I found for a-long time was when I tried to remember my head, right at the top, I would feel paralized and hurt with the effort. Today I have fairly good recall of the past, but say little facts like Columbus sailed in 1492 were hard to remember. A lot of times I'll try to recall something that happened in the morning and my brain would feel paralized and just not work and I can't recall. I'll forget what I'm talking about in the middle of a sentence on rare occassions.

I had a mark all along my hair line where I was apparently burnt. It was all scaley and red.

On observing others after shock you can really see the effort it takes to function.

The thing that gets me is they seem to want to use it for every excuse. in Montreal they wanted to use it because they felt I wasnt displaying enough emotion when my husband left with my children while I was in hospital. What was the point, you tell me, when they were standing ready to jab me with needles if I get overwrought. Doesn't make much sense to me. It's a difficult thing to be mentally ill and even more difficult to get well with proper experimenting with you and adding to the fear you feel from being locked away from loved ones, familiar things and your freedom completely gone. You can't say no to anything and aren't credited with any sense. I think what I'm trying to say can be summed up in a little joke the patients shared at the Nova Scotia Hospital.

It has very beautiful grounds there and people often drive in for a look around. One such man was there and on his tour the wheel came off his car. A patient out for a stroll observed the situation and said, "Why don't you take a nut from each wheel to hold it on til you get to near a garage." The deal worked perfectly and the man said,"are you a patient here you seem pretty smart." The patient looked at him and said,"that's the problem I'm crazy, not stupid."

Well thats all I have to say. Hope it helps you out.

NAME WITHHELD ON REQUEST

I had 36 shock treatments over the period 1973-75 some at the Vancouver General and the rest at Riverview. I feel that shock treatments destroy brain cells and leave the victim with an inability to think properly. I started off as a school teacher but could never do it now. Also, there are periods in my life that I cannot remember. Psychiatrists say I don't want to remember but that's not so.

My biggest problem with EST was that one of the last treatments, they gave me the anaesthetic and the shot to relax the muscles, only the anaesthetic wasn't strong enough and I woke up unable to move or breathe. It felt when they gave me the shock when they gave me the shock treatments, as if a million wires were bugging inside my head. I still have nightmares sometimes about this.

Sharon.

Dear Ms Kidd & Mr Belfrage:

I am a 28 year old woman who underwent EST 26 times in a period of six months. This occured 3 years ago while being treated for "involutional melancholia."

I have since trained as a psychiatric nurse and am now working on the "inside" to improve treatment of mental patients a little. Believe me, it is a frustrating and almost hopeless process.

My experiences with shock were very negative. The whole procedure has a rather barbaric and tortous aspect. In fact, working in psychiatry now, I frequently encounter overt and covert threats of shock if a patient doesnt "smarten up."

During my course of treatments, when I expressed my terror of electricity shooting through my brain, or asked why I was being tortured and punished; I was told these "delusions" were part of my sickness.

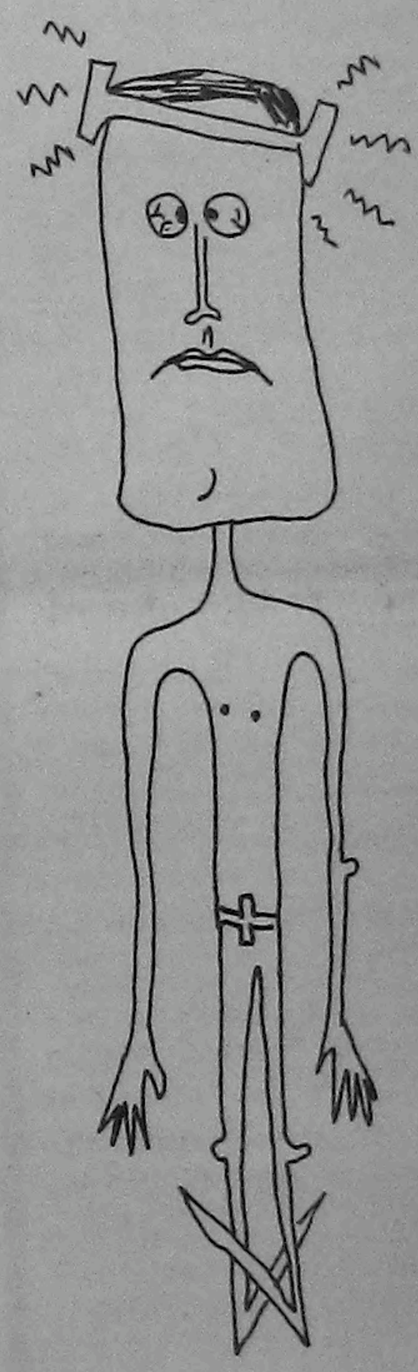
The helpless confusion following treatments is overwhelming. It is of little consolation that I temporarily "forgot" why I was depressed. My long-term memory was definitely impaired. My recall for names places, and incidents had been excellent prior to these assaults. Even today there are huge gaps in my past.

I have met patients who say they have been helped by EST. Unfortunately, these people have been "taught" to depend on the treatments- in the same way that psychiatric staff reinforce dependence upon psychotropic drugs. "Take your pills or you'll be back in hospital."

I personally feel that abolition of this 'therapy' would prove a step towards a more humane psychiatric care.

Unfortunately I feel compelled not to sign my name. Of course my past experience as a 'mental patient' has been kept a deep dark secret in my new career. The stigma is still very strong - especially in the psychiatric profession.

Good luck in your work.



In April of 1970, at the age of 29 years, I was admitted to the Royal Hospital, Kamloops in a state of depression. Depression is my own diagnosis of my condition as I was not aware of having been told exactly what was wrong.

I had not previously suffered from depression or any mental disorder, nor to my knowledge, is there a history of depression or mental illness in my family. I had a reasonable childhood, an emotionally satisfying marriage, along with two reasonably well-adjusted children and an ample financial status.

Upon admittance to the

hospital, I was subjected to a most frightful experience. The hospital was overcrowded as most are. I was put into a room which contained a bed and a mattress on the floor. I was assigned to this bed. The person on the mattress, although quiet while the nurses were in attendance, tried desperately to relieve me of my clothing and other belongings. Her personal effects had been confiscated due to her condition and she was determined she would clothe her naked body and escape her surroundings. I was about ready to join her.

My inability to cope with my own emotions left me ill-equipped to handle this sad creature. It was shattering and detrimental to my condition.

I am told that during this time I was interviewed by a psychiatrist of whom I have no recollection. I was given drugs and slept a great deal of the time. On the third day after admittance I was told, that as a course of treatment, I would receive shock treatments. I was frightened. I was not consulted as to whether or not I would feel that this treatment would be beneficial. I expect I was considered incapable. On the morning of the first treatment I was put on a stretcher and wheeled into the TV and recreation room. As I mentioned the hospital was crowded. There were between 15-20 patients on stretchers male and female. The nurses came and taped adhesive over the rings on your fingers and asked for your dentures. We were strapped into the stretchers, and told that upon waking we may feel nauseous and headachey. We were like a herd of animals.

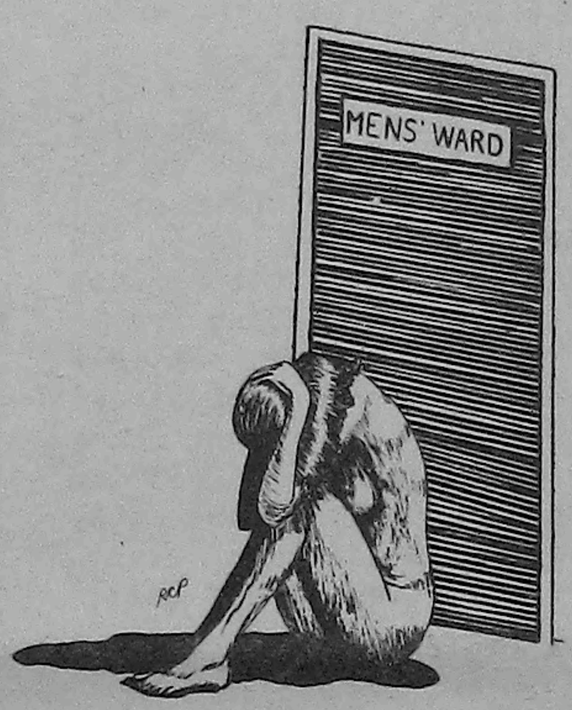
One by one we were wheeled into a very small room where two psychiatrists and an anesthethist sat around a complicated machine. They did not explain what the machine was, what it did or what was about to happen to you. There was no reassurance and fear of the unknown is a hard thing.

They put a jelly substance on my temples and hooked me up to this machine. Then a needle in the arm and a complete loss of self. I received five or more of these treatments during my 8 day stay in the hospital. This was the only therapy I received. I did not suffer headaches or nausea. I did experience a confusion of where am I and who am I. I returned as an out-patient, for perhaps five treatments. Always the same, strapped into a stretcher, and your dentures please.

Six months later I was again treated for depression I think this depression may have been caused by my inability to cope with the trauma of Electro-Shock Treatment. If anything they have made me feel abnormal and ashamed. I don't talk about my shock treatments.

Physically there is one thing I seem to have a lot of irregular heart beats. I mentioned this to my G.P. and he asked me if I had ever suffered from depression.

Sharon Listad.



Shock Treatment: I was hospitalized in the summer of 1964 in the Bay Pavilion of Royal Jubilee Hospital in Victoria. I was severely depressed and given shock treatments.

Treatments were given Monday, Wednesday and Friday mornings. The patients who were to receive them gathered in the lobby, outside the dining room and across the hall from the shock room. There would be about twenty of us, waiting in our pyjamas while the other patients filed in for breakfast- we just sat, numbly waiting our turn. Sometimes we held hands, to comfort ourselves and each other. Every twenty minutes or so the door of the shock room would open and a patient would be wheeled out on a stretcher. one of the doctors would emerge and call the next in line, and escort them into the room. the doctors always held our hand for this short terrifying journey, and mine continued to hold my hand inside the room each time, until I was asleed.

There is something inexpressibly frightening about being put through a really bad experience in the name of kindness. The idea that someone can do ugly things to your body and your mind while claiming that they are only interested in your welfare, is so alienating, I still can't handle it. It always reminds me of the stories about the experiments carried out on inmates of German concentration camps in World War 11. I think it's a socially acceptable version of the same thing. I have never dared say that before, certainly never in the hospital- I would have quickly been labelled paranoid psychotic and consigned to the scrap heap.

Anyway, the treatment room looked like a small operating room, more or less. I was helped to lie on the table, given a shot of soduim pentothal in the arm. The doctor talked softly to me and held my hand until I was unconscious. On one occasion the shot apparently went into an artery instead of a vein, and my left arm went completely cold and dead, but the rest of me didn't. They put a rubber wedge in my mouth, clamped my head, strapped my arms and legs down - and then someone noticed I was still awake, fortunately before they pulled the switch. The second shot put me out.

About the soaking wet pyjamas; one of the less lovely side effects of shock treatment is that it makes you urinate, so you wake up sopping and stinking.

Every time I woke up I would take a mental inventory to see what I had forgotten; because I would be aware that I had had shock treatment and that it was supposed to make me forget things. Once I couldn't remember where I was, but that wasn't so bad because that often happens when you wake up in a strange place. The one time that really scared me was when I couldn't remember where I lived. I knew I had a husband and three small children - someplace. I could picture them but I couldn't form any mental image of where they were I cried for a long time that morning because I felt so cut off from them, I felt like I'd lost them forever. Lord, may I never be that lonely again.

Several times I have had strangers come up and greet me with great affection, and I've had to tell them, look, I don't know you, I don't remember you, I never saw you before; and that hurts them. And it hurts me. The first time it happened with a woman that had been my next-door neighbour in Victoria, and I tried at first to tell her she'd made a mistake. But she knew me knew all about me, and finally I just had to admit, there are things I will never remember.

It is not true that shock treatment cures. What it does is terrify. For some people, that pressure is greater than the pressures that put them in hospital in the first place. These people, and I was lucky to be on of them, react by pulling themselves as together as they can, simulating the behavior the doctors want, and getting themselves released. Then they get well, or they don't, by themselves. They have found out that there is something worse than their lives outside the hospital, and that is life inside the hop
hospital. For me, and I'm sure for others too, just the memory of being a thing in a bed (or on a floor) is enough to keep me going. Whatever happens to me, it can never be that bad again; and since I survived the hospital more or less intact, I expect to be able to handle anything. If I were ever again faced with the prospect of being in a mental hospital, I would kill myself rather than go through it again.

And what about the patients who can't get themselves together enough to get away, get out, defend themselves? For them, shock treatment must be just the world beating on them again proving the hopelessness of their situation. Because when you are sick and needing help so desperately, you reduce the world to terms simple enough for you to handle. It doesn't matter to you then how softly the doctors talk or how sympathetic they seem to be - all that counts is what they do to you. Does it comfort or threaten you? Does it soothe or hurt? Shock treatment, when you strip off all the pretensions, is cruel, and no amount of expressions of good intensions will make it otherwise. It's in the same class with beating a child "for his own good". It couldn"t possibly help anyone. ★★★

DIRECTORY

MPA Drop-In Centre	2146 Yew St.	738-5177
		738-1422
Riverview Office		521-1911
		LOCAL 538
MPA Residences:		
2021 E. 8th		255-5312
1754 W. 11th Ave.		732-8222
1656 E. 4th Ave.		253-6996
2805 W. 7th Ave.		733-5733
2756 W. 10th Ave. (Womens)		738-7421

LEGAL HELP

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

DROP IN CENTRES

Coast Foundation	876 E. 18th	879-2363
MPA	2146 Yew St.	738-5177
Vancouver Activity Centre (CMHA)	719 E.30th	876-9511

CHEAP PLACES TO STAY

Jericho Youth Hostel ($10 membership/ $2 per night/ 4 night stay) ft. Discovery and N.W. Marine		224-3208
YWCA	580 Burrard $7.50	683-2531
YMCA	955 Burrard $7	681-0221

HOSTEL BEDS (FREE)

Catholic Charities	150 Robson	683-0281
Lookout	412 E. Hastings	253-6418
Central City Mission	233 Abbott	681-3348
VRB Night Line (when hostels full)		733-8111
Crisis Centre	1946 W. Broadway (in a crisis only)	733-4111
St Francis Hotel (women) Cordova and 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) 199 W. 6th		874-9009

PLACES TO EAT FREE

Harbour Lights (Salvation Army) 119 E. Cordova.	11:30 a.m./8 p.m.	
Downtown Community Health Society 373 E. Cordova/	soup at noon	
MPA	2146 Yew. Wed. dinner	
	Sat. breakfast	
Kits House	7th & Vine Thur. dinner	

EMERGENCY

Fire and Inhalator	34-1234
Police/Police Ambulance	665-2211
Ambulance	872-5151

HOSPITALS

Vancouver General	876-3211
St Pauls	682-2344
Health Sciences UBC	228-3731
Riverview	521-1911
Lions Gate	988-3131
Burnaby Mental Health Centre	434-4247

CRISIS LINES

Crisis Centre	733-4111
Now (Youth Line)	733-4115
Vancouver Emotional Emergency Ctre	872-7914
Chimo (Richmond)	273-8701
Lifeline (Coquitlam)	526-4444
MPA	738-5177

FREE MEDICAL

Pine St. Clinic	1985 W. 4th	736-2391
V.D.Clinic(VGH)	828 W. 10th	874-2331
Reach	1144 Commercial	254-1354
Vanc'r Womens Health Collective	1520 W. 6th	736-6696
Downtown Community Health Society	373 E. Cordova	685-2744

FREE DENTAL

Vancouver General Hospital 9-12 weekdays:	876-3211
Emergency dental 6p.m.-midnight:	874-9848
Reach 1144 Commercial	254-1354

PLACES TO EAT CHEAP, GOOD FOOD

nr. MPA

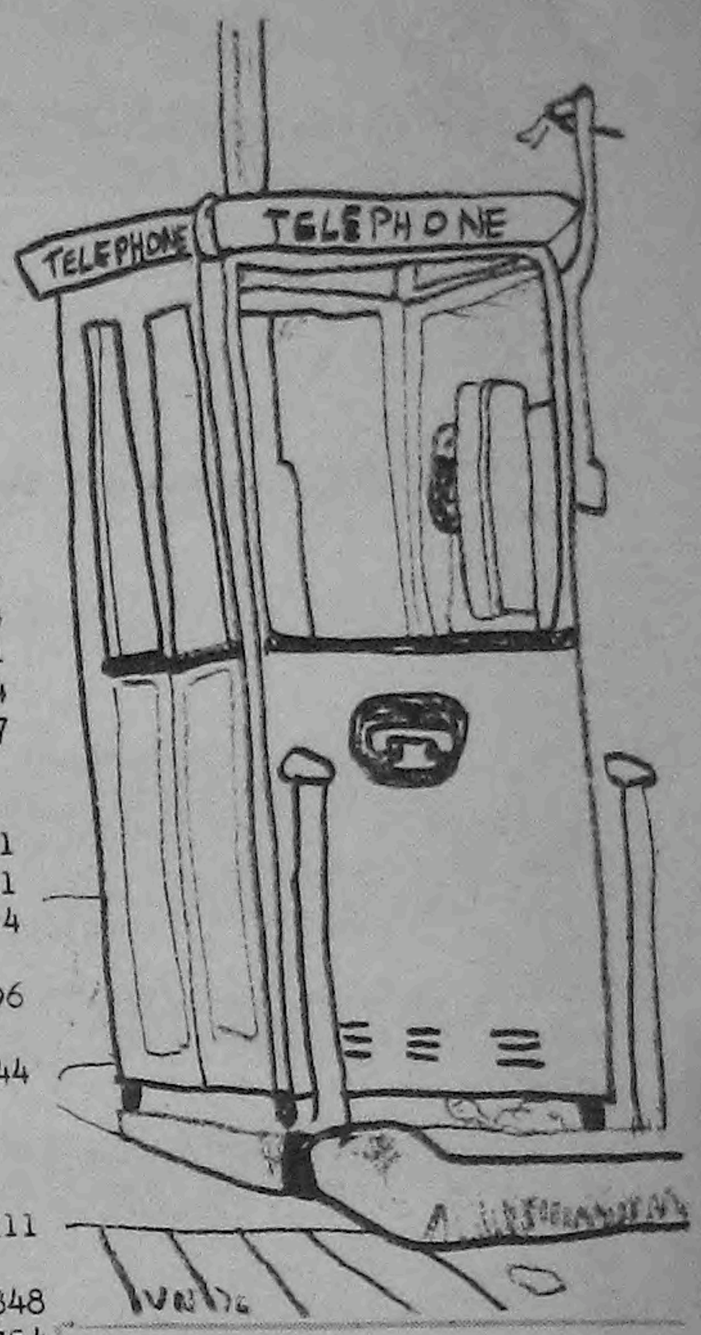
Gladys Snack Bar 4th near Yew

Minnie-Vern W.10th near Yew (open 6 a.m. to 3 p.m.)

Rice Bowl, Chinese food Broadway & Main

OTHER HELPFUL SERVICES

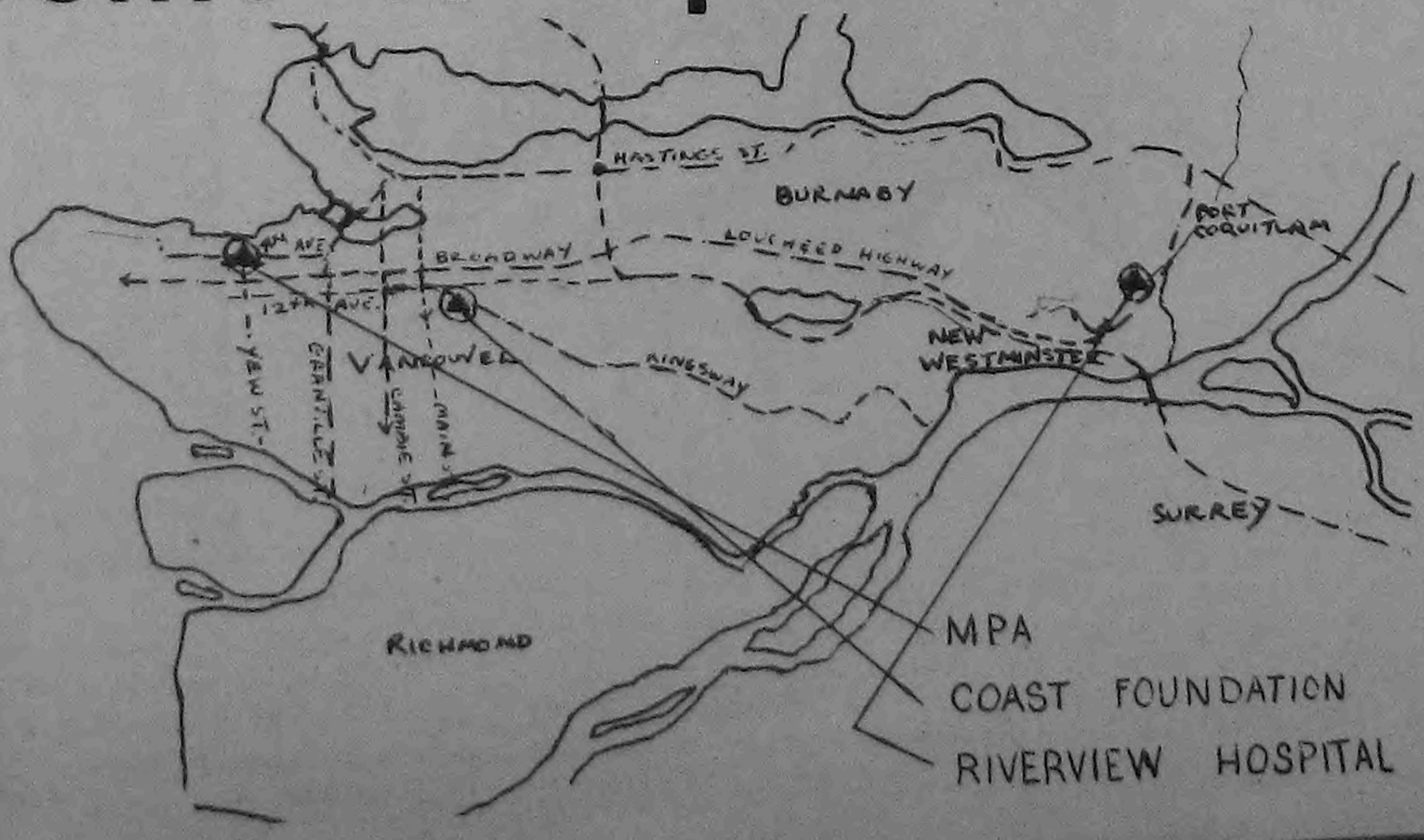
City Centre Youth Resources 52 Water	688-2565
VEEC 220 W. 6th	872-7914
Kits Information Centre 2741 W. 4th	736-3431
The House (soft drug bummers) 2nd flr. 820 W. Broadway	732-3301



Come to the MPA drop-in centre for the day where you are welcome to sit around and talk to ex-patients, play pool, take part in any activities, drink coffee, use the phone, etc.

MPA co-ordinators will be glad to talk to you about housing in Vancouver, your legal problems, where to find inexpensive restaurants at reasonable prices, places to go for entertainment or dancing, hostels where you can spend the night if you have a weekend pass, and bus tours of the city.

got a day pass? NOWHERE TO GO? come to mpa



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.

WHERE ELSE TO GO?

If you'd like to go to the Coast Foundation Drop-in Centre, 876 E. 18th Ave., travel to town the same way but get off the 933 Lougheed bus at Main and Hastings. Walk up to Pender & Main and transfer to 19 Kingsway. Get off at 18th and Kingsway. See you soon!

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.