Between Care and Control: A Discourse Analysis of Vancouver's "Mental Health Crisis"

by

Christopher John Van Veen

Master of Social Work, York University, 2009

Bachelor of Social Work, Thompson Rivers University, 2008

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Name: Christopher Van Veen

Degree: Doctor of Philosophy (Health Sciences)

Title: Between Care and Control: A Discourse Analysis of Vancouver's "Mental Health Crisis"

Examining Committee:

Chair: Mark Brockman
Professor, Health Sciences

Marina Morrow
Supervisor
Professor, Health Policy and Management
York University

Katherine Teghtsoonian
Committee Member
Professor Emerita, Public Health and Social Policy
University of Victoria

Susan Erikson
Committee Member
Professor, Health Sciences

Eugene McCann
Examiner
Professor, Geography

Thomas Kerr
External Examiner
Professor, Medicine
University of British Columbia

Abstract

In 2013 the municipal government of Vancouver, British Columbia, Canada declared itself to be in the midst of a “mental health crisis”, evident in increasing rates of psychiatric hospitalizations and violent incidents involving people with “untreated severe addictions and mental illness” (SAMI). This discourse analysis engages with policy texts published between 2008 and 2016 that problematize the “mental health crisis” and propose a range of solutions aimed at resolving it. Attention is given to the ways in which psy and security discourses reinforce the notion that people who struggle with mental health and substance use are sick, incompetent, and prone to irrational outbursts of violence. I argue that this characterization opens the door for a range of new technologies of governance in the inner city. Particular focus is given to proposals that Assertive Community Treatment (ACT) teams be implemented in partnership with the local police department to manage the risks that people with untreated “SAMI” were said to present for the security of the city.

ACT typically involves a range of interdisciplinary mental health professionals who collaborate to deliver outpatient care to people with mental illness living in the community. However, in the Vancouver context, several teams have been modified to include roles for police officers in clinical service provision. There remains a scarcity of research on the forms of governmentality present in mental health program modifications that involve law enforcement. This dissertation uses Carol Bacchi’s (2009a) What’s the Problem Represented to be? (WPR) approach to interrogate the problem representations found in mental health policy documents that position ACT as key to ameliorating Vancouver’s “crisis”. The WPR approach starts with the basic premise that policies make a variety of assumptions in the way they understand the problems they seek to address. Instead of studying “problems”, it examines the *problematizations* surrounding the “crisis”, and the discursive, subjectification, and material effects they produce. I also elucidate how forms of resistance advanced by activists, critical scholars, and people with lived experience of mental distress and substance use challenge the coercive practices of new regimes of community-based care.

Keywords: Vancouver Mental Health Crisis; Discourse Analysis; Assertive Community Treatment; Housing First; Harm Reduction; Severe Mental Illness and Addiction; What’s the problem represented to be approach

Dedication

I dedicate this dissertation and every other accomplishment, no matter how big or small, to my mother Nancy Van Veen and grandmother Elizabeth Stout.

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I would like to first acknowledge that this research was undertaken on the unceded and occupied territories of the Musqueam, Squamish, and Tsleil-Waututh First Nations, where I have lived and worked as an uninvited settler since 2007.

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List of Acronyms

ACT	Assertive Community Treatment
AOT	Assertive Outreach Teams
BC	British Columbia
BCMHA	British Columbia Mental Health Act
CDA	Critical discourse analysis
DTES	Downtown Eastside
DPA	Deliberative policy analysis
DSM-5	Diagnostic and Statistical Manual, Fifth Edition
EDP	Emotionally disturbed persons
EWS	Early warning system
FACT	Forensic Assertive Community Treatment teams
FDA	Foucauldian discourse analysis
HCV	Hepatitis-C virus
HIV	Human immunodeficiency virus
MHCC	Mental Health Commission of Canada
PRIME	Police Records Information Management Environment
SAMI	Severe Addictions and Mental Illness
VCH	Vancouver Coastal Health
VPD	Vancouver Police Department
WPR	What's the problem represented to be?

Chapter 1.

Introduction

1.1. Introduction

We are now in a situation where there are hundreds of people with severe but untreated mental illnesses that are at a high risk to both themselves and residents of the city.

Vancouver Mayor Gregor Robertson (Cited by Woo, 2013)

The judges of normality are present everywhere… [w]e are in the society of the teacher-judge, the doctor-judge, the 'social worker'-judge; it is on them that the universal reign of the normative is based.

Michel Foucault (1995; 304)

In 2013, the municipal government of Vancouver, British Columbia (BC) cited data from local health authorities and anecdotal reports from the Vancouver Police Department (VPD) to alert the public's attention to what was described as a state of "mental health crisis" (VPD, 2013). Referencing the "public health crisis" declared by the Vancouver Richmond Health Board a decade earlier in response to rising rates of HIV transmission and overdose deaths in the inner city, a police department report explained that the "current situation regarding untreated, severely mentally ill people is on par with, if not more serious than, what Vancouver faced a decade ago… [t]he "public health crisis" is now a "mental health crisis" (p. 30). A year later, Mayor Gregor Robertson described the crisis as evident in "a surge in people with severe, untreated mental illness and addictions at St. Paul's Hospital[1], a dramatic increase in people taken into police custody under the Mental Health Act, and several violent episodes that indicated a major crisis in the health care system" (City of Vancouver, 2014; p.4). This characterization of people with mental health struggles as representing a violent threat to

[1] St. Paul's Hospital is a large acute care, teaching and research hospital operated by the Providence Healthcare Authority in Vancouver's downtown core. The hospital prides itself on its "world class" approach to urban health, particularly in the areas of HIV/AIDS treatment, mental health care, and addictions treatment.

the security of the city helped to pave the way for increased involvement of police in mental health service delivery, leading to significant reconfigurations of care and control in the years to follow.

This dissertation examines BC mental health policy texts, published between 2008 and 2016, that focus on the "mental health crisis" and various government proposals put forward to address it. The documents come from a variety of sources, including the City of Vancouver, BC Ministry of Health, local health authority and Vancouver Police Department (VPD). The choice to examine this period in BC's history of mental health policy was made because it produced significant reconfigurations in care in response to the crisis, most notably increased disciplinary practices brought by including police in mental health service delivery under a new "joint service" Assertive Community Treatment (ACT) team model and its forms of governmentality which aim to reshape and responsibilize the conduct of people deemed "severely mentally ill and addicted" (SAMI[2]).

ACT is an intensive community-based outreach program for people struggling with severe mental illness. Originating as a treatment alternative to inpatient care during the US state of Wisconsin's deinstitutionalization efforts in the 1970's, ACT has come to be recognized as one of the most "evidence-based" models of community mental health care, recommended by the Canadian Mental Health Association and BC Ministry of Health. ACT teams are interdisciplinary, staffed by psychiatrists, nurses, social workers, and occupational therapists who offer social supports and pharmacological treatments. In Vancouver, ACT was first introduced by the Vancouver Coastal Health Authority in 2011. A year later the health authority struck a new "joint service arrangement" with the local police department, placing plain clothes officers on the teams. New forms of governmentality present in ACT's local implementation are a key focus of the chapters to follow. In them, I approach ACT as a key entry point for examining the problematization of "untreated SAMI" and Vancouver's "mental health crisis".

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[2] People are said to have "SAMI" if they are diagnosed with least one "of the major Axis I Disorders as defined by the Diagnostic and Statistical Manual (DSM-IV-TR) … individuals whose functional capacity is seriously compromised... [including] forms of substance use, eating, and anxiety disorders as well as mood and psychotic disorders" (Patterson, et al., 2008a; p.8) combined with persistent substance use.

While ACT was being implemented in Vancouver in the early 2010's, I was working as a clinician in community-based harm reduction and supportive housing programs. The modification to include police officers on ACT teams appeared to be an abrupt and potentially coercive change in the way community mental health services were being delivered. I desired to better understand how this shift in "care" came to be, and so proposed doctoral research on the subject. The initial steps of my research involved systematically collecting texts which reference ACT as a "solution" to the "problems" of "severe untreated mental illness", "addiction", and "homelessness" in BC. However, as I refined my research questions and poured over the documents it became apparent that ACT was viewed principally as an intervention well-tailored to address several key problem representations in Vancouver's "*mental health crisis*", including: the danger that people with mental health struggles are thought to represent to themselves and to the security of the city; a lack of capacity for psychiatry to extend its reach into the community in the post deinstitutionalization era; and rising costs being incurred by the state as a result of "inefficient" care for people with untreated SAMI (VPD, 2013). Therefore, a range of additional documents that reference the broader local problem space surrounding mental health and substance were also collected and analysed.

Although I focus on texts published over a short period over a decade ago, an analysis of discourse surrounding the "mental health crisis" and ACT is relevant for present debates about the complex and at times fraught relationships between community-based mental health care, substance use, homelessness, and policing. Indeed, the "crisis" that will undoubtedly be more freshly on the minds of readers is that of the tragically high number of illicit drug toxicity deaths that have occurred in British Columbia since 2016—the year that brackets the end of my analysis. In many respects, my analysis of "addicting" assumptions, and of the disciplinary power of policing psychiatrized people and people who use drugs foreshadows present circumstances and offers insights to inform a range of reform efforts regarding community policing and mental health and substance use services.

1.2. Research Questions and Introduction to the WPR Approach

This research unsettles the common story that police, municipal officials, healthcare administrators, and researchers tell about why so many people are living in such profound states of distress in one of the world's most "livable", affluent cities (Jung, 2019). Carol Bacchi's (2009a) What's the Problem Represented to be? (WPR) framework forms the theoretical backbone for my analysis of the discourse involved in constructing the "crisis". The WPR approach upends the notion that everyone *knows* what the "problems" are in society, and that the job of policy analysts is to simply define them, measure their severity, and recommend what ought to be done to resolve them. Many researchers and policy makers empirically approach health and social "problems" like "untreated mental illness", "gaps in community-based treatments", and "homelessness", as though they are pre-established, taken for granted, and relatively fixed objects of thought. That is not the approach of this dissertation.

Instead, I start with the premise that all policies make deep ontological assumptions about the "problems" that they seek to address, rejecting the positivist notion that problems exist "out there" beyond the cultural values and assumptions that shape our knowledge of them. Although I address the broader socio-historical context of the problem representations found in texts, I do not offer an assessment of the "real problems" facing Vancouver's inner city. Following Bacchi (2009a), the emphasis of my research "is not on the nature of those conditions but rather on the shape of the implied 'problems' in specific proposals" to solve them (p. 31). This type of analysis draws attention to the important political role that policies play in shaping the very "problems" that they seek to resolve.

In order to undress problems and reveal the discourse that shapes them, we must "'[work] backwards' from concrete proposals to reveal what is represented to be the 'problem' within those proposals" (Bacchi, 2009a; p. 3). My study works backwards from an initial interest in researching coercive program modifications in ACT, to examine the broader problematizations in policy documents that focus on the "mental health crisis". Instead of studying problems, this kind of post structural policy analysis studies *problematizations*: the historically contingent "terms of reference within which an issue is cast" (Bacchi, 2012; p. 1). To these ends, I have adopted the series of

six questions from the WPR approach to interrogate problem representations found in policy documents on Vancouver's "mental health crisis":

1. What are the problems represented to be in the "mental health crisis"? (Chapter 4)

2. What assumptions underlie the problem representations of the "mental health crisis"? (Chapter 5)

3. How, when, and where did these problem representations emerge? (Chapter 6)

4. What is left unproblematic in the "crisis"? (Chapter 7)

5. What effects are produced by these representations of Vancouver's "crisis"? (Chapter 8)

6. How could these problem representations be questioned, disrupted, and replaced? (Chapter 9)

My use of the WPR approach to study contemporary mental health and substance use policy is not in uncharted water. Bacchi's (2009a) framework has been used to guide a number of PhD projects[3], and research examining mental health and substance use policies, such as: Seear and Fraser's (2014) study of the construction of "the addict" in Australian drug policy; Lancaster, Seear, and Treloar's (2015) research on public health policy related to syringe exchange programs and the criminalization of drug users in New South Wales; Martin and Aston's (2014) analysis of the gendered ways in which female drug users are problematized in legal texts; the role that clinical technologies play in new forms of governmentality in Australian addictions policy documents (Moore and Fraser, 2013); and Henderson and Fuller's (2011) discourse analysis of Australian government's problematization of people with "mental health disorders". The WPR approach has also been used to study a range of social policy on issues like immigration (Agergaard and Michelsen la Cour, 2012), vocational training and education (Cort, 2011), and disability legislation (Marshall, 2012b).

[3] For examples see Partridge's (2014) dissertation using the WPR to examine federal government policy in relation to Australia's Indigenous peoples, Cort's (2011) dissertation on European policy on vocational education and training, and Marshall's (2012a) dissertation on the construction of "disability" in international development policy.

While Bacchi's (2009a) research questions function as a useful framework for policy studies on a range of phenomena, they are especially useful for elucidating the temporal representation of Vancouver's "mental health crisis". Both Bacchi (2012) and Foucault (1985a) hold "crisis moments" to be empirically important because they point to times and places where shifts in governing logics often occur. This dissertation will demonstrate how the problematization of an urgent, episodic "mental health crisis" in Vancouver's inner city paved the way for new forms of collaboration between police and healthcare providers to manage "untreated mental illness", which has contributed to a trend of increased clinical reliance on forms of compulsory treatment permitted under the British Columbia Mental Health Act (BCMHA).

The decade surrounding Vancouver's "mental health crisis" was one wherein municipal and provincial policy makers, researchers, community activists, and people with lived experience of struggles with mental health and substance use overwhelmingly agreed that the state of community-based care and social supports available in the city were woefully inadequate. This dissertation does not argue that changes to health and social services in Vancouver are not still urgently needed, that more mental health outreach support for people in community would not be beneficial, or that police officers do not frequently encounter people in mental distress and feel frustrated with the mental health system's inability to help. Rather, my goal is to politicize the texts by drawing attention to assumptions made in how the "mental health crisis" was problematized, what was left unproblematic, what effects were produced, and how or if we might be able to think differently about the situation.

Consistent with many post structural approaches to policy analysis, I do not leave the impression that local actors like police or municipal government staff deliberately framed issues in order to justify the oppression of particular groups of people. My approach is not concerned with the motives of elite politicians, governing classes, or bureaucrats, but rather with identifying the "deep conceptual premises operating within problem representations" (Bacchi, 2009a) on which these actors rely. Forms of Foucualtian Discourse Analysis (FDA) like the WPR approach decenter human agency from the politics involved in policy making. Post structural policy analysts tend to challenge the assumption that there is an objective vantage point from which health or social "problems" can be assessed in a given time and place.

Hanlon's razor is an aphorism that instructs one never to attribute malice to that which can be more aptly explained by ignorance. My more generous hope is that this dissertation does not attribute malice to that which can otherwise be explained by *discourse*, which shapes and reshapes the parameters regarding what can be said in a given time and place. Keeping this spirit requires a commitment to the position that "problematization is more a description of thinking as a practice than a diagnosis of ideological manipulation" (Bacchi, 2012; p. 1). While this post structural approach to discourse analysis does not presume individuals or organizations to be speakers of discourse, able to selectively wield it to advance their own interests, it does recognize that forms of resistance are always present and that the meaning of concepts like "the mental health crisis" are the product of heterogeneous power relations. Moreover, it explicitly identifies how particular political rationalities[4] implied within problem representations can result in *harmful effects* for particular people.

Although tempted by the norms of the social sciences and my commitment to improving the conditions in Vancouver's inner city, where I have lived and worked for a decade and a half, this dissertation does not leave a normative conclusion. That established, drawing attention to how the problems are constructed around the "mental health crisis" ought to be viewed as itself a political act. For example, I identify opportunities for resistance by exposing points of conflict, where regimes of truth produced through alliances between psychiatric and security discourses are challenged by competing problematizations. Foucault's (2007) concept of "counter conducts" is helpful to this task of tracing resistance to disciplinary practices and neoliberal governmentality, particularly where psychiatric patients at the centre of the "mental health crisis" are constructed as having a particular aversion to psychiatric treatment, which creates a mutually reinforcing push and pull pattern of applying clinical coercion to overcome "non-compliance" with psychiatric treatment.

The WPR's approach to unsettling common problem representations can at times be felt as confrontational for positivist-inclined policy analysts and researchers who labour in good faith to advance important concepts like "patient-centred care" and "recovery-focused" approaches to mental healthcare. Indeed, as I discuss in my conclusion, the practice of scrutinizing my own closely held problem representations has

[4] The role of political rationalities in relation to problematization will be explained in chapter three.

led to unsettling insights regarding the ways in which neoliberalism permeates my own work to advance government policy that respects the rights and autonomy of people who struggle with mental health. Bacchi and Goodwin (2016) offer helpful reflective advice for appreciating this challenge when conducting or reading post structural policy analysis on matters close to one's heart:

While some may find it disconcerting to so scrutinize concepts and categories commonly adopted in their work, this process of defamiliarization makes it possible to reflect on the limitations and possible deleterious consequences of well-established frameworks of meaning and the conceivable need for alternative problematizations. In this way, space is opened to think differently (94).

Following Bacchi and Goodwin's (2016) stylistic advice for post structural policy analysts, this dissertation routinely wraps scare quotes around the "problems" (e.g., the "mental health crisis"), "places" (e.g., the "Downtown Eastside"), "subjects'' (e.g., people with "SAMI", the "non-compliant, treatment resistant patient"), and "objects" (e.g., "mental illness", "refractory psychosis", "addiction") found in the texts. Scare quotes offer a grammatical reminder that "problems", "places", "subjects", and "objects" are not fixed or natural but rather historically contingent and produced through discourse. Although it may at times be irritating to the reader, this technique has been used wherever it might not be obvious that a term is discursively contingent. The intention behind using scare quotes in this way is to consistently disturb the naturalism in the ways in which particular things are problematized in the texts. The "DTES" and "SAMI" are two notable examples of where my analysis emphasizes a fluid discursive contingency rather than a fixed identity of a place and people within it.

1.3. Data Collection and the Use of Texts

The first step in the WPR approach is to identify a place to start the analysis. This jumping off point is often a set of problem representations that are of particular interest to "one's work and political priorities" (Bacchi and Goodwin, 2016; p. 20). As discussed in the previous and next sections, this research began with a personal interest in analysing familiar problem representations which made coercive reconfigurations of ACT a mental health service reform priority in Vancouver. The texts which form the core of my analysis were published in BC from 2008-2016. They are listed in Appendix One, which

includes a table detailing titles, publication dates, authors/institutions, and brief summaries of the relevance of each text to this study. The documents come from a variety of publicly available sources, including provincial government reports and media releases, the local health authority, municipal planning documents, research and provincial program guidelines on ACT, and a series of position papers published by the VPD. Many of these texts were produced by provincial government ministries or agencies holding a mandate to fund, implement, monitor, and/or evaluate mental health and substance use services in BC. I also included additional research literature containing epidemiological descriptions of people with "untreated SAMI" in Vancouver, and local media reports that disseminated the problematization representations found in the government texts.

The years that temporally bracket my discourse analysis (2008-2016) coincided with the long-standing reigns of the centre-left municipal Vision Vancouver political party, and right-wing provincial Liberal Government. Throughout this time Vancouver gained infamy not only for hosting the 2010 Olympic Games, but also for its extreme rates of inflation in local housing costs, widening gaps in wealth inequality, and lack of federal government investment in non-market housing to keep its lowest income residents from slipping into states of economic desperation and/or homelessness (Lee, 2016). In 2016, the Vancouver Homeless Count identified 1,847 people living in conditions of homelessness, the highest number since the City started counting in 2002 (Thompson, 2016). Although self-identified Indigenous peoples only represent 2.2% of Vancouver's total population, they face disproportionate inequities when it comes to housing status, making up roughly 40% of the local unhoused population (City of Vancouver, 2019). After 2016, there was a change in governments at both the local and provincial level, and health and social policy attention shifted toward addressing the rising rates of overdose deaths and managing emerging homeless encampments across BC. Although the mental health crisis may feel like an artifact of the past, its proximity to and importance for our present will be made clear in the chapters to follow.

The documents under analysis in my study represent examples of what Foucault (1986) calls *practical* or *prescriptive texts*. Practical texts problematize a particular issue and offer recommendations, guidelines, or "programmes of conduct"—prescriptions regarding how one ought to conduct behaviour of others and themselves (Foucault, 1991a). It is this "doubleness"—that policy texts offer instructions on how to

govern *and* provide us with artifacts that reflect the historically contingent political rationalities that make those governing practices intelligible in the first place—that makes them so fruitful for discourse analysis (Blix, et al., 2013). Through careful attention to discourse, Foucault (2007) proposes that "we could reconstruct the function of the text, not according to the rules of formation of its concepts, but according to its objectives, the strategies that govern it, and the program of political action that it proposes" (p. 36).

However, for all their value in providing inroads into the study of political rationalities involved in mental health care, what is it that these prescriptive texts accomplish? How are they used by the governments, clinicians, police, and non-profit organizations involved in managing mental illness? To invite a conversation about the form and function of prescriptive texts, Pigg, et al., (2018) use the term "document/ation: the suffix 'ation' indicates a process, action, state, condition, or result" (p. 168). Approaching otherwise ordinary texts in this way helps reveal the complicated multitudes of meaning, actions, and new power relations that they help make possible. When it comes to the various policy responses to the crisis, many of the documents, particularly the City of Vancouver's *Caring for All Report* (2014), seek to establish long-term bureaucratic work plans aimed at coordinating and monitoring actions taken by organizations like the VPD, health authorities, local government, and the non-profit sector to better manage mental illness. These proposals tell us much about the relationships between local institutions and the particular political rationalities that dominate their efforts to preserve public safety and the local economy. They also reveal that multiple effects are produced when subjects encounter these rationalities, illuminating that the problem representations that converge in the "mental health crisis" are far from settled or complete.

In order to make sense of all this heterogeneity, my study applies the list of sequential research questions adapted from the WPR approach (Bacchi, 2009a) to each of the core documents. Several rounds of close readings were conducted. Excerpts were drawn out from the texts and annotated notes were made with attention to each research question. These readings also provided data to identify particular subjects/objects, themes, patterns of political rationalities, and discourses in the texts. These data were then analysed and used to set the empirical analysis off with my first research question, which identifies the main thematic problem representations found across the texts. Several more rounds of close reading were then conducted to identify the range of

assumptions contained in these main problem representations, what they left unproblematic, what effects were produced, and where there might be opportunities to advance competing problematizations into the fold.

I would be remiss not to mention that my analysis was also assisted by extensive dialogue with my senior supervisor (Dr. Marina Morrow), one of my committee members (Dr. Katherine Teghtsoonian), and a close research collaborator (Dr. Mohamed Ibrahim), which led to the publication of two first author publications in recent edited collections of critical Canadian mental health studies (see Van Veen, Ibrahim, and Morrow, 2018, and Van Veen, Teghtsoonian, and Morrow, 2019). The notes and iterative discussions involved in early drafts and peer review process surrounding these manuscripts, which focus on many of the problem representations found in texts on Vancouver's "mental health crisis", also helped to refine my analysis and open new questions to take up in this dissertation. Therefore, these two papers are cited throughout the pages that follow.

1.4. Originality of the Study

My research is not the first to question the evolving fraternity between psychiatry and law enforcement in order to problematize "untreated mental illness" in Vancouver. Recently, three scholars took up Bacchi's (2009a) WPR approach to study the role of police in constructing Vancouver's "mental health crisis" (see Boyd and Kerr, 2015 and Boyd, Boyd, and Kerr, 2015). These studies raise important questions about police influence in mental health policy and the discursive construction of people with "SAMI" as an irrational, indiscriminate threat of violence to an innocent public (Boyd, Boyd, and Kerr, 2015). However, the scope of their analysis does not include the range of effects produced by the problem representations surrounding the crisis—most notably the new roles that police have come to occupy in clinical service delivery.

Referencing a report informed by this dissertation (see Ng and Van Veen, 2015), a subsequent ethnographic observational study investigating surveillance practices in Vancouver's supportive housing[5] settings also revealed that new coercive regimes of

[5] Supportive housing is a form of state subsidized housing with on-site supports. In BC, most supportive housing stock is owned by BC Housing, a crown corporation. Non-profit organizations are commonly contracted to manage the buildings, offering on-site services to residents in the

community mental health care are emerging with the introduction of police into local ACT teams (See Boyd, Cunningham, Anderson, and Kerr, 2016). However, the ethnographic findings of this latter study largely focus on the intricate forms of social control found in supportive housing environments, rather than on how control is mobilized across the community with outreach programs like ACT. My analysis also expands on this important local research to consider the role that the local government, health authorities, researchers, and provincial government played in constructing the "mental health crisis" and ACT as one means to solve it.

There is also subtle methodological difference between my research and Boyd and Kerr's (2015), and Boyd, Boyd, and Kerr's (2015) approach, where the term discourse is used to describe the way police advanced certain arguments or claims about the "crisis", rather than as the broader forms of knowledge that make it possible for such an argument to occur in the first place. My analysis uses the concept in the latter sense, approaching *discourse as knowledge*. Following Foucault, via Bacchi and Bonham (2014), I also take aim at the *discursive practices* involved in shaping new forms of power in care. Discursive practices are the "relevant networks of relations and practices" which imbue certain discourses with the power to produce what is understood to be in the realm of "truth" regarding things, people, and/or places (Bacchi and Goodwin, 2016; p. 22). Reading with an eye to uncovering the discursive practices reveals the ways in which psy and security discourse are operationalized in the texts to construct untreated "SAMI" as a dangerous thing in need of monitoring, management, and when necessary, discipline. An understanding of discourse as forms of socially constructed knowledge which forge the epistemological boundaries regarding what can be thought and said, differs from the understanding of discourse as a rhetorical device. Treating discourse as knowledge draws our attention to how psychiatric knowledge can function as a security apparatus: the "systems of technologies, discourses, and practices whose goal is securing the body and mind of the patient" (Swerdfager, 2016).

Perhaps the most novel contribution my analysis makes to the literature is regarding the new arrangements of power produced by modifications to ACT teams that

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form of home support, skills training, and harm reduction services. Staff often refer residents to off-site primary care, and mental health and addictions treatments. In some exceptional circumstances primary care, and mental health and addictions treatments are provided on site through a clinic space on an "in-reach" basis.

increase police involvement in mental health service delivery. Addressing this topic is particularly crucial in a time when the model is being rapidly expanded[6] to provide mental health services to BC communities in a time where activists are calling for alternative models of crisis response that reduce police interactions with people in distress in order to prevent police violence (Owen, 2020). I also contribute unique insights into how policy makers, mental health clinicians, activists, and researchers might challenge the harmful effects of psy and security discourse in mental health and substance use policy and practice by advancing competing problematizations in complex and challenging practice environments.

1.5. The Reflexive Agenda

My interest in ACT and the "mental health crisis" does not come from an intellectual distance. As a former community-based mental health and substance use social worker and current senior public health policy leader in Vancouver, the problem representations found in various policy documents on the "crisis" are familiar territory. However, being so close to the routine practices of operational service delivery rarely afford the time and space to rigorously explore new and unsettling questions about the micro politics surrounding day-to-day work. Bacchi (2009a) offers helpful reflexive advice for scholars who have such close, complex relationships with their research. She notes that "[g]iven the almost endless variety and numbers of texts that could be selected, it needs to be recognized that choosing policies to examine is an interpretative exercise… [t]hat is, you will already be involved in an analysis when you select a policy or policies for examination" (p. 20). Indeed, when it came time to undertake doctoral studies on the discursive construction of the "mental health crisis" and ACT as its logical solution, my analysis was already under way.

For over a decade I have been involved in enacting, undermining, and struggling to make sense of neoliberalism and disciplinary power in mental health and substance use policy and services. Like many, my desire to work in the "helping professions" initially came from a commitment to emancipatory politics and grassroots community development. Throughout my undergraduate degree in social work, I was drawn to scholars like Mullaly (2006), who challenge us to reflect critically on the roles social

[6] See BC Ministry of Mental Health and Addictions, 2020.

services play in reproducing oppressive structures of the capitalist welfare state. Mullaly (2006) urges social service workers to find practical techniques to subversively challenge oppression while working *within* government agencies, in what he calls *outside* agencies like non-profit organizations, and through activist commitments in our private lives. The provocative pedagogical message given to students in most social work faculties is that with a critical approach to practice, and a strong commitment to professional ethics, it is possible to develop an anti-oppressive praxis.

Despite this early-career optimism, subsequent years of frontline experience challenged the viability of this possibility and the conception of power on which it relies. Addiction assessment forms, mandated counselling methodologies, electronic medical records, referral templates, and standardised income assistance applications shaped most of my days as a social worker. The science of psychiatry and medicine trumped the context and relational knowledge of social workers, nurses, and peer support workers, who are often relegated to lower status in decision-making hierarchies in clinical settings. Later, while undertaking graduate studies, I became acquainted with Foucault and other post structural thinkers that some social work academics have begun to draw on to challenge the power of psy “expertise” in social work policy and practice (see Chabon, Irving, and Epstein, 1999). These studies demonstrate, amongst other things, how surveillance and monitoring of “clients” and social workers alike permeate social services settings like income assistance offices (Moffatt, 1999). By showing us how governance takes place through shaping the conduct of social workers in their mundane day-to-day duties, these post structural approaches offered me a new conceptual understanding of the politics involved in health and social services.

However, trying to make use of this post structural sensibility in practice was challenging. In my experience working in community-based mental health services, coercive clinical practices are routine, often unquestioned, and almost mundane. The “clients” my colleagues and I were tasked with caring for were frequently hospitalized and released on compulsory treatment orders under the BCMHA. These orders often contained instructions from the attending psychiatrist for my team to monitor compliance with anti-psychotic medication. Medication adherence was commonly viewed as the most important indicator of success in a patient’s recovery, which in turn shaped successful social work practice as that which inspired biomedical treatment compliance *within* our patients. Much of my time was spent monitoring electronic

medical profiles and medication administration records. A patient's refusal to comply with care would often result in them being recalled to inpatient psychiatric units. At times I participated in administrative review panel hearings at the request of patients who hoped I could help to advocate that their extended leave be revoked, and treatment be made voluntary. Occasionally it would pain me to inform the client that it was not in their interest for me to attend because my observations could be used by the panel to uphold the initial certification. I didn't want to risk losing a therapeutic alliance built on trust, honesty, and respect for self-determination.

These instances where my professional obligations under the BC Association of Social Workers Code of Ethics, with its focus on social justice and human rights, came into conflict with legislation that so easily allows for the rights of psychiatrized people to be revoked, were distressing. I felt pulled into conformity with those roles that Foucault (1995) dubs the "judges of normality"—those modern professionals assigned with investigating deviance and applying techniques to re-align behaviours with the realm of what is thought normal in a specific time and place. Amy Rossiter (2001) reflects on how difficult it is to teach Foucault to social work students who just want to know "what to do" in these challenging, constrained practice environments, stating that her modest pedagogical goal is "tactfully to get [social work students] to be a little more suspicious of impulses that seem quite pure to them" (1). This is easier said than done. It took significant effort to prevent my suspicion from leading to post structural immobilization.

Around this same time, ACT teams began to be implemented in the community to manage "hard to house" people with "untreated SAMI". While I tried to approach work with suspicion of the power that psychiatric knowledge had over the bodies and minds of my clients, steering interventions towards alternative forms of social supports and respecting people's right to make decisions about their own care, ACT seemed rigidly clinical and disciplinary. If ACT clients refused medication during home visits from the team, the presence of an accompanying plain-clothed police officer made the ignominious ultimatum obvious: *we can provide "treatment" the easy way or the hard way*... This shift in care appeared more coercive than assertive and indicated a change from the practices commonly used in supportive housing programs or community mental health clinics which focused more on "patient-centred care"—a concept considered further later. It also differed from the creative forms of peer supports developed through

the rich history of mental health and substance use advocacy that Vancouver has come to be known for.

The early morning of September 30th, 2011, serves as a memorable example of that collectivist, activist spirit. Canada's Supreme Court was set to rule on a case that challenged the federal Conservative government's attempt to revoke a temporary exemption that allowed Insite, North America's first supervised consumption site, to operate under a section 56(1) exemption from Canada's Controlled Drugs and Substances Act. As I gathered on the sidewalk alongside drug users, critical scholars, Indigenous leaders, and my colleagues from local non-profit organizations, news broke that the court had determined that pulling the exemption would violate the rights of people who use drugs under Canada's Charter of Rights and Freedoms. As a result of the ruling, the federal government was required to allow for the permanent operation of the facility (CBC News, 2011). In his book *Fighting for Space: How a Group of Drug Users Transformed One City's Struggle with Addiction* (2017), Travis Lupick describes how a "huge roar went up from the street" in front of the site when news of the decision made it to the crowd; and meanwhile, upon hearing the news across the country in the lobby of the Supreme Court in Ottawa, Dean Wilson, a user of the site who was a lead plaintiff in the case, "stopped pacing, closed his eyes, and raised two clenched fists above his head in victory" (p. 324).

That event is etched into memory not just because of its pathos, the diversity of the crowd, or the important health human rights legal precedent it established, but for what it meant for the personhood of the people discussed throughout this dissertation. Many of the activists in the streets that morning were the same people depicted as dangerous, irrational, mentally ill criminals in documents published on the "mental health crisis" around the same time. This is but one example of when psychiatrized people and people who use drugs in Vancouver successfully exercised collective forms of political action to reclaim their dignity and rights. I struggle to square these experiences working with people in Vancouver's inner city—through advocacy efforts, committee work, or in clinical and policy practice—with the way in which they are represented in mental health policy texts. Although the material conditions of the "DTES" are undoubtedly deprived, the spirits of people who struggle with mental health and substance use who live there are strong, compassionate, and politically engaged. This dissertation goes to great length to describe how people are subjectified in policy produced by the government and

police. However, I hope it also honors their personhood and does not run the risk of reproducing a dehumanizing effect.

1.6. Chapter Summaries

Chapter two of this dissertation provides an overview of four different approaches to discourse analysis: deliberative policy analysis, the Essex approach, critical discourse analysis, and Foucauldian discourse analysis. It describes the conceptual underpinning of each, concluding with an argument for why FDA was most useful for this research on the “mental health crisis”. Finally, it details five useful methodological cautions for researchers who use FDA.

Chapter three describes how the WPR approach was an effective framework with which to undertake an FDA of government policy documents. The chapter also provides an in-depth examination into two concepts—neoliberal political rationalities and governmentality—which are central to the six research questions I have modified from the WPR approach for this dissertation.

Chapter four begins the empirical analysis by posing the first question of the WPR approach to the documents: what are the problems represented to be in the “mental health crisis”? It starts with an introduction to the policy documents that played a key role in constructing the “crisis” and advancing ACT as a means with which to solve it. It then identifies four main problem representations in policy texts on the "mental health crisis”, including the notion that people with untreated “SAMI” represent risks to the security of the city, that there are insufficient psychiatric services to manage this “dangerous” population, that there is not enough cross-sectoral collaboration on “assertive” community-based psychiatric interventions, and that taken together, these “problems” result in a “crisis of cost” for government administrators.

Chapter five puts the second research question to the documents, asking what assumptions underlie these problem representations in the “mental health crisis”? The purpose of this chapter is to unpack the “presuppositions, assumptions, ‘unexamined ways of thinking’, knowledges/discourses” (Bacchi and Goodwin, 2016; p. 21) that constructs the “mental health crisis” as a particular, identifiable, and measurable object of thought. It argues that neoliberal and psy assumptions proliferate the documents,

particularly in the way people with “untreated SAMI” are pathologized for their mental distress and substance use, anticipated as presenting a risk of violence, and require interventions that foster their internal motivation to align their behaviours with government ambitions to cut down on health and criminal justice costs.

Chapter six takes a step back from the empirical analysis of the texts to consider a broader historical context by asking: *how, when, and where did these problem representations emerge*? This chapter explores the history of mental health discourse in BC, tracing the evolution of psychiatric institutionalization and deinstitutionalization, mental health law, prohibitionist drug policy, supportive housing programs, and ACT teams. Situating the problem representations within their historical context helps us to see that Vancouver’s “crisis” is not necessarily episodic in nature. It also demonstrates how the problem representations in the policy texts found success in the games of truth—that is, the “set of rules by which truth is produced” (Foucault, 1997; p. 297)—that shape provincial policy related to substance use and mental illness. Approaching “mental illness” as contested territory opens a conversation about how or if BC mental health policy could have emerged differently.

Chapter seven builds on the contextual foundation laid in chapter six, but returns to the analysis of the texts, asking the fourth question from the WPR approach: “what is left unproblematic in the mental health crisis?” It also considers the silences in the texts and how the “problems” might be thought about differently. This step in the Bacchi’s (2009a) approach helps to demonstrate how some problem representations, like “untreated SAMI”, have come to be produced as “truer” and more necessary to solve than others, like Vancouver’s high rates of poverty, legacy of colonization, or policing of people struggling with mental health and substance use in the inner city.

Chapter eight pivots to consider the tangible impacts of the various policy proposals, asking “what effects are produced by the representation of Vancouver’s “mental health crisis’”? Three kinds of effects are elucidated: subjectification effects, lived effects, and discursive effects. I argue that the way the documents construct people with “SAMI” as “concurrently disordered” leads to a double burden of pathologization that dehumanizes people who are already subjected to intense forms of stigma and discrimination. The chapter also argues that targeting people with “untreated SAMI” with coercive forms of outpatient psychiatry leads to acute lived effects in the form of

psychiatric detention and increased policing—with disproportionate impacts on racialized people.

Chapter nine concludes Bacchi’s (2009a) line of problem questioning by asking “how can the dominant problem representations surrounding the “mental health crisis” be questioned, disrupted, replaced, or reproblematized?” It draws attention to the ways in which security and psy discourses were contested in the documents and through activist efforts waged throughout the years coinciding with their publications. Section 9.3 takes a reflective look at the assumptions I often make about the “crisis” and its normative “solutions” as a professional problematizer. Finally, the chapter offers a concise conclusion to the dissertation, summarizing key findings, limitations of the study, and implications for future research and policy reform efforts.

Chapter 2.

Approaches to Discourse Analytic Research

2.1. Introduction

There is not a singular approach to discourse analytic research. It is a varied methodology, with distinct ontological differences between frameworks, which has been used to study a range of health, social, and environmental policy issues. Thus, the decision to use the WPR approach informed by Foucault required great contemplation regarding fit with my research. Choice of data, theoretical orientation, and the research questions all had to be considered to arrive at the right framework (Wetherell, 2004). In the discussion to follow I summarize the common approaches to discourse analysis, exploring the ways in which the concept of discourse is taken up, with attention to the underlying ontological assumptions reflected in each. I also address how different conceptualizations of discourse analysis (DA) might apply to policy documents on Vancouver's "mental health crisis", examine the notion of subject agency in DA, and discuss definitions of discourse as language versus discourse as practice, how political resistance is theorized in different approaches to DA, and why I settled on Foucauldian Discourse Analysis (FDA) for this project.

Discourse analysts, especially those following in the wake of Foucault, are often reluctant to delineate a clear methodology for their research (Graham, 2005). Reacting to the criticism that this methodological apprehension lacks rigor, many take great care to describe what is meant by the term "discourse", and how it guides their analysis. Wetherell (2004) groups most discourse analyses into three general domains: social interaction; minds, selves, and sense-making; and culture and social relations (p. 381). Others are more specific. Torfing (2005) describes the evolution of DA research, starting with content or conversation analysis, which emphasizes semantic foundations of speech or text, to critical discourse analysis (CDA), with its strong linguistic focus and post-Marxist ontology, and finally onto a broad social constructionist notion of discourse drawing on Derrida (1978), and Laclau and Mouffe (1987). Glynos, et al (2009) offers an even more detailed list, distinguishing between several approaches to DA research,

such as political discourse theory, rhetorical political analysis, CDA, interpretative policy analysis, discourse psychology, and Q methodology.

For the purpose of this research, I differentiate between four key DA approaches and their related conceptual frameworks: first, Deliberative Policy Analysis (DPA), with its use of the explanatory concepts of framing and discourse coalitions; second, The Essex approach and its use of the concept of hegemony; third, Critical Discourse Analysis (CDA); and fourth, Foucauldian Discourse Analysis (FDA) or Post-structural Policy Analysis (PPA). Bacchi's (2009a) WPR approach is aligned with the latter and its conceptual aids of neoliberalism and governmentality, which are discussed at length in chapter three.

2.2. Deliberative Policy Analysis, Frames, and Discourse Coalitions

Attention to argumentation, deliberation, and the institutional instruments that facilitate policy development are central to DPA, as are the frames through which deliberative potential is created and constrained. DPA can be traced to the intellectual lineage of Fischer and Forester (1993), Fischer and Gottweis (2012), and Hajer (2003; 2005). Practitioners of DPA often make use of frame theory, which views policymaking as driven through the "ongoing discursive struggle over the definition and conceptual framing of problems, the public understanding of the issues, shared meanings that motivate policy responses, and criteria for evaluation" (Fischer and Gottweis, 2012; p. 7). In this approach the concept of discourse is used to explain the "ensemble of ideas, concepts and categories through which meaning is given to social and physical phenomena, and which is produced through an identifiable set of practices" (Hajer, 2005; 300). Dominant frames either succeed or fail to set the terms under which policy is debated, practiced, and produced. If a particular coalition is successful in framing an appealing position and controlling the terms of deliberation, then policy naturally evolves to reflect their priorities and objectives. Many studies that take up DPA focus attention on intentional efforts of individual actors and specific groups which are assumed to have a greater degree of conscious agency in manipulating the discourse at play than in more post-structural approaches.

Juilet (2007), uses DPA to study environmental policies surrounding migratory bird protection and the socio-legal historical land claims of northern First Nations. The analysis shows that the success of dominant frames early in the debate was derived from the adversarial environmentalist movement's ability to gain access and set the tone in the traditional corridors of power that drive policy making processes (e.g., with government officials, in legislative committees and legal settings). Her study also demonstrates how environmentalist groups were able to successfully convince policy makers that they represented a powerful constituency of voters in Canada and the United States, and that by comparison, northern First Nations came to be viewed as a small, disempowered group less able to advance their land-use claims in policy. However, the legitimacy of the socio-legal position of the northern First Nations changed over time as the terms of the public debate were slowly reframed under new legislation that supported the legality of the First Nations land-use claims, thus validating Indigenous people's "storyline" and shifting policy in their favour. This kind of linear interpretation of the way in which policy changes over time is common in research using frame theory.

Metaphor, narrative and storylines are also important concepts that highlight the dramaturgical struggle around discourse in DPA. Storylines allow actors to advance their account of the truth of a problem and to differentiate their notions of appropriate solutions from those that might stand in opposition (Hajer, 2005). Coalitions are defined as the congregation of actors who unite in mutual attachment to particular storylines. This conception of discourse as driven by narratives that individuals and groups become invested in can be connected to the thought of twentieth century sociologist Joseph Gusfield (1981), who posits human drama as central to the way in which knowledge about social problems and normative moral order are constructed and maintained in society. DPA is also indebted to Jurgen Habermas (1991), particularly his preoccupation with the importance of communicative rationality in settings of public deliberation, styles of argumentation, and discursive democracy (Fischer and Gottweis, 2012; citing Dryzek, 2000 and Forester, 1999, 2009). The strength of DPA rests in the relative clarity of its analytical framework. Practicing policy workers would no doubt find the focus on stakeholder analysis, coalitions, and storylines to resonate with the modern communications strategies used in government policy shops and consulting firms.

DPA is optimistic about subject agency, trusting that the use of sound sociological reasoning and research can allow one to trace the discourse that produces policy priorities and practices through three elements of analysis: the *terms* of discourse, the formation of *discourse coalitions*, and the identifiable institutional and administrative *practices* wherein discourse is produced (Hajer, 2003). Some accounts of the method are detailed and systematic. For example, Hajer (2005), explains that there should *always* be several key steps to conducting an "argumentative discourse analysis", which I group under the banner of DPA. These include:

- a document survey including chronology of events;
- key informant interviews;
- document analysis;
- re-interviews with key informants;
- further research into "sites of argumentation";
- "identification of key incidents";
- analysis of institutional or administrative practices;
- data interpretation; and
- a third visit with key informants (p. 306-7).

For those practicing post positivist qualitative research, these clear steps could offer an effective methodology for crafting a convincing analysis of the discourse at work in the "mental health crisis". However, when taken as a strict methodological guideline, DPA can become linear and over prescriptive—a matter of sequentially "going through the motions" to reach a valid conclusion. In this sense, DPA often falls victim to into the kind of post positivist trap that unwillingly reproduces discourse of scientific rigor, constraining what counts as "good" discourse analytical research as that which fits into a checklist that is easy to follow and evaluate. However, there are several pitfalls with this kind of approach to discourse analysis that this dissertation sought to avoid.

Although my research required close and careful reading, it is less concerned with DPA's focus on the nuances of argumentation, and more with how the problems of

the "mental health crisis" are represented in the first place, what powerful knowledges and knowledge practices underpin those problem representations, and what solutions are made possible as a result. Moreover, DPA is relatively unconcerned with elucidating the significance of the silences in "discourse coalitions". As we will see in subsequent chapters, my approach also considers these silences as just as important as the discourse that appears in the texts. Examining what is absent offers clues about which knowledges are marginalized, discredited, or sidelined all together.

Another risk of DPA rests in its tendency to view the subject as one who speaks the discourse to be analyzed. This assumed argumentative agency and strategic intent of actors stands in contrast to other forms of DA, like those inspired by Foucault, where subjects are not thought to be "discourse users" or speakers, but rather are "constituted in discourse" (Bacchi, 2005; p. 20). As Hall (2001) puts it, "the discourse itself produces 'subjects'—figures who personify the particular forms of knowledge which the discourse produces" (p. 80). Within DPA there are attempts to resolve this question of agency. In a study on the politics of midwifery in Ontario, Paterson (2010) notes the presence of these two different views of subject agency in framing analysis and offers Critical Frame Theory as an attempt to bridge the divide. Critical Frame Theory is said to provide a means by which to "interrogate the ways in which frames both intentionally *and* unintentionally open or close discursive space" (p. 131; emphasis added). However, again this view casts discourse in terms of strategic argumentation in a space of public deliberation, and not in how expressions of powerful knowledges come to constitute subjects, set the parameters surrounding what and how they "know", and derive the rules regarding what counts as "evidence" or "truth".

In a study on the politics of community-based mental health care, a focus on language and argumentation would prevent a fuller analysis of the specific discursive practices and politics at work in inviting the specific range of interventions that came to be seen as viable solutions to the "mental health crisis". For example, throughout texts on the "crisis" psychiatric discourse establishes powerful truth claims about the problem of "broken brains" amongst those in "crisis", which led to a set of "evidence based" biomedical treatment practices as logical solutions. In texts on the "crisis", the power of truth claims is not necessarily drawn from effective argumentation or the strength of discourse coalitions, but rather from an epistemological hierarchy that elevates biomedical knowledge over other ways of knowing. Frame theory does not account for

how discourse constitutes the epistemological foundation that cements the “rules of the game” which so strongly influence its outcomes.

2.3. The Essex Approach and Hegemony

In the 1970’s a coalition of scholars working out of the University of Essex began to reject the notion that policy making processes are simply positivist exercises that seek to locate problems, gather and review evidence, and offer recommendations aimed at resolution. For Essex scholars, problems do not simply exist *out there* in the *real* world of material social and economic relations. Instead, they call policy documents themselves into question as constitutive sites of human meaning making. The Essex approach can be described as problem driven—rather than theory driven—research, informed by psychoanalytical and post-Marxist traditions.

Somewhat similar to the WPR approach, the Essex approach to problem driven research puts emphasis on starting one's analysis by examining the problematizations that policy documents seek to address (Glynos, et al, 2009). Bacchi (2018) commends the spirit to replace “theory-driven” research with “problem-driven” research in order to avoid a situation wherein “a phenomenon is characterized so as to vindicate a particular theory rather than to illuminate a problem that is specified independently of the theory” (citing Shapiro, 2002; p. 601). However, she prefers the term “problem-driven theory” which still maintains the quest to approach problem representations rather than “problems” untethered from theory as “taken for granted starting points in the analysis” (Bacchi, 2018).

There are a number of approaches to discourse analysis that can be considered to fall under the Essex School banner, including: Poststructuralist Discourse Theory (Torfing, 2005); Poststructural Policy Analysis (Howarth and Griggs, 2013); Post-Marxist Discourse Theory (Howarth, 2005; 2009); and Political Discourse Theory (Glynos, et al, 2009). Many of these accounts take up discourse not as a phenomenon arising in cognition, ideology, or argumentation, but rather as a force that constitutes the social world and its contingent power relations in a broader sense (Howarth and Griggs, 2012; p. 306). If it can be said that those working in DPA make an “argumentative turn” to an analysis of language, then scholars in the Essex tradition make a “discursive turn” (Torfing, 2005). This distinction is made through the latter’s more broadly constitutive

concept of discourse that is allied more with poststructuralism than postpositivism. However, many Essex frameworks still retain elements of rhetorical policy analysis and materialist leanings of Critical Discourse Analysis (Fischer and Gottweis, 2013)—a framework discussed next.

In the Essex approach, discourse is differentiated from the discursive. The discursive is an "ontological category—i.e., a categorical presupposition for our understanding of particular entities and social relations—whereby every object or any symbolic order is meaningful, that is, situated in a field of significant differences and similarities" (p. 313). In other words, discourse is the particular, which we can single out in our analysis and explore. The discursive, on the other hand, is the broad ontological landscape in which human meaning making and politics takes form. Central to the Essex approach is attention to the methods of articulation and logics that constitute discourse in a given empirical site.

Social changes are understood to arise from practices of articulation, whereby smaller components are brought together to compose logics. Three kinds of logics can be found within discourse articulations: social logics, political logics, and fantasmatic logics (Howarth, 2009; 2005; Glynos and Howarth, 2007). Social logics focus on particular social practices that establish social norms. The diagnostic categorization of "untreated SAMI", and subsequent interventions to contain the illness and restore social order could be understood as a social logic, manifested in the practices of psychiatric discourse. Political logics are used by followers of the Essex approach to point to the development of a discursive regime. Howarth (2009) provides a historical example: "the emergence, formation, and maintenance of the apartheid regime in South Africa involved the linking together of different demands and antagonisms into a new hegemonic project that contested the dominant policy discourse of 'segregation'" (p. 326). Finally, fantasmatic logics bring a dramaturgical element, explaining how subjects are emotively compelled by discourse and come to be invested in particular signifiers associated with them.

While it is clear that the Essex approach has a post structural leaning, its theoretical focus on cultural hegemony posits it along a more post-Marxist tradition. Gramsci's concept of cultural hegemony is used to describe how dominant groups maintain their status over the working class through "the negotiated construction of a

political and ideological consensus which incorporates both dominant and dominated groups" (Strinati, 1995: p. 169). Essex scholars often use hegemony to elucidate the role of discourse in building ideological coalitions that drive social change. Key to this process is the push of fantasmatic logics which are said to bring visceral enjoyment to subjects won over by political projects. Howarth (2009) demonstrates this in his study of the UK aviation industry's success in countering environmentalist discourse that constructed airport land expansion as a signifier for an overarching danger to the ecosystem brought by industrial capitalism.

Howarth and Griggs (2012) attribute all policy shifts or stagnations as the consequence of these hegemonic power struggles. Hegemony explains how power is exercised through the forming of coalitions which benefit the interests of the "intellectual and moral leadership" in a society. These interests are advanced and maintained by cultural practices that shape the governing elite's dominance over the working class in particular times and places (p. 311). Hegemony helps to explain how cultural and ideological processes are important to consider, rather than reducing social change in terms of the universal economic determinism of classical Marxism. The Essex approach claims to hold a view of a socially contingent world characterized by heterogeneous power relations. However, argumentation and rhetoric remain at the forefront of its mostly linguistic focus and a latent theme of class reductionism sits uncomfortably in the background.

For example, one can read a post-Marxist leaning into the concept of fantasy. The power of fantasy is seen as vital in establishing hegemony and the "grip" discourse comes to have on its subjects. However, like Marx's concept of false consciousness, where subjects are manipulated into actively maintaining capitalist wage economy, fantasy also functions to subdue resistance to dominant discourse (Howarth and Griggs, 2012). These accounts assume that there is an ideal form of class consciousness that is obscured from the subjugated and serves to benefit the bourgeoisie. Indeed, Dean (2013) contends that the very notion hegemony is based on the "idea of a community of morally autonomous subjects who freely consent to the binding commands of sovereign political authority" (p. 7). This differs from post structural analyses informed by Foucault, where there is no absolute liberation from power or singular truth from which we have been alienated.

Using an Essex framework in research on mental health policy and practice might assist in examining the conditions that have led to coalitions forming around particular solutions to the "mental health crisis". The Essex approach might lead one to question how the intellectual (academic researchers and mental health "experts") and moral elite (media and politicians stressing an ethical imperative to do something about untreated "SAMI") gained passive or active support of key decision makers and the subjects of interventions themselves. However, in order to form a more nuanced description of the politics at play in the "crisis", an Essex approach might miss important forms of governmentality in the texts. Attention to the discursive practices (e.g., practice guidelines, assessment and referral forms, databases), how "expert" knowledges can contradict one another (e.g., biomedical/psychiatric, nursing/social work), and the resistance to dominant problem representations could be lost in the Essex approach's emphasis on fantasy, hegemony and coalition building.

2.4. Critical Discourse Analysis

Critical Discourse Analysis (CDA), a form of discourse analysis that has gained popularity over the last twenty years by scholars in the social sciences and humanities, can be traced to the work of Fairclough (2001, 2010, 2013) and van Dijk (1987, 1998). CDA is a cousin to the Essex approach, however its theoretical orientation is more aligned with a Marxist version of "critical realism". CDA generally focuses on the dialectical relations *between* the discursive and the material (e.g., capital accumulation). Fairclough (2013) notes that more post structural approaches—such as the work of Bacchi (2012) and Howarth and Griggs (2012)—often fail to recognize that discursive struggles exist *because of* material processes, and that those material processes (e.g., capitalist market forces) exist independently of our knowledge about them. In CDA the study of discourse focuses more on linguistics, cognition, semiotics and texts (van Dijk, 2009), than discursive practices (e.g., diagnostic criteria, the use of mental health assessment forms, or police database surveillance algorithms).

In his analysis of moralizing medical discourse in a British Columbia high school drug education manual, Tupper (2008) uses CDA to explain how dominant ideologies construct drugs as inherently *bad* and *risky* by successfully silencing contesting notions that substance use exists on a spectrum and can offer benefits. Through illustrating how the text contains an emphasis on the "choice" to use drugs or not, Tupper (2008)

concludes that the only appropriate decision presented to students is the commitment to complete abstinence from substance use. Despite the fact that knowledge surrounding drugs and drug use is a highly contested space, the education manual establishes a prohibitionist, fear-based, abstinence discourse for students to internalize as “true”. In CDA discourse is used to describe the games of argumentation surrounding the risks and benefits of drug use. It does not necessarily elucidate how expert knowledge establishes and legitimizes those “facts” in the first place.

While CDA takes a “problem-driven” approach to discourse analysis, it often holds a more moderate constructivist view compared to those inspired by Foucault (Fairclough, 2013). Those who use CDA’s critical realist framework often focus on discourse found in talk and/or text, seeking to reveal how subjects are manipulated by ideologies that function to serve dominant groups at the expense of subjugated ones. Those using CDA tend to make assessments regarding the material consequences of discourse. The framework requires that the analyst take an activist stand, levying normative critiques at ideologies that sustain and reproduce the social inequalities. This normative position is part of a reflexive framework cognizant of the politics involved in research itself. It argues that we cannot be passive in our analysis—a charge Fairclough (2001, 2012) levies toward post structural frameworks. Instead, CDA urges us to use our work to challenge and ideally change, the deleterious effects of the problems that we choose to study.

Kolar (2018), a registered psychiatric nurse, uses CDA to examine coercive features of BC’s Mental Health Act. Their work critiques the discursive practices of confinement and involuntary treatment, concluding with a recommendation that nurses must work to counter harmful psychiatric discourse by embracing and amplifying calls for health equity and human rights to lobby for legislative changes. This spirit of questioning of our own practices is shared between CDA and the reflexive agenda of Bacchi’s (2009a) WPR approach. In contexts outside the humanities, normative claims and commitments are an expectation. Steadfast “ought” statements are a prerequisite to the policy worker’s routine tasks of composing briefing notes, grant proposals, clinical education guidelines, evaluation frameworks, media releases, and in work plan meetings, email correspondence, and watercooler conversations. While CDA offers relative clarity about the ethical considerations that should guide our political actions in these situations, its account of policy activism carries omissions. The strong linguistic

and materialist focus of the approach does not appreciate the powerful knowledge that shapes policy making processes *and* constrains and informs resistance.

The strength of CDA rests in its clarity of design. Fairclough is often credited with presenting the most approachable methodology for discourse analysis, which has contributed to CDA's widespread use in the social sciences in recent decades (Engelbert, 2012). However, as with the Essex approach, CDA can be overly prescriptive. Graham (2005) notes that it is the virtue of "rigorousness" that CDA gloms onto which distinguishes it from FDA. However, while CDA attempts to establish a degree of objectivity in its linguistic analysis of text, FDA rejects the notion that research and language can be separated from knowledge. It is tempting to follow CDA's soft objectivity and set one's sights on a clear and rigorous social scientific research plan with recommendations resulting from critique. This path allows for critical research without entirely disregarding the positivist basis of the human sciences. However, it may also unwittingly reproduce the same truth games (e.g., struggles over what knowledge counts as "expertise", how some interventions come to be seen as "evidence-based" while others not) that I seek to analyse through FDA.

Another important limitation of CDA rests in how its adherents tend to reproduce humanist assumptions in their view of subject agency. There is an inclination to view subjects as in possession of extra discursive interests, such as control over capital or other material resources. These a priori interests guide particular groups or actors to seek domination over others. Engelbert (2012) notes that in CDA

> we can consider discourse constructing particular versions of events for how it bears the traces of actively negotiating and refuting that such problematic interests are at play… [p]roblematic interests or commitments, then, are not only something that discourse producers have and conceal, but also something they might anticipate being accused of having (55).

FDA avoids this emphasis on the extra-discursive interests that subjects are anticipated to have and consciously advance. Instead, those following Foucault (1972) tend to view subjects as the products of discourse, bound to conceptual logics which set the boundaries of what can be said and thought in particular times, places, and spaces.

2.5. Foucauldian Discourse Analysis

FDA holds a different conception of discourse and its role in governing the conduct of human subjects than the other approaches I have presented thus far. The concept of discourse appears to change throughout Foucault's early work, leading to some confusion. In Foucault's later writings discourse takes the shape of broad foundations that operate within a field of knowledge to establish the truth about things like "mental health" or "drug use". For example, security discourse, an important thread of analysis in my study of texts on the "mental health crisis", references the political rationality that seeks to minimize "what is risky and inconvenient, like theft and disease" (Foucault, 2007; p. 19), through "a whole series of techniques for the surveillance of individuals, the diagnosis of what they are, of their specific pathology, and so on" (p. 8). Security discourse is realized in practices that operate to secure the bodies and minds of psychiatrized people, and also efforts to identify, manage, and monitor the impacts of "untreated mental illness" on the health of the population writ large.

Reading with an eye to uncovering discursive practices at play in a text requires one to pay attention to the "mechanisms, procedures, and processes" that generate discourse (Bacchi and Goodwin, 2016; 37). Foucault (1973) offers an example of a discursive practice in *The Birth of the Clinic* where he describes how medical knowledge of "disease" shifted over time from considering it as something that existed "out there" in the world, independent of the human body, to an object of study that exists *within* the human anatomy. This change in medical discourse opened up new technologies of rule that target the body through diagnostic assessments, research, and treatments. Foucault describes discursive practices as those which "systematically form the objects of which they speak" (Foucault, 1972; p. 49). Discursive practices are historically contingent, representing the rules that dictate the production of forms of knowledge, like medicine, which come to be understood as true in a given time and place.

FDA is helpful to this dissertation's task of elucidating how the documents on Vancouver's "mental health crisis" play a role in dividing people with untreated SAMI from those more willing to engage in treatment and particular forms of self-management, leading to production of new "truths" about the relationships between violence and mental health which are essential for mobilizing coercive reforms in care. A Foucauldian conception of discourse as knowledge helps one locate how certain interventions like

ACT come to establish themselves as “best practices”, while other important forms of social and/or spiritual supports are dismissed as not “evidence-based”, relegated as distal “solutions” to the “crisis”. FDA leads one to uncover the “best knowledges”, epistemological assumptions within those knowledges, and the discursive, subjectification, and material effects that are produced.

Subject agency is also approached differently in FDA compared to other approaches to discourse analysis. In FDA subject agency is concerned less with intentional frames advanced out of capitalist material interests and more with the messy, heterogeneous social contexts constructed by discourse and discursive practices. This differs from DPA, the Essex School, and CDA, for “just as there are no subjects using discourse in Foucault, nor are there subjects or interests shaping discourse, reflecting Foucault’s opposition to humanist conceptions of the subject” (Bacchi and Bonham, 2014; p. 181).

Foucault (1980) approaches power as a diffuse force operating all around and through us, not just in language, rhetoric, or particular frames. This is appealing for my research on the crisis for two reasons. First, I wish to avoid normatively implicating the extra-discursive interests of particular institutions (e.g., municipal governments, police departments) or individuals (e.g., elected officials, senior bureaucrats, or researchers) in the effects of problem representations surrounding the crisis; and second, and most importantly, approaching “policy as discourse” under an FDA framework provides explanatory value for a study on the rationalities that shape both policy “problems” and their “solutions” (Goodwin, 2011), leading to a more fruitful conversation regarding the micropolitics involved in problematizing mental illness.

However, for all of its conceptual value in opening opportunities to question taken-for-granted “problems”, Foucault’s writing is challenging to understand even for the most careful reader. Many concepts are used in different ways throughout his work and can appear contradictory, leading to diverse uses in the years since his death. For this reason, along with the fact that Foucault was often reluctant to define method at all, there are remarkably few accounts of how *to do* FDA. Some question whether FDA is a thing at all (Graham, 2005). Moreover, claiming to *do* FDA would go against Foucault’s approach to research, in the sense that he never limited himself to a particular methodology. Instead of a set of *prescriptions*, Gilbert (2003) offers five helpful

methodological *precautions* for FDA that I have considered in relation to my research below. While not to be taken as an overarching framework, the following principles are consistent with the WPR approach and helped to guide my research:

1. Power should not be conceived of as operating at the centralized level of the state[7]. Instead, we should attend to the power relations inherent in knowledge practices that make governing possible. This helps us to locate the specific micropolitics of local policy proposals, such as having police join nurses in psychiatric outreach programs like ACT.

2. We should seek to analyze the targets of subjectification. Targets may be mental health clinicians, policy workers, patients (e.g., people with "untreated SAMI"), organizations, and/or "places" (e.g., Vancouver's Downtown Eastside).

3. Power circulates in the social world in a heterogeneous and at times contradictory way. The analysis must look to uncover the multiple discursive practices that play a productive role in new power relations. We must caution against the urge to make over-arching claims about the relative power of a particular policy solution. For instance, my research focuses on the Canadian province of BC which has a unique social context, most notably the obscured but enduring legacy of colonization of Indigenous people (Culhane, 2003). Situating my analysis in this socio-historical specificity helps to elucidate how Indigenous concepts of healing and wellness provide a unique and important counterweight to the dominant psychiatric discourse present in the policy texts.

4. The analysis should endeavor to "identify how particular social practices, which have their own internal logic, become recruited into wider strategies of power" (Gilbert, 2003; p. 44). This helps to link discursive practices present in the "mental health crisis" with wider political strategies (e.g., broader neoliberal policy orientations within BC mental health and public safety policy, the ongoing presence of

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[7] Commenting on the historical propensity for social theorists to direct much of their energy to analyzing power at the level of the state, Foucault (2007) provoked: "[a]fter all, maybe the state, is only a composite reality and a mythicized abstraction whose importance is much less than we think… [w]hat is important for our modernity, that is to say, for our present, is not then the state's takeover (*etatisation*) of society, so much as what I would call the "governmentalization" of the state" (p. 109). For Foucault contemporary forms of governmentalization were often less concerned with protecting capital or ruling over property, and more with producing particular qualities (e.g., self-motivation to engage in psychiatric treatment) within the "population".

disciplinary power in clinical practice, contemporary calls for police reform).

5. Finally, we can locate discourse within the knowledge articulated in the "particular field of operations" of our empirical site (Gilbert, 2003; p. 44).

Chapter 3.

Key Concepts of the WPR Approach: Governmentality and Neoliberalism

Taken up with the methodological precautions discussed at the end of chapter two, the WPR approach represents one of the most helpful frameworks for operationalizing FDA in a major research project. In addition to problematization, which was discussed at length in chapter one, Foucault's concepts of governmentality and neoliberalism form the analytical backbone of Bacchi’s (2009a) approach. This chapter explores the relevance of these two concepts to the WPR approach and my research on Vancouver’s “mental health crisis”. Some charge that governmentality studies tend to read neoliberal political rationalities into every political project, failing to recognize that it is possible for multiple forms of governmentality to be present in an empirical site (Collier, 2012). In this chapter I note that in addition to neoliberal political rationalities, documents on the crisis contain other “arts of government”. I also describe how resistance is theorized within governmentality studies, addressing questions of agency and the criticism post structural scholars who employ ethnographic methodologies direct toward those who primarily study texts.

3.1. Governmentality

Emerging from Foucault’s (2007) lectures at the College de France, “governmentality studies” have developed into a diverse field of theory-driven research in the social sciences. Foucault uses the term governmentality to describe “a particular form of government, with its origins in sixteenth century Western Europe and characteristic of contemporary Western Democracies, in which the security, reproduction, productivity, and stability of the ‘population’ are concerns of the state” (Bacchi and Goodwin, 2016; p. 41). Policy documents on Vancouver’s “mental health crisis” demonstrate these concerns in their categorization of “untreated SAMI” as a particular kind of threat: to the stable and efficient operation of the local economy and municipal and provincial health and social service budgets; to the security of the general “low risk lifestyle” population in the city; and to the ideal of the self-managing psychiatric patient who contributes to society. My research implicates the policy texts in producing

“untreated SAMI” as emblematic of these particular kinds of problems, which in turn shapes concrete plans—like the City of Vancouver’s (2014) “23 priority actions” for improving the mental health system of care—that give governmentality form and effects. Bacchi (2016) argues that in this regard, we are not governed by policies, but rather by the problems created within them (p. 12).

Governmentality studies like the WPR approach shift away from conceiving of power as enacted primarily through top-down disciplinary practices of state actors like police who exert control over individual bodies, to governance “from a distance” through problematizing and seeking the regulated autonomy of political subjects. Rather than exercising power through direct coercive means, like confining patients to inpatient psychiatry units, this involves “*eliciting* desired behaviours” from the subjects of health and social service interventions (Bacchi, 2009a; p. 161). Governance at a distance “takes place on the one hand between political strategies and the activities of [authorities] and, on the other, between [authorities] and free citizens, in attempts to modulate events, decisions and actions in the economy, the family, the private firm, and the conduct of the individual person” (Rose and Miller, 2010; p. 278).

Latour (1987) argues that places (e.g., the “DTES”) and people (e.g., people with “SAMI”) can only be governed at a distance when they are reduced to “mobile” objects so that knowledge about them can be transported to nearby or faraway places (e.g., university research groups, provincial ministry departments), kept relatively constant so their characteristics, definitions, and problematizations are not rapidly changed in ways that might destabilize their essence, and made “combinable” so that their component parts (e.g., administrative data demonstrating rates of homelessness, health system utilization patterns, numbers of supportive housing units, full-time equivalent police officers present in the streets) can be “cumulated, aggregated, or shuffled like a pack of cards” (p. 223). The policy texts in my study demonstrate a great degree of collaboration in cross-referencing and firming up the component parts of different problem representations that form Vancouver’s “mental health crisis”. For example, local research cited in the documents provides estimates of population prevalence of “untreated SAMI” and establishes its proximal relationship to homelessness, violent crime, and inefficient health expenditure outputs. These calculations are in turn mobilized by governments as “proof” of the problems and stand as indicators for evaluating progress in addressing them.

Following Foucault's studies of the discursive construction of objects of thought like "madness" and "human sexuality", the "WPR approach is crucially interested in investigating the role of the human sciences in supplying 'special knowledges' and 'analyses' of 'population'" (Bacchi, 2009a; p. 235). "Expert" psy knowledge is frequently referenced and relied upon in documents that problematize high rates of "severe untreated mental illness" within Vancouver's inner-city population. Bacchi's questions help to understand how discursively contingent objects like "untreated SAMI" are first problematized, fixed, and categorized in discourse, then positioned in policy as amenable to interventions like ACT. For Foucault and Bacchi, the problematization of objects of thought like "untreated SAMI" is critical for governing because it helps to establish the "truth" about what is believed to constitute "good mental health" and "recovery" from mental illness (e.g., a patient's compliance with a "recovery-oriented treatment plan", low health system utilization, infrequent contact with the criminal justice system, and the ability to maintain independent housing). Taking up such problematizations as the focus of study helps to "open up relations of ruling for critical scrutiny" (Bacchi, 2012; p. 2).

Foucault's late work on the problematics of government draws an explicit connection between discourse and governance. Lemke (2002) highlights the significance of this conceptual relationship where he notes that in fact "[the] semantic linking of governing (*gouverner*) and modes of thought (*mentalite*) indicates that it is not possible to study the technologies of power without an analysis of the political rationality underpinning them" (p. 50). Political rationalities involve appeals to aspirational social ideals like "freedom, justice, equality, mutual responsibility, citizenship, common sense, economic efficiency, prosperity, growth, rationality and the like", but also hold an "epistemological character" in their assumptions about "the nature of objects governed—society, the nation, the population, the economy" (Rose and Miller, pp. 276-77).

Studying the forms of governmentality in reform proposals found in texts on Vancouver's "mental health crisis" requires identifying the political rationalities at work in constructing particular problems (e.g., the "untreated SAMI", "treatment non-compliance", the economic costs of mental illness, a lack of cross sectoral collaboration), people (e.g., *individuals with* "untreated SAMI", community-based clinicians, police officers), and places (e.g., the "DTES", "supportive housing projects", "the community"). The second research question I adopt from Bacchi's (2009a) WPR approach identifies

these particular political rationalities in the texts, while the fifth looks to identify the discursive, subjectification, and lived effects of the problem representations that follow from them—a task which demonstrates that political rationalities have real world impacts.

The political rationalizations central to governmentality often draw strength from “expert” knowledge/discourse, or technical “know-how”. Attention to the role that “expertise” plays in the problematization of things like a “mental health crisis” implicates professionals like researchers, clinicians, police administrators, and policy makers within networks of governmentality (Miller and Rose, 2008). Governmentality studies locate specific forms and functions of professional “know-how” in shaping political relations, recognizing that:

> what makes human conduct intelligible and constitutes certain forms of expertise as appropriate for knowing and acting upon it… [t]ruths, explanations, categorizations and taxonomies, vocabularies and diagnoses concerning human beings individually and en masse are conditions for the governability of conduct (Rose, 1996; p.3).

The documents I analyse are rife with reference to “expert” validation of the problematization of “mental health crisis”. From the At Home Study’s (Currie, et al., 2014) epidemiological account of the significant co-morbidities found in the local homeless population and promotion of calculations from health economists that illustrate ACT’s cost-saving potential, to the Hotel Study’s (Vila-Rodrigues, et al., 2013) finding that existing supportive housing sites in the “DTES” do not provide sufficiently intensive psychiatric interventions, to the local police department’s analysis of call volumes indicating a rise in mental health emergencies (VPD, 2008), a range of technical prowess paints a portrait of a range of urgent problems in need of fixing.

Foucault (1982) defines governmentality in shorthand as “the conduct of conduct”. Attempts to “conduct the conduct” of people and populations are made through practical extensions of professional knowledge, which can be empirically identified “at the level of rationalities, programmes, techniques and subjectivities which underpin [them] and give [them] form and effect” (Walters, 2012; p.2). These practical activities include “indirect techniques for leading and controlling individuals” (Lemke, 2002; 59). Mental health clinicians use indirect treatment techniques not with the ambition to “cure” illness per se, but rather “to teach the skills of coping, to inculcate the responsibility to

cope, and to return the individual to a life with which he or she can cope" (Rose, 1996; p. 12). Governmentality relies on subjects like psychiatric patients, clinicians, and the population writ large to take on and embody political rationalities which assume that the ability to self-manage one's illness absent intensive forms of government support is what ought to be equated with "wellness".

Professional expertise like psy science "provides a kind of *intellectual machinery* for government, in the form of procedures for rendering the world thinkable, taming its intractable reality by subjecting it to the disciplined analyses of thought" (Rose and Miller, 2010; 280). In the context of mental health reforms in Vancouver, Bacchi's (2009a) approach to problem questioning will show how the "disordered" lives of psychiatrized people and populations are "rendered thinkable" through epidemiological calculations that divide people with "untreated SAMI" from ideal, self-motivated, treatment compliant psychiatric patients. My research also shows how the problematization of the "costs" of the "mental health crisis" gave rise to efforts to help "disordered" people to reorder their behaviours in ways consistent with market logics by reducing reliance on state expenditures brought by disproportionately high use of emergency health services and involvement with the criminal justice system.

3.2. Criticisms of Governmentality Studies

Some argue that governmentality literature verges into self-fulfilling prophecy when it too easily reads neoliberal political rationalities into every empirical site (Collier, 2012). Walters (2012) argues that we ought to remain aware of the *three* arts of government that Foucault locates in the history of western Europe: pastoralism, raison d'état, and liberalism—or what Walters calls liberal governmentality, Rose (2006) calls advanced liberalism, and I refer to as *neoliberal political rationalities*—a concept defined in detail in the next section. Lippert (2005) demonstrates that multiple forms of governance operated simultaneously in his case study of Canadian immigration events where pastoral power—the primacy of god's law over the legal power of the modern nation state—was found to reside over several cases where refugees sought sanctuary in churches to avoid deportation. Collier (2012) notes that even in the Washington Consensus, a collection of prominent economic policies that formed the basis for broad global economic reforms throughout the 2000's and thought to be emblematic of

neoliberalism, there are textual traces that hint at fractures in neoliberal political rationalities.

Approaching my discourse analysis of documents on the “mental health crisis” with an openness to discover multiple forms of government reduced the risk of presenting neoliberal political rationality as a “totalizing, seamless condition that blankets all governmental logics and powers” (Lippert, 2005; p. 6), or as a “big leviathan” with unending power and a hypnotic grip over its subjects (Brown, 2012). I tried not to read neoliberal political rationalities into every document and instead be attuned to the possibility that they might mingle with other forms of power. For instance, later chapters outline how the widespread use of the most coercive aspects of the BC Mental Health Act, such as compulsory treatment and psychiatric confinement, represent “harder” forms of discipline that more closely resemble early 20th century forms of custodial mental health care than emerging “mental health recovery” paradigms which seek to responsibilize patients to care for themselves. Indeed, the routine reversion to custodial care in Vancouver’s mental health treatment system produces a notable tension with neoliberal political rationalities present in mental health recovery practices, like motivational interviewing, which clinicians on ACT teams and other community-based interventions use with the aim of instilling better “life skills” within individual psychiatric patients in order to bolster their auto regulating capacities.

Collier (2009) similarly eschews the view that particular techniques of government are static and confined to specific eras, and instead looks to “patterns of correlation among different forms of power” (89). Perhaps the most novel finding in my analysis of the “mental health crisis” is how its many problem representations came together to produce heterogeneous effects, many harmful, under a specific project of healthcare reform. A range of knowledge claims derived from security and psy discourse mingle throughout the documents on the “mental health crisis”. At times different problematizations and implicit political rationalities seem to be at odds with each other. For example, a close reading of the City of Vancouver’s *Caring for All* (2014) report reveals that the dominant problematization of the risks associated with “untreated SAMI” are challenged by oppositional groups holding competing understandings of the “problems” at stake in the “mental health crisis” (Van Veen, Morrow, and Teghtsoonian, 2019).

Some believe that governmentality studies which focus on analysis of texts fail to adequately capture the heterogeneous experiences of people targeted by interventions and the paths of resistance that these subjects manage to carve (Li, 2007; McKee, 2009, 2011). These critics argue that governmentality studies tend to formulate political projects as too successful and programmatically complete. If we are always being governed, then how do we explain instances when governing does not go smoothly, when subjects refuse to be regulated or to regulate themselves? In order to better elucidate non-compliance, or "the gap between what is attempted and what is accomplished", these scholars see more empirical value in ethnographic methods than post structural policy studies that focus only on analysis of texts (Li, 2007; p. 1).

Ethnographic approaches can help demonstrate how subjects are not always—or even often—complacent. Evans (2012) uses a grounded governmentality approach to observe the day-to-day lives of previously homeless "street-drinkers" in a Housing First managed-alcohol[8] program in Hamilton, Ontario. He describes how many program participants were ambivalent about the program's goal to reduce "street drinking" and resisted attempts by staff to reduce public disorder by containing all alcohol consumption at the housing site, away from public view. His field observations show that some participants regularly left the institutional environment of the housing program to go back to the downtown to drink in "the streets" with friends. In this case, he was able to capture resistance to attempts to problematize and govern "street drinking" and associated "public disorder" in a way that an analysis of texts might miss.

Most clinicians working in community-based mental health and addictions services will agree that a fissure certainly exists between what health and social service interventions attempt to do and how their targets respond. My clinical experience in Vancouver provides countless examples of where the subjects of interventions resisted. Psychiatric patients on my case load would occasionally go so far as to flee the province to escape the jurisdiction of the BC's mental health law. They would also skip mental health clinic appointments when they felt a poor sense of therapeutic alliance with their

[8] Managed alcohol programs are intended to reduce the harms associated with alcohol use disorder by providing participants with small doses of prescribed beer, wine, or spirits at regular intervals. This approach is thought to prevent non-beverage alcohol consumption (e.g., the drinking of mouthwash, cooking wine, or hand sanitizer), and offer participants stability and refuge from life on the street.

psychiatrist, or when they did not want to face the indignity of having medication administered in the form of forced intramuscular injections by clinic nurses.

Although the ethnographic critique of post structural policy studies resonates in some ways, it also misinterprets the way many governmentality studies explain these kinds of agentic struggles. The concept of "counter conducts" is used in some governmentality literature to explicitly draw attention to the "will not to be governed thusly, like that, by these people, at this price" (Foucault, 2007; p. 75). Throughout Foucault's work power is something that is always contested, never completely dominant. In fact, resistance is central to his conceptual use of governmentality (Walters, 2012; Rosol, 2014). Contestation is not defined in Marxist terms as grand refusal or return to a nature that we have been alienated from through false consciousness or cultural hegemony. In *Discipline and Punish*, Foucault (1980) explains how failure is a necessary part of the very functioning of the carceral system because the networks of power present in broader society rely on it to produce delinquency as a dividing practice that plays an important function in reinforcing social norms within
the broader population.

The concept of counter conducts has been used to explore different practices of resistance and their role in reshaping specific governing regimes. Such studies provide accounts of how oppositional attempts to create social change come to be recast and implicated within the web of governing practices (Teghtsoonian, 2015). Death (2010) illuminates the non-exteriority of resistance to power through the captivating image of a protester kicking over a Nike sign while wearing Nike sneakers during Seattle's 1999 World Trade Organization protests. Rosol (2014) examines the counter conducts involved in discursive struggles surrounding a municipal rezoning process to designate land for a corporate big box store in Vancouver, BC. Her study gives nuance to the different shapes that resistance took within a specific activist project. Some participants of the public engagement exercise appealed to "expertise" in their work in order to undermine the City's direction to approve zoning for a Walmart store, while others chose to work both within the committee *and outside it* by supporting activists who challenged the ways in which the process was ultimately subservient to the planning rationalities of the municipality. Her research found that in the end, the "CityPlan Community Visions Policy" planning process "demonstrated that resistance towards a specific re-zoning

application may indeed take the form of a struggle *for* the implementation of a City program" (p. 80; emphasis in the original).

Identifying the counter conducts present in political struggles helps to show how governmentality and resistance are frequently ongoing, incomplete, and mutually constitutive. Examining the role of resistance in the "mental health crisis" is the task with the sixth question I have adapted from the WPR approach, which considers how the problem representations in documents on the "mental health crisis" could be "contested, disrupted, and replaced" by competing ones (Bacchi, 2009a; p. xii). My analysis avoids positing mental health interventions like ACT as sure-fire bets to contain the "risks" posed to public safety by people with "untreated SAMI" through surveillance, counseling, and compulsory psychiatric treatment. Instead, I point to where the texts reveal that ACT and other mental health interventions encounter failures in their attempts to govern individuals "at a distance". I also show how resistance on behalf of psychiatric patients plays an important role in forging new arrangements of psy power. In some respects, Vancouver's "crisis" presents a predicament, where "recovery-oriented" approaches to care which seek to responsibilize patients are deemed insufficient, causing adjustments that summon the disciplinary power of policing and psychiatry to regain control.

3.3. Neoliberalism

Of the three arts of government that Foucault locates in western European history, neoliberal political rationality is the most recent, and has come to be articulated through many aspects of modern life. Following from the way neoliberalism is conceived of in Foucault's lectures from 1978 and in Rose (2006; 1998) and Brown's (2015) work, I use it to describe a political rationality of individual freedom, which is often assumed as natural for the governance of human beings, shaping their relationships to themselves, each other, and things. Under this specific political rationality, "economic principles become the model for state conduct, the economy becomes the primary object of state concern and policy, and the marketization of domains and conduct is what the state seeks to disseminate everywhere" (Brown, 2015; p. 62). The WPR approach (Bacchi, 2009a) proposes that we can use problematizations, like "untreated SAMI" or Vancouver's "crisis", as empirical entry points for studying neoliberal political rationalities within specific public policies.

Neoliberal political rationalities are articulated through a range of practices that help bring them into being in times, places, and spaces, not just in talk and text, but also in human (e.g., counselling techniques) and non-human (e.g., evaluation and monitoring of outcome indicators) technologies which result in the "government of individuals from a distance" (Larner, 2000; p. 6). In this sense, neoliberal political rationalities are less a totalizing governmental logic or generalizable economic theory that structures all political relations—an essential "thing" that sits outside discourse—and more a particular *kind* of rationality that shapes and reshapes a range of problem representations in the mental health and substance use policy landscape (e.g., "untreated SAMI", "problematic substance use", "addiction").

Neoliberal political rationalities invite the assumption that less government intervention, not more, is key to helping individuals to solve their own health and social "problems". This thinking creates a range of subjectification effects that the WPR approach prompts us to consider. Brown (2015) contends that these effects are omnipresent in our day to day lives, particularly in the way every sphere of human activity, from mental health, to education, exercise, diets, social media profiles, housing status, and dating, has come to be imbued with a market value. Inherent in this problematic of the individual is the notion that freedom is not in opposition to government, but rather becomes a self-governing force in the way it compels individuals to conduct themselves with "autonomy, self-responsibility, and the obligation to maximize one's life as a kind of enterprise" (Rose, et al, 2006; p. 91). This rationality contains a political aspiration to produce a population of rational, "enterprising selves" (Larner, 2000; Rose, 1998; Teghtsoonian, 2009). In the context of Vancouver's "mental health crisis", enterprising selves are those who voluntarily seek treatment and undertake the kind of self-work necessary to ensure that their healthcare utilization patterns are cost efficient for state-funded health and social services.

However, although their grip is strong, one should be careful not to view neoliberal political rationalities as having complete discursive dominance over our lives. Its logics are constantly and characteristically self-limiting, cautious not to govern too much for fear of diminishing individual freedom by relying on more authoritarian forms of disciplinary power exercised by the state. In this sense, Walters (2012) describes neoliberalism as "the art of least possible governance" (p. 30). As we will see in later chapters, a tension over how much state interventions into mental health care in

Vancouver is *too much* is present in the way texts from the VPD chastise mental health clinicians for their lack of willingness to institutionalize psychiatric patients through the most coercive means available under provincial mental health law.

Brown (2015) contends that since Foucault's death in 1984 there have been significant developments in how states, individuals, and organizations operate and that these shifts should have repercussions for the ways we use the concept of neoliberalism. She argues that contemporary neoliberal political rationalities can be traced to where:

> transformation of economic actors and action by governance such as teamwork, responsibilization, and stakeholder consensus replace individual interest; the shift, in short from a neoliberal discourse of free subjects to a discourse featuring more explicitly governed, 'responsibilized', and managed subjects (p. 71).

In this new form of subjectivity, people are no longer rationalized as political animals endowed with rights, but rather economic ones holding the *responsibility* to act in ways which enhances their human capital and future potential.

Despite Foucault's interest in psychiatry and health sciences in *The Birth of the Clinic* (1973) and *Madness and Civilization: A History of Insanity in the Age of Reason* (1988), his later lectures do not clearly spell out the relationship between neoliberal political rationalities and "mental illness". However, Parton (1985, 1994, 1999), drawing on Rose (1993), picks up on Foucault's late work to forge the connection. Parton (1999) identifies a range of neoliberal rationalities at play in contemporary mental health and social services, including:

> extending market rationalities—contracts, consumers, competition—to domains where previously social, bureaucratic, or professional logic reigned; governing 'at a distance' by formally separating activities of welfare professionals from apparatuses of central and local state, and governing them by budgets, laws, audits, standards, codes of practices and logics of consumer demands; making individuals and 'communities' themselves 'interested' in their own government in the sense that they should take responsibility for their own present and future welfare and for the relations which they have with experts and institutions (p. 12).

In contemporary mental health discourse, the concept of "self-care" is often deployed to responsibilize individuals to manage their own illnesses. This is evident in BC mental health policy and practice that positions recovery from mental illness as an individualized, personal journey that ought to rely less on state support and more on

one's own "recovery capital" (Morrow, 2013). Lemke (2002), describes what is involved in processes of responsibilization succinctly:

> The strategy of rendering individual subjects "responsible" (and also collectives, such as families, associations, etc.) entails shifting the responsibility for social risks such as illness, unemployment, poverty, and so for, and for life in society, into the domain for which the individual is responsible and transforming it into a problem of "self-care". One key feature of the neoliberal rationality is the congruence it endeavors to achieve between a responsible and moral individual and an economic-rational individual (p. 59)

My research demonstrates how "untreated SAMI" presents a unique, specific, and significant risk to the "good" mental health subject who responsibly aligns her recovery and life choices with the market through a devotion to psychiatric treatment, self-care, self-control, and economically rational behaviour: "for people who are not perceived (or do not perceive themselves) as rational, and those psychiatrized are by definition precisely that, there can be no rational choice in a so-called free market" (O'Leary and Ben-Moche, 2019; p. 131). It is through "mental health treatment" and its techniques of responsibilization that the "risks" that psychiatric patients' irrational behaviours present to the broader population and economy are managed (Rose, 1996). This logic is also found in public health, which frequently positions a range of adverse population health outcomes as the result of poor, "risky", and undesirable lifestyle choices of individuals—a problem representation which guides health promotion efforts towards educating people to make *better* decisions rather than focusing on improving the structural determinants of their health (Lupton, 1993). As we will see in the chapters to follow, the problem representations surrounding Vancouver's "mental health crisis" provide fertile empirical ground to open up neoliberal political rationalities in mental health policy for novel lines of scrutiny.

Chapter 4.

What are the Problems Represented to Be in The "Mental Health Crisis"?

4.1. Introduction to the Problem Representations

This section provides an overview of the problem representations contained in each of the core texts selected for analysis based on their relevance to establishing new police-involved ACT models as a key intervention into Vancouver's "mental health crisis". This document-by-document approach is intended to provide the reader with an overview of each, so there will be a sense of familiarity when they are repeatedly referenced later in the analysis. Then, in four subsections, I delve deeper into the most prominent problem representations repeated across the texts: "SAMI" as a threat of violence; untreated severe mental illness and addiction and a lack of psychiatric services; a crisis of "cost"; and poor cross-sectoral collaboration.

This chapter begins the WPR analysis by asking "*what are the problems represented to be in texts on Vancouver's "mental health crisis?*" This question sets off my discourse analysis with the simple notion that "what we propose to do about something indicates what we think needs to change and hence what we think the 'problem' is" (Bacchi and Goodwin, 2016; p. 16). In order to arrive at a more fulsome discussion about how the texts construct new regimes of care and control in Vancouver's inner city, the first step is to parse apart the specific problem representations found within each.

It is clear from the length, scope of data collection and analysis, and polished graphic design, that the city and police department put considerable organizational resources into producing their mental health reports published from 2008-2016. When a new document was published, press conferences were often held with local elected officials or the police chief to present recommendations and answer questions from the media. This signals that significant collaborative effort was made throughout this period on the part of the VPD, elected officials, and municipal staff to problematize the situation. This cooperation is referenced where the VPD's Project Lockstep: A United Effort to

Save Lives in the "DTES" (2009) report notes that it: "benefitted greatly from the contributions of numerous individuals… Mayor Gregor Robertson and the members of the Vancouver Police Board, the staff of the City of Vancouver's Social Policy Department in particular must be thanked for sharing their insight into the *problems* experienced by those living in the Downtown Eastside" (p. 1; emphasis added). Here and elsewhere, the texts communicate with one another, building the scaffolding for certain problem representations to rise to the top, while pushing others to the bottom.

Lost in Transition*: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources (Lost in Transition)* (VPD, 2008) is the first in the series of mental health texts produced by the police department. The text was composed with "valuable input from various people who work for the Vancouver Coastal Health Authority" (p. i) and the municipality and problematizes a "profound lack of capacity in mental health resources in Vancouver", resulting in "an alarmingly high number of calls for police service to incidents that involve mentally ill people in crisis" (p. 3). The VPD undertook original research to inform the document, finding that the prevalence of calls for police services frequently involves "mentally ill clients" who are in crisis. The text acknowledges that because incident reports were composed by frontline officers who do not have clinical expertise in mental health and addictions, it is challenging to determine if calls for service in fact involved people with "mental illness". Despite this methodological limitation, the VPD went ahead with a time-limited pilot where a sample of officers working the inner-city beat were provided purposefully developed forms to track service calls attended throughout their workdays (p. 8).

The cards used to collect data were unsophisticated, noting basic information such as date, district, shift, incident number and whether the call should be—in the lay opinion of the officer—recorded as a "mental health crisis" event. The report acknowledges that the VPD's research pilot "was conducted based on several guiding assumptions" (p. 9):

> that there was a need for the VPD to understand the nature and extent of calls for service that involved people who were mentally ill… this was grounded in the belief that mental health calls were pervasive to the extent that understanding them was of value, particularly to the VPD, but also to the community at large (p. 9-10);

that officers who carried out the data collection had the personal and professional experience necessary to make accurate determinations of mental health involvement in the calls they attended;

that "based on anecdotal observations… many people who interacted with police did so because they were mentally ill and were not receiving appropriate mental health treatment to address their illnesses; and that police interactions with people who are mentally ill increase in the absence of appropriate mental health treatment (p.9-10)

Notwithstanding these limitations, the findings from the pilot are presented as sound and accurate. The report notes that "generally speaking, when police identify that a mental health issue exists, the symptoms are readily apparent and would likely be obvious to any layperson", and that "the expectation of the involved officers to use their subjective opinions in determining mental health involvement in an incident for the purpose of [the] study [was] congruent with the intent of the [British Columbia] Mental Health Act, whereby officers are afforded the power to apprehend people based on their observations" (p. 10). The results of the pilot confirm the VPD's frequent assumption that mental health is a factor in a large proportion for its calls for service in the inner city, drawing significantly on police resources that could be better used elsewhere.

Project Lockstep: a United Effort to Save Lives in the Downtown Eastside (Project Lockstep) (VPD, 2009) is a VPD discussion paper generated with input from the City of Vancouver, a local physiatrist, and the former BC Liberal Party Minister of Public Safety and Solicitor-General, and the Minister of Housing, amongst others. While the *Lost in Transition* (VPD, 2008) report focuses largely on establishing that people experiencing "mental health crises" are not being provided with adequate treatment in the community, *Project Lockstep* (VPD, 2009) takes a broader scope in its problematization of the "DTES". The text notes that "the lives of many of the people residing in Vancouver's Downtown Eastside (DTES) are negatively affected by mental health issues, illicit and licit substance use, drug trafficking, alcoholism, physical health issues like HIV and Hepatitis C infections, substandard and insufficient housing, illegitimate business, crime and public disorder, an entrenched survival sex trade, and a historical reduction in police presence" (p. 2).

Project Lockstep (2009) goes on to describe how the VPD used to have a stronger historical presence in the neighbourhood, with street patrols working the beat going back to the late 1800s. This physical police presence peaked in the post-war

period when a large police headquarters was operated at 312 Main Street, a block away from Main and Hastings—an intersection widely regarded as the heart of the “DTES”. The document hypothesizes that locating the police headquarters so close to Main and Hastings from 1954-1994 meant that for decades there was a natural police presence that brought order and stability to the neighbourhood. It also notes that in addition to the relocation of the police headquarters in the 90’s, recent cuts to the department’s budget translated into a reduction in beat officers in the “DTES”. Calls for more police resources to manage poor and psychiatrized bodies in the inner city is a common theme in the report, inferring that the problems of the neighbourhood—(e.g., violence, “substandard and insufficient housing”, high rates of HIV and Hepatitis C, mental health issues, addictions, etc.)—can be remedied through increasing municipal investments in law enforcement. The text reads as part indictment of the local health and social system, part business case for growth of the police department.

Policing Vancouver’s Mentally Ill: The Disturbing Truth, Beyond Lost in Transition (Beyond Lost in Transition) (VPD, 2010) summarizes progress made and gaps remaining since the publication of *Lost in Transition* (VPD, 2008). *Beyond Lost in Transition* (VPD, 2010) offers a glimpse into police frustration with health providers, at one point stating that “unfortunately the police concern regarding chronic individuals in the community who cause harm to themselves and others carry little or no weight in the health system” (p. 5). The report calls for health administrators to start to use “reduction in police contacts” as an “important measure of ‘success’” when evaluating mental health treatment outcomes. Noting that at the time there was only one ACT team operating in Vancouver on a pilot basis without police involvement, the report recommends that additional teams be added under a new model wherein police and health “work in partnership and share appropriate information as well as measure and evaluate the effectiveness of response and treatment across a broader range of criteria which would include the number of police contacts” (pp. 30-31). The document also raises for the first time the potential to improve treatment outcomes and create cost efficiencies through enhanced information sharing agreements. These agreements are envisioned to increase police abilities to surveil mental health patients who flee confinement in the hospital and/or are engaged in community treatment by granting officers ready access to private electronic health records.

Vancouver's Mental Health Crisis: An Update Report (2013) is the first to declare that Vancouver is in the midst of a "mental health crisis". It calls on the provincial government to mitigate the crisis by funding more ACT teams and creating "joint VPD-VCH Assertive Outreach Teams for mentally ill persons who do not yet qualify for ACT teams" (p. 2). The text problematizes existing "service gaps" as increasingly "dangerous" and requiring significant cross sectoral collaboration as a remedy. The report notes that health authorities and the police department generally agree that "the VPD and the Criminal Justice System *are part of the continuum of care* for mutual clients who suffer from severe and persistent mental illness and substance abuse disorder (sic)" (p. 11; emphasis added). It goes on to state that the police department's lack of access to confidential health records regarding a person's mental health diagnosis results in a risk to public safety and leads to a waste of government resources when police are routinely called to apprehend the same mentally ill individuals in crisis. It also echoes earlier calls from the department for the province to amend the BCMHA to provide police and clinicians a more efficient path to involuntarily hospitalize people.

The BC Ministry of Health's report, ***Improving Health Services for Individuals with Severe Addiction and Mental Illness*** (2013) was composed in response to a letter sent to the Premier of BC by the Mayor of Vancouver, VPD, and the chair of the local health authority that points to concerns raised in the VPD's *Update Report* (2013), published two months earlier. The ministry report accepts claims made by the municipal officials and police that "a significant sub-group of people with severe addictions and/or mental health illness (sic) do not have access to adequate treatment", that this population of people with "untreated SAMI" is increasing, and that "in addition to the significant social and health risks facing this population, there is also a growing public safety risk to bystanders" (2). It notes that the letter from the Vancouver officials calls for the Ministry to respond with more funding for additional ACT teams and to "improve urgent hospital care for individuals in mental health and/or addictions crisis" (Ministry of Health, 2013; p. 1). The Ministry concludes by conceding to the request for funding for two new ACT teams and also commits to "reconfiguring services" at Vancouver's inner-city hospital in order to better meet the needs of psychiatric patients and police.

The ***At Home/Chez Soi Project: Vancouver Site Final Report (At Home Study Final Report)*** (At Home Study) (Currie, Moniruzzaman, Patterson, and Sommers, 2014) presents findings from the Vancouver arm of the Mental Health Commission of

Canada's randomized control trial aimed at understanding the impact of Housing First interventions on a population of formerly homeless individuals over a two-year period. Study participants were selected because they presented symptoms of mental disorders and/or addictions upon intake. The report presents an "analysis based on narrative interviews, questionnaires, and administrative data sources", concluding that Housing First interventions—both ACT and a congregate arm of single-site supportive housing—positively benefitted participants and produces cost savings for government when compared to a control group who received "treatment as usual" (e.g., no additional supports).

The report contains a lengthy description of the epidemiology of Vancouver's homeless population, indicating high rates of mental disorders. It also provides summaries of baseline health service utilization rates, prevalence of adverse childhood events, and patterns of substance use amongst homeless people in the inner city. It goes on to describe outcomes for people randomized to the Housing First interventions, stressing the health and economic benefits of improved housing stability, decreased emergency department visits, "reductions in offending", and self-reported improvements to "quality of life", "community functioning", "patterns of recovery", and "exiting homelessness".

The decision to structure the study as a randomized control trial has been criticized by some for its placement of people into a "treatment as usual" arm (homelessness), which is universally regarded as damaging to human health (Patton, 2012; Van Veen, Ibrahim, and Morrow, 2018). As might have been easily predicted, the At Home research concludes that a range of outcomes were worse for the "control group" of people left homeless. The study was also met with criticism by activists and some local social service providers for attracting such significant government funding to research whether or not there are health, social, and cost benefits of implementing Housing First programs—an intervention already widely considered to be "evidence based" (Vancouver Magazine, 2014).

Despite the high profile of the study, the financial investment it attracted, and its implications for mental health practice reforms, there has been a remarkable dearth of analysis on the study design and how its results were used to mobilize mental health practice reforms. My discourse analysis fills this gap by elucidating how the locally

produced science of the *At Home Study Final Report* (Currie, et al., 2013) problematizes "mental illness", "addictions", "homelessness", and Vancouver's "DTES" in ways that lend empirical validation to political rationalities that "reify pathological individualism" (Rimke, 2018; p. 17) while ignoring or minimizing the roles of poverty, gentrification, colonization, and police violence in creating and sustaining mental distress. Morrow (2013) describes this dynamic as the "healthification of social problems". Willse (2010) puts it succinctly when he describes how healthification plays out in research on homelessness: "the biopoliticization of homelessness can be understood in terms of the reconceptualization of homelessness as a health problem—which is to say, a problem of population health dynamics and trends—as opposed to simply a medical problem belonging to individuals" (p. 176).

The ***Caring for All: Priority Actions to Address Mental Health and Addictions (Caring for All)*** (City of Vancouver, 2014) report presents the findings from the Vancouver Mayor's Task Force on Mental Health and Addictions. It summarizes themes from a series of events where the City of Vancouver convened diverse stakeholders to "share evidence, drive change, and create enhancements to better support, serve and interact with residents struggling with serious mental health issues and addictions" (p. 11). Workshop participants included members of the VPD, researchers, professional practitioners, policy makers, community groups, youth, Indigenous leaders, and people with lived experience of mental illness and/or substance use.

The report cites evidence from several local research and policy texts to build the rationale for declaring that the City is indeed in the midst of a "mental health crisis". As evidence of this "crisis", the report problematizes that:

- There has been a 43% increase in visits to the emergency department of the City's main urban hospital between 2009-2013;
- Increases in police apprehensions under the BCMHA[9] indicate evidence of a "crisis";

[9] The BCMHA provides the legal basis for the lawful apprehension of people with "mental disorders". Form 4 grants physicians the ability to order involuntary detention, which usually involves forcibly apprehending the individual to return them to an inpatient setting. Form 21 gives the attending physician a similar ability to order apprehension if a patient leaves an inpatient setting on a community pass but fails to return at a specific time. Finally, Section 28 allows police

- Data from the Hotel Study (Vila-Rodrigues, et al., 2013) demonstrates that there are 2000 tenants of local single room occupancy hotels who are thought to be receiving poor quality or no care for their "mental health and addictions problems";

- Data from the City's annual homelessness count suggests that two-thirds of the homeless population should be deemed to be in "urgent need of adequate mental health and addictions supports" (City of Vancouver, 2014; p. 6);

- Research from City staff demonstrates that the "overall *cost* of mental health and addictions is over $30 million per year including costs such as policing, first responders, emergency housing needs", etc. (p. 10; emphasis on cost added); and that

- The local population of people with "untreated mental health and addictions" have become increasingly implicated in "several violent episodes" (p. 4) and are themselves also at risk of victimization.

Caring for All (City of Vancouver, 2014) puts emphasis on the need for more collaboration between law enforcement and healthcare to generate novel forms of "integrated community supports". The document gives ACT a strong endorsement as a model befitting this image of successful integration. However, although the psychiatric and security discourse present in the report give weight to recommendations to re-configure mental health services in coercive ways, there are competing problematizations present as well (Van Veen, Teghtsoonian, and Morrow, 2019). The City groups 23 recommendations under six "action areas": "work better together and address service gaps - the game changer"; "a peer-informed system – right faces in the right places"; "de-stigmatization – feeling safe and included"; "focus on youth – better transitions and outcomes"; "focus on wellness for Aboriginal peoples – a City of reconciliation"; and "enhance addictions knowledge – training and treatment choices" (City of Vancouver, 2014; p. 14).

The way that the report draws on feedback from multiple stakeholders and arrives at so many disparate "action areas" reveals that competing understandings of the situation arose in taskforce meetings. For example, the recommendation to invite leaders from Vancouver's urban Aboriginal community to form an "advisory group" to help establish culturally relevant concepts of wellness and "outcome measurements and indicators" demonstrates that colonization and a lack of cultural safety for Indigenous

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to detain individuals before consultation with a physician if the officer perceives the individual to be a threat to others or themselves. If an individual is apprehended under Section 28, police must bring them to a healthcare facility for physician assessment.

people is problematized as contributing to the "crisis" and hindering effective "solutions". Similarly, the report's recommendation that "people with lived experience of mental illness and addiction" be invited to continue engagement through a newly formed "peer leadership table" offers a glimpse into activist efforts to problematize policy making processes that exclude the voices of service users. The intention of this new peer group is to partner with local non-profits, to "develop professional peer training programs" and "work with other funders to align peer-led initiatives and programs" (City of Vancouver, 2014; p. 23). Van Veen, Teghtsoonian and Morrow (2019) note that "these acknowledgments make visible in the text contributions by task force members who refused the notion that "expertise" is the sole property of psy-science" (p. 71).

Vancouver Police Mental Health Strategy: a comprehensive approach for a proportional police response to persons living with mental illness (Mental Health Strategy) (2016) The VPD *Mental Health Strategy* (2016) text bookends my analysis as the final report to problematize Vancouver's mental health crisis. The document is "designed to provide clear and concise information about the VPD's position and intent, and to serve as a framework to support operational deployment, organizational partnerships, education and training initiatives, and a commitment to the community relative to interactions with persons living with mental illness" (p. 5). Although the text provides evidence of disciplinary mechanisms involved in police efforts to manage mental illness, it also hints that psychiatrized people successfully contested the dominant problem representations found in previous documents published by the department.

Although earlier documents from the VPD almost exclusively value the truth produced by "expert" psychiatric knowledge, the *Mental Health Strategy* (VPD, 2016) contains the first appearance of the perspectives of "people with lived experience". Noting that the new strategy was not "created in isolation", the text describes how the department found great value in "a consultation session with the [City of Vancouver's] Persons with Lived Experience Committee" when coming up with its recommendations. The *Mental Health Strategy* (VPD, 2016) describes that engagement with the peer committee "resulted in meaningful feedback from this affected population" (p. 5). Feedback from people with lived experience shines through where the text cautions that "criminalization" of people with mental illness should be viewed as a threat to effective crisis response.

4.2. Untreated Severe Addition and Mental Illness as a Public Safety Risk

Despite frequently presenting “SAMI” in a way that suggests that *we all know it when we see it*, the representations of mental illness and addiction and *people* with mental illness and addiction are problematized in multiple ways across the texts. The term “SAMI” is simultaneously represented as a distinct population (e.g., “the SAMI”), a “subgroup” of that population (e.g., the proportion of people with “untreated SAMI” who are in personal crisis at any given moment), and as a particularly severe biogenetic form of concurrent mental health and substance use disorder. The common characteristic between all these definitions is that “untreated SAMI” is regarded as a violent threat to the safety of the public.

In September 2013, around the same time that the VPD’s *Update Report* (2013) was published, the Mayor of Vancouver, flanked by the Chief of Police, held a press conference to present the document’s findings. The two officials concluded that the city was in the midst of an urgent “mental health crisis” and that the Update Report’s recommendations needed to be urgently taken up by senior levels of government. The mayor made a desperate appeal to the province to fund more ACT teams under a joint service arrangement with police, and to open hundreds of new inpatient mental health units to house the sizable proportion[10] of people who are “in crisis” at any given moment.

When it arrived at his turn to speak, the police chief made the stakes clear: if the province did not act on the department’s recommendations, the public would be left unprotected to the dangers of untreated “SAMI”. The chief went on to recount for the media several graphic anecdotes of spontaneous acts of violence attributed to individuals with untreated “SAMI”, noting that:

> In one of those cases, a man viciously beat three elderly women, kicking and stomping each of them in the head. In another case, a man walking his dog was stabbed multiple times and was eviscerated, with his internal organs being visible to the responding officer. In a third case, [police chief] Chu said, a mentally-ill person stabbed an innocent woman at a convenience store so hard that the knife broke off in her head. (Lee, 2013; Cited in Van Veen, Ibrahim, and Morrow, 2018)

[10] See Patterson, et al. (2008a) for a detailed population size estimate of people living with SAMI in Vancouver that the Mayor referenced.

Another report describes an incident where officers were alerted by a bystander that a woman was giving birth to twins in a nearby park. Officers describe the "chaotic scene" as follows:

> she was gripping both babies by their heads and necks and told police to leave and to not touch her or her babies when [the officers] attempted to get her medical attention… [t]he women was clearly in a psychotic state and police officers had to struggle with her to save the children (VPD, 2013; p. 22).

Another disturbing vignette describes a stabbing that occurred at a local convenience store, noting that surveillance video from the scene showed "the sudden unprovoked savagery of the attack" which was perpetrated by a "diagnosed schizophrenic" who was left untreated in the community after he had "ceased taking his medication" (p. 20). The documents present these violent incidents as a broad population health trend, resulting in a situation wherein "mentally ill suspects" are described as representing the "the greatest risk of an unprovoked attack on citizens living low-risk lifestyles in Vancouver" (p. 2).

While the narrative anecdotes of these violent incidents presented by police proved compelling for media, the VPD's policy reports also attempt to quantitatively substantiate the severity of the "crisis". One document notes that from January 2012 to September 2013 (the date of the press conference and publication of the *Update Report* (VPD, 2013)) the VPD's crime analysts "identified 96 serious incidents ranging from suicides to random violent attacks inflicted on innocent members of the public" (VPD, 2013), including an "elderly women being stomped in the head, multiple stabbings, and assaults on children as young as three years old" (p. 1). Similarly, the *Beyond Lost in Transition* report (VPD, 2010) presents findings drawn from a departmental review of administrative records from purposeful sample of individuals who had been referred to the health authority for care by the Car 87[11] program. Examining a subset of 19 people from the original sample of mentally ill chronic offenders referred for follow up care, it concluded that these individuals were often left untreated, resulting "in some 619 incidents where [the individual] potentially victimized other citizens through criminal

[11] Car 87 is a police unit that responds to mental health crisis calls to 911. It pairs a nurse with a VPD constable. The VPD note that the nurse and police officer "work as a team in assessing, managing, and deciding the most appropriate action, which may include referrals for community-based mental health follow-up or emergency intervention" (VPD, 2018).

offences and/or engaged in behaviours that caused disorder and a level of apprehension, tension or fear in the community" (VPD, 2010; p. 17).

The earliest published texts argue that the "DTES" has become "infamous and has gained world-wide notoriety for its high crime rates", accounting for 35% of the "serious assaults" and 23% of the robberies in the City in the prior year (VPD, 2009; p. 22). Reference to the dysfunction of the neighbourhood is served up as causal evidence that people with "SAMI" destabilize the normative order of the communities in which they reside by presenting a range of health and criminal problems, including, but not limited to risk of disease transmission, violence, survival sex work, and general criminogenic behaviour. The problem of violence caused by people with "SAMI" is constructed as an urgent threat, not just to the safety, but also to the moral, economic, and population health vitality of the neighbourhood.

Security discourse also problematizes the "DTES" itself as a pathological community producing poor health and violence for everyone who lives there—a geographical disease requiring targeted treatment, so its risks do not metastasize. This is highlighted in the VPD's *Update Report* (2014), which describes how "dangerous service gaps" in the mental health system are putting innocent people at risk. The report states that an "increase in serious violent offences committed by the mentally ill can be partially attributed to the reduction in secure care beds, as these are the same dangerous individuals who would have [otherwise] been institutionalized and would not have posed a risk to the public and themselves" (p. 25). Similarly, alongside a blurry photo of a man flailing on a side walk that is presumably in the "DTES", the VPD's *Project Lockstep Report* (2009) paints a portrait of a neighbourhood full of criminogenic pathologies which lead to forms of crime and disorder: "[t]he lives of many of the people residing in Vancouver's Downtown Eastside (DTES) are negatively affected by mental health issues, illicit and licit substance abuse, drug trafficking, alcoholism, physical health issues like HIV and Hepatitis C infections, substandard and insufficient housing, illegitimate businesses, crime and public disorder, an entrenched survival sex trade, and a historical reduction in police presence" (p. 2). The *At Home Final Report* (Currie, et al., 2014) lends scientific credibility to this depiction, stating that the area has become "notorious for its visible homeless population, high crime rates, open drug market, high prevalence of infectious diseases, and premature mortality" (p. 9).

The connection between criminality and mental illness is also forged in the VPD's *Update Report* (2013) where more police collaboration to assist clinicians to enforce mandatory mental health treatment is regarded as a solution to many of the "problems" plaguing the neighbourhood. Similarly, the *At Home Study Final Report* (Currie, et al., 2014) concludes that Housing First ACT Teams had "significant and measurable impacts" on an indicator that researchers and police agree is important to evaluating the performance of mental health intervention's ability to keep the neighbourhood safe and reduce government expenditures: "criminal convictions" (p. 26). The rationale for including police on Vancouver's ACT teams is that officers are more likely to encounter people with "SAMI" on a daily basis, while healthcare providers are only able to "see the patient once a month or even less" (VPD, 2013; p. 11). Therefore, police are seen to be in an optimal position to monitor the patient's baseline mental health status in the community and alert a psychiatrist if decompensation is observed.

The *Mental Health Crisis: Update Report* (2013) goes on to state that if this important opportunity for collaboration between health and police is wasted, "the patient may continue to self-harm or harm others", leading to a persistent "public safety risk" (p. 11). A number of research studies that demonstrate an "increased likelihood of violence associated to certain types of severe mental illnesses" are cited to support this claim (p. 11). The text concludes definitively that violent offenses are much more likely to be perpetrated by people with "SAMI" than members of the general, "low risk population" (p. 18). These examples illustrate how security discourse constructs individuals with "untreated SAMI" as criminogenic, irrational threats to the normal, rational decision making, and "low risk lifestyle" population.

Another way in which the "mental health crisis" is represented as a threat of violence is where people with "untreated SAMI" are not only constructed as a population integral to the dysfunction of the "DTES", but also where the whole pathologically destabilized neighbourhood is viewed as itself a threat to the stability of the rest of the city. For example, a text published by the police department notes that amongst the many "problems" of the "DTES", "crime and public disorder in particular, harm surrounding Vancouver neighbourhoods, the metro region, and the Province of BC" (VPD, 2009; p. 2). The threat that the "DTES" presents to other communities is also

evident where one document predicts that "with appropriate prioritization and action, the lives of the vulnerable in the DTES can be improved and a positive "ripple effect" can be achieved in surrounding communities, and the rest of the province through the reduction of crime, public disorder and improvements in the health crisis" (VPD, 2009; p. 3).

The construction of the "DTES" as a geography marked as a pathological blight on the city as a whole is also visible within the *At Home* Study's goal to evaluate the presumed positive effects of relocating people with mental illness and histories of homelessness away from the "DTES" and into more "normal" neighbourhoods:

> Historically, projects in Vancouver that have tried to house people who were formerly homeless or experiencing mental illnesses in neighbourhoods outside of the DTES have met opposition and sentiments of "not in my backyard." That has not been the case for VAH[12] participants, who have successfully joined neighbourhoods scattered throughout the City of Vancouver (Currie, et al., p. 26).

Implicit in this notion of successful relocation and assimilation is the problematization of the "DTES" as a community where individuals are not able to access the necessary tools to reshape their conduct in order to realize "wellness".

The texts do offer some problem representations that nuance the notion that people with "SAMI", or communities with high rates of "SAMI", are criminogenic perpetrators of cycles of violence and disease. Documents published by the police acknowledge that some research shows that "mentally ill persons are at a much greater risk of *becoming victims* of crime than the general public", noting that especially when it comes to violent crime, "persons suffering from mental illness are 23 times more likely to be victims than the general public" (VPD, 2013; 2). This is affirmed by the municipal government who cite the same statistic in their *Caring for All* report (City of Vancouver, 2014; p. 7). The high prevalence of victimization of people with "SAMI" in Vancouver is further validated by the findings in the *At Home Study Final Report*, which notes that self-reported experiences of childhood abuse are common amongst participants, as are more recent forms of victimization like theft or threatened theft (reported by 36% of the total sample), being threatened with physical assault (reported by 48% of the total sample), and/or being physically assaulted (36% of the total sample) (Currie, et al.,

[12] "Vancouver At Home" (study) participants.

2014). Although people with SAMI are predominantly problematized as victimizers in the texts, at times they are depicted as victims as well.

4.3. A Lack of Psychiatric Services

The “mental health crisis” is not primarily focused on the problem of “mental illness” per se, but rather “*untreated* SAMI”. The problematization of biomedical “under treatment” is present where the texts frequently reference the need to improve access to psychiatric interventions through a variety of mechanisms including community-based psychiatric outreach delivered by ACT teams, and Assertive Outreach Teams[13] (AOT) for those who are not yet in need of ACT services but are anticipated to require them soon. It is also evident in calls from the municipal government and police asking the provincial government to provide immediate funding for the construction and operation of “300 long-term and secure mental health treatment beds” for people who are too dangerous and ill to reside in the community (City of Vancouver, 2014; p. 15, VPD, 2013; p. 28). For those with less severe illness who are thought to be able to remain in community, further integration of “on-site psychiatric services” in all government funded supportive housing facilities is thought to be required to ensure easy access to treatment (VPD, 2013; p. 28). The municipality notes that at present the “gap in access to treatment and supports for individuals with serious mental health and addictions, even when housed, is substantial” (City of Vancouver, 2014; p. 6).

While insufficient addictions treatment, homelessness, housing unaffordability, adverse childhood events and poor housing conditions are problematized at various points, the way the documents primarily advance highly specific recommendations to bolster psychiatric treatment capacity and compliance indicates that this is the solution of paramount concern. This is particularly the case in texts produced by the police department which advocate for more police collaboration with ACT and other healthcare

[13] The VPD’s Update Report (VPD, 2016) describes ACT as a health authority led comprehensive mental health program “which provides higher intensity and greater frequency support for more challenging mental health and/or substance use clients, where traditional mental health services have been unsuccessful”. Police are partners on many ACT teams, with officers embedded in the program. AOT, on the other hand, is a health authority-VPD partnership program that “provides short-term transitional support for more challenging mental health and/or substance use clients as they transition from hospital or corrections to primary care service providers” (p. 13). In short, while ACT provides ongoing care from police and clinicians, AOT supports patients over the short term while referrals to existing community mental health or primary care are made.

teams, and for inner city hospitals to establish “standing bodies” with police, for staff from emergency departments, psychiatric wards, to “monitor, identify, debrief and resolve critical incidents and other police/health related incidents” (VPD, 2013; p. 6).

VPD position papers also lobby the province to make legislative changes to the BCMHA to facilitate easier processes for involuntary psychiatric admissions to reduce burdensome police wait times at emergency departments (VPD, 2013; p. 6). Local researchers present data to support the notion that there is a lack of psychiatry to sufficiently manage people with “SAMI” in the community. The *At Home Study Final Report* notes that prior to involvement in the ACT and congregate Housing First interventions of the study, “participants with objectively more severe mental illnesses (e.g., psychotic disorder, bipolar disorder)” (Currie, et al., 2013; p. 25) were less likely to access services than those with “less severe illnesses” (e.g., depression, anxiety disorders), concluding that the status quo is insufficient and more biomedical management of people with untreated “SAMI” is needed.

However, documents from the police department represent the problem of a “lack of system capacity” for mental health treatment slightly differently than researchers do. One report argues that not only is a lack of service access the issue, but also that the full power of BCMHA is not being used routinely enough to enforce compliance with involuntary psychiatric treatment. The VPD reports explain that from the perspective of front-line officers who routinely detain and escort patients to hospital, clinicians tend to be too cautious in their approach to care. The texts problematize this “minimally intrusive” and patient-centred ethos as resulting in a “lack of balance between a patient’s right to refuse care and their protection” (VPD, 2010; p. 18). VPD texts also problematize the patient’s legal right to a review panel hearing under the BCMHA, stating that it contributes to an incorrect “balance of care” versus control. As evidence of these ineffective clinical practices, one document cites “confidential personal communication” with “one senior psychiatrist who works at a Vancouver hospital [who] expressed frustration with these [review] panels, describing them as often being barriers to care” (VPD, 2010; p. 18).

In this characterization of the barriers to care facing people with mental illness, the human rights enshrined for all Canadians under its Charter of Rights and Freedoms (1982) and the United Nations Convention on the Rights of Persons with Disabilities

(CRPD)[14] (2006) are constructed as an unnecessary burden that ought to be superseded by psychiatric knowledge. The position that the BCMHA offers *too many* rights to patients is present across the texts produced by the police department despite local mental health legal scholars[15] finding that in practice the BCMHA is often used in ways that produce little accountability for psychiatrists, while the right for psychiatric patients to challenge their involuntary treatment through review panels is routinely denied in clinical practice.

While strict anti-psychotic medication compliance is frequently referenced as the most important indicator of "treatment success" for people with "SAMI", addictions treatments like managed alcohol programs, opioid agonist therapy, and/or offering safer alternatives to the illicit drug supply are almost never put forward as potential solutions. The *At Home Study Final Report* (Currie, et al., 2014) does highlight this need, albeit with very little specificity, where it calls "for more services that integrate treatment for both substance use and mental illnesses" (p. 25). One VPD document notes that "up to 70% of all psychiatric admissions to St. Paul's Hospital involve a person who has multiple addictions and that over 50% of people with a mental illness abuse illegal drugs and alcohol" (VPD, 2018; p. 55), indicating that especially in the "DTES" where the illegal drug market is widely accessible, more treatment for substance use disorders is needed. However, it is clear from texts produced by the VPD and province that improved access to the full range of opioid agonist treatment medications, the first line treatment for

[14] Although Canada is one of the 163 countries counted as signatories to the CRPD (2006), its embrace of the convention is lukewarm. Canada registered a "conditional reservation" to article 12, which sets criteria for equal recognition for people with disabilities—including "mental illnesses"—before the law. Article 12 clearly states that "persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life", and requires signatories to "ensure that all measures that relate to the exercise of legal capacity provide for appropriate measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body". Mental health activists have expressed concern that Canada's "conditional reservation"—made because the federal government likely recognizes that present provincial mental health law permits widespread violation of the spirit of the article through compulsory treatment orders—supports the notion that clinical knowledge regarding mental fitness or capacity takes primacy over human rights laws intended to prevent discrimination based on disability (Shimrat, 2020).

[15] See Johnston's (2017) report written for the Community Legal Assistance Society, *Operating in Darkness: BC's Mental Health Act Detention System*

"opioid use disorder", was not a primary consideration when arriving at the dominant psychiatry-focused recommendations.

This lack of focus on substance use related harms will undoubtedly be surprising for readers now aware that in 2016, two years after the "mental health crisis" was declared by the mayor and police, BC would enter another public health emergency declared by the Provincial Health Officer in response to shocking rates of overdose death across the province. The overdose crisis continues to inflict particularly dire impacts on rates of mortality in the "DTES", leading to an overall decline in life expectancy[16] in the neighbourhood after two decades of gradual improvement due to advances in HIV treatment and prevention (VCH, 2018). Between 2016 and 2021 there were over 1600 illicit drug toxicity deaths in Vancouver alone (BC Coroners Service, 2021). One wonders if equal focus had been put to improving the addictions system of care alongside psychiatric services throughout the early 2010's, would so many people still be reliant on the heavily contaminated illicit drug supply that is causing the preventable loss of so many lives?

4.4. A Crisis of "Cost"

Another problem representation that carves a discursive path across the documents is that which represents "mental health crisis" in economic terms, as crisis of "cost" for governments and "taxpayers". Rampant expenditures related to managing untreated mental illness are consistently referenced by police, health administrators, the mayor, and researchers as evidence of the magnitude of the problem. Putting emphasis on the cost of the "crisis" creates an urgent economic imperative to solve it.

Expenditures are detailed through myriad line items listed in the texts, the sums of which are determined through calculations applied to health, social service, and criminal justice data. The time police spend waiting in emergency departments with patients apprehended under the BCMHA is represented as a waste of wage labour. Revolving patterns of inpatient stays, missed appointments at community health centres,

[16] The decrease in life expectancy is particularly felt by men between the ages of 30-59. In 2018 the VCH Medical Health Officer noted that "the discrepancy in life expectancy between men who live in Vancouver's Downtown Eastside and those who live in Vancouver's Westside was nearly 15 years" (VCH, 2018; p. 10).

and overrun emergency departments are thought to be wasting health human resources. Finally, scarce social housing resources are thought to be squandered on emergency shelters and temporary housing programs that co-locate people struggling with mental illness, which only leads their mental health to "decompensate" further.

The costs of the "crisis" and the savings derived from interventions like ACT are often calculated down to the penny in the texts. In determining the expense of "walk aways"—i.e., when people committed under the BCMHA leave hospitals against medical advice—which result in officers being called upon to locate and transport patients back to the emergency department, the VPD report estimates that 230 such incidents occurred between a one-year period in 2009/10. The price of police labour per emergency mental health call is pegged at an average of $140.03, which adds up to a total of $32,206.91 per year (VPD 2010; p. 7). Through constant monitoring of patients in the community, ACT is thought to be able to prevent this wasted capital by keeping people out of the emergency room, thereby freeing up police and emergency department resources to treat more appropriate patients. In 2013 the BC Ministry of Health assured that with scale up of ACT and further investment in services at local emergency departments (ED), efficient care will be realized through "faster hand-offs" of people detained under the BCMHA between police and ED staff, "improved assessments", and assertive outreach services to follow individuals after they leave the hospital (p. 6).

The *At Home Study Final Report* (Currie, et al., 2014) contains a whole chapter on "costing outcomes", which articulates the expense of providing people with Housing First ACT— "$28,282 per person per year on average"—and the savings realized for the health and criminal justice systems from the intervention— "$24,190 per person per year" (p. 21). It concludes that economic value is being squandered by the Vancouver mental health system's status quo: "every $10 invested in HF [housing first] services resulted in an average savings of $8.55 for [high needs] participants" (p. 21). The *Caring for All* (2014) report from the municipal government also devotes a separate header documenting the "costs of crisis and impact on City resources", arguing that:

> The impact of mental health and addiction on City of Vancouver services is also sizable. Results from a review that builds on a 2009 analysis indicate that the overall cost to the City was over $28 million per year… including costs such as policing, first responders, emergency housing needs, as well as expenditures which focus on prevention and interventions such as capital for housing, homelessness outreach and social grants (10).

Consistent with the problematization of the cost that mental illness produces for health and police budgets, the municipal government also makes a value proposition to the province, noting that the *At Home Study* "demonstrated that a 'housing first approach' aggressively supported by appropriate community-based treatment and other supports can address homelessness and is a *sound investment*" (p. 8; emphasis added). Documents from the VPD lend support to the rationalization that ACT holds investment potential not just for treatment outcomes but also for the state's pocketbook, noting that "these teams are a very efficient use of public funds as [they] reduce the amount of additional resources (such as police, health care, and the criminal justice system) which are required to deal with mental health emergencies and public safety issues, including criminal actions" (VPD, 2013; p. 27). These arguments are consistent with research that estimates that when compared to "treatment as usual" ACT has an 80% chance of reducing a patient's overall costs to society (Latimer, et al., 2020).

The assumption is that if officers are positioned on ACT teams and given access to medical records, they can better observe a patient's baseline mental health status in the community. This would result in more timely preventative interventions, thus reducing the cost of police labour and health system resources associated with apprehension under the BCMHA. On the other hand, "if this information sharing does not occur, the patient may continue to self-harm or harm others prior to being seen again under a s. 28 apprehension". The text goes on to note that only does this status quo approach "cause a public safety risk, it is also a very *inefficient use of public resources* as these [section 28] apprehensions tend to be a much more resource intensive than a follow-up appointment with a psychiatrist" which could be facilitated by an officer if they were provided with clinical records (VPD, 2013; p. 11; emphasis added).

Like the City's (2014) *Caring for All* report, texts from the police department also prominently reference the problem of unnecessary human resource costs produced by untreated mental illness, presenting evidence that a significant volume of 911 calls are made in response to preventable incidents involving untreated "mentally ill persons". Quantifying the costs of these incidents to its budget, one text from the department calculates that: "the direct police workload is equivalent to approximately 90 full-time officers, at a cost of about $9 million per year; other agencies such as the ambulance service, hospitals and the court system also bear costs" (VPD, 2010; p. 52). Another

document states that “mental illness is believed to contribute to 21% of incidents handled by VPD members and 25% of the total time spent on calls” (VPD, 2013; p. 1).

The documents from the police frequently problematize a lack of overall financial resources provided to fund law enforcement activities in the inner city as a part of the problem. One of the texts describes how the trend of increased apprehensions under the BCMHA has led the VPD to “assign more resources to deal with this problem”; specifically, they note that “in the 1990s the VPD only had 1.5 full-time employees assigned to deal with those suffering from mental illness and addiction… [h]owever, in 2013 this has increased to more than 17 full-time employees” (VPD, 2013; p. 1). VPD reports from 2010 and 2013 build a business case for additional funding allocations for police positions on ACT teams so that collaborative efforts can be made to realize cost savings across sectors.

Paradoxically, these accounts position increased police spending on “mental illness” both as evidence of a “mental health crisis” *and* as the means through which to solve it. This theme of fiscal prudency makes consistent use of a neoliberal logic which “pathologizes thoughts and behaviours that deviate from what the market defines as functional, productive, or desirable” (Esposito and Perez, 2014; p. 414). It’s unsurprising then, that so many of the recommendations about what to do about these deviations seek to bring the conduct of people with “mental illness” back in line with the market.

4.5. Poor Cross-Sectoral Collaboration

The fourth problem representation found across the documents is a lack of cross-sectoral collaboration in managing mental illness in the inner city. The BC Ministry of Health’s report, *Improving Health Services for Individuals with Severe Addiction and Mental Illness* (2013) notes that following the publication of the *Vancouver’s Mental Health Crisis: An Update Report* (VPD, 2013) earlier that year “a letter was sent to the Premier of B.C., outlining concerns and recommendations for action, signed by the VPD, the Mayor of the City of Vancouver and the chair of VCH” (p. 2). According to the Ministry, the correspondence focused on the fact that the population of people with “SAMI” is increasing, receiving insufficient biomedical treatment or none at all, and that “in addition to the significant social and health risks facing this population, there is also a

growing *public safety risk* to bystanders" (p. 2; emphasis added). The report argues that a cross-sectoral response is needed to address the issue.

Although the texts suggest a great degree of agreement when constructing the "problems" and the sense of urgency surrounding the "crisis", they also consistently problematize a fractured relationship and lack of timely communications between healthcare providers and police. This is apparent where the need for more "joint-service models" of mental health care designed to break down the silos between health and police departments is referenced. It is also particularly salient where the municipal government's *Caring for All* (City of Vancouver, 2014) report focuses on the "need to bridge across jurisdictional divides" under a "collective impact" framework. Collective impact is a corporate managerial methodology intended to guide collaboration between disparate government authorities, businesses, agencies, and professions across five general areas: "a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone organization" (Flood, et al., 2015; p. 655). The VPD's *Project Lockstep* (2009) report makes the case that this kind of collaboration should be guided by a committee of "top-level" decision makers, including the police department, who come together to make "firm decisions" about future direction of the "DTES" and lives of the most vulnerable individuals who inhabit it. It suggests that the committee's "firm decision making" should "not mean dictating action to stakeholders; instead, it means that the committee enables the stakeholders to reach consensus about actions that need to be taken and facilitating the implementation of those actions" (p. 48). Collaboration is required for consensus, which is key to addressing the crisis.

To better collectively manage the danger that people with "SAMI" are said to present to the broader population and local economy, "solutions" could not rest only in additional funding for nurses, social workers, and psychiatrists, but also in care being "integrated" with disciplinary tools hitherto exclusive to police—e.g., apprehension under the BCMHA and enhanced healthcare surveillance utilizing "justice based collateral information" (VPD, 2013; p. 11). The lack of pre-existing collaboration between police and the healthcare system in managing people with "SAMI" is routinely criticized in the documents, especially in ones from the police: "social, medical, police, and other services in the [DTES] have been delivered using a discipline-based approach where agencies focus on their own area of mandate and expertise" (VPD, 2013; p. 2). The *At Home Study Final Report* (Currie et al., 2014) lends scientific validation to this problem

representation, glossing over political differences in its description of a fractured local health and social service landscape: “service agencies and institutions have struggled to overcome differences of organizational cultures, mandates, and styles of work” (p. 26). A VPD text similarly notes: “typically, social, medical, police, and other services in [the DTES] have been delivered using a discipline-based approach where agencies focus on their own area of mandate and expertise” (VPD, 2009; p. 2).

To improve this flawed “discipline-based approach”, the need for new forms of collaboration is emphasized: “the development of a shared leadership philosophy among high performance teams that can transcend organizational boundaries is vital for not only the success of the [Housing First project], but for the country to gain the knowledge needed to provide effective housing, health, and social services to individuals in need” (Currie, et al, 2014; p. 26). The VPD’s *Update Report* (2013) accepts that over time steps have been taken to address this problem, describing how since the publication of earlier VPD reports (2008, 2010), the department signed a letter of agreement establishing a new, more “collaborative relationship” with the local health authority under the banner of *Project Link*. Project Link is guided by a “joint-service partnership” terms of reference that seeks to achieve outcomes under three main categories: “health service, police service, and criminal justice system”. It seeks to promote collective actions to reduce “street and community disorder related to the target population [of people with SAMI]”, the “number of mutual clients in the court system”, and “police calls for [mental health] related service” (VPD, 2013; p. 7). Critical to promoting cross-sectoral collaboration, Project Link also proposes “changes in partnered service delivery” through the “establishment of standing bodies with appropriate terms of reference” with local hospitals and “linking the practices of health and policing through the appropriate participation of police officers in access to care” (VPD, 2013; p. 7). Put simply, the initiative is intended to foster more police involvement in the planning and delivery of health services.

Earlier documents produced by the VPD are explicit in their view that these practical partnerships with health are required to more effectively contain the danger associated with people with untreated “SAMI”. For the sake of accountability, the document proposes that a new “Director of the Most Vulnerable” position be created within the municipal government infrastructure. Reporting to the cross-sectoral committee of “top level” senior bureaucrats from the municipality and provincial

government, this new director is envisioned to have the administrative authority to "establish intervention strategies", "hold service agencies accountable", and "coordinate information sharing and cooperation" between health, police, and local government (VPD, 2009; p. 2). As the following chapters demonstrate to be the case with care, cross-sectoral coordination is also thought to ultimately require some enforcement to be effective.

Chapter 5.

What Assumptions Underlie the Problem Representations of the “Mental Health Crisis”?

5.1. Unpacking the Assumptions

This chapter applies the next research question adapted from Bacchi’s (2009a) approach, asking *what assumptions underlie the problems representations that came together to form the “mental health crisis”*? These assumptions reflect the taken-for-granted epidemiological and ontological baggage that informs policies and policy making (Bacchi, 2009a). However, the goal of this question is not about uncovering the conscious or unconscious bias of policy makers; rather, the intention is to go “beyond what is in people’s heads to consider the *shape* of arguments, the forms of ‘knowledge’ that arguments rely on, the forms of ‘knowledge’ that are necessary for statements to be accorded intelligibly” (p. 5; emphasis in the original).

5.1.1. The Assumed Threats

Throughout the documents—especially those published by the VPD—people with untreated “SAMI” are assumed to present a pervasive risk to public safety and to themselves. The Police Record Information Management Environment (PRIME), an electronic police records management system which stores collateral information on people who have contact with law enforcement officers in BC, assumes that people with mental illness pose a threat by their very definition. PRIME labels someone an “emotionally disturbed person” if they are, according to the observations of officers, “a subject who appears to be mentally unstable and who might pose a threat to an investigator, him/herself or others” (VPD, 2010; p. 2). When someone is labelled as an “emotionally disturbed person” in the database, that dividing categorization is etched onto their personhood, retrieved and read into all their future encounters with police.

The second assumed threat is that the population of people with “SAMI” present a risk to the healthy functioning of the “DTES”. One document from the VPD states that providing care to people with untreated SAMI is the most important prerequisite for

“other neighbourhood improvement initiatives to succeed” (p. 2). Improving the “DTES” through better regulation of people with SAMI is also posed as an imperative for healthy functioning of other areas of the city. Since the “DTES” is said to contain a concentration of violent, “emotionally disturbed people”, the neighbourhood is itself viewed as a dangerous and pathological site for medical intervention, posing a risk to the stability of other parts of the municipality by dragging overall crime rates up and property values down. Although these two depictions of risk are featured consistently in narrative accounts and supported by local research, the documents occasionally acknowledge that people with “mental illness” are disproportionately victimized as well. Nevertheless, the assumption that people with mental illness are more violent than the general population, and that they destabilize the normative order of otherwise functional neighbourhoods is present across the documents.

However, this assumption that mental illness carries with it a risk of violence is contradicted by research on the topic. In a systematic review of the literature on the relationship between mental illness and violence, Varshney, et al., (2016) describe mixed findings and a range of variations in definitions, study designs, and context. They conclude that existing research *does not* support the common perception that people with mental illness are inherently dangerous. More importantly, given risks that the widespread perception of this false association can create—namely increased discrimination against an already stigmatized population—they urge public health practitioners to publicly dispel the myth that people with mental illness are dangerous.

The Canadian Mental Health Association (CMHA) (2011) similarly emphasizes that research *has not* established a “definitive causal relationship between mental illnesses and violence”; although there is much literature to suggest that the inverse is true—people with “mental illnesses” seem to be at *greater risk* of victimization than the general population (6). The CMHA explains that the misunderstanding of the nature of the relationship between violence and mental illness is often reinforced by sensationalist media accounts—like those that reference the narrative descriptions in the texts from the VPD—of gruesome details of rare incidents where people with mental illness are involved in acts of violence. While violent incidents involving people with mental health struggles are depicted with disproportionately high frequency, media rarely report on the positive roles that people with mental illness play in their families, communities, and broader society.

Some argue that this association between violence and "untreated SAMI" leads to forms of dehumanization (Van Veen, Ibrahim, and Morrow, 2018). This dehumanization is strong in the gendered assumption that men represent the most obvious harbingers of this assumed threat. Security discourse constructs men with mental illnesses as particularly dangerous where the texts repeatedly depict incidents of violence perpetrated by a small number of men in Vancouver, which together act as *proof* that police and health providers need to do a better job of identifying, monitoring, and disciplining these men to thwart the inevitability of the violence lurking inside them. Joseph (2018) locates a similar gendered assumption of violence in his analysis of the discursive practices of detention in national immigration policy where confinement—of mostly young men—relies on the racialized application of mental health legislation and "the production of the innocent Canadian public in need of protection" (p. 42) against sick and dangerous masculine "others".

Indeed, because mentally ill men are viewed as more violent than mentally ill women, practices of compulsory treatment and psychiatric detention are more frequently exercised on male bodies (Mah, et al., 2015). In the case of the new ACT teams in Vancouver, the male to female ratio is about two to one, with about eighty percent of all patients receiving care on an involuntary basis (Van Veen, Ibrahim, and Morrow, 2018; citing personal communication with the BC Ministry of Health). These practice shifts mobilized in response to the threat of violence assumed to be presented by (mostly) men with "SAMI", create a new form of violence: the material threat of police apprehension under the BCMHA which now frequently "looms over every clinical encounter with nurses, social workers, and doctors that are regularly accompanied by police officers to client visits" (Van Veen, Ibrahim, and Morrow, 2018; p. 255). Threats are viewed as required to manage threats, not in the name of coercion, but rather "care". Having plain clothed officers work with clinicians to monitor people in the community through outreach (e.g., accompanying nurses to give injections of anti-psychotic medications) is proposed as a technique promising for the goal of reducing police contact and arriving at better care outcomes. However, this logic begs the question of whether or not the inverse would be true, that this modification would *increase* people's interactions with police, albeit for new purposes: through involvement in ACT officers are now tasked with investigating people's mental health in addition to their violent, criminal activity.

5.1.2. Psy Assumptions

Another set of assumptions found in the problem representations surrounding the "mental health crisis" are the products of psy discourse, where "untreated severe mental illness" is the object most often assumed as the biogenetic driver of the social dysfunction of the inner city[17]. "Mental illness" is often constructed as the cause of distress rather than as a symptom of it. For example, in the case of the City of Vancouver's recommendation to increase psychiatric supports for people living in supportive housing, there is an implicit assumption that "SAMI" is the source of poor health outcomes, rather than the deprived material infrastructure of social housing buildings and lack of municipal government enforcement of building bylaws intended to uphold basic forms of human health and safety[18]. Proposing psychiatric treatment as the solution to the problems associated with low-income housing assumes that it is brains that need the "fixing", rather than the decaying hallways, stairs, bathrooms, and rooms in which people reside.

Psy assumptions are also evident in numerous appeals from the municipal government and police department for the provincial government to devote additional resources towards improving engagement and retention in psychiatric treatment. Specifically, in order to manage the violent risks associated with "SAMI", more police-assisted ACT teams are said to be needed, along with additional inpatient tertiary mental health beds. Police are positioned as doing their part by apprehending risky people under the BCMHA in order to engage them with treatment, but better information sharing and clinical collaboration between police and healthcare services and additional coercive psychiatric supports both in acute and community settings remain the missing pieces to improve treatment retention and prevent cycles of violent decompensation.

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[17] See for instance, the VPD Update Report's (2013) conclusion that the "current situation regarding untreated, severely mentally ill people is on par with, if not more serious than, what Vancouver faced over a decade ago" (p. 30)—referencing the 1990's public health emergency concerning high rates of overdose and HIV in the "DTES".

[18] The SRO Collaborative, a tenant's rights advocacy organization, recently began a community-driven research project to study the "relationship between maintenance conditions of single-room occupancy (SRO) hotels, tenants' experiences of livability, and their experiences reporting city bylaw violations around maintenance" (see https://dtescollaborative.org/tenant-experience-study/). This group often problematizes the very conditions in these SRO's and the City's reluctance to enforce basic building safety bylaws, as contributing to poor health.

Many of these "key recommendations" assume that psychiatric knowledge is that which holds the professional *"know how"* necessary to solve the "mental health crisis". What counts as "treatment" is often vaguely defined in the texts, but reference to the authoritative expertise of psychiatry is persistent. For example, the Update Report (2013) postulates that to "aid in the treatment of those suffering from psychiatric emergencies", a "dedicated crisis centre facility" should be built, where a psychiatrist would be "the initial contact point, rather than an emergency physician who may not have the expertise to diagnose mental illnesses" (p. 24). A quick and decisive psychiatric diagnosis is viewed as vital to initiating the *correct* treatment—presumably psychopharmacological interventions, while other forms of expertise or knowledge, like Indigenous healing practices, peer support, nursing, social work, addictions medicine, housing outreach workers, or primary care are subjugated as less important.

The way psy discourse works to problematize mental illness and establish parameters about what counts as "treatment" reveals an implicit sanism. Sanism refers to processes that construct people with "mental illness" as "incompetent, not able to do things for themselves, constantly in need of supervision and assistance, unpredictable, violent, and irrational" (Chamberlin, 1990, p.2; cited in Menzies et al., 2013; p. 339). Sanism informs the way the texts position psychiatric treatment as the most vital solution to the threat of violence that irrational people with "SAMI" present. Over and over again, the reports argue for increased funding for psychiatry to extend its reach in the community.

The very notion that people who struggle with "mental illness" might be able to choose which "treatment" is best suited to their needs, or be able to make the choice *not* to seek treatment, is never considered. Instead, people with "untreated SAMI" are constructed as lacking insight into their lives, dangerous to themselves and others, and requiring compulsory, highly monitored medication regimens. The VPD Update Report (2013) offers an example in the form of a case study used to illuminate the need for more psychiatry. The vignette describes a violent incident involving a "diagnosed schizophrenic" who attacked a woman at a convenience store, stating that the suspect had recently completed a prison sentence and upon release "treatment for his mental illness ended and he ceased taking his medication" (p. 20). The story ends there, leaving the assumption that the violence would have been avoided had psychopharmacological treatment continued under the care of a psychiatrist.

Beyond the presence of sanist assumptions, a broader neoliberal rationalization of psychocentrism is also widespread throughout the documents. Rimke (2018) describes psychocentrism as "the dominant view that pathologies are intrinsic to the person, promoting a hyper-individualistic perspective at the expense of understanding social, political, economic, historical, and cultural forces that shape human experience", noting that such discourse has led to the proliferation of self-help technologies and an ever-expanding market for prescription drugs to manage perceived abnormalities (p. 17). Psychocentrism is evident in the way local research goes to great lengths to validate the notion that "psychotic disorders" are highly prevalent problems in Vancouver's homeless population (Currie, et al., 2014). It is also found where ACT teams are lauded for their abilities to manage disordered individuals through "psycho-social rehabilitation"—a mental health treatment framework intended to "assist persons with a severe mental illness and those with a concurrent substance use disorder in the recovery to effectively manage their illness and adjust to the functional deficits associated with the illness" (Ministry of Health Services, 2008; p. VII).

Psychocentric assumptions also drive the tendency of the documents to favour "solutions" that attempt to guide people with "SAMI" to better auto-regulate their pathologies. For example, the provincial ACT guidelines hold an "inability to consistently perform the range of activities of daily living required for basic adult functioning" as important criteria to consider when screening referrals. The way the provincial ACT program description describes what counts as "basic adult functioning" is telling. Basic functioning is thought to be achieved when one behaves in a way that reflects that they are mindful of the need for "caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; and maintaining personal hygiene" (p. 4).

5.1.3. "Addicting" Assumptions

The texts also present several assumptions about substance use and the medical model of addiction that permeates the psy discourse in the documents. The severe and persistent use of (mostly) "illegal" substances is problematized in multiple ways, through terms like: "addiction", "illicit substance abuse", "substance abuse issues", "substance use disorder", "substance abuse disorder", "alcohol and drug addiction", "use of illicit drugs", "drug addicted", and "daily substance use". All substance use is generally

assumed to fit within the clinical criteria for "addiction", and addiction is assumed to be inherently deleterious in its impacts on the "addicted" individual and their community.

Terms like "SAMI", "drug addicts", "addicts", and "the drug addicted" are products of medical discourse that appeals to a range of human sciences, including addictions medicine, that pathologize "addicted brains" as the most important sites of interventions. Elsewhere terms, like "illicit drug users" are used in ways that connect substance use to criminality. The arbitrary division between illicit and licit drug use reinforces a dichotomy between acceptable drugs (e.g., alcohol, tobacco, cannabis etc.) and unacceptable ones (e.g., non-prescription opioids and stimulants). Fraser, et al., (2014) remind us that "addiction" is not a "unified anterior object available to be studied", but rather a concept produced through the "addicting of contemporary neoliberal society and their subjects" (p. 236). Deploying verb forms ("addicting") instead of nouns ("addiction"), what some call "gerunding", helps to demonstrate how texts play an active role in creating objects of thought (Bacchi and Goodwin, 2016; Bacchi, 2018).

At times the texts engage in addicting in a way that presumes that substance use is the source of the dysfunction in the inner city, but more often both mental health *and* addictions are represented as the key problems of the "crisis". This is clear where the municipal government's *Caring for All* (City of Vancouver, 2014) report bemoans a "surge in people with severe, untreated mental illness and addiction" being treated at a local hospital (p. 4). Elsewhere, like in the very title of the VPD's "Vancouver Mental Health Crisis: An Update Report" (2013), the crisis is characterized as predominantly related to poor mental health, or severe mental illnesses.

Rarely are "addictions" or "substance use" referenced as constituting a "crisis" in and of themselves without reference to "mental illness". However, the texts often point out that Vancouver has a disproportionately high rate of "substance use" and "addiction", which is assumed to exacerbate the situation. For example, in addition to the police reports describing the "DTES" as "notorious" for its "open air drug market", the *At Home Study Final Report* (Currie, et al., 2014) presents evidence that Vancouver has higher rates of substance use amongst its local homeless population compared to other large Canadian cities. Similarly, the City of Vancouver's *Caring for All* (2014) report singles out the need to "enhance addictions knowledge" through "training for primary care providers

and integration of addiction specialists in existing medical system" to complement its mental health crisis response efforts (p. 14).

5.1.4. Neoliberal Assumptions

Neoliberal assumptions are made in a number of the problem representations surrounding the crisis. The documents problematize the "DTES" neighbourhood through an array of medical and criminological calculations, as a pathological community in urgent need of more interventions to assist the "mentally ill" and "addicted" population that inhabits it. In order for the state to help people with "SAMI" to improve their own lives, interventions like ACT are thought to be able to support patient's self-motivations to voluntarily comply with biomedical treatments. However, the texts assume that this motivation is unlikely to be fostered in the "DTES", and therefore people with "SAMI" should be relocated into inpatient psychiatric units or placed in scattered site market apartments elsewhere in the city. One text notes that because of its high prevalence of social supports and services and "the fact that the DTES provides most of the affordable housing in the region for very low-income individuals" people with "mental illness" are attracted to the neighbourhood (VPD, 2009; p. 15). Shuffling individuals to scattered site market housing in areas outside the "DTES" is viewed as a promising housing policy avenue to break the pattern of migration to the inner city for those struggling with mental health. For those who are unable to obtain scarce rent subsidies, who must remain in social housing in the "DTES", it is thought that "more psychiatric supports" are urgently required. This characterization of the "DTES" and people's relationship to their homes and community befits "a neoliberal clientist model of health that treats people as patients and the DTES as a site of clinical encounter rather than as a community in its own right" that Masuda and Chan (2016; p. 590) observe in a recent community healthcare plan for the area.

Rather than having people remain in this community, the documents position "social mix" as key to helping people with untreated SAMI to live rational, autonomous, and productive lives. This is most prevalent in the *At Home Study Final Report* (Currie, et al., 2014), which provides evidence to suggest that the best housing option for homeless people with "high needs" is "scattered site" market rental apartments outside the "DTES". The practice of housing people who struggle with mental health and homelessness in "ordinary" neighbourhoods is thought to assist them to better exercise

freedom through “personal choice”, which helps people struggling with homelessness to realign their conduct with the norms of the general low risk lifestyle population (Blunden and Flanagan, 2020). Finkler (2013) describes “social mix” as a common government solution to poverty and homelessness which “attempts to address social problems associated with concentrations of poor tenants in public housing… [by] dispersing and/or ‘integrating’ tenants on social assistance into areas with a large number of homeowners or private renters” (p. 229). For people with untreated “SAMI”, relationships with and proximity to others who struggle with mental distress and substance use are assumed to be inherently unhealthy and untherapeutic.

The VPD’s *Lost in Transition* (2008) report offers a vignette to illustrate the importance of “social mix” to responsibilizing people with mental illness. Recounting the struggles of a mother to relocate her “mentally ill” son who was ill and at large in the city, it states that she believed “he had to get out of the Downtown Eastside to be able to live independently in peace and safety” (p. 47). Here and elsewhere in the texts the inner city is constructed as a place that breeds irrational behaviour, criminality, welfare dependency, drug use, and violence. In order for the ideal self-managing psychiatric subject to find independence, “peace and safety”, and minimize their costs to the state, they must relocate to parts of the city where these norms are more naturally realized. The calls to treat and relocate people with “SAMI” into market housing in mixed neighbourhoods is also intended to avoid the “mixed results” that the VPD’s (2013) *Update Report* claims generally occur when state owned supportive housing projects concentrate “persons suffering from the same type of illness” in the same building (10). Moreover, relocation to market housing also allows for “normal” neighbourhoods to successfully welcome in people with “SAMI” without having to tolerate new brick-and-mortar social housing developments being built close by—projects which local residents often oppose, citing potential adverse impacts on neighbourhood businesses and property values.

Complementary to the focus on moving people with “SAMI” *out of the “DTES”* and into more “normal” and “healthy” parts of the city where they might be more inclined to seek voluntary treatment and pay state provided rent subsidies to private landlords, the texts also highlight the need for the municipality to approach urban planning in a way that encourages more “legitimate businesses”, homeowners, and middle-class renters to move *into the neighbourhood*. Blomley (2004) describes how economic rationalities that

constantly seek to create a more balanced, mixed income environment in the “DTES” are often taken up by business and property owners to encourage the exclusion of undesirable residents who represent a threat to the local economy. Supporting this gentrifying rationality, the VPD (2009) reports consistently reference the economic “problems” in the neighbourhood arising from undesirable people with “untreated SAMI”. For example:

- “illegitimate businesses have thrived” (p. 21);
- “an underground market for stolen goods has thrived” (p. 22);
- “a major deterrent to legitimate business development in the DTES is the fear of crime” (p. 27);
- “changes in the area have made the DTES an efficient, though self-defeating, system where a synergistic underground economy fuels drug use and criminal behaviour and provides little incentive or encouragement for people to leave and improve their lives” (p. 28);

A neoliberal rationalization of the market as the means through which people must align their lives in order to improve them is also visible in the *At Home Study'*s (Currie, et al., 2014) goal “not only test the effectiveness of [scattered-site Housing First] for people experiencing homelessness and mental illness in Vancouver, but to also evaluate the feasibility of mounting support services, and the logistics of locating and negotiating housing options in a highly competitive rental market” (p. 11). In their discourse analysis of the Vancouver municipal government’s (2014) *Caring for All* report, Van Veen, Teghtsoonian, and Morrow (2019) find reverberations of neoliberal political rationalities in the way the municipal government emphasizes research on the cost effectiveness of ACT, and in how “new funding or initiatives are not referred to as social spending but rather as investments, conjuring the promise (and requirement) of fiscal return and prudence” (p. 68). The At Home Study’s statistical validation that investments in ACT are sound and strategic helps to build a business case for intervention. This emphasis on costing metrics alongside health outcomes befits a broader neoliberal political rationalization present in contemporary health reforms, where “health risk and investment risk use some of the same numbers to measure and evaluate before (baseline) and after (outcomes) to determine if particular health interventions, ventures, and speculations [are] ‘*worth it’*” (Erikson, 2012; p. 369; emphasis added).

The *At Home Study Final Report* (Currie, et al., 2014) dedicates a whole section analysing indicators chosen to represent the "costs incurred by society" related to untreated mental illness in Vancouver. It argues that not only does ACT help the state avoid costs incurred by irrational behaviours of people with SAMI, but also produces value. The research demonstrates that for "high needs participants" treated by ACT and housed in scattered site market apartments outside the "DTES" every $10 "invested" results in government savings to the tune of $8.55. Savings are realized through minimizing expenses related to avoided hospitalizations, incarceration events, and shelter stays (p. 8). Spending on ACT is pitched as an investment that will pay dividends down the road. This finding of "cost avoidance and cost effectiveness" (p. 28) also supports the assumption that "social mix" is a successful recipe for helping psychiatric patients to conduct themselves in ways that minimize the expenses that their lives would otherwise create for society under the status quo. Treatment success is equated with "cost avoidance", which is quantified through audits of health spending. Personal responsibility, economic rationality, and mental health recovery are therefore intricately linked under this governing regime.

The focus on interventions at the level of the personal responsibility of psychiatric patients assumes that if these patients are given the right living circumstances and assertive mental health interventions, they ought to be able to successfully self-manage their disorders. Although people with "untreated SAMI" are thought to have significant biogenetic challenges that limit "their ability to actively engage in personal, social, and/or occupational areas of daily life" (Ministry of Health, 2013; p. 4), ACT is said to be able to provide tools for self-improvement. This optimism is legible in the BC Program Standards for ACT (BC Ministry of Health Services, 2008), which puts emphasis on the efficacy of "motivational interviewing"—a counseling methodology intended to "enhance a patient's motivation to change and build self-efficacy" (Hall, et al., 2012; Miller and Rollnick, 2013). Motivational interviewing is a "non-confrontational" and "client determined" approach to care which assumes that through better autoregulation, patients will no longer need treatment coercion. Rather, the counselling method guides patients to actively weigh discrepancies between their ideal self and present state and learn to make use of a "decisional matrix" to improve their behaviours. In this sense motivational interviewing practices help psychiatry to exercise the "will to govern in terms of, and through the regulated autonomy of their subjects" (Walters, 2001; p. 61).

The BC ACT program guidelines encourage clinicians to exercise care under an overall clinical ethos of “psycho-social rehabilitation”, which aims to produce better self-management skills within patients. The way the psycho-social rehabilitation paradigm characterizes recovery as a “personal journey” shifts the state’s focus away from social determinants and towards maximizing value through improving the personal choices of patients (Pilling, 2019). It also assumes that in order to provide support for people to find success in their journey, mental health programs must provide the “means for the re-empowering of the disempowered self, (re)equipping the self with the skills necessary for autonomous coping with the tasks of conducting a prudent life of freedom and choice” (Rose, 1996; p. 15).

This responsibilizing impulse is at times subtly articulated in how the texts conceive of psy subjects’ relationships to health, social systems, and themselves. Still, the discourse present undoubtedly resembles broader orientations in contemporary BC mental health policy that have “fashioned a new kind of self-monitoring psychiatric consumer whose ‘mental illness’ is purely an individual concern to be managed through self-caretaking, the administration of expert technologies and, where necessary, aggressive health interventions that proceed without any gesture towards the structural roots of human distress” (Menzies, et al., 2013; p. 16). However, while neoliberal political rationalities assume that subjects ought to exercise personal freedom by approaching life and recovery as an enterprise, they also play an active role in “constructing and constraining the paths one must choose to create a life of supposed value” (O’Leary and Ben Moshe, 2019; p. 116). In addition to the normative constraints of what counts as a life lived in accordance with maximizing value to the private market and minimizing cost to the state (e.g., cost avoidance, compliance with pharmacological treatment, maintaining tenancy in market rental housing), the paths afforded to people are further constrained in the Vancouver context by rampant poverty, income inequality, housing unaffordability, and ongoing settler colonialism.

Under its psycho-social recovery approach, BC’s ACT practice guidelines (see BC Ministry of Health Services, 2008) also display neoliberal political rationalities where they steer clinicians to master the “art of least possible governance” by keeping “client centered” in service delivery. Client centred care is believed to promote patient autonomy, collaboration, and self-ownership over care plans. Motivational interviewing assists clients to identify clear goals, such as abstaining from drug use, complying with

anti-psychotic medication regimens, and/or keeping one's apartment clean and quiet in order to prevent eviction. However, this assumption that client choice and autonomy hold inherent therapeutic value is undermined in documents from the VPD which make the case that more disciplinary, custodial approaches to care are also needed. This tension between neoliberal political rationalities and disciplinary practices indicates that although efforts are made to motivate patients to align their lives with the aims of the market, many "fail" to live up to these aspirations by choosing to continue to use "bad" (illicit) drugs and abstain from taking "good" (prescribed anti-psychotic) ones.

Van Veen, Teghtsoonian, and Morrow (2019) also detect this contradiction in the municipal government's *Caring for All* (2014) report, noting that "responsibilizing impulses sit somewhat awkwardly alongside practice recommendations that reveal a more directly disciplinary form of power" (p. 68); most notably, where police officers are given a role in enforcing treatment compliance in ACT programs. The move to deviate from the "client-centred" approach in the provincial ACT guidelines by entering into "joint service agreements" with police departments might be a sign that attempts to govern at a distance encounter failure. This point will be of importance to the concluding chapters on resistance to neoliberal political rationalizations, where I highlight how subjects of local mental health interventions do not always passively accept the forms of governmentality imposed through new regimes of community care.

Chapter 6.

How, When, and Where Did These Problem Representations Emerge?

This chapter takes a brief detour from the empirical analysis of the policy texts to situate the problem representations surrounding the "mental health crisis" within BC's history of mental health and substance use discourse. Here I answer Bacchi's (2009a) third question: "*how, when, and where did these problem representations emerge?*" The purpose of this question is twofold: first to show that the problem representations found in chapter four relate to historical decisions and developments in mental health reform, prohibitionist drug policy, and supportive housing policy and practice; and second, "to recognise that competing problem representations exist both over time and across space, and hence that things could have developed quite differently" (Bacchi, 2009a; p. 10).

I will take a closer look at how BC's mental health policy and practice has shifted over time, focusing on deinstitutionalization in the late-twentieth and early-twenty-first centuries, along with the move away from custodial care with the advent of "community" as a new site of psychiatric power. Then I discuss how the post-deinstitutionalization enterprise of community-based mental health care came to be widely regarded as a failure in the 2010's. Finally, this chapter provides a brief historical glimpse into Canada's history of drug policy, elucidating the different ways substance use has been problematized as a criminal, medical, and moral issue.

The problematization of mental illness and substance use have shifted over time in BC, discursively intersecting with other problems like homelessness, poverty, crime, and connected to the colonization of Indigenous peoples. However, throughout the 2010's the "mental health crisis" was represented as a phenomenon which was episodic and temporally contained, a characterization which omits socio-historical context. Evoking Nixon's concept of "slow violence", Van Veen, Teghtsoonian, and Morrow (2019) argue that by approaching the analysis of the "problems" of mental illness and addictions without the temporal constraints of the present day "epidemic", it is more

possible to view “the violence that unfolds around mental health reform in Vancouver as historically *endemic* and multifaceted” (p. 64; emphasis added).

6.1. Institutionalization and Deinstitutionalization in British Columbia

Prior to the mid nineteenth century there were few state statutes or interventions to manage mental illness in BC. People who were problematized as “lunatics” or “imbeciles” were expected to be cared for in their home communities, often by immediate family members. However, as BC’s population expanded alongside the vast capital generated by the rapid commodification and extraction of natural resources throughout the early-to-mid nineteenth century, municipal jails became increasingly relied upon to confine “the insane” away from their families and outside of public view. Shortly thereafter, “mental illness” began to be problematized as a phenomenon that provincial government health administrators needed to manage and monitor, prompting the opening of the Victoria Lunatic Asylum in 1872 on the Songhees First Nations reserve on the southern tip of Vancouver Island (Chunn and Menzies, 1998). In 1873, the provincial government passed the *Insane Asylum Act*, its first legislation establishing guidelines on how state institutions should approach care for people with mental illness (Yearwood-Lee, 2008, citing Ferguson, 2002). This new law set the stage for widespread institutionalization of people with mental illness in the decades to follow.

In 1904, after purchasing a large plot of land near the metro Vancouver suburb of Coquitlam, the provincial government began construction of Essondale, BC’s first large-scale psychiatric institution. The hospital was mandated to provide inpatient treatment under the new *Hospitals for the Insane Act*. In 1913, Essondale’s first year of operation, it was populated with 453 male patients (Yearwood-Lee, 2008). In the years that followed, capacity on the ward quickly doubled to over 900 patients, many of whom would spend their days working the fields of the nearby Colony Farm, which produced significant yields of crops to support the nearby population centres of Vancouver and New Westminster (Laanela, 2014). Shortly afterward a separate forensic inpatient mental health institution was opened on Vancouver Island with a mandate to segregate the care of a small but growing number of male patients who were deemed to be “criminally insane”.

It was not until 1930 that the first inpatient psychiatric ward exclusively for women was created at the Female Chronic Building at Essondale. In the mid-twentieth century, Essondale was renamed "Riverview Hospital" and quickly centralized inpatient mental health care in the province. Riverview grew to its largest state in the post-war period of the 1950's (Yearwood-Lee, 2008). Canadian sociologist Erving Goffman coined the term "total institution" to describe the administrative environments that structured life in large psychiatric hospitals like Riverview in the mid-century. For Goffman (1961), the total institution is a place where "a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (p. xiii). Morrow, et al. (2010) describe how the approach to care in total institutions like Riverview was "characterized by a custodial model in which patients were subject to institutional routines such as set meal and bath times, minimal personal autonomy and limited contact with the outside community" (p. 18).

While custodial care attempted to exercise control over individual patient bodies through the architecture of the institution and its clinical practices (e.g., confinement, restraint, and mandatory medication regimens), it also fostered efforts of physicians to purge mental illness from BC's population through eugenic practices. At least 200 compulsory sterilization procedures are known to have been performed by clinicians at Riverview between 1940-1968 (Belshaw, 2016). In 2000, fourteen former female patients of Riverview launched a class-action lawsuit against the provincial government, claiming that they were subject to sterilization without their consent (Mickleburgh and Matas, 2000). These eugenic procedures were legally permissible under the *Sexual Sterilization Act*, which passed through the BC legislature in 1933. At the time that these procedures were being conducted, their "proponents contended that sterilization of those with mental illnesses, criminals and the poor would be an acceptable method of improving society" through purifying the genetic composition of the population (Mickleburgh and Matas, 2000).

Simultaneous to a range of legislative changes that amalgamated several different mental health laws under the umbrella of the new BCMHA in the 1960's, discursive shifts occurred regarding practices of segregating "mental patients" from the general population. Health administrators and care providers started to believe that custodial care was not achieving therapeutic outcomes, and that patients could be better rehabilitated in the community. This led Riverview down the path of slowly depopulating

the number of patients from its wards. From its peak of 4630 patients in 1951, only 1,100 patients remained at the hospital by 1978 (Ronquillo, 2009). The shift towards from custodial to community care was not only becoming understood as more humane and beneficial to the new goal of "mental health recovery", but also one that would realize savings for the provincial budget. In 1979, the BC government released the *Report of the Mental Health Planning Survey* (Mental Health Planning Staff Survey, 1979), which contains findings of widespread financial mismanagement and administrative problems at Riverview. In the 1980's the politically conservative Social Credit government started planning to rein in healthcare spending by decentralizing inpatient mental health services and shifting care towards the community (Laanela, 2014). By the mid-90's, only about 1,000 patients remained in Riverview (Macfarlane, et al., 1997).

The pull away from custodial care led to "the formation of a new territory for psychiatry in the postwar period: community" (Rose, 1996; p. 4). The "community" became a new discursive site which posed unique challenges in the treatment of patients with "severe mental illnesses" outside the walls of the asylum. Key to making the decentralization of mental health services a success was the establishment of new regional health authorities with the mandate to provide community care across the province. Masuda and Chan (2016) argue that in BC "regionalization was the mantra of neoliberal health reforms, and the newly implemented health authorities inherited a seemingly impossible task of delivering a more effective and affordable health care system simultaneously" (590). During this time healthcare came to be viewed by the provincial government as a "business" which required strong corporate management processes to minimize expenditures and maximize value. Under this neoliberal political rationality, patients began to be reconceptualized "clients" or "consumers", and care viewed as a commercial encounter as much as a clinical one. The new health authorities were intended to be smaller, more efficient and responsive business units that the province could use to organize health services to better meet local population health needs, while also being cost-effective through helping patients to rely less on expensive institutional care and more on community-based services.

In 1994 the BC Ombudsman published a report, *Listening: A Review of Riverview Hospital*, which raised concerns about a range of issues brought to the office's attention from current and former patients and their family members. It highlighted how the hospital frequently failed to comply with the basic standards of care set out in the

BCMHA, leading to a range of poor outcomes regarding patient quality of life, treatment, and discharge planning. In 1998, a few years after publication of the report, the province announced its intention to close the hospital completely. Efforts to deinstitutionalize care intensified between 2002 and 2012 with the Riverview Redevelopment Project, a key feature of the provincial government's new mental health plan (BCMHSUS, 2015). The project signaled a discursive shift towards the emerging psycho-social "recovery" framework that promoted patient independence and self-regulation through individualized care plans. This new framework assumed that integration into the community was important to therapeutically normalize people with "mental illness". However, the process of transitioning people out of Riverview and into communities around the province was not a smooth one. A lack of income security, and affordable, supportive mental health housing options often made the community integration and "psycho-social recovery" a challenge, even for stable individuals who were ready for independent living (Morrow, et al., 2010).

Ministry officials described the central administrative goal of the $138 million Riverview Redevelopment Project as to "build capacity for intensive and highly specialized services within the regional health authorities—bringing care into communities and closer to families, services and local health resources" (Providence Health Care, 2010). In some instances, these "highly specialized services" would remain in inpatient tertiary mental health units located in local general hospitals. At the time, funding for 209 new inpatient community beds was earmarked for the Vancouver Coastal Health Authority, although by 2007 roughly 200 of those beds had yet to be made available to patients (Wilson-Bates, 2008). The province did complete its goal for replacement beds in other regional health authorities, with 396 new inpatient beds created across BC. As of 2008, only 245 people remained at Riverview (Morrow, Dagg, and Pederson, 2008). In addition to creating inpatient units at local hospitals, regional health authorities also created community mental health teams with the mandate to provide outpatient treatment in small clinics scattered throughout the province.

In the early-to-mid-2010's VCH embarked on an ambitious new community health service redesign in Vancouver's inner city, the *DTES Second Generation Strategy* (2015). One of the goals of the new plan was to prevent reoccurring incidents of short-term institutionalization in inpatient psychiatric units. The strategy also intended to develop "a common purpose for DTES services, grounded in the needs and interests of

the neighbourhood”, through consultation with contracted non-profit service providers, patients, community members, and “expert” stakeholders like the VPD and various provincial ministries (VCH, 2015). The redesign echoed the problem representation of a lack of cross-sectoral collaboration surrounding urban health service delivery that is featured in texts produced by the municipality and VPD around the same time. Central to the material changes that the strategy brought about in the neighbourhood is a shift away from “stand-alone silo services”, like those offered by community mental health teams at local clinics, and towards unifying the efforts of primary care, substance use, and mental health services under one roof in new “Integrated Community Clinics”. The health authority also pledges to better coordinate and individualize care through improved service collaboration between outreach services like ACT and AOT.

This new approach to care intends to provide flexible services to support people with mental health and substance use challenges in order to “achieve lasting improvement and progression to less intensive treatment options” over the long term (VCH, 2015; p. 15). VCH pledges that the changes under the strategy are “cost neutral”, with no net cuts to service. In fact, the strategy aspires to produce system wide savings over time. If successful, savings would be realized through a natural client progression to “less intensive” (i.e., costly) services than those provided in inpatient settings. This ideal trajectory is intended to address the problematization of the “crisis of cost” by exercising closer monitoring of patient outcomes by specific clinicians responsible for working with patients to develop effective individualized care plans. Clinicians are viewed as doing their part to reduce costs if they could steer individuals with complex care needs to scale back reliance on specialized services as they learn to self-manage their health. This neoliberal task of producing auto-regulating, “responsible” patients that minimize their cost to health administrators is evident where the strategy hypothesizes the track of the ideal patient under the new scheme: “as my health gets more manageable and has less negative impact on my life, I can do more… we can shift our plan [away from the integrated teams] to connected with general health services on my own as I need” (p. 10).

However, even in a time when community-based integrated care clinics and new ACT teams found favour amongst healthcare administrators, politicians, and law enforcement agencies for their potential to provide care in a way that would remedy the problems of costly care and poor cross sectoral collaboration, questions remained about

the efficacy of these services for people with untreated “SAMI” who continued to be largely disengaged from the health system. In 2014 the City of Coquitlam—a large metro-Vancouver municipality that surrounds the grounds where the Riverview operated—hired a clinical psychologist who had formerly worked at the asylum to draft a report on options for future uses of the hospital grounds. The document notes that the decision to close Riverview resulted in a net loss of psychiatric services for “traditional” persons with “serious mental illness” who are thought to still require long term custodial care. The needs of people with “serious mental illness” are said to exceed the capacity of community-based clinics, outreach teams, and/or local hospitals, no matter how “integrated” these healthcare services might be. Furthermore, it argues that a “new” population of people with untreated “SAMI” “have emerged who have complex treatment needs and who are now placing great pressure on hospital emergency departments and psychiatric units”, resulting in danger to the public, high costs for government, and poor patient outcomes (Higenbottam, 2014; p. 5).

This “new subpopulation” of people with untreated “SAMI” is described as uniquely challenging to treat in the community, likely requiring long-term confinement to institutional settings where custodial care can help achieve better outcomes. Reference to the lack of capacity or political will to re-institutionalize people with SAMI is found in many texts on the “crisis”. For example, the VPD Mental Health Crisis Update Report (2013) contends that: “[t]he increases in serious, violent offences committed by the mentally ill can be *partially attributed to* the reduction of secure care beds, as these are the same dangerous individuals who would have [in previous eras] been institutionalized and would not have posed a risk to the public or themselves” (p. 25; emphasis added).

Addressing the aspirations of deinstitutionalization, Rose (1996) argues that:

> The dream of the early years of sectorization and community care was of a kind of hygienist utopia, which placed great faith in the powers of psychiatrists to devise measures of prevention, to diagnose conditions which did occur, to allocate them to treatments, to contain, moderate and even cure mental illness, in conjunction with a whole variety of other professional groups and in a wide range of specialist sites (p. 15).

The “mental health crisis” provides a wakeup call from this dream. Like in many countries that deinstitutionalized mental health care in the twentieth century, the aspiration of psychosocial rehabilitation through community care has not been entirely

realized for many people who were discharged from large psychiatric hospitals in recent decades. In fact, discursive struggles between the “solutions” of custodialism and psycho-social recovery have led to attempts to re-institutionalize certain patients.

In 2017 the BC Ministry of Mental Health and Addictions[19] and Office of the Premier responded to this pressure, announcing that a new 105-bed treatment centre would be built on the old Riverview grounds, with the intention of treating adults with “SAMI” (Office of the Premier, 2017). There are contradictions between policy that positions community-based care models like ACT as a positive evolution from the inhumane, archaic practices of custodial care, and those which lament mid-to-late twentieth century decisions to end institutionalization. This tension is a viscerally familiar one for Vancouver mental health administrators and policy workers like myself, who are routinely asked at all manner of community consultation events: “*why don’t you just re-open Riverview!!?*” This contradiction has attracted scant attention save for a small group of critical mental health scholars in BC who argue that:

> Calls for re-institutionalization reflect the historic tension between providing support and imposing control on people with mental health challenges, as well as public understandings of the nature of mental illnesses, their treatment and their impact upon the community… [further], in the current neo-liberal context of mental health reform and welfare state restructuring, re-institutionalization is attractive to policy makers and community leaders seeking to make homelessness and poverty in urban centres less visible (Morrow, Dagg, and Pederson, 2008).

Data regarding volumes of involuntary psychiatric hospital admissions since the closure of Riverview suggest that although some view deinstitutionalization as a relic of the past, its practices have merely shifted into the community and health authority operated hospitals. In 2016/17 over 15,000 unique individuals were involuntarily admitted to BC psychiatric facilities, with over 20,000 involuntary detention events occurring over the year (Johnston, Milne, and Morrow, forthcoming). These figures represent the most recent indication of a trend wherein involuntary psychiatric

[19] After forming government in 2017, BC’s New Democratic Party created the province’s first Ministry of Mental Health and Addictions. The new ministry is tasked with drafting and implementing a new mental health strategy and managing the government’s response to the ongoing overdose emergency.

admissions have gone up over 70% over the past decade (ibid)—a timeframe commonly thought to mark the beginning of BC's post-institutionalization era.

6.2. Supportive Housing Programs and Psychiatric "Know-How"

The later period of deinstitutionalization coincided with extensive neoliberal policy reforms aimed at broad disinvestment in health and social services under the direction of the BC Liberal Government's almost two-decade reign between 2001 and 2017 (Teghtsoonian, 2009). Throughout the 2000's, community mental health programs were unable to accept the influx of people requiring their already strained services. Cuts to investments in BC's affordable housing programmes by the federal government also left many people who struggle with mental distress without basic shelter over this period (Gaetz, 2010, Lee 2016). In BC, housing options are scant for people living in poverty, struggling with homelessness, mental health, and/or substance use. Supportive housing, often the only viable shelter option people on income assistance are able to afford, has become almost unattainable. During the Riverview Redevelopment process, a period which coincided with rampant inflation to market housing rental prices, supportive housing waitlists ballooned in Vancouver. People are often forced to endure years of precarious housing situations before being granted one of the few subsidized units available. In 2008, BC Housing, the crown corporation responsible for financing the construction, maintenance, and operations of supportive housing buildings, had over 13,400 people on its waitlist (Klein and Copas 2010).

In addition to a lack of availability, the conditions in many government-funded, non-profit managed supportive housing sites have also been subject to criticism. "The Hotel Study" (Villa-Rodriguez, et al., 2013), a local longitudinal research project examining the health of 293 adult residents of Vancouver single room occupancy hotels, argues that below standard living conditions[20] contributed to research participants experiencing "greater than expected mortality and high levels of multimorbidity with adverse associations with role function and likelihood of treatment for psychosis" (Vila-

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[20] The text defines "below standard" housing as that which falls "short in at least one of the following criteria: adequacy (not in need of repairs, according to residents), affordability (costs <30% of before-tax household income), or suitability (makeup of bedrooms and household)" (Villa-Rodriguez, et al., 2013).

Rodriguez, et al., 2013; p. 1). The Hotel Study was frequently referenced in local policy circles throughout the time of the “mental health crisis”, often to problematize supportive housing as a model unequipped to meet the needs of people with untreated SAMI.

This problematization of a lack of psychiatric support in supportive housing upholds the notion that ACT—with its preference for scattered-site, market housing to address homelessness—is the preferable option to support psychiatric treatment retention, psycho-social rehabilitation, and cost savings across multiple government sectors. Instead of recommending further government investment to increase availability, affordability, and quality of supportive or non-market housing, many of the texts on the mental health crisis use the evidence from the Hotel Study to criticize supportive housing as a flawed model that should be replaced with opportunities to access government subsidies to secure permanent accommodations in the private housing market. Psychiatric patients are viewed as unlikely to recover from mental illness if they continue to rely on the state to provide them with housing.

Although the Hotel Study (Villa-Rodriguez, et al., 2013) assumes that housing conditions are an important social determinant of health, it is rife with psy discourse that focuses on neurological functioning, adherence to psychopharmacological treatment for psychosis, and medication to treat HIV and addiction as the most important indicators of housing success. The lack of social context in the research’s epidemiological depiction of the population living in “DTES” single room occupancy hotels offers little to nuance how outcomes might vary across different supportive housing sites depending on management policies, built design, sense of community, and/or services offered to residents. For instance, some supportive housing buildings are purpose-built with well-designed rooms and are run by non-profit organizations that go to great lengths to ensure that their programs meet the diverse needs of people who use drugs and/or struggle with mental health. Some programs offer addictions treatment, harm reduction services like supervised consumption, medication management, primary care in-reach, peer support programming, peer employment opportunities, laundry, and/or free meals for its residents. Many also work hard to ensure that residents are not evicted, even if they display behaviour (e.g., hoarding, drug use, repeated noise violations) likely to result in eviction by market landlords.

There is great diversity in how services are delivered at these sites. Some housing programs have been criticized for exercising intense forms of surveillance on residents (Elliot, 2014; Boyd, Cunningham., Anderson, and Kerr, 2016) and certain operators are known to routinely evict people who are suspected of drug use or trafficking. Moreover, local ethnographers have observed that the uneven and inconsistent application of provincial tenancy laws across supportive housing sites undermines housing security for some (Fleming, et al., 2019). All of this heterogeneity in supportive housing service delivery, and opportunities to advance recommendations to improve them, is lost in the oversimplified way the texts construct the model as a failure due to a lack of embedded psychiatric support. Moreover, introducing more psychiatric supports in these settings might in fact increase the intense forms of surveillance that some residents cite as detrimental to their quality of life.

Around the same time the Hotel Study (Villa-Rodriguez, et al., 2013) was underway, and the "mental health crisis" began to take shape in local policy documents, a report from a Simon Fraser University research centre indicated that over 18,759 people with untreated "SAMI" were either living in conditions of "absolute homelessness" or "at imminent risk of homelessness" in Vancouver (Patterson, et al., 2008b). Researchers and policy makers problematized this population as too expensive to keep unhoused and untreated, yet too difficult to keep compliant with psychiatric treatment within the limitations of existing supportive housing programs, and too challenging to keep engaged in care at community-based clinics. This conundrum set the stage for reports from the VPD and municipal government to conclude that it would be more effective to implement ACT under a new cross-sectoral partnership with police than to continue with the status quo.

6.3. The Emergence of Assertive Community Treatment

This section briefly touches upon the history of the ACT in order to understand how the intervention gained status as an evidence-based, community-based mental health service reform priority. ACT was first introduced in Madison, Wisconsin in the late 1970's in response to a shift in state mental health policy that began the deinstitutionalization of large-scale psychiatric hospitals. The founders of ACT argued that existing community-based treatments and supports were likely to be insufficient to meet the needs of patients with complex needs making the transition from custodial to

community care. The researchers predicted that without more intense forms of on-going supervision these patients would experience regular re-hospitalization as they struggled to adjust to life in the community (Test, 1979). In the decades that followed, ACT teams were implemented in many U.S. and Canadian cities, with strong endorsement from state/provincial, and national health organizations (Stull, et al., 2012; Salyers, 2009; Watts and Priebe, 2002). As the model spread, a proliferation of implementation science followed. There is no shortage of research on ACT from a variety of human science disciplines, including psychiatry, clinical psychology, nursing, social work, and health economics.

Research findings have generally emphasized ACT's benefits in terms of cost savings (Slade, et al., 2013; Chandler, et al., 1999), efficacy in reducing psychiatric symptom severity and homelessness (Coldwell and Bender, 2007), positive association with decreasing rates of re/hospitalization, and abilities to produce improvements to general well-being amongst patients (Currie, et al, 2014). ACT's well-established program standards have been persuasively disseminated, refined, and promoted by influential organizations like Pathways to Housing in New York, the Mental Health Commission of Canada (MHCC), BC Ministry of Health, and Ontario Ministry of Health and Long-Term Care. The MHCC identifies Housing First ACT as a central component of its national treatment recommendations for provincial governments looking to develop long term plans to support people with vulnerability to homelessness and severe or complex mental illness (MHCC, 2013). The MHCC also mobilized significant federal government funding to advance research on ACT in the Canadian context through its *At Home Study*, which operated arms in several cities during the early-to-mid 2010's[21]. This push by the federal government to create more research evidence on the program was exerted despite the fact that ACT was already long recognized as one of the most heavily studied community-based mental health treatment models in existence (Lehman, et al., 1999).

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[21] It is beyond the scope of this chapter to provide a comprehensive overview of the program evaluation literature regarding Housing First in Canada. Indeed, at least 80 research papers have resulted from the At Home Study alone, and others have gone to great lengths to summarize the program model and results (Goering and Streiner, 2015; Aubry, Nelson, and Tsemberis, 2015; Ly and Latimer, 2015). Instead, the purpose of this chapter is to situate how the development of Housing First in Vancouver has played a role in forming the problems representations found in texts on the "crisis".

In 2008, two years before the MHCC's Vancouver arm of the *At Home Study* began, the BC Ministry of Health Services released its first ACT program guidelines. The document details provincial best practices regarding intake, admission process, discharge criteria, service intensity and capacity levels, staffing requirements, program organization, communication between clients and clinicians, client-centred assessment, individualized treatment/service planning, required services, record keeping, client rights and complaint resolution procedures, strategies to reduce barriers to services, performance improvement, and evaluation and accountability. The Ministry describes ACT's target clients as those:

> with severe and persistent mental illnesses that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability and because of ACT's proven effectiveness with this population… All ACT teams are encouraged to admit clients who meet ACT admission criteria, that is, individuals with severe and persistent mental illness. Clients that also suffer from other issues should similarly be admitted, particularly those with issues that would benefit from a coordinated treatment approach, including but not limited to involvement with the criminal justice system at all levels, homeless clients, and those with developmental disabilities and substance use disorders (BC Ministry of Health Services, 2008; p. 4).

In selecting the highest priority clients during intake, ACT clinicians are instructed to take additional considerations into account, including whether clients have an "inability to maintain consistent employment at a self-sustaining level or inability to consistently carry out the homemaker role", have been subject to repeated housing evictions or experienced struggles to maintain safe housing, have "severe and persistent mental illness who make high use of general hospital psychiatric services, specifically hospital services, tertiary level services, or psychiatric emergency services such as mental health response services", have concurrent "substance use and mental health disorders", criminal justice system involvement, and/or "difficulty effectively utilizing traditional office-based out-patient services" (pp. 4-5) such as local integrated community health centres.

ACT teams are proactive in their efforts to fix these "problematic behaviours" by guiding patients to become "self-sustaining" adults, committed to psycho-social recovery and able to live up to the expectations that market landlords have of "good tenants". The teams also aim to lead patients to rely less on costly emergency and inpatient services

and more on outpatient ones. “Best practices” suggest that the teams be staffed in a way that provides patients with services 24 hours a day, seven days a week. The Ministry also recommends that they operate with low patient-to-clinician ratios in order for frequent attempts to be made at patient contact and monitoring. Clinicians must have the flexibility to devote time to tracking patients down in the community. The guidelines also recommend that the teams be multidisciplinary but led by a manager and head psychiatrist responsible for directing overall care. Other team members should be comprised of professionals from “core mental health disciplines” such as psychiatric nursing, with at least one peer (person with lived experience) specialist, and administrative support staff (BC Ministry of Health Services, 2008).

Both the BC Ministry of Health and MHCC recommend that ACT programs be implemented under a Housing First approach, where patients are provided care on a voluntary basis and offered immediate access to rent subsidies to help them obtain market-apartments where the day-to-day stability required for recovery can be realized. Housing First programs do not require the common prerequisites of some supportive housing or shelter programs, such as abstinence from substance use and/or participation in psychiatric treatment. Biomedical treatment is encouraged, but it is intended to be optional, with client choice and autonomy preserved as a core ethos of the program.

A critical component of ACT’s fidelity standards holds that a client’s refusal of treatment services should not impact their access to a housing subsidy. No treatment bribes are permitted. “Choice”—of where to reside and what treatment to engage with—is viewed as the most important principle of the intervention. In fact, the goal of supporting patients to exercise internally motivated “choice” and “autonomy” is viewed as an element of the program which is therapeutic in-and-of itself (Tsemberis, Gulcur, and Nakae, 2004). In many respects the ACT practices recommended by the BC Ministry of Health, MHCC, and others promote a neoliberal political rationality that seeks to clinically instil a sense of autonomy and autoregulation within patients—positive forces thought to improve long-term housing stability and overall health and reduce “drain on the system”.

ACT teams make commendable attempts to engage and support a population who are undoubtedly “slipping through the cracks” of existing underfunded health and

social services. However, their impetus to govern patients “at a distance” by responsibilizing them to make better decisions for themselves, lapses into forms of disciplinary social control when the programs are modified to include police officers to help enforce psychiatric treatment compliance. As I have demonstrated in previous sections, the will to control patients through disciplinary technologies which resemble forms of custodial care is still on fertile ground in BC. Coercive practices in community-based treatment continue beyond the walls of the asylum and are enabled by the BCMHA’s permission for compulsory treatment. Moreover, involuntary treatment orders—including community treatment orders—appear to be increasingly relied upon in the BC context, with very few checks and balances in place to uphold patient rights (Johnston, 2017; Johnston, Milne, and Morrow, forthcoming; Kolar, 2018; Van Veen, Ibrahim, and Morrow, 2018).

Despite the remarkable volume of research on ACT stretching back over two decades, the model has largely escaped scrutiny over its potential to exercise intense forms of control over people it seeks to care for (Gomory, 2002; Spindel and Nugent, 2001). Extensive literature searches of major health research databases conducted from 2013-2020 discovered few studies on the power dynamics in ACT programs. Crilly (2008) provides one of the few critical accounts, which offers equal parts endorsement and caution. He notes that although ACT has proven effective in increasing engagement and retention in psychiatric treatment for people with mental illness, the model is intrinsically coercive by virtue of its intention to assertively target individuals who explicitly *do not* wish to have mental health treatment and/or contact with mental health professionals (p. 69). ACT clinicians often go to great lengths to track down patients, including making unannounced visits to patient’s houses, and even searching for them throughout the community. Crilly (2008) notes that “such intrusive activities are well justified but can also be considered coercive and possibly detrimental (or at least make no difference) to the client’s outcome” (pp. 69-71).

The unintended consequences of these exercises of healthcare surveillance and coercion warrant further examination. Mental health consumers, psy-survivors, and critical mad researchers have fought to advance a range of human rights to counter psychiatrization by respecting the will of individuals to define their own recovery goals and make informed choices about their treatment (Costa, 2013; Morrison, 2005). The ACT model, backed by the authority of research evidence and policy makers who accept

its shaky promise of client choice and autonomy, has the potential to normalize coercive practices in mental health care. This is especially the case when the model is implemented in contexts like Vancouver where provincial mental health law does not adequately protect the rights of patients once they have been labelled as incompetent, a danger to themselves or others.

It is clear from the body of scientific research and clinical guidelines produced by government health agencies that ACT has been implemented in uneven and inconsistent ways. Beginning in 2010, the MHCC's *At Home Study* (see Currie, et al, 2013) examined the efficacy of a Housing First approach to ACT over a three-year period in five major Canadian cities. Local Vancouver researchers and social service agencies partnered to operate several study arms, and the results support the view that the model is effective in engaging and retaining people with untreated "SAMI" in stable housing and care. Concurrent to and following the research project, six new ACT teams were implemented by the Vancouver Coastal Health Authority (VCH) with a mandate to help curb the "mental health crisis" and address homelessness. In 2012, Vancouver's first ACT team involving a partnership between the health authority and police was launched, following a similar initiative in Victoria, BC. Speaking to the rationale for police involvement in the program, a text from the VPD explains that:

> It was realized that the police have a significant role to play in the care of the mentally ill in Vancouver due to the fact that officers tend to have daily contact with those who are chronically mentally ill. While VPD officers are by no means mental health practitioners, they are able to observe changes in an individual's baseline state and are often the first point of contact for persons in crisis (VPD, 2013; p. 9).

In two Vancouver ACT teams, clients are recruited *not* through referral from healthcare providers, family, or self-referral, but through an automated pathway generated from an information sharing arrangement between the health authority and police department. Police and healthcare workers in these teams use the VPD's Police Records Information Management Environment (PRIME) to identify potential patients. PRIME is an electronic records management system used by police departments across the province to, amongst other things, help officers identify "emotionally disturbed persons" (EDP's). EDP's are defined as "a subject who appears to be mentally unstable and who might pose a threat to an investigator, him/herself or others" (VPD, 2010; p. 2).

Once an EDP is referred to ACT through PRIME, the team makes contact and begins to follow them. If the individual is receiving treatment involuntary under the BCMHA, contact with the team is mandatory. If a patient resists the community treatment orders imposed by the ACT psychiatrist, police "proactively engage" the patient, transporting them to a local hospital where anti-psychotic medication is forcibly administered, usually in the form of a long-acting intramuscular injection (VCH,2016). When patients come into contact with police between regular appointments with the nurse or psychiatrist, police are able to flag the contact and record their observations about the client's behaviours relative to their assumed "baseline state" in PRIME. This triggers an alert for the ACT team to review the patient's case plan at their subsequent morning team meeting (VCH, 2016).

A health authority manager notes that this surveillance partnership with the VPD enhances the ACT team's knowledge of "what goes on in the lives of some of our clients outside of our contact with them" (VCH, 2016; p.11). It is important to emphasize that care for no other "disease" is jointly managed by police and healthcare providers. For example, it would be viewed as highly inappropriate for individuals with HIV, cancer, or diabetes to have all their contacts with police flagged and shared with their primary care provider. So too is it hard to imagine a scenario wherein a middle-class person with an "anxiety disorder" would have their police contacts reported to the private-practice cognitive behavioural therapist who they were receiving treatment from. In fact, the Canadian Psychological Association's Code of Ethics clearly forbids this kind of information sharing without explicit informed consent from the patient (Canadian Psychological Association, 2017). This is not to suggest that it is a new phenomenon for "mental illness" to be managed in ways different from other illnesses; Burstow (2013) puts it eloquently where she notes that "psychiatry is a regime of ruling", evident in the fact that it is "the only profession allowed to incarcerate people who have committed no crime" (p. 80). However, what *is* noteworthy in this new arrangement of community-based mental health care is that police have taken up new roles in the regime.

A 2016 presentation from the health authority outlines the benefits of partnership with the VPD to deliver mental health care. It notes that under the BCMHA, police have long held "legitimate" roles in the provision of health services. The presentation also makes clear that the law provides several mechanisms where police "are given certain

powers directly related to helping mental health clients in the community", most notably in situations where:

> it looks like a person is acting in a manner likely to endanger that person's safety or the safety of others *and* is apparently a person with a mental disorder, the police can apprehend the person and immediately take them to a physician for examination… [this] is not an arrest, but is a way to make sure that someone has the opportunity for an evaluation and treatment (Slide 6).

Statements like this show how ACT relies on public safety knowledge to determine and act on the risks associated with people with "SAMI".

Calling attention to this significant shift in police and healthcare practice is not intended to unfairly criticize local officers who are routinely called to respond to challenging situations where they perceive a "mental disorder" to be the cause of the distress. In these situations officers must sense that law enforcement is not the optimal intervention. I accept the argument that in these instances people in distress would be better served by health or social service providers. However, as the VPD continues to follow its mission to go "beyond the call"[22] in their enthusiastic approach to managing mental health, officers increasingly play formal roles in psychiatric assessment and care provision. Under the new "joint service arrangement", officers assist clinicians to enforce compulsory psychopharmacological treatment by positioning apprehension under the BCMHA as an ultimatum. Although mental health apprehensions can be traumatic and at times violent, it is understood as sometimes necessary for the sake of better care: "[apprehension] is not an arrest, but is a way to make sure that someone has the opportunity for an evaluation and treatment" (VCH, 2016; p. 7). Coercion is positioned as important clinical tool to increase opportunities for the healthcare system to reinforce treatment compliance.

This relationship between police and the health authority is evolving. A VCH text (2016) notes that the insertion of police into front line mental health care began many years ago with "car 87/88", a program that pairs a nurse with a police constable to jointly respond to 911 calls involving mental health crisis situations. Close cross-sectoral

[22] "Beyond the Call" is the VPD's corporate motto. Although likely meant to convey a hard-working ethic of public service, taken another way it could be read that the police are perhaps too eager to venture into territory usually reserved for health and social service professionals.

collaboration between health and police is key to the program: “the nurse and the police officer work as a team in assessing, managing and deciding on the most appropriate action” (VPD, 2010; p. 2). This partnership was soon deepened, with police taking a more active role in “managing long-term clients requiring assertive and intensive supports with ACT” and then “evolved to forecasting and early interventions that prevent crises and decline in client functioning with AOT” (p. 23). AOT is the newest in the joint health-police partnership intended to solve the problem representation of a lack of cross-sectoral collaboration. Instead of involving the range of interdisciplinary professionals present in ACT, such as social workers, occupational therapists, and peer specialists, the AOT only employs nurses and police. Its goals are: “increased engagement”, “stabilization and improved health outcomes”, “connection to appropriate services”, “risk mitigation”, “prevention of mental health-related arrests and offenses”, and to “decrease use of emergency resources” (p. 23).

Another other important modification occurred in how the new Vancouver ACT model largely did away with the Housing First approach recommended by the MHCC. Housing First, a term first coined in the US, but used as a philosophy of supportive housing service delivery in Vancouver since the 1990’s, is “a recovery-oriented approach to homelessness that involves moving people who experience homelessness into independent and permanent housing as quickly as possible, with no preconditions, and then providing them with additional services and supports as needed… [t]he underlying principle of Housing First is that people are more successful in moving forward with their lives if they are first housed” (Gaetz, Scott, and Gulliver, 2013; p. 2). Although access to safe and affordable housing is understood as a key social determinant of health under the Housing First ACT approach, clients of the Vancouver ACT teams are rarely provided with a subsidy to obtain private market rental housing. Without offering housing to clients, these new ACT teams might be more accurately described as *psychiatry first, housing second*. Psychopharmacological interventions supported by local law enforcement take precedence over housing, food and income security, and other forms of basic social support.

6.4. The British Columbia Mental Health Act

Prior to the mid-1960's, a number of different laws directed BC's mental health care, including: the *Clinics of Psychological Medicine Act; Mental Hospitals Act; Schools for Mental Defectives Act; Provincial Child Guidance Clinics Act; and Provincial Mental Health Centres Act* (Yearwood-Lee, 2008). Then, with deinstitutionalization already partially underway, the BCMHA was passed into law by the provincial legislature in 1964. The new framework replaced the functions of five previous Acts and still oversees all mental healthcare in the province (Yearwood-Lee, 2008). Patients were constructed as more medicalized subjects in the new Act compared to earlier legislation. References to "lunacy", "idiocy", and/or "imbecility", were replaced with emerging psychiatric knowledge regarding of a range of "mental disorders" articulated in the Diagnostic and Statistical Manual of Mental Disorders (Fraser, 2015).

The BCMHA also set criteria that physicians must meet in order for patients to be eligible to receive involuntary treatment. Involuntary treatment is only permitted if the attending physician views it as necessary for the protection of the patent, typically when they are deemed incapable of adequately self-managing their disorder(s). Kolar (2018) shows how the concept of "protection" is employed in practice to problematize psychiatric patients as "incompetent, vulnerable, dangerous, un-trustworthy, dysfunctional and irrational" (p. 76), a characterization that invites stripping patients of the right to have a say in their own care.

In 1979 the BCMHA was amended to provide patients with the option to legally contest their involuntary committal through access to review panel hearings. In 1996 the Act was revised again to include criteria for "extended leave", where involuntary treatment could continue in the community after discharge from the hospital (Fraser, 2015). Although extended leave provisions are intended to promote community re-integration on a trial basis following an inpatient stay, some argue that these treatment orders represent "an extension of psychological confinement" (Clarke and Ruthen, 2017) which undermines patient autonomy over their bodies and minds.

Each Canadian province has its own mental health law which serves the central function of setting parameters for involuntary treatment. It is common for involuntary treatment to be initiated by police, who are permitted to detain and escort people

assumed to be "at risk of decompensation", "decompensating", and/or presenting a "threat to others or themselves" to the hospital for assessment. In BC, if a patient is admitted to hospital, they may eventually be permitted to leave under Section 37 of the BCMHA. Section 37 allows psychiatrists to give patients permission to leave the hospital and return home for a "pre-discharge trial placement in the community" as long as the leave has an "anticipated therapeutic value" (BC Ministry of Health, 2005; p. 27). Extended leave can be prolonged beyond the recommended 14-day trial period if a separate form is completed by the attending psychiatrist. After the first month spent on extended leave, a physician can renew it for an additional month, and following that, three months. If at that point the psychiatrist still determines involuntary treatment to be necessary, the leave can be extended indefinitely until the physician, or a review panel hearing determines that it is no longer required.

While on extended leave patients can be recalled to the hospital at any time (BC Mental Health Act, 2019). Although the BCMHA intends for the conditions (e.g., to reside at a particular address with family members or at a supportive housing site) of extended leave to be patient-centered, the most common prerequisite to being able to remain in community is medication adherence, which is closely monitored by the physician and/or case manager. Anti-psychotic medications like risperidone[23] are typically required to be regularly taken in the form of an intramuscular (IM) injection. The IM route of administration of slow-release medication is preferred because it can be provided on a biweekly basis by an outreach nurse, rather than relying on the patient to comply with daily oral medication regimens. This gives the psychiatrist more certainty that the care plan (medication adherence) will be followed.

The other significant criteria often mandated by physicians as a part of a care plan is the requirement for the patient to reside at an "approved home" (BC Mental Health Act, 2019). The approved home could be with family members, in specific apartments arranged by case managers, or at supportive housing sites. If a person on

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[23] Risperidone is a commonly used medication in the treatment of Schizophrenia and Bipolar Disorder. It has been known to increase risk of cerebrovascular disease, and "may cause somnolence, postural hypotension, motor and sensory instability, which may lead to falls and, consequently, fractures or other injuries" (Medscape, 2017). Indeed, the whole class of anti-psychotic medications carry "the risk of troubling, sometimes life-shortening adverse effects", including "increased likelihood of sedation, sexual dysfunction, postural hypotension, cardiac arrhythmia, and sudden cardiac death" (Muench, and Hamer, 2010; 617).

extended leave chooses to live in an alternative location (e.g., with a romantic partner or friend) that the psychiatrist deems to be likely to increase risk of decompensation, the patient can be involuntarily re-hospitalized until they re-commit to residing at the "approved home". In this sense, the only "choices" that can be made are those which are "good" ones in the eyes of the psychiatrist.

Each Canadian province provides some mechanism for patients to challenge involuntary treatment[24]. In 1979 the BCMHA was revised to allow a person to appeal their case to the BC Mental Health Review Board. The review board is an independent tribunal established under the BCMHA with a mandate to administer review panel hearings on involuntary admissions or extended leave. The BCMHA requires that the adjudicating panel "consist of a medical practitioner, a member in good standing of the Law Society of British Columbia or a person with equivalent training, and a third member who is neither a medical practitioner nor a lawyer" (BC Ministry of Health, 2018). The hearings provide a vital procedural check to the BCMHA's exceptional authority to strip away a person's right to liberty and protection from unlawful physical restraint under section 7 of the Canadian Charter of Rights and Freedoms[25] (1982).

The VPD *Lost in Transition* (2008) report argues that in practice these case appeals function as a "barrier to care" because they focus too much on "strict dangerousness criteria" in their adjudication and often include arbitrators who may not be medical professionals and yet are able to "override [a psychiatrist's] medical opinion" (p. 18). In this characterization, the police texts problematize the BCMHA for offering *too many* checks and balances, and that in cases involving "mental illness", human rights ought to be subservient to the expert biomedical knowledge of psychiatry. However, for

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[24] Although most Canadian provincial mental health law references the discourse of *mental health* in their titles (e.g., Mental Health Acts), in the maritime province of Nova Scotia the legislation is more aptly titled: The Involuntary Psychiatric Treatment Act. This nominal specificity is more accurate (i.e., most mental health law focuses narrowly on criteria for involuntary admissions for people with *mental illness*) and forthright about its limitations (i.e., provincial governments in Canada are not required by law to fund programs aimed at upholding mental wellness, or mental health promotion).

[25] Section 7 of the Charter of Rights and Freedoms holds that every Canadian "has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice". Section 7 of the Charter is intended to protect Canadians from unlawful physical restraint or the threat of imprisonment. The BCMHA can revoke the right to liberty, allowing for psychiatric confinement for patients deemed to be a risk to themselves or others (BC Mental Health Act, 2019).

patients who would like to challenge their involuntary committal, access to a hearing is not simple or easy. Johnston (2017) argues that the administrative procedures of the BCMHA and clinical environments in which they enacted gives healthcare providers ample opportunities to persuade clients *not* to file a hearing, or to cancel hearings after an initial request. In 2016 the Mental Health Review Board only heard just over a third of the over 2152 applications for hearings, with the remainder cancelled for unknown reasons (p. 98).

The BC Mental Health Review Board does not publish annual reports. Without filing expensive Freedom of Information requests to the provincial Ministry of Health and/or regional health authorities, it is difficult to know how many hearings are held each year. The Board also does not publish statistics on patient demographics, outcomes of hearings, or trends in rates of apprehensions under the BCMHA or numbers of patients on extended leave at any given time. However, a recent report from the Office of the BC Ombudsperson found that in 2016/17 "around 15,000 people were involuntarily detained in one of B.C.'s over 70 psychiatric facilities… a number that has grown by approximately 70 percent in the last decade" (2019; p. 1).

How many of those cases are appealed through review panels and their outcomes remains unclear. This lack of basic transparency rests in stark contrast to the Canadian province of Ontario, where its Review Board publishes annual reports[26] listing active members of its Board, along with professional association, date of appointment, and when their current term expires. Ontario also publicly reports on overall statistics and trends relating to the number of patients involuntarily treated, number of hearings held, and rates of absolute discharges. By comparison, BC's system is the weakest in the country when it comes to monitoring performance standards (Johnston, 2017).. Legal scholars have decried the government's mental health system and documentation of involuntary care as "opaque, unclear, and obscure—a system in which people are tucked out of sight with no monitoring oversight, or accountability" (p. 6). What *is* known, is that BC's rates of involuntary hospitalization for mental health and/or substance use events are the highest in Canada (Johnston, Milne, and Morrow, forthcoming).

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[26] For example, see Ontario Review Board Annual Report, 2017/18. Accessed from http://www.orb.on.ca/scripts/en/resources/Annual%20Report%202017-2018-EN.pdf

6.5. The Legacy of Prohibitionist Drug Policy

Illicit drug use is widely problematized throughout documents on the “crisis”, under a range of assumptions about the criminogenic and inherently deleterious impacts of psychoactive substance use. This section examines the ways in which illegal drugs have been problematized throughout BC’s history. This retrospective view through the history of drug policy helps us understand how “severe addiction” came to be discursively featured as an urgent problem in documents. Mental illness and the use of psychoactive substances have stood in close discursive proximity in Canadian law and politics. This was especially the case in the latter half of the 20th century and early 21st, where drug use—especially the use of stimulants like cocaine, crack cocaine, and methamphetamine—drove a moral panic through the population because of its assumed association with mental illness and violent, irrational criminogenic behaviours. Stimulant use was perhaps the biggest source of fear, with medical discourse connecting regular consumption with “progressively enhanced susceptibility to abnormal behaviours, psychotic state, and relapse” (Ujike, 2002; p. 177).

Documents on Vancouver’s “mental health crisis” make use of the terms “mental health”, “mental illness”, and “addictions” almost interchangeably (e.g., the “mental health and addictions crisis”). However, the documents also contain dividing practices, separating people with “mental illness” from those with no substance use disorder indicated, or vice versa, from those with severe, untreated comorbidities (e.g., people with “concurrent disorders”, people with “SAMI”). When it comes to healthcare, psy discourse surrounding the relationship between substance use and “concurrent disorders” has led services for people with “mental illness” and “addictions” to be organized within the same department in most of BC’s regional health authorities: “mental health and substance use services”. The medicalization of illicit substance use alongside mental illness represents an evolution from earlier medical discourse where the “problems” of drug use/addiction and mental illness were often understood as distinct phenomena.

While mental health has been primarily understood as a medical problem for the past 150 or so years, the "medical model"[27] of addiction proliferated much more recently. In 2013 the Diagnostic and Statistical Manual (DSM-5) was revised with the release of its fifth edition. The new manual carries a significant discursive shift in how "addiction" is characterized compared to earlier versions. In the fifth edition, "substance use disorders" are posited as principal disorders and replace other core disorders found in the fourth edition. In short, "substance dependence" and "substance abuse" are out, and "substance use disorders" are in. The new DSM-5 has been broadened to include ten different distinct "substance use disorders". Clinicians are instructed to consider "diverse elements such as harms, risk, misuse of time, loss of self-control, pathological desire and biological disturbance into the condition of addiction and locates it within the individual" (Fraser, et al, 2014; p. 44).

Critics challenge the normative assumptions contained in the clinical criteria that the DSM-5 puts forth for determining a pathological pattern of substance use. Fraser, et al., (2014) argue that by focusing on evidence of substance use in physically hazardous situations (e.g., when operating heavy machinery) the DSM-5 positions certain individuals, like working class people who regularly operate machinery as a routine part of employment, as more likely to be diagnosed with a "substance use disorder". By comparison, a white-collar worker who takes a taxi to and from her downtown office building and only operates a laptop and smartphone would be inherently less vulnerable to the diagnosis, even if she regularly consumed drugs or alcohol over her lunch break. Moreover, the DSM's focus on productive and appropriate use of one's time, and ability to practice particular forms of self-control also presuppose an ideal auto-regulating neoliberal subjectivity which people with "substance use disorder" are thought to deviate from.

Over recent decades public health knowledge has expanded the individualist, purely medicalized understanding of "addictions" into the broader field of "substance

[27] The medical model, or disease model, of addiction refers the modern scientific belief that substance use disorders are chronic, life-long, relapsing medical conditions. Although some view medical model's shift away from viewing addiction as a moral failing and towards understanding it as a disease is helpful to reduce stigma and promote non-judgmental treatment, others assert that the "disease diagnosis diminishes moral judgment while reinforcing the imperative that the sick persons take responsibility for their condition and seek treatment" (Hammer, et al., 2013; p. 30).

use”, which acknowledges the disparate ways in which people use drugs. The BC Health Officer’s Council (2005), a group of practicing medical health officers from public health departments around the province, describes psychoactive substance use as existing across a spectrum, from beneficial use (e.g., the therapeutic use of psychedelic substances for psycho-spiritual benefits currently being studied across North America), to casual or non-problematic use (e.g., recreational use that has insignificant health or social effects; for example, casual cannabis use or moderate alcohol consumption in settings which produce social connections), to problematic use (e.g., that which starts to produce negative consequences for the individual and their community/society, such as “drunk driving”), and chronic dependency or addiction (where problematic psychoactive substance use patterns continue despite adverse health and relationship consequences for the individual).

Perhaps the biggest shift toward a population health discourse related to substance use came with advancement of the concept of harm reduction in Canada, Europe, and Australia during the 1980’s and 90’s. Harm reduction emerged largely in response to high rates of Human Immunodeficiency Virus (HIV) and Hepatitis C (HCV) in urban centres with large populations of injection drug users (Inciardi and Harrison., 2000). While the trafficking, possession and personal use of drugs like non-prescription opioids and stimulants was and still is criminalized in these countries, harm reduction programs such as syringe distribution programs and supervised consumption sites have slowly become accepted as practical techniques to reduce the spread of HIV and HCV, prevent overdose deaths, and engage people in treatment should they desire it. Harm reduction does not explicitly seek to “treat” addiction, rather offers low-barrier, non-judgemental access to care and services that minimize harms associated with it (Marlatt and Witkiewitz, 2002).

Although surprisingly not visible in texts on the “mental health crisis”, Vancouver is considered to be a global leader in addictions treatment and harm reduction policy and practice. Local health authorities, non-profits, and researchers have generated many innovative substance use programs and a substantial body of literature through studies on its local drug-using population (Bozinoff, et al. 2017). InSite, North America’s first

supervised injection site, and the Crosstown Clinic[28] injectable opioid agonist treatment program serves as two notable examples. However, notwithstanding this more recent embrace of the medical model and population health approaches to harm reduction, for most of BC's history substance use was widely understood as a criminal "problem".

In fact, Vancouver was centre stage in the discursive struggle around the problematization of drug use in early Canadian law. It might be said that the city is the birthplace of modern Canadian drug prohibition. In 1907, violent racist riots broke out in Vancouver's Chinatown, with significant destruction targeted at Chinese-owned businesses and residences. It was during the federal government's forensic investigation into the causes of the riots and assessment of the damages incurred, when then Deputy Minister of Labour William Lyon Mackenzie King first hypothesized that opium smoking was the source of Chinatown's dysfunction and the local animosity directed towards Chinese businesses who were said to be trafficking the substance (Malleck, 1997).

The problematization of opium smoking led the federal government to take steps to prohibit the production and sale of non-prescription opioids for the first time under its *Opium Act*, which passed into law in 1908 with "little media attention, parliamentary debate, or pharmacological evidence to support the regulation of this drug" (Boyd and Carter, 2010; p. 224). The new Act established criminal sanctions for the import, sale, and possession of opium. Police enforcement targeted mostly at Chinese dealers of opium rather than individual, often Caucasian users (Office of the Provincial Health Officer, 2018). Malleck (1997) contends that in addition to anti-Asian racism, broader notions of "racial purity" and "vigilance over the national character" were central to how non-medical opium use was problematized in Canada throughout the early 20th century (p. 276). If the national character was to be preserved, Canada's citizens are expected to exercise self-control and mastery over their own wills. However, the Anglo-protestant will was thought to be under *external* threat by the racialized "other", and confronted with an *internal* biological threat from the potential of addiction to substances like opium which was thought to compromise one's moral purity and the sanctity of the body (Razack, 2015). Thus, widespread enforcement of prohibition on drug importation,

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[28] See Oviedo-Joekes, et al., (2008) for a description of the North American Opiate Medication Initiative, North America's first trial study into heroin-assisted treatment operated out of the Crosstown Clinic in Vancouver's "DTES".

trafficking, possession, and personal use was viewed as a necessary step for the government to take in order to preserve the souls of its citizens.

Myths about the morally corrupting nature of illicit substances drive our cultural understanding of drug use as a threat to moral order and help us ignore the shortcomings of prohibition. Boyd and Carter (2010) argue that “drug scares”—sensationalist media representations that construct the use of particular substances (e.g., methamphetamine) in particular times (e.g., “the mental health crisis”) as emblematic of the violence, moral decay, and social problems in modern society—have roots in North America’s anti-drug movements which stressed temperance and prohibition. Canada has experienced a number of drug scares, starting with the dramatic media accounts of the problems attributed to sale and use of opium the 1920’s that described “dangerous Chinese traffickers who sought to seduce and corrupt innocent White Christian people” (Boyd and Carter, 2010; p. 42). In the 1950’s another drug scare took hold, with moral panic surrounding the “epidemic of youthful heroin use” in east Vancouver. Fear about illicit drugs reached its fever pitch in North America in the 1960’s, when widespread assumptions about the links between LSD, cannabis use, and madness permeated popular culture. This led Canada to introduce its new federal *Narcotic Control Act (1961),* which stepped up the severity of criminal sanctions for trafficking and personal possession. Under the new law maximum prison sentences for drug offenses increased from 14 to 25 years (Office of the Provincial Health Officer, 2018).

The decade before Vancouver’s “mental health crisis” brought with it a new drug scare in the “epidemic of methamphetamine use” which was the subject of extensive local media reporting (Boyd and Carter, 2010; pp. 224-226). Methamphetamine use, especially when the user was thought to have a pre-existing mental health disorder, is said to produce dangerous results. VPD reports offer a glimpse into this discursive connection between methamphetamine use, concurrent disordering, and dangerousness. Noting that hospitalization rates for “amphetamine-induced psychosis” have been dramatically rising since 2010, one text blames “the increased availability and affordability of crystal meth on the street, and an increase in the toxicity of marijuana” (VPD, 2016; p. 35). The document goes on to note that despite putting significant training resources into educating officers about how to manage people with mental

illness, “the complicating factor of a drug-induced psychosis creates additional risk and uncertainty for all involved” (p. 35).

As we can see through a dive into Canada’s history of drug policy, Vancouver’s “DTES” has been consistently constructed as a spatial symbol for drug scares and crisis points. Reflecting on Rob Nixon’s (2011) concept of “slow violence[29]”, Van Veen, Teghtsoonian, and Morrow (2019) question the representation of the “mental health crisis” in the mid-2010’s, or the HIV and overdose crisis declared by the Vancouver Richmond Health Board of the 1990’s as temporally confined, and instead “suggest that the chronology of the neighbourhood reveals not a series of separate and distinct “crises”, but rather a monotonous and continuous history of slow violence experienced by the population that inhabits its streets and single-room occupancy hotels” (p. 66). Historical representations of the criminal problems of drug use have obscured prohibition’s intersection with poverty, colonization, racism, and police violence that many people diagnosed with “SAMI” struggle within their daily lives.

Given that BC has now been in a new state of emergency related to high rates of overdose mortality associated with extreme illicit drug toxicity since fentanyl was introduced as a contaminant in the local drug market in the mid-2016, it is remarkable how police and government policy texts focusing on mental health *and* addiction fail to problematize drug prohibition itself as contributing to the situation. Without problematizing criminalization, the documents avoid a tough but critical conversation about how “prohibition and punitive-based drug policy magnify harms associated with substance possession, such as communicable disease transmission, increased stigmatization of people who use drugs, and increase drug-related mortality, while having little impact on reducing drug use rates” (Office of the Provincial Health Officer, 2018; p. 22). This also leaves scant possibility for viewing prohibition as *war on people* who use (some) drugs, arbitrarily criminalizing those who use certain substances (e.g., opioids, cocaine, and/or methamphetamine) but not others (e.g., alcohol).

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[29] Nixon (2011) describes “slow violence” as “a violence that occurs gradually and out of sight, a violence of delayed destruction that is dispersed across time and space, an attritional violence that is typically not viewed as violence at all” (p. 2; Cited in Van Veen, Teghtsoonian, and Morrow, 2019)

Chapter 7.

What is Left Unproblematic in the "Mental Health Crisis?"

This chapter applies the fourth question that I have adapted from Bacchi's (2009) WPR approach to texts, asking *what is left as unproblematic in documents*? Answering this required close reading with an eye to uncovering silences, those things which largely escape problematization in the texts. In particular, this chapter illustrates that the colonization, poverty, intense healthcare surveillance, and policing practices that disproportionately target people with "SAMI" are absent, dismissed, or marginalized in discussions surrounding the "crisis". Implicit in this research question is the possibility that there are alternative ways of understanding mental distress. Illuminating silences in the texts helps to challenge the normative hierarchies established around what problems are thought to be causes of the "crisis", and whose knowledge or technical "expertise" counts in constructing them.

For instance, while psychiatry represents the "crisis" as a problem of broken brains inside pathologized individuals, and security discourse represents "untreated SAMI" as a threat to the broader population living in the city, others might contest these representations by re-problematizing the politics of the present to consider the roles that income inequity, inadequate living conditions, ongoing settler colonization, and/or a failed war on (some) drugs play in creating and sustaining mental distress. By drawing attention to these silences, this chapter advances the shared goal of the emerging field of Canadian mad studies, "in which the medical model is dispensed with as biologically reductionist whilst alternative forms of helping people experiencing mental anguish are based on humanitarian, holistic perspectives where people are not reduced to symptoms but understood within the social and economic context of the society in which they live" (Menzies, et al., 2013; p. 2).

7.1. Poverty

Over the past two decades, Vancouver has gained notoriety for its extreme income inequality and housing unaffordability. Although much public attention and urban planning effort has focused on the role of city's real estate and rental housing prices—which are vastly out of touch, even for people with middle class incomes—in producing precarious economic conditions for residents, the city also has significant income inequalities. In 2013, a year before the *Caring for All* (City of Vancouver, 2014) was published, a municipal planning report estimated that 21% of its residents could be considered as "low income"[30]. The material conditions for people living in the "DTES" are particularly stark: 53% of residents are low income, making it one of the most impoverished urban areas in the country.

When the *Caring for All* (City of Vancouver, 2014) report references poverty in the "DTES", it is thought to add "an additional layer of stigma to mental health and addictions", rather than being a cause of mental distress and substance use. This makes urgent the need to address the *stigma* associated with poverty, but not necessarily poverty itself. Similarly, the VPD *Beyond Lost in Transition* (2010) report nods to material deprivation where it suggests that more supportive housing is needed, but avoids the topic of income assistance or wealth inequality. This apolitical lack of representing poverty as a productive force of mental distress, substance use, and/or homelessness is present across documents from the VPD and municipality despite well publicized local activist concerns[31] about rapid gentrification of the "DTES" brought about from the emergence of new "legitimate businesses", high-priced market condominium developments, and land use plans that cater to the wills, tastes, and desires of middle-class residents. It also ignores the fact that during the time when the documents were published, rates of income assistance (including the portion of income assistance the province earmarks for housing costs, one's "shelter allowance") had not been raised in

[30] The municipal government uses the after-tax low income cut off (LICO) to measure poverty. The LICO is a "relative measure identifying families or individuals who spend 20 percentage points more than average on a basket of basic household goods" (City of Vancouver, 2013; p. 11).

[31] See, for example, Pedersen and Swanson (2010) Assets to Action: Community Vision for Change in Vancouver's Downtown Eastside. Carnegie Community Action Project.

over a decade despite out-of-control inflation occurring in the local housing market over the same period.

Perhaps the lack of commitment to ending poverty on the part of the municipality could be explained by the fact that in Canada local governments have few policy levers or revenue generating capacities to meaningfully reduce it. While municipal decisions regarding land use zoning, accessibility, and affordability of core public services like libraries and community centres, and childcare services all play important material roles in quality of life, it is largely the responsibility of the provincial government to determine the rates and re-distribution priorities of income and sales taxes. Other policy areas, such as minimum wage, and core operating funding for childcare, transportation, and education, also fall under the purview of the province rather than local governments. At the time when the texts on the “crisis” were published, many important forms of income and social supports had been eroded by the governing BC Liberal Party which enacted deep cuts to health and social programs. These austerity measures were made under a neoliberal policy rationality that sought to responsibilize British Columbians to take care of themselves rather than rely on the state for assistance (Teghtsoonian, 2009). The impacts of these cuts have been particularly hard felt by psychiatrized people due to their multiple barriers to securing traditional forms of paid employment and the bureaucratic hoops they must jump through in order access scarce employment supports or disability benefits (Morrow, et al., 2009).

As the decade passed into the early 2010’s, the neoliberal aspiration to produce a population capable of taking care of itself through labour market participation remained largely unrealized. Prominent BC political economists note that “the decline in social welfare is a result of decisive government policy (both federal and provincial) that affected not only public support for the general population and those in poverty, but also lessened the ability for the substantial portion of the population to stay out of poverty through paid work” (Griffin, Cohen and Klein, 2011; p. 61). The first in the series of reports published by the VPD acknowledges that many low-income people in the “DTES” are unable to find employment, noting that many residents have “mental health issues, drug addiction, or developmental problems such as Fetal Alcohol Syndrome” in addition to “a low level of education, and few skills” (VPD, 2009; p. 18), which makes finding and keeping a job challenging. This characterization positions the pathologies of individuals

as the most significant barriers to realizing the kind of economic autonomy that “healthy” residents are assumed to enjoy.

While the *Caring for All* (City of Vancouver, 2014) report once concedes that poverty plays a contextual role in the “crisis”, documents from the VPD rarely mention income insecurity or any form of material deprivation at all, save for “poor conditions” in public and private single-room occupancy housing stock. The subjects of focus in the VPD documents are not “poor individuals” or “people living in poverty”; instead, they are simply “poorly served” by psychiatric services. Where housing is mentioned in texts from police it is often in recommendations to increase additional supportive housing units, with the important caveat that they must come with funding for “on-site medical staff” (VPD, 2013; p. 32). The municipal government’s *Caring for All* (2014) report, referencing the Hotel Study (Villa-Rodriguez, et al., 2013), similarly notes that the roughly 2000 people living in “DTES” single room occupancy hotels are not getting adequate treatment, which has led to “greater than expected rates of mortality, and a prevalence of multiple issues, including substance dependence, mental illness, brain injury, and infectious diseases were common amongst the [Hotel Study's] 293 study participants” (p. 8). Income inequality, stagnant and inadequate rates of income assistance, and a lack of affordable rental housing for those who do not want or need supportive housing are rarely referenced as determinants of this poor health of the population.

Documents from the province also put the onus on the medical system to improve the lives of people with “SAMI” through better and earlier interventions, noting that that people with SAMI “suffer from chronic, disabling poly-substance use, and often severe mental illnesses”, rely on “crisis and emergency services”, and “have frequent criminal justice involvement” (Ministry of Health, 2013; p. 2; citing Hay and Krausz, 2009). This is consistent with broader mental health reforms in the province at the time that limited what constituted “mental health care” to clinical assessments, diagnosis, psychopharmacological treatment, and emergency crisis management, rather than taking a broader aim to improve social and income supports (Morrow, Frischmuth, and Johnston, 2006). Individuals constructed as having the most severe forms of “SAMI” are assumed to be particularly unable to self-manage their illnesses, never mind find employment or market housing, and therefore are said to “require long-term high-intensity care in the community or permanent hospitalization” (p. 5).

Poor housing conditions and homelessness are problematized less in terms of their impacts on mental health, and more for the challenges they create for the efficient delivery of psychiatric services. The poverty and income inequality that many local activists cite as the cause for so much suffering in the “DTES” are notably absent from these accounts of the “mental health crisis” which put primary emphasis on psychiatric treatment gaps. This is particularly evident where the VPD’s list the “problems” thought to be contributing to the situation:

> the lives of many of the people residing in Vancouver’s Downtown Eastside (DTES) are negatively affected by mental health issues, illicit and licit substance abuse, drug trafficking, alcoholism, physical health issues like HIV and Hepatitis C infections, substandard and insufficient housing, illegitimate businesses, crime and public disorder, an entrenched survival sex trade, and a historical reduction in police presence (VPD, 2009; p. 2).

Notably silent in this account is the ways in which poverty intersects with and contributes to the survival sex trade, housing instability and affordability, property crime, substance use, and mental health struggles. This omission is extraordinary given that the texts were produced in time when knowledge regarding the importance of the “social determinants of health (SDOH)” proliferated in public health and social policy literature. The World Health Organization’s Commission on SDOH was very active in the mid-to-late 2000’s, producing a vast literature that illustrates the significant role that poverty plays in population health outcomes across a range of domains (CSDH, 2008).

Where poverty is referenced in documents on the “crisis”, it is not constructed as a SDOH, but rather as a problem of individual failures to find footing in labour market participation. For example, the VPD’s Project Lockstep (2009) report notes that many people with untreated “SAMI” who reside in the “DTES” “often fail to find and maintain employment, and thus most live below the poverty line”, and therefore turn to crime to “support their addictions” (6). Consistent with the insistence that people with “SAMI” are mentally incompetent and unable to care for themselves, their individual failings are used to explain why they so frequently end up in poverty.

7.2. The Colonial Context

The role that ongoing settler colonialism plays in producing mental, emotional, and spiritual distress amongst Indigenous people living in the "DTES" is also discursively inaudible across the texts. While the documents acknowledge that the "mental health crisis" has a disproportionate impact on Indigenous people, decolonization or reconciliation are not put forward as recommended "solutions" because colonization is never called into question. In this section I examine how this silence undermines the potential for a conversation about the role of the settler colonial city in producing many of the problems—e.g., mental distress, homelessness, substance use—represented to intersect as an episodic "crisis". I also argue that the silence surrounding the roles that psychiatry and police have played as colonial instruments in BC's history, leads to "solutions" (e.g., closer monitoring of Indigenous bodies by ACT teams and police) that run the risk of undermining important efforts that the healthcare system must take towards creating culturally safe, trauma-informed services for Indigenous peoples.

The Red Women Rising report, a document that presents qualitative findings from a participatory action research project with Indigenous women on the "DTES", describes settler colonialism as:

> an ongoing structural project designed for settlers to permanently occupy and assert sovereignty over diverse Indigenous nations through the imposition of foreign government and legal systems… [e]stablishing jurisdiction over Indigenous lands can only be accomplished through the dismantling of Indigenous nationhood and elimination of Indigenous people through genocide, dispossession, and assimilation (Martin and Walia, 2019; p. 59).

Critical scholars have remarked on how much of the research literature and state produced accounts of the "problems" associated with the "DTES" has obscured or ignored these processes of on-going colonial dispossession that have pushed so many Indigenous people to migrate to the materially impoverished conditions of Vancouver's inner-city (Blomley, 2004).

Psy discourse which represents the "mental health crisis" as a problem of poor biogenetic health reproduces this pattern of silence regarding Vancouver's colonial context. Many of the documents assume that psychiatric care is the most important intervention for both Indigenous people and settlers caught up in the "crisis". The way

the texts position psychiatry as a benevolent science ignores the significant role it has played BC's colonial history. Critical mental health scholars have illustrated how pathologizing mental distress has been central to enacting processes of racism, sexism, and colonization in Canada and around the globe (Ibrahim and Morrow, 2015; Joseph, 2019; Morrow and Malcoe, 2017; Van Veen, Ibrahim, and Morrow, 2018; Menzies, 1999). Van Veen, Ibrahim, and Morrow (2018) argue that intersecting and contingent "colonialist, racist, and sexist beliefs and structures are woven intricately into the very understanding of what constitutes sanity or insanity" (p. 247), and that throughout BC's history the psychiatric gaze has routinely fixed itself on disciplining and dividing the Indigenous "other".

Perhaps nowhere was the intersection of colonization and psychiatry clearer than in the disproportionate confinement of Indigenous people, especially Indigenous men, in the province's large mental hospitals like Woodlands and Colquitz throughout the twentieth century. These asylums were intended to remove psychiatric patients from the general population and impose order on their bodies through custodial care. BC's asylums also enacted racialized dividing practices *within* their walls through the segregation of Indigenous patients from the general patient population—a technique thought necessary to preserve the racial purity of their Anglo-European patient counterparts (Menzies, 1999).

Reflecting on the practices of medical colonialism in BC's early days of institutionalization at the Woodlands school, Roman, et al, (2009) argue that

> administrators and medical authorities articulated their metropolitan knowledge of coming from and living within the metropolitan urban cities of their former empire, the United Kingdom, in the mutual constitution of the colonized and the colonizer, medical authority and patient cum inmate, the social construction of the so-called 'fit' and 'unfit,' the medicalized colonizing of lands, peoples, bodies, and minds (p. 19).

When Indigenous people resisted medicalization and fled confinement from these hospitals in attempt to return to their rural communities, it sometimes ended in deaths from exposure to BC's harsh winter weather (Menzies and Palys, 2006). The great physical risks that these Indigenous people took to evade the psychiatric gaze reveals tremendous efforts to resist dominant medical discourse in search of culture, wellness, and belonging on their traditional lands.

Despite an increasingly widespread acknowledgement of the damages that BC's colonial history has inflicted on Indigenous peoples, documents on the "crisis" silence the connection between this colonial past and the "DTES"' present. Although Indigenous people represent about 2% of Vancouver's overall population, they account for 40% of its homeless population, reflecting stark racialized inequities in housing status and income distribution (Lupick, 2018). Indigenous people are occasionally referred to as "marginalized" in the texts, which leaves some room for acknowledgement that racism and colonization might contribute to this overrepresentation. However, the processes that produce "marginalization" and the racism at their roots remains elusive. Marginalization is referenced vaguely, alongside statistical calculations of Indigenous people's rates of disease and criminal justice involvement.

In its description of the "problems" confronting Indigenous people in the "DTES", the VPD's *Project Lockstep* (2009) report lists high poverty rates amongst "aboriginal (sic) children" in the neighbourhood, and disproportionate rates of homelessness amongst Indigenous adults. It goes on to note that from the observations of (mostly white settler male) police officers "Aboriginal women make up the majority of sex trade workers", many of whom "are infected with HIV/AIDS and in fact have been displaced from their communities due to a lack of acceptance regarding the diagnosis" (p. 27). The report constructs Indigenous people as less responsible in their drug use and sexual behaviours—e.g., non-condom use and needle sharing—compared to their Caucasian counterparts, a neoliberal way to rationalize their disproportionately high rates of infection from communicable diseases. This account also blames Indigenous people's communities of origin for not accepting them to return home, a situation which leaves the "DTES" as a last refuge. While the documents occasionally reference impacts of material deprivation on Indigenous children in Vancouver, no attempts are made to connect racism and colonization to the poverty experienced by their parents.

Key to maintaining this silence regarding colonization is the healthification of Indigenous people's struggles in the inner city. This is present in the repetitive summaries of their high population-prevalence of substance use disorders, mental health disorders, and rates of communicable diseases like HIV and Hepatitis C. In one description of the geographical distribution of people with "untreated SAMI", the province notes that in Vancouver "urban Aboriginal populations are particularly overrepresented…, being estimated to make up approximately 20 percent of the SAMI

population" (BC Ministry of Health, 2013; p. 7). The *At Home Study Final Report* similarly notes that 15% of the roughly 500 study participants were Indigenous (Currie, et al., 2014), and a VPD text makes an anecdotal observation that of the 1,000 to 1,500 sex trade workers estimated to be active in the city/"DTES", 70% are Aboriginal women, and most "regularly use drugs" (VPD, 2009; p. 25).

This narrow emphasis on the poor health outcomes of Indigenous residents in the urban core positions the institutions of the settler state as failing only in their mandate to provide adequate clinical prevention services. This begs for relatively simple solutions: more and better *healthcare* programs delivered by psychiatrists and addictions physicians to keep Indigenous people healthy and out of trouble. Absent from the problematization of a lack psychiatry and primary care for Indigenous people is a discussion about the routine racism experienced by Indigenous people in their interactions with state agencies, including health authorities. Experiences of racism are particularly routine when Indigenous people attempt to access healthcare. A recent independent review indicated "wide-spread systemic racism against Indigenous people" exists across BC's healthcare system, including in urban hospitals in Vancouver (Turpel-Lafond, 2020). Anti-indigenous racism experienced in Vancouver's hospitals and community clinics often leads Indigenous people to disengage from the healthcare system and/or feel a great sense of apprehension when needing to seek care in the future (Goodman, et al., 2017).

Although the VPD reports acknowledge that there are structural factors which contribute to poor health outcomes for Indigenous people—e.g., "up to 80% of aboriginal (sic) children in the DTES live in poverty", and "aboriginals (sic) constitute 34% of the homeless population in Vancouver and most live in the DTES" (VPD, 2009; p. 27)—there is an ahistoricism in the way the settler colonial city and intergenerational trauma are never considered for their roles in producing these outcomes. Losman (2019) describes the settler colonial city as "a place in which the respectable, civilized public (the sane, the white, the affluent) maintain dominance over uncivilized, degenerate "Others" (the Mad, the racialized, the Indigenous, and the poor)" (p. 333).

Not only do the deficit-focused summaries of the pathologies present within Indigenous individuals reinforce the "othering" that Vancouver's colonial project relies upon, but it also closes off a discussion about the value that Indigenous cultural

practices and community can provide as “solutions” to suffering. This is surprising given the fact that in the “DTES” community has produced some of the most innovative and successful urban Indigenous peer-to-peer support services in the country through organizations like the Western Aboriginal Harm Reduction Society (Goodman, et al, 2017; Goodman, et al., 2018), and PHS Community Services Society’s Culture Saves Lives[32] program. The diverse forms of cultural healing practices present in BC’s many First Nations’ cultures are also almost never summoned as potential “solutions” to the “crisis” because its “problems” are said to be located in individual minds and bodies—sites the documents construct as the terrain of biomedicine.

The absence of “solutions” that focus on cultural safety, and cultural healing and wellness practices is particularly notable in texts from the police. This can perhaps be explained by the fact that the VPD’s efforts at stakeholder consultation in drafting its policy documents appears to have left out Indigenous voices. In the spirit of promoting the kind of “cross-sectoral collaboration” thought necessary to solve the “crisis”, the VPD’s *Mental Health Strategy* (2016) notes that “input was received from numerous stakeholders and partner organizations, including Vancouver Coastal Health, the Canadian Mental Health Association, the City of Vancouver, and mental health professionals from St. Paul’s Hospital, Vancouver General Hospital, and UBC Psychiatry” (p. 5). Notice that missing from this list are not only representatives from local First Nations, but also prominent Indigenous leaders and elders from important organizations like the Metro Vancouver Aboriginal Executive Council. The VPD’s *Lost in Transition* (2008) report, which set the stage for the declaration of the “crisis”, barely acknowledges the existence of Indigenous peoples, despite their significant over-representation in the “DTES” and the fact that the city sits on the unceded and occupied territories of the Musqueam, Squamish, and Tsleil-Waututh First Nations.

Although the colonial context is rarely acknowledged by the province or police, documents from the city offer a glimpse into efforts to problematize the situation slightly differently. The *Caring for All* report (City of Vancouver, 2014) offers evidence that the discursive shackles of dominant biomedical accounts of “mental illness” and its

[32] Culture Saves Lives is a program operated in the “DTES” by the PHS Community Services Society which “combines culture and harm reduction” in order to “address the need for cultural and spiritual care, reconnecting or helping people to connect for the first time to traditional, spiritual, and cultural practices” (see: https://www.phs.ca/our-services/culture-saves-lives/)

treatment are occasionally shed. For example, it notes that for “Aboriginal Peoples, including youth, connection to culture as a sense of identity and a source of pride is fundamental to wellness… [b]eing re-united with culture plays a significant role in healing and wellness and needs to be recognized along with the western model of health care” (p. 32). It recommends that more cultural safety programs should be integrated into “formal health care” environments, which infers that a lack of cultural safety came up in the task force proceedings. No doubt this demand for recognition of the central role of culture in healing is partly explained by the more inclusive efforts made by the municipal government to engage Indigenous people and organizations throughout the policy making process.

Unlike the police reports, Indigenous voices are audible in *Caring for All*’s (City of Vancouver, 2014) recommendations for resolving the crisis, where one of the six main “action areas” makes an explicit commitment on the part of the municipality to “focus on wellness for Aboriginal peoples”. This recommendation comes with a pledge to create a municipal “Aboriginal Healing and Wellness Strategy” (p. 14), which would entail “convening an advisory group of partners to create concepts of Aboriginal healing and wellness centres in Vancouver” (p. 14). Breaking from the dominant biomedical discourse that permeate the documents from the police department and provincial government, the municipal government report also highlights that “healing through the arts, including carving, music, theatre and dance [should be] integrated into recovery and wellness” and even recommends that Indigenous elders ought to play a role in the delivery of “formal and informal health care” (City of Vancouver, 2014; p. 31).

These recommendations suggests that Indigenous stakeholders at the Mayor’s Taskforce found some success in contextualizing the “problems” of the “mental health crisis” within the broader ongoing settler colonial project. Moreover, the municipal government’s formal commitment to implement the report’s recommendations makes an ongoing conversation about the role of colonization as a social determinant of health[33] possible. However, when read alongside the more specific “evidence-based” biomedical recommendations under the report’s “working better together” and “enhance addictions knowledge” goal areas, it is clear that the discursive space surrounding the “crisis”

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[33] See Czyzewski’s (2011) call on critical public health policy workers to approach on-going settler colonialism as a distal determinant of health for Indigenous peoples in Canada.

remains constrained. Van Veen, Teghtsoonian, and Morrow (2019) note that the report's epistemological partiality towards biomedicine is still evident "where the document lists health authorities, government ministries, non-profit agencies, policy and researchers as *partners* in the task force, while Aboriginal leaders and people with lived experience are there to provide *input*" (p. 72; emphasis in the original). This demotion serves to subtly subjugate cultural and/or experiential knowledge in the truth games surrounding the "crisis".

7.3. The Disciplinary Power of Policing

The next significant silence is found in how the texts represent police officers as occupying therapeutic roles in the treatment of mental illness. This characterization is frequently made without acknowledgement of the coercion and violence that policing practice can entail, particularly in upholding the front lines of Canada's war on drugs, which some have more accurately reframed as "a war against people who use drugs" (Merkinaite, 2012). The disciplinary power of policing is also evident, but absent from texts from the municipality and province, in the consistent pattern of troubling events of police killings of people in mental distress in Canada. These incidents have led to activist calls for new forms of mental health crisis response that do not involve officers. Where the issue of police violence is found in documents from the VPD, it is discursively constructed as "victim-initiated homicide", or what some call "suicide by cop": the supposedly unavoidable result of violent, threatening behaviours of people with mental illness. Police error, or willingness to engage people with violence without first exhausting every method of de-escalation first, is never problematized.

In some respects, the new alliances formed between policing and mental health care forged under a neoliberal rationality in the documents. This is the case where the VPD reports construct mental illness and addiction as threats to the security of the city and local economy that can be fixed by responsibilizing people to seek out psychiatric treatment. However, the documents also reveal a contradictory commitment to disciplinary techniques of power. Foucault (1980) describes disciplinary power as that which is exercised through practices that continuously observe people or populations in order to produce "docile bodies" that can easily be controlled. Disciplinary power is present where police on ACT teams use surveillance technologies like the "early warning system" which uses an algorithm drawing from police logged "incidents involving a

‘mental health factor’” in order to “identify clients at risk” and wage interventions before a violent or mental health decompensation event occurs (VPD, 2016; p. 9). It is also present when ACT patients, aware that their medication administration records are being fastidiously monitored by clinicians, might comply with mandatory psychopharmacological treatments rather than risk being returned to the hospital under police escort. These disciplinary practices differ from neoliberal technologies like motivational interviewing, which seeks to "govern from a distance” by shaping the conduct psychiatric subjects through fostering in them an *internal* drive to comply with psychiatric treatment in the absence of external threats.

The VPD note that key to implementing disciplinary surveillance tools successfully is more collaboration: “[d]eveloping an information sharing agreement and formalized discharge agreements between police and health, enabling the exchange of critical client information between the two organizations to facilitate proper care for each individual client” (p. 9). The notion that proper care requires police to have access to private electronic health records leaves unproblematic significant privacy issues and the potentially traumatic effect that including police in the delivery of care might produce. Given the central function police have played in BC’s colonial history, in the management of all things viewed undesirable about urban life (e.g., bylaw infractions like illegal street vending and homeless encampments, noise complaints, public intoxication, etc.), and in waging the war on people who use (some) drugs, the fact that many psychiatrized people view police as a violent threat should not be surprising; and yet, the very notion that police presence on healthcare teams might be met with fear from patients is never considered. Instead, the documents frequently position police as caring professionals with admirable intentions to improve health services and maintain public safety.

I have argued throughout this dissertation that the war on people who use (some) drugs in North America has inflicted widespread harm, however its tactics particularly target Black, Indigenous, and people of colour (Dasgupta, Beletsky, and Ciccarone, 2018; Khenti, 2014; Earp, et al., 2021). The fact that maintaining prohibition requires day-to-day conflict between police and people who use or traffic illicit substances is obscured partly because the VPD enjoy a progressive reputation when it comes to drug policy. The department charges far fewer people with simple possession than other municipal police forces in North America. However, a recent look at the charges VPD

officers recommended for prosecution since 2014 reveals that Black and Indigenous people represented 6.4 per cent and 18 per cent of cases, despite only accounting for 1 and 2.2 per cent of the city's overall population (Fumano, 2020). The way texts on the "crisis" omit racialized local enforcement of drug laws prevents an important conversation about health equity and social justice in a time when there are widespread calls for police reform under the Black Lives Matter movement.

It would be redundant to offer an account of the commonplace actions police take to maintain drug prohibition in Vancouver, or the complaints regarding police violence from people who struggle with mental illness, substance use, and/or participation in criminalized sex work. Many local advocates, like PIVOT Legal Society[34], and criminologists are adept at documenting and intervening in these cases. Instead, following Lemke (2002), my effort "not only concentrates on the mechanisms of the legitimization of domination or the masking of violence, but focuses on the knowledge that is part of the practices, the systemization and 'rationalization' of a pragmatics of guidance" (p. 55). Nowhere is police violence against psychiatrized bodies rationalized more clearly than in the VPD's guidelines for officers who encounter people in mental distress.

Texts produced by the police department consistently reference the failures of psychiatric practices, reasoning that the mental health system is unequipped to prevent serious incidents involving people in distress, and that physicians are too cautious in their use of the disciplinary technologies available under the BCMHA. The documents also describe de-institutionalization as a failure and assume that more options for custodial care are needed for "severe" cases of mental illness. However, the possibility that policing *itself* could be contributing to the "crisis" is rarely considered. This is evident where one VPD report notes that: "[h]alf of all police-involved fatal shootings in the City of Vancouver since 1980 involved some sort of mental illness or depression on the part of the deceased person; this is the most tragic and extreme manifestations of a mental health system that is failing" (VPD, 2008; p. 53). The fact that calls to emergency services regarding people in mental distress who need care occasionally end in

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[34] See, for example: Pivot Legal Society (2018). Project inclusion: confronting anti-homelessness and anti-substance user stigma in British Columbia. Accessed at URL: https://www.pivotlegal.org/project_inclusion_full

spectacular outbursts of police violence is not problematized; rather, the healthcare system is to blame for these deaths.

The possibility of police violence, either intentional or in error, against innocent people is never referenced. However, we can glean more about how the department conceives of police violence in a report prepared for the Mental Health and the Law Advisory Committee of the Mental Health Commission of Canada (Mental Health Commission of Canada, 2015). The report presents findings of a review into policing policy and practice regarding interactions with people experiencing mental distress, concluding with several recommendations aimed at improving outcomes. Its summary of the VPD's "Crisis Intervention Training" curriculum tells us more about the conceptual premises present in the department's understanding of mental illness. Below is a list of the topics covered in the courses:

- **Mood Disorders:** An overview of mental illness and its impact on society; Living with mental illness – the person, their family, friends and community; and specific focus on bipolar disorder;
- **Depression, suicide:** An overview of depression and suicide risk; Overview of suicide intervention strategies for police officers; and awareness of depression and suicide risk for yourself, family and friends;
- **Early psychosis intervention and schizophrenia:** An overview of signs and symptoms of early psychosis, and focus on early intervention; community resources in Vancouver; and specific focus on schizophrenia, including a presentation from the BC Schizophrenia Society;
- **Critical incidents, post-traumatic stress disorder (PTSD) and self-care of the officer:** An overview of critical incidents and post-traumatic stress disorder (PTSD); with a specific focus on officer 'self-care';
- **Geriatric mental health:** Goal to increase awareness of the most common psychiatric illnesses of the older person; An overview of basic tools to assess cognitive function and risk in the elderly and services available in Vancouver for older adults with psychiatric illness;
- **Developmental disabilities:** An overview of mental illness and developmental disabilities; Specific focus on impact on behavior, learning, and presence of mental health illness; and management and treatment of offenders with developmental disabilities;
- **Police tactical considerations:** Assessing the situation and scene with a person in crisis; and review of tactical options for police officers;

- **Drugs and psychosis:** An overview of drug use, drug-induced psychosis, drug use and mental illness; Impact of drug use on the body – duration, physiological effect; and specific focus on crystal methamphetamine, cocaine and cannabis;
- **Victim-initiated homicide:** An overview of ‘suicide by cop’ (SBC) and preparation for the officer before, during and after a SBC encounter; and
- **Crisis intervention with a psychologist:** Focus on communication theory and strategies for first responders and practical application through role-play(s).[35]

The VPD’s *Lost in Transition* report (2008) briefly references the training course, noting that its high-level goal is to “educate participants about services available in Vancouver for this clientele and how to access these services” (p. 28). Consistent with the VPD text’s characterization of the biogenetic origins of mental distress, the curriculum educates officers to understand that mental distress is the result of the schizophrenia, mood disorders, drug induced psychosis, developmental disabilities, and suicidality that exist *inside* the brains of dangerous, “sick” individuals. This characterization can carry life and death consequences for psychiatrized people during encounters with police.

Although none of the documents on the crisis problematize the impacts of police violence on people who struggle with mental health, the VPD’s internal training module anticipates that extreme violence is the inevitable end to the lives of some people with “SAMI”. One course is intended to prepare officers for “before, during and after” expected incidents of “suicide by cop”. Although presumably the “police tactical considerations” module offers guidance on how to avoid firearms discharges through the use of less lethal force like beanbag guns and tasers, the curriculum assumes that any police involved killing of someone with mental illness is the result of deliberate self-harm, what police dub “victim-initiated homicide” (VPD, 2008; p. 28). This silences the consideration that police occasionally use violence when it is not required—for it is the “victim”, overtaken by all their irrationality and severe disease, who “initiates” the violent encounter and therefore is responsible for its inevitable outcome: their own death.

The silence surrounding police violence is surprising given that several well-publicized cases involving questionable police killings of people in mental distress

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[35] Adapted, but reformatted from Mental Health Commission of Canada (2015) page 19-20.

occurred around Vancouver in the years surrounding the "crisis", triggering widespread public debate about use of force. In 2007 Robert Dziekański, a man in the process of immigrating to Canada from Poland, was killed by police after being found to be in mental distress at the Vancouver International Airport. An inquiry into Mr. Dziekański's killing concluded that police were not justified in their use of force and that the four officers involved in the incident misrepresented their actions in subsequent court proceedings (CBC, 2010).

The case of Phuong Na (Tony) Du provides another high-profile example of a "victim-initiated homicide" that occurred in Vancouver during the timeframe coinciding with the publication of texts on the "crisis". Mr. Du was shot and killed by members of the VPD in November of 2014, roughly two months after the City of Vancouver's *Caring for All* (2014) report was published. Mr. Du had been approached by officers as he was swinging around a piece of wood in the middle of the street while in mental distress. As he advanced towards the officers on the scene, Mr. Du was shot and killed (Crawford, 2018). Later, a BC Coroner's inquest into the incident released 29 recommendations to prevent future police shootings during mental health crisis calls (Ministry of Public Safety and Solicitor General, 2018), including that:

> The VPD:
>
> - Develop mental health de-escalation training scenarios which incorporate obstacles that make verbal communication impractical, such as hearing impairment, loud environments or language barriers;
>
> That all police agencies in BC:
>
> - Explore creating an early warning system in their jurisdiction, akin to the already established Vancouver Police Department's Early Warning System (EWS), incorporating police and health data which identified persons living with severe mental illness and/or substance use who may be decompensating in the community and who are at the most risk to themselves or others;
> - Explore creating a mental health unit dedicated to tracking EWS persons identified in the Early Warning System in order to connect those persons with longer-term mental health solutions akin to the already established Vancouver Police Department's Assertive Outreach Team; and
> - Explore creating mutual information sharing agreements, akin to the mutual information sharing agreements already established between the Vancouver Police Department and Vancouver Coastal Health, to assist with the sharing of information and collaboration between police services and health authorities in

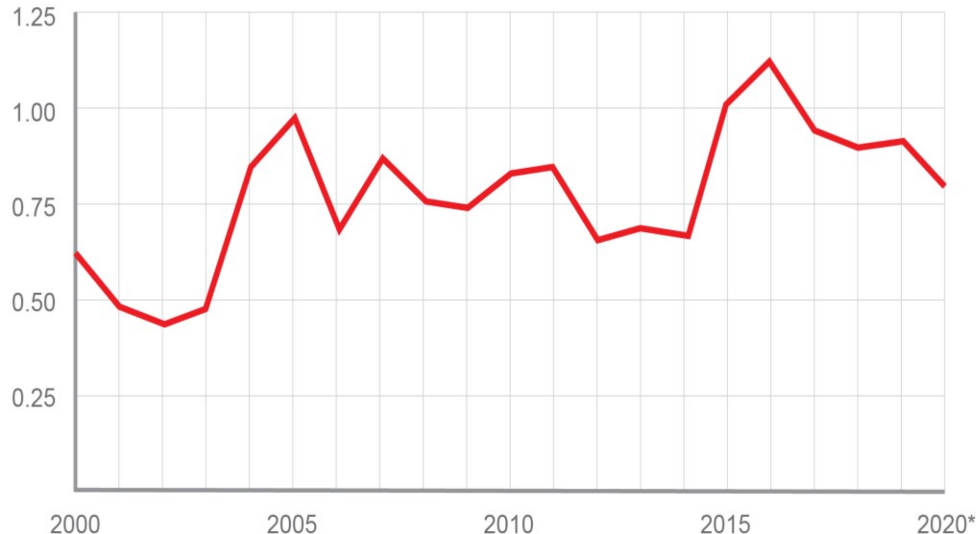
order to improve services for most at-risk persons living with severe mental illness and/or substance use; and

That the City of Vancouver:

- Prioritize increased funding to expand the scope, availability and training for police-based mental health intervention services presently delivered by Vancouver Police in conjunction with Vancouver Coastal Health (Crawford, 2018).

Despite the inquest's recommendations for improved joint service arrangements and de-escalation training for officers, there has been a steady upward trend in the percentage of police encounters that turn fatal across Canada in recent decades. The Canadian Broadcasting Corporation recently complied statistics demonstrating that from 2000-2020, the decades that corresponded with the "crisis", the number of people killed in police encounters per one million population almost doubled, even when considering population growth. They also reported that "mental health and substance use issues were present in the majority of the cases", that Indigenous peoples accounted for roughly 16 percent of the killings despite representing only about 4 percent of the overall population, and that Black people accounted for almost 9 percent of the killings yet only roughly 3 percent of the population (CBC News, July 2020). Table one illustrates the arch of this disturbing trend.

Table 1. Number of people killed in police encounters in Canada per 1 million population, 2000-June 2020 (CBC News, July 2020).



Police are trained to handle routine emergencies involving criminal behaviour (e.g., robberies, assaults) by exercising authority and when necessary, force. When this approach is applied to situations involving persons in mental distress, who might be better approached with compassion and de-escalation techniques, it increases the possibility of a violent outcome. To curb this trend, many citizens in Vancouver have followed movements in other North American cities to call on their City Council to cut the police budget and reinvest in "community-based harm reduction and safety services" (St. Denis, 2020). Supporters of the "defund the police" movement point to the presence of systemic racism in the force and call for a shift toward alternative approaches to community policing. Mental health activists also argue that when it comes to police shootings of people in distress, there is a silence that leaves little consideration for the possibility that "racism and *sanism* (or the presumed association of both Blackness and madness with violence) results in police pulling the trigger too quickly" (Zwarenstein, 2018; p. 47; emphasis added).

In addition to the disproportionate application of police violence on psychiatrized people, the fraught historical relationships between police and Indigenous peoples are also unconsidered in documents on the "crisis". Indigenous people are constructed as victims of an inadequate healthcare system, and police as well-meaning professionals stretched thin in their efforts to manage mental illness on the frontlines. The way the texts omit mention of the role police play in governing Indigenous bodies is significant, for Sherene Razack (2015) powerfully describes the deep colonial roots police have in the settler project in British Columbia:

> From its inception as a colonial police force, the Northwest Mounted Police, which would become the Royal Northwest Mounted Police (RCMP), assisted in securing the territory, ultimately transforming its largely military function into a domestic policing of the settler's town, a town surrounded by reserves. Colonial policing… persists into the present. Keeping order in public space still largely means non-Indigenous police controlling the movements of Indigenous peoples in city space… Colonial policing emerges from and maintains a colonial project (pp. 14-15).

Ignoring this history closes off the possibility of focusing recommendations on educating police about racism and their role in ongoing settler colonization[36]. It also fails to appreciate that for Indigenous people, police apprehension and confinement under the BCMHA may result in re-traumatizing experiences associated with negative interactions with other state apparatuses of colonial control, such as child protective services, the court and prison system, and/or residential school system—a dynamic that undermines reconciliation and BC's formal commitments to the United Nations Declaration on the Rights of Indigenous Peoples (United Nations General Assembly, 2007).

[36] For example, the Vancouver Coastal Health Authority has a staff training program that acknowledges that many Indigenous people "view institutions, such as hospitals, with mistrust and suspicion due to the history of colonization, including the Residential School System". The program offers education modules intended "to assist VCH to become a more culturally safe organization for Indigenous people accessing care" (VCH, 2019).

Chapter 8.

What Effects are Produced By These Representations of Vancouver's "Mental Health Crisis"?

8.1. Subjectification Effects, Lived Effects, and Discursive Effects

This chapter puts my fifth research question to work, asking: "*what effects are produced by these representations of the problems of the mental health crisis*?" Preceding chapters hinted that psy and security discourses found in the problem representations surrounding the "crisis" produced particular impacts, particularly through the creation of new regimes of care and control from "assertive" mental health interventions. However, to this point I have strained to avoid the normative impulse of positivist policy analysis, where health interventions are evaluated through attention to whether or not their outputs produce better or worse outcomes for target populations. This chapter offers a compromise between this evaluative impulse and the instinct to avoid normative claims in post structural policy analysis. It will help us understand how the problem representations surrounding the crisis "function to benefit some and harm others, and what can be done about this" (Bacchi, 2009a; p. 15).

This research question interrogates three interrelated effects produced by the problem representations surrounding the "crisis": *discursive effects; subjectification effects; and lived effects*. Discursive effects are those that "follow from the limits imposed on what can be thought and said" (Bacchi, 2009a; 15) in a given time and place, with a focus on the authoritative knowledges and "technical expertise" that shape epistemological boundaries. Subjectification effects are found in the way particular subjects are categorized (e.g., people with "SAMI", the "SAMI" population) and divided from others (e.g., the "low-risk lifestyle" population). Focusing on the subjectification effects in the texts helps to implicate policy making in the practice of "making up people" (Bacchi and Goodwin, 2016; Hacking, 2004). Finally, examining the lived effects of the problem representations makes it clear how certain assumptions in the documents (e.g., that people with "SAMI" represent a threat of random, indiscriminate violence) produce

harmful impacts on the lives of psychiatrized people (e.g., bodily confinement, compulsory medication adherence, and frequent, unwanted police contact).

Chapters four through seven already provided lengthy discussions on the discursive effects of the way in which the “mental health crisis” is problematized, arguing that psy and security discourses dominate the texts, while Indigenous ways of knowing and critics of psychiatric knowledge and the war on people who use (some) drugs are subjugated to the periphery or silenced all together. This discursive dynamic is perhaps most significant in texts produced by the police department which close off conversations that might build alternative understandings of mental distress which deviate from “expert” psychiatric knowledge regarding biogenetic mental illness and its treatments. I argued that lost in the psy accounts in the texts are the roles that policing, poverty, and colonization play in producing mental distress, violence, and poor health outcomes in the inner city. Therefore, this chapter will only focus on subjectification effects and lived effects and not risk repetition by revisiting the discussion on discursive ones.

8.2. Subjectification Effects

The term subjectification describes “the production, or *making*, of provisional ‘subjects’ of particular kinds through policy practices” (Bacchi and Goodwin, 2016; p. 49). Throughout the years surrounding the “crisis”, policy makers and researchers laboured to qualitatively define people with SAMI as a particularly sick, dangerous, and “difficult to treat” population. Parsing out the abnormalities of particular “clients” or “populations” in order to establish their characteristic undesirable difference from the general population is central to what Foucault (1982; p. 208) calls “dividing practices”. The power to divide is derived from authoritative knowledge like psychiatry, which takes as its raison d'être the classification of the normal functioning of minds and bodies while problematizing abnormal, pathological, and/or deviant ones (Bacchi and Goodwin, 2016). The dividing of people with dangerous, “untreated SAMI” from “good”, harmless psychiatric subjects that voluntary seek out care reinforces the association between violence and mental disorders, leading to dehumanization and identity violence for a population already subject to extreme forms of stigma and discrimination.

8.2.1. Concurrent Dangers

Just as people with “SAMI” are constructed as carriers of a double burden of disease (i.e., “concurrent disorders”), so too are they constituted as presenting concurrent threats to public safety. The first threat rests in the assumed association between violence and “untreated mental illness”, while the second follows from a more recent historical artifact wherein new formulations of methamphetamines introduced into the illicit drug market in Vancouver in the late 1990’s, led to a drug scare that constructed users as “dangerous, out of control, and subject to instant addiction after one use” (Boyd, 2010; p. 219). Although the documents rarely distinguish between which kinds of illicit substances people with “SAMI” are thought to be “addicted” to, where specificity is found polysubstance use—but particularly use of illicit stimulants like methamphetamine and cocaine—is the primary problem. People who use illicit substances are constructed as dangerous to the public, but also themselves because their drug use is thought to be out of control and exacerbating their mental illness. This is evident where one VPD report notes that the department was in a constant state of alarm throughout the 2000’s due to “spike in suicides and other crisis situations” largely attributed to rising rates of substance use and mental illness (VPD, 2013; p. 1).

Illicit substance use is key to constructing people with “SAMI” not only as a threat to themselves, apparent in the VPD document’s concerns with substance-use related suicide, but also to “innocent bystanders”. This threat to the innocent is articulated in countless vignettes which describe in detail acts of indiscriminate violence and public suicides[37] committed by people with “untreated SAMI”. Daly, Costa, and Beresford

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[37] Perhaps the most illuminating example of this is found in the VPD’s *Lost in Transition* report (2008), where a twelve-page vignette is devoted to “Cory’s Story” (pp. 39-51). The report describes the decompensation of an “intelligent, good looking” middle class white man with a career in the tech industry. The document recounts Cory’s history of self-harming behaviour and unwillingness to engage in treatment voluntarily. It also chastises the healthcare system for failing to confine him to hospital in order to keep him away from cocaine long enough for psychiatrists to treat his schizophrenia. The vignette concludes with a description of Corey committing a tragic public suicide, jumping from a downtown bridge. In summing up the root causes of Corey’s death, the document cites the perspective of his mother: “many of the people involved in [Corey’s] care were simply unable to provide for his needs”; “mental health professionals who were overworked, lacked practical resources and were generally frustrated trying to function in a dysfunctional system that is unrealistic in regard to institutionalization and the sharing of information” (p. 51). The report notes that Corey, and by inference all people with “SAMI”, would have been impossible to treat in the community without first “being institutionalized for a number of months” so his “medication could have been stabilized and he could have spent time learning how to cope with his illness”, followed by “a program of reintegration that started with housing and involved

(2019) argue that “association with a diagnostic category linked with violence puts people into a different camp and resurrects all the folks fears of insanity, irrationality, and threat” (p. 352). The new disease of “SAMI” that permeates reports on the “crisis” resurrects not only the old nineteenth century tropes of dangerous incompetence and incapacity associated with madness, but also twentieth century assumptions about the criminogenic and violent nature of “junkies”, “crackheads”, and “addicts”.

Finally, beyond merely presenting a threat to themselves and others, people with “untreated SAMI” are constructed as a threat to the budgets of the police department and the healthcare system, along with the normative ideal of a citizenry that conforms to the “law and order”[38] ethos necessary for the functioning of the modern city. Indeed, the dangerous and dysregulated psychiatric subject found in the documents represents an attack on the “robust, autonomous, trustworthy, self-governing citizen of the liberal dream” (Beresford and Menzies, 2014; p. 83). However, Van Veen, Teghtsoonian, and Morrow (2019) argue that “not only is this focus on “ill” individuals and their (violent) behaviours demonstrate neoliberal political rationalities, it also opens the door to policy responses that intertwine violence with care by establishing a significant role for the police in enforcing the delivery of healthcare services to those deemed incapable of “self-managing” (2018; p. 69).

Noting that health care providers provide insufficient care to people with concurrent disorders, one VPD text argues that the threat posed by people with SAMI must be co-managed through “multi-agency” responses where police and healthcare workers regularly communicate confidential information about patients “with the sole purpose of assisting the involved to improve their quality of life and reduce police interactions” (VPD, 2008; p. 23). For their quality of life to be improved, people with concurrent disorders are thought to require interventions that help them *help themselves* comply with desired norms such as voluntarily seeking out psychiatric and addictions treatment, and reducing the economic waste associated with their inappropriate use of police services and emergency care.

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closely monitored care along with administered medication” (p. 51). Only then, it was thought, could he become “a functioning, contributing member of society” (p. 51).

[38] For example, the VPD note that people with “SAMI” “create considerable demands for police services, and destabilize communities”, both in the “DTES” and the rest of the City and province (VPD, 2008; p. 15).

8.2.2. Dehumanization and Identity Violence

Another subjectification effect found in the documents is that people with "SAMI" are discursively dehumanized by having their personhood reduced to their pathologies ("addiction" and "mental illness"'). This pathologization is akin to forms of epistemic and identity violence where the documents represent people who use drugs and/or struggle with mental health as incompetent, illegitimate knowers, not worthy of the right to make choices about their own care. Delegitimization is found where the terms "addict", "the mentally ill", "the SAMI population", "mentally ill and addicted", "drug addicted offenders" and "drug addicted prostitutes" are frequently employed as a dividing practice to differentiate sick and dangerous people with untreated SAMI from "good", treatment compliant psychiatric subjects. Here is an example from a VPD text:

> Bill[39] lives in the Downtown Eastside. He is a crack cocaine addict and is diagnosed with both schizophrenia and bipolar disorder. In the 1970's Bill was found not guilty by reason of insanity for attempting to kill someone in BC. He spent ten years in a psychiatric facility as a result of this incident and was then released onto the streets of New Westminster where he wreaked havoc until 2003 when he moved to Vancouver (VPD, 2008; p. 36).

People with mental health struggles are constantly subjectified in ways that discursively prioritizes their pathologies (e.g., addict, mentally ill) before their personhood (e.g., person with an addiction, person who struggles with mental health)—a pattern which produces a dehumanizing effect. Livingston (2021) argues that when it comes to substance use, this kind of "derogatory language written into laws and policies (e.g., abuser, addict, non-compliant, clean/dirty) can fuel stigma by reinforcing negative stereotypes, permitting stigmatizing practices, and legitimizing unfair treatment" (1). Around same time the documents on the "crisis" were published, advocacy groups and policy workers in BC began to challenge these kinds of negative representations of people who use drugs, demanding a shift towards "person first language" to help in efforts to reduce stigma and discrimination. Person first language emphasizes the importance of linguistic patterns that put "emphasis on the person first rather than the

[39] Relevant to the discussion regarding the threat of violence to the community that people with "SAMI" are represented to present, a later VPD report revisits Bill's case, noting that it "illustrate[s] the negative impact untreated mental illness and addiction have on the community", and going on to note that Bill "(and the community) would be better served by an institutional model of care versus one based in the community" (VPD, 2010; p. 5).

disability (e.g., “person with schizophrenia” rather than “a schizophrenic”)” (Jensen, et al., 2013; p. 147).

Researchers and public health institutions have warned that just as the language we use to describe people who use substances carries significant power to shape public perceptions, it can also lead to “self-stigma”, where people can come to self-identify with negative associations conjured by stigmatizing language (e.g., “addict”, “junkie”, “substance abuser”) (BCCDC, 2017; Livingston, et al., 2012). Self-stigma is dangerous. It can prevent people from seeking substance use treatment and supports, leading to increased risk of substance use-related harms including overdose (Office of the Provincial Health Officer, 2018). Pauly, et al., (2015) argue that care avoidance as a result of stigma related to the ways in which the healthcare system still moralizes substance use has “far reaching public health implications” and that as clinicians we must be more cognisant of this in our approach to care (134). To these ends, the BC Centre for Disease Control (2017) recommends that healthcare providers and policy makers help prevent self-stigma and encourage people to reach out for care by consistently employing humanizing language which “reflects the medical nature of substance use disorders and treatment” (e.g., person with a substance use disorder, person who uses drugs) and eschewing “slang and idioms” like “addict” or “junkie” (p. 2).

Although the spirit of these new person-first guidelines acknowledges the harm produced by stigmatizing language, the document from the BCCDC and broader public health approach nevertheless falls back on discourse that produce substance use and mental distress as inherently, and importantly “medical” in nature. Karen Ward, an artist and former member of the Mayor’s Taskforce “people with lived experience advisory committee”, cautions against the over medicalization of mental health, arguing that this spirit led to recommendations in mental health reports from the municipal government that miss the mark in some respects. Ward notes that rather than simply expanding psychiatry to solve their woes, “what people with mental illness really need is three things: home, income, and friends” (Hladikova, 2015). Many Vancouver activists like Ward refuse dehumanization and levy powerful challenges to dominant biomedical discourse.

The Vancouver Area Network of Drug Users have taken up the oft-cited disability activist mantra “nothing about us without us” as shorthand for the demand that

substance use research, policy making, and service planning includes meaningful engagement with people who use drugs and the “expertise” that comes with their diverse lived experiences (Closson, et al., 2016; Jozaghi, et al., 2018). Mad activists go further, arguing that when the voices of psychiatric survivors are absent from mental health policy, and when psy discourse gaslights and “disorders people”, forms of “identity violence” result. Identity violence also occurs where psy-discourse subjectifies people to “think of themselves and act on themselves as though they are ‘mentally ill’” (Mills 2014; p. 76). Similarly, the term “epistemic violence” has been mobilized to challenge biomedical discourse that undermines the legitimacy of psychiatrized individuals as “legitimate knowers” of their own life circumstances and needs (Liegghio, 2013).

8.3. Lived Effects

This section focuses on how the problematization of “untreated SAMI” as a threat to public safety and the normative order of the city produces *lived effects* in the form of increased psychiatric confinement and policing of psychiatrized bodies. I argue that the disordering undertaken in the texts renders specific bodies and minds visible for coercive psychiatric interventions permitted by the BCMHA, and creates new disciplinary practices through increased police involvement in mental health services. Drawing attention to these lived effects allows my discourse analysis of the “mental health crisis” to “return politics to policy analysis” (Bacchi, 2009a).

8.3.1. Psychiatric Detention

While my research was being conducted, others began to raise concerns about the repercussions that the most coercive features of the BCMHA have for health human rights. *Operating in Darkness: BC’s Mental Health Act Detention System* (Johnston, 2017), a report generated with support from the Community Legal Assistance Society[40], chronicles widespread abuse of the BCMHA in clinical practice. Noting that psychiatric detention represents one of the most “extraordinary and intrusive exercise of state power” permitted under law, the report describes how confinement results in the

[40] The Community Legal Assistance Society is a BC-based non-profit organization that provides legal aid to people facing discrimination. They specialize in legal advocacy in the areas of housing, income security, mental health, and human rights law.

psychiatric inpatient facility controlling “virtually every aspect of your life and your body” (p. 5). It also details a range of disciplinary techniques commonly used to discipline patients in these settings, including restricting phone or internet access; prohibition on having visitors or calling loved ones; being forbade from going outdoors; having clothing and personal items confiscated; being forced to accept psychiatric treatment; and in cases of non-compliance with treatment, being put in mechanical restrains, under chemical restraint, and/or in seclusion rooms for days on end (p. 5). This kind of isolation, confinement, and restraint can produce significant physical and psychological harm for patients (Jacob, et al., 2019). Furthermore, the routine enactment of these practices creates healthcare environments where other patients and staff are traumatized by witnessing them. They can also spark adversarial relationships between patients and clinicians that may increase incidents of violent resistance from patients, which in turn leads to further practices of restraint and/or seclusion (McKeown, Scholes, and Aindow, 2019).

Perhaps most troubling, the *Operating in Darkness* report (Johnston, 2017) documents widespread administrative failures regarding healthcare provider oversight of involuntary treatment orders. It found that interpretation of the BCMHA’s basic safeguards to protect patients' rights are flawed, inconsistently applied, and at times deliberately misused by clinicians. It also discovered that there is often insufficient legal ground to justify routine practices of seclusion, restraint, and clothing removal. Additionally, patients are frequently prevented from receiving legally-protected access to third-party advice regarding their rights. The documentation required to authorize compulsory psychiatric treatment is also found to often be inadequate under the expectations of law, with patients consistently denied opportunities to plead their case for release at mental health review board hearings. When review board hearings are made available to patients, the recommended best practice to include people with lived experience as panel members is routinely ignored by administrators at the review board (p. 173).

Two years after Operating in Darkness (2017) was published, the BC Ombudsperson, an independent officer of BC’s provincial legislature tasked with investigating complaints against provincial and local public authorities regarding accusations of unjust treatment of citizens, published *Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (Office of the

Ombudsperson, 2019). The investigation described in the report was initiated in response to a number of complaints from people who had been involuntarily detained and felt that their legal rights had been violated. It concludes with an admission that the basic protections for psychiatric patients under the BCMHA are routinely disregarded by clinicians and healthcare administrators:

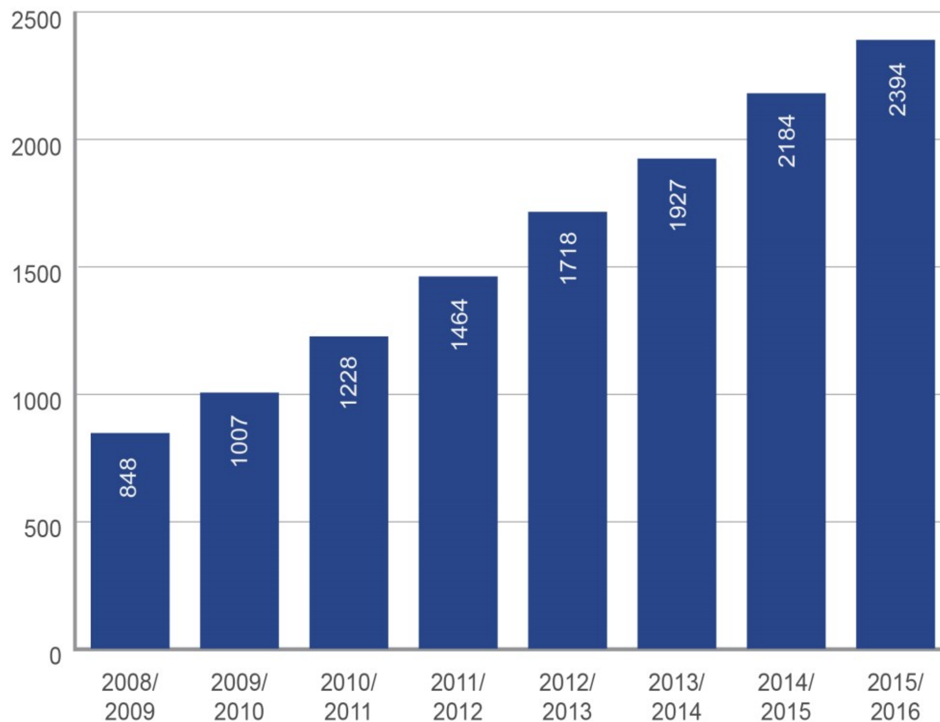
> In many cases, forms were simply not completed. In many other cases, the forms were completed late or in a manner that did not provide anything close to adequate reasons. For example, some facilities used standard rubber stamps to describe a broad range of possible authorized treatment for individual patients instead of describing the specific treatment prescribed. Some physicians failed to explain why a person met the criteria for involuntary admission. Some forms lacked the necessary signatures or dates (p. 6).

In fact, the Ombudsperson's investigation found that the legally required forms were only completed or adequately explained to patients in 28 percent of cases—a finding indicating widespread failure of the healthcare system to uphold the most basic safeguards of the BCMHA. The findings validated concerns raised in the *Operating in Darkness* (Johnston, 2017) report; namely that BC has normalized a mental health system wherein physicians, police, and healthcare administrators regularly exercise extraordinary power to confine people with "mental illness"; and yet, little recourse exists for these patients to challenge decisions to strip them of their right to the security of the person under Canada's Charter of Rights and Freedoms. The findings contained in the two reports are eerily reminiscent of decades old critiques of abuse in BC's twentieth century system of custodial care. For instance, a 1994 report from the BC Ombudsman similarly concluded that throughout the 1970's and 80's Riverview Hospital had "not had in place the kind of comprehensive, receptive and fair mechanisms for responding to concerns about its service that must exist in a psychiatric hospital", and that reforms were needed make the BCMHA more responsive to patient complaints of abuse and maltreatment (p. ii).

This dissertation has argued that assumptions made about the violent, criminogenic nature of people with "SAMI" living in Vancouver throughout the 2000's and early 2010's invited a renewed clinical commitment to practices of confinement and compulsory treatment under the BCMHA. The documents I analyzed call for increasing the number of secure inpatient mental health beds. New assertive forms of community treatment were implemented in the years corresponding to their publication. The table

below highlights that from 2008-2016, the number of patients released into the community on extended leave in BC almost tripled, from 848 in 2008, to almost 2400 in 2015/16. The new ACT teams positioned as key to ameliorating the “crisis” undoubtedly played a role in increasing surveillance and disciplinary techniques directed on people who are thought to have “untreated SAMI”. Van Veen, Ibrahim, and Morrow (2018) found that in 2016, local Vancouver ACT teams provided care to roughly 380 clients, with over 75% receiving treatment involuntarily under extended leave (citing personal communication with Ministry of Health, 2016). Table two below illustrates the year-over-year increases in the numbers of patients receiving involuntary treatment in BC.

Table 2. Number of patients on released on extended leave in BC, 2008-2016.



Adapted from Johnston (2017)

Extended leave carries significant lived effects for people who struggle with mental health. Its requirements often include surveillance of a patient's day-to-day life, such as having clinicians or pharmacists witness the oral consumption of anti-psychotic medication, receiving home visits from an outreach worker to confirm that a patient is residing at an "approved home", and having all police interactions logged for follow up in the VPD's "early warning system". If clinicians observe poor compliance with oral medications, patients can be forced to accept intramuscular injections of anti-psychotic medications which are known to come with undesirable side-effects. Together, these kinds of practices forge a disciplinary model of care which more closely resembles custodial inpatient settings than what is commonly thought of as "recovery-oriented" care in the community. Breaking with the neoliberal proclivity to govern individuals "at a distance" through the shaping of autoregulating mental health patients, disciplinary techniques like forced medication compliance through extended leave "[make] possible the meticulous control of the operations of the body, which assures the constant subjection of its forces and imposed upon them a relation of docility-utility" (Foucault, 1977; p. 137).

There is a contradiction present in the heterogeneous ways in which power is exercised over psychiatric patients in BC. For example, despite routine reliance on disciplinary practices, at the core of the model, ACT espouses a neoliberal conception of "mental health recovery"[41], where clinicians are instructed to focus efforts on improving patients' abilities to self-manage their "activities of daily living" in conformity with middle class norms such as "independent living" in market housing with no involvement with criminal justice system. The co-existence of these different forms of power reveals that when the responsibilizing aspirations of neoliberal political rationalizations in mental health care fall short, disciplinary power is conjured to compensate.

8.3.2. Policing Psychiatrized Bodies

Another lived effect produced by security discourse in the texts is an overall increased presence of police in the day-to-day lives of people struggling with mental health and substance use in the inner city. Chapter four argued that the policy documents construct people with "SAMI" as a distinct threat to themselves and the

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[41] See Morrow, 2013.

public, as well as to the cost and effective administration of health and police bureaucracies, which opens the door for new roles for officers in healthcare services. The reports recommend increased funding for police positions on ACT teams and for new “joint VPD-VCH Assertive Outreach Teams for mentally ill patients who do not yet qualify for ACT” (VPD, 2013; p. 28). Both investments are aimed at producing economic efficiency by “increasing public safety *and* improving the quality of life for those suffering from mental illness” (p. 28; emphasis added). However, adding police to healthcare teams, and implementing information sharing agreements that provide officers access to confidential health records without consent should raise questions.

Many people who use drugs and/or struggle with mental health have histories of negative experiences with police. For those who have been criminalized for using illicit substances, experienced violent arrest at the hands of officers, or have a history of apprehension and confinement under the BCMHA, police involvement in “care” could be traumatic. This should prompt policy makers to exercise caution when arriving at recommendations to incorporate policing into community healthcare services. For if we take the BC Provincial Mental Health and Substance Use Planning Council’s (2013) call for clinicians to practice “trauma informed care” seriously, it requires that we consider not only the trauma a patient might have experienced in their past, but also the potential for re-traumatizing them through future interventions (Hall, et al., 2016). Moreover, if people struggling with mental health and substance use come to fear arrest in their healthcare encounters, the goal of improving access to treatment for people who might otherwise voluntarily seek it will surely be undermined.

Recent research in the “DTES” supports this argument. An ethnographic study drawing on qualitative interviews with people who use drugs in Vancouver found that many reported using drugs alone in risky situations to avoid the police contact that can occur while traveling to and from supervised injection sites (Collins, et al., 2019). Interviewees also reported hesitancy in calling emergency medical responders in the event of an overdose for fear that police might attend and arrest them. The research concludes that for people struggling with substance use, fear of police contact creates a barrier to accessing healthcare services and increases risk of overdose death (Collins, et al., 2019).

Qualitative work has also examined patient perceptions of coercion in ACT teams in the United States, arguing that involvement with the teams is not experienced negatively (Tschopp, Berven, and Chan, 2011). However, little work has been done to examine the experiences of patients with ACT teams that included police roles and/or a widespread reliance on compulsory treatment orders like extended leave—a formula somewhat unique to the Vancouver context (Fast and Cunningham, 2018; Van Veen, Ibrahim, and Morrow, 2018). It might be unsurprising then that policy documents fail to acknowledge that this new "joint service" arrangement between health and police could result in patients taking deliberate actions to *avoid* voluntary care, thus reinforcing the need for more assertive, compulsory forms of treatment. In a contradictory way, adding police to the teams might actually reinforce the very "problems" (e.g., a lack of mental health care opportunities, and "untreated SAMI") that ACT seeks to solve in the first place.

Over and again, the police reports cite the need for more disciplinary mechanisms to prompt early mental health interventions that prevent "care avoidance". Police frustrations with healthcare providers are clear where they claim that the mental health care system is "failing" in part because clinicians are unwilling to mandate treatments to the full extent permitted under the BCMHA. One VPD (2008) report asserts that there are three key reasons for this reluctance on the part of clinicians. First, healthcare providers are disinclined to use coercion because they feel pressured to be "minimally intrusive". Although this patient-centred impulse is viewed as commendable, the text stresses that it tends to lead to "a lack of balance between a patient's right to refuse care and their protection, to the point that it is not in the patient's best interest, nor the public's". It goes on to state that "[a]fter decades of forced psychiatric care resulting in horrific examples of institutional abuse as documented in various lawsuits in British Columbia, there is widespread reluctance to engage in compulsory treatment" (p. 18). This disciplinary reluctance is chalked up to clinicians simply giving in to "the politics of public opinion"—opinions which expect that the healthcare system disavows custodial care in favour of practices that allow patients to live in community with a certain degree of freedom and autonomy.

The second reason why clinicians are viewed as not coercive enough—and contrary the findings in reports from Ombudsperson's (2019) and Community Legal Assistance Society (Johnston, 2017) which suggest otherwise—is because the

BCMHA's limited safeguards (e.g., the right to review panel hearing) are thought to undermine effective care since "panel members, (a majority of whom may not be medical professionals themselves) often override [the psychiatrist's] medical recommendations" (VPD, 2008; p. 18). Again, the neoliberal caution to avoid *governing too much* is itself problematized, while the expert knowledge and disciplinary practices of psychiatry are represented as "more effective" in treating SAMI. Finally, the VPD text explains that because clinicians are acutely aware that there is a lack of available resources to institutionalize patients through long-term admissions in tertiary mental health units, physicians often view compulsory confinement under the BCMHA as futile to the task of getting patients back to their baseline state of mental health (VPD, 2008).

The way police reports suggest that clinical decision-making consistently fails to utilize the full disciplinary technologies of BCMHA and call for a return to custodial care demonstrates that a struggle exists between illiberal political rationalities that hold preference for disciplinary techniques to manage mental illness, and neoliberal ones that seek to responsibilize psychiatric patients to take care of themselves. However, this tension appears to shift slightly over time in the texts. A later document from the VPD notes that "the objective moving forward must be to ensure that there are sufficient secure beds, *but not to 'over-institutionalize'* those who do not require secure care" (VPD, 2013; p. 26; emphasis added). While the police reports tend to hold a penchant for more disciplinary approaches to care than the "minimally intrusive" clinicians subject to their critique, later documents from the department start to subtly swing, albeit in a contradictory way, towards a neoliberal rationalization that interventions ought to be "assertive", but careful not to govern *too much*.

Another governing technique that produces lived effects for psychiatrized people is found in a VPD report's description of how officers use databases and software to monitor people flagged as having "SAMI". The coroner's inquest recommendations following the police shooting of Tony Du offers more details about how these technologies work. One of the main recommendations from the inquest is for police agencies across BC to create EWS, similar to the one employed by the VPD. The EWS links "police and health data which identified persons living with severe mental illness and/or substance use who may be decompensating in the community and who are at the most risk to themselves or others" (BC Ministry of Public Safety and Solicitor General, 2018; p. 3). The joint health authority-VPD AOT uses the software to "readily assess

risk” and “proactively locate individuals in risk-laden environments” like the “DTES” (VPD, 2016; p. 22). Once the algorithm identifies a person at risk of decompensation, police alert clinicians who intervene with motivational interviewing techniques to inspire patients to self-correct the risky course of their illness by recommitting to antipsychotic medication adherence.

The technology complements the power granted to police officers to detain people under the BCMHA by enabling new forms of governmentality within the risky and unpredictable domain of the “community”, where complex social problems are subjected to programmatic attempts to render them down to technical challenges (Li, 2011). The EWS helps to reduce the elusive risks associated with untreated mental illness in Vancouver’s “DTES” down to a perceptible, measurable phenomenon so that it can be acted upon swiftly. It also allows the risk of violence associated with mental illness to be viewed not just as an object of the past, like the countless depictions of incidents of “random violent attacks inflicted on innocent members of the public” (VPD, 2013; p. 1) documented retrospectively in police records, but rather as events which can be anticipated and acted upon so they can be prevented. In this sense, the VPD’s foray into practices of clinical document/ation temporally fix police encounters with individuals in distress. This helps to ensure that “as fleeting events become the past, a record can be carried forward into the future” (Pigg, Erikson, and Inglis, 2018; p. 171). The implications of fixing these records to marginalized people without their consent or opportunity for review requires further research.

Chapter 9.

Conclusion: Challenging Dominant Discourse

This chapter concludes the line of questioning that I have adapted from Bacchi's (2009a) WPR approach by asking: *how can the dominant problem representations surrounding the mental health "crisis" be questioned, disrupted, replaced, or reproblematized?* Answering this question requires first investigating how security and psy discourses are contested in the documents and through local advocacy efforts. I then fulfil Bacchi's (2009a) reflective agenda by unpacking my own assumptions about the "mental health crisis" and its normative solutions. This required undertaking a brief discourse analysis of a report, *Maladjusted: Humanizing Mental Health* (Ng and Van Veen, 2015), which I co-authored with a community-based arts organization in order to raise important questions arising in my research and a series of participatory action theatre performances involving people with lived experience of substance use and mental illness. Finally, this chapter ends with a succinct conclusion to this dissertation, summarizing the findings of my discourse analysis of Vancouver's "mental health crisis", and leaving with a call for researchers, policy workers, clinicians, and advocates to question dominant problem representations that create harm.

Before exploring how the "crisis" could be questioned, disrupted, or reproblematized, it is important to reiterate that the psychiatric and security discourse in the documents is not static or complete. Rather, these discourses are plural, inconsistent, and at times contradictory. Competing problematizations emerged from the margins to subtly reshape the discursive landscape over time. The texts suggest that the policy debate was at times tense, with disagreement taking place about which "problems" ought to sit atop the normative hierarchy in the "mental health crisis" (Van Veen, Teghtsoonian, and Morrow, 2019). While police reports construct "mental illness" as a phenomenon that represents a danger of indiscriminate violence that must be contained by law enforcement and psychiatry, reports from the municipal government contain traces of resistance to this understanding of the problems. Competing problem representations are especially evident where, alongside biomedical discourse establishing people with "untreated SAMI" as a pathological population in need of medical treatment, the *Caring for All* (City of Vancouver, 2014) report problematizes a

lack of peer-informed health and social services, insufficient attention to Aboriginal conceptions of healing and wellness, and the stigma associated with mental illness and addiction (Van Veen, Teghtsoonian, and Morrow, 2019).

Drawing attention to these discursive inconsistencies and competing problematizations in the truth games surrounding the "crisis" helps carves a path towards a soft normativity that politicizes "taken-for-granted 'truths'" (Bacchi, 2012; p. 1). It also renders the politics of the documents visible for analysis. Amplifying the competing problematizations challenges the adverse effects that dominant discourses produce for the bodies, minds, and personhood of psychiatrized people and people who use drugs. In the first two sections of this conclusion, I argue that although psy and security discourse in the documents enacted forms of violence, so too did they reflect long, labourious struggles to resist this harm on the part of people with lived experience, advocates, and critical scholars and clinicians. This temporal aspect of the analysis helps to explain how efforts to undermine dominant discourses can be seen as a "part of a process of slow justice, the nimble exercises of resistance practiced in non-ideal situations over time" (Van Veen, Teghtsoonian, and Morrow, 2019; p. 74).

9.1. Challenging Security Discourse

The security discourse found in documents is not anchored in consensus. Conflict surrounds which interventions are seen as the best solutions to managing the risks associated with people with untreated "SAMI". According to the VPD, the failure of the healthcare system to intervene early and impose compulsory treatment is the fundamental problem. However, a closer reading of the discourse in the texts reveals that the healthcare system is not just viewed as failing to treat individuals with "SAMI", but also to produce professionals *willing to* make use of the full range of disciplinary mechanisms available under the BCMHA to enforce treatment retention. This, according to the police, leads to a "lack of balance between a patient's right to refuse care and their protection" (VPD, 2010; p. 18). It is not just people with "SAMI" that were problematized in the texts, but clinicians too.

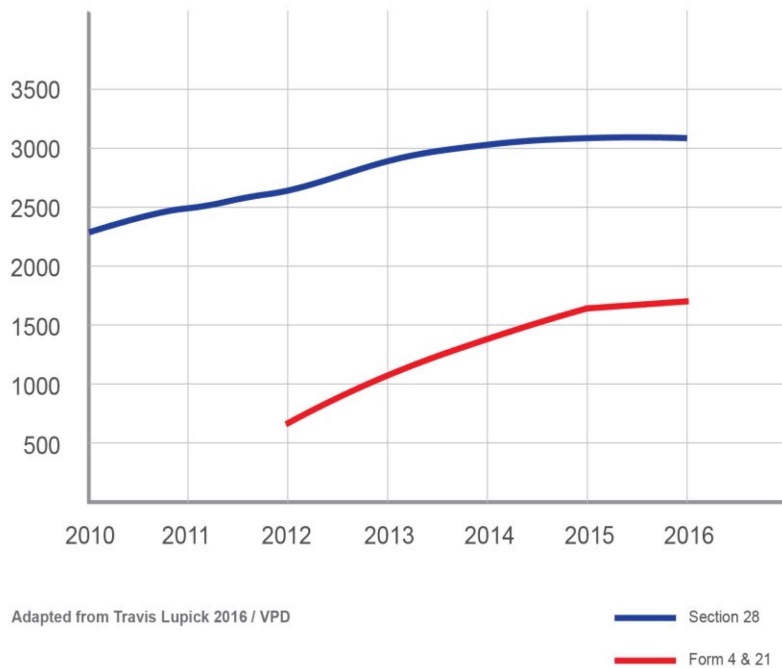
The VPD *Update Report* (2013) acknowledges that this criticism of healthcare providers' apprehension to use the full powers of the BCMHA to enforce treatment created conflict: "[t]his report, while contentious at first, eventually led the way to a

healthy and productive working relationship between the VPD and both VCH and PHC [Providence Health Care], at both the staff and Board levels" (VPD, 2013; p. 6). This improved cross-sectoral collaboration may have softened the problematization of a lack of clinical coercion over time. The VPD *Update Report* (2016) indicates a shifting political rationality regarding patient autonomy, where it acknowledges the importance of safeguarding the limited patient rights under the BCMHA for the first time in a text from the department. It goes so far as to evoke person-first language to state that "collaborative solutions must include sufficient capacity within health care to respond to a high-needs population and expanded community services to serve chronic patients effectively, while *respecting the rights of persons living with mental illness* and de-escalating conflict to ensure that use of force is the last line of defense" (p. 7; emphasis added). The shift occurred following the workshops of the Vancouver Mayor's Taskforce, where people with lived experience of psychiatrization were included in an attempt to arrive at a more "collaborative plan" for addressing the "crisis", perhaps leading to successful challenges to the way that a lack of psychiatric treatment is problematized in earlier documents.

Over time discourse in police reports indicates subtle swings—albeit in a somewhat contradictory way—between a preference for the disciplinary power of custodial care in earlier reports, toward a neoliberal political rationality that guides patients to master the skills of self-management necessary to minimize their reliance on state health and criminal justice systems in later ones. This is perhaps most clear where the latest document from the VPD argues that collective efforts to promote avenues for "access to care" might help patients to comply with psychiatric treatment, and that in many cases this voluntary approach is preferable to "criminalization" (see VPD, 2016; p. 8). This is also apparent where later reports from the department insist that the force is "intent on diverting persons living with mental illness away from the criminal justice system [and towards psychiatric care] when the circumstances of the criminal activity are minor in nature, have little immediate impact on the community at large, and are grounded in the individual's mental illness" (p. 7). Shifts can also be identified where the VPD commits to "systematically reducing stigma within the Department" (p. 7)—a reflective gesture which, for the first and only time, acknowledges that stigma and discrimination against people with "SAMI" exists *within* the law enforcement profession.

Although these discursive shifts may indicate successful attempts to challenge dominant psy and security discourse through appeals to individual freedom rooted in human rights discourse, data on rates of apprehension under the BCMHA suggest that the changing rationality is not necessary reflected in practice. Reporting on the number of forms 4/21[42] and section 28 apprehensions under the BCMHA in 2016—around the same time the most recent VPD report was released—a local journalist noted significant increases in recent years. Table three demonstrates that use of form 4 and 21 almost tripled in the four-year period from 2012-2016, while section 21 apprehensions gradually grew, then plateaued in 2014.

Table 3. VPD Mental Health Act apprehensions, 2010-2016



[42] See the footnote at the bottom of page 65 for an overview of the functions of forms 4 and 21 in the BCMHA.

These trends suggest that there is an increasing reliance on the most punitive features of the BCMHA, a trend which is out of step with the health authority and VPD's optimistic goals of promoting "access to care" rather than "criminalization". Searching for an explanation for this trajectory, Lupick (2016) explains that these trends were first brought to light by a local human rights lawyer from the Pivot Legal Aid Society who hypothesized that they "could point to more collaboration between the police and the health-care system", warning that there are "unintended implications of police having more access to data about people's health". We may recall from chapter four that forms 4 and 21 of the BCMHA can be used by physicians and police to apprehend individuals who are not complying with compulsory care plans or who are deemed to be at risk of "decompensation". What role the VPD's EWS or record sharing agreements with local health authorities has played in the increased reliance on coercion in healthcare remains unclear and requires further inquiry.

In the meantime, clinicians and community members continue to air widespread concern about the effects that reliance on police and psychiatric coercion have on some of Vancouver's most marginalized citizens (Ng and Van Veen, 2015; Van Veen, Ibrahim, and Morrow, 2018). Underscoring the material effects these practices produce, Fast and Cunningham (2018) note that involuntary hospitalization frequently leads to periods of homelessness and other harms for individuals who lose their housing while confined to inpatient care. For those struggling with opioid addiction, police apprehension and involuntary confinement for mental health treatment can be deadly. If a person who is addicted to opioids is involuntarily hospitalized, they are likely to be forced into immediate cessation of illicit opioid use while in the ward. However, if the person does not desire treatment, they are likely to return to drug use when released into the community. When tolerance is diminished after the hospital stay, risk of overdose death is elevated upon release (Lewer, et al., 2021). The risks involved in these scenarios have led substance use researchers to push back against coercion, recommending extreme caution when it comes to involuntary confinement of people who struggle with addiction (Kisely, et al., 2017; Rafful, et al., 2018).

These critiques suggest that while security discourse positions practices of law enforcement-assisted psychiatric confinement as a "proportionate police responses" to mental health crisis events, this understanding is not universally accepted. Contradictions within and between police reports reveal discursive fractures and

reconfiguration taking place regarding the question of how much governance is too much. Bacchi (2009a; p. 139) holds that these types of shifts offer inroads to opportunities to re-problematize situations like the "mental health crisis" in ways that produce less harm.

There is plenty of evidence to suggest that re-problematization occurred from 2008-2016. Reflecting on the contributions of people with lived experience of substance use and mental health struggles in shaping *Mental Health Strategy* (VPD, 2016), the text notes that "the engagement and contributions from this group were invaluable and served as a vital part of framing this strategy and ensuring it met the expectations of those most affected" (VPD 2016; p. 30). It goes so far as to state that "recognizing that persons' interactions with systems and institutions can create trauma on its own, it is imperative that the underlying mental health issues be addressed, while minimizing the criminalization of the individual" (p. 11). This is the only time the term "criminalization" appears across the texts that form the basis for my study. The admission that involvement with carceral systems creates trauma for people with mental health struggles represents an insight absent from earlier documents from the department. To prevent the trauma resulting from criminalization, the VPD pledge to continue "working with people with lived experience to further de-stigmatize mental illness" (p. 10).

Cynicism might lead one to argue that these shifts are lip service and immaterial without legislative amendments to the BCMHA and changes in the way police interact with people with mental health struggles. Instead, I view them as evidence that attempts by the municipality and people with lived experience to engage in a more inclusive policy-making process created successful challenges to psy and security discourse. Over time, these kinds of challenges made their way into other local policy debates. Van Veen, Ibrahim, and Morrow (2018) describe a City Council debate regarding a recent budgetary approval meeting in BC's capital, the City of Victoria:

> Drawing on findings regarding cost efficiency and medication adherence from the At Home/Chez Soi study, and the BC Ministry of Health's continued endorsement of ACT as a 'best-practice', City Council in Victoria, BC recently approved funds to embed two police officers in the region's four operational ACT teams. However, contestation also worked its way into debate on the new policy. Advocates from the Mad activism community and critical social service workers organized through a closed Facebook group to strategize how to keep officers off the teams. When the new funding for police was debated in council chambers, activists lined up to

> point out that the proposal ‘sends the message that people with mental illnesses are dangerous’ and that the new configurations of police-involved ‘care’ could actually make some people apprehensive to reach out for help (Derosa, 2017; p. 257).

The Victoria Police Department’s budget was ultimately approved, and it moved forward to implement the new ACT teams in partnership with the local health authority. However, activists continue to raise concerns about coercion in the model. In 2019, Victoria City Council reduced the police budget, leading to newspaper headlines like “VicPD budget request sparks debate on role of police in mental health, addiction calls” (Grossman, 2019). After the council vote, the Victoria Police Chief noted that the “future of [the ACT] pilot project maybe up in the air now” (Gaetz, 2019).

In late 2019, activists in Vancouver similarly lined up in municipal council chambers to argue that an ever-expanding police mandate and budget ought to be met with alarm. Addressing the VPD’s involvement in ACT teams specifically, the Vancouver Area Network of Drug Users, a local drug user advocacy organization, argue that “this new frontier of militarized community services needs to be rejected and discarded” in order to halt the “deep and systemic injustices” and growth of the carceral state in the inner city (Crompton, 2019).

9.2. Challenging Psy Discourse

Alternative problematizations challenged dominant psy discourse through a number of local forums and mediums, including the Vancouver Mayor’s Task Force meetings, advocacy campaigns, op-eds, research symposiums at Simon Fraser University’s (SFU) Centre of Gender, Social Inequities, and Mental Health (CGSM)[43], and in social media posts. One of the most direct confrontations came in 2016, when two former involuntary psychiatric patients launched a court challenge to argue that their

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[43] The CGSM Operated at Simon Fraser University in Vancouver from 2009-2015—a timeframe that corresponded to the publication of many of the government policy documents on the “mental health crisis”. The centre was interdisciplinary and cross-sectoral, bringing together a range of researchers, policy workers, mad activists, and psychiatric survivors with a shared interest in “the complex and varied ways in which structures of power related to poverty, racism, heterosexism, sexism and colonialism operate to produce and maintain inequities and how these play out in the systems set up to support people in the fields of mental health and substance use” (Morrow and Van Veen, 2016; p. 1). A wide range of critical mental health research was supported with funding from the centre, and collaborators met in person to advance the mad studies movement at its regular “critical inquiries” workshops.

treatment under the BCMHA represented a violation of their human rights. The plaintiffs claimed that they were required to accept forced electroconvulsive therapies and injectable medication regimens against their wills. Laura Johnston, the lawyer who authored the Operating in Darkness (2017) report, represented the clients. She argued that the forced treatments violated her clients' right to life, liberty, and security of the person under Canada's federal Charter of Rights and Freedoms (Woo, 2016). Had the case gone to court, Johnston might have also argued that the forms of involuntary treatment that her clients were subjected to also violated the spirit of international disability law[44].

Although this potentially precedent-setting charter challenge regarding involuntary treatment practices was eventually dismissed after the plaintiffs dropped out of the court proceedings, Vancouver activists continued to call into question new regimes of coercive psychiatric care. The West Coast Mental Health Network, a Vancouver-based mental health consumer advocacy organization, levied criticisms against ACT's reliance on disciplinary powers of the BCMHA through online blogs. In one post, network member and well-known local mad activist Dr. Richard Ingram noted that with respect to ACT, ""assertive" is a word that hides the use of what is violence… [it] means that the system has coercion that it can use to oblige people to take medications in the community" (Carten, 2013). Other activists took action to prevent police apprehensions under the Act, setting up subversive and compassionate forms of peer support. In the mid-2010's, a group of psychiatric survivors in Vancouver set up a peer support "Warm Line" for people to call if they were experiencing mental distress but reluctant to reach out to healthcare providers for fear of police apprehension and compulsory treatment (Van Veen, Ibrahim, and Morrow, 2018; Mad Society of Canada, 2017).

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[44] In 2008 Canada signed the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which clearly prohibits depriving the liberties of people with disabilities—including those with "mental disorders". However, after consultation with the provinces and territories regarding implementation of the CRPD, federal officials decided not to sign onto article 12, which requires that people with disabilities receive equal recognition under the law. Citing "challenges in removing barriers that prevent persons with disabilities from participating fully in society and ensuring that they have access to appropriate services and programs", and the fact that there would be administrative struggles to bring provinces, territories, and municipalities into compliance with the article, the federal government opted instead to come up its own strategy (Walker, 2013; p. 5). Indeed, if Canada were to have signed onto article 12, BC would have likely had to overhaul its Mental Health Act in order to comply with the CRPD.

Examining these efforts to resist psy discourse helps us to build a better understanding of how governing works through specific regimes of community mental health programming. Resistance to psychiatry's efforts to shape rational, responsible, treatment seeking subjects that conduct themselves in ways that avoid financial costs to health and criminal justice systems plays a defining role in the "mental health crisis". However, this resistance also opens the door for new coercive practices to emerge. In fact, the decision to modify ACT to include VPD officers is rationalized as necessary in order overcome the "non-compliance", or counter conducts, that people with "SAMI" present for community mental health clinics.

One report notes that "[clinic staff] do not follow up to ensure that treatment is received and will not see clients who are 'difficult' (i.e., refuse to take their medication or are volatile)" (VPD 2008, pp. 22-23). Community based clinics are often unable to engage "difficult" patients despite best efforts from staff to motivate them to voluntarily seek services and avoid decompensation. In some cases, patients go so far as to flee BC in order evade extended leave and enforced psychopharmacological treatment. The term "psychiatric refugees" has been used to describe this growing group of people escaping the province to avoid the jurisdiction of the BCMHA's legal authority (Brown, 2016).

Even the "evidence-based" Housing First ACT model researched in the *At Home Study*, which provided housing and assertive outreach services—in essence bringing the clinic to the patient—is viewed as insufficient to adequately contain the agency of people with untreated "SAMI". Somewhere along the line police enforced treatment compliance and new surveillance software to monitor patients in the community was thought to be necessary to improve ACT's efficacy. Disciplinary practices are conjured to contain psychiatric patients when efforts to govern them at a distance fail. This push and pull dynamic illustrates that *resistance* on the part of psychiatric patients *and* coercive discursive practices play mutually reinforcing roles in producing new forms of governmentality.

Resistance is found not only in the efforts of individual subjects to avoid psychiatry and police, but also where collective energy is put to reject the dominant problematizations of the "mental health crisis". Reproblematization comes from people with lived experience, Indigenous leaders, and scholars who question the ways in which

spiritual and emotional suffering are represented as biogenetic “mental illness”. Instead of accepting the story the police, researchers, and health administrators tell about “untreated SAMI” and its causal relationship with violence, these groups re-problematize the situation as one of widespread suffering resulting from on-going settler colonization, poverty, and criminalization. This shift would not have been possible without challenges to truth games that result in “lived experience” and Indigenous knowledge becoming incrementally accepted as relevant forms of “expertise” in the production of health and social policies.

In the years surrounding the “mental health crisis”, some clinicians also challenged the coercive roles that the BCMHA creates for them, pointing to a tension between their legal obligations under the Act and professional ethics which require them to practice in ways that are person-centred, equity-focused, and compassionate at all times (Van Veen, Ibrahim, and Morrow, 2018; Kolar, 2018). More research is needed to elucidate the specific, tactical ways in which nurses, social workers, and other clinicians resist forms of governmentality that compel them to enact coercive practices. In the meantime, appeals to the concepts of human rights, patient centred care, and the social determinants of health might help them find footing to challenge the authority of professional psy knowledge. Each of these concepts, if repurposed strategically, might lead to “cracks in the foundations of the neoliberal order [that] can be worked to advance the causes of justice, empowerment, and social change” (Beresford and Menzies, 2014; p. 8). As critical voices increasingly refute the notion that psy knowledge ought to sit atop the epistemological hierarchy in mental health policy and practice, scholars, policy workers, and clinicians might find “new areas of collaborative resistance against the tyranny of expanding carceral and psy networks” (Rembis, 2018; p. 80).

9.3. The Reflexive Agenda

This section analyses discourse in a position paper I co-authored with community advocates to challenge dominant problem representations regarding the “crisis”. The purpose of this reflective exercise is to conclude this dissertation by undressing my own assumptions about the problems surrounding mental health policy and practice in Vancouver. Part of what makes the WPR approach politically meaningful for those engaged in academic research *and* professional policy practice is that it “enables policy workers to reflect critically on governing practices, to theorize their location within those

practices, and to resist practices deemed to have deleterious consequences for specific people and groups" (Bacchi and Goodwin, 2016; p. 9). Furthermore, Daley, Costa, and Beresford (2019) reiterate that just as there are material effects of discourse, so too are there material implications of *discourse analysis*. Accepting this, post structural analysts engaged in studies on the politics of mental health policy have an imperative to ask themselves "how and where are de-medicalized accounts of madness and mental distress prioritized in order to more authentically take account of the range of experiences and concerns of mental health service users/survivors?"; and "how can the process of seeking support for mental and emotional distress be less distressing, or violent?" (p. 353).

Bacchi and Goodwin (2016) note that there is tendency for governmentality studies to assume that policy workers are merely professional problematizers, unconsciously engaged in the normative task of defining problems and crafting recommendations about how to solve them. In order to bring more nuance to the politics of policy making, they argue that we should eschew "'fixing' the role, identity, or work of the policy analyst as a technician or a programmer, to see, instead, the policy worker *cum* analyst as engaged in the practices of interrogating, criticizing, and evaluating policies, and through these practices, unmaking and re-making policy" (Bacchi, and Goodwin, 2016; p. 9). This is an optimistic view of the agentic potential for policy workers to bring a "post structural sensibility" to bear in government policy shops.

Li (2008) is more skeptical, arguing that the roles of the critic and policy worker are inherently conflicting, and that distance between them is necessary in order to preserve the critical integrity of research. For Li (2008), policy workers are under intrinsic pressure to simplify complex problems in order to make them "amenable to technical solution". Critical researchers, on the other hand, are afforded the time, space, and intellectual freedom necessary for questioning the political context of policy (p. 116). While this observation about the expectation that policy workers must render everything down to a series of technical fixes for institutions to implement is astute, my experience working in municipal government and a local Health Authority has also revealed potential for bringing a "post structural sensibility" to bear in variety of subtle ways in day-to-day work as a professional problematizer.

Uncomfortable moments have undoubtedly occasionally arisen with some co-workers and partner organizations who have taken issue with the critical work[45] I have published on coercion in BC mental health policy and practice. Questioning dominant problem representations in meetings and emails is also often viewed as contrarian, and not sufficiently "solution-focused". However, appeals to the discourse of health equity and health human rights with the goal of avoiding harmful unintended consequences of our work provides good opportunities for pause. Moreover, some of the most basic questions in Bacchi's (2009a) WPR approach are effective to ask in policy-making settings and have potential to help undermine the naturalism of the "problem-solving paradigm" (p. 272). Even the most committed positivist policy worker is open to asking: what are the problems represented to be in this specific instance? What assumptions are we making about them? And even how have these representations of the problems come about?

They may also be convinced of the need to explore harmful unintended consequences, as long as those consequences can be reduced to indicators (e.g., rates of BCMHA apprehensions, average duration of extended leave orders, rates of review panel hearings per hospital admission) and measured by available data sources (e.g., electronic medical records, mental health review panel administrative reports, police surveillance software). If we generally accept the often-cited adage that in policy work *what gets measured gets managed*, then redirecting the attention of health and human service administrators towards alternative indicators (e.g., rates of poverty, statistics on numbers of people who are homeless, racial disparities in mental health admissions) that measure the state's performance in improving a broader range of social determinants of mental distress, might lead to less harm. This might motivate provincial, territorial, state, and/or federal governments to consider forms of "crisis response" which include increasing rates of income assistance, establishing more affordable and supportive housing units, and increasing trauma-informed cultural safety and humility training for clinicians.

However, under the trappings of neoliberal political rationalizations, this strategy might also reinforce the administrative logic that "[if] it can't be enumerated, it won't

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[45] See Ng and Van Veen (2015), Van Veen, Ibrahim, and Morrow (2018), and Van Veen, Teghtsoonian, and Morrow, (2019).

work" (Erikson, 2012; p. 380). This pitfall is foreshadowed in the *Caring for All* (City of Vancouver, 2014) report's proposal to solve the problem of a lack of cross-sectoral collaboration through bridging "across jurisdictional divides" under a "collective impact" framework with shared indicators embraced by all relevant stakeholders. It is also found in the VPD's *Project Lockstep* (2009) report's section on the importance of creating shared metrics of success in addressing the problems of mental illness in the "DTES". Without such ongoing measurement of key indicators, the report cautions that there will be no way of knowing that interventions are working, and that the "the situation" in the neighbourhood is improving over time (p. 46). Some use the term "audit culture" to describe how these kinds of business-minded efforts to organize, measure, and monitor what counts as "success" across health and social service systems (Adams, 2016, Inglis, 2018). Audit culture constrains acknowledgement of the less tangible, more "messy social realities" that exist beyond reductive performance indicators (Inglis, 2018). How is one to measure and monitor improvements in the traumatic experiences perpetuated by police and psychiatric containment? How does one enumerate decolonization?

The challenge for post structural policy analysts working in these constrained settings rests in shifting the conversation beyond positivism and towards the discursive, subjectification, and material effects produced by the problem representations we rely on. These lines of inquiry are more easily taken up in post structural policy studies, but are necessary to pursue also in policy-making environments. WPR workshops might be a promising avenue to this end. Workshops could bring together policy workers to collectively apply the questions of the WPR approach to a particular issue that analysts are tasked to address through a briefing note, strategy document, or plan. One might wonder what the City of Vancouver's *Caring for All Report* (2014) would have looked like if the vast and impressive network of stakeholders convened in their taskforce worked through Bacchi's (2009a) questions with reference to the "mental health crisis"? The pedagogical value of such a process might eclipse that of the report that would result.

9.3.1. Applying the WPR Approach to My Own Representations of the "Mental Health Crisis"

In the early stages of this research, an opportunity arose to partner with local advocates to draft a report about the coercive features of ACT's implementation in Vancouver. In the early 2010's, a community non-profit theatre organization put on a series of participatory social justice-oriented plays involving people with lived experience of psychiatrization called *Maladjusted: Humanizing Mental Health*. In 2015, after reconvening participants from earlier performances, the organizers noted that a theme was surfacing concerning community member and participant experiences with the new ACT teams in Vancouver (Ng and Van Veen, 2015). Upon hearing of this dissertation research and my frontline clinical observations of ACT's roll out in the community, the group's coordinator elicited my assistance to co-author a report to deliver to the organization's funder—the provincial government—and to the public via the theatre group's website.

Collaborating on the document provided a knowledge translation opportunity for my research, and a chance for "the community to voice some of these concerns [about the ACT teams] … in hopes of giving a fuller picture of the experiences that people are having on the ground" (p. 1). The result, *Maladjusted: Humanizing Mental Health*, criticizes ACT's "biomedical reliance on psychiatry, and medication", its role in apprehensions under the BCMHA, and widespread clinical proclivity to use "extended leave as a means to 'manage' 'difficult clients'" rather than "looking at ways to enhance voluntary treatment and finding creative ways to support individuals" (p. 3). It concluded with a number of recommendations for the provincial government, including that:

- Police be disengaged from roles on ACT teams out of concern that their involvement in mental health visits could be experienced as threatening by patients;
- ACT patients be provided with rent subsidies[46] to assist them to obtain safe and affordable housing—as recommended in the "best practices" of Housing First ACT programs—rather than only medications and surveillance;
- There be "increased pressure on the burden of proof for psychiatrists placing clients on extended leave", noting that "the ease of placing people on

[46] Most of BC's ACT teams do not provide rent subsidies to clients, leaving them without many options in the context of BC's notoriously expensive housing market. This is contrary to the "Housing First" approach to ACT that serves as the foundation for its "evidence base".

extended leave is, from talking to people on the ground, quite dangerous and can lead to very dehumanizing situations that are not optimal for the betterment of some mental health patients". The reported pointed out that rates of mandatory treatment orders under the BCMHA have risen sharply in recent years, and stated that "action should be taken to curb this trend" (p. 4);

- Steps be taken to regularly review Extended Leave cases, and that "participant choice and autonomy should be at the forefront of clinical decision-making" (4); and that
- There be "increased dialoguing between clients and ACT teams, through creative means" (p. 4), noting that there is a sense from "people on the ground" that ACT is "more coercive than assertive" and discussion between clinicians and people who struggle with mental health could facilitate a better understanding of the "impact the model has on people's lived experience" with the healthcare system.

Providing input into the Theatre for Living's Community Report (Ng and Van Veen, 2015) forged a creative partnership with an arts-based activist group in order to draw the Ministry of Health's attention to the coercive features of local ACT implementation and how they are being experienced by psychiatrized people. However, co-authorship was not without discursive risks. I was sought out to provide input because I was a doctoral student and had a strong clinical practice background in mental health and substance use. In this sense, I was able to offer professional psy "expertise" derived from my education and clinical work experience with Health Authorities to validate the experiences of members of the theatre group. This appeal to "expertise" reinforced the privileged role that professional biomedical knowledge has atop the epistemological hierarchy in mental health policy and practice, thus perpetuating politics that this research argues are central to rationalities of advanced liberalism (Rose, 1993; 1996).

While on the one hand co-authorship helped to unsettle certain discursive practices (e.g., police involvement in ACT and coercion under the BCMHA), it also reinforced the power of clinical, psy knowledge. Moreover, recognizing the faith that local researchers and health administrators have in the ACT's ability to manage contemporary "problems" of mental illness, the *Maladjusted: Humanizing Mental Health* report makes a strategic compromise where it avoids going so far as to recommend that the government abandon the intervention all together. It also evades criticizing the neoliberal political rationalizations that promote ACT's efficacy as a solution to the "mental health crisis",

such as its objective to create auto-regulating, self-motivated clients that willingly accept—or better yet voluntarily *seek*—treatment for their psychopathologies.

In fact, the way the report problematizes coercion leaves an implicit assumption that "choice" and "autonomy" are important principles of care that ACT ought to aspire toward. This characterization is somewhat out of step with the fact that throughout this dissertation I have argued that "choice" and "autonomy" in mental health care is a fantasy without broadly addressing social determinants of mental health. Under BC's current mental health law, a threat presides over every "choice" made by patients. For as O'Leary and Ben-Moshe (2019) note, if an individual defies psychiatric advice and exercises the choice *not* to take psychiatric medications, "how will they regulate their body/mind and be efficient and productive citizens so they can avoid the surveillance and violence imposed by psy-expertise?" (p. 127).

Advocating for incremental change was a compromise. Rather than calling for the unlikely abolition of ACT or for changes to the BCMHA that would take years[47] to pass through the legislature and into law, the report recommends more immediate actions that the government could take to improve care. For starters, it calls for abandoning ACT's clinical reliance on the disciplinary practices of policing and extended leave. This recommendation is likely to be compelling for policy makers because it highlights contradictions that disciplinary practices present for the government's proclivity to enact policies that govern at a distance through improving mental health patient capacities to make "better choices", leading to savings for the state.

These trade-offs reveal the ways in which policy workers, clinicians, and activists are forced to personally and professionally negotiate a complex maze of knowledge/power, with all its restraints and possibilities. Foucault's (1984) concept of "counter conducts" offers a useful analytical tool to help professional problematizers see that "where there is power, there is resistance, and yet, or rather, consequently, this resistance is never in a position of exteriority in relation to power" (pp. 94-95). Seeking to "open up a space for the politics of the present", Newman's (2013; 2000) qualitative research exploring the work of feminist activists in professional and non-profit settings

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[47] During 2015, the time of the report's publication, the governing BC Liberal Party had enacted widespread cuts to health and social services in the province and had advanced ACT as a key element of their long-term mental health strategy.

resonates with my experience as a health authority and provincial government senior policy leader; particularly how her interviewees describe their complex, intricate engagements with multiple, co-existing forms of governmentality in "*particular* sites at *specific* moments", with unpredictable, sometimes mixed outcomes (p. 206).

Highlighting the Maladjusted (Ng and Van Veen, 2015) report as an artifact of a specific, intentional, but contingent, and at times contradictory effort to resist psy and security discourse is not intended to downplay their constitutive force; for as Foucault notes: "people know what they do; frequently they know why they do what they do; but what they don't know is what what they do does" (Dryfus and Rabinow, 1982; p. 187). What the example *does* illuminate is that political agency is possible through our attempts to introduce competing problematizations into the fold, leaving hope that discursive victories through reproblematization might coexist with trespasses in our efforts to enact a post structural praxis.

9.4. Conclusion

At face value what the documents on Vancouver's "mental health crisis" achieve is difficult to know. However, this dissertation opened new questions to uncover the multitude of possible subjectification, discursive, and lived effects that the texts help to make possible. The "crisis" point and emerging political rationalities certainly led to rapid changes in the way mental health programs function in the discursive site of "the community". These changes are most notable in how the roles that psychiatry and policing play in the lives of marginalized people have been reconfigured under new provincial investments in clinical interventions like ACT and AOT. Chapter one began with the proposition that the set of problems that nest together to form Vancouver's "mental health crisis" are not given or politically neutral, but rather fashioned through historically contingent psy and security discourse that are etched into policy and practice. It then introduced the WPR approach and provided background on the key policy documents analyzed in my research. Chapters two and three provided an overview of how the concepts of problematization, governmentality, and neoliberal political rationalities are vital to Bacchi's (2009a) WPR approach.

Chapter four went on to describe "what the problems are represented to be" in the policy documents, including: public safety risks associated with untreated "SAMI", a

lack of psychiatric services in “community settings”, economic costs associated with hospitalizations and justice system involvement for people with “SAMI”, and a lack of cross-sectoral collaboration between healthcare providers and police. In the chapters that followed, the historical context of how, when, and where these problem representations emerged (chapter six) was elucidated to demonstrate how the “mental health crisis” ought not be viewed as a temporarily contained, episodic event, but rather as contingent on BC’s history of problematizing “mental illness” and substance use as medical and criminogenic phenomena. This required exploring the socio-legal progression of BC’s mental health legislation, practices of psychiatric institutionalization and deinstitutionalization, and the war on people who use (some) drugs.

Chapter seven advanced the analysis by highlighting the silences, what the documents omitted to problematize; namely poverty, the role of police and psychiatry in BC’s colonial history, and the role of policing in maintaining the settler colonial city through criminalizing and disciplining the bodies of psychiatrized people and/or people who use (some) drugs. Then, in chapter eight the analysis turned to the subjectification and lived effects produced by the problem representations. The most pronounced subjectification effects are found in the way the texts engage in discursive practices of “concurrent disordering”. Frequent reference to pathologies of people before their personhood—evident in the use of pejorative terms like “addict” and “the mentally ill”—also produces forms of identity violence and dehumanization.

However, the forms of violence in the texts are not limited to the subjective. Violence also manifests in the *lived effects* that the dominant problem representations produce for psychiatrized people. The production of people with “SAMI” as criminogenically dangerous “others”, predisposed to commit random acts of violence against innocent, law-abiding, “low risk lifestyle”, and economically productive citizens of the city opens up the door to increased policing and psychiatric confinement. The dissertation went on to describe how this range of effects produced by the documents serves to further undermine Canada’s already lukewarm commitments to health human rights, particularly for urban Indigenous peoples and people with disabilities recognized by international law.

Despite the deleterious repercussions that the new forms of “cross-sectoral” mental health programs prescribed as remedies to the crisis might hold, remarkably little

critical scholarship has focused on how police come to occupy roles in the healthcare system. Perhaps the most significant and original contribution that this research makes to the emerging field of mad studies in Canada is its elucidation of the ways in which policing, psychiatry, neoliberal political rationalities, and disciplinary power have become intricately enmeshed in a specific community-based mental health program. In some respects, the new regime of psychiatric and police control formed under Vancouver's ACT program abandoned the proclivity to *govern at a distance* through mental health recovery paradigms that bolster the auto regulating capacity of psychiatric patients in favour of disciplinary forms of custodialism, enacted through practices of forced confinement, mandatory medication administration, and police involvement in psychiatric outreach.

In other ways the local crisis response salvaged neoliberal political rationalities that draw the focus of policy on measuring and managing what Rose (1996) refers to as the "'administration of risk' across the territory of the community". In the Vancouver context, the administration of risks associated with mental illness evolved throughout the 2010's to rely on "joint service arrangements" between health authorities and police, "motivational interviewing" techniques that attempt to inspire patients to care for themselves absent support from the state, and the use of new surveillance technology like the VPD's EWS, which combines confidential health and police data in an attempt to anticipate mental health "decompensation" and intervene to prevent it. More research is needed to understand how these techniques are being used by clinicians and law enforcement, and what implications they have for the health human rights of psychiatrized people and people who use drugs.

Following Van Veen, Teghtsoonian, and Morrow (2019), I also argued that what came to be understood as an urgent state of "crisis" regarding mental health in the inner city is not in fact episodic, but rather part of a historical process of what Nixon (2011) calls "slow violence". Slow violence is evident in the way policing, poverty, the war on drugs, and the role of the settler colonial city are largely absent in the problematization of the "crisis", and so remained unaddressed in proposed solutions. However, the efforts to resist the dominant problem representations chronicled earlier in this chapter also reveals that multiple projects of "slow justice" have been introduced over time. Slow justice appears "at the seams where consensus might not have been achieved, where the efforts to problematize the "crisis" differently shined through, opening up spaces for

problems and solutions to be enacted in different ways" (Van Veen, Teghtsoonian, and Morrow, 2019; p. 73).

I have witnessed slow justice in many forms throughout my career as a researcher, and in working as a professional problematizer with health authorities, and municipal and provincial governments. The recommendations in the City of Vancouver's *Caring for All Report* (2014) to establish a "peer leadership table" and Aboriginal "healing and wellness strategy", the VPD's subtle discursive shifts towards recognition of the epistemological value of "lived experience" and the need to have more diverse voices involved in policy making, and the BC government's recent move to decriminalize personal possession of illicit substances (BC Ministry of Menal Health and Addictions, 2021) all serve as notable examples. Some might dismiss these artifacts of slow justice as neoliberal cooptation, where government planning processes intended to find and manage stakeholder consensus regarding desired "priority actions" and outcomes glosses over ongoing struggles for social justice. However, viewed another way, they represent years of struggle on behalf psychiatrized people, people who use drugs, and critical policy workers to challenge pathologizing discourse with the hope that a more compassionate, just, and equitable City is possible (Van Veen, Teghtsoonian, and Morrow, 2019; p. 73). However, these efforts of advocates to work *within* government policy planning processes should not be viewed as the only forms of effective resistance. Activists who set up the "warm line" also resisted by refusing engagement with the mental health system and instead focusing efforts to forge radical new forms of empathetic peer-to-peer support that undermines psychiatric power in order to prevent violent encounters between police and clinicians, and people in distress.

My research does not intend to soften urgent calls for improving health and social services in Vancouver. Interdisciplinary models of community-based care like ACT have potential to offer important forms of support for people who struggle with homelessness, mental distress, and substance use. However, in order to achieve more just and equitable outcomes for program participants, state and non-profit service providers must be a little more wary about the potential for our mechanisms of care to slip into harmful forms of control. This is only possible if mental health policy and practice extends beyond psychopharmaceutical treatment, and instead, or also, focuses efforts on improving social determinants of mental health like safe and affordable housing, income assistance, and access to culturally safe forms of social connection and peer support.

It must also be recognized that as long as the war on people who use (some) drugs remains in place under Canada's federal Controlled Drugs and Substances Act, criminalization remains an inevitable, unjust, and dangerous barrier to care for people who rely on illicit substances to manage mental, physical, and emotional pain. I have also argued that because psychiatry and law enforcement have long played a significant role in the colonization of Indigenous people in BC, so too must they work towards reconciliation by taking responsibility for addressing anti-Indigenous racism within their professions.

This dissertation has opened new questions, not just for researchers, but also for policy workers, police, clinicians, and activists working day after day to problematize mental health and substance use. As a government policy worker, these questions keep me up at night wondering how, and whether to continue the hard work of advancing competing problematizations in spaces so restricted by psy knowledge and neoliberal political rationalities, where our progress is often slow, uneven, and difficult to measure. The questions about agency involved in the "how to" are complex matters for future research and reflection about professional ethics, but the resolution that eventually lets me sleep is relatively simple: "*have to!*" For, as McKeown, Scholes, Jones, and Aindow (2019) note, "if the problem of violence within psychiatric services is one of interaction between an oppressive system, staff working within it, and detained patients, then arguably solutions have to involve all interested parties" (p. 275). Let us start this challenging task from a place of care, by putting collective effort into confronting problem representations that permit our violent trespasses against psychiatrized people and people who use drugs to occur in the first place.

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Appendix.

Core Texts for Analysis

Year	*Document Title*	*Author*	*Relevance to the analysis*
2008	Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources	Vancouver Police Department	Presents the first "evidence" that there is a "mental health crisis" occurring in Vancouver's inner-city. Traces of problematizations (the cost of mental illness to police resources, the risk of violence and other "extreme behaviours" from untreated "SAMI") that would later build a rationale for ACT as a solution to the crisis begin to emerge in the text. The document calls for more data sharing and surveillance collaboration between police and healthcare providers.
2009	Project Lockstep: A United Effort to Save Lives in the Downtown Eastside	Vancouver Police Department	Report summarizing the "deleterious effects of the high incidence of mental illness, drug addiction, disease, crime, homelessness, and poverty [that] have devastated the most vulnerable people in [the Downtown Eastside]" (6). Calls for the establishment of a steering committee with all levels of government and local police and community advisory groups, chaired by a "Director of the Most Vulnerable Population". Presents evidence of competing problematizations of the Downtown Eastside and proposes a number of information sharing and collaborative efforts between police and government.
2010	Policing Vancouver's Mentally Ill: The Disturbing Truth, Beyond Lost in Transition	Vancouver Police Department	The second in a series of reports from the VPD that works to construct the "mental health crisis". ACT is mentioned for the first time in a significant BC policy document. References the promise of At Home to promote local health and police understandings of the "SAMI", and provides crime statistics to construct individuals struggling with mental health and homelessness as dangerous to the public and fiscally burdensome for health and police.
2013	Improving Health Services for Individuals with Severe Addiction and Mental Illness	BC Ministry of Health	Report by the BC Ministry of Health to summarize key "provincial actions" in response to VPD and City of Vancouver recommendations. Indicates provincial intention to implement ACT teams around the province in order to improve outcomes for "a harder-to serve addictions and mental illness population who present significant aggressive behavioural issues" (p1).

Year	*Document Title*	*Author*	*Relevance to the analysis*
2013	Vancouver's Mental Health Crisis: An Update Report	Vancouver Police Department	Report builds on a growing municipal consensus prescribing ACT as a solution to the perceived "crisis". Proposes police embedded ACT teams as a beneficial program modification, and signals support for increasing collaboration between City of Vancouver, Vancouver Coastal Health Authority, and the VPD.
2014	At Home/Chez Soi Project: Vancouver Site Final Report	Currie, Moniruzzama, Patterson, and Sommers.	Final report on evidence from the MHCC's Vancouver At Home Study. Provides research evidence to demonstrate the efficacy of ACT with what the report describes as a nationally distinct—for its high rates of severe addictions—homeless population in Vancouver, BC. Cost savings are reported through reduced emergency department visits and criminal justice involvement for research participants.
2014	Caring for All: Priority Actions to Address Mental Health and Addictions	City of Vancouver	Final report from the Mayor's Taskforce on Mental Health and Addictions. Summarizes findings from stakeholder meetings including researchers, policy makers, police, service users, and practitioners, on the state of the "crisis" and recommended solutions. ACT is recommended as a key solution to the "crisis" along with more inpatient mental health units and a focus on Aboriginal wellness and youth.
2016	Vancouver Police Mental Health Strategy: A Comprehensive Approach for a Proportional Police Response to Persons Living with Mental Illness	Vancouver Police Department	The most recent report from the VPD to specifically address mental health and policing in Vancouver, the strategy document references earlier reports, and summarizes how policing practice has shifted, through increased police training and mental health service programs and partnerships, towards "improving outcomes relating to police interactions with peoples living with mental illness" (5). The report regularly references the municipal government's Caring for All (City of Vancouver, 2014) report and articulates practical details regarding the decade-long growth of the close working relationship between health, police, and the municipality regarding mental health policy and practice.