MENTAL INSTITUTIONS: THEIR STRUCTURE FUNCTION AND EFFECTIVENESS.

by

John William Seager

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Name: John William Seager

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Examining Committee:

Chairman:

Thomas J. Mallinson, Ph.D.
Senior Supervisor

M. Patricia Hindley, M.S.
Examining Committee

Frederick J. Brown, Ph.B.
Examining Committee

Dr. John Kyle, Ph.D.
External Examiner

Date Approved 14TH FEBRUARY 1974

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Author: _____

(signature)

John Seager.

(name)

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ABSTRACT

Within the last twenty years a social movement in the mental health field has occurred. With it has developed a common view of the nature of mental illness; a theory of "total institutions" which attacks the dehumanized and custodial orientation of large public mental hospitals; and an alternate mode of treatment, the community mental health program. The thesis offers an evaluation of this concept of mental illness, a description and critique of the theory of "total institutions", and a discussion and analysis of the community health program in British Columbia.

In the initial chapters the theoretical and empirical critiques of public mental institutions are examined and appear to be based on a common view of mental illness. This view is illuminated and evaluated before a complete examination is made of the theory of "total institutions" and the concept of dehumanization which flows from it.

The basic elements involved in the concept of "total institutions", and the consequent dimensions of dehumanization, are described in summary form. The main ideas maintain that many of the characteristics ascribed to psychiatric illness are a function of the communication patterns inherent in the social systems in the mental hospital.

Chapter III is a critique of the concept of total institutions and reviews the analyses of mental health practises in terms of whether or not they conform to contemporary conceptions of a therapeutic milieu. They have observed that large public mental hospitals generally fall far short of reasonable requirements.

The concluding chapters explore the alternative institutional arrangements which are explicit in the critique of the large public mental hospital. After a brief history of mental health care in British Columbia, and a description of the proposed mental health program for Vancouver, there follows an examination of the positive and negative dimensions of the community mental health idea. It reveals the necessity to integrate more fully the large public mental hospital into an ongoing meaningful community mental health program.

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I am greatly indebted to Pat Hindley, Fred Brown, and Tom Mallinson all of whom have made helpful contributions to this study. To all of these people goes my deep appreciation.

DEDICATION

To my wife Sheila,

and son Mark

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Chapter I

MENTAL ILLNESS AND THE PSYCHIATRIC CRITICS

Introduction

The theoretical and empirical critiques of public mental institutions appear to be based on a common view of mental illness. It is first necessary to illuminate and evaluate this view before complete examination can be made of the theory of "total institutions," and the conception of dehumanization which flows from it.

The Psychiatric Critics

The bulk of "medical-sociological" writing in the subject matter of psychiatry appears to represent a parallel with the developed science of epidemiology in the prevalence and incidence of physical diseases by different social classes, age ranges, cultures and other social variables: these researches take it for granted that "mental illnesses" exist as facts of life (to be correlated with other social facts) and do not discuss the logical status or the social nature of either diagnosis or therapy in the psychopathological field. The trend in the sociology of psychiatric classification and treatment which, on the contrary, takes "mental illness" and its "treatment" as

being problematic, to be analyzed as value laden social constructions is a more contemporary and unpopular trend in psychological medicine.

What exists, in brief, is a contrast between what might be called an exterior sociology of mental illness and an immanent (or in-dwelling) sociology of "mental-illness-as-a-social-construct." The same contrast is visible in the sociological treatment of several other social problem areas outside the aetiology of madness: prostitution, homosexuality, drug addiction and criminal delinquency are all topics which can be discussed either by way of an external sociology analyzing pathological "givens" or from an immanent, critical perspective which sees the official counts and categories of deviancy as mere projections of society's formal or informal control process, and performs an imaginative entry into the deviant's own actions, viewing them as an attempt to manufacture significance for his life within and against a rejecting, "labelling" world.[1]

Theorists of mental illness, whether in sociology or outside it, have usually had to begin by denying the validity of a natural-science perspective on psychological abnormalities.[2] Thus we have Szasz and Goffman drawing a sharp distinction between the natural-scientific, value-free language of physical medicine and the socially and politically loaded language of psychiatry. Szasz believes that, in physical illness, the notion of a bodily symptom

is tied to an anatomical and genetic context as distinct from the social or ethical context which informs psychiatric judgments.[3] Erving Goffman, the most influential sociological theorist in the "anti-psychiatry" tradition, appears to offer a number of quite distinct approaches in the demarcation of physical and psychiatric disorders. In Stigma he applies an interpersonal analysis to the victims of physical handicap and disfigurement with a method similar to that used in "The Moral Career of The Mental Patient."[4] But in some of his most recent works he seems to fall back on the Szasz-type contrast between the purely biological, value free substrate of medical classifications and the socially-determined character of judgements about mental symptoms.[5]

Michel Foucault, contributes to and deepens this perspective.[6] He is not concerned to destroy the concepts of psychiatric diagnosis and treatment, but wishes only to point out that each age of civilization from the medieval period to modern times, has had its own view of madness which closely reflected the general social and logical preoccupations of the time. Psychopathology is not independent of social history, for each age has drawn the split between madness and reason at a different point and in a fundamentally different fashion. Still, he maintains, it is permissible to seek a psychodynamic or a

genetic or an existential account of the individual patient's behavior, so long as one does not "make these aspects of the illness into ontological forms," real essences which require a "mythological explanation like the evolution of psychic structure, or the theory of instincts, or an existential anthropology" to support them.[7] Thus Foucault claims that the images of psychoanalysis, with their percipient charting of defense shields, traumas, anxieties and other embodiments of conflict, do not (as the analysts imagine) reveal the true workings of an inner psychic machinery but rather reflect how mankind has made mankind into a contradiction-laden experience.

It, therefore, appears that while many of the "immanent" theorists of mental illness diverge, to some extent, in theory they simultaneously converge in their criticism of the established doctrines of psychiatric medicine. It is certainly to the permanent credit of the critics of psychiatry that they have exposed the inadequacy of the positivist* framework for the understanding of mental illness. Whatever exaggerations the radical anti-psychiatrists and labelling-theory sociologists have engaged in, they have shown that both diagnoses and

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*Positivism, meaning the approach towards the investigation of human pathology which postulates a) a radical separation between facts and values, declaring only the former to be the subject matter of the professional investigator and b) inhibits the interactive relationships between the investigator and the facts on which he works.

treatment-measures in psychiatry are founded on ethical judgments and social demands whose content is many times left unstated. It seems beyond argumentation that mental illness is, indeed, a social construction and that psychiatry is a social institution, incorporating the values and demands of surrounding society.

To say that somebody is mentally ill or to announce oneself as mentally ill, is to attach complex social meanings to acts and behaviors that in other societies, or in different contingencies within our own society, would be interpreted in the light of quite different concepts. The accidents of heredity and the blows of environment do not add up or multiply into the social position and personal identity of being "mentally ill." Stress and predisposition are valuable categories for the understanding of organisms and their malfunctioning, but if one is concerned with the understanding of human beings, with the impact of stressful meanings as these affect the predisposition of individuals to screen and consolidate these meanings into their established images of self, then further steps must be taken.[8]

Trauma and resistance to trauma can, in the human case, be understood not on the analogy of a physical force striking a more or less brittle object, nor on the lines of the invasion of an organism by hostile bacteria, but only through the

* abuse by labeling identity

transformation of elements in a person's identity and his capacity to relate to other persons and social collectives. And what positivist accounts of mental illness most flagrantly omit is the serious "stress" (of socially charged meanings and not of physical or biological influences) imposed on the subject-patient by the acts of diagnosis, classification, hospitalization and even (in many cases) "treatment."

Negative Dimensions

The insights of men such as Goffman and Szasz have resulted in a definition of mental illness as the expression of social value judgements about the patient. This definition has, in turn, been the foundation for a critique of contemporary psychiatric practices, especially as they are carried on in large, public mental institutions. The concept of "total institutions" and the theory of dehumanization flow directly from this perspective as does the treatment alternative of community mental health programs.

However before an examination of these subjects takes place, it is important to keep in mind certain negative social consequences of this viewpoint. First, the critics of current psychiatric practices have seemingly left psychiatry with two alternative definitions of mental illness: either to say that personal, psychological and emotional disorders are really states

of the body, objective features of the brain tissue, the organism under stress, the genes; or else to deny that such disorders are illnesses at all. If the latter, then the way is open to view mental illness totally as a social construct with psychiatry's role no longer belonging to the disciplines of objective, body-state medicine. Instead it will be analogous to the value laden, and non-medical discipline of moral education, police interrogation or religion.

This dilemma of definitions can be resolved if it is argued that the nature of all illness is largely a social construction.[9] Illness, whether conceived in localized bodily terms or within a larger view of human functioning, expresses both a social value-judgment (contrasting a person's condition with certain understood and accepted norms) and an attempt at explanation (with a view to controlling the disvalued condition).[10] Thus the physicalistic psychiatrists are mistaken in their belief that they can find objective disease-entities representing the psychopathological analogues to diabetes, tuberculosis and post-syphilitic paresis. Quite correctly Szasz and others have pointed out the psychopathological categories refer to value-judgments and that mental illness is deviancy. On the other hand, Szasz and Goffman are possibly mistaken when they imagine physical medicine to be essentially different in its

logic for psychiatry. A diagnosis of diabetes or paresis also includes the recognition of norms and values.

What is most important from this argument, however, is that the concept of illness, whether mental or physical, remains. It seems that mental illness like mental health is a fundamentally critical concept: or can be made into one provided that those who use it are prepared to place demands and pressures on the existing organization of society.

Yet it may well be that many of the revisionist theorists have produced a paradoxical social consequence. Their theory of mental illness can be used to expose the hypocrisies and annotate the tragedies of official psychiatry and public psychiatric care but the simultaneous tendency to blur the line between normality and illness removes and reduces the entire concept of mental health care; this makes it more difficult for a powerful campaign of reform in the mental health services to get off the ground. Thus, although public outrage is mobilized against large custodial institutional care, conservative politicians can also use Szasz's theory of mental illness to justify cuts in local community health centers, ultimately throwing the victims of mental illness on to the streets--with the occasional shot of tranquilizer injected in them to assure the public that something medical is still happening.[11]

Mental illness can still be viewed as a social construction without reducing all mental disorders to the same level and thus implicitly subverting the quality mental health care which is now needed. Hence this negative social dimension should be kept in mind as one evaluates the theory of "total institutions" and dehumanization and studies alternative approaches to intensive psychiatric care on a community level.

Chapter II

TOTAL INSTITUTIONS AND DEHUMANIZATION

Introduction

This chapter will first describe, in summary form, the basic elements involved in the concept of "total institutions" and the consequent dimensions of dehumanization. The main ideas for this section are derived from Erving Goffman's Asylums, David J. Vail's Dehumanization and the Institutional Career and Russell Barton's Institutional Neurosis. These men, in effect, maintain that many of the characteristics ascribed to psychiatric illness are a function of the existing social systems in the mental hospitals. That is, the hospitals were and are literally making their residents sicker.

Theory

From certain points of view it is useful to regard the mental hospital as a bureaucracy. It is, after all, a place of work with a formally defined division of labor; its operation is governed, perhaps as much as in any bureaucracy, by a normatively defined code. The authority system is officially

"rational-legal" in Weber's classic analysis. At the same time, the mental hospital can be a place in an analytically different rubric, that of a community or a small society.[12] For patients, it is a relatively self-contained, tightly bounded world -- though even this is changing as the boundaries between hospital and outside society are made more permeable.

It may however be misleading to say simply that the mental hospital is a bureaucracy, or is a community. In an effort to combine the bureaucratic and the communal aspects in a single model, Goffman developed the concept of total institution.[13] The mental hospital, prison, boarding school, concentration camp, merchant ship and monastery are variant forms. His definition is as follows: "The total institution is a place of residence and work 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 life." The key fact is the "handling of many human needs by the bureaucratic organization of whole blocks of people." He comments also on the "basic split between a large managed group... and a small supervisory staff."

From this definition of total institutions, its essential Characteristics can be isolated.[14]

(1) A place of residence and work; major portions of human experience enacted in one spot.

Use this
chart for
total institution
*

(2) Large number of like-situated individuals; a double phrase, including both of masses and that of like-situated individuals.

(3) Cut off from the wider society; separation, isolation

(4) For an appreciable period of time; duration as an important force.

(5) Together lead an enclosed formally administered round of life; a triple phrase including togetherness, enclosure and formal administration.

(6) Handling of many human needs by the bureaucratic organization of whole blocks of people.

(7) Basic split between a large managed group...and a small supervisory staff; two conflicting classes.

Other interlocking characteristics of the total institution stemming from the above, are as follows:

(a) an organized system of roles and rules

(b) an organized system of punishments and rewards involving the total life experience of the person

(c) a rationale or doctrine of the organization, binding staff and inmates alike

(d) People-work, a Goffman term connoting man as inanimate object

(e) mortification

(f) Self-perpetuation

Practice of Total Institutions

Typically the person's entire life, during the time of his stay is lived in one circumscribed setting. In advanced situations he may eat, sleep, loaf, work and take his meager sexual and other pleasures, if any, within the confines of a single building. More usually, work, recreation and living quarters are separated by at least a few yards of ground and open sky. The totality of the experience is what counts. It contrasts with the normal style of life which allows major sections of living to occur in different settings, involving different sets of people--one's parents or spouse in the evening, one's teachers or friends or co-workers during the day.

The large group size is another critical feature of total institutional life. Furthermore the group is usually based on like situations which may not take into account at all the essence of the identities of the individuals involved. In fact, the grouping may obliterate their individual differences until one is left with an amorphous mass. The effect, according to Goffman and others, is to rob the person of his identity, so that in all eyes including his own he is no longer anything but disturbed.[15]

Thus a total institution usually offers a setting for

individuals in which life is regimented, where routines are mandatory, where scrutiny and evaluation are constant, and where most of the ordinary privileges of life are suspended. Because of these characteristics and practices, the total institution emphasizes the dichotomy between its existence and that of the outside world. It separates the individual from usual family life and imposes a new social framework upon him.

The time fact is also important. What may make the total institution almost unbearable and destructive is its very timelessness. Often this is accentuated by a paucity of materials such as calendars and clocks, that will keep the time sense alive, so that one day drifts into another in an endless blur. It would certainly seem plausible to claim that indefinite duration adds to dehumanization.

The Organizational Rationale

Every organization, by definition, has some purpose, else it would not be called into existence. This purpose leads to some rationale, a logical explanation for what the organization does. Vail maintains that the total institution carries this simple principle to extremes.[16] He claims that everything that goes on in the institution from the time the experience begins, is explained on the basis of the rationale. This is supposedly true even when, as often happens, there is

no logical connection between the activity and what it purports to accomplish. The rationale may in fact be a rationalization, a set of explanations put in after the fact to justify in terms of "logical reasons" what the organization does.

The rationale of the military boot camp is to take uninformed, undisciplined youths from various walks of life and make soldiers out of them; all hazing, drilling and regimentation can be ascribed to that end. The rationale of the boarding school is to make upper class ladies and gentlemen and the rationale of the monastery is to make true and complete servants of God.

It can be seen from these examples that one theme of the total institution is to produce a career of a certain sort. The above examples are successful in their own terms. The same might be said for tuberculosis sanataria; by strictly imposed regimens of rest and diet these could restore persons to health, often in the absence of any more specified remedies. However in the behavioral fields the outcome is not so clear or successful.

In corrections, for example, one part of the rationale is to protect the community; this is successful enough. But it is also to "correct" the prisoner, to change his career from wrong-doer or deviate into something more acceptable. In the latter regard, the record appears to be largely a failure.

The effect seems all too often the opposite of what is intended, that is to accentuate or aggravate his career further toward wrongdoing.

Similar disparities can be seen in the mental hospital field. Here the rationale of the institution, around which everything hinges, is treatment. Thus the patient may be moved to a less desirable ward because of his "undesirable response to treatment." His work assignment, though ever so lack-luster, based simply on preventing idleness and/or keeping the institution running, can be explained as treatment. The point is that the treatment may have no relationship with its ostensible aims in the real world.

People-work

People-work, a Goffman term, is the application of industrial production techniques to human affairs. The system--a seemingly inescapable one--is that society requires that accountings be made; this in turn requires that the agencies keep track of their work and this in turn inevitably means that the accounting is done not in human terms but in arithmetical, abstract terms. The result is the continual degradation of man into statistic. No level of bureaucracy, it appears, no matter how beneficial its intentions, escapes the structure of people-work. The record is kept not really of individual persons and what besets them but simply of categories. So

many cases "open" or cases "closed."

A simple benign example of this, according to Vail, is the urge for hospitals to show good discharge rates which may lead to premature release of people who should remain; or the agency which enhances its justification by "opening cases" and "closing cases" not according to the true requirements of the community, but according to a pattern which will show high usage rates and rapid turnover, like library circulation figures. Vail maintains that the rapid treatment and "cure" orientation of the medical and health professions helps to set the pace for this assembly line.[17]

Total institutions supposedly make a specialty of people-work. The core reason appears to be the complex of small supervisory staff, with a large subject population. The very exigencies of daily institutional life, for example, may seem to stipulate that so many persons be counted in the dining room and the same number counted out a half-hour later.

Mortification

Goffman discerned the initiation rites, for which he uses the term mortification, as a universal characteristic of total institution life. Mortification appears to also stem from the fact of a small supervisory staff and a large subject population.

Forms of mortification vary. Hazing in military and other

schools is one example. There are many forms of hazing: standing at attention for long periods in an exaggerated posture, running silly errands, wearing silly articles of clothing and various other humiliations. One very common form of mortification is what Goffman calls stripping. That is, upon entry into the total institution the initiate loses everything; possessions, clothing, even hair. The forms of stripping vary but the pattern is remarkably the same. The monastic life requires the surrender of possessions and the tonsure. Military induction requires hours of shivering nakedness and the close haircut. Mental hospitals have traditionally required the ritual bath and the surrender of possessions (for safety reasons). The stripping process is clinched by the organization uniform which must be worn: the plain robe denoting poverty and humility, the G.I. fatigue, the horizontal stripes and the denim of the public mental hospital.

EFFECTS OF TOTAL INSTITUTIONS ON THE MENTAL PATIENT

Institutional Neurosis

According to Russell Barton, institutional neurosis is a disease characterized by apathy, lack of initiative, loss of interest more marked in things and events not immediately personal or present, submissiveness and sometimes no expression

of feelings of resentment at harsh or unfair orders.[18] There is also a lack of interest in the future and an apparent inability to make practical plans for it, a deterioration in personal habits, toilet and standards generally, a loss of individuality, and a resigned acceptance that things will go on as they are--unchangingly, inevitably and indefinitely.

Barton claims that these signs vary in severity from the mute stuporose patient who sits in the same chair day after day, through the ward worker who has without protest surrendered the rest of her existence to the institution, to the cheerful patient who enjoys the facilities available, often does some handicraft during the day, but shows no desire to leave the hospital, shows no interest in plans for the future outside hospital and raises numerous difficulties and objections when anyone tries to help her to be discharged.

Occasionally the passive, submissive co-operation of the patient is punctuated by aggressive episodes which are casually attributed to mental illness but which if carefully investigated often seem to be provoked by some unkindness from another patient, a nurse, a doctor, or visitors.

Barton states that the patient often adopts a characteristic posture; the hands held across the body or tucked behind an apron, the shoulders drooped and the head held forward. The

gait has a shuffling quality, movements at the pelvis, hips and knees are restricted, although physical examination usually show a full range of movement at these joints. The muscular power is also found to be good when the patient co-operates in testing it.

It is only in the last six or seven years, according to Barton, that the symptoms he has described have been recognized as a separate disorder from the one which was responsible for bringing the patient into the hospital. The disease apparently is produced by methods of looking after people in mental hospitals and sometimes exists alongside the illness which was the original cause of entrance. He believes that the condition may be indistinguishable from the later stages of schizophrenia. Often it is complicated by residual schizophrenic features such as delusions or hallucinations. Barton believes that in such cases the diagnosis can only be made retrospectively after subjecting the patient to an intensive course of rehabilitation.

Barton maintains that the causes of this type of dehumanized existence are associated with many factors in the environment in which the patient lives. He states that the factors commonly found in the environment can be grouped under seven headings.[19] The seven factors are:

(1) Loss of contact with the outside world

(2) Enforced idleness

(3) Bossiness of medical and nursing staff

(4) Loss of personal friends, possessions and personal events

(5) Drugs

(6) Ward atmosphere

(7) Loss of prospects outside the institution

The patient's loss of contact with the outside world begins with his illness. The process is increased by removal to a mental hospital, often some miles from home and maintained by detention behind locked doors, systems of parole, and begrudged or condescending granting of leave often made more difficult by complicated form-filling rituals. Letter writing is usually not encouraged and patients may find it difficult to acquire pen and ink and find a quiet place to write at the same time.[20]

Visiting is often limited to two hours a week, often when relations are working. To visit at other times is often regarded as a favour bestowed by medical or nursing staffs. In addition the hospital may be many miles from the place the patient comes from, difficult to get to by virtue of crowding on buses on visiting days and expense may be considerable.

Enforced idleness, according to Barton, takes many forms. In many wards, nurses, perhaps assisted by one or two special patients, make beds for the patients and if asked why reply "it is quicker to do it yourself" or "many don't make them properly" or "it takes them so long to get going." Many patients

may not be allowed to wash or bath themselves and after getting dressed, often with help, patients may wait idly for their turn in the communal work facilities, because of failure to organize groups with alternative activities. This may be followed by a further period of sitting at tables while nursing aides and a few ward workers bring around meals.

After breakfast patients may be herded into the day room or garden and left to sit. A few may indulge in desultory occupational therapy such as knitting or rug making. If a patient gets up she may be told to sit down; if she goes out she may be snubbed or kept waiting. Individual activity of almost any sort may make the nurse afraid of imminent aggression. The nurse's behavior may actually cause an aggressive act which may be countered by sedation. Towards the end of the morning is lunch time; the patient usually has no hand in purchasing, choosing or preparing the raw materials or serving the finished product. After lunch a few patients may help clear away or a queue may file past a table putting dirty dishes and utensils in it. The regular ward workers then wash up, supervised by a nurse or ward orderly. Both afternoon and evening usually present only other arid vistas of idleness.

Barton further maintains that an authoritarian attitude is the rule in many mental hospitals. He believes that it is revealed in many ways, e.g. the use of the imperative mood in written orders; "Patients will not pick flowers," "Nurses

will report immediately..." Orders are often given in a dictatorial voice, such as "Sit Down," "At Once," "When I tell you," "How dare you," "You know you mustn't...."

There is also a tendency for sisters and nurses to decide which clothes, shoes and aprons a patient must wear, if and when and how their hair is dressed, where they must sit at tables, which bed they must sleep in at night, what personal possessions they can have, if any, how much pocket money and "extra comforts" they can appreciate, if and when they can leave the ward, and so on.

Many critics have suggested that this type of attitude on the part of supervisory personnel is primarily the fault of administrative structure.[21] A nurse in charge of a ward may receive conflicting instructions from a consultant, a ward doctor, or assistant matron, and an administrator. The greater the number of persons to whom she is responsible the greater the danger of disagreement, the greater the tension and the worse the atmosphere.

Personal friends may visit the patient at first but very soon the combination of expense, difficulty in traveling and little welcome from the patient on the ward makes the visits less frequent until they eventually cease. Barton states that the possibility of one patient making a friend and confidant of

Isolation *

another inside a mental hospital is great, but it is surprising to him how infrequently it happens. Isolation and loneliness beget apathy which in turn causes further isolation. Large numbers of patients in some mental hospitals have no place in which they can keep personal possessions, no lockers by their beds. Often clothes are issued to a ward and there may be no guarantee that if a patient keeps her frock clean for one day she will wear the same one the next day.

Drugs also contribute to a dehumanized atmosphere in the ward. Barton says that it is not surprising that the majority of patients forced to go to bed by 7:00 p.m. after an idle day require sedatives to sleep nor that they wake after 8 hours at 3 or 4 a.m. and they require more sedatives for further sleep. The effect of the sedative may not wear off from 4 to 12 hours after it is given, so that during the morning the apathy produced by the absence of a planned routine and loss of contact with the world outside the hospital is furthered by the effects of barbituric derivatives and tranquillizing drugs.

The general environment of the ward also will have a definite impression on the patient. This may include many different factors:

a) color of wall, ceilings, floors, and carpets

b) color and designs of furniture, beds, chairs, windows •

lampshades, pictures, rugs, cushions, curtains

c) Intensity of illuminations (lights)

d) Space, arrangement of furniture and presence or absence of crowding

e) Views from windows

f) Flies and presence or absence of dirtiness, dinginess and dilapidation

g) Appearance of other patients, hair styles, hair on faces, clothes, stockings, shoes

h) Noise: clatter of ward activity, jangling of keys, doors slamming, telephone ringing, noise of electric cleaners, patients shouting

i) Helpfulness or off-handedness of nurses and aides

j) Smell of the ward: the smell of feces, vomit, urine, paraldehyde, disinfectant, moth balls, cooking or the smell of flowers and freshness

k) Temperature of the ward and humidity

l) The other patients reactions to the ward, their relationship with nurses and their attitude to visitors

m) Posture, and occupation of other patients

Finally, after admission to a mental hospital, as time goes by the prospects of finding a place to live, a job to work at, and friends to mix with diminish rapidly. Many patients say they never wish to leave the hospital. They can see little

prospect beyond living in a room with no one to talk to or visit. The promise of social clubs, visits, and support from psychiatric social workers and out-patient clinic facilities does not usually overcome these forebodings, and the need to accept the institution as a permanent home is again emphasized. Many other prospects seem poor to the patient. Admission to hospitals may seem the final confirmation that there is no longer any chance of fulfilling their ambitions, be they of marriage, children, social advancement, acquisition of wealth or position. It seems that with this realization many people resign themselves completely to their lot, becoming more apathetic than the situation demands.

Erving Goffman in Asylums uses a somewhat more sophisticated method than Barton's to describe the process of dehumanization for mental patients.* Using a downward oriented model he writes of the progressive degradation of the hospitalized patient due to a number of successive institutional occurrences that affect the patient's self-esteem. In effect Goffman describes a process by which the new patients have already suffered initial degrading experiences and by which they endure further demoralization in the hospital.[22]

Furthermore Goffman found both sides acting in a terrible masquerade. The patients didn't take the doctors seriously unless

*In 1955-56 Goffman attached himself to St. Elizabeth's Hospital in Washington D.C. to observe firsthand the daily life of mental patients and staff.

they acted aloof, somewhat condescending and skeptical about the patient's signs of distress. Patients didn't catch the doctor's attention unless the inmates acted manic, or in some other way that the doctor could quickly recognize as "crazy."

What Goffman really adds to the picture of institutional neurosis traced by Vail and Barton is the insight that under certain conditions of hospital life, both doctors and patients may want to live up to their images. Doctors who suffered when they saw the suffering of their patients but nonetheless behaved condescendingly towards them, patients who didn't feel particularly manic but went through the motions of appearing so, did so because they were building a social order together.

Conclusion

Like a prison, or a farm worked by slaves or a monastery, an asylum is a total institution. In such places all the rules of social life are laid down by a single authority. Goffman shows how, even in this extreme and powerful setting, the life that is dictated becomes subtly modulated so that it is different from the lives people in the institution actually lead. A formal principle of a mental institution is that if the patient submits to treatment i.e., to acting along the lines laid down by the institution, he will in time be able to leave the hospital. To give this obedience meaning, however, the person under treatment begins to form a "career" for himself

as a sick person. So long as he remains noticeable he gets attention, his visible signs of illness are common ground that he can discuss and that connect him with other patients and with the staff. To act in such a way as to free himself finally from the institution becomes less and less important. As the patient establishes smooth and stable relations by managing his appearance so that he is marked as sick, the patient gradually becomes trapped in his role.

Thus Goffman's theory of total institutions clearly communicates a sense of the crushing impact of an organization on persons whose individuality is viewed as protected largely by willingness. The patient tears his hair out, the doctor sneers and they achieve a type of stable relationship yet are caught in prescribed roles which lead to dehumanized behaviour and a form of institutional neurosis.

Chapter III

CRITIQUE: CONCEPT OF TOTAL INSTITUTIONS

Introduction

As indicated earlier, large mental institutions have been subjected to criticism both by psychiatrists and social scientists engaged in collaboration or consultation with the psychiatric profession. The critics, such as Barton and Vail, have generally examined the mental hospital in terms of whether or not it conforms with contemporary conceptions of therapeutic handling of patients and have found--to nobody's surprise--that public mental hospitals generally fall far short of reasonable requirements. In this literature the large, centralized, public mental hospital generally tends to be equated with custodialism.[23] Although many of the referents for the notion of custodialism remain vague, they presumably include first a fundamental pessimism about the chances of recovery from mental illness and therefore about efforts to ameliorate mental illness.

Second, the custodial orientation includes excessive interest in security: protecting society from patients and

patients from one another, not to speak of protecting staff from patients. The critics tend to note that psychiatric aides are largely in control of the hospital wards and that these aides are at best ignorant and untrained but kindly and well-intentioned--and at worst suffering from such personality inadequacies as rigidity, paranoia and compulsion.

The point of view of sociologists who have studied the public mental hospital system does not usually differ fundamentally from that of the psychiatrists. Goffman and Weinberg have asserted implicitly that the system is anti-therapeutic. Their analyses are first directed toward detailing not only its psychiatrically questionable practices, but how its systems block the mobilization of any effective therapeutic action. The concepts of total institutions and institutional neurosis have taken this analysis a step further and suggested that certain characteristics ascribed to psychiatric illness are in fact a function of the existing systems of large mental hospitals.

However, although a number of common observations about the mental hospital system have gradually accumulated in recent years, it is important to point out that this general knowledge is apparently highly colored by a specific underlying perspective of the observer. First, it appears that many of the sociologists and psychiatrists presenting critiques are of a higher social

class perspective of critics 32

class than either the patients or most mental hospital employees. Thus viewing an institution with middle class ideals of privacy, human dignity and independence, these observers are understandably horrified by what they see and pose their own "humanistic" orientation against the custodialism of the large mental hospital. Second, as was indicated in an earlier chapter, observers from psychiatry and the social sciences have approached the mental hospital with a specific psychiatric ideology. That is they have hewed to a set of conceptions about the nature of mental illness and how it should be treated that has influenced what they have observed about the large mental hospital and how they have responded. Thus both a humanistic and a type of reductionist psychiatric viewpoint have been fused in criticism.

ideologically charged

Consequently, it can be argued that this type of inquiry has possibly paid insufficient attention to the basic conditions of the hospital and the relationships among elements that underlie the "unfortunate consequences." Furthermore the critic's focus upon the antitherapeutic features of mental hospitals has possibly prevented them from seeing a number of other features that can be conceivably construed as strengths and positive elements in the system. It is therefore necessary to discuss in more detail some of the basic institutional conditions of large mental hospitals, especially the chronic wards.

This examination will supplement the critique of theorists such as Goffman and possibly contribute to a more complete understanding of mental institutions and a better basis from which to suggest alternatives.

Institutional Resources: Problems and Requirements

Most public mental hospitals are located outside of large cities and surrounded by spacious grounds. They usually house an overly large number of patients in an assortment of buildings. Perhaps a foremost problem is the continual influx of patients and the need to accept, diagnose, allocate and at least maintain them.[24] The number of patients assigned to each ward usually varies with the ward's physical characteristics and the kinds of patients housed there.

In such a large institution the major problem of employees center around providing, with minimum resources, a modicum of decent care for masses of patients. Ward personnel are confronted with a number of responsibilities for patients. First they must maintain them in reasonable physical health. They are responsible for discovering ailments and bringing them to the attention of a physician assigned to the ward. If the sick patient can be maintained on the ward, the personnel usually must nurse him. They are also responsible for preventing injuries among the patients.

Second, they must administer the routines of daily life.

They must see that patients go to bed at night and get up in the morning; that they eat; that they are reasonably clean, neat, adequately clothed; and that the ward as a whole is reasonably presentable. The personnel must secure whatever equipment is necessary for these tasks. Third, the personnel are generally confronted with the problem of controlling the patient's behavior, so that the latter hurt neither themselves nor others and can be contained within the ward.

These multiple tasks devolve upon the aides and occassionally upon the practical nurses. When the vastness of the hospital and the usual patient-staff ration are taken into account, it is evident--as many observers have pointed out--that the actual responsibility for running wards must fall upon these ward personnel rather than upon professional supervisors. Many times there is a shifting of personnel from ward to ward in a daily struggle to keep each ward covered with at least one aide.[25]

Aide Perspective and Ward Management

Studies of aide programs for patients indicate that they are not those that professional psychiatric workers could create.[26] The programs are not organized to treat patients but to "help" them; and they do not interfere with the aides' efforts to maintain the ward but are an integral part of ward life and work.

In this sense some observers argue, in contrast to the views of Goffman and Vail, that chronic wards are not sheerly custodial.

Aides and practical nurses working on wards are usually of lower-class origins, and they operate with common sense and relatively nonabstract notions. They tend to have little or no training in psychiatry: They think and talk outside the universe of psychiatric discourse while working within the concrete province of psychiatry. No academic theory, no formulated therapeutic ideology, govern their perception or feelings toward patients--or, it seems, their conceptions of work tasks. There is little drive to cure, to engineer psychological change, to move the patient out, to play therapist--a phenomenon frequently observed and associated with middle-class parapsychiatrists.

One study claims that "the ward is the aide's":[27] She is proud of it and definds its integrity and her pre-eminent position in it. The patients are viewed as her charges, who need guidance, control and care "like children". Some patients are good or troublesome or occasionally mean; other are good but lazy,and so on.

The attitudes of aides are revealed in the judgments and decisions they continually make in their everyday world. The dealings with patients reflect more often than not the central work requirement: maintaining the integrity of the ward.

As understood and expressed by the aides, this integrity depends on an ordered, co-operative and happy home for the patients. To the aides in this particular study, the public mental hospital is generally, and certain wards in particular, good places for the patient: "better than most had before."[28]

Concrete experience quite often seems to validate judgmental process: Most patients have lower-class backgrounds, and the hospitals may indeed represent improved living conditions. Many have been abandoned by relatives; many are too sick to leave; others are well enough but unwilling to leave either because they are frightened or because they have found a satisfactory way of life. Thus contrary to the dominant trends which Barton, Vail and Goffman revealed, there may in fact be an inner logic and a positive dimension to large mental institutions, which is illuminated once one takes into consideration the lower-class system of thought and the public hospitals' institutional requirements.

The general strategy for handling the mass of patients, particularly in the chronic wards, is to organize their lives into daily and weekly routines. The patients carry out these routines in large groups. There are set times for getting up in the morning and going to bed at night. There are times for eating and times for bathing, nail cutting, shaving, combing and so forth. The apparent efficiency of this kind of organization

where limited personnel must handle large numbers of patients is illustrated in the following example. On a female ward near the bottom of the hospital continuum, in the Chicago State Hospital, all extremely infirm and untidy patients are seated together in one wing of the ward, watched over either by an aide or a ward worker (when the ward is short of personnel). Not only are the usual routines followed but additional routines are apparently adapted to these patients. There are times for taking each to the toilet. Since these patients require special care, the aides meet the situation by placing them together spatially and organizing special routines.

Then there are routines for maintaining the ward in a reasonable state of cleanliness and order. Certain patients have special jobs--taking charge of the clothing for the ward and running errands or serving as scrubbers, clerks and so forth. Most manual work is done by patients. The aide acts as a foreman over a number of ward workers.[29]

Thus it seems that on many wards in public and state mental hospitals a great deal more work goes on than appears necessary for basic maintenance. Barton and Vail noting this type of activity tended to explain it as a result of the aide's being willing (and needed) victims necessary to the functions of the total institution. Yet this interpretation possibly overlooks important aspects of the aide's mentality. It can be argued that most aides genuinely believe that work is good for patients. And since occupational and recreational

activity is rarely provided for chronic wards, aides may feel that constructive work is of more value to the patient than other "frivolous" pursuits.7

In order to maintain ward organization aides also make fine distinctions among patients. In the Chicago State Hospital the first principle frequently reiterated is "know your patient." And they appear to know their patients, not in the same way that a psychiatrically orientated professional would know them, but in terms important in their own frame of reference. On one male ward, for example, six general aggregates existed for the aides:

(1) the stable-deteriorated (hopeless incurable patients who though not actually infirm are relatively immobile)
(2) deteriorating (patients on their way down)
(3) stable sick (the majority)
(4) improving (patients beginning to come around)
(5) good most of the time (still have to be watched)
(6) very good (help run the ward and could leave the hospital)

Clearly these aggregates define the amounts and kinds of work that the aides must do for the patients, and the relationship between aides and patients are patterned by these definitions. Another crucial point about these aggregates is that they are not static. Some patients are "deteriorating" while others are "improving." It appears that the aides are aware of this movement

and attempt to control and capitalize on it. They try to prevent patients from deteriorating or to slow the process down and they do what they can to further improvement.[30]

It appears that in chronic wards, during any given month aides perceive a number of patients as in transition and scrutinize them carefully with an eye to improving their condition. They do so for probably two very concrete reasons. First, the better the conditions of the patient, the less work and worry he occasions. Second, aides want not only to cut down on their own work but, if possible, to make the patient more useful. These attitudes seem to flow from the work problems of the aides.

The tactics of aides "working with" patients depend mainly upon infinite patience. Changes in their charges occur slowly and they wait for opportune moments. The first stage of this process, according to the aides, is watching and waiting for the proper moment. The aide "studies" the patient and when he or she thinks the patient is ready, she approaches him. There is definitely nothing systematic or abstract about her recognition of readiness. It appears that aides perceive a patient's natural phasing "moving in" when they see any break in his condition.

The next stage consists of coaching the patient. On a male ward, for example, aides conduct self-styled "classes" for patients on how to dress and undress themselves. When they have time, aides line up patients who are not doing these

things for themselves and coach them. Self-care and the more primitive kinds of work are thus used as levers for inducing movements in patients.[31]

However, there appears to be no additional push to get the patients out of the hospital. Many aides do not encourage patients to leave the hospital, this may conceivable be a kind of exploitation of the patients, as indicated by Vail and Barton--the aides do not want to lose their best workers. This judgment is valid to some extent, but probably more pertinent is the aide's recognition that their patients have made adjustments to the hospital and are no longer able to adjust to the outside world. Realistically too, they see that most of these patients no longer have homes, their families having died or dropped them long since. This aloneness seems to make adjustment to the outside world all the more precarious.

In sum, this view of a large public mental hospital stands in contrast, to some extent, to the dehumanization of patients in the "total institution" model. The social system just described is seen more as a consequence of a number of conjunctive phenomena, the social, political and administrative requirements; social class and other extraphychiatric characteristics of the personnel; patient-personnel ratio; and the routines of the hospital.

If emphasis is placed on lay personnel and their perspectives it is possible to elucidate more clearly the logic

of the work system and to see lay methods for developing programs around the patients and for "helping patients." Since the life of the units is built around the maintenance or enhancement of its shape and integrity, the work done with, to, or for patients is largely a reflection of this requirement. The logic of such chronic services seems to derive from the handling and disposition of patients in accordance with those requirements. The downward escalation appears to be a brutal fact and all effort to intervene or slow it down is both the chronic service's answer to "treatment" and its own attempt to integrate patients into continuing institutional life.

If the Chicago State Hospital is at all representative, it is evident that the bulk of patients are being "helped" rather than treated--but not merely because there are few hospital personnel and other resources. The acute wards or services screen out the young, acutely ill, and physically unimpaired. The chronic wards receive the aged, the senile, the abandoned, the brain-damaged, the physically deteriorated--all those with the very poorest prognoses. Without psychiatric prescriptions and associated resources the chronic services proceed, as would any social system, to receive, to socialize and to integrate patients into the basic social unit.

Conclusion

It is important to be explicit about the models

underlie assertions about patient's fateful sojourns within hospitals, not only to maximize clarity of thought but to further judgments about alternative assertions. Goffman's moral career and "total institution" model emphasizes both the unforseen consequences of institutional arrangements and the various stages of patients' careers. Other studies by such people as Caudill and by Stanton and Schwartz explore the effects of administrative tensions.[32] Yet it seems important to point out that Goffman's model (as appears common in most sociological literature about psychiatric hospitals) emphasizes primarily the negative consequences of institutional arrangements and tends to underemphasize the positive actions of lay personnel, especially in the chronic wards, of large public hospitals. The main reason for this is that his model and Vail's and Barton's fail to take into consideration, among other things, the lower class origins and practical adaptations of the ward staff. Their psychiatrically trained, primarily middle class viewpoint tends to present constructive, adaptive techniques under difficult conditions, in a primarily negative light. But the consequence of ignoring the difficult social circumstances of a large mental hospital is to picture most ward activities as almost conspiratorially twisted against the patient's welfare. Thus the theory of total institutions, while providing valuable insight, should not be taken as a totally accurate reflection of the functioning of most mental hospitals.

Chapter IV

BRITISH COLUMBIA: A CASE STUDY

Introduction

In summary, we have looked at Goffman's view of mental illness which emphasizes the importance of social-value judgments. It seems to follow logically that such a conception would eventually lead to a critique of the existing social systems of public mental institutions and their effects on mental patients. The model of "total institutions" was then developed and we then examined the work of other individuals such as Vail and Barton who added further concrete data to the picture of the dehumanized patient.

However, the negative social implications of this conception of mental illness have also been pointed out, especially the danger of reducing the idea of mental illness to a point where it is difficult to acquire public funds for further mental health care. Furthermore it has been argued that the Goffman model, because of its preconceptions and class bias may tend to ignore the positive contributions of lay personnel in chronic wards.

Keeping these objections in mind, it is now necessary to explore the alternative institutional arrangements which are implicit in the Goffman critique of the large public mental

hospital. This will first entail a brief history of mental health care in British Columbia and a description of the city's proposed community health program. Such an examination will reveal the positive benefits of such a system of mental health care and also indicate some dangers and possible limitations.

Historical Overview of Mental Health Services

The history of mental health treatment in the Province of British Columbia, is, to a large extent, the history of the development of the Provincial Medical Health Services. From 1872 until 1901 what existed in the way of institutional services was primarily custodial care for the dependent insane. This consisted of two buildings, one, the New Westminster Asylum was described as an ugly structure with windows so high that the outside could only be seen by standing on a table. Further, it was poorly heated by means of open grates and so overcrowded that two patients were compelled to share a single small room.[33]

The only physician at the institution was embattled with the problem of keeping the per diem cost at a low level (it was 48¼ cents per day in 1891), of urging construction to house the increasing patient population, of ensuring adequate water supplies and of visiting the Royal Columbian Hospital. The cruelty of the "keepers" during this period was apparently scandalous. Equipment such as handcuffs, leather mitts, straps

camisoles, and straight jackets with the cruel rope halter called "the martingale" (used as a type of strangulation device), were in almost daily use. Also applied were tortures such as the dip in which a patient, arms handcuffed behind his back, was plunged head-down into a tub of cold water until he very nearly drowned, and the "cage" a box constructed of wooden slits and made only large enough for a human body in which a patient might be kept confined for many hours.[34] By 1897 most of the staff involved in these affairs had apparently resigned and the Provincial Asylum was re-named the Public Hospital for the Insane (P.H.I.).

In 1902 annual reports contained, for the first time, a table of diagnoses (mania, melancholia, dementia, and paranoia). Supposedly General Paresis formed 12% of the total number of admissions for the year (14 patients out of the total 115.) A statement of treatment principles, given the general title "Moral Treatment" was also issued at about that time. These principles were listed as (1) essential medicines, (2) good food,(3) regularity of living habits, (4) employment, (5) amusement, and (6) recreation. A need for separate facilities to deal with acute cases, the mentally defective, the tuberculous patient and the criminally insane was also called for.[35]

In 1904 a colony farm was created. Patients were segregated into "incurable" "curable" "feeble" and "infirm" upon admission. Work became more departmentalized and the hospital

atmosphere heightened by using the word nurses rather than "keeper" or attendants. By the end of 1912, in spite of serious overcrowding, there was reason for optimism. There was a call for new buildings, in stages, each specialized as to function: an administration building, an acute building, sick and infirm buildings, an epilepsy building, a pair of chronic buildings and an adequate living quarter for nurses.

It was decided that one of the chronic buildings should be constructed first so that it could be used to house the overflow from the PHI and the structure now known as West Lawn was begun. The first building on the new ground, named Essondale, was opened on April 1, 1913. Two institutions were now in existence: PHI at New Westminster and Essondale. During the period from 1914 until 1918 the dual institutions began to have increasing difficulties. Many of the nursing staff joined the armed forces, overcrowding was again rampant, and syphilis was the cause of 12% of admissions.

The period from 1912 until 1950 was one of primarily custodial care. All of the buildings added during this interval, before they were officially opened, were doomed to become the site of suffocating overpopulation at an estimated average of more than 55% of rated capacity. The resident population at the end of each 10 year period during this interval increased by approximately one thousand. In 1912 it was 722, in 1924, when the first acute building, now known as Centre Lawn was opened

it had risen to 1,784; in 1930 when East Lawn was opened, to 2,411. By 1951, the number resident at the end of the year was 4,602.[36]

During this period, wards overflowed into the attics and basements, choking out areas needed for day use and therapy, especially that of the occupational and recreational variety. On the wards, conditions were such that towards the end of the period, there were more patients than beds. Those unfortunate enough to be in excess had to sleep on mattresses placed on the floor. Furthermore, a return to locked wards and even to physical restraint took place. As many as 30 patients in restraint and 51 in seclusion, mostly women, were counted by an inspection team as late as 1951.

Various departments were formed during this period, and although each suffered from severe limitations, they were at least available when a resurgence occurred. Directors were found for Occupational Therapy and Recreational Therapy. Physicians on staff were appointed to direct or to work in major departments such as Pathology, X-Ray, and Pharmacy but held these positions as duties secondary to their ward work, so that activity in one field was detrimental to efforts in the other. A study of the reports on the laboratory, for example, reveals a variable load, usually contingent on the presence or absence of a laboratory technician, as well as the freedom of the Medical

Officer in charge. The chief cause of death for many years was given in the reports as "exhaustion, due to...", followed by the psychiatric diagnosis.[37]

There were definite trends in treatment during this period but limitations of staff and spaces reduced the number of patients who received it. By 1926 intravenous tryparansomide had been used for syphilis and found to be effective but palliative only for general paresis. By 1946, with bismuth, sulfa and penicillin added to the therapeutic agents, treatment was more definitive. Hydrotherapy, the chief physical treatment in the 1907 period, continued in use in the 1950's. The use of insulin shock was first reported being carried out on 20 patients at a time, in a 1938 medical report. And surgery for mental illness was introduced in 1946 when 9 lobotomies were performed in the Vancouver General Hospital. The following year there were 45 cases but over the next five years, psychosurgery suffered a gradual loss of popularity as other means became available.

On April 1, 1950 the various mental health activities were organized into the Provincial Mental Health Services. The Provincial Mental Hospital's "chronic buildings" were re-named "Lawn Buildings," thus updating the semantics of mental illness. On January 1, 1951 The Clinics of Psychological Medicine Act was proclaimed. This act caused plans for a second large hospital to be shelved and stimulated thought on new alternatives--

e.g. reaching further into the community with day hospitals and out-patient clinics. This act made voluntary admissions and certified admissions without the loss of civil rights possible for a maximum period of four months.

The first year of operation of the Crease Clinic was indicative of success; according to the new standards 791 of the 963 patients admitted were returned to the community within the statutory period. During this year (1951-52), the first consultants in general surgery and neuro-surgery were retained by means of a Mental Health Grant and a survey of overcrowding was made at the request of the Federal Government. The results of the latter were shocking. One building (the male side of Centre Lawn) was found to be 81.8% overcrowded; that is a facility designed for 143 patients was housing 260. West Lawn (male), East Lawn (female), and Centre Lawn (female side) were 30.8%, 56.8% and 42.5% overcrowded respectively.

However the year 1951 marked the commencement of a policy to establish "open wards" in the P.M.H. and Crease Clinic. The following year, all forms of physical restraint, were, once again, abolished, except for seclusion under strict safeguards; and a year later children under six years of age were permitted direct admission to the Woodland School, thereby ending the tragic mixing of small patients with adults suffering from various types and degrees of mental disorder.

During the mid-1950's facilities for occupational therapy, recreation and amusement were improved. General paresis, was also partially eliminated and it was calculated that 50% of schizophrenics could be assisted back to the community after a relatively short period of treatment. In the 1956-60 period, for the first time in history there were actual decreases in the resident population; 78 patients less in 1956-57 and 90 less in 1958-59.

Contemporary Situation: Riverview Hospital

During the 1960's there were a series of differing theories and proposals for improving mental health care in British Columbia. In 1964 the dominant perspective seemed to be that all institutions should be closed and all patients placed in psychiatric wings of general hospitals. This proposal ignored the fact that, at the time, there were as many psychiatric patients filling hospital beds in institutions as there were patients in general hospitals and it did not seem to consider the anomaly of adding 1200 psychiatric beds to Vancouver General Hospital, thus turning it into another Provincial Mental Hospital.[38] By the late 1960's many professionals were in favor of the Saskatchewan plan; to close down the large institutions and build regional psychiatric centres, the result being a number of little Essondales rather than one big one.[39]

Despite these various proposals, the situation at the Riverview Hospital at Essondale (the major active treatment hospital for the mentally ill) continued to reflect many of the characteristics of Goffman's "total institution," and the dehumanizing consequences for patients outlined by Vail and Barton. The Registered Psychiatric Nurses Association of British Columbia characterized the situation as follows:

> "Our members have seen, during 40 years of experience, the prejudice which 'society' or the 'state' demonstrates against the mentally ill, the mentally retarded and the geriatric citizen. It will not be new to the Health Security Program Project to learn of institutions which still exist with conditions that would not be tolerated in a general hospital."[41]

Patients are, in many cases, crowded together in large dormitories and large dayrooms, some holding over 50 patients at a time, stripped of privacy and dignity. The long-term patient is quite literally kept at a level of abject poverty for as long as he lives in one of these institutions. He has less than one third of the daily per capita spent on his care compared to what is spent on his fellow citizen in a general hospital. He must do with crowded facilities, because there are no funds to provide room and privacy; he must do without constant therapeutic care because there are insufficient funds to educate and hire an adequate number of nurses; he must many times do without adequate psychiatric and medical care because

there is a chronic shortage of doctors and qualified psychiatrists; he must put up with drab surroundings, drab clothes and drab meals; he must suffer loss of dignity in even the most basic activities of bathing and toileting. [40]

In a recent position paper, this same organization of psychiatric nurses reveals, in more detail, the situation at Riverview Hospital. They state that Riverview is the major active treatment center for the mentally ill in British Columbia. They claim that there are less than 50 beds readily available in the two psychiatric wings at Vancouver General Hospital and the Lions Gate Hospital in North Vancouver. The situation then is that the majority of mentally ill patients in the greater Vancouver area, and indeed the whole province, are admitted to the Riverview Hospital, either to the Crease or Center Lawn units.

The report goes on to state that the Riverview hospital is also the only major hospital in the province which has the bed capacity to care for the large number of long-term mentally ill patients whose primary need is custodial care. It maintains, that from a nursing standpoint, the ability to provide care needed by the individual is extremely hampered.

Situation in the Wards

The report attacks the lack of segregation of patients according to types of illness. In the female ward of the

Crease Unit, there was an average of 40 patients, of which 22 were first admission and 20 were readmissions. Of the total number of patients, one-third were considered neurotic or psychotic, and the remainder social problems. Of the social problems, out of the total of 42 patients 6 to 10 were chronic welfare cases, 4 were either ex-convicts or from Oakalla, 6 were alcoholics, 2 were drug addicts, 3 were prostitutes, 1 was a homosexual and 4 to 7 were classified as juvenile problems.

In the male ward of the Crease Unit, a similar situation existed with the ward being full to capacity and no beds available for new admission. In an integrated ward of the Crease Unit there were 46 patients and the male count showed 5 more male patients than there were available beds, and these patients slept either in female beds or off the ward, depending on the fluctuation of the female count.[42]

Thus a situation seemed to exist in which 5 of the wards were overrun by readmissions and social problems with the genuine neurotic and psychotic patients "lost in the shuffle." The report claimed that many of the readmissions were quite familiar with the hospital rules and frequently broke them, to the detriment of the neurotic and psychotic patient. Furthermore the social problem type of patient was characterized by the nurses as making continuing demands on staff time which had the consequence of leaving little or no time for the treatment and care of the neurotic and psychotic patient.

One ward in particular was pictured as being threatened by fights between an ex-convict and a juvenile delinquent type, with the shortage of male nurses allowing for only partial control of the situation. It was also claimed that drug addicts were bringing or having sent in large amounts of narcotics. Ironically, in this case, the open ground and open ward policies instituted for the benefit of the neurotic and psychotic patient, was contributing to the flow of drugs. The result was, that because of the overwork of the medical and nursing staff, there were no nursing treatment plans available for over 90% of the patients.[43]

Shortage of Staff and Wastage of Available Staff

The report then details staff shortages and wastages at Riverview. In the R3 male maximum security ward with 80 patients (less than the average ward) there were 36 staff (about double the average ward). But the nurses association maintained that this more than sufficient staff was providing no active nursing care but were instead acting as mutual protection for each other and the weaker patients.

Another area of waste of nursing staff was in the sector of cleaning services. The nurses apparently expect that as part of their duties they are to keep the patients' beds and clothing in clean and tidy order and to be responsible for the treatment, surgery and nursing stations. However, graduate

and student nurses were expected to clean the entire ward area. This included stripping old wax from dayroom, dormitory and hallway floors and laying new coats, scrubbing rubber matting, washing windows, cleaning doctors'offices and lavatories. And in some cases the nursing staff was required to wash the walls,yet where this was not required the walls showed an accumulation of several years' dirt.

The nursing staff maintains that this type of duty further detracts from the time available to provide active care to the patient. They state that the only alternative available at the present time is to have the patients do the cleaning, indicating that the social problem cases will not help and adding that it is not therapeutic to force the genuinely ill patient to perform massive wax stripping projects in order to earn their way.[44]

Further wastage of valuable time occurs in the following area: endless duplication of records--the charting is claimed to be repetitive and many graduate nurses who are completely familiar with a patient's condition must search through the confines of a large hospital looking for a nursing supervisor in order to obtain permission to give a medication that the medical staff has already ordered. They state that in the Valleyview Hospital, the results of staff shortages is a higher rate of staff injuries, more sick time being taken,

staff overwork and poor patient care. Staff shortages in the West Lawn Unit of the Riverview Hospital are pictured as being acute and even in the Crease Unit occasions have apparently arisen when an all female ward of 40 patients has been covered by a male graduate nurse, two female students and a female aide. The result is purely custodial activity.

The nurses' report also points to some of the incongruities in funding priorities. They mention a new admitting suite in the Centre Lawn Building that has wall to wall carpeting yet they question this expenditure based on the fact that there are only two bath tubs in the whole of the West Lawn Building to serve over 700 patients. The result is a situation in which the patients stand naked in long lines waiting for a bi-weekly shower. In addition the single shower handles up to three patients squeezed into the same stall at the same time.[45]

They also note the difficult situation which exists at the Valleyview Hospital. Two wards are composed solely of elderly patients over 70 years of age, a number of whom have cardiac conditions. The physical structure of the building is such that the main dormitories are on the top floor, the day room and offices on the main floor, and the dining facilities are in the basement. This requires the elderly patient with a cardiac condition to climb two flights of stairs several times per day.

The nurses close the section of the report on ward situations with what they label as a "damning condemnation." They claim that the nursing staff on the admitting wards of the Riverview Hospital state plainly and in no uncertain terms that if they had a wife or daughter or son or elderly mother or father who required mental care, they would not permit them to be admitted to the Riverview Hospital as it now functions.

Report of Senior Medical Staff

The senior medical staff at the Riverview Hospital (senior physicians responsible for clinical care) have also submitted a recent report on staffing which serves to supplement the perspective of the nurses.[46] They claim that the British Columbia Civil Service has failed to recruit staff either in sufficient numbers or of sufficiently high professional standards to meet even the barest requirements.

They claim that in a one year period, 17 physicians, of whom 4 were certified psychiatrists, had left full time positions in the hospital. Of the 8 replacements not one is a certified psychiatrist as recognized by the Royal College of Physicians and Surgeons of Canada. The result is a situation in which there are only 8 certified psychiatrists on full time staff and 5 on part-time staff, and this for an in-patient population of approximately 3,000 with over 4,000 admissions per year and well over 1,000 patients in boarding homes or attending after care.[47]

They also state that insufficient numbers and inadequacy of training and experience are only part of the problem. Language and cultural barriers also appear to prevent many of the physicians from making anything other than a superficial contact with the patients. Such a situation is totally ironic and unsatisfactory since a failure of communication, particularly in psychiatric practice, will have disasterous effects on any therapeutic program.

The report also illuminates some serious management problems involving staff being placed in responsible positions without the authority to act effectively. An example of this occurred when the medical staff was directed to establish, without prior consultation and without additional staff, an adolescent unit. Had they been asked about such an addition, they would have reported (a) that such a service had been denounced, in this setting, by numerous workers in the field, and (b) that they were unable to assume responsibility for such a service with the present skills available. They maintain that responsibility for services cannot be assumed in name alone, for if one is really to assume responsibility it must also include the dimension of adequate functioning.

The report also details how similar problems relating to responsibility, authority and communication occur in staffing, where they have little say in hiring of medical staff; in financing where they have no say in the allocation of funds and

where they must accept a rigid, compartmentalized distribution. The report also claims that the hospital administration is bogged down in details which should have been delegated.[48]

Alternative: Community Mental Health Program

A cooperative boarding home program between the Mental Health Services and the Department of Social Welfare became operational in late 1959. Through various administratively approved agreements the chronically hospitalized but improved mental patient could be, after adequate clinical assessment, selected for placement in a licensed boarding home in the community.

The community boarding home, supervised and licensed to give personal care and attention to disabled persons, is oftentimes a useful resource, for a variety of reasons, for patients who are being discharged or placed on leave from a Mental Health Facility. However, licensed boarding homes are proprietary business operations from which a service may be bought, and as such have the right to choose their clientele. Furthermore, they have the right to give notice to any boarder whom they no longer wish to house, or whose condition has become such that the license does not permit giving the type of care indicated.

The holder of a Welfare Institutions License issued under

Section 2, subsection (c) of the Welfare Institutions Licensing Act, is permitted to accept as guests persons who are in need of "care and attention" as defined in Welfare Institutions Licensing Act Regulation 1.01,

"care or attention" means

(a) assistance that can be rendered by a person who is not trained or skilled in nursing and being

(i) help in walking or getting into and out of bed;

(ii) assistance in bathing, dressing, feeding, or in the preparation of food specified in a special diet;

(iii) assistance in the taking or application of medications of a type which are normally self-administered under the instructions of a duly qualified medical practitioner; or

(iv) any type of personal service similar to the foregoing; or

(b) occasional skilled care by a person formally trained in nursing and other services rendered intermittently or periodically under an arrangement approved by the Inspector, in an amount or to a degree or with a frequency which, in the opinion of the Inspector, is less than that which would necessitate the individual being lodged in a nursing home or hospital in order to be properly cared for.

This license does not cover the care of the mentally ill persons, but of the person who may be disabled as a result of mental illness.

During the 1960's some important strides had been taken in establishing mental health clinics throughout the province of British Columbia. However, workable arrangements for establishing community services in the Vancouver area had not materialized. In fact, the description of staff, ward and administrative problems at Riverview Hospital seemed to indicate a growing problem in finding competent mental health care in Vancouver.

Furthermore, several of the general hospitals, even very large ones, had no psychiatric services. This was particularly dramatic in the case of St. Paul's Hospital, a major downtown structure with a large emergency and outpatient clinic, but with no provision for psychiatric casualities and it was known to refer these to the Vancouver General Hospital. Similar practices prevailed in Burnaby, in New Westminster, in Richmond and in several other city hospitals. The result was overloading of Vancouver General and low morale in that service. Little therapeutic work was accomplished and most of the staff spent their time finding hostels and other places to discharge the patients to.

Worse still, large numbers of patients during the early 1970's found their way into treatment through the police and courts, being then either certified or remanded to the mental hospital (which contributed to the type of ward crises described in the nursing report). That the system was at a point of major crisis was reflected in high rates for the area of both completed and attempted suicide, in estimates of both heroin and alcohol habituation, and many other social indicators. No one seemed to have the energy or resources to pull out of the downward spiral yet the need for a concerted program of development was apparent to all.[49]

According to a report by John Cumming, in mid-1972 a number of developments occurred which were of long-range consequence. In the spring the Department of Psychiatry held a retreat at which one of the themes was the breakdown in communication between the different service sectors in the Vancouver area. In mid-summer, under the aegis of the Vancouver Medical Health Officer, a Mental Health Planning and Advisory Committee was formed, which accepted as its mandate the planning of a total mental health system for the Vancouver area, to include the whole array of services from emergency and acute care to educational programs for professionals and volunteers. In September of 1973 a meeting sponsored by the Section of Psychiatry of the B.C.M.A. took place. It was an attempt to bring together psychiatrists from the private, public and

university sectors for a joint consideration of local problems.[40]

The planning committee had the most persistent influence. The initial request for representatives from various professional groups involved in services met with considerable response, and the group rapidly grew to some thirty agencies representing all the service sectors described above, e.g. the hospitals, the community services, the university, the Alcohol and Narcotic Addiction Foundations, the public health departments, the Regional Hospital Planning Board, the Section of Psychiatry, etc. This committee operated under the control of the Metropolitan Board of Health, a quasi-political body which operated as a clearing house for information to the health departments in the area, but without power or budget.

Three initial proposals, by health departments in two suburban communities and Vancouver, to increase their staff and significantly expand services they were already providing, were immediately rejected in a favor of a more sustained approach to planning an orderly development. A byproduct of these initial decisions was the acceptance of the premise that unless a community could involve its citizens in the planning process and come up with a coherent and widely acceptable local plan, the Planning and Advisory Committee and the Board of Health should not be asked to endorse it. In these early discussions, the board outlines of a planning machinery emerged. Each of the three suburban areas was recognized as being of sufficient

size to develop its own community service system. But Vancouver, because of its size and complexity, required a different treatment.

As early as 1967, the United Community Services, a voluntary social planning agency in the city, had recommended the division of the city into twenty-one neighborhood areas which were subsequently adopted by the city as a basis for neighborhood planning. In addition both City Social Services and the Health Department had made some progress towards organizing their services in the five areas based on multiples of these smaller service area groupings. Yet by the fall of 1972 most of these planning proposals remained on the drawing board or in planners' heads, with very few communities so defined having more than a nominal identity as a community with identifiable boundaries or as an area in which an information or self-help group was viable. Despite this, the need to both plan and to implement a community program on a local basis was generally agreed on; recognizing that services might, in a particular community, be ahead of or heir to prior community development.[51]

At this point Cumming claims that a larger set of events intruded into the local developments and totally altered their course. The Provincial Mental Health Branch had been consulted throughout the formative stages described, but a significant

extension in their commitment occurred with the appointment of a program consultant to the Vancouver area. A second significant development was the New Democratic Party sweep of September 1972 and the installation of a health Ministry heavily committed to the just published Hastings Report and the development of local initiatives and citizen-controlled primary health care centers.

In essence, the Hastings Report indicated a growing consensus in government and professional circles that Canada had built and misused an excessive supply of hospital beds and had failed to face up to serious inadequacies in other essential components of the health care system.[52] The principal recommendations of the Hastings Report were as follows:

(1) The development by the provinces, in mutual agreement with public and professional groups, of a significant number of community health centers, as described in this report, as non-profit corporate bodies in a fully integrated health system.

(2) The immediate and purposeful re-organization and integration of all health services into a health services system to ensure basic health service standards for all Canadians and to ensure a more economic effective use of all health care resources.

(3) The immediate initiation by provincial governments of dialogue with the health professions and new and

existing health service bodies to plan, budget implement coordinate and evaluate the system, the facilitation and support of the activities by the federal government through consultation services, funding and county-wide evaluation.[53]

Several of the people involved with the Vancouver planning had been participants in the work groups of the Hastings Commission, and the Vancouver Medical Health Officer, in particular, had given considerable thought to the merging of treatment services and "public health" functions. Using the Hastings Report as background, the Mental Health Branch then released as a basis for discussion a plan which they were willing to support. It proposed, according to Cumming, to make the very lack of services a major asset in innovating a new system without having to tear down an existent one. Rather than waiting for both community development and the better ordering of hospital-based facilities to occur, the community care plan proposed to alter significantly the need for hospital-based services. Thus while not built from the Hastings model it was planned to be compatible with Community Health Centres should they be developed.

The Community Care Proposal

The Vancouver plan is supposedly aimed at alleviating many of the problems of what John Cumming has called "the present non-system."[54]

(a) The problem of overplacement: a majority of the patients in inpatient facilities within incomplete systems are overplaced in that they needed neither the support and control of such a service, nor do they require the availability of such a number of techniques as are usually available in the inpatient setting. Therapeutically and fiscally inpatient treatment should be minimized.

(b) The problem of two kinds of psychiatry: public and private psychiatry. While they are overlapping fields, they differ greatly in the therapeutic style used, in their patient mixes and in their perception of "what psychiatry really is." This dichotomy works against optimal patient care since the use of a complete range of resources is not available to either group. The system, according to Cumming, came about not because one group of therapists was morally superior to the other or that one group was vigorous while the other was apathetic, but by misguided administration which by regulation and the management of funds divided these groups to the detriment of patient care.

(c) Problems of continuity of treatment and finding treatment. In the current situation getting treatment is a matter of having the energy or competence

to seek it out and demand it for oneself. This is not appropriate for a class of illnesses, some of which manifest themselves through lack of competence.

(d) The problem of cost.[55]

The plan itself appears to comprise a mixture of three elements which were viewed as being novel to the city of Vancouver: (1) the use of less professionalized persons as prime therapists, (2) the use of minimal control systems for the management of severe and chronic illness, and (3) the treatment of even severe illness through the provision of adequate resources in the community without the usual dependence of hospitalization.

The core of the treatment is the Community Care Team consisting of a psychiatrist, two senior mental health workers (social workers, nurses or psychologists with at least a master's level training), from four to eight mental health workers, an occupational therapist, and a secretarial staff to complete the group. Depending upon the amount of pathology, it was estimated that such a group could handle the problems of a population between 25,000 and 100,000 people.

It is estimated that with some sharing of cases, each basic worker (probably a psychiatric nurse) could handle a case load of thirty persons in addition to some followup, diagnostic and sporadic contacts. The team would be the first

contact with the public treatment center for the seriously mentally ill person, though drawing from a wide range of referral sources, doctors, nurses, social workers and crisis centers.

As soon as contact was made an assessment would follow, preferably in the patient's home. The basic worker assigned would always be involved in the assessment and often could be accompanied by a senior mental health worker or psychiatrist. The assessment is to determine the nature of the problem and to make a plan to handle it. Most importantly, the team is to be prepared and able to take immediate steps to lessen the stress situation which is the precipitant of an acute episode. The techniques to accomplish this are supposed to be common sense manipulations. They could include solving a housing crisis for an elderly person, untangling a problem with welfare services, removing a person temporarily from a home situation or placing a visiting home-maker in the house for a short period. At the same time, the basic decision as to whether or not the person can be treated without hospitalization is made.

From this point on the mental health worker remains the key person in the treatment plan. His role may be as friend or advocate, advisor or therapist, teacher or helper. If more specialized treatment resources are to be used, they would continue to monitor the patient's progress during these periods of special attention and must be ready to resume the prime role whenever the special treatment is concluded. Thus the

basic worker is to be the first person who sees the patient as he enters treatment and the last they see as they leave it.[57]

Other Elements of the System

Cumming believes that even a well established system of treatment teams is obviously not a complete treatment system and therefore certain additional elements are needed to make it effective. He does not envision eliminating the need for inpatient beds, but believes their use should be confined to those who are a threat to themselves or others, or to carefully planned and specific interventions. However if the number of patients in 24-hour care is reduced, a functional equivalent should be devised, with possibly greater therapeutic value.

He suggests the use of hostels for moderately confused or disturbed patients and day hospitals to provide programs similar to those which could be expected in a good inpatient service. In effect what is being suggested is the separation of essential maintenance functions from activities of a therapeutic nature, e.g. socialization groups, activities skills, symptom control. A short-term hostel would enable the treatment team to separate patients from difficult situations for relatively short periods of time. They would apparently require a staff sufficient in size and number to deal with moderately disturbed patients where this could not be provided by his friends or family. It would operate on a two-shift system and

could entail the creation of eight such centers.

The day hospital would provide a strong emphasis on group interaction. One of the two proposed would supposedly focus on a therapeutic community type organization while the other might be more overtly aimed at skill training. This element would replace the ward program of an inpatient service and would be used both for those who have never been hospitalized and as a continuation of treatment for those who are discharged from inpatient services.[58] The proposed staff of a day hospital would be:

1--½ time psychiatrist

1--½ time social worker

1--occupational therapist

1--occupational therapist assistant

1--basic mental health worker

This system would also include specific services designed to increase competence among the patients.

(1) sheltered workshops and rehabilitation centers

(2) emergency and crisis centers

(3) living accommodation

(4) family care program workers

Sheltered workshops and rehabilitation centers could have two important aspects: to provide work and adaptive skills. The

emergency and crisis centers would be operated by volunteers and family care program workers could be taken over by the various other parts of the network as it becomes developed.

In a general sense, it appears that these elements of the program, would primarily be geared to meeting the future crises of the patient. They would involve problems of goals norms and values, instrumental skills and problems of interpersonal relationships. Rehabilitation services could include training in using transportation systems, using a telephone, the meaning of payroll deductions, as well as more focused skill training.[59]

Finally, it is indicated in this community plan, that a certain portion of patients may be so disturbed at the time of first contact that hospitalization becomes a necessity. It is suggested that hospital care, whether in a large hospital or a community general hospital, be much less frequent than is usually the case and for shorter periods of time. Emphasis is placed on inpatient service being organized into units which deal with patients from a given geographic area which would coincide with that served by a community care team. The care team would be involved in the process of hospital care and the hospital would serve part time in the community services.*

The Vancouver Plan then suggests devices which could be

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*See chart p. 75 which diagrams relationship of treatment services.

used to link the treatment center with other agents and agencies:

a) the sharing of staff

b) the sharing of work space

c) the sharing of organizational sponsorship

d) agreements on division of labor or the sharing of the client

e) consultation both ways--on the sharing of skills and information

Direct links with the system include:

1) the general medical care system, with special emphasis on community health clinics

2) the welfare system, including job placement agencies

3) the systems devoted to controlling behavior--especially police and probation

4) the educational system

5) the network of community groups and agencies who define needs and monitor services

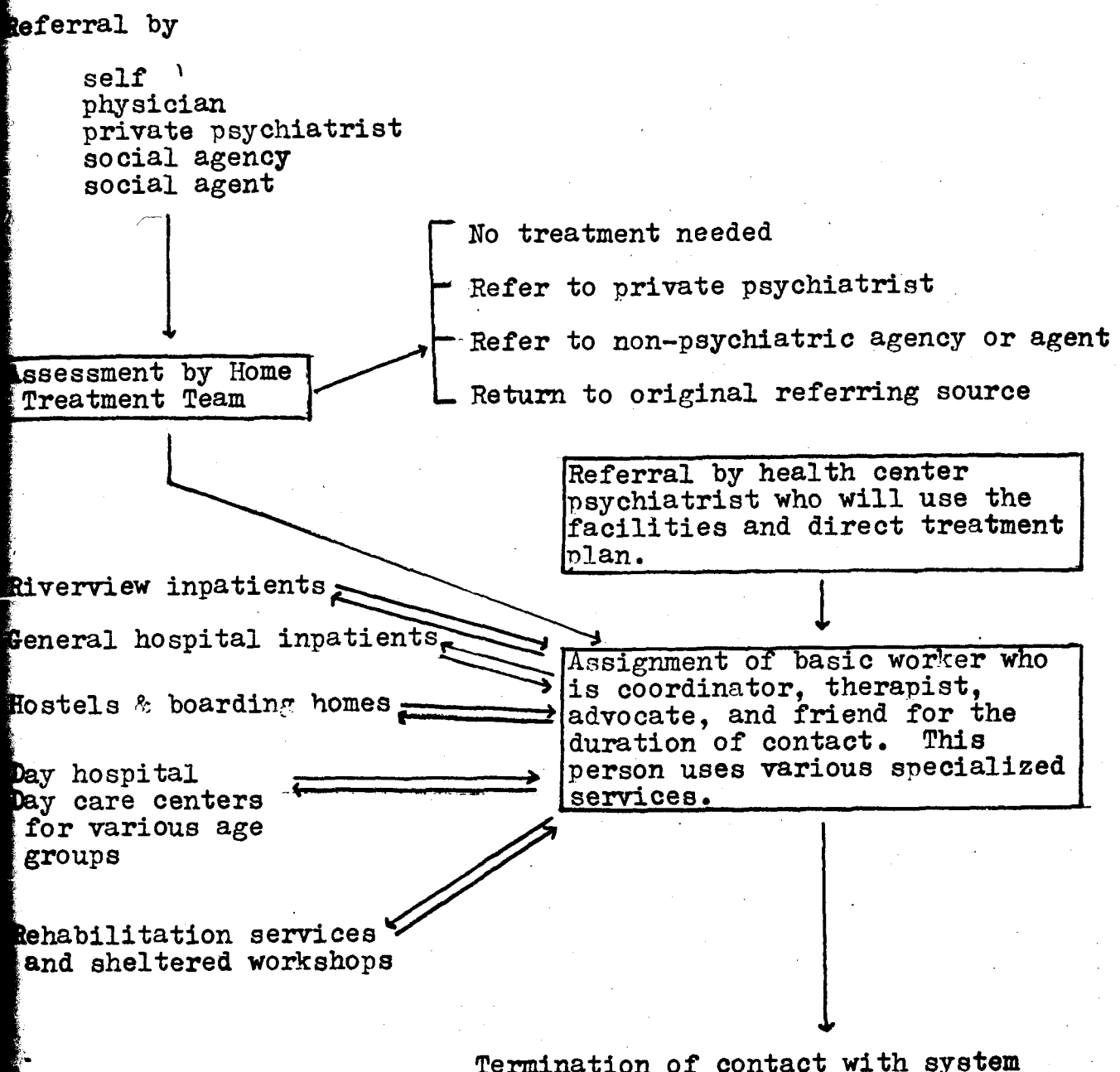
6) the private psychiatric practice system

Cumming argues that the sharing of staff is perhaps the most important of the co-ordinating mechanisms suggested. If for instance, a community health center felt that they needed the full time service of a psychiatrist it could negotiate with them to split this position and hire two half-time persons who would be employed part time within the system. When it was appropriate the resources of the system could then be used by

these psychiatrists without referring the patient to another psychiatrist. When this happens the patient supposedly becomes a link, being involved with both organizations.[60]

RELATIONSHIPS OF TREATMENT SERVICES

- THE PATH OF THE PATIENTS



Chapter V

THE VANCOUVER PLAN AND THE COMMUNITY MENTAL HEALTH IDEA

Introduction

The Vancouver Plan for community Mental Health is one proposal, among many which have been discussed and partially implemented, in both Canada and the United States. This type of proposal seems to reflect the critique of mental health care which sociologists and psychiatrists launched in the 1950's and 1960's. Goffman, Szasz, Barton and Vail suggested that many of the characteristics ascribed to psychiatric illness were a function of the existing social systems of mental hospitals.

As a consequence there has evolved a widespread belief, strongly reflected in the Vancouver proposal, that mental disorders are best treated in the local community, preferably on an outpatient basis or some alternative to hospitalization such as day care. Under this concept inpatient treatment, if necessary, should be of brief duration and also accomplished within the community either in the psychiatric service of a general hospital or specially created community psychiatric facilities

and procedures. Removal of the mentally ill to a distant public mental hospital is considered an inferior practice, to be utilized only for chronic or intractable conditions which require prolonged institutionalization.[61]

Yet the question still remains, to what extent is the concept of community mental health care a valid one and will it provide the necessary quality of mental health services which the general public needs? What, in effect, are the positive and negative dimensions of this entire trend?

Conceptual Foundations of Community Mental Health Programs

Adverse Effects of Hospitalization

The community approach appears to include at least two basic assumptions which bear directly on the ultimate future of mental health care and the public mental hospital. The first tenet of the community approach endeavours to correct the presumed adverse effects of hospitalization for mental illness. In essence, this premise maintains that hospitalization be avoided whenever possible, but if necessary, be of brief duration and accomplished within a community facility.

It was argued in Chapter I of this paper that one possible origin of this attitude was to be found in the concept of mental illness developed by the psychiatric critics. This attitude blurred the distinction between normality and mental illness and

helped to support a legitimate bias against custodial care which eventually resulted in a criticism of any type of hospitalization for mental illness.

Albert J. Glass supports this perspective to some extent when he argues that perhaps part of the underlying reason for this trend stems from a widespread tendency to regard mental illness on the basis of a quantitative continuum.[62] In this approach, all mental disorders are considered basically similar only differing in severity from so-called normality to psychosis. It is thus understandable that when mental disorders are equated as being a single large category, only differing in severity, there arises an inevitable tendency to employ the same treatment technique or program for all patients regardless of type.

Glass also links the present insistence upon the avoidance or limitation of hospitalization for mental disorders to techniques largely developed by World War II military psychiatry.[63] Wartime military psychiatry was forced to deal mainly with temporary emotional disorders which were associated either with severe deprivation, hazard hardship, or with immature and inadequate reactions to minor or moderate situational stress.

Hospitalization for these symptoms, according to Glass, evoked powerful gain in illness mechanisms and subsequent fixation of symptoms along with a sequence of guilt and self-recrimination for failure which further perpetuated disability.

Under these circumstances it became imperative to prevent hospitalization for transient or situationally induced mental disorders. Once an extramural approach was adopted, it became increasingly apparent that aiding the individual while he still struggled to maintain adjustment was of major therapeutic benefit and gave far better results than hospitalization. It enabled the individual to become identified with and responsive to the needs of his reference group, thereby receiving sustaining emotional support from others.

However, Glass adds, this concept and technique was not employed in severe neuroses or psychoses. He then concedes that it may well be that severe depression, functional psychoses, and even organic psychoses, can be handled by community efforts, such as the treatment teams in the Vancouver Plan. Yet he also maintains that such procedures should not be based on any slavish adherence to a generalization that hospitalization must be prevented, but rather developed with realistic consideration of the indications for such treatment and a critical evaluation of the results thereby obtained.[64]

Emphasis on brief duration of presumably needed hospitalization for mental illness is more difficult to explain than avoidance of hospitalization. Cumming, in his argument for the Vancouver Plan, felt that his proposal had appeal because it offered to lessen the overloading of the provincial hospital and the emergency service at Vancouver General. Cumming also

said it raised the possibility of offsetting part of the expense by effective savings through decreased usage of the provincial hospital and therefore had attraction to the politicians.[65]

It seems that in recent years this philosophy has become more and more accepted by psychiatrists and even public mental hospital practitioners. Briefness of hospitalization seems to have acquired a magical virtue, i.e., the less time spent in inpatient treatment, the better the treatment. However, it should be recognized that at least part of the decrease in the average length of hospitalization for mental illness is due to changes in the type and severity of admissions. Non-psychotic disorders, as indicated in the Vancouver psychiatric nurses report, are occupying an increasing proportion of admissions to public mental hospitals and also to community input facilities. These non-psychotic categories either exhibit acute symptomatolgy superimposed upon characterological difficulties, which often promptly subside after admission, or manifest personality disorders for which there is little need of continued inpatient treatment. In effect, a rising number of non-psychotic admissions will reduce the average length of hospitalization which is calculated for all admissions. Yet Glass maintains that even if the duration of hospitalization was considered separately for the various entities such as schizophrenia, psychotic depression, etc., there is no doubt that the same trend toward

decrease in the length of hospitalization would be demonstrated in more severe mental disorders.

In further pursuing an explanation for the increasing practice of brief hospitalization Glass believes that a pertinent question arises relative to the goals or objectives of inpatient treatment for mental illness. Should the major goal of hospitalization be centered upon the prompt discharge of patients after subsidence of acute symptomatology, or is the objective a more complete remission of symptoms; or should inpatient treatment endeavor not only to achieve a relief of symptoms but to enable the patient better to cope with the problems of day to day living after release from hospital; or finally should the hospitalization not only strive for the alleviation of mental symptoms but have the additional objective of preparing appropriate patients for gainful employment by vocational training and rehabilitation programs.

It would seem reasonable to conclude that the duration of hospitalization should depend upon the nature and severity of the mental disorder in question and would further vary according to the particular goal of inpatient treatment for each patient. But Glass argues that the rising trend toward decreasing the length of hospitalization can only be understood as being based upon the assumption that all mental disorders are essentially alike, thus requiring similar goals, i.e. the subsidence of acute symptoms, and a similar brief duration of inpatient treatment.[66]

In fact, the Vancouver proposal is specifically based on this treatment attitude. Cumming argues that long institutional stay is relatively ineffective and very expensive. He claims that the nature of much serious mental illness, particularly schizophrenia is inherently chronic and can remain a powerful influence on the person between more flamboyant episodes. He believes that the major symptom of the chronic state is a relatively pervasive lack of competence under normal life stresses. However it is his hope that the community health team, through the administration of drugs and a reshuffling of the environment (problem-solving) can minimize the acute symptoms and consequently reduce the long-stay category of the hospital population.

Furthermore, it is a curious commentary that despite the increasing popularity of brief hospitalization various private mental hospitals and university psychiatric inpatient services continue to consider months or even years as necessary in the inpatient treatment of severe mental disorders, such as schizophrenia. No doubt most patients in such institutions are different from those of patients in community or public hospitals. Clearly the objective of treatment in such private or teaching institutions is to effect a more lasting improvement than merely subsidence of symptoms. Perhaps it is a matter of economy, better treatment is costly, or are these high status psychiatric treatment services operating under erroneous concepts in keeping patients dislocated from family and community for

prolonged periods? Whatever the case, it is valid to claim that the goals or reasons for hospitalization requires considerable thought and critical discussion.

Economic Dimension

At this point in the evaluation it is also important to mention the economic dimension as a casual factor in the advocacy of briefer periods of hospitalization. The Vancouver Plan was quite straightforward on this aspect. The Mental Health Branch of British Columbia, in supporting the community team concept, claimed that its advantage lay in the fact that it proposed to make the very lack of services a major asset in innovating a new system.

It has also been suggested in Chapter I that the ideology of community mental health care itself is being used by politicians to justify the cutback of public funds for the support of large public mental institutions, and then, when the community program is instituted, will it,in turn, be strangled for funds. In fact there is some evidence that this is occurring in California.

That state passed the Lanterman-Petris-Short Act of 1969 which called for the treating of mental patients in their home communities. The act was justified as being necessary in order to escape the old policy of "warehousing" mental patients. As a consequence since 1967 three state mental hospitals have been closed and the state mental hospital population has

dropped from 22,000 to 7,000. However the shift from state hospitals to community care has seen an increase in the problems of funding. Several local facilities in Southern California are presently on the verge of closing because the State government refused to provide the money necessary to keep them open.[67] The situation of Linda Vista Convalescent Hospital in Marin County reflects a situation that California officials have admitted is statewide.

In response to the State Government's long-range plans to move as many patients as possible out of state hospitals and closer to their homes Linda Vista opened a unit for mentally retarded children and young adults who need 24-hour care. At the same time the facility established various treatment and educational programs for the retarded which the state required before patients could be placed there. To date, however, the facility continues to receive from the state for each retarded patient a Midi-cal rate of $15.52 a day, intended primarily to cover basic care, largely room and board, for geriatiric patients. Linda Vista officials contend the actual cost of operating the unit for the retarded is $22.00 a day per patient. Linda Vista initially planned to shut down the retarded unit in the middle of October 1973, but has delayed the closing while it pleads for more funds.[68]

A similar process may be at work on a national level in theUnited States. The Community Mental Health Center Program

(CMHC) will be terminated when present grant commitments expire. The nine-year old program has brought 515 CMHC's into existence and has been credited with helping to reduce institutionalization of the mentally-ill by one-half but whether the credit should go to CMHC's or tranquillizing drugs is unclear. Furthermore the program has been plagued from the beginning with disagreements about approaches to treating mental illness, the direction of community-based programs and the scope of services which should be included. Consequently the National Institute of Mental Health which administers the program has never been able to formulate criteria by which to judge the success of CMHC, and had come under increasing fire for disregarding the criticisms of even its own evaluators in funding particular CMHC's.[69]

Use of Public Mental Hospitals

The second major assumption of the community approach maintains that with increased and presumably more effective community treatment, there will eventually occur a decreasing need, except in chronic cases, for the removal of mentally ill patients to more distant public mental institutions. Glass argues that while no one would take issue with such a desirable goal, it is difficult to find evidence which will support the complete validity of this prediction.[70]

Statistics from the 1960's indicate that in the past three decades, patients served by community outpatient clinics have almost doubled[71] and admissions to the psychiatric services of community general hospitals now exceed first admissions to public mental hospitals and are nearly equal to total admissions to public mental hospitals.[72] In addition the trend of psychiatrists entering private practice continues. And from 1956 until 1962, admissions to public mental hospitals increased 46%, whereas the general population increased only 11%.[73] Furthermore most statistics on overcrowding indicate that this trend has continued into the 1970's and it is possibly pertinent to ascertain the reasons why expansion of community-based services has failed to stem the rising rate of admissions to public mental hospitals.

First, the increasing availability of local mental health facilities including private practitioners provides a volume of care which was previously unobtainable in the community. Inevitably, these new resources serve as excellent case finders of mental disorders which had been formally ignored or untreated. It, therefore, seems that if you have two overcrowded mental health clinics in a community and you build a third, you may well have three overcrowded mental health clinics. The more severe disorders from this increasing caseload could well account for the rise of admissions to community inpatient psychiatric services. Sooner or later public mental hospitals cannot fail to receive

a portion of these severe cases, particularly patients whose symptoms have been recurrent.[74] In the event the community approach is fully implemented present trends indicate that even a small proportion of difficult or refractory patients from the large caseload thus created would demand the full utilization of many public mental hospitals. It is also evident that unless primary prevention efforts or the more practical secondary prevention activities, as envisioned in the community concept, can be at least partially successful, the mere addition of local evaluation and treatment facilities may only produce a correspondingly larger caseload. Such an outcome is particularly likely when the community approach moves into the neglected but legitimate areas of mental health concern such as alcoholism, narcotic and other addictions, adolescent disorders, juvenile delinquency and sex offenders.

Secondly Glass reports that only a small minority of public mental hospital admissions have sought prior help from community mental health services, including private practitioners of psychiatry. As indicated in the description of the Chicago State Hospital, the majority of public mental health patients come from lower socio-economic groups, or have cultural values which do not recognize or understand the need for professional help in mental illness. It is only when symptoms or behavior cannot be tolerated in the home or community that such individuals

become involuntary admissions to public mental hospitals.

Understandably, increased community mental health services could little curtail admission to public mental hospitals from this category. Indeed one gains the impression that for the most part, community facilities and public mental hospitals seem to operate as two separate systems, each serving mainly a distinctive population in terms of severity of symptoms, clinical course and socio-economic status.

Thirdly, available statistical data complicates any understanding of the relationship between the current community mental health efforts and total admission rates to public community mental hospitals. In the last 15 years public mental hospitals have more and more adopted liberal policies of discharge. As a consequence, increasing numbers of readmissions (very much in evidence at Riverview) returns from convalescent leave and rehabilitation from other categories of line release, have markedly raised total admission rates to public mental hospitals.

With liberal discharge policies have come the opening of locked wards. Increased discharges for AWOL have resulted and the return of most of these patients has further inflated total admission rates. It is, therefore, evident that total admission rates to public mental hospitals are mainly determined by their own policies of control and discharge. If such policies are conservative, as was practiced by the custodially oriented

public mental hospitals of the past, few patients leave the hospital, few can be readmitted and total admission rates are low. Conversely, with rapid discharge and open door policies, as currently in vogue, large numbers of former patients are rehospitalized and a rising total admission rate is inevitable.

Under these circumstances, patients may be admitted and discharged several times in one year. It is quite likely that rising admission rates to community hospitals are in part similar due to rapid discharge policies and consequent high frequency of readmissions. Undoubtedly, transfer or referral of chronic or refractory cases, previously hospitalized in community facilities, contributes to some extent to the total admission rates of public mental hospitals. However, it seems that for the most part the marked rise of total admission rates to public mental hospitals cannot be related positively or negatively to increased community based activities.[75]

Other Issues

Another key element involved in the community mental health concept is the necessity supposedly to change the location of mental health facilities. It is charged that public mental hospitals, because they are usually built in isolated areas, tend geographically and psychologically to isolate patients from the main stream of society. One can readily grasp and agree with the necessity and practicality of providing freely accessible local mental health services for outpatients who live

and work in the community yet it is difficult to understand why inpatient facilities must also be located within the community. There does not seem to exist any compelling reason or evidence that the geographical location of inpatient treatment bears any significant relationship to the outcome of treatment. And it can again be stated that high prestige private and teaching psychiatric services calmly ignore the issue of distance from the patient's residence.

It is clear from a study of the Vancouver proposal and other mental health community plans, that these many new diverse procedures and projects have in common either prevention of hospitalization or expenditious release from the hospital or efforts to preclude readmission to the hospital. In effect the common goal is the retention of the mentally ill in the community. It is also evident that at the present time the multitude of changes in mental health care constitute what can be termed a revolution in social psychiatry. The first social psychiatric revolution took place many years ago when there began a move for the hospitalization of mental patients (as indicated in the history of mental health care in the Vancouver area). At this time, approximately 100 years later, the second social psychiatric revolution is underway having for its purpose the return of the mentally ill to the community for apparently similar humane reasons, i.e. to circumvent the adverse effects

of prolonged institutional existence.

There have been many abortive attempts to initiate this change in social psychiatry. However, the major obstacle always has been the inability to find a practical procedure or treatment which would improve or alter mentally ill persons so as to mitigate or resolve the concern and fears of the family and community. There have been periodic efforts to "empty" the public mental hospitals with electroshock, insulin coma and even lobotomy, but these procedures fell far short of producing the needed changes in symptoms. Finally, in the last decade, with the introduction of the phenothiazine drugs and other psychotropic agents, a feasible method has been found which could be mass employed and met the crucial test of markedly decreasing or otherwise altering overt manifestations of the seriously mentally ill so that they appear less odd, less bizarre, less unpredictable and thus much less of a threat to the community. The drug method is not without drawbacks, but it is the best so far developed and has been sufficiently effective to initiate and maintain the momentum of a widespread movement in mental health care.

Once the profound significance of this revolutionary movement is grasped, the current ferment of activity in mental health becomes more understandable. All of the essential elements of the comprehensive mental health center including partial hospitalization such as day care and night care, emergency

services, consultative service, and preference for local in-patient treatment can be readily understood as measures to hold and treat mental disorders in the community.

The conceptual framework and technological assumptions for the community approach need not even be based on reason nor necessarily supported by substantial evidence. A social movement is based on strong and emotional need for change; once launched, the movement redoubles in momentum and intensity with each small success achieved as the desired goal becomes possible of attainment.

The needs of the current social psychiatry movement were born in a new and monolithic conception of mental illness and a revulsion against the sins of custodial institutionalization. Once the dehumanized aspect of institutional care were documented and exposed we saw ironically the convergence of two polar approaches to mental illness in response to which many mental hospitals responded by being in the forefront of the movement to return the mentally ill to the community. As a result locked wards were opened and liberal policies of discharge established which made necessary the creation of aftercare programs in the community to safeguard the gains made by hospitalization. With the patients back in the community there arose the necessity for supporting programs such as day care, inpatient social clubs, halfway houses, vocational rehabilitation and sheltered workshops.[76] It thus appears that if the current

cummunity approach had not been devised, a similar program would have evolved, possibly by public mental hospitals, in their intrinsic need to reach out to the community in order to provide aftercare and precare services.

The major problem is not differences in goals or objectives, although there are some differing viewpoints on methodology. More important is the matter of jurisdictional disputes between the community agencies and public mental hospitals brought forth by an artificially induced dichotomy based largely on unproven assumptions. It does seem clear that large, public facilities cannot accept a future which only involves the care of chronic and intractable patients (a definite implication of the Vancouver proposal). Even if such an impossible role could be established, it would ironically defeat the very goal which is sought by the present social psychiatry movement; for it would create inadequate defeatist institutions that would become a dumping ground for the inevitable failures of community treatment. Thus, the old custodial institutions would return with all their sins of dehumanized care.

Chapter VI

CONCLUSION

We have seen that within the last two decades a social movement in the mental health field has occurred. It has developed a common view of the nature of mental illness; a theory of "total institutions" which attacks the dehumanized and custodial orientation of public mental hospitals; and an alternative mode of treatment, the community mental health program. The material has offered an evaluation of the concept of mental illness, and a description and critique of the theory of "total institutions." We discussed and analyzed the proposed community mental health plan for Greater Vancouver.

It is evident from the evaluation of the community mental health idea, that if the reality of custodial institutional care is finally to be eliminated further steps must be taken than those outlined in the Vancouver proposal. The reports of the psychiatric nurses indicate that many elements of dehumanization are still in existence at Riverview. Yet the Vancouver Plan, if carried to fruition, may only magnify the problem by becoming a dumping ground for mental rejects. It thus seems imperative that the large public mental hospital must be integrated more fully into any community proposal if dehumanization

and chronicity are to be fully dealt with and not ignored.

A first step could be a program for the reduction of the hard-core group at Riverview and any other public mental institution which is to play a crucial role in community programs. The largest component of any hard-core group are long term schizophrenic disorders. Next largest are usually organic disorders, mainly secondary to senile, vascular and other degenerative diseases of the central nervous system. A final category is generally composed of adult mental retardates.

At present the accelerated admission and discharge rates of public mental hospitals involve perhaps less than a third of the patient population. The remainder are composed of this hard core group who persist year after year as a permanent majority of the patient census. Any effort to significantly diminish the patient population of large public mental hospitals (such as Riverview) must involve reduction in this category. This, however, is a difficult task for these residents represent not only chronic severe mental disorders but residual cases who failed to improve under various previous treatment attempts. Moreover, these patients are further complicated by marked dependency upon institutional existence and seem to have been forgotten or abandoned by their families.

A comprehensive community mental health program must, therefore, include among its facilities special programs in

addition to the already active intensive care which may exist. Diagnostic and Treatment centres for geriatic mental disorders could be created. Patients 65 years and older who are admitted to the public mental hospitals represent a group of complex socio-economic and physical disease problem of aging. A thorough consideration of the multiple causative factors in each case is necessary to provide appropriate treatment and determine proper disposition. The community team, suggested in the Vancouver proposal, could work as an intregal part of the geriatic unit to maintain a sustaining relationship with patient families.

The major function of the team, in this area, would be to obtain collateral information, participate in pre-release planning and visit homes and nursing homes of patients after discharge. Many geriatric admissions can be considerably improved and discharged to their homes provided a satisfactory relationship can be made with families from the time of admission with an understanding that hospitalization does not represent the final destination of the patient. Aged infirm patients who are found to mainly require nursing care which cannot be accomplished in the home could be placed in a suitable nursing home in the community of the patients' residence.77

As the special geriatric service gains experience, all elderly patients from the hard core group could also be processed through this unit. These hard core older patients usually

include a high proportion of chronic schizophrenic disorders who have grown old in the hospital. Many might be found suitable for nursing home placement and such placement could be expedited. Approximately 25-30% of the public mental hospital patients' population is 65 years or older. With the prevention of geriatric admission being added to the chronic patient category, and the placing in nursing homes of infirm members of the hard core group, a gradual decrease of the geriatric population of the public mental hospital could be expected.

Expansion of intensive treatment services for chronic mental disorders also seems necessary, particularly the non-geriatric hard core schizophrenic patients. Most of these patients have achieved adjustment to institutional life, are housed on open wards and carry out limited work assignments.[78] However, they are unable to adjust outside the hospital because of marked dependency upon the institution and an absence of social skills due to prolonged isolation from the community. An intensive program is required utilizing some form of milieu therapy with emphasis upon learning or relearning social skills. It can be expected that at least some of these patients can be returned to the family and community, supported by appropriate aftercare activities, while others who have no suitable home may be improved sufficiently for foster home or family care placement.

It also seems necessary to integrate more fully the public mental hospital into ongoing community mental health programs. Necessary facilities and personnel of the public mental hospital could be administratively organized into the program. They could also provide additional elements of the community program, such as the inpatient facility for brief or prolonged treatment. Separate wards or buildings could be set up to receive admissions only from particular geographic areas which can be set aside with the professional personnel of such autonomous units working directly with their counterparts in the community.

Riverview

The Registered Psychiatric Nurses Association of British Columbia has suggested a further positive role which an institution like Riverview could play in a community program.[79] They claim that there will always be a fair number of long-term and permanent mentally ill, mentally retarded and psychogeriatric patients in the Vancouver area who will require care in a protected environment. They state that the realities of the situation are such that the general hospitals and extended care hospitals in the Vancouver vicinity will never be able to provide the number of beds necessary. Essondale has two particular assets which they see as being crucial to a community program: spacious and magnificant grounds with plenty of room for its

facilities and a good basis for social recreational facilities which no general hospital has or regional psychiatric centre will ever have.

They envision that Essondale, the Education Centre and the nurses' residences, could become part of an excellent facility for providing the mental health care needs of the long-term patient. The Education Centre could possibly be conducive to utilization as small apartments or sleeping rooms for some of the capable, ambulatory patients. Furthermore, all of Essondale could be turned into a community. The grounds could house some facilities such as small stores (so patients could obtain their clothes from the store rather than have it issued on the wards), theatre, barbershop, hair dresser, bus depot, gas station (staff and hospital vehicles, but providing employment for patients), motel coffee shop, dry cleaner, produce market, doctors' and dentists' offices and anything else feasible that comes to the imagination.

Staff

Possibly the very fact that an integrated arrangement could be developed would ensure a high quality staff. Historically only a minority of personnel were motivated to accept full-time salaried public positions rather than engage in more lucrative private practice. And many community mental health programs

which ignored the public mental institution only guaranteed the loss of skilled personnel to more favored community health centers. These circumstances insure a return to the previous custodial role for public institutions. But if integrated facilities could become a reality the prestige and salary factor would be equalized and quality could be maintained.

Final Word

The theoretical and practical foundation of the community mental health model have been described and analyzed. And it has been suggested that while there are limitations in its approach, the community proposal is technically feasible and represents a significant advance in the prevention and treatment of mental illness especially if it joins with a large public mental institution in developing new programs. What must be avoided at all costs is a community program which is only a substitute for lack of funding, staff and facilities, for such a program can only compound the problems in the mental health field in the long run.

Economic criteria should not be the sole standards to be applied to the allocation of resources. We must ensure that warmth and humanity do not go out of the hospital as planning comes in. If this could be borne in mind and carried into practice by all concerned with the Mental Health Service, the outlook for the sick citizen would, indeed, be bright.

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