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IMPLEMENTING THE 1987 DRAFT PLAN TO DOWNSIZE RIVERVIEW HOSPITAL: EXPANDING THE SOCIAL CONTROL NETWORK

by

Susan D. Chambers

B.A., Simon Fraser University, 1988

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF

THE REQUIREMENT FOR THE DEGREE OF

MASTER OF ARTS

in the School

of

Criminology

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Implementing the 1987 Draft Plan to Downsize Riverview Hospital: Expanding the Social Control Network

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ABSTRACT

This thesis explores the impacts of psychiatric deinstitutionalization on the practices of mental health and social service workers and on the lives of their clientele. Using a local illustration – the origins and aftermath of the 1987 **Draft Plan to Replace Riverview Hospital** – the research charts the relationship between shifts in welfare policies and the emergence of control patterns imposed on chronic mental patients in the city of Vancouver between 1987 and 1991.

The study is informed by a theoretical framework which addresses both institutional and human influences on the genesis and subsequent implementation of this particular mental health initiative. It also incorporates the views of mental health workers, criminal justice personnel and mental health patients as a major source of data.

The thesis combines both a quantitative analysis of aggregate statistics obtained from four of the participating community agencies, and semi-structured interviews with 21 mental health and criminal justice professionals and 19 mental health clients on a range of issues.

On the basis of these data, it is argued that political, economic and ideological forces have constrained the ability to implement the recommendations set out in the 1987 **Draft Plan**, and have perpetuated recurring crises in mental health service delivery throughout this jurisdiction. Many mental health clients are not getting their needs adequately met and struggle to survive in the Downtown East Side of Vancouver. Furthermore, there is a subgroup of "difficult clients" who become involved in more than one system.

Safe, affordable housing and increased financial support should be considered as priorities in an effort to facilitate a reasonable level of mental stability among chronic mental health patients. Moreover, policy makers must consult both front-line workers and mental health clients, within the latter groups' social habitats, prior to implementing mental health

initiatives. Failure to (a) give higher priority to meeting the basic needs of chronic mental patients; and (b) consult clients and front-line workers about the likely effects of implementing changes in service delivery may ultimately lead to more severe breakdowns of both the system and the population it purports to treat.

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INTRODUCTION

Overview

Beginning in the mid-1950s and extending into the present, a number of advanced capitalist states started implementing policies designed to depopulate mental hospitals (Scull, 1984). This depopulation is continuing in provinces across Canada (MacNaughton, 1992). Bureaucrats persist in justifying such social policies on the grounds that it is less expensive and more humane to treat psychiatric patients in the community (MacNaughton, 1992), despite a profusion of empirical evidence to the contrary (cf., Cohen, 1985, 1987; Dear & Wolch, 1987; Isaac & Armat, 1990; Lerman, 1982; Ralph, 1983; Scull, 1984, 1989; Trainor & Boydell, 1986; Torrey, 1988).

Several theoretical perspectives, reviewed in Chapter I, have developed to account for the emergence of the decarceration[1] movement in the 1950s[2]. In addition, an extensive review of the literature indicates that deinstitutionalization policies are closely linked to the restructuring of the welfare state (cf., Dear & Wolch, 1987; Rose, 1979; Scull, 1981, 1984; Warren, 1981). Proponents of this view note that cutbacks in welfare programs, the privatization of many social services, and mental health care policies which emphasize community-based treatment have all had significant consequences for both the quality of life and the locus of care for psychiatrically disabled individuals (cf., Dear & Wolch, 1987; Kirk & Therrien, 1975; Rose, 1979). The evidence presented in this thesis suggests that this claim has some validity.

A major limitation of many of the depictions of deinstitutionalization and the empirical studies which they have spawned is that they ignore the experiences of patients and

[1]For the purposes of this thesis, I have adopted Lerman's (1982) broad conceptualization of this term. Lerman defines decarceration as "... a reduction in the use of traditional institutions *without* offsetting increases in the use of non-traditional facilities ... [or other social control systems]" (1982:202). The terms "decarceration", "deinstitutionalization" and "downsizing" are used interchangeably throughout the thesis.

[2]The deinstitutionalization movement emerged in Canada about a decade after it first appeared in the United States.

front-line staff, even when the human consequences of such mental health initiatives are being considered. However, a compelling argument can be made that focusing only on the role of the state and the professional, at the expense of the patients, results in a distorted picture at best.

The Current Study: Charting a Critical Humanist Perspective

This study seeks to reclaim the human element in both the theory and the empirical research which comprise the thesis. It does this by using a local example — the downsizing of Riverview Hospital in Coquitlam, B.C. — to illustrate the relationship between shifts in welfare policies and the emergence of social control[3] patterns imposed on ex-mental patients in the city of Vancouver between 1987 and 1991. I analyze this geographically and historically specific example in the context of a theoretical perspective which addresses both the role of political-economic factors and the influence of human agency, as well as the impact of these forces on mental health clients residing in Vancouver's "zone of dependence" (Dear & Wolch, 1987) in the Downtown East Side. Specifically, the present study examines three main research questions:

1. How have political-economic, ideological and cultural forces influenced the implementation of the **Mental Health Consultation Report** (1987)?
2. How have these forces been mediated through the perceptions and practices of specific groups and individuals within the mental health and criminal justice systems in Vancouver?
3. How has the decision to replace Riverview Hospital affected the lives and experiences of chronic mental patients in the Vancouver area?

Empirically, the study combines both quantitative and qualitative research methodologies. An analysis of aggregate statistics obtained from various service providers in

[3]Social Control is defined by Cohen as " the organized ways in which society responds to behaviour and people it regards as deviant ... in some way or another" (1985:1). The concept is more fully defined and discussed in Chapter I.

the city and interviews with both personnel and clients in the mental health system is undertaken in an effort to answer the questions set out above. The data are analyzed and reported within the context of these questions and the presentation of the findings is guided by the theoretical framework set out in Chapter I.

Chapter I reviews the strengths and weaknesses of existing theoretical accounts of deinstitutionalization, the rise of the welfare state and the link between the two phenomena. The narrative focuses on a select number of historically specific factors identified as contributing to the decarceration movement, as well as some of the resulting social welfare concerns which have emerged out of it. Chapter I also reviews the extent of empirical research pertaining to deinstitutionalization, transinstitutionalization and homelessness, particularly with respect to ex-mental patients.

Chapter II moves from a general account of downsizing mental hospitals and the concurrent development of community mental health services to a specific example. This chapter provides historical background information on the deinstitutionalization experience in Vancouver, British Columbia. Also included is a description and critique of the **1987 Draft Plan to Replace Riverview Hospital**, the documented guidelines for the current mental health initiative. Overall, the chapter sets the stage for the current study.

Chapter III comprises a description of the empirical research. Methodology and data collection are outlined. The demographic characteristics of the research subjects are described. Results of the study are examined in terms of problems and limitations of the research.

Chapters IV and V present analyses of the data collected. The data are examined in terms of their relationship to the theoretical framework of the study. Specifically, Chapter IV describes Vancouver's network of social care and social control agencies in which decarcerated and non-institutionalized mental patients become enmeshed. This “ghetto”, and the clients who travel through it, are viewed from the perspective of front-line workers and

mental health professionals. This chapter also describes mental health and criminal justice workers' perceptions of how the 1987 **Draft Plan** has affected this social "landscape" (cf., Dear & Wolch, 1987).

Chapter V analyzes the responses of professionals, front-line personnel and mental health patients to a range of questions pertaining to deinstitutionalization and its consequences in the lower mainland. I compare professionals' perceptions of the social care network with the clients' own experiences with community-based mental health care. Implications of the results are considered. Some recommendations and strategies for realizing small improvements in mental health services are offered. These are based on the comments provided by both front-line workers and mental health clients.

Chapter VI provides a summary and overview of the results of the empirical component of the thesis. I discuss my findings in the context of the research questions posed in the Introduction. I conclude by speculating about the future impact of the **Draft Plan** (1987) on the mental health, criminal justice and social services systems.

CHAPTER I

TRACING THE DEINSTITUTIONALIZATION MOVEMENT

Introduction

This chapter reviews varying accounts of the emergence of the deinstitutionalization movement. In the present account, decarceration as a social policy is examined in the context of the rise of the welfare state. Much of the literature indicates that cutbacks in welfare programs, the privatization of many social services, and mental health care policies concerned with downsizing psychiatric institutions have all had significant impacts on both the quality of life and the locus of care for ex-mental patients (Dear & Wolch, 1987; Kirk & Therrien, 1975; Rose, 1979; Scull, 1981, 1984; Warren, 1981).

Four major theoretical approaches have developed to account for social transformations such as the restructuring of the welfare state and the downsizing of mental hospitals. Following a brief review of the principal tenets of these various explanations, a narrative will be developed which traces the decarceration movement from early progressive efforts in the 1930s, to mental health and social welfare concerns of the 1990s such as the proliferation of transinstitutionalized and homeless mentally ill persons (Dear & Wolch, 1987; Lerman, 1982; Scull, 1981, 1984; Warren, 1981). In the process, I examine a select number of historically specific conditions and factors identified by the theoretical traditions as contributing to the emergence of the decarceration movement. I also discuss the limitations of the existing theoretical frameworks. This critique is offered in the spirit of a developing humanist perspective which has sought to amend gaps in the conventional literature created by overlooking the actions and responses of both community workers and patients. At the forefront of this humanist trend are a number of researchers who have conducted ethnographic studies which focus on subjects' personal and contextual experiences

(e.g., Baxter, 1991; Dear & Wolch, 1987; Estroff, 1981; Harrison, 1983; Herman & Smith, 1989; Johnson, 1990).

Four Theoretical Approaches

As indicated in the previous section, four main theoretical approaches have developed to account for the unfolding of the decarceration movement (Cohen, 1985; Ralph, 1983). Cohen maintains that the contemporary debates on this issue "... are not just competing versions of [what has] happened. [Rather], they are informed by fundamentally different views about the nature of ideology[1] and hence quite different ways of making sense of current policies and change" (1985:14-15). The four theoretical frameworks to be examined in the ensuing discussion are: (1) the traditional/clinical perspective (e.g., Torrey, 1988); (2) the liberal critique, reflected in the arguments of labelling theorists (e.g., Goffman), anti-psychiatrists (e.g., Laing, Szasz), and revisionists such as Rothman (1980); (3) the critical structuralist theories such as those developed by Ralph (1983) and Scull (1984, 1989); and (4) Cohen's extension of discipline theory (1979, 1985). Cohen defines social control as " the organized ways in which society responds to behaviour and people it regards as deviant, problematic, worrying, threatening, troublesome or undesirable in some way or another" (1985:1). According to Cohen, social control appears in many guises, including punishment, treatment, prevention, segregation, rehabilitation and social defence (1985:1).

[1]Marchak conceptualizes ideology as a set of assumptions, beliefs, explanations, values and orientations which are rarely conveyed in an explicit or systematic fashion (1975:1). According to Bocock, ideology also "... carries the connotation of either something which is untrue ... or which disguises other, material interests within itself" (1986:69).

The **first**, and traditional, approach to explaining reform is through an incremental, albeit uneven, story of progress[2] (Cohen, 1985:18). Within the context of deinstitutionalization, the shift to community-based services is portrayed as "... merely the latest development in a progressively enlightened and humane evolution of psychiatric services" (Ralph, 1983:19). From this perspective, it is assumed that "... the government is a humanitarian and natural dispenser of services for the benefit of all" (Ralph, 1983:20). The overall effect of such assumptions is the development of an apolitical, technological explanation of the policy shift toward developing a community-based system of mental health care (Ralph, 1983:20).

This theoretical view is based on the premise that the driving force for change lies in the realm of ideas, visions, intentions, and advances in knowledge (Cohen, 1985:15, 18). Indeed, Scull argues that "... the reformers' claims for the purity and humanitarianism of their own motives ... have served to inculcate in most people the notion that [shifts in mental health care] represent progress towards enlightenment..." (1979:254-255). Furthermore, because this traditional conceptualization of reform is especially tenacious, such perceptions are not readily modified or overturned (Cohen, 1985; Scull, 1979:255).

The steadfastness of these beliefs and assumptions carries with it certain implications for explaining apparent failures in the implementation of specific reforms. According to Scull, the tendency is to "... discount facts which fail to fit a 'progressive' interpretation as atypical ... and to attribute them to the inevitable imperfection of all human institutions" (1979:255). Consequently, failures, even of tragic proportions, are construed as the frustration of dedicated reformers' efforts by forces over which they had no control

[2]Cohen remarks that "as a view of history and a rationale for present policies, [this theoretical framework] is by far the most important story of all ..." primarily because it continues to represent the mainstream of reform rhetoric as well as dominating the centre of social care/social control systems (1985:18, 38).

(Cohen, 1985:18). From this perspective, "... good intentions are taken entirely at their face values[3] and are radically separated from their outcomes" (Cohen, 1985:18).

Not only are intentions separated from results, but both are isolated from the social context in which they occur (Cohen, 1985). Consequently, this theoretical orientation not only fails to analyze the connections between trends in mental health and other social services, but also neglects to consider political and economic motivations underlying policy shifts (Ralph, 1983:23).

The **second** model for explaining transformations in the locus of mental health care emerged in the 1960s and represented a significant challenge to the traditional perspective (Cohen, 1985; Scull, 1979). This position reflects an anti-interventionist ideology about the desirable limits of state intrusion into the lives of individuals (Cohen, 1985:21) and is most clearly exemplified in the arguments of the anti-psychiatrists and civil libertarians.

The anti-psychiatrists romanticized madness (or, in Szasz's case, dismissed its existence as a myth), played down the troublesome aspects of disordered behaviour, and recast society's official response to the mentally ill as a struggle between the victimized patient and the psychiatrist as a repressive agent of social control (Scull, 1979:256). According to Ralph, the anti-psychiatrists maintained that community-based mental health simply widened the scope of an oppressive psychiatric system (1983:30-31).

The anti-psychiatrists' controversial attacks were useful in demystifying the righteousness and claims about the benevolent underpinning of the clinical interpretation of mental health care (Cohen, 1985; Scull, 1979:256). However, their narrow focus on the politics of patient-therapist relations weakens this theoretical framework in two ways: (1) it fails to place an analysis of the purpose of controlling psychiatric patients into a larger

[3]Scull suggests that by taking these "good intentions" at face value, people avoid having to doubt the benevolent character of society. Specifically, "... by not inquiring too deeply ... and by not being too sceptical of the officially constructed reality, people are rewarded with a comforting reassurance about the essentially harmless nature of their society and the way it deals with its deviants" (Scull, 1979:260).

structural context; and, (2) it abstracts mental patients from the social conditions which may have contributed to their being labelled as "deviant" in the first place (Ralph, 1983:33-34).

The **third** model for explaining decarceration comprises critical structuralist explanations of this movement. These theories emphasize the role of the state in shaping social welfare and mental health policies. Specifically, structuralists maintain that the shift to "... community psychiatry reflects a general state policy to cut public expenses for services to unemployable people under pressure of its fiscal crises" (Ralph, 1983:20).

According to Spitzer's theory, unemployable individuals such as chronic mental patients are perceived by the dominant class as "social junk": a "... costly yet relatively harmless burden to society" (1975:645). Ralph contends that "social junk" is generally perceived as being undeserving of social welfare benefits and therefore processed as cheaply as possible (1983:37). Ralph further suggests that in order to discourage productive workers from dropping out, community mental health services tend to exert a complex blend of disciplinary – i.e., punitive and exclusionary – and therapeutic control over their clients[4] (1983:37-38).

Although the critical structuralist model certainly accounts for the tendency to slash community psychiatry's budgets and services to mental patients (Ralph, 1983:23), it is not without theoretical short-comings. It not only over-emphasizes the role of political economy at the expense of adequately considering the roles of ideology and human agency (Cohen, 1985), but also fails fully to explain the ideological and structural shift to a community-based network of social control (Cohen, 1979). Furthermore, it does not account for the facts that, in some U.S. jurisdictions, state-run psychiatric hospitals are either still being used *as a last resort* (cf., Cohen, 1987), or that there is a move toward *reinstitutionalizing* mental patients (cf., Dear & Wolch, 1987).

[4]The fusion of social care and control functions of welfare and mental health agencies will be further explained below. For a more comprehensive analysis of this historical development, refer to Satyamurti (1979).

A **fourth** theoretical model is therefore required when considering various accounts of decarceration. This framework draws on the works of both Cohen (1979, 1985) and Dear and Wolch (1987). Cohen argues that an analysis of social control agencies must be located within both the "... physical space of the city [and] ... the overall social space: the master patterns of social control,... the network of other institutions ..., and broader trends in welfare and social services" (1979:340). According to Cohen, the shift toward community-based systems of control (or care) *appears* to be a reversal of the tendency to rely on segregative modes of control: i.e., institutions such as mental hospitals, prisons, and the like (1979:341). However, many of the community-based alternatives are "... difficult to distinguish from the old institutions and reproduce the very same coercive features of the system they were designed to replace" (Cohen, 1979:343). Cohen further argues that: (1) the boundaries between institution and community have been deliberately blurred; and, (2) as a result of this, the social control net has actually been widened (1979: 344, 347). Cohen refers to these agencies as the social control network, and uses a metaphor – "the punitive city" – to describe the dispersal of control in urban settings (1979).

Dear and Wolch (1987) also contend that deinstitutionalization must be placed in a geographical context: namely, the inner city in which many ex-psychiatric patients become ghettoized. The authors refer to the network of social service agencies in this area as the "service-dependent ghetto" (1987:8, 10). According to Dear and Wolch, "the service-dependent ghetto has been created by skilled and knowledgeable actors ... operating within a social context ... which both limits and enables their actions" (1987:10). Thus, the authors incorporate the interaction between human agency and social context into their narrative. Dear and Wolch also point to the social control practices which are a part of service delivery in the inner city (1987:12); in this respect, their account complements Cohen's model of the punitive city.

The Welfare state - Mental Health Link

Dear and Wolch argue that it is crucial to address the specifically urban nature of deinstitutionalization within the context of both the history and future of current social welfare dilemmas (1987:4). Indeed, a number of scholars (e.g., Block, Cloward, Ehrenreich & Piven, 1987; Lerman, 1982; Parry, Rustin & Satyamurti, 1979; Scull, 1984) have identified a connection between social welfare spending and the implementation of policies such as the large scale depopulation of mental hospitals.

Piven and Cloward point out that the term social welfare is a concept with diverse meanings: it can be defined narrowly to refer only to social policies and services which ensure minimum living standards for all individuals within a society, or more broadly to include "... virtually all state interventions in the economy and society[5]" (1987:4-5). In this thesis I favour an integrative conceptualization of "welfare" which incorporates both quantitative indices and qualitative aspects of acceptable minimum standards of living[6].

Although some early social welfare provisions were in place by the end of the nineteenth century[7], the literature indicates that a fully developed welfare state did not emerge until the 1930s[8], with continued expansion into the 1960s (Block et al, 1987; Finkel, 1977; Lerman, 1982; Scull, 1984).

At approximately the same historical juncture, a number of Western societies (e.g., Britain, Canada, the United States) experienced ideological shifts in conceptualizations of the state, which came increasingly to be conceived as an "organism" in need of "preventive

[5]An example of a broader definition of the term is to be found in Wilensky's view that "... [the] essence of welfare is government protected minimum standards of income, nutrition, health, housing and education, assured to every citizen as a political right" (1975:i; cited in Piven & Cloward, 1987:5).

[6]As with any other social phenomenon (e.g., decarceration),explanations for the emergence of the welfare state have been written from various theoretical perspectives. These range from meliorist accounts (e.g., Corrigan & Corrigan, 1979; Block et al, 1987) to political economic analyses (e.g., Finkel, 1977; Moscovitch & Drover, 1987; O'Connor 1973; Scull, 1984) to ideological histories (e.g., George & Wilding, 1985; Piven & Cloward, 1987).

[7]Corrigan and Corrigan suggest that social policies arose as a response to the widespread poverty generated by the capitalist labour market during this period (1979:2).

[8]Particularly in Canada and the United States.

and curative treatment" for the social pathologies of the day, including rampant poverty and disease (Unsworth, 1979:119). This new vision was also conducive to the enthusiastic recruitment of professionals[9] both to administer draconian social policies and to define the criteria for being deserving or not[10] (Unsworth, 1979).

The result has been an expanded welfare state which ultimately merged social care and control functions, administered by a top-down, expert-oriented[11] system of service delivery (George & Wilding, 1985:139). Furthermore, the service delivery model has come to be characterized by its wide discretionary powers to intervene in the lives of individuals (Unsworth, 1979) and by the credo that "the customer is always wrong" (Yeo, 1979:53).

According to Unsworth, this approach to the provision of welfare services has had its most far-reaching effects in the sphere of legislation governing mental health care (1979). Under this system, persons experiencing mental health problems could find themselves facing indefinite hospitalization if a professional deemed it was in "their best interest" to be treated in such a place. Following discharge from a psychiatric hospital, many ex-patients are caught in the social control network, and rendered dependent on the mental health/welfare system(s): a complex web from which it is difficult to free oneself or regain any sense of autonomy (Cohen, 1984).

The question then arises as to why the locus of care shifted to the community. Scull (1984) and, to a lesser extent, Ralph (1983) attribute this policy shift to an emerging fiscal crisis of the state in the 1950s and to a subsequent decrease in welfare spending and funding to state institutions. Ralph (1983) acknowledges, albeit indirectly, that the decrease in

[9]The latter part of the nineteenth century and the early twentieth century were characterized by burgeoning professionalism in a number of fields, including social work, psychiatry, and crime control (Dear & Wolch, 1987; Scull, 1989).

[10]See Satyamurti's (1979) account of the welfare state for a more detailed discussion of how providers of social welfare created a demarcation between the deserving and undeserving poor.

[11]e.g., psychiatrists, social workers, probation officers and the like.

welfare spending was not a unitary phenomenon, but was instead based on the above-noted distinction between deserving and undeserving groups in society.

Scull explains the reversal of welfare spending patterns in terms of O'Connor's (1973) theory of the fiscal crisis of the state. Scull argues that an increased demand on the welfare system to meet the needs of a growing class of unemployed individuals, in conjunction with increased state expenditures in other areas of capitalist social formations, led to the development of a public funding crisis (1984:131, 138) that has yet to be resolved.

Scull goes on to suggest that the fiscal crisis and subsequent cut-backs in welfare spending also had significant implications for the state's social control mechanisms. Specifically, segregative means of control were seen as being too costly, given the availability of welfare programs for the mentally disabled: hence the shift toward "reintegrating" ex-mental patients into the community (1984:135).

There are inherent weaknesses in a theory which relies on structural determinism, economic reductionism and a unitary approach to understanding the interaction between welfare spending and decarceration policies. In recognition of these failings, Scull has subsequently backed away from this position and acknowledged that decarceration has not occurred to the same extent across various systems of social control (Scull, 1989). Moreover, there is evidence to suggest that not all capitalist states – e.g., Canada – even experienced a fiscal crisis prior to the 1980s (cf., Taylor, 1983).

It is also apparent that ideological and policy shifts that focused on depopulating mental hospitals had been occurring *prior* to the manifestation of a fiscal crisis; thus, factors other than the political economy played a role in unleashing the large-scale decarceration movement of the late 1950s. Clearly, the structuralist conception of deinstitutionalization must be integrated with a range of alternative accounts — technological, cultural and ideological — in order to generate a more comprehensive understanding of transformations in mental health policies and practices.

The Move Toward the Community as a "Treatment" Setting

Prior to the mid-1940s, the mainstay of public psychiatry was the custodial care of chronic mental patients in state-run institutions, the traditional dumping ground for the "unemployables" (Ralph, 1983:46). Ralph claims that as early as the mid-1930s, policy makers began to recommend plans for releasing "manageable" patients to family settings as a means of saving money[12] (1983:12).

Rothman (1980) and Scull (1989) also note that in the early decades of the twentieth century, progressive reformers in the United States attempted to introduce noninstitutional alternatives in the treatment of the mentally ill. But such alternatives were not promoted on a wide-spread basis; on the contrary, progressives believed that remedies should be tailored to the needs of the individual (Rothman, 1980:5). Lerman contends that such programs were based on pragmatic and humanitarian grounds, and were used to both relieve overcrowded conditions and "test" mental patients' capacity for social adjustment (1982:85).

Progressive efforts to implement a "preventive and curative" approach within the "community" met with dismal failure in the United States (Scull, 1989:262). According to Scull (1989), efforts to move treatment into the community floundered primarily because the reformers were forced into competition with the state hospitals for funding. Consequently, progressive reforms either folded altogether or were reshaped to suit the needs of the asylum, thus ensuring the endurance of the existing institutional system (Scull, 1989:262). Scull (1989:262) also notes that community oriented reforms met with fierce opposition from patients' families and from the community. However, he does not explain why the patients' families and communities did not share in the reformers' enthusiasm about the benefits of such programs.

[12]Unfortunately, Ralph does not offer an explanation for the reduced funding to mental hospitals at this historical juncture in her labour theory account of the rise of community-based psychiatry (1983).

One hypothesis is that families could not realistically assume the burden of caring for a mentally disabled relative. Certainly there was little economic incentive attached to caring for mentally disordered individuals within a family setting prior to the Depression in the 1930s (Lerman, 1982:210).

There is a second possible explanation for public resistance to community-based care at this historical juncture. At the time, there was a widespread belief that the mentally ill were carriers of bad heredity (Lerman, 1982:102). Hence, most people were reluctant to welcome ex-mental patients into their neighbourhoods. Such resistance provided a justification, in both U.S. (Lerman, 1982:89-90) and Canadian jurisdictions, for mental health policies which supported expanding institutional capacities for eugenic purposes[13].

Lerman notes that over the span of a decade (1927 - 1938), leading individuals in the mental health movement revised their beliefs about the role of heredity in mental illness. These people now began to argue in favour of social and economic factors in the development of mental disorders (1982:85).

By the late 1940s, a number of Western societies (Britain and various regions of the United States[14]) "... had already adopted a policy of placing emphasis on early discharge, or the avoidance of admission altogether, in order to prevent the accumulation of long-stay institutionalized patients ..." (Wing & Brown, 1970:74; cited in Scull, 1984:82). Structuralists such as Scull (1984) attribute the adoption of such a policy to economic and material factors which emerged during this time: namely, the large-scale unionization of state employees, the elimination of exploited patients as unpaid labour, and the need for major repairs to the physical state of the buildings. Huge sums of money were required if hospital administrators were to adequately meet these demands (Scull, 1984). From the

[13]Eugenic explanations of mental disorder, as well as the associated practice of sterilizing mental patients, were also followed in B.C. up until the late 1950s (Ross, 1961).

[14]In California, however, depopulation of mental hospitals did not commence until after 1955, in spite of a sufficient level of resources to support such a policy as early as 1946 (Lerman, 1982:98).

administrators' perspective, the choice was limited to either phasing out the use of public asylums or facing bankruptcy (Scull, 1984:139).

While the economic and material circumstances of the 1940s no doubt played a role in restricting admissions to mental hospitals, pharmaceutical developments would also prove to have a significant impact on the locus of psychiatric treatment. By the end of the 1950s, a variety of drugs (e.g., major tranquillizers and psychotropic medications) were being used to treat both chronic mental patients and non-psychotic individuals (Ralph, 1983:103; Scull, 1984). Such medications had the advantage of being eminently suitable for administration on a mass basis (Scull, 1984:81) and were capable of almost completely replacing more expensive, cumbersome forms of "treatment" such as electro-convulsive therapy (Lerman, 1982).

A decade after the introduction of new psychotropic drugs in the mid-1950s, a new set of ideological factors began to emerge. These were characterized by an emphasis on humanitarian values, a growing legal concern with mental patients' rights and civil liberties, the growth of the anti-psychiatry movement of the late 1960s, and a general destructuring impulse (Cohen, 1985).

According to Gordon and Verdun-Jones, "... the 1960s and 1970s witnessed a burgeoning of an exciting body of case law [in the United States] establishing a number of critical rights[15] [for mental patients] ..." (1988:833). The newly emerged focus on legal protection of mental patients' rights in the United States during the 1960s and 1970s had a considerable impact on the direction of deinstitutionalization policies.

[15]Due to differences in the structure of mental health laws and the lack of an effective **Bill of Rights**, a similar body of case law pertaining to mental health was largely absent in Canada during this same historical time frame (Gordon & Verdun-Jones, 1988). On the contrary, Ross's 1961 **Survey of Mental Health Needs and Resources of British Columbia** actually recommended *relaxing* legal procedural safeguards with regard to involuntary commitment procedures.

It is a rather unfortunate irony that both the anti-psychiatrists' rhetoric and court decisions ruling in favour of patients' rights to be left alone and to exercise greater personal freedom were ultimately employed by policy makers as justifications for mental hospital depopulation policies grounded in less humanitarian motives (Scull, 1984). According to Scull:

> ... the primary value of [humanitarian] rhetoric (though far from its authors' intent) seems to have been its usefulness as a camouflage, allowing economy to masquerade as benevolence and neglect as tolerance (1984:152).

Scull concludes that anti-psychiatry discourse became a smoke-screen for state policies based on cost reduction; however, this explanation is one-sided and fails to acknowledge the widespread **increases** in welfare spending that occurred during this same period[16]. In fact, Lerman argues that in the short term, "actual costs increased due to the expense of matching funds necessary to support the new nontraditional alternatives, expanding public assistance payments and growing outpatient services" (1982:209). Consequently, no substantial savings were realized by state-run mental hospitals in the U.S. until 1972 when new federal legislation provided for the transfer of state costs onto a permanent federal funding source (Lerman, 1982:104).

In any event, it soon became clear that decarceration was not unfolding in the directions envisioned by reformers. Varying explanations have been offered to account for this discrepancy between rhetoric and reality. A common denominator in this debate is an apparent backlash against the antipsychiatrists and civil libertarians from both clinicians (e.g., Isaac & Armat, 1990; Torrey, 1988) and critical scholars (e.g., Cohen, 1987; Ingleby, 1981; Ralph, 1983; Scull, 1984). Practitioners such as Isaac and Armat contend that

[16]The Canadian welfare state was also expanding during this period. For example, the Canada Assistance Plan was implemented as a means of providing federal support to provincial resources for disabled and unemployable populations (Johnson, 1987:35). However, it is not clear whether or how such initiatives had any bearing on deinstitutionalization policies implemented in the early 1970s.

misguided mental health policies "...resulted from a convergence of movements, ideas, and academic theories fashionable [on the political left] in the 1960s" (1990:14). For their part, critical structuralist theorists point to deficiencies in the theories of anti-psychiatrists. Ingleby (1981), for example, argues that the movement was so intent on dismantling psychiatry as a social control agency that it failed to relate mental illness to the larger social context in which it was situated. Cohen also suggests that had the anti-psychiatrists been better theoretically informed as to the nature of the state, it would have been "... clear from the beginning that nothing good could have come from the original reform visions" (1987:365).

The Unintended Consequences of Decarceration

Commentators began to evaluate the outcome of decarceration as early as the mid-1970s (cf., Kirk & Therrien, 1975). Scholars writing from all four theoretical perspectives (e.g., Cohen, 1985, 1987; Isaac & Armat, 1990; Lerman, 1982; Scull, 1984; Torrey, 1988) have noted that, in practice, mental hospital depopulation as a "humanitarian" social policy has fallen drastically short of its stated objectives. According to Cohen (1987), proponents of deinstitutionalization portrayed community treatment and residential facilities as cheaper, more effective and humane alternatives to public institutions and as a means of narrowing the ambit of state power over individuals. The destructuring vocabularies of reform implied that institutions would ultimately be phased out altogether. Yet, as Cohen (1987) points out, alternatives have been co-opted and absorbed; "abolitionist" reforms were transformed into "legitimating" reforms which only served to strengthen the old regime.

Within the mental health context, this tendency has culminated in the development of numerous "community" agencies, while state-run institutions survive relatively intact, albeit with fewer beds available to chronic patients who are unable to function on their own outside a hospital setting. Furthermore, a quarter of a century later, far from achieving the

"withering away of the institution", there appears to be a growing interest in the possibility of *reinstitutionalizing* mentally disordered persons (Dear & Wolch, 1987).

Overall, critics of the decarceration movement have reached the following conclusions. **First**, ex-mental patients have not been reintegrated into the "community", nor have their needs been adequately met by existing community resources and facilities (Kirk & Therrien, 1975; Lerman, 1982; Ralph, 1983; Rose, 1979; Scull, 1984). More often than not, discharged — and growing numbers of non-institutionalized — psychiatric patients find themselves segregated in deteriorating inner-city districts, in the company of other deinstitutionalized populations[17] (Dear & Wolch, 1987; Lerman, 1982; Scull, 1981, 1984). Having found their way to the "deviant ghetto", the mentally disordered must then struggle to

> ... eke out a precarious existence, supported by welfare cheques they may not even know how to cash. They spend their days locked into or out of dilapidated 'community-based' boarding houses. And they find themselves alternatively the prey of street criminals and a source of alarm to ... 'normal' residents ...(Scull, 1979:263-4).

Second, the quality of life experienced by these individuals outside of institutions is often worse than that endured in hospital settings (Ralph, 1983). Ex-mental patients are generally consigned to a state of permanent unemployment and chronic poverty (Dear & Wolch, 1987:135-6; Ralph, 1983). They are "frequently referred upon discharge to core-area accommodations and services that are often found to be unsatisfactory and ineffective ... "; and, in the face of diminished social networks, such individuals are forced to withdraw into themselves (Dear & Wolch, 1987:137).

Third, decarcerated mental patients continue to experience the imposition of therapeutic control following their "discharge" into the community: residential facilities, to

[17] i.e., the mentally handicapped, ex-offenders, physically disabled individuals and dependent elderly persons (Dear & Wolch, 1987).

varying degrees, impose constraints on the autonomy of their mentally ill residents (Lerman, 1982; Scull, 1984). Lerman (1982) reports that in some places in the United States, numerous forms of coercive mechanisms — ranging from physical and chemical restraints (i.e., psychotropic drugs) to restrictions on curfews and/or spending money and access to the community — are employed to facilitate the "management" of mental health clients.

Furthermore, as "unemployable social junk" (Spitzer, 1975) ex-mental patients often become caught up in the multiple social control nets of criminal justice, welfare and mental health (Cohen, 1985; Ralph, 1983). It would seem more accurate to conclude that mental patients have been *"transcarcerated"*[18], as opposed to decarcerated (Warren, 1981).

More recently, attention has been called to an additional consequence of the decarceration movement: specifically, the increasing numbers of mentally ill individuals among the homeless populations in large Western cities (Bassuk, 1984; Lamb, 1984; Snow, Baker, Anderson & Martin, 1986). Some disagreement exists about the proportion of homeless persons suffering from psychiatric disorders. Estimated figures tend to vary according to the criteria used to identify or define mental illness (Snow et al, 1986) and homelessness[19].

Although Snow and his co-researchers do not deny that a significant number of homeless individuals may be mentally disturbed, they maintain that the disproportionate attention focused on deinstitutionalization detracts from other socio-economic factors which have also contributed to homelessness (1986:420). However, it is difficult to overlook the fact that, in the process of implementing hospital downsizing policies, "the lack of planning for structured living arrangements ... in the community has led to many unforeseen

[18]Also referred to as "misassignment" (Dear & Wolch, 1987), transcarceration refers to the specific patterns of retracking the mentally ill between the mental health, criminal justice and social welfare systems encompassed by the creation of a hidden custodial system within the community (Cohen, 1985:62).

[19]Even if there is no definitive statistic to illustrate the extent to which the decarceration movement contributed to homelessness in the 1980s, the pervasiveness of the problem is nevertheless apparent in general estimates of the homeless population (cf., Isaac & Armat, 1990).

consequences such as homelessness ..." (Lamb, 1984:899). Other factors contributing to homelessness — such as acute shortages of low rent accommodation, wide-spread demolition of old rooming houses, and reduced welfare rates (Fulton, 1986) — greatly exacerbate the problems of finding shelter for the mentally ill. Dear and Wolch conclude that:

> ... it should not now be surprising that the atrophying service system should be accompanied by a massive surge in homelessness amongst service-dependent populations. Nor is it unexpected that many groups are being misassigned to inappropriate social settings and reinstitutionalized ... because they lack other shelter options (1987:3-4).

Overall, the evaluative literature has reached the dismal conclusion that "... deinstitutionalization [is] an ironic hypocrisy in light of the rapidly increasing number of people who are hospitalized [albeit, for very brief periods of time] and the equally institutionalizing conditions of many 'community' placements" (Ralph, 1983:31). That this particular reform enterprise has turned out so disastrously comes as no surprise to structuralists such as Scull. After all, if one dispels the fog of rhetoric, it is clear that the entire decarceration enterprise was undertaken without first considering the consequences for mental health clients (Scull, 1979).

The Move Toward a Humanist Vision

Throughout this chapter, I have considered four major theoretical perspectives in my attempt to trace the link between the welfare state and mental health policies, and more specifically to identify a number of factors that, in conjunction, functioned as catalysts for the emergence of the deinstitutionalization movement in the late 1950s. Ingleby argues that "every historical account is shaped by the view of society and power that its author subscribes to" (1983:144). This observation has been amply illustrated in this review and applies no less to the account of decarceration which has emerged in this chapter.

Ingleby also makes a second observation about historical studies of mental health: namely, that these accounts inevitably seem to focus on professional goings-on and the machinery of government (1983:144). Yet to focus only on the state and the professional, whether as humanitarian care providers or agents of social control, overlooks an important part of the picture — the patients themselves. Ingleby draws an analogy between these narratives and the histories of colonial wars: "these accounts tell us more about relations between the imperial powers than about the 'third world' of the mentally ill themselves [or the front-line workers as the foot soldiers out in the field]" (1983:144).

Indeed, many depictions of deinstitutionalization completely ignore the perspectives of the patients and the line level staff — even when the human consequences of deinstitutionalization are ostensibly being considered. Fortunately, this situation is beginning to change in response to some scholars' recognition of the value of including in their work the perspectives and experiences of clientele, via the use of interviews and other types of ethnographic research designs (e.g., Dear & Wolch, 1987; Estroff, 1981; Herman & Smith, 1989).

Moreover, some academics have endeavored to introduce a humanist perspective into their theoretical frameworks. For example, Dear and Wolch's (1987) account of deinstitutionalization considers the activities of specific individuals in shaping the landscape of power in which they are situated. The authors provide an analysis of the actions and strategies of service providers, planners, communities and politicians (1987:Ch.1). By focusing attention on the impact of these agents — in conjunction with larger social forces — on the patients' lives, Dear and Wolch succeed in developing an account of deinstitutionalization which addresses the interaction between human agency and structure (1987: Ch. 3, Ch. 5).

It is my intention to reclaim and consider human agency in my empirical work, thereby continuing in a similar theoretical vein to that developed by Dear and Wolch (1987).

In Chapter II, I shift from a general review of how decarceration as a widespread policy emerged to a specific example of the deinstitutionalization story in the Lower Mainland of British Columbia.

CHAPTER II

THE HISTORICAL EVOLUTION OF THE 1987 DRAFT PLAN

Introduction and Overview

The 1987 **Draft Plan to Replace Riverview Hospital** is a recent and local illustration of the continuing propensity for implementing decarceration policies. Originally, this mental health initiative was intended to discharge an increasing number of chronic mental patients into the community over a five year period, although the projected time span has now been increased to ten years. This plan represents the continuation of a shift towards an increasing reliance on community resources[1] which first emerged in Vancouver during the early 1970s. The decision to implement the **Draft Plan** appears to have been based on both material and ideological considerations. These will be explored more fully in this chapter against the background of historical developments in community-based mental health care and decarceration as they have unfolded in Vancouver, B.C. from the 1970s to the present.

Historical Background

Riverview Hospital[2] has been the primary centre of mental health service delivery for the province of British Columbia since the early decades of the twentieth century (**Draft Plan**, 1987:1). Foulkes' account of the history of Essondale clearly indicates that the institution was plagued by "staffing problems, meagre budgets and bureaucratic bungling ..." (1972:17) from its inception in 1913. In addition, the institution soon became overcrowded to a suffocating extent; reaching its highest level in fiscal year 1955-56 with a total population of 6,327 residents (Davies, 1988:6).

[1]Mental health initiatives aimed at phasing out Riverview Hospital over a period of several years have been raised periodically since at least 1967 (cf., **The Sun**, November 15, 1967:4; **The Province**, July 25, 1967:21).
[2]Originally called Essondale.

In light of these difficulties, this facility has, in the past, been depicted as " ... a snake pit that often held more than [6,000] patients at one time" (Fitterman, 1987: C21). This comment echoes the conclusions of a survey of existing mental health facilities and resources conducted between 1958 and 1960 by Dr. Matthew Ross and the American Psychiatric Association (1961). This survey had found Riverview Hospital to be overcrowded, understaffed and in a deplorable physical condition (Ross, 1961). In addition to recommending major improvements in staffing and programs, and the renovation of buildings, Ross recommended the implementation of after-care facilities and services in the community (based on a treatment team approach) and the coordination of various health and social welfare agencies (Ross, 1961).

The **Ross Report** was never implemented as a social policy for improving mental health services within British Columbia (**The Vancouver Sun**, October 14, 1961:8; **The Province**, October 26, 1962:3). Although the Ministry of Health did agree with the report's major recommendation to regionalize mental health services (**The Province**, October 26, 1962:3), the government of B.C. (ca. 1961-2) was disinclined to act on the recommendations of the **Ross Report**. Indeed, Health Minister Eric Martin clearly indicated that the **Ross Report** would "... never become the master plan of B.C.'s psychiatric services ..." (**The Province**, October 26, 1962:3).

Although some steps were taken to expand the availability of after-care services in the community during the early part of the 1960s, the general trend was toward a deterioration of mental health services in the province, culminating in a near-rebellion on the part of mental health staff[3] in early 1967 (**The Province**, July 25, 1967:21; **The Vancouver Sun**, November 15, 1967:4). This situation prompted the government to appoint a

[3]Deteriorating working conditions and inadequate levels in the quantity and quality of staffing sparked threats of mass resignations from psychiatric nurses and loud complaints from psychologists and psychiatrists within the public mental health system (**The Province**, July 25, 1967:21).

committee, headed by then Deputy Minister of Mental Health Dr. F.G. Tucker, to examine what was perceived as a crisis in mental health services (**The Province**, July 25, 1967:21). The end result was a "blueprint" which called for a major reorganization of mental health service delivery within the province (**The Vancouver Sun**, November 15, 1967: 4; Foulkes, 1974). Ironically, but not surprisingly, Tucker's plan to reorganize and improve mental health services in British Columbia was essentially a reiteration of the recommendations made several years earlier in the **Ross Report** (**The Vancouver Sun**, November 15, 1967:4). As one journalist for a local newspaper observed, Tucker's recommendations were "...absolutely nothing new to the government's ears ..." and if the government had not acted on previous recommendations in 1961, why would it act on the latest blueprint to revamp mental health services (**The Vancouver Sun**, November 15, 1967:4)?

In addition to calling for the decentralization of services and reforms in both the level and quality of staffing (Foulkes, 1974; **The Vancouver Sun**, November 15, 1967:4), the plan also advocated the establishment of preventive and community-oriented services. However, community care services were not implemented in a comprehensive fashion in Vancouver until 1973 (Cumming, J., D. Coates & P. Bunting, 1976:19), more than a decade after Ross's 1961 recommendations. Cumming et al suggest that a considerable level of antipathy between the City of Vancouver and the Social Credit provincial government (ca. 1971) inhibited progress in organizing a system of essential services (1976: 20). Consequently, "[t]he planning of mental health facilities ... [in Vancouver] began in the context of a crisis and a comparative service vacuum ..." (Cumming et al, 1976:19).

The Expansive 1970s: Vancouver's Community Mental Health System

Prior to 1973, the delivery of psychiatric care in the greater Vancouver area was provided via four relatively independent systems: the private psychiatric sector; public psychiatry; public health services; and a fourth sector made up of social and voluntary agencies (Cumming et al, 1976; Seager, 1982). In addition, a psychiatric emergency service

at Vancouver General Hospital (VGH) functioned as a "central clearing house for major psychiatric disorders ..." for the metropolitan area of Vancouver (Cumming et al, 1976:19). The VGH emergency service also provided an effective means of rerouting recurring psychotic patients to Riverview Hospital at a time when there were no restrictions on admissions (Cumming et al, 1976:19; Schwarz, 1963).

In spite of these systems of service delivery, there were numerous problems. Private psychiatrists were often faced with a scarcity of beds for their patients (Seager, 1982), and "[public] psychiatry was often in a state of chronic chaos" (Cumming et al, 1976:19). Severe hospital staff shortages within the provincial mental health system led to the adoption of early discharge and restricted admissions policies (Goodacre, Coles, MaCurdy, Coates & Kendall, 1975; Seager, 1982). The combination of staff shortages and the ensuing policies to control the size of the in-patient population had profound effects on the location and duration of treatment[4] and on the limited emergency facilities available within Greater Vancouver (Seager, 1982). Furthermore, none of the existing social service agencies within the Vancouver area had the resources or training to deal specifically with the complex after-care needs of psychiatric patients (Seager, 1982:3).

This situation, in conjunction with an increasing area population, gave rise to a crisis in which neither the provincial hospital nor the community could provide adequate psychiatric care to patients (Cumming et al, 1976:19). Cumming et al describe the situation as follows:

> ... several of the largest general hospitals had no psychiatric services .... The burden on the Vancouver General Emergency resulted in low morale, little therapeutic work, most staff time being invested in finding hostels or other places in which to dispose patients. Worse still, were the large numbers of

[4]At the time (ca. 1971-1972), a research project known as the Vancouver Home Treatment Project had been initiated as a study of hospital bed replacement and a comparison between home treatment and hospitalization. The principal investigator R.H. Goodacre held the position of Sociological Consultant within the B.C. Mental Health Branch of the Ministry of Health and Hospital Insurance (See Goodacre et al, 1975).

> patients ... who found access to treatment only through the police, jail and the courts, where they were either certified or remanded to the mental hospital. Suicides in public places were frequent ...(1976:20)

According to Cumming et al, the most dramatic manifestation of the extent of this crisis was the August 14, 1972 murder-suicide of a young woman psychiatrist by a [former] patient (1976:20). The incident was attributed to several underlying structural, economic and social factors by other psychiatrists within the system. For example, the head of the forensic psychiatric department at UBC was of the view that the murder-suicide was "the result of the 'revolving door syndrome' emerging in the province [due to a lack of] ... intermediate care facilities between hospitals and out-patient clinics" (**The Sun**, August 6, 1972:1).

Psychiatrists working within the public system of mental health care (i.e., at Riverview Hospital) were quick to attack the provincial government for failing to provide adequate funding for staffing and facilities, and for the consequent overcrowding of existing mental health facilities (**The Sun**, August 16, 1972:1). According to Dr. W.J. Mahabir, Director of the Crease Clinic (an adult acute care clinic), Riverview Hospital was not able to function properly because it was critically over-crowded and understaffed (**The Sun**, August 16, 1972:1). Furthermore, the hospital had difficulties attracting competent psychiatrists due to the unappealing salary and working conditions (cf. Mental Health Branch, Ministry of Health 1972 **Annual Report**, 1973:12; **The Sun**, August 16, 1972:1).

It would appear that, to some extent, this one dramatic incident had the effect of crystallizing the inadequacies of the public mental health system, whether in the institutions or the community, and framing the situation in clearly political terms. Indeed, the director of the Crease Clinic went so far as to suggest that "...[perhaps] because an election is near it has become a political matter" (**The Province**, August 17, 1972:27). It could be argued that the politicization of a crisis situation did lead to results.

The 1972 **Annual Report** for the Mental Health Branch indicates that by the end of that fiscal year, several interesting developments had occurred. **First**, possibly in response to the multitude of published criticisms by staff concerning working conditions at Riverview Hospital, a revision of salary scales and efforts to improve the level of qualified staffing at Riverview Hospital were undertaken and implemented (Mental Health Branch, 1973: 11-12). It was hoped that these reforms would facilitate the recruitment of an adequate number of trained staff and that working conditions would be improved (Mental Health Branch, 1973: 12).

Second, the community component of mental health care had been expanded to include the implementation of some significant changes in the Greater Vancouver region (Mental Health Branch, 1973: 11). In August 1972, an Advisory Mental Health Committee[5] was appointed to the Vancouver Metropolitan Board of Health (Mental Health Branch, 1973: 11). The task of the Advisory Committee was to "coordinate and plan a composite community mental health programme for the Vancouver region, with a special emphasis on alternative methods of care and provision of 'back-up resources'" (Mental Health Branch, 1973: 11). It is not clear from the Annual Report whether this committee was a response to the critical reaction triggered by the shooting incident or whether it would have been created, in any event, as a logical step in the implementation of mental health community services in Vancouver. But in light of the existing antipathy between the Mental Health Branch and the City of Vancouver (Cumming et al, 1976:20), the timing does appear to be something other than mere coincidence.

In addition to the planning activities of the Mental Health Advisory Committee and the U.B.C. Department of Psychiatry, the British Columbia Medical Association (B.C.M.A.),

[5]This committee, jointly chaired by Vancouver Medical Health Officer Dr. Gerald Bonham and Director of Mental Health Services for Vancouver Health Department Dr. Roberta McQueen, primarily comprised public/private sector psychiatrists, health personnel and representatives from other social and medical planning agencies in Vancouver (Cumming et al, 1976; Foulkes, 1973).

Section of Psychiatry, also organized a meeting[6] to assess the major problems in the system (Cumming et al, 1976; Foulkes, 1973). The end result of the B.C.M.A. meeting was the organization of a Task Committee to identify areas of immediate concern and make the appropriate recommendations[7] (Foulkes, 1973: 3-4). At the time, the most pressing concern was the "... lack of emergency and acute treatment facilities in the Greater Vancouver Area ..." in conjunction with an absence of back-up facilities and services to provide long-term community care and social support (Foulkes, 1973:4).

When a comprehensive system of community mental health care was finally established, it emerged as the outcome of an historically specific combination of socio-political factors, and the influence of particular individuals (Cumming et al, 1976; Foulkes, 1974; Seager, 1982). In accounting for the rapid and intensive expansion of community services after mid-1972, it would appear that the actions and beliefs of specific individuals and organizations (e.g., the Mental Health Planning and Advisory Committee) within the mental health field played a crucial role (Cumming et al, 1976). Of course, these policy initiatives did not occur in a vacuum. Political and economic variables were also integral to the unfolding of these events.

The August 1972 election of an NDP government that was committed to community initiated and controlled primary health care centres provided an opportunity for the Mental Health Planning and Advisory Committee to gain support for their proposals to implement a community care program based on a (care) team approach (Cumming et al, 1976: 20-21). Indeed, it was likely that the introduction of a new set of players in the provincial mental health system, because of the election of an NDP government, enabled groups such as the

[6]The B.C.M.A. Section of Psychiatry meeting was held September 25, 1972 (Foulkes, 1973). The meeting was attended by over 100 public and private sector psychiatrists working in the Vancouver area; the new NDP Minister of Health Dennis Cocke and a special consultant were also present (Cumming et al, 1976).

[7]See R.G. Foulkes' **Report of the Task Committee of the Section of Psychiatry, B.C.M.A.** (1973) for a discussion of the problems identified and subsequent recommendations proposed by the Task Committee.

Mental Health Planning and Advisory Committee and the Metropolitan Board of Health to overcome the system's previous antagonism towards developing a coherent plan for community services in Vancouver. The rapid increase in the level of power granted to the Metropolitan Board of Health within the space of a year would seem to support this view[8] (cf., Cumming et al, 1976:20).

The members of the Planning and Advisory Committee approached their mandate to coordinate and implement a comprehensive system of community-based mental health care from the perspective that "... piecemeal efforts to improve individual services would never be a sufficient response to the overwhelming problems on every front" (Cumming et al, 1976:20). This approach was reflected in a discussion paper entitled "A Plan for Vancouver"[9], released by the Mental Health Branch toward the end of 1972 (Cumming et al, 1976). The discussion paper "... proposed to take advantage of the service vacuum by introducing a new system without having to tear down an existent one" (Cumming et al, 1976:20). The plan focused on altering the need for hospital-based services through the provision of appropriate community-based treatment and support services for adult mental patients[10] (Mental Health Branch 1974; Seager, 1982).

Specifically, a system of community treatment teams[11] scattered throughout the city would serve as "... the first contact with the public treatment system for the seriously mentally ill person ..." (Cumming et al, 1976:21; Persky, 1974). The emphasis would be on

[8]By the end of 1972, the Mental Health Planning and Advisory Committee represented approximately 17 organizations including the health departments of Vancouver, Richmond and the North Shore; Vancouver General and Lions Gate Hospitals; UBC Department of Psychiatry; B.C.M.A. Section of Psychiatry; the provincial Mental Health Branch; the Alcoholism and Narcotic Addictions Foundations; and several additional medical-social agencies (**The Province**, October 27, 1972:39; **The Province**, December 20, 1972:10).

[9]The principal author of this proposal was Dr. John Cumming, a special program consultant/analyst in the Mental Health Branch, and liaison to the Advisory Committee (Persky, 1974; **The Province**, October 27, 1972:39).

[10]The results of the "Vancouver Home Treatment Project" (Goodacre et al, 1972) were relied on to support the argument for community-based services (Seager, 1982:ii).

[11]These teams each comprised a psychiatrist, two senior mental health workers, several mental health workers, an occupational therapist and office support staff (Cumming et al, 1976; Seager, 1982).

developing a treatment plan that would allow the patient to remain in her or his own community as much as possible (Cumming et al, 1976; Persky, 1974). At an administrative level, the care teams and concomitant support services such as vocational rehabilitation, short-stay facilities, day programs and the like would be coordinated through one organization, the Greater Vancouver Mental Health Service[12] (Seager, 1982:4).

Cumming's plan was received enthusiastically by the provincial government, although the B.C.M.A. Section of Psychiatry indicated a more cautious acceptance of the "Vancouver Plan". Specifically, Foulkes observed that Cumming's plan was targetted on a limited and special group of mentally ill individuals and would not address the needs of the majority of mental health patients (1973:3).

Nonetheless, the proposal was accepted by the provincial government. A news release in December 1972 announced that funding had been authorized for the implementation of the program (**The Province**, December 20, 1972:10). As Cumming et al point out, the proposal was politically appealing ideologically and fiscally as it would have the effect of reducing overcrowding in the provincial hospital and help to offset some of the cost of the new service through the savings realized from the decreased use of the provincial hospital (1976:21). Certainly, as Persky observes, the decision to support the Vancouver Plan enabled the NDP government to carry out its promise to "do something about Riverview" (1974:9).

Implementation of the Vancouver Plan[13] commenced in early 1973, following the provincial government's commitment to funding the development of the care teams and related support services proposed by Cumming et al[14] (Persky, 1974; Seager, 1982).

[12]According to Seager, the Greater Vancouver Mental Health Service (GVMHS) began as an experimental project; however, it was launched as an established agency by 1973 (1982:4).

[13]Subsequently referred to as the Greater Vancouver Mental Health project.

[14]According to Seager, funding for the project was to be administered through the Greater Vancouver Mental Health Services (GVMHS) which, in turn received initial funding from the Community Care Services Society (1982:4).

Additionally, the Mental Health Branch provided some guidelines[15] to assist in planning the number and nature of community facilities required to establish a system of decentralized mental health services (1974:31).

Clearly, a mental health project committed to a goal of hospital bed replacement would require a comprehensive and coordinated system of treatment and support services that would be at least functionally equivalent to and, ideally, more therapeutic than a hospital based system of care (Cumming et al, 1976:22). Furthermore, many GVMHS clients, as a consequence of lengthy psychiatric histories, lacked basic personal care skills, let alone the ability to secure shelter and food for themselves (Seager, 1982). Evidently, the provision of suitable housing would have to be a major consideration in the development of a community system of care since traditionally "... [one] of the main functions of the ... [psychiatric] hospital has been to provide food and shelter to those who find it hard to obtain these elsewhere ..." (Cumming et al, 1976:22; Seager, 1982).

Indeed, the need for varied types of housing was accounted for in the Vancouver Mental Health Project (Cumming et al, 1976; Seager, 1982). But at the time (ca. 1972 - 1973), most of the psychiatric boarding homes were overcrowded, lacked privacy and were generally substandard in the quality of care they provided (Tomlinson & Cumming, 1976:25). Furthermore, opportunities for autonomous living[16] were almost non-existent (Tomlinson & Cumming, 1976:25). In practice, "autonomous living arrangements" translated into placing patients in dilapidated, dismal and exorbitantly priced rooms or housekeeping suites in welfare hotels[17] (Tomlinson & Cumming, 1976:25). An acute general

[15] Preparation of these guidelines was based on the results of Branch Patient Categorization Surveys conducted in 1970 and 1972 (Mental Health Branch, 1974:31).

[16] Apparently mental health workers (from the Coast Foundation, established earlier in 1972) involved in developing a recreational program for psychiatric boarding home residents had observed that at least some of the residents were capable of dealing with more autonomous living arrangements (Tomlinson & Cumming, 1976:25).

[17] Apparently, mental health workers were convinced that such substandard living conditions were a significant factor in the cycle of hospitalization, dependency, relapse and readmissions observed among deinstitutionalized patients (Tomlinson & Cumming, 1976:25).

housing shortage[18] further constrained patients' efforts to re-establish themselves in the community (Tomlinson & Cumming, 1976:25).

By November 1975, the Vancouver Mental Health Project had succeeded in implementing at least some of Cumming's recommendations. For example, two of the general hospitals within the city had added psychiatric wards to accommodate the need for inpatient treatment, St. Paul's Hospital had developed a day hospital program and the Vancouver Mental Health Project observed some growth in the field of social agency support for mental patients (Cumming et al, 1976:22). But "[a number of] ... the support services initially planned had not yet been developed; consequently, there were still gaps in the system" (Cumming et al, 1976:22). Nonetheless, Cumming et al maintained that, overall, "... Vancouver [was] no longer in a state of crisis" (1976:22).

But if Cumming and his colleagues in the mental health project were satisfied with the rate of progress, clearly the "front-line" agencies responsible for delivering support services were *not* happy with the circumstances in which they found themselves (**The Province**, November 28, 1975:40; **The Province**, December 9, 1975:4). Many of the organizations desperately required funding (**The Province**, December 9, 1975:4). Unable to meet the increased demands on their services, organizations were forced to create waiting lists and needy clients languished in acute care beds (**The Province**, December 9, 1975:4).

A special committee[19] representing medical and social services in the city was formed to address the issues of insufficient funding[20] and a lack of coordination between various agencies within the city, both of which apparently contributed to the "revolving door syndrome" of mental patients (**The Province**, November 28, 1975:40). The committee

[18]However, certain local organizations took the initiative in alleviating housing problems for ex-mental patients. For example, the Mental Patients' Association established several community group homes, and by 1974 the Coast Foundation had also made plans to enter the housing field (Tomlinson & Cumming, 1976: 25).
[19]The Ad Hoc Committee on Community Resources for Persons With Emotional Difficulties.
[20]According to one media report, "... the B.C. government spent over $27 million for institutional care of various sorts in 1974, but less than $2 million on community programs" (**The Province**, November 28, 1975:40).

devised and subsequently presented to the provincial government a plan which called for the "... logical organization of crisis centres, community care homes, halfway houses and sheltered workshops, properly funded[21] and fulfilling their role in the mental health field" (**The Province**, December 9, 1975: 4). According to the committee's Chair Ralph Buckley, the total cost of implementing these recommendations would be between one and two million dollars (**The Province**, November 28, 1975:40).

By the end of the 1970s, two committees[22] had conducted evaluations of Vancouver's community mental health services. Of some concern to the 1978 Psychiatric Services Study Committee was the disproportionate number of "difficult" patients on the care team caseloads and the related problem of getting the hospitals to accept such individuals on an in-patient basis when necessary (Lambert, 1978:41,44). Apparently, many private psychiatrists were choosing not to become affiliated with an inpatient hospital unit; consequently, the more difficult patients [and therefore least popular psychiatric cases] were left to the community care teams[23] (Lambert, 1978:41). The chronic condition of many patients in the community mental health system was also noted in the Mental Health Planning Survey Team's (M.H.P.S. Team) 1979 report; however, the primary concern of this report was the uneven development of services[24] in the community system. In retrospect, the findings of these two reports were to become trends which continued into the 1980s.

The 1980s: Recession, Restraint and Retrenchment

Overall, the 1980s proved to be deleterious to any hopes of further expanding a community-based system of mental health service. The economy was in a recession, and in

[21]The Ad Hoc Committee apparently perceived the failure of the province's health and welfare departments to agree on a cost-sharing formula as a major impediment to achieving adequate funding and a coordinated network of support services for the mentally ill (**The Province**, December 9, 1975:4).
[22]The Psychiatric Services Study Committee (1978) and the Mental Health Planning Survey Team (1979).
[23]According to Lambert, the care teams generally attracted "... patients without community social support, and who [suffered] from chronic psychotic and/or personality disorders" (1978:44).
[24]For example, the M.H.P.S. team found that in contrast to housing, sheltered work was probably the most poorly developed element of the Vancouver system of services (1979:26).

1983 the B.C. government introduced a policy of fiscal restraint (Allen & Rosenbluth, 1986). According to Redish, a significant characteristic of the government's "restraint" program was "... its attack on ... the group of people [e.g., mental patients living in the community] who [were dependent] on the income assistance and social service programs of the [then] Ministry of Human Resources" (1986:152). The budget for mental health services[25] was also attacked, resulting in decreased availability of beds, rehabilitation programs, transition houses, and the like (**The Vancouver Sun**, December 10, 1984:A6).

By 1987, care team caseloads had increased from a staff/patient ratio of 1:30 in 1973 to as high as 1:60 (depending on the geographical location of the care team[26]), yet the number of staff had diminished (City of Vancouver, 1988:1). Consequently, the care teams were unable to offer outreach services or preventative care and they could only just provide emergency support (City of Vancouver, 1988:1).

It was not only the care teams that were operating at full capacity. The mental health system also had to contend with an inadequate number of boarding homes (most of which were still substandard in quality) and short-stay emergency facilities were asked to accept people with acute care needs (City of Vancouver, 1988:1). According to a report[27] by the Social Planning Department of Vancouver, funding from the Ministry of Health had been insufficient to keep pace with both the escalating number of patients and the increased severity of illness in many patients[28] (1988:1). In short, in 1987, the City of Vancouver was

[25]Derived from the Ministry of Health.

[26]In 1987, the Broadway, West Side and Strathcona teams were carrying the heaviest caseloads. Monthly averages of active cases for each of these three teams were 774, 443 and 453, respectively (City of Vancouver, Manager's Report, 1988: Appendix II).

[27]The report, entitled **Status of Mental Health in Vancouver: Deficiencies and Recommended Solutions**, was prepared for the Standing Committee of Council on Neighbourhood, Cultural & Community Services. The report outlines 18 initiatives required to address existing deficiencies in the community mental health system.

[28]According to the GVMHS, not only had there been an increase in the severity of illness amongst the patients, but there had also been a shift in patient characteristics over the previous decade. For a more detailed discussion of this issue, see the aforementioned report by the Social Planning Department of Vancouver (1988).

confronted with a new mental health crisis and the ensuing problems were spilling over into other jurisdictions (City of Vancouver, 1988:1).

As in the early 1970s, increasing numbers of mentally ill individuals were finding their way into the criminal justice system[29] (City of Vancouver, 1988:8). And, once again, a revolving door situation began to emerge where mentally ill persons often went back and forth between the mental health system, the criminal justice system and social services. It would appear that by 1987 an increasing number of mentally ill individuals were "multi-system"[30] users. Two initiatives were developed in response to this situation (City of Vancouver, 1988). **First**, the Multi-Service Network (MSN)[31] was set up in 1985 (1) to assist front-line workers in the implementation of a case management approach for multi-system users and (2) to identify gaps in mental health/social services. **Second**, the Inter-Ministerial Project (IMP)[32] was established in 1987 to meet the needs of a specific group of mentally ill persons who were frequently in and out of court and often barred from most social services in the city as a result of their behaviour.

The 1987 Draft Plan

In 1987, the provincial government released a mental health initiative which proposed to further downsize Riverview Hospital and redefine the role of this facility in B.C.'s mental health system. The **Draft Plan** is the "blueprint" for a revamped delivery system of mental health services within the province of British Columbia and is intended to influence the extent and development of mental health services over the next decade. The

[29]In many instances, charges were dropped and the individual was released. But in cases where the person was incarcerated, treatment or support for mental disorders was seldom received (City of Vancouver, 1988:8).

[30]According to the Social Planning Department report, it was estimated that in 1987 there were 400 multi-system users in Vancouver's lower east side, 73% of whom were mentally ill (1988:8).

[31]The purpose of MSN is to function as a referral system and mechanism for coordinating services between agencies and systems.

[32]IMP is jointly run by Probation, GVMHS and the Forensic Psychiatric Commission. The service provides aggressive case management and supervision for mentally ill offenders (City of Vancouver, 1988).

development of this document[33] is be traced in the remainder of the chapter. Specific responses to and criticisms of the **Draft Plan** are also considered in light of the present status of Vancouver's system of community mental health.

The 1987 **Draft Plan** is commonly understood as the end product of a two year consultative planning process, undertaken to "...address the need to replace outdated buildings at Riverview Hospital and, concurrently, to recommend improvements to the over-all mental health service system" (Ministry of Health, 1987:1). In tracing the actual background and development of the 1987 **Draft Plan**, however, it turns out that the whole process — from the original solicitation of Cabinet approval in the early 1980s to undertake a consultative process to its public announcement by Health Minister John Jansen in February 1990 — has spanned almost a decade.

The current plan to deinstitutionalize increasingly large numbers of mental patients from Riverview Hospital appears to have been influenced by a number of material[34] and ideological factors. According to one of its co-authors[35],who was interviewed in the course of the thesis research, an internal personnel shuffle in Mental Health Services was a significant precipitating factor in the evolution of the **Draft Plan**. Specifically, in the early 1980s, Mental Health Services appointed a new executive, director Brian Copley. The **Draft Plan** co-author observed: "[with] a new executive director in place, there was a thrust to reorganize headquarters's operations and to review the operation of existing programs".

Copley approached the government in 1982 about replacing Riverview Hospital and, surprisingly, gained planning approval for a standard replacement; i.e, the construction of a new hospital. Further consideration of the issue, however, led Copley to question

[33]The Draft Plan was intended as an outline and guide for planning services but has been interpreted by some sectors of service delivery as social policy.

[34]A key material consideration is the run-down state of the buildings and an inadequate levei of staffing; the same conditions which have prevailed for more than 25 years.

[35]Interview methods and respondents will be described in detail in Chapter III.

whether a simple replacement of the facility was, in fact, the best approach (interview with **Draft Plan** co-author).

In order to address this question, the executive director conducted an internal review of most mental health services in B.C. Two very clear messages emerged from this process. **First**, there was a need to develop a new concept for the role of Riverview Hospital. **Second**, this would require a public process due to the large number of organizations with a stake in the issue. The results of the internal review were therefore used to support a request for such a public consultation process. Since open policy initiatives of this kind were not regarded positively by the Social Credit government of the early 1980s, Copley had to gain Cabinet's approval before undertaking such a process. Approval for the project was finally granted in 1984 and initial steps were taken to develop a consultative planning approach to mental health (interview with **Draft Plan** co-author).

The Consultative Process

The planning process is depicted in the 1987 report (p.1) as having been conducted in a democratic, consultative manner. According to the report, it focused on identifying the issues relevant to mental health care as they were experienced by various individuals and groups, ranging from patients to professionals, involved with the mental health system with a view to developing a broad consensus. But in the view of the director of an advocacy organization, some consumers perceived their involvement as no more than token representation. According to her, "there were some doubts as to how seriously [consumers] were listened to, in terms of expressing their concerns and suggestions" (interview with Administrator 6[36]). In fact, she questioned whether consumers could participate as equals if they were not provided with the skills to articulate their needs and wishes, as well as an

[36]Categories of participants with more than one respondent in them have been assigned a number, and are referred to as, for example, Administrator 6 or Psychiatrist 2 (See Appendix A, p. 151).

understanding of the protocol (e.g., conducting meetings according to Robert's Rules of order) involved in such meetings.

Nonetheless, according to the **Draft Plan** co-author, he and his colleagues sought to achieve the goal of a democratic process through disseminating selected questions about Riverview Hospital in as public a way as possible. These questions were sent to everyone the authors could think of: professionals, community agencies, consumers, universities and any other groups who might be interested in the issue. The final tally "... amounted to about 7,000 meetings[37] province-wide and about 800 written submissions[38]". An interim report was produced in 1986, based on the first round of submissions from participants. Copies of the interim report were sent to those organizations and individuals who had participated in the process and a subsequent round of submissions was received prior to analyzing the data and writing the report.

The next step in the process consisted of integrating, synthesizing and ultimately identifying major themes, issues and principles[39] within the body of information received by the Mental Health Services Division (1987:1). According to the **Draft Plan** co-author, this step was achieved by having all three authors read every submission, highlighting the various themes which emerged and categorizing them into several groupings. Each author also read and discussed the co-authors' interpretations and categorizations of the material in an effort to identify and develop a structure and some consistency in the overall analysis. The authors of the report point out that this process "... involved a great deal of summarizing and

[37] According to the **Draft Plan** co-author, verbal submissions were not formally organized. Rather, meetings were held on a demand basis as a means of accommodating groups or organizations that specifically indicated an interest in making a verbal submission.

[38] Of the 800 written submissions, about 300-400 letters were from formal organizations and approximately the same number of letters were submitted by consumers of mental health (interview with **Draft Plan** co-author).

[39] According to the document's co-author, "... a tremendous level of agreement existed across the various groups of participants" in terms of general themes and issues of concern. Although different groups varied slightly in their views about the kinds of services needed, all groups were quite consistent in their stance on key issues.

interpreting of information [and] setting priorities based upon a sense of what is pragmatic, possible, effective and efficient ..." (1987:1).

As executive director of Mental Health Services, Copley was responsible for setting priorities and deciding on the interpretation of the materials analyzed. After numerous revisions, the **Draft Plan** was presented to Cabinet in 1987; however the **Draft Plan** did not gain official approval, via a public announcement by the Ministry of Health, until February of 1990[40]. The **Draft Plan** co-author attributes the delay in Cabinet to a number of internal upheavals which emerged in government and took priority, asserting that when Cabinet did finally look at the **Draft Plan**, the document was received with little difficulty[41]. However, in the opinion of one critic, Psychiatrist 2, the report presented to Cabinet was not a "plan" in the true sense of the word; rather, it was a collection of general purpose statements. Furthermore, in his view this version not only failed to reflect a consultative spirit, it also lacked any criticisms of the system's efficacy[42]. The net result was a document which was less valuable than the interim report which had been previously distributed to contributors. In the context of these contrasting evaluations, what follows is a description of the overall structure and content of this controversial document.

The Anatomy of the Document

The **Mental Health Consultation Report** (i.e., the **Draft Plan**) is a 42 page document comprising five major sections (Background, Report, Fiscal Strategy, Implementation and Conclusion), a summary of recommendations, appendices, a list of contributors and an extensive bibliography pertaining to deinstitutionalization and the care of

[40]Participants in the consultative process received a final copy of the **Draft Plan** well before the public announcement in February, 1990.
[41]The greater difficulty was in having to continually justify the process to a new health minister as there was no continuity within the government over the span of the entire process.
[42]According to this source, the report was subjected to political editing due to an internal policy which prevented the authors from including criticisms of the system.

the mentally ill. For the purposes of this discussion, a brief outline of the substantive segments will be provided. Selected issues will be discussed in more detail.

The Background serves as an introduction to the report. It provides an overview of the consultative process, sets out the major premises and themes of the **Draft Plan**, identifies core philosophies and principles, defines the target population, and describes the current structure of mental health services delivery within the province (1987:1-5).

Overall, the major premises and working assumptions which have shaped the development of the **Draft Plan** are based on a continued commitment to the decentralization and regionalization of service delivery (1987). Statements pertaining to decentralization, regionalization, community-based care, normalization, consumer and family participation pervade the thematic content[43] of the report (MacNaughton, 1992:3; Noone, 1988:415). In its introduction, the **Draft Plan** is specifically identified as "... a 'blueprint' to guide the development and improvement of mental health services in British Columbia"[44] (1987:2).

The document's introduction also includes a discussion of the core philosophical values and service principles adopted by the **Draft Plan**. According to the official discourse employed in this subsection, the plan is based on a set of humanitarian values and service principles aimed at facilitating comprehensiveness, coordination of services, continuity of care, availability, accessibility and accountability (1987: 2-3). These values and principles, informed by a communitarian ideology, function as both performance guidelines and standards; that is they provide the document with a normative frame of reference, as indicated by the frequent use of prescriptive discourse throughout the background discussion and introduction to the report (see pp. 2-3). Overall, this section of the **Draft Plan** conveys the message that "community care" will provide a more humane, more effective and less

[43] According to MacNaughton, the thematic content of the **Draft Plan** is remarkably consistent with recent mental health policy documents emerging in provinces across Canada (1992:3).

[44] Paradoxically,the co-author of the report argues that the document is not really a blueprint, but a conceptual plan which allows for flexibility in implementation and varies with different contexts.

expensive approach to the provision of mental health care in the lower mainland and throughout British Columbia. Appeals to the benefits of community-based treatment (i.e., more humane, less expensive) to support policy changes in mental health care have become a recurring theme in the push for deinstitutionalization and are well documented in the literature (e.g., Cohen, 1987; Rothman, 1980; Scull,1984, 1989).

The main text of the **Draft Plan** describes the various providers of psychiatric services: e.g., general community services, community mental health support services, hospital care, and services for the elderly. It also offers relevant recommendations for improved services (1987:8-16). Issues of system coordination and accountability, personnel recruitment, and research are considered, and recommendations in these areas are provided (1987:16-18). A general discussion which reiterates the key underlying assumptions of the recommendations precedes an examination of the specific concerns outlined above.

These underlying assumptions reflect the adherence to themes of community, normalization, the role of family, decentralization, and a biological basis of mental disorder (see pp.7-8). Many of these themes become dovetailed and must be assessed together. For example, the emphasis on a normalization effort includes issues of community care and the role of families in the patients' experiences. In fact, the very first recommendation states that "[the] vital role of families in the rehabilitation of mentally ill persons should be encouraged and strengthened" (1987:8). According to the **Draft Plan**, the move to community-based treatment is based on "... the firm belief that the mentally ill should be united as much as possible with their families, friends, and local community environments in order to reinforce the whole *normalization* [original emphasis] effort ..." (1987:7). A picture is painted of ex-patients learning the requisite living skills (i.e., the capacity to function independently) in a supportive family-like environment once they are already in the community. The report contends that "[if] patients are expected to ultimately live in the community, then that is the best place for them to learn the skills they will need to function there" (1987:7). But it is

unrealistic (and unfair) to expect discharged patients to learn these skills "on the job", so to speak, or to be placed in a community equipped with only a minimum of basic living skills, acquired just prior to being discharged from the hospital. Furthermore, as the literature points out, deinstitutionalized patients are often discharged into inadequate aftercare facilities and have troubles coping due to a lack of preparedness for "living on the outside" (cf. Herman & Smith, 1989:389; Scull, 1981). Nonetheless, several of the **Draft Plan**'s recommendations address the issue of providing ex-patients with life skills training in a variety of community settings (1987:8-9).

In spite of the emphasis on maintaining mental health clients in the community, the **Draft Plan** acknowledges the ongoing need for hospital-based care in some instances (1987:11-12). The emphasis, however, is on utilizing general hospitals to provide assessments and psychiatric care for acute cases. The report takes the position that medium and long-term inpatient care should be decentralized and reserved for the most seriously mentally ill (1987:13). In order to support this view, the plan asserts that smaller inpatient units located throughout the province would offer mental health patients better quality services that are close to home (1987:13).

Although critics (such as Psychiatrist 2, interviewed for this thesis) have not taken issue with the recommendation to provide smaller, decentralized medium-care hospitals, they have questioned the overall number and distribution of beds allocated for this purpose. The document recommends that 550 beds for medium or long-term psychiatric inpatient care should be distributed throughout the province in the following manner:

Vancouver/Lower Mainland	300 beds
Okanagan/Kootenay	100 beds
Vancouver Island	100 beds
North	50 beds (1987:15).

Psychiatrist 2 criticizes this recommendation on several grounds. **First**, he argues that 550 beds is an inadequate allocation of resources for medium or long-term care in the province. In his opinion, " the numbers are flawed [and] ... the chances of reducing to 550 beds is unrealistic". **Second**, he suggests that "the idea of scattering resources throughout the province doesn't make much sense", given the number of psychiatric referrals to Vancouver and the incidence of urban drift among mental health patients. Such recommendations, according to this source, must ultimately be examined in light of the true intent of the plan (cost containment or system enhancement) and an understanding of government funding strategies. Certainly costs and the allocation of funding are treated as important considerations in formulating the **Draft Plan**'s fiscal strategy (1987:19).

Section III (Fiscal Strategy) begins by identifying then current concerns about escalating health care costs and the impact of increased spending on taxes (1987:19). Given that the consultative process unfolded in the midst of the Social Credit government's policy of "fiscal restraint", it is not surprising that the plan was "overshadowed by the awareness of escalating overall health care costs" (1987:19). The true intent of the plan was viewed as suspect both by those who feared cutbacks in services and by those who wanted to control spending and tax increases. The discourse employed in this section of the document suggests that, ultimately, these tensions were addressed by using statements that would appear to satisfy everybody concerned. Consequently, remarks pertaining to developing enhancements "within the overall economic reality of the Province" are juxtaposed with a clearly stated commitment to "maintaining existing resources" (1987:19).

As a fiscal strategy, this translated into a practice of reallocating existing resources ($73 million) from Riverview Hospital for the development of replacement services in the community (1987:19). The dispersement of fiscal resources within this allotment is clearly

set out in this section of the **Draft Plan**[45]. This funding scheme has been a source of controversy and criticism. What follows is an examination of some responses to both the tactic of redistributing existing resources and the fiscal impact of this approach on the implementation of the **Draft Plan**.

Implications of the Fiscal Strategy for Community Agencies

According to the **Draft Plan**, the 1987 proposal to replace Riverview Hospital was based on the continued use of community care teams and an increase in the availability of other community facilities (1987:21). Essentially, resources would be transferred to communities to provide services for discharged patients (City of Vancouver, 1988:1). But according to a report by Vancouver's Social Planning Department, the **Draft Plan** failed to address existing deficiencies in the system and the service delivery system was facing a crisis situation (1988:1).

Consequently, the Director of Social Planning and the Medical Health Officer for Vancouver urgently recommended that a request be made to the Ministry of Health to "... defer any further downsizing of Riverview until substantial progress [had] been made in addressing the existing deficiencies in Vancouver services ..." (1988:10). The **Draft Plan** co-author concedes that, initially, the mental health initiative to replace Riverview Hospital focused on the issue of institutional resources and the reallocation of such funds to the community.

The difficulty with this fiscal strategy, however, is that additional funds were, and are, needed to address short-comings (i.e., lack of adequate staffing and available programs) in existing community mental health services (1987:19). Indeed, the co-authors of the report found that over the span of the consultative process, the economic basis and resources for operating existing services had actually eroded to some degree. Furthermore, the **Draft Plan**

[45]According to the co-author , the decision to include actual numbers was an unprecedented step, given that "these kinds of documents don't usually contain specific numbers".

did not address the problem of how "... to meet a shortfall that ... exists between current service capacity, and [the] replacement process itself" (Noone, 1988:417).

In light of these considerations, a commitment to maintaining an existing level of funding through the reallotment of available fiscal resources suggested to some critics (e.g., Noone, 1988) that despite the rhetoric about improved and increased community services for the mentally ill, deinstitutionalized patients would continue to receive a "humble" standard of community care at best. The tendency of policy makers to uphold an ideological focus on community mental health reintegration as a means of supporting a fiscal policy of reallocation, even though the authors of the **Draft Plan** admitted that the mental health initiative could not be successfully implemented without bridge funding, was clearly incongruent (Noone, 1988:417). In his review of the **Draft Plan**, Noone concluded that:

> [the] fiscal strategy articulated [in the **Draft Plan**] is inherently contradictory. If government insists that only the 'existing resource' allocation is to be applied, then by the report's own argument the plan must be shelved as it could not be successfully implemented (1988:417).

Ultimately, Mental Health Services reached the conclusion that catch-up resources would have to be provided to address the existing shortfall in services, and that bridge funding was indispensable for the eventual development of care facilities and the closure of gaps in service delivery. This additional financial support ($20 million for enhancement purposes) was addressed in a budget presented to Cabinet. Cabinet accepted the request for additional capital; however, Mental Health Services were not able to commit or spend the money until the Ministry of Health made an official announcement. Consequently, the **Draft Plan** co-author asserts that no steps to begin implementing the **Draft Plan** were taken until December, 1990. Since then some of the fiscal support (about $4 million) has come through;

however, this money has not, to date, been applied to real costs[46] and the shortfall in community services continues to exist. The **Draft Plan**'s co-author also notes that mental health care providers are well informed of and sensitive to financial issues and are likely to be highly critical of the government if the promised resources are not secured.

Indeed, a government decision in 1991 to renege on an extra $10 million it had committed to mental health spending (part of the enhancement funds earmarked for developing housing and programs) was met with outrage (cf. **The Province**, September 12, 1991:1). Psychiatrist 2 observed that "... within one year of announcing the plan, they [the government] have stopped the bridge funding, they have cut Riverview's budget by $4.1 million and GVMHS's budget by $2 million". True to the **Draft Plan** co-author's prediction, mental health care providers proved to be extremely critical of the government over this issue. Many parties[47] expressed frustration with the delay and criticized the government's funding "backflip" (**The Province**, September 12, 1991:1). According to an article in a local newspaper, Dr. John Blatherwick described the government's decision to continue downsizing Riverview hospital without simultaneously providing a long-term financial commitment to mental health spending as a "recipe for chaos" (**The Vancouver Sun**, May 29, 1991:B1).

Perhaps in response to the government's spending practices, mental health became a major issue during the October 1991 provincial election[48]. In fact, candidates from all three political parties[49] were "... asked to present their party's position on mental health issues" at an election forum (**The Vancouver Sun**, October 9, 1991:B8). According to Canadian

[46]There has been no increase in the actual number of people who deliver mental health services at the community level.

[47]Including the then president of Riverview Hospital John Yarske and Dr. John Blatherwick, Vancouver's Medical Health Officer.

[48]Several respondents interviewed early in 1991 suggested that mental health spending would emerge as a political issue if an election was called during that year.

[49]Social Credit, the NDP and the Liberals.

Mental Health Association (B.C. Division) executive director Barbara Grantham, the forum's audience wanted assurances of "... a definite commitment from all of the parties that they [were] not only philosophically committed to the mental health initiative but that they [would] ... follow it up with the resources ... [needed] to make it happen" (cited in **The Vancouver Sun**, October 9, 1991:B8). Several respondents in this study fervently hoped that an impending election would result in an NDP government which would be more committed to funding social services. Certainly, NDP candidates stated unequivocally that their party supported the 1987 **Draft Plan** and promised to provide the necessary resources (**The Province**, October 11, 1991:A32).

In October 1991 an NDP government was elected. In keeping with its pre-election commitment to support the mental health initiative, the NDP allocated $52 million to community mental health services in the March 1992 provincial budget (**The Vancouver Sun**, May 5, 1992:B5). Needless to say, mental health leaders were "...ecstatic about [the] unprecedented boost ..." in the mental health budget (**The Vancouver Sun**, March 28, 1992:A9). According to the acting executive director of mental health services, Alan Campbell, the increase, which represents a 50 percent gain over the 1991-92 budget, "... restores past funding that had been eroded, as well as adding money to enhance community services" (cited in **The Vancouver Sun**, March 28, 1992:A9). In addition, $3 million has been committed for transition purposes to facilitate the transfer of patients from Riverview Hospital to the community (**The Vancouver Sun**, March 28, 1991:A9). It now remains to be seen how these political and economic factors will influence further implementation of the 1987 **Draft Plan**.

Summary

This review of the historical development of Vancouver's community mental health services, and of the consultative process which culminated in the 1987 **Draft Plan**, has

served as a point of departure for the thesis research. Specifically, this review establishes a framework for considering how the **Draft Plan** has been perceived and interpreted by a variety of policy makers, professionals, line-staff and consumers in the Vancouver mental health community. Before proceeding to an analysis of the data collected (guided by the research questions set out in the introduction), I outline in Chapter III the research methods adopted for the collection of interview and documentary materials in this study.

CHAPTER III

RESEARCH METHODS

Overview of Research Methods

The existing research on the decarceration phenomenon and on the retracking of mental patients within and across systems of mental health, criminal justice and welfare has enlisted two principal methods, each of which has strengths and weaknesses which must be assessed in light of the research question(s) to be investigated.

The **first** technique is the analysis of financial data and aggregate statistics[1] pertaining to existing deinstitutionalization policies and practices (e.g., Boydell & Trainor, 1988; Felton & Shinn, 1981; Kirk & Therrien, 1975; Lerman, 1982; Lurie & Trainor, 1992; Rose, 1979; Scull, 1984)[2]. One of the major strengths of this approach is that it allows one to "... zero in quickly on the gap between policy and reality" (Lurie & Trainor, 1992:12). Furthermore, according to Lurie and Trainor, such quantitative analyses are based on facts[3], rather than (mis)perceptions of what has actually occurred, in terms of policy implementation[4] (1992:12).

However, an exclusive reliance on quantitative designs can lead to an incomplete understanding of the phenomenon in question. As one author has observed, quantifiable data rarely tell the whole story (Johnson, 1990). Estroff argues that to fully appreciate the complexity of deinstitutionalization as a policy and practice, one must analyze the roles of human agency and social circumstances at both the individual and system-wide levels

[1]For example, shifts in hospital discharge rates, caseloads and client profiles of community services/residential facilities over specific time periods.

[2]See Chapter I.

[3]However, a counter-argument can be made that these "facts" are also a construction, since any systematic collection and analysis of data are based on the researcher's perception of what constitutes "appropriate and timely information" (Johnson, 1990:236-237).

[4]As discussed in Chapter One, a number of scholars have observed that the underlying ideological forces and rhetoric pertaining to deinstitutionalization have distorted policy makers' (and many practitioners') perceptions of what has actually occurred (Felton & Shinn, 1981; Kirk & Therrien, 1975; Rose, 1979; Scull, 1981).

(1981:117). As discussed in Chapter I, one of the dangers of considering policies, funding concerns and program evaluations solely at a system-wide level (i.e., a "top-down" approach) is the potential for adopting purely structural explanations which fail to consider the subjects' experiences and perspectives[5]. Indeed, several researchers (e.g., Estroff, 1981; Herman & Smith, 1989; Johnson, 1990) have commented on the tendency in much of the deinstitutionalization literature to ignore the patients' point of view. Consequently, alternative tactics have been employed to reintroduce the client into the literature.

This **second** set of techniques focuses on the analysis of qualitative data, obtained through in-depth interviews with care providers and clients and through ethnographic fieldwork (e.g., Bachrach, 1984; Ball & Havassy, 1984; Estroff, 1981; Herman & Smith, 1989; Lamb, 1979; Snow et al, 1986). The major advantage of a qualitative design is that it provides an opportunity for the investigator to observe the subjects' environment(s) and to acquire a perspective on the overall context which cannot be obtained from quantitative analyses. As Estroff observes, "[we] learn a great deal about the quality and content of [ex-mental] patients' lives by examining their living situations in the community" (1981:120). Furthermore, semi-structured or in-depth interviews permit one to develop an understanding of patients' individual experiences with deinstitutionalization, as well as the "intentions, interrelations, and values of respondents, staff, and community members as they interact with and contribute to the socio-cultural context" (Estroff, 1981;117). In essence, such studies provide outcome evaluations and explanations of deinstitutionalization from the "ground level".

The integrative approach used in this thesis has enabled me to conduct a multi-tiered assessment of responses to the 1987 **Draft Plan to Replace Riverview Hospital**. In the following discussion, a focus on the individual perceptions of professionals, front-line

[5]This point is illustrated all too clearly in Herman and Smith's observation that "[in] all the scenarios of mental hospital depopulation, the ex-patients have been rarely heard" (1989:387).

workers and clientele is merged with general trend statistics[6] which trace the aggregate circulation of deinstitutionalized mental patients within and across institutions of care and control throughout the City of Vancouver. A statistical analysis of the numbers of mentally ill persons in the Vancouver Jail[7] between January 1987 and June 1991 comprises a substantial portion of the quantitative methodology.

The empirical data for the thesis were collected between February and September 1991 in the Greater Vancouver Regional District. Interviews were conducted with 40 participants from a broad range of professional and personal backgrounds. This chapter describes both the sampling technique and the interview procedure employed in the study. A description of the sample is also provided. Methods and central themes in the research are discussed, as are the limitations of the data. A framework is established for the analysis of data in Chapters IV and V.

Preliminary Strategies

Prior to generating a snowball sample of respondents, I developed a network of contacts within the mental health field in Vancouver. Initially, informal discussions were held with previously established contacts[8] and with individuals to whom I had been referred through mutual acquaintances. The purpose of these preliminary consultations was threefold: (1) to outline my interest in this area and my proposed research plan; (2) to invite potential respondents to participate through agreeing to an interview or through suggesting

[6]These data were obtained in the course of conducting interviews with various community services and agencies that participated in the study. They comprise aggregate statistics compiled by agencies for the purposes of plotting increasing caseloads and demographic characteristics of the clients.

[7]These data are derived from notes and records of the jail doctor . The respondent had amassed 10 years worth of detailed notes and provided me access to these data for analytical purposes.

[8]Some of these contacts had been established as a result of an undergraduate research paper on "Criminal Justice Misfits" as one of the course requirements for a field placement with Crown Counsel, September to December 1986. These individuals included the Mental Patients' Association Court Worker, Administrator 3 (a care team employee) and Mental Health Coordinator 1 (MSN). My contact at IMP was established informally in early September, 1990.

other approaches to the topic and other issues which could be addressed; and (3) to solicit the names of other agencies and individuals who could be accessed.

I approached three organizations (Mental Patients' Association Court Worker Project, Inter-Ministerial Program and Triage) with my request to arrange an informal meeting with a contact person in each agency, for the purpose of information gathering. From these early discussions I was able to generate an additional 10 - 12 contact names and organizations[9].

Based on these initial discussions, it became clear that the sample should include those who were affected by — or who had an impact on — the 1987 **Draft Plan**; for example, individuals from the Ministry of Social Services and Housing (MSSH), the criminal justice system, and personnel from within the mental health field (including the Forensic Psychiatric Services Commission). I was able to classify my potential sample into several groups of players (see Appendix A, Table 1): Financial Aid Workers (MSSH), community workers and administrators within shelters and residential settings, community mental health care teams, mental patients' advocates, service agencies (e.g., IMP), police, the jail, courts (e.g., prosecutor, court worker, a Provincial Court Judge), mental health residential services, administrators (e.g., the directors of Riverview Hospital and the Greater Vancouver Mental Health Service Society), one of the authors of the **Draft Plan** and, of course, the patients themselves.

Given the organizational structure of the agencies included in my sample, interview data or statistics were not collected until permission had been granted by the agency or ministry involved. Although I did not anticipate problems in obtaining permission to work with many of the community agencies, I recognized that I might encounter some difficulties

[9]Snowballing efforts to increase my network of contacts were further enhanced by my regular attendance at Police-Community Liaison meetings, at the invitation of my contact within the Vancouver City Police.

in dealing with institutions such as the police, the courts, Riverview Hospital[10], the Forensic Psychiatric Services Commission (FPS) and MSSH. In fact, both MSSH and FPS declined to participate in the study. The decision by MSSH not to cooperate meant that I was unable to interview financial aid workers. Likewise, FPS's unwillingness to take part eliminated the opportunity to rely on primary sources to determine FPS's response to the **Draft Plan**. However, I was able to obtain some of this information through secondary sources (i.e., local news articles). Although refusals to grant permission on the part of these agencies constrained the scope of my study to some extent, they did not pose insurmountable difficulties in completing the project.

While establishing the preliminary network of contacts, I approached several of the agencies' Directors or Coordinators about the possibility of recruiting some of their clients as interview respondents. Initially, my contacts at Triage and IMP indicated verbally that I would most likely be granted permission to spend some time at these locations talking to clients. Unfortunately, permission was denied by the Directors of these two organizations. A shuffling of key personnel resulted in a reversal of the former open door policy. Fortunately, two other organizations (Lookout and Coast Foundation) subsequently expressed an interest in the thesis project and I was able to make appropriate arrangements for including their clients in my sample of respondents. However, the decision by FPS not to participate in the study prevented me from gaining access to IMP[11] clients (in addition to FPS outpatients), and consequently reduced the availability of individuals known to be involved in more than one system.

[10]For example, the process of seeking formal permission to interview personnel from Riverview Hospital as participants in the study spanned a total of five months (February to July 1991).

[11]As indicated in Chapter II, IMP is run jointly through Corrections, the Forensic Psychiatric Services Commission and the Greater Vancouver Mental Health Services Society. A condition of obtaining permission to interview IMP clients was a unanimous agreement on the part of these three organizations.

The Sample

A sample of 40 participants — including both professionals[12] and clients — was amassed using the snowballing technique previously outlined. An attempt was made to achieve an equal number of respondents in both cohorts. Within each group, different criteria were considered in an effort to attain heterogeneity. For example, a key consideration in selecting the cohort of care-givers and other personnel was to include respondents from mental health, criminal justice and social work backgrounds.

Professional Cohort

The 21 professionals who participated in the study comprised a cross section of lawyers (a Provincial Court Judge and Crown Counsel), court workers, employees in community agencies, psychiatrists in administrative and clinical roles, physicians, emergency shelter and community residence administrators, coordinators/directors of social service agencies, police, academics (a professor of nursing), GVMHS and emergency services administrators and Ministry of Health personnel. The group included 14 males and 7 females. Overall they demonstrated a high degree of homogeneity with respect to social class (predominantly middle to upper-middle class) and ethnic background (20 caucasians, 1 native). Some variation existed in the educational backgrounds of the professional participants (see Table 3.1). Overall, six individuals (4 males, 2 females) had the equivalent of a B.A. degree, three respondents (1 male, 2 females) had no formal post-secondary education or training, and 12 persons (9 men, 3 women) had attained some kind of professional[13] or post-graduate level of education.

[12]I am using this term in a very broad sense to include paraprofessionals and line staff, in addition to respondents who have attained professional educations in the fields of law, medicine, or social work. According to Cohen, "the professionalization of deviancy [care and] control ... is a story of continual expansion and diversification" (1985:161). From this perspective, paraprofessionals and line staff could be considered "professionals".
[13]I have included nursing programs as well as legal, medical and social work education programs.

TABLE 3.1 PROFESSIONAL COHORT (N=21)
EDUCATIONAL AND OCCUPATIONAL CHARACTERISTICS

CHARACTERISTIC	MALES (N=14)	FEMALES (N=7)
LEVEL OF EDUCATION		
B.A	4	2
Post B.A. *	9	3
No Post Secondary Education	1	2
ACADEMIC DISCIPLINE		
Law	2	0
Psychology	1	1
Nursing	1	3
Social Work	3	0
Medicine	3	0
Other	3	1
N/A	1	2
OCCUPATIONAL FIELD		
Criminal Justice	3	0
Mental Health **	3	1
Community Services	5	5
Medicine/Psychiatry	3	0
OCCUPATIONAL POSITION		
Administrative	8	5
Outreach/Case Worker	2	1
Other ***	4	1

* Includes graduate (i.e., Masters or Ph.D.) and professional (e.g., law, social work, medicine, nursing) education programs.

** Includes GVMHS, B.C. Mental Health Society, care teams and Mental Health Emergency services.

*** Refers to respondents who are neither administrators or front-line staff; i.e., criminal justice personnel, academics, participants in private practice.

The range of occupational roles held by the males in this cohort appears to be broader than for the females. Specifically, whereas the professional backgrounds of the males encompassed law (judge, lawyer), policing, social work (directors, coordinators and community workers), medicine (psychiatrists and doctors), and administrative positions (from such varied disciplines as nursing, psychology, health planning), for women, the career experiences primarily comprised nursing and social work. However, five of the seven women in the group applied their training/expertise in administrative or managerial positions and one was an associate professor of nursing.

Client Cohort

Given the ethical implications of obtaining informed consent from mental health clients, my selection of 19 participating clientele (see Table 3.2) from community mental health and social service agencies was guided by the staff in the two cooperating organizations. In the process of arranging these interviews, I emphasized to staff the importance of advising clients that their participation was entirely voluntary.

Ten of the respondents in this cohort had lodgings in an emergency shelter in the skid road area of Vancouver. Nine individuals lived in subsidized housing provided by the *Coast Foundation*. Six of the nine *Coast* clients resided in satellite housing. The remaining three persons dwelled independently in subsidized apartment suites.

Like their counterparts in the professional cohort, the group of clients comprised more males (12) than females (7) and was mostly caucasian (17 Caucasians, 1 African-Canadian, 1 Native). Ages ranged from 29 to 55 years. Personal backgrounds varied in terms of family ties, marital status, level of education, employment history, current level of functioning, and the age of initial onset of psychiatric disorder.

TABLE 3.2 CLIENT RESPONDENTS (N=19)
DEMOGRAPHIC CHARACTERISTICS

CHARACTERISTIC	MALES (N=12)	FEMALES (N=7)
Race		
Caucasian	10	7
African-Canadian	1	0
Native	1	0
Average Age	39	45
Psychiatric Diagnosis		
Schizophrenia	7	3
Schizophrenia-Manic Disorder	1	1
Depression	0	3
Other*	3	0
Marital Status		
Single	8	4
Separated/Divorced	3	2
Married	1	1
Living Arrangements		
Emergency Shelter	8	2
Satellite Housing	2	4
Subsidized Independent Living	2	1
Level of Education		
Less than Grade 12	4	2
Completed Grade 12	5	2
Completed 1-2 yrs. University	1	3
Completed Bachelor's Degree	2	1

* Includes brain aneurysm, nerves disorder, and alcoholism.

Three members of this group were involved in the criminal justice system[14], in addition to their links with the mental health and welfare systems.

Of the 19 client respondents, 12 had been diagnosed with some form of schizophrenia. Three suffered from depression, one experienced short term memory loss due to a brain aneurysm, one was a former alcoholic, one had a "nerves complaint"[15], and one declined to discuss the topic of psychiatric diagnosis.

The prevalence of schizophrenia within such a small sample raised several interesting questions around the issue of psychiatric diagnoses. My curiosity was further piqued by one respondent's (Client 4) cynical observation that "when in doubt, psychiatrists would simply diagnose a person as schizophrenic and put them on some kind of medication". In fact, several commentators have remarked upon North American psychiatrists' predilection for diagnosing patients as schizophrenic[16] (Friedrich, 1975, cited in Cockerham, 1981; Halleck, 1971; Sheehan, 1982; Szasz, 1976). Such observations are rather disconcerting since, despite the absence of a definitive diagnostic tool, let alone a clear conceptualization of the disorder, psychiatrists continue "... to infer the presence of [schizophrenia] on the basis of very little evidence ..." (Halleck, 1971:102; Sheehan, 1982). It is not surprising that Client 4 and several other client respondents expressed scepticism about the validity of their psychiatric diagnoses.

[14]This information was offered in the course of answering a question pertaining to involvement with other community services/agencies. No questions on the interview guide specifically sought to elicit information pertaining to involvement with the criminal justice system.

[15]The respondent chose not to specify his ailment beyond this description.

[16]According to Szasz, in 1975, 25% of all psychiatric hospital admissions were made on the basis of a diagnosis of schizophrenia (1976:97). Even as recently as 1981, schizophrenia continued to be "... the most commonly diagnosed mental disorder requiring hospitalization ..." (Cockerham, 1981:142). This diagnostic trend has continued into the 1990s: according to GVMHS data for 1990, schizophrenia accounted for 43.7% of all initial diagnoses (N=3,555) by care team psychiatrists (GVMHS, 1990: 32).

Interview Procedure

Obtaining Consent

Prior to conducting any interviews, ethical approval, along with approval of interview guides and informed consent documents[17], was obtained from the Simon Fraser University Ethics Review Committee. Potential interview respondents in the professional cohort were initially contacted by telephone. In these preliminary conversations, I identified myself, indicated my referral source, and outlined the nature and purpose of the study. If the person expressed an interest, (s)he was provided with a written statement of introduction and a summary of the research proposal. Where requested, a copy of the interview guide (see Appendix B) was also forwarded to her or him. This procedure was followed up by a phone call to confirm receipt of the materials and the possibility of setting an appointment for an interview. Involvement was voluntary and respondents were apprised of their rights to fully or partially withdraw consent at any time. Participants were also informed that the study carried no risks or harm, nor would it confer any benefits. In light of the potentially sensitive nature of the information and views that might have been imparted to me, individuals were guaranteed personal anonymity. These ethical concerns were reiterated in a research protocol (see Appendix B) which I designed to accompany the interview guide; this document was read and signed by respondents prior to commencing the interview. One copy of the signed informed consent document was left with the participant and I retained a second copy for my files.

The procedure for including mental health patients in the sample varied slightly from that outlined above. As indicated, access to clients necessitated seeking permission from the Directors of the two cooperating organizations, *Lookout* and *Coast Foundation.* Following initial contact by telephone, a formal written request as well as a copy of the

[17]Adapted from a sample ethics protocol in G. McCracken's **The Long Interview** (1988).

interview guide and research protocol were forwarded to both organizations. The logistics of meeting and interviewing respondents differed slightly between *Lookout* and *Coast*. At *Lookout*, staff introduced me to both emergency clients and tenants who were potential candidates for inclusion as respondents. My presence at the shelter over several days attracted the curiosity of a few individuals who then expressed an interest in being interviewed. I agreed to include them in the study although I did consult with the staff about their assessment of these persons' abilities to give informed consent. Furthermore I was careful to thoroughly inform respondents of their rights as research participants. I explained that they could choose not to answer a question or to end the interview at any time they wanted. I also stressed to these individuals that their involvement was voluntary, and that none of the information imparted to me would be shared with staff or anyone else.

Interviews with *Coast Foundation* clients were arranged through the coordinator of the Satellite Housing Program. In my initial discussion with the coordinator I stressed the importance of conveying to interested residents the voluntary nature of their participation, and its lack of bearing on their relationships to the organization.

As with the professionals, signed consent forms were obtained from all client respondents. I retained one copy of this document and one copy was placed on file with the respective organizations (in case any unforeseen problems arose). No other data pertaining to these interviews have been made available to the staff at either site.

Interview Sites

Eighteen of the 21 interviews with the professional cohort were conducted in the respondents' offices. Of the three interviews that occurred elsewhere, one took place at Simon Fraser University — an arrangement which was mutually convenient for the respondent and myself. Another participant indicated a preference for conducting the interview over lunch at a local restaurant. Finally, one respondent agreed to meet me at a location (GVMHS) which would be convenient and central for both of us, as we were

travelling from opposite directions in the lower mainland. This particular interview proved to be quite extensive and had to be concluded the following day by telephone.

Nine of the ten interviews with *Lookout* clients were conducted either in the courtyard or in the lounge/dining room area, depending on the weather. Only one interview (the first) in this facility took place in the office space made available to me. This interview experience seemed much too formal and uncomfortable to clients; hence, for the remaining interviews, the venue was changed to the other two settings. I thought it best to respect clients' choices in order to maximize rapport. I learned very quickly that interviews were more productive if I adapted to the pace of individual clients. Consequently, interviews often included accompanying individuals on a walk to the corner store or taking a break while the person went for a coffee or smoked a cigarette.

Five of the nine *Coast* clients were interviewed in the housing unit in East Vancouver. A small, comfortably furnished room (like a small T.V. lounge) was made available for this purpose. The remaining four *Coast* respondents were interviewed at the organization's office, located in the Mount Pleasant area of the city. Two individuals were interviewed in the board-room and two in a vacant office.

The Interview Process

Interviews ranged from 25 minutes to two hours. On average, they lasted about 45 minutes with clients and about one and a half hours with respondents from the professional cohort. The openness of responses across both cohorts ranged from very circumspect to quite candid. Attempting to determine the appropriateness of probing for additional details was a delicate task. I was more reticent about pursuing respondents' answers on some issues in the earliest phases of data collection. I also had to work much harder at establishing rapport, and at feeling comfortable in the use of probing questions, with some participants than with others. In many cases, the interview process became a two-way exchange of information and was often an effective means of encouraging individuals to respond more

openly. I also urged respondents to offer feedback on their perceptions of the experience and any suggestions pertaining to the structure and coherence of the questions. Through this practice, I received valuable feedback about the usefulness of the interview and about the relevance and timeliness of the study more generally.

The interviews were not tape-recorded. Although note taking had its drawbacks, I decided that in light of the potentially sensitive nature of the information imparted during the interview process, respondents would feel more comfortable if their views were not taped. Furthermore, some mental health clients would most likely be highly suspicious of my identity and affiliations and hence refuse to participate in a voice-recorded discussion. Indeed, even the activity of taking notes seemed to generate suspicion on the part of some individuals at the emergency shelter. The need to take detailed notes of responses impeded, to some extent, my ability to attend to all of the dynamics in the interview situation. Note taking also limited the opportunity to obtain verbatim accounts of dialogues with respondents. Nevertheless, every effort was made to confirm that responses were accurately recorded. Notations were checked for accuracy and legibility as soon as possible after completing each interview. I made it a practice to find a quiet place in which I could review the notes, as well as to record my own observations and impressions of the dialogue which had transpired. Since the original interview notes were recorded on the actual interview guide, the transcription process involved retyping the interview questions and responses in their order of appearance on the research instrument.

Research Techniques and Questions

The forty interviews were conducted using semi-structured interview guides which included both closed and open-ended questions. This approach simultaneously permitted both the establishment of an overall research framework, and the opportunity to clarify and elaborate questions and responses. Two general instruments were developed: one for

professionals and one for mental health clients in the sample. The interview guide constructed for use with the professionals was divided into subsections which incorporated the study's three major strands of inquiry, namely:

1. The role of political-economic, ideological and cultural factors in the implementation of the 1987 **Draft Plan**.

2. Discrepancies and convergences between the official discourse of the **Draft Plan** and the lived experiences of subjects and authorities within the community.

3. The impact of the **Draft Plan** on the nature and extent of transcarceral trends imposed on chronic mental patients within the Vancouver area.

The instrument used with criminal justice and mental health personnel included questions pertaining to the following areas: educational and career history; current positions and duties of the respondent; information concerning the structure, mandate and policies of their affiliation; knowledge and impressions of the 1987 **Draft Plan** and views on the deinstitutionalization movement in general; suggestions for changes or improvements in service delivery; and closing statements.

In developing the section of questions pertaining to the **Draft Plan**, I drew on specific statements and information contained within the document[18]. These were transformed into questions addressing the perceived impact of the **Draft Plan** on the ability of existing community services/facilities to cope with an increasing number of deinstitutionalized and noninstitutionalized mental patients within the City of Vancouver and specifically in the skid road area. Interview questions also sought to elicit respondents' interpretations of how the current economic and political climate within the province has

[18]Refer to Chapter II for a description of the document's contents.

influenced mental health policies and service delivery between 1987 and 1991 (see Appendix B).

Additional interview guides were constructed in order to address issues which were specific to certain respondents in the sample. For example, questions about the interface between the criminal justice system and mental health systems[19] were incorporated into the research instruments used with the judge, lawyer and police, respectively. I also developed a separate questionnaire for use with a coauthor of the **Mental Health Consultation Report** (i.e., the **Draft Plan**). In this case, I relied on the report to construct a line of inquiry which focused on the series of events and processes that culminated in the publication of this document.

The research instrument developed for use with mental health clients is loosely based on a questionnaire used by Estroff (1981) in her ethnographic study of a community mental health service in Wisconsin[20]. I examined Estroff's survey to gain some ideas about the type of concerns that could be addressed in my discussions with mental health clients, and about how these questions might be phrased. What emerged was a semi-structured interview guide focusing on respondents' experiences with community living, their thoughts about social services and mental health care delivery in this city, and their views on current social or political issues that might have relevance for their lives. The interview guide comprised 10 major categories and a concluding section which provided respondents with the opportunity to ask questions, give feedback, and comment on their perceptions of the interview. Each category contained between two and 12 questions, with the larger sections

[19]Material for these questions was drawn from the research findings reported in Teplin (1984).

[20]Estroff (1981) used the Community Adaptation Survey, adapted from S.R. Roen & A.J. Burnes' (1968) instrument. As employed by Estroff, this survey consists entirely of series of closed-ended questions pertaining to work (paid and volunteer positions), general living circumstances, social life, network of social contacts (family, friends, neighbours, co-workers), recreation, finances, interest in local political and social issues, involvement with social service agencies, etc.

incorporating a number of probes for the purposes of encouraging individuals to elaborate on or clarify their responses (see Appendix B).

Quantitative Data

In addition to conducting interviews, I was also able to obtain aggregate trend statistics for the years 1987-1990 from a total of seven sources. Four sets of data were provided directly by participating organizations (or respondents)[21], and three were obtained indirectly through publicly accessible annual reports and other documents[22]. These materials were included for two reasons: (1) to examine the extent to which ex-mental patients in Vancouver have been retracked within and among the criminal justice, mental health and welfare systems since 1987; and (2) to provide a numerical assessment of professional respondents' perceptions concerning transcarceral patterns against the index of official trends recorded in research years. Most of the quantitative data provided via respondents or annual reports had already been collapsed by the agencies into yearly totals for specific variables. These statistics were analyzed to discover whether any pertinent trends emerged which were germane to the study's research questions. The findings will be discussed in more detail in Chapters IV and V.

The data provided by the Vancouver city jail doctor were presented to me in raw form[23]. I decided to examine these records over a 4-1/2 year period (January 1987 - July 1991), and used a total of 939 cases. Through a statistical analysis of the data, I attempted to establish

[21]The sources were GVMHS (which includes data for Emergency Services, Residential Services and Care Teams), Lookout, MPA, and the jail doctor.

[22]These include annual reports for Riverview Hospital and Forensic Psychiatric Services Commission as well as the 1988 City of Vancouver Manager's Report. As these are incomplete sets of data, they can only be interpreted cautiously at best.

[23]i.e., the respondent's notes for each patient seen for the time period included in my analysis. Confidentiality was maintained by assigning a numerical code to each subject in the sample.

TABLE 3.3 JAIL DATA (N=939)
DEMOGRAPHIC CHARACTERISTICS OF SAMPLE

VARIABLE	FREQUENCIES	PERCENT
GENDER		
Males	826	88.0
Females	113	12.0
RACE/ETHNICITY		
Caucasian	765	81.5
Native	31	3.3
Asian	50	5.3
Other	80	8.5
Unknown	13	1.4
AGE		
Range	18–78	
Mean	35	
EMPLOYMENT STATUS		
Employed	149	15.9
Unemployed	638	67.9
Other (Student)	33	3.5
Unknown	117	12.5
SOURCE OF INCOME		
Social Assistance	417	44.4
Employment Income	201	21.4
Other (Pensions, U.I.C.)	132	14.1
Unknown	189	20.1
MARITAL STATUS		
Single	510	54.3
Married	62	6.6
Divorced	43	4.6
Other (Separated, Widowed)	49	5.2
Unknown	275	29.3
LIVING ARRANGEMENTS		
Place to stay	589	62.7
No place to stay	139	14.8
Unknown	211	22.5
PRIOR CRIMINAL RECORD		
Yes	591	62.9
No	94	10.0
Denies *	158	16.8
Unknown	96	10.2

* Means the person would not divulge this information to the jail doctor.

TABLE 3.4 JAIL DATA
PSYCHIATRIC HISTORY: AGGREGATE TRENDS, 1987–1991

YEAR	YES	NO	DENIES	UNKNOWN	TOTAL
1987	85	70	15	22	192
1988	101	77	18	23	219
1989	143	29	69	25	266
1990	106	33	33	13	185
1991 *	42	23	5	7	77

* These data are for January to July 1991, only.

TABLE 3.5 JAIL DATA
OUTCOMES: AGGREGATE TRENDS, 1987–1991

DIAGNOSIS	1987	1988	1989	1990	1991
No Disorder	47	48	69	37	11
Alcohol/Drugs	25	41	37	37	12
Mentally Disordered	98	106	146	98	51
Immigration—disordered	10	14	13	4	1
Immigration—okay	3	6	1	1	1
Personal Problems	9	4	9	8	2

the existence of any general trends in the number of mentally disordered persons coming into contact with the criminal justice system between 1987 and 1991.

The variables were coded accordingly: year, type of offence charged, existence of a prior record, evidence of psychiatric history, sex, age, race, employment status, source of income, marital status, housing arrangements, and opinion (i.e., the doctor's diagnosis, based on interviews averaging about 20 minutes). Frequencies and histograms were computed for all variables using SPSS-x (see Table 3.3). Aggregate trends were computed for two variables: 'psychiatric history' and 'opinion' (see Tables 3.4 and 3.5). The demographic characteristics, results, and their implications will be considered further in Chapter IV.

Unfortunately, I was unable to gain direct access to any statistics from MSSH which might have indicated how many of its clients were also involved with the mental health system. However, the data provided by Lookout (See Appendix E, Table 1) do include clients' sources of income, thereby giving some indication of the number of clients receiving aid from MSSH. I was also prevented from obtaining crown counsel or police statistics pertaining to contacts with mentally disordered persons between 1987 and 1990, but relevant information was forthcoming from two other sources; the Mental Patients' Association Court Worker Project (see Tables 4.3b and 4.4c) and the jail doctor. Based on the data provided, I was able to determine, as will be discussed in Chapter IV, a general pattern consistent with the transcarceration of mentally ill persons into the criminal justice system.

Limitations of the Study

The exploratory nature of this thesis research imposes some important limitations. **First**, the sample is not fully representative of all professionals or clients in the mental health field. Although efforts were made to include staff and professionals from each of the three major systems of care/control affected by the transcarceration of the mentally ill (namely, criminal justice, mental health and social services), one of the major players, MSSH

(representing the welfare system) declined to participate. I was able to gain some information indirectly, from other respondents[24], about the impact of the **Draft Plan** on MSSH financial aid workers and their experiences dealing with chronic mental patients. However, I had no means of juxtaposing the accounts of others against the experiences of MSSH front-line staff. Similarly, I was unable to directly ascertain the responses of FPS personnel to the **Draft Plan** and related issues, except through media reports. Although the absence of these two major players constrained the scope of my analysis, given the diversity and richness of alternative sources, these limitations were not critical to the overall results of the research.

A **second** weakness of the study arises from the partial self-selection of respondents in each cohort. One cannot be certain, for example, whether participants in the professional cohort are representative of their counterparts[25] or whether consenting mental health clients resemble those excluded from the research.

The **third,** and perhaps most significant limitation in the study, is the lack of verbatim accounts of interviews. As discussed previously, the decision not to tape interviews restricted the opportunity to reproduce verbatim responses as well as the volume of information that could be recorded. However, these concerns had to be balanced against the potentially negative repercussions — specifically, the inhibition of responses — that would have been engendered by the presence of a tape recorder.

Description and Analysis of Data

The data are described and analyzed in Chapters IV and V. Some replies have been depicted numerically to indicate prevalence or uniqueness. However, quantified responses

[24]The interview guide incorporated several questions which specifically asked respondents to speculate about the impact of the **Draft Plan** on other systems of service delivery (see Appendix B).

[25]This was due to time and resource constraints on the researcher, and to refusals on the part of individuals who were approached as potential respondents.

are not conclusive as not all questions were presented to all participants. The analyses which emerge from the qualitative and quantitative data will be examined within the context of the theoretical framework employed by the study and set out in earlier chapters. The implications of the study's results will also be explored.

CHAPTER IV

THE SOCIAL CONTROL NETWORK

Introduction

This chapter examines Vancouver's "landscape of despair" (Dear & Wolch, 1987): the network of social care and social control agencies in which decarcerated and non-institutionalized mental patients become enmeshed. I begin with a brief description of the evolution of the "service dependent ghetto" (Dear & Wolch, 1987), and a short historical overview of Vancouver's inner city area. Following this, I provide an account of the types of services and organizations within this network and the manner in which these agencies interact within the social control network.

This leads to an examination of the demographic characteristics of clients (from the perspective of service providers), in an effort to assess whether and why there have been any shifts in these characteristics, and in the numbers being assisted by these agencies. Finally, I consider how the **Draft Plan** has affected this social "landscape". This question is explored from the perspectives of the caregivers and professionals interviewed for this research.

The Emergence of the Service-Dependent Ghetto

According to Dear and Wolch's account of the urbanization process, early industrial cities in the late nineteenth century encompassed neighbourhoods[1] which were populated by low income earners, social misfits and charitable agencies (1987:13). These inner city areas were the forerunners of the twentieth century "service-dependent ghettos". A shift toward deindustrialization, decentralization and suburban growth in the middle of this century

[1] Also referred to as zones of transition. These zones are traditionally areas of "... housing conversion, cheap accommodation and social services ... [and have] become... the home for society's marginal people" (Dear & Wolch, 1987:14).

created a vacuum in the inner city, characterized by widespread abandonment and urban decay (Dear & Wolch, 1987:14).

This vacuum has subsequently been filled by deinstitutionalized populations and other groups who have gravitated toward these core areas of the inner-city (Dear & Wolch, 1987:14; Ralph, 1983; Scull, 1984). Dear and Wolch argue that "... a self-reinforcing cycle of ghettoization ..." has emerged in which increasing numbers of service-dependent groups in the area "... attract more services which themselves act as a magnet for yet more needy persons ..." (1987:4).

The historical development of Vancouver's inner city area has also followed this pattern. It would appear that early in Vancouver's development, the lower east side was a prototypical "zone of transition". According to Barman, while "... Vancouver residents with social pretensions and the money to effect their realization were [moving out of the core area] ... those at the other extreme of the socio-economic scale were becoming clustered in the city's East end" (1986:100).

As affluent entrepreneurs and members of the professional and managerial classes moved to the West side of the city, the large houses which remained were converted into boarding houses, providing "... refuge to the poor, to the transient, and to [immigrants][2] ..." (Barman, 1986:100). Additionally,

> ... in the neighbourhood known as Strathcona, other forms of housing similarly intended for new arrivals of modest status or for males seasonally employed[3] ... had also grown up, including ... two-roomed tenement cabins ... and rooms in blocks, where

[2]Demographically, this area historically contained greater populations of single, older males [and] non-English speaking populations as well as higher levels of illiteracy and greater overcrowding than in other parts of the city (Barman, 1986:104-105).

[3]According to McDonald, the seasonal nature of the resource and construction industries based in this area attracted a population of predominantly single male mobile workers who resided in the downtown and lower east side of of the city (1986:40).

> whole families [were] crowded into one dark room without ordinary conveniences (Barman,1986:100-101).

During the inter-war years, the social importance of the Downtown East Side diminished significantly[4] and by the mid-1960s the area "... had truly become [Vancouver's] skid road" (Canning-Dew, 1987:10, 13-14). Similar to inner city districts in other jurisdictions, Vancouver's skid road — with its abundance of cheap accommodation — was populated by transients, the economically disadvantaged, prostitutes and drug dealers (Turvey, 1987; in Canning-Dew, 1987).

Given the historical development of Vancouver's lower east side as a "zone of transition", it is not surprising that a cluster of agencies which operate as both social care and social control mechanisms would be situated in this area. The following section provides a description of the structure of, and inter-relationships within, Vancouver's "service-dependent ghetto".

Vancouver's Landscape of Despair

According to Dear and Wolch, the service-dependent ghetto functions both as a reception area for deinstitutionalized populations and as a reservoir of clients for social service agencies located in the vicinity (1987:9). The inner city also offers its residents various forms of support which can be found within relatively close proximity to their accommodations (Dear & Wolch, 1987:21). Interspersed with the welfare-oriented activities and material supports provided by the state is the overt social control apparatus of the criminal justice system which comprises the police, the city jail and the law courts.

In the greater Vancouver area, this institutional amalgam incorporates organizations from three major systems: the Ministry of Health (i.e., mental health and related social

[4]However, the neighbourhood did retain its economic significance as part of the business and industry sector of the downtown core (Canning-Dew, 1987).

services), the Ministry of the Attorney-General (i.e., the criminal justice system) and the Ministry of Social Services and Housing (i.e., income assistance and other services not provided by the Ministry of Health). In practice, the divisions between these systems, in terms of service delivery, are frequently blurred. Specific organizations often come under the jurisdiction of at least two systems; for example, the Inter-ministerial project (IMP) is administered by both Corrections and Mental Health.

The components in the network of care and control agencies can also be categorized according to the type of services they provide, namely: clinical/medical; shelters and residential facilities; outreach programs; socialization, vocational or advocacy organizations; and social control agencies. I have chosen this latter organizational scheme for the purpose of charting Vancouver's "landscape of despair".

Clinical Care

Throughout the lower mainland of B.C., clinical (psychiatric) care is provided on both an inpatient and outpatient basis. Mental health services are furnished and funded by the Mental Health branch of B.C.'s Ministry of Health. According to the Interagency Mental Health Council[5] (1986), there are approximately 200 psychiatric acute care beds, dispersed among five major hospitals in the city (see Table 4.1). These hospitals also provide care through outpatient clinics and day programs, albeit on a limited basis.

TABLE 4.1 # PSYCHIATRIC BEDS IN VANCOUVER *

HOSPITAL	# ACUTE BEDS	# EMERGENCY BEDS	OUTPATIENT
Shaughnessy	25	1	Yes
St. Paul's	20	10	Yes
St. Vincent's	20	–	Yes
VGH	39	15	Yes
UBC Health Sciences	60	–	Yes

* Source: IMHC Data, 1986

[5]Hereafter referenced as IMHC.

Despite the apparent availability of resources for psychiatric care, a rapid turn-over of beds, in conjunction with stringent admissions criteria, impose severe limitations on the accessibility and efficacy of hospital care for some patients. **First**, according to one care team worker, (Mental Health Coordinator 3), individuals in acute crisis are often hospitalized for as little as 48 hours.

This would suggest that patients are rendered just stable enough to discharge back into the community, even if they are not ready to cope with the stresses of community life. **Second**, none of the general hospitals is prepared to accept patients who "act out" — i.e., are overtly aggressive and/or violent, or whose primary treatment needs are related to substance abuse (IMHC, 1986). In light of the changing characteristics of mental health clients, in particular the influx of young chronics, a manager at the Greater Vancouver Mental Health Services (Administrator 1) suggests these restrictions on admissions criteria may have grave implications for future accessibility of inpatient care.

Riverview Hospital continues to accept both acute and chronic cases; however, even this facility now focuses on stabilizing patients for rapid discharge. According to IMHC's **Directory of Mental Health Services**, "the overall treatment philosophy is to prepare patients for return to community living wherever possible" (1986:63). This treatment philosophy is clearly in keeping with the goal to scale Riverview Hospital down to a 550 bed facility for medium and long-term care patients who are "... not realistic candidates for community living" (IMHC, 1986:63).

Inpatient treatment for both acute and continuing care is also provided through the Forensic Psychiatric Institute (FPI). This institution is a locked facility for mentally disordered offenders who are either not fit to stand trial or have been found not criminally responsible due to mental disorder. Hence, inpatient admissions are on the basis of a court order only. The FPI also provides services on an outpatient basis (IMHC, 1986:63), and

indeed, according to the prosecutor I interviewed for the thesis, FPI court ordered assessments are now administered on an outpatient basis whenever practicable.

Psychiatric care is also offered through the Greater Vancouver Mental Health Services (GVMHS). Essentially, GVMHS is an umbrella organization responsible for operating eight community care teams[6] in addition to Venture (an emergency residence for clients in crisis), Vista (a residence for female clients), Mental Health Emergency Services (MHES), and Mental Health Residential Services — MHRS — (IMHC, 1986:46). According to Administrator 1, GVMHS focuses on the provision of comprehensive services, enlisting a multidisciplinary team approach to seriously chronic mentally disordered individuals. GVMHS fulfills this mandate through liaising with other social service agencies and with residential facilities.

GVMHS also has links, via MHES, with the Vancouver City Police through the jointly run program "Car 87", in which a psychiatric social worker rides along with a police officer to provide on-the-spot assessments and crisis interventions with violent, possibly mentally disordered individuals. Although the Vancouver City Police are very supportive of "Car 87", the respondent from MHES (Administrator 5) maintains that it is unlikely the program will be expanded to more than one car. While the limited scope of the program is occasionally frustrating from an enforcement perspective (Police Officer), expansion is not a high priority since the police tend not to see themselves as a mental health resource.

Not withstanding this perception, the reality is that in modern inner cities the role of "social worker" is being imposed on the police to some extent (cf., Teplin, 1984: 155, 157-175). Indeed, as a result of deinstitutionalization policies in the United States, more stringent commitment criteria and changing characteristics of mental health clients, all levels of the criminal justice system are experiencing more frequent interfaces with the mental health

[6]Broadway, Kitsilano, Mt. Pleasant, Richmond, South Vancouver, Strathcona, West End, West Side.

system (Teplin, 1984:14). The following subsection examines the roles of the police and other criminal justice agencies in relation to the community care and control of mentally disordered persons in Vancouver, B.C.

The Criminal Justice System and Community Mental Health

Although the criminal justice system is primarily concerned with social control functions, the boundaries between control and care are becoming increasingly blurred in the response to mentally disordered offenders[7]. A pattern seems to be emerging in which the criminal justice operators are becoming the "gatekeepers" of the mental health system. At every stage, players are given some discretion to decide whether a mentally ill offender should be re-routed into mental health services or processed through judicial and penal institutions.

In the wake of ongoing deinstitutionalization, increasing numbers of mentally disordered persons are coming to the attention of the criminal justice system (Boodman, 1985; cited in Dear & Wolch, 1987:174). Steadman, McCarty and Morrissey report that a number of mentally ill persons who are incarcerated in local jails are there as a result of minor offences that are related to their frustrations and difficulties with community living (1989:8). Dear and Wolch cite the lack of adequate community supports for mental patients as one reason for the incarceration of the mentally disabled within the criminal justice system (1987:174).

Data collected in the present study seem to confirm such conclusions. In Vancouver, the three major facets of the criminal justice system — police, courts, corrections — are all confronting the task of developing appropriate responses to the mentally ill caught in the social control network. The amount of time and resources expended on meeting this challenge are a function of professional attitudes toward the

[7]Indeed, the **1987 Draft Plan** clearly identifies the criminal justice system (i.e., Ministry of the Attorney-General of B.C.) as playing a role in the delivery of certain types of mental health services within the province (1987:5).

appropriateness of mental health responses, of players' direct experiences with mentally ill people in the community, and of perceptions concerning the magnitude of the transcarceral problem and its application to members' own professional environments.

Being on the front line, the police have the most contact with the community and are therefore most aware of pressing social issues in their jurisdiction. In Vancouver, the police have initiated several programs to liaise with the communities in which they work. One program, discussed earlier, is "Car 87".

Another initiative is the community-liaison program which has been in place since the mid-1980s (See Appendix D). Perhaps as a result of liaising with community leaders, police officers assigned to Team 3-4 (i.e., the lower east side of the city) are better informed than before about available social services and more sensitive to incidents arising out of mental health concerns.

Since the police are familiar with many of the services available in this area, they are sometimes able to rely on informal dispositions[8] in their interactions with mentally disordered persons. For example, the police may simply provide a verbal reprimand and send individuals on their way if they are merely being a nuisance but not a danger to others. According to the police officer respondent, if such persons are unable to take care of themselves, the police will try to find them a bed in a shelter. Alternatively, "... if it's something for which they can be arrested, [they are held in jail overnight]". "At least", he commented, "it gets them indoors overnight in the winter". Thus, we see police taking on a role as outreach workers and jails doubling as emergency shelters.

If charges are laid against a mentally disordered individual, the police report then goes to the "mentals" prosecutor for charge approval. The "mentals" prosecutor is apprised,

[8]The police seem to dislike using formal dispositions under the **Mental Health Act**. From a police perspective, it is both frustrating and time consuming to have to "go the rounds" in order to find a hospital bed for a mentally disordered person in acute crisis. It is equally frustrating to process the individual through the justice system when the charges are not likely to proceed (Police Officer respondent).

via a report from the police or the jail doctor, of an offender's mental health status prior to his or her court appearance. The very fact that Crown Counsel have assigned a senior prosecutor to deal with cases involving mentally disordered offenders[9] suggests that problems have flowed from increasing numbers of mental health clients in the court system.

If the Crown chooses not to proceed with the case, arrangements will be made to try to find a bed for the mentally disordered person. Occasionally, the court may not be aware that an accused's mental health is an issue until he or she first appears in court. As a Provincial Court Judge observes, "behaviourally, [mentally disordered accused] ... run the gamut from passive to quite vocal". According to him, a judge's role includes "... attempting to identify those individuals with psychiatric problems and [ensuring] that the criminal justice system isn't being used to warehouse them when they could be better off receiving treatment in the community". The shortage of beds — especially for court ordered assessments — and of community programs is occasionally a source of frustration for Provincial Court Judges in Vancouver, although the problem is not generally perceived to be critical at this juncture.

Some mentally ill offenders may find themselves reassigned to either the forensic psychiatric services or the corrections system. Perhaps in recognition of the increasing numbers of psychiatrically disabled persons entering the ranks of prison populations, more institutions are beginning to establish special programs to meet the needs of this group (cf., Steadman et al, 1989). Locally, this is best illustrated by the creation of a special disordered offenders' unit in the Vancouver Pretrial Detention Centre (**The Vancouver Sun**, December 11 1992:B10).

[9]According to the MPA Court Worker, this position was created in response to an incident in which a mentally disordered person committed suicide after being detained in jail for a week. Apparently, nobody knew the individual was suffering from a mental disorder.

Other mentally disordered offenders remain in the community, with the assistance of community workers, in programs such as the MPA Court-Worker Project and IMP. Often these organizations are able to get their clients connected with housing and with community programs designed to facilitate personal care or vocational skills. The availability and accessibility of these services will be further explored in the following subsection.

Community Services and Residential Facilities

The 1986 **Directory of Mental Health Services for the Lower Mainland** (IMHC) indicates that a plethora of services exist for the psychiatrically disabled, ranging from housing options to organizations providing emotional support and advocacy, to programs designed to facilitate employment and/or social skills. Below, I consider the following services: shelters and residences; outreach programs; employment and socialization programs; and other, specialized, programs or services.

There are at least three emergency shelters (Lookout, Triage, Venture) which provide short-term accommodation for mentally disordered individuals. There is also a variety of long-term residential facilities available, including Cordova House, Loma Residence, Adera House, Saint James' Social Services (SJSS) Annex and Victory House. Furthermore, subsidized housing at varying levels of support is provided by both Coast Foundation and the Mental Patients' Association.

Long-term residential placements are generally arranged through Mental Health Residential Services (MHRS). According to one MHRS employee (Community Worker 3), MHRS is mandated to screen clients and match them up with an appropriate placement. However, the process of matching clients to suitable accommodations is often easier said than done. Much of the long-term housing available is meant either for elderly chronic mental patients or for clients who are emotionally stable and "... have the potential ability to keep up therapeutic support and medication compliance" (IMHC, 1986:91). Candidates must also possess a satisfactory level of personal care and life skills (IMHC, 1986:91). Such

criteria tend to exclude many of the younger, less stable —but equally chronic — clients from placement in these settings. Because the clients are relatively stable, the turn-over of residents is fairly low in long-term facilities and subsidized housing; consequently, there are long waiting lists (Community Worker 3).

Unfortunately, there are few options for those mentally disabled people who lack the requisite skills and compliant behaviour expected of residents in these facilities. Consequently "difficult" clients — i.e., those who are not medication compliant, do not have basic personal care skills, and/or engage in "socially inappropriate" behaviour — are caught in the revolving door syndrome, circulating between shelters, welfare hotels, the streets and occasionally the criminal justice system. Although organizations such as Lookout and Victory House (run by SJSS) have acted as a safety net and provided some long-term accommodation for "hard to house" mental health clients, such "bandaid solutions" have the long-term effect of ghettoizing lower functioning mentally ill persons in the Downtown East Side. Furthermore, chronic mentally disordered clients who are perceived as being "difficult" are also excluded from many community based programs and are, in that sense, doubly ghettoized.

According to the **Directory of Mental Health Services**, there is a wide variety of employment and socialization programs (cf., Appendix E, Table 2) available to mental health clients living in the greater Vancouver area. However, in practice, a significant proportion of the mentally ill population living in the Downtown East Side, whose behaviours do not meet organizational entry criteria, are unlikely to have access. A perusal of the programs' admissions requirements clearly indicates that stable, medication compliant individuals with a moderate to high level of social skills are the preferred clientele (IMHC, 1986).

Moreover, many of these community-based facilities are scattered throughout the city and are not physically accessible for many of the mental health clients residing in the Downtown East Side. According to Mental Health Coordinator 3, these individuals may be

unable or simply unwilling to take public transport across the city to participate in these activities. To date, there is no 24 hour drop-in/activity centre in the Downtown East Side specifically for mental health clients, although this is not for lack of lobbying on the part of community leaders in the area.

Several specialty programs have been established in an effort to shore up cracks in the services network. These organizations include the MPA Court-Worker Project, the Multi-Service Network and the Inter-ministerial Project[10]. More recently, a clinical program for dual-diagnosis clients has been established by GVMHS in response to the unique needs of these individuals.

Shifting Client Characteristics

In seeking to develop a demographic and diagnostic profile of individuals who travel through Vancouver's social control network, I have canvassed their care givers and criminal justice professionals[11]. The following analysis is based on a combination of empirical data collected by participants' organizations, and the respondents' perceptions and observations of the mental health clients with whom they interact.

Demographic Attributes

Eighteen of the 21 professional respondents whom I interviewed provided me with some data about the demographic profiles of their clientele[12]. In developing the following portrait, I included data pertaining to ethnicity, age, gender, education, occupation, source of income and living arrangements (i.e., type of accommodation).

[10]Refer to Chapter Two or to the Glossary of Organizations (Appendix D) for a discussion of these organizations' mandates.

[11]I will deal with the attributes of mentally disordered offenders in a separate subsection.

[12]I did not discuss client characteristics with the **Draft Plan** co-author or Psychiatrist 2 as neither of these individuals had direct contact with mental health clients in the Downtown East Side's service-dependent ghetto. Additionally, the Nursing Professor declined to speculate on demographic statistics of mentally disordered shelter clients prior to completing her study on this topic.

Chronic mental health clients in Vancouver are predominantly caucasian, and comprise between 67% and 81% of caseloads. Although some organizations in the Downtown East Side (e.g., the care team) are treating increasing numbers of Asian clients, for the most part visible minorities and Aboriginal peoples are markedly under-represented (See Appendix E, Table 3). Natives are perceived by some respondents (e.g., the police officer) as more likely to have alcohol-related problems than mental health problems. The sources of this perception, and of the under-representation more generally of visible minorities among mental health clientele, are not clear from the data.

Respondents' estimates of gender representation in their caseloads varied. On the one hand, 14 participants reported a higher ratio of male to female clients. Within this group, three individuals quoted a ratio of 3:1 males to females; one person (Mental Health Coordinator 3) estimated the ratio to be as high as 10 males to one female; an outreach employee (Community Worker 1) claimed that men comprised 80% of his caseload; the jail data indicated a split of 88% males to 12% females; two respondents reckoned their caseloads averaged out to a proportion of 60% men to 40% women; and six participants did not provide an estimate to support their perceptions. Four of the professionals maintained that males and females were fairly evenly represented in their caseloads. Only one respondent (Administrator 1) reported a slightly higher ratio of female (51%) to male (49%) clients.

According to the respondents, clients' ages range from 18 to 80 years. In general, most of the mental health clients are in their late twenties to mid-forties. Residential facilities and substance abuse treatment facilities seem to attract clients in their forties and older. The shelters seem to be servicing younger age groups. Indeed, a shelter worker (Administrator 2) notes that over the span of two decades, the average age of shelter clients had dropped from 65 to 33 years. On the basis of the data collected, it would appear that

older chronic mental patients are more likely to be found in more stable settings such as long-term care facilities and boarding homes.

Most mental health clients' housing arrangements vary from having no place to stay, to living independently[13], to living at home with their families. Ten of the 18 care providers interviewed indicated that the majority of chronic mental patients live in welfare hotels or shelters. However, according to Mental Health Coordinator 3, such accommodations offer very little security in terms of a stable tenancy agreement and mentally disordered residents are often forced to move on a monthly basis and periodically find themselves shelterless.

An MHRS employee (Community Worker 3) notes that some of the older, more stable individuals are placed either in boarding homes or in subsidized housing with some home-care support. A recurring theme in the data is the lack of accommodations and other services tailored to clients who are low functioning, non-compliant or in need of intensive supervision (cf., IMHC, 1986). According to Community Worker 1, the primary reason for restrictive entry criteria is quite simply that most of the residential facilities lack both the funding and human resources to deal with such time-intensive clients. As a result, this group remains trapped below the poverty line, and in the revolving door between the street, shelters and squalid welfare hotels in the Downtown East Side.

Fifteen of the 18 participants indicated that almost all of their clients are on social assistance. Several respondents estimated generally that from 44% to 68% of mental health clients receive social assistance or Handicapped Persons Income Assistance (HPIA)[14]. Those individuals who are not receiving welfare depend on a fixed income from UIC or various pensions (see Appendix E, Table 1). According to Psychiatrist 1 and the Crown prosecutor, a few psychiatrically disabled persons receive financial support from their families. The MHRS employee (Community Worker 3) and Court Worker claim that such individuals are

[13]Either in welfare hotels, boarding homes or, less frequently, subsidized housing with some home-care support.
[14]A disability pension which offers a slightly higher monthly income than the regular social assistance rates.

exceptions to the norm, however, since a large proportion of mentally disordered people have few family ties. Several of the community workers indicated that some of their clients had no money at all when they first sought help from that agency. Very few chronic mental patients are financially independent in the sense that they receive a wage from a regular job.

Only a few of the respondents systematically collect data on the employment status of clients. Sixty-eight percent of the individuals interviewed by the jail doctor were unemployed; however, it is not clear from the data what proportion of this group is mentally disordered. According to 1990 data collected by Administrator 1, 47.5% of GVMHS clients are unemployed, 18.7% are employed competitively, and 4.5% work in sheltered workshops. More often than not, mental health clients are only able, at best, to get work as seasonal or unskilled labourers (Court Worker).

According to several participants, the chronic nature of most mental disorders and the early age of onset have prevented a significant proportion of the pyschiatrically disabled from gaining any substantial work experience. However, the data do not unequivocally confirm that all mental patients lack vocational training or work experience. As the director of a self-help organization (Administrator 6) points out, a client's employment history is related to age of onset. Moreover, according to her, mental disorders are "... equal opportunity illnesses — they afflict people from all walks of life ..."; hence, there is a wide range of occupational backgrounds, from working class to professional.

It follows that if employment histories and occupational opportunities are limited by the onset of mental health problems at a young age, the same pattern might also apply to educational experiences. Certainly frequent hospitalizations, in conjunction with impaired memory, concentration and thought processes[15], would impede educational progress.

[15]Probably due to the side-effects of medications, as much as to the disorder itself.

Few of the professionals interviewed actually keep statistics on the educational level of their clients. A widespread perception among the care providers, though, is that most chronic mental health patients have no more than a high school education. Three participants estimated that the mentally disordered persons with whom they interact had gone no farther than the eighth or ninth grade. Another respondent (Administrator 1) was not prepared to "hazard a guess" about educational level; however, he reported having a vague recollection of data which indicated a normal distribution of educational levels among mentally disordered individuals. My sample of mental health clients offers some support for this view (see Table 3.2).

Other Characteristics

In response to the question "Have you noticed any other client characteristics that you perceive as significant?", eight participants framed their responses in terms of diagnostic profiles and the complexity of clients' difficulties; two commented on the level of income; two focused on the absence of interpersonal supports and low social status experienced by the mentally disabled; three respondents drew attention to behavioural characteristics; and two remarked on clients' lack of ties to other family members. Following is a sample of the professionals' observations about chronic mental health clients:

> About 70% of shelter clients have psychiatric problems, they almost always have other problems as well. (Administrator 2)
>
> On the whole, ... I would say that the clients are all disadvantaged economically. I don't think they'd be in shelters if they had money. (Community Worker 2)
>
> They seem to have really low self-esteem; they really do look like people who have been beaten by life. (Nursing Professor)
>
> They are alone. Most of them have no family ties, no one to talk to. They are at the bottom of the pecking order, they are the lost crowd. (Court Worker)

> There is a high mortality rate among clients due to their lifestyle. They tend to be both victimized and victimizers. (Mental Health Coordinator 1)

> There are a lot of dual diagnosis clients now .... (Community Worker 3)

> Cases are getting more complex. (Administrator 3)

> The diagnostic profile stands out .... (Administrator 1)

> I've noticed [that] women tend to be diagnosed differently from male clients; females are diagnosed as having personality disorders, anxiety disorders, rather than as psychotic. (Mental Health Coordinator 3)

> Mentally ill offenders are unpredictable .... (Crown Counsel)

In the process of collecting data on the demographic profiles of mental health clients, the impression I received from the participants in this study is that while demographic data may be useful in some respects, they are not a critical source of understanding about the day-to-day concerns of clients. Of greater interest to front-line care providers are the psychiatric histories and diagnoses of their clientele.

Diagnostic Profiles of Mental Health Clients

Overall, the data indicate that the diagnostic profile of chronic mental health clients comprises schizophrenia and other affective disorders, clusters of major personality disorders, behavioural disorders, and some combination of psychiatric or personality disorders in conjunction with substance abuse — i.e., multiple diagnoses. For a more detailed breakdown of psychiatric profiles, see Table 4.2, which is based on 1990 data compiled by GVMHS. Generally speaking, several community workers reported that schizophrenia and other major affective disorders seem to account for approximately 65% of the caseload's diagnostic profile. The remaining 35% includes personality disorders, substance abuse, organic brain damage and behavioural disorders. Other respondents claim that the majority of their clientele are diagnosed with personality disorders. At least one

TABLE 4.2: PSYCHIATRIC PROFILES —GVMHS CLIENTS*
(N=5574)

DIAGNOSIS	FREQUENCY	PERCENT
Schizophrenia	1580	28
Major Affective Disorders **	721	13
Other Psychotic Disorders	94	2
Child Psychosis	1	0
Dys/Cyclothymia	225	4
Other Anxiety Disorders	155	3
Alcohol/Substance Abuse	559	10
Organic Mental Disorders	184	3
Personality Disorders	850	15
Behavioural Disorders ***	219	4
MR/Borderline MR	129	2
Eating Disorders	16	0.3
Other Psychiatric Disorders	120	2
V-Codes	592	11
Deferred	75	1

* Based on GVMHS Data, 1990
** Includes Bi-polar Affective Disorders
*** Encompasses adjustment, attention and conduct disorders

third of the participants indicated that they are seeing increasing numbers of multiple diagnosis individuals among their clientele.

Psychiatric History

In response to a question about the proportion of clients with a history of psychiatric hospitalizations, mental health workers' estimates ranged from as low as 20 percent to as high as 95 percent of the respondent's caseload. It is important to note that while almost all clients have been hospitalized at some point, the pattern of institutionalization is changing in response to the "short revolving door syndrome". Administrator 3 explains that "... a client could have many hospitalizations but when you start counting in terms of the numbers of days, [the length of time] is quite short".

Two of the participants also draw attention to an apparent correlation between the age of the clients and the pattern of hospitalization. Specifically, older mental health clients have typically experienced relatively lengthy hospitalizations in facilities such as Riverview. In contrast, the "new young chronics" are more likely to have been subjected to short-term admissions to community or general hospitals (Court Worker).

According to the research participants, it is not just patterns of hospitalization that are shifting. The demographic and diagnostic profiles of the mentally disordered segment of the service-dependent population have also undergone profound changes in recent years.

Emerging Demographic and Diagnostic Trends Among the Mentally Ill

When asked whether client characteristics have altered, 10 participants reported that clients are now more severely disordered, are more chronic, have more complex problems, and are often assigned multiple diagnoses. Five of the professionals expressed concern about increasing numbers of chronic mental patients with substance abuse problems. Six had noticed a shift toward a younger age group of clients who have never been hospitalized, let alone diagnosed. Administrator 3 remarked that he was beginning to see more women moving into the system and living in the Downtown East Side.

Several community workers remarked on how poverty-stricken mental health clients appeared to be. Given that the mentally disordered are living well below the poverty line (Court Worker), it is hardly surprising to see this population attempting to supplement their incomes by panhandling on the streets (Professor of Nursing).

Overall, mental health professionals are most concerned about the increasing numbers of younger, never hospitalized clients: the new young chronics. This group of mental health patients is often struggling with substance abuse in addition to coping with mental disorder. Drawing from the anecdotal evidence of line staff, Administrator 1 describes the "new young chronics" as being "... too antisocial to be good patients and too crazy to be antisocial. Consequently, they tend to fall through the cracks of agencies' service mandates". Many of the new young chronics are perceived by community workers as being "completely screwed up", more hostile and aggressive, and generally more difficult to deal with.

Only two members of community agencies (Community Worker 2 and Mental Health Coordinator 3) remarked that their recent clientele seem to be lower key or more compliant and pleasant. The latter explains this development as follows: (1) the newer clients have not yet exhausted the available services in the area; and (2) the system has become more sensitive to identifying and responding to groups with special needs. The former notes that the alteration in client characteristics is mostly the result of a policy decision not to accept violent individuals on the shelter's premises.

The interview data depict a situation wherein an increasing number of severely disordered (i.e., low-functioning) individuals are being treated in the community. Furthermore, Administrator 2 claimed that "many people who used to be locked up are now living in the Downtown East Side and can't get back into hospital" even when they want and need to be there. Given their fragile mental status, and due to the stressful and impoverished living conditions of the inner city, psychiatrically disabled persons may find themselves in

crises. According to one MHES worker (Administrator 5), when such individuals decompensate to the point of requiring hospitalization, they are admitted only for very brief periods, and are discharged, before they are sufficiently stabilized, back into the *same* social conditions. Added to this is the number of undiagnosed new young chronics who have never been hospitalized and have different needs from those of the deinstitutionalized mental patients.

According to two participants (Administrator 2 and Administrator 5), a lack of community support, in conjunction with an absence of political will to adequately fund mental health services, have limited the ability of existing services to adequately meet the needs of clients and have circumscribed opportunities to develop new services. Other participants (e.g., Mental Health Coordinator 1 and Community Worker 1) maintain that projects aimed at gentrifying the inner city areas have further reduced space needed to expand the service system, and have signalled the destruction of many welfare hotels, which are often the only available accommodation for mental health clients.

Respondents attribute changes in the behavioural characteristics and interpersonal skills of the mentally disordered to a range of psychological, social and structural factors. For example, the co-author of the **Draft Plan** cites increased substance abuse, resulting in psychotic-like problems, as a factor contributing to shifts in behaviour and level of functioning. However, this account does not explain a perceived trend toward increased substance abuse among chronic mental patients in the first place.

Administrator 3, a care team employee, attributes this phenomenon to the presence of a drug culture in the Downtown East Side of Vancouver. But this begs the question as to why drug use among psychiatrically disabled persons has only become an issue, from the perspectives of care providers, within the last five years. An outreach employee (Community Worker 1) correlates substance abuse with escapism and feelings of low self-esteem among mental health clients. Given the impoverished, oppressed lifestyle experienced by most

chronic mental patients, it is hardly surprising that they would seek some form of escape. While the data collected allow for little more than speculation, it is possible that a relationship exists between greater incidences of substance abuse among the mentally disordered and worsening social conditions in terms of access to adequate housing and support services.

There are also many unanswered questions with respect to the apparently higher numbers of women who are finding their way into the service dependent ghetto. Administrator 3 argues that the creation of more facilities and services for women has attracted more female mental health clients to the Downtown East Side. Although this account suggests that the cycle of ghettoization is possibly becoming more feminized, it does not explain the origins of such a trend, since presumably these services would have developed as a response to a prior influx of female ex-mental patients into the area.

In light of several respondents' observations that: (1) women exhibit different help seeking behaviours; (2) female patients tend to be older and diagnosed differently from males; and (3) women tend to deal better with their disorders, it is puzzling to hear reports that the number of women among the service dependent residents of the inner city is apparently increasing. Unfortunately, the data collected for this thesis provide insufficient information for any conclusive analysis of this phenomenon.

Mental Health Clients and the Criminal Justice System

According to data provided by the jail doctor (see Table 3.3), the demographic characteristics of mentally disordered offenders are similar to the profiles of both the service-dependent and offender populations in general. Specifically, this group of offenders comprises predominantly caucasian, male, unemployed individuals. Young mentally disordered offenders in their twenties and early thirties are pervasive within the criminal justice system. Community workers in agencies specifically dealing with these populations

report that their clients are generally quite young. As the MPA Court Worker remarked, "older clients get burned out from the meds and do not commit so many offences".

According to two of the criminal justice professionals, most of the mentally disordered offenders they see do have a psychiatric history which includes periods of hospitalization. Crown Counsel estimates that "about 80 percent of mentally ill offenders have a history of hospitalization. [Moreover], it is unusual to find no history after getting a report from the examining psychiatrist". A Provincial Court Judge reports a similar experience. In general, the "mentals" prosecutor and the judge rely on police reports, and on letters from the jail doctor or defence counsel, for information about an offender's mental health status. Occasionally, a judge may suspect that an accused appearing in court is mentally disordered, based on behavioural observation and a "gut feeling".

The types of offences committed by psychiatrically disabled offenders range from minor infractions to the occasionally very serious crime (see Table 4.3a). One Provincial Court Judge contends that most of these accused are charged with minor offences such as food fraud, mischief (breaking windows), or breaking and entering. According to Crown Counsel, these individuals also tend to commit "random" assaults, although he questions the randomness of such violence, given that the victims tend to be predominantly lone females. Overall, the "mentals" prosecutor contends that mentally ill offenders "...[tend to] commit either fairly minor offences or very dangerous acts; [there is not] ... a lot of middle ground".

Both Crown Counsel and the judge indicated that mentally disordered offenders are generally more difficult to deal with in court, although this does vary by case. The difficulties seem to arise out of a failure to understand the court process and a tendency to act out in the court room. Although judges' responses to such outbursts vary, the judge who participated in this study takes the view that psychiatrically disabled accused are "... by and large, people who want to say something". Based on his experience, he concludes that "... if you give them an ear and listen, it tends to alleviate some of the stress".

Overall, participants from the criminal justice system have not noticed any changes in the demographic and psychiatric profiles of mentally disordered offenders. According to Crown Counsel, about 25% of these individuals get caught up in the revolving door syndrome. This group generally comprises street people and shelter people who do not have anyone to take care of them.

The judge noted that some individuals have become more violent over time, and attributes this to the level of frustration they likely experience in dealing with their life problems.

If mental health clients are becoming more chronic and have fewer coping skills, one can presumably expect to see escalating numbers of psychiatrically disabled persons getting tangled up in the social control net. One might also predict that if the size of the mentally ill population continues to grow at a faster pace than available resources, such individuals will experience decreasing levels of support from available service facilities.

Keeping Up with the Numbers: Caseload Sizes

Caseload sizes vary quite a bit from one agency to the next within the transcarceral network (see Tables 4.4a - 4.4e). There are differences within, as well as across, systems. For example, within the criminal justice system, the police department and the jail doctor report a greater number[16] of interactions with mentally disordered individuals than do Crown Counsel and judges[17]. Within the mental health and social services systems, caseloads range from a total of 15 clients to upwards of 143 persons per month.

It is generally the case that organizations providing clinical services, emergency interventions or psychiatric assessments on an outpatient basis deal with relatively greater

[16] Approximately 30 individuals per month.

[17] For example, the judge only deals with approximately six to eight mentally disordered offenders per month.

TYPE OF OFFENCES COMMITTED BY MENTALLY ILL OFFENDERS

TABLE 4.3a: JAIL DATA: OFFENCES BY MENTALLY DISORDERED OFFENDERS* (N=477)

CATEGORY+	FREQUENCY	PERCENT
Offences against person	146	30.6
Mischief/Public Nuisance	106	22.2
Property Offences/Fraud	78	16.4
Violent Offences against person	35	7.3
Weapons and Firearms	28	5.9
Immigration/Miscellaneous	26	5.5
Violent Property Offences	23	4.8
Administrative (e.g., breach probation, F.T.A)	14	2.9
Driving Offences	7	1.5
Non-violent Sex Offences	6	1.3
Drug Offences	2	0.4
Missing Data	6	1.3

* These data represent all offences by mentally disordered offenders from January, 1987, to July, 1991.

+ These are based on the approximate organization and categorization of offences in the **Criminal Code of Canada.** See Appendix C for examples of the types offences included in each category.

TABLE 4.3b
MPA DATA: MOST FREQUENT OFFENCES, 1987–1990

	1987	1988	1989	1990
Theft Under $1000	923	1022	1120	1270
Assault	821	913	1001	1066
Mischief	482	523	566	637
Obtaining Food by False Pretenses	123	119	163	99

Source: Mental Patients' Association Court Worker Project, 1991

numbers of mental health clients than agencies such as emergency shelters which depend on the availability of resources such as beds. Several of the outreach programs provide high levels of one-to-one contact and prefer to limit the caseload to a ratio of approximately ten clients to one community worker. According to Mental Health Coordinator 3, smaller numbers of clients help to keep the program more personal and less bureaucratized, thereby facilitating the establishment of strong interpersonal connections between workers and clients.

Participants' responses to questions about perceived changes in caseload size over recent years are quite divergent. Two of the criminal justice respondents report that the number of mentally ill offenders appearing in Remand Court has remained quite stable. The jail doctor maintains that the number of psychiatrically disabled individuals whom he sees in jail has actually decreased over the last two or three years (see Table 4.4a). Conversely, the police claim that over a four year period, the number of "mentals" calls reported by civilians has risen from 1,440 in 1985 to a total of 1,793 in 1989 — an increase of approximately 16 percent.

Within the mental health system, two participants report that their caseloads seem to fluctuate; four maintain that their caseloads have been steadily increasing; three indicate that the number of clients has remained stable; and one respondent admits that her caseload has decreased. According to one shelter employee (Administrator 2), "... it is not so much that there have been significant changes in the numbers, but now the clients are staying longer; they have less alternatives. We are seeing more turn aways".

Based on aggregate statistics provided by some of the participating organizations (see Tables 4.4a to 4.4e), it appears that caseloads fluctuated between 1987 and 1990. This general pattern seems to apply to various agencies throughout the social control network. Yet, there is no consistency in the directions of these fluctuations across the network of various community agencies. The following provides an overview of how the mental health

and criminal justice professionals account for fluctuations in their caseloads between 1987 and 1990.

In the process of analyzing participants' responses to the question "How do you account for shifts in the size of your caseload?", several themes emerged. Three individuals cited the downsizing of Riverview Hospital as a significant factor in burgeoning caseloads. In the words of a GVMHS administrator:

> Deinstitutionalization is a major factor, it's not a migration factor. There is nothing to suggest an increased prevalence of the mentally ill population. The most likely explanation is that Riverview is shrinking daily.

Although the participant from GVMHS (Administrator 1) maintains that migration into the system is not a major consideration, his position on this issue is not shared by other respondents. As the police officer respondent observes, "...[the Downtown East Side] is a drawing card for these individuals. There is a lot more tolerance in the area; there are a lot of services for them down here and ... they seem to fit in here". This comment suggests that mentally disordered individuals are migrating into the Downtown East Side of Vancouver, perhaps from other jurisdictions within the lower mainland. Yet, a psychiatrist affiliated with a general hospital (Psychiatrist 1) maintains that migration into the mental health system is mostly by people who are already living in the city. The safest conclusion to draw, based on the data collected, is that the perception of a migration phenomenon — and the weight attached to it as an explanation for increasing caseloads — is dependent on where the respondents are situated within the social control network..

Three participants identified structural forces as contributing to fluctuations in caseloads. By "structural", the respondents seem to be referring to the policy decisions of government ministries, and to the human, financial or material resources available to meet

TABLE 4.4a: SUMMARY OF JAIL DATA

	1987	1988	1989	1990	1991
# Psych. History	85	101	143	106	42
# Diagnosed as Mentally Disordered*	108	120	159	102	52

* These data include reports for both court and immigration hearings.

TABLE 4.4b: MHRS CASELOAD 1987–1991*

	1987/88	1988/89	1989/90	1990/91
# Referrals	1255	1016	999	1021
# Placements	469	433	519	489
% Referrals Placed	37%	43%	52%	48%
Referrals from Riverview	207	164	183	167
Direct Placement from Riverview	106	67	96	71

*Source: GVMHS data, 1991

TABLE 4.4c: MPA COURT-WORKER CASELOAD, 1987–1990*

	1987	1988	1989	1990
# Criminal Charges+	1298	1452	1485	1932
Total # Appearances+	3915	4426	4959	5743
# Assisted by Worker+*	845	907	1008	3032

* Source: MPA Court-Worker Project, 1991.

+ Does not include the offence of "Failure to Appear".

+* Assistance comprises setting client up with housing and/or welfare; offering counselling, advocacy services.

TABLE 4.4d EMERGENCY SHELTER CASELOAD*, 1987–1990

	1987	1988	1989	1990
Total # Aided	1964	1921	1519	1885
# New Referrals	900	938	1186	975

*Source: *Lookout* Emergency Shelter, 1991

TABLE 4.4e GVMHS— TOTAL CASELOAD OF ALL CARE-TEAMS*

JAN. 1987	JAN. 1988	JAN.1989	JAN. 1990
3125	3450	3650	3600

*Source: GVMHS data, 1991

the demands for services. The most obvious example of the latter is the gap between the level of funding received and the size of the service dependent population. As the Court Worker points out, "ministry budgets for health and social services are not keeping up with the size of the problem".

A reallocation of resources might also be described as a structural influence on caseloads. For example, Psychiatrist 1 speculates that a cut-back in the number of beds available for acute psychiatric care in one hospital may be balanced by increased admissions at other hospitals, thereby contributing to fluctuations in caseloads.

Other respondents contend that the availability of some resources has been restricted as a result of "... agencies tightening up on their own criteria in terms of the clients they will accept". In a climate of general retraction, it is much more difficult to access service agencies providing social (e.g., housing) and/or financial assistance. According to

Administrator 2, the individuals who fall through the service cracks typically end up in a revolving door between the streets and emergency shelters.

The same individual asserts that the resurgence of conservative ideologies has also played a role in maintaining an inadequate level of resources within the community mental health system. An example of this is the belief that the psychiatrically disabled are undeserving of support. Given the historical development of the welfare state in general[18], and societal responses to the mentally ill in particular[19], it is reasonable to suspect that decisions to fund mental health resources may be influenced by such attitudes[20].

The Shifting Landscape

In this section, I consider how the implementation of the 1987 **Draft Plan** has reshaped Vancouver's "landscape of despair" (Dear & Wolch, 1987) by considering the perspectives of the mental health and criminal justice professionals interviewed in this study. It is important to keep in mind that these accounts are subjective and therefore may not reflect the actual process of implementation. Since the interviews for this thesis took place between February and September 1991, respondents' perceptions of the impact of the **Draft Plan** on community-based care reflect the earliest phases of the implementation process.

After asking several preliminary questions designed to gauge subjects' familiarity with this document (see Appendix E, Tables 4a and 4b), I asked them the following three questions: (1) How has the decision to implement the **Draft Plan** affected your organization? (2) What, if any, impact has this had on the clients? (3) In your opinion, how well is the **Draft Plan** being implemented?

[18]As discussed in Chapter I. Also, cf., Ralph (1983), Satyamurti, 1979; Unsworth, 1979).
[19]cf., Ralph (1983), Rothman (1980), Scull (1984).
[20]After all, even the **Draft Plan** (1987) alludes to the fact that mental health is in the lowest position on the totem pole with respect to the Ministry of Health's funding priorities.

***How Have Organizations Been Affected by the* Draft Plan?**

Answers to this first question varied across agencies, depending on the type of service provided and the organization's role in the social control network. Most of the participants in the criminal justice system reported that the **Draft Plan** had no impact in their work environments, vis-a-vis interactions with mentally disordered offenders. Only the police reported that as a result of this document, their call load had been pushed up.

Overall, several general themes emerge from the data, including: pressures from increased caseloads and insufficient services; heavier work demands on staff in community agencies; and frustration at being unable to hospitalize clients when necessary. A few respondents expressed some optimism about small gains that had occurred in the numbers of front-line staff, and in the provision of enough funding to ensure adequate services to their clientele. One individual from a community care team (Administrator 3) maintained that over the long-term, implementation of the **Draft Plan** should result in more housing, lighter caseloads and a community that is more accessible to mentally disabled persons.

Two professionals reported that although their organizations were able to provide good care and operate efficiently, staff resources were "... stretched to the absolute limit". A staff member at Mental Health Emergency Services (Administrator 5) described the situation as follows:

> We remain efficient but we're overworked; the stress increases and the consequence is less humanity offered to the client. I can see over the years how some of the extras have been pared down. Now the clients get the regular service at a faster pace. I think we are still able to meet the needs of clients because we have a dedicated staff. But how long can you overload even a dedicated staff and expect them to stay on without burning out?

Similarly, a manager from GVMHS (Administrator 1) speculated that implementing the **Draft Plan** "... may have an effect on the nature of the services provided — i.e., less proactive outreach work".

Several community workers involved in outreach work and case management commented on how newer clients require many more services and contacts over a longer period of time. This observation is consonant with the view that patients who are now being discharged are more chronic and lower functioning. Along these lines, Mental Health Coordinator 3 anticipated seeing "... more people ... who are more institutionalized and would therefore need more supervision". Mental Health Coordinator 2, maintained that community workers in the Downtown East Side are coming across "... a lot more people on the street now who otherwise would have been institutionalized if such facilities were more accessible".

Many psychiatrically disabled persons are turning to emergency shelters to get their basic needs met. Indeed, Mental Health Coordinator 3 described the shelters as being akin to "mini-institutions". It may be more accurate to describe them as short-term places of asylum for attaining at least a modicum of stability. According to Community Worker 2, the facility is "... almost full to capacity, so we try to encourage clients to move on as soon as they are stable". The problem with this, according to the same participant, is that "... they end up [in situations where] they are victimized or start to decompensate again, especially if they are not taking their meds".

A Professor of Nursing concluded that, based on her research, deinstitutionalization "has completely changed the whole purpose of [emergency shelters]. They are acting as half-way houses for ex-psychiatric patients, rather than meeting their mandates as emergency shelters". She argued that emergency shelters are providing a band-aid solution to fundamental needs that are not being met elsewhere. Furthermore, the shelters are having to cope with situations for which they do not have either adequate or appropriate resources.

Specifically, staff in these kinds of places are not equipped to deal with a mentally disabled person who is experiencing a crisis. Yet, these community workers do not seem to get much support from clinicians in care teams or hospitals when a client requires institutionalization. Two of the participants in this study expressed moderate to high levels of frustration about this issue. Neither of these individuals foresaw this situation improving at all in the near future.

Not all mentallly disabled persons end up living in shelters or welfare hotels. According to the director of a self-help organization (Administrator 6), "... a lot of patients are coming back home to live with their families". It would appear, however, that policies which stress the return of patients to their families do not always consider the implications for other family members. Administrator 6 pointed out that in many cases, "... the families can't cope with the stresses and difficulties that arise out of this situation and it leads to a lot of family breakdowns and dysfunction".

Moreover, family members often have to "... take on the task of dealing with various bureaucracies because the patient is not always able to deal with these issues" (Administrator 6). In other words, a relative with presumably little knowledge of, or experience in dealing with, bureaucratic organizations is expected to take on the roles of case-manager and service broker. Given that families are not provided with adequate support to deal with these situations, it is hardly surprising that they are not always ecstatic to discover that a mentally disordered relative is being decertified and discharged back into the home.

Overall, the data suggest that even in the early stages of implementation, most community workers viewed the **Draft Plan** as having a negative impact on the network of service agencies in the lower east side. Mental health professionals perceived the implementation of this policy as exacerbating a situation in which resources were already stretched to their limits and caseloads were swelling with increasingly needy, dependent clientele.

Ironically, while the community-based system of care was experiencing a crisis of service delivery, Riverview Hospital apparently benefitted tremendously from the implementation of the **Mental Health Initiative**. According to Psychiatrist 2, the process of transforming this document into reality actually improved services at the hospital and resulted in better utilization of available beds. Expanding on this comment, he explained that, among other things, "the hospital had to go out and hire more professional staff". Furthermore, the facility was forced to "... start looking at how to move from custodial to rehabilitative care, [as well as] refocusing on the clinical aspects of a community orientation [and] ... developing ... programs".

Overall, Psychiatrist 2 expressed a fairly high level of optimism that if the hospital "... had the support of a community board, [it] would become even more accountable ... in terms of the services [it] provides". This participant stressed the importance of establishing a basis of accountability and coordination within the system of service delivery.

Given that some of the service providers in the community have not perceived much in the way of either accountability or efforts at coordination from the direction of Riverview Hospital, one suspects that these participants would be rather cynical about the above comments. Certainly one is inclined to question why these issues had not been dealt with before the hospital started discharging patients into the community. In general, there is a strong feeling among community agencies that Riverview Hospital administrators had been intent on going ahead with the downsizing well before 1990, and prior to developing any structure of accountability and coordination with the community-based system of care.

Perceived Impact of the Draft Plan on Clients

The following discussion considers how, from the perspective of the care providers, the lives of mental health patients have been affected by the implementation of the **Draft Plan**.

Eight of the 15 participants who responded to this question maintained that, overall, clients were probably experiencing a worse quality of life. What emerges from the data is a picture in which an ever greater number of individuals are trying to gain access to a system that is increasingly limited in its capacity to provide adequate services. According to Mental Health Coordinator 1, at times it is "... difficult to impossible to meet the needs of clients".

An out-reach worker (Community Worker 1) notes that many of the chronic mental health patients who are unable to get their needs met struggle to survive . An MHES employee (Administrator 5) claims they are often victimized by the "... sleazeballs [who] also like to hang out in the Downtown East Side" . According to Community Worker 1, many are preyed upon by drug dealers who exploit their lack of power, self-esteem and finances.

To the extent that mental patients are able to access resources, they are often treated with disrespect and are rarely given any extra assistance. At least two participants (Community Worker 2 and Administrator 5) commented specifically on the tendency of Social Services employees to treat psychiatrically disabled clients "... less humanely and more as a nuisance"[21]. With pressures on agencies to provide more services to escalating numbers of individuals, clients are moved along as quickly as possible in all parts of the system. Certainly this is the perception of Community Worker 2. As he pointed out, with increasing frequencies of emergencies, the facility simply has to ensure that the turn around time for available bed space is as short as possible.

The same time constraints are experienced in the clinical sector of mental health services. For example, according to the participant from GVMHS (Administrator 1), most clients generally see their psychiatrists for a maximum of 15 minutes per month. In fact, one

[21]Hence, it is hardly surprising to read news stories about mental health clients assaulting Financial Aid Workers or creating a disturbance in MSSH offices (cf., "His blowup at welfare highlights frustration" in **The Province**, May 14 1991: p.4).

of the biggest complaints from GVMHS clientele is that they do not get enough time to really talk to their psychiatrists[22]. As a mental health worker from MHES (Administrator 5) pointed out, clients now get "the regular treatment at a faster pace".

Only two respondents in community services perceived the implementation of the **Draft Plan** as having a positive impact on mental health patients. Interestingly, both of these individuals framed their replies in terms of the greater freedom enjoyed by mental patients in the community. One of these professionals, Psychiatrist 1, qualified his position by alluding to the trade-off between this enhanced liberty and the loss of support that many patients had experienced in hospital. In contrast, Administrator 3 seemed quite confident that although "some ... clients want to go back to Riverview, ... by and large, ... many would say it is better in the community".

Most of the mental health professionals agree that it is generally better to treat mental health patients outside of institutions. However, it is questionable whether they would agree that a community lacking in sufficient resources to meet the demand for services is the best environment for such a vulnerable population. As the Professor of Nursing declared:

> I think a lot of [mental health clients] have been left without the resources they need. That's why we see them wandering around on the street hallucinating. I think we've done an awful disservice to the mentally ill. These people need services and housing at all different levels of support .... Shelters are a band-aid treatment for the problem. Many of them end up ... in welfare hotels, with no one to monitor their medications and few social contacts, [and] they end up getting sick again.

To say that most of the professionals who participated in this study are distressed at how their clients' lives have, so far, been affected by the **Draft Plan**, is an understatement.

[22]The clients' perceptions and opinions of the quality of care they are receiving will be examined in Chapter V.

As the following section documents, several respondents expressed concern and dismay at the overall lack of accountability demonstrated in the implementation of the recommendations to improve services and in the overall coordination between agencies.

How Well Organized has Implementation of the Draft Plan Been?

Six of the 20 respondents declined to answer this question, as they believed they did not know enough about the **Draft Plan** to comment fairly. Three participants questioned whether the plan had actually been implemented. Two of these three individuals did concede that funds were being loosened up and that a few things were occurring on a haphazard basis, but that they had seen nothing on a consistent basis.

Mental Health Coordinator 1 expressed concern that the **Draft Plan** was "just a bunch of political double-talk; [after all], they [Victoria] would have had to beef up the services and that hasn't happened". Furthermore, according to this individual, many of the patients at Riverview, upon being decertified, "... just up and leave without waiting to do discharge planning". My impression is that she, and other participants in this study, were most frustrated by the fact that "the powers that be" were denying the occurrence of downsizing[23], while their own professional experiences and observations suggested precisely the opposite.

An analysis of the data suggests that the majority of mental health professionals are disappointed with how well the **Draft Plan** has, to date, been implemented. Most participants contend that implementation has been poorly organized in terms of both fortifying existing services and developing new programs. These improvements, in conjunction with the provision of additional housing facilities, should have been in place *before* any more patients were discharged into the community. Furthermore, according to the MHES worker (Administrator 5), "it is too late to start educating communities to accept the

[23]According to Psychiatrist 2, Riverview Hospital publicly stated that they were being pressured to start downsizing before many of the recommendations to improve and expand existing services had been implemented.

mentally ill in their midst. Most people have very negative ideas about the mentally ill; it takes some time to re-educate them or even to get them to rethink their ideas".

From the perspective of Community Worker 1, "the government has been slow to put the services in. The money has not followed the patients into the community; there has only ever been one transfer of funds". He concludes that "this thing had nothing to do with people, it had to do with money".

Two of the professionals I interviewed chose to frame their opinions rather more cautiously. One of these respondents (Administrator 3) qualified his response by suggesting that "it is too early to tell generally how well the plan is being implemented". The second (Mental Health Coordinator 3) maintained that referring to the **Draft Plan** as a blueprint for 'downsizing' is a mischaracterization. According to the latter respondent, "Riverview Hospital was downsized [about] five years ago. Now we're only talking about 300 people, so it's not a big deal. The problem down here is trying to deal with the 4,000 who have already been deinstitutionalized".

Despite the more circumspect assessments of these two participants, the general consensus among the mental health workers in my sample is that the early stages of implementing the **Draft Plan** have been disappointing at best, and a complete disaster at worst. As Psychiatrist 2 observes, although implementing the **Draft Plan** may have had a positive impact on Riverview Hospital and its patients, the process "did not get off to an auspicious start" and has had a devastating impact on the community.

There is nothing in the data to suggest that perceptions of how well the **Draft Plan** has been implemented are correlated with actual knowledge of the document or with respondents' direct participation in the consultative process. Some individuals are completely familiar with the document (e.g., Administrator 3), participated in the consultative process, and adamantly insist that it is a good document but that it is simply too soon to assess how the policy will ultimately affect the community. Other participants (e.g.,

Psychiatrist 2), with the same level of familiarity and experience in the consultative process, do not hesitate to castigate the lack of organization and accountability in the failure to act on recommendations for improving services before discharging patients. Still others are disillusioned with the implementation process, yet continue to maintain that the **Mental Health Initiative** is a great document from a philosophical and ideological perspective.

In Chapter V, the responses of professionals, front-line personnel and mental health clientele will be canvassed on a range of questions pertaining to deinstitutionalization and its consequences in the lower mainland of B.C.. I also compare professionals' perceptions of the social care network and its operations with the clients' own experiences with social service agencies.

CHAPTER V

EVALUATING THE SYSTEM: A STREET-LEVEL PERSPECTIVE

Introduction

Chapter IV described the social control network as a "landscape of despair" (cf., Dear & Wolch, 1987). The themes which emerged from canvassing front-line care providers on the effects of the **Draft Plan** suggest that the service-dependent ghetto is a wasteland within which existing services are withering and almost depleted. Certainly no new resources could take root or thrive on the small amount of cash which has been trickling forth from the government's funding wellspring. Indeed, during 1991, the money flowed neither fast nor far enough to replenish the service network's ability to meet clients' needs.

In this chapter, I report the responses of professionals, front-line personnel and mental health patients to a range of questions pertaining to deinstitutionalization and its consequences in the lower mainland. These questions were intended to ascertain respondents' opinions on what ails the system and to elicit suggestions for improving the delivery of mental health care in the lower mainland of B.C. I also compare professionals' perceptions of the social care network with the clients' own experiences with community-based mental health care.

Mental Health Workers Evaluate the System: The Insiders' Views

In order to determine care providers' level of satisfaction with the delivery of mental health care and social services, I consider their answers to the following questions: (1) Are you satisfied with the range of services available to mental health clients?[1] (2) What is your opinion, overall, of the availability, accessibility and accountability of the system at present?

[1]Prior to asking this question, I canvassed respondents' familiarity with the existing service network (this information is available in Appendix E).

(3) Are you satisfied with the current level of coordination between agencies in this system? (4) What kinds of improvements would you like to see in the delivery of mental health care and social services? (5) What kinds of reforms are possible, realistically? Specifically, could you speculate on the political and fiscal implications of implementing these changes?

Range of Services

I canvassed 14[2] of the 21 individuals in this cohort for their answers to the question "Are you satisfied with the range of services that is currently available to your clients?". Six individuals responded with a qualified "yes". When asked to expand on their assessments, three persons alluded to gaps in the services that restricted accessibility to certain groups of clients[3]. Two community workers expressed dissatisfaction with the lack of facilities available for clients with physical and/or mental handicaps. One of these respondents pointed out that many of the welfare hotels are not wheelchair accessible, thereby effectively eliminating affordable housing options for many mental health patients. A director of a residential facility (Administrator 4) observed that, although appropriate services are in place, "... the right not to seek treatment influences whether clients will actually utilize the services available to them." According to this respondent, "... the right to refuse treatment ... is often a contributing factor when a client decompensates" [4].

Two participants maintained that insufficient resources prevented agencies from keeping up with patients' demands for services. Psychiatrist 1 summarized the situation when he commented that "... there are more patients than services, but they are good services". From the perspective of Administrator 1 (a GVMHS manager), there are plenty of

[2]This question was not relevant for two of the people in this group. Two individuals declined to answer this question on the grounds that they were not familiar enough with the network of service agencies. In three cases, time constraints prevented me from raising this question.

[3]Specifically, these were low-functioning and/or "disruptive", time-intensive clients.

[4]In the backlash against the "liberal" approaches to mental health in the early 1970s, traditional scholars often cite mental patients' right to refuse treatment as a significant barrier to effective after-care and a major source of frustration for care providers on the front line (cf., Fuller, 1988; Isaac & Armat, 1990).

services available; the problem is that they "... are all fragmented into various divisions and operate independently, with little coordination between them".

Only the police officer expressed unequivocal satisfaction with the range of services available to mental health patients in the Downtown East Side. In his opinion, "... they're excellent. The community may have a problem with them, but we [the police] have [found them to be helpful]". He believed that community agencies generally "... would not throw anyone out or not accept them, even if they had to keep them in the lobby".

Crown Counsel was more concerned about finding available beds than about the range of services in the community-based system of care. According to him, Riverview has always had a bed problem, but it has not become any worse. Now mentally ill offenders are re-routed through Vancouver General Hospital. The facilities are there for a normal flow [but] it also depends on the resources for others ... in the community who need hospital beds. Recently the ability to place people has improved.

Of the five participants who expressed dissatisfaction with the extent of services available, at least three specifically pointed to the lack of adequate housing for chronic mental health patients. The general consensus was that "... the city needs more varied kinds of supportive housing" to accommodate "... individuals at different levels of functioning". Community Worker 2 maintained that more recreational and socialization programs were needed to improve the quality of clients' [social] lives.

I also canvassed mental health workers' perceptions regarding their colleagues' levels of satisfaction with the array of services available to clients in 1991. Three individuals limited their responses to a cautious "I don't know". The police officer elaborated on his response, suggesting that "... it depends on whether they look at the big picture". He also pointed out that this is an issue which fellow police officers "... would rather not deal with".

Overall, the data seem to confirm various participants' speculations that mental health workers across the system generally share the same concerns and complaints about the

network of service agencies. For example, both Psychiatrist 1 and the MHES director (Administrator 5) held the view that "... the existing services are good; we have the expertise ... but we just don't have adequate levels of resources ...". As Mental Health Coordinator 3, "... most ... would say there are not enough services, there is not enough money — the usual party line".

Perceptions of Clients' Treatment Needs

In response to the question "What are your perceptions of clients' treatment needs?", five individuals cited the need for continuing medications in conjunction with good medical follow-ups and a consistent care plan as essential to successful long-term care outside of an institutional setting. In particular, the criminal justice personnel maintained that mental health clients were more likely to become involved with social control agencies when they stopped taking their medications, for whatever reasons.

Thirteen participants identified adequate housing and financial support as a top priority for community-based treatment. Four respondents perceived a correlation between inadequate financial support, poor eating habits and subsequent mental breakdowns.

Twelve participants also listed rehabilitation services (for both personal care skills and vocational training) and recreational opportunities as necessary components of on-going treatment. Psychiatrist 2 maintained that mental patients' coping skills should be rehabilitated before they leave a hospital setting. The police officer questioned the wisdom of discharging patients who are unable to care for themselves in the community.

Five respondents emphasized the importance of providing recreational programs and opportunities for social interaction among clients. As Community Worker 2 and Mental Health Coordinator 3 pointed out, mentally disordered persons also want to feel that they are accepted and belong somewhere. Furthermore, psychiatrically disabled people often feel lonely, isolated, depressed and unmotivated, according to other mental health workers. The director of a residential facility (Administrator 4) further suggested that some kind of

incentive program would be useful in motivating clients to participate in recreational activities.

In response to the question "Do you think mental patients' needs are being met?", 11 respondents answered in the negative. Three expressed concern that social and economic needs were not being adequately addressed by the mental health and social services systems. According to the **Draft Plan** co-author, "... the big problem [is] this imbalance in providing for the social needs of mental health patients". The participant from GVMHS (Administrator 1) observed that "generally, there is an over-emphasis on clinical services, as opposed to long term re-adjustment". As far as the MHES director was concerned, mental health clients were "... barely getting their basic needs seen to, let alone any other needs."

Two participants attributed the inability to meet clients' basic needs to the lack of available resources. Psychiatrist 2 offered the following assessment:

> [Clients'] needs are not being met, although there are some interesting attempts on the part of agencies to meet [these] needs. The problem is, if resources become over-stressed, the system gets into a crisis ... upset because ... can't put money in ... to take pressure off the front line. I think if we don't get more money into the mental health system, we will have a big crisis on our hands in terms of service delivery.

Other participants maintained that some chronic mental patients did not get treatment because they could not or would not "... take advantage of the system or services available to them". Based on his experiences with a small group of mentally disordered offenders, the "mentals" prosecutor concluded that some of these individuals go around in circles until someone takes charge and helps them to sort themselves out. Psychiatrist 1 also commented on the existence of a group of patients who "... are difficult to follow [because they] are not willing to participate in the resources available to them". This same respondent

wondered if, perhaps, clients did not utilize these services because they were not sufficiently tailored to their needs.

Based on his experiences in the Downtown East Side, the police officer maintained that mental health clients are most likely to run into problems when "... they get caught up in drugs and alcohol and don't take their meds". Given the plethora of licensed premises within that area and the lack of organized recreational opportunities available for mental patients, it is hardly surprising that some of them get into difficulties with alcohol and drug use.

I asked 11 mental health care workers whether they thought their clients were satisfied with the care they were receiving and with the range of services available to them. There was little consensus on this question.

On the one hand, the MPA Court Worker maintained that "... they're not satisfied; they know there is nothing out there for them. It's very frustrating for them". On the other hand, an outreach worker (Mental Health Coordinator 2) reported that, according to his clients, "... there is no reason to be in want of anything; there are plenty of free services [see Appendix D] that provide clothes and food. A lot of [individuals] tend to rebel against the bureaucracies". Still other service providers questioned whether clients were even capable of appreciating whether their needs were being met, as many of their difficulties stem from "... a lack of insight into their needs".

Nonetheless, four individuals speculated that mental health patients would express dissatisfaction with some aspects of the service delivery system. Three of these respondents guessed that clients would most likely complain about the lack of adequate housing and not having enough money to live on. Mental Health Coordinator 3 reported that mental health patients were unhappy with the lack of information they are given about their "mental conditions and all of [the] attendant consequences". As the GVMHS administrator (Administrator 1) pointed out, the mentally disabled "have the same needs as other people.

They would probably [articulate] the same types of concerns and comments that have been raised by workers [in the system]".

Evaluating Availability, Accessibility and Accountability

Opinions on the availability and accessibility of mental health services varied across the cohort of mental health and criminal justice professionals. Three participants shared the view that access to care was not generally a problem; however, "plugs" in the system meant that resources are not always available immediately. The **Draft Plan** co-author attributed restrictions on availability to a combination of "... the heavy demands on existing agencies and a deficit of resources in the area".

Several front-line workers commented on the lack of services tailored specifically to the needs of "difficult" (e.g., time-intensive) mental health patients. As one shelter employee (Community Worker 2) pointed out, "there are a lot more options for the quiet, pleasant clients; accessibility to programs [and] housing is limited for the difficult clients". Mental Health Coordinator 3 commented that "not enough of [the services] are willing to take on the difficult kinds of clients ...." Needless to say, this situation is not likely to change if community agencies must continue to operate in an environment of fiscal restraint.

Although the jail doctor did not feel qualified to comment on the community-based system of care, he did address the issue of psychiatric care for mentally disordered offenders in jail. He indicated that he was "... impressed with the amount of help ... available in this situation". However, he was less optimistic about the prospects for ongoing treatment, as "... the doctors basically provide [help] on a crisis management [basis]".

Very few participants commented directly on accountability within the mental health system, although a number of them did allude to this issue in their general assessment of the system. What emerged from the interview data was an indirect connection between the principles of accountability and continuity of care.

Ideally, a community-based system of mental health care should be responsible for providing patients with a consistent care plan across various agencies and institutions. Given that some mentally disordered persons are involved in more than one system, the "continuity of care" service principle[5] should be carried over to the other systems in which these persons find themselves. Yet, in practice, this principle does not seem to carry much weight. Two participants cited situations in which individuals were caught in a conflict between two independent systems. Psychiatrist 2 maintained that an attitude of "It's not our department; you take care of it" facilitates an evasion of responsibility for providing help to service-dependent clients.

According to the GVMHS administrator (Administrator 1), the mental health system often finds itself in a "Mexican stand-off" with the Ministry of Labour over the issue of dual-diagnosis clients. Prior to October 1991, the Ministry of Labour[6] was technically responsible for providing drug and alcohol treatment programs; however, the Ministry maintained that persons who were also affected by psychiatric disorders should be treated within the mental health system.

Apparently, similar dynamics occur between the mental health and criminal justice systems. From Psychiatrist 2's perspective,

> ... the criminal justice system takes the view that mentally disordered offenders are our problem; they don't have the resources to deal with this group. I've noticed ... that if they don't have the time or the skills to deal with something, it is easier to shift the responsibility to someone else. My attitude is that the criminal justice system should provide proper care for [them], wherever they are in that system.

[5](cf., **The Mental Health Consultation Report**, 1987:3).

[6]Following the 1991 election, the NDP government shifted the responsibility for providing drug and alcohol treatment from the Ministry of Labour to the Ministry of Health.

Despite this criticism, the same respondent seems optimistic that this approach is changing, based on his comment that he is "... impressed with some of the initiatives and programs that are beginning to be developed in the jails". He is steadfast in his conviction that "... [mental patients] get the care they need, whether it be in the mental health system as inpatients or outpatients, or in the criminal justice system".

Although the **Draft Plan** clearly spells out service delivery responsibilities of the mental health system[7], it fails to delineate a hierarchy of accountability: specifically, to whom the system is or should be accountable. According to two professionals, it is "the community" and "the clientele" who must ultimately guide and assess the quality of service delivery. Indeed, the director of one organization (Administrator 6) claims that "[accountability] ... comes with more community input into decisions. The community is more aware and takes on more of a watchdog role when it is actively involved in [a] decision-making role". In her opinion, "[we] need to have medical professionals, patients and families involved in decision making and working together". Psychiatrist 2 recommends establishing community boards to increase the overall accountability of the system. He also advocates that evaluations of the mental health system be conducted by independent academic researchers. In his opinion, "... the universities should not take the attitude of being ivory towers, detached from these kinds of issues".

Neither of these respondents clearly stated what they meant by the term "community". Indeed, much of the literature suggests that, from its inception onward, the deinstitutionalization movement has relied upon the rhetoric of a communitarian ideology (cf., Cohen, 1985; Isaac & Armat, 1990). In this context, "community" is romanticized and portrayed as a place of "... open warmth ... concern and capability" (Jones, 1986:48; cited in

[7]According to the service principles set out in the background to the **Report**, "the mental health system should be accountable for the quality and efficiency of the care that it delivers to enhance effectiveness and efficiency of services" (1987:3).

Isaac & Armat, 1990:287). In practice, "community" means either immediate family (Isaac & Armat, 1990) or the service-dependent ghetto of the inner city (Dear & Wolch, 1987). Despite the obvious discrepancy between rhetoric and what actually exists, the widespread political appeal of "community" persists[8] and is seldom questioned by professionals or lay persons.

Coordination among Agencies

According to Psychiatrist 2, a responsible mental health system requires *both* accountability and the coordination of services. Participants' opinions on the level of coordination between agencies and systems which provide mental health care are somewhat divergent. Respondents suggest that while a certain amount of coordination occurs both formally through the Multi-Service Network (MSN) and informally through workers' initiatives, there is no mechanism or structure in place to administer inter-agency arrangements in the system, overall.

Several community workers indicated that they liaised with other agencies and systems as needed. As a care team employee (Administrator 3) pointed out, "... in responding to clients ... you do whatever is necessary; this often involves coordinating resources ...". Community Worker 1 made a regular policy of calling a case-conference for persons involved with several agencies. In his opinion, "[the] advantage of a consultative approach [is that it results in] greater coordination [and] fewer conflicting directions ...".

Two of the respondents (the Court Worker and Administrator 5) maintained that, overall, coordination and lines of communications among agencies were generally very good. They commented that the problem is that, on many occasions, many of the workers are simply too busy to return phone-calls. According to Administrator 5, as staff become

[8]See Cohen (1985:117-123) for a more in-depth analysis of the symbolic power and iconography associated with the rhetoric of "community".

increasingly "over-loaded and stressed ... the quality of communications [between agencies] ... decreases".

At a broader level, several front-line workers identified the Multi-Service Network and GVMHS as centres of coordination for many of the organizations within the Greater Vancouver area. Despite the improvements associated with the advent of MSN and GVMHS, there is still a perceived overall lack of coordination between in-patient facilities and community agencies. As the Professor of Nursing remarked, based on her conversations with staff at emergency shelters, "it sounds as though the hospital needs to coordinate its planning more with the community services. We need to provide [more] case-management".

Mental Health Coordinator 3 indicated that while the coordination among services is good, he did not foresee the establishment of an overarching coordinating structure[9], given the "... many different opinions and factions within the system". According to the **Draft Plan** co-author, the installation of such a central mental health authority "... would be very difficult ... in the lower mainland because there are so many powerful players, each with their own agendas. Trying to establish a system of coordination between Ministries is even more difficult, for the same kinds of reasons."

Whether or not centralization is feasible, a number of respondents clearly believed that increased coordination, at least between in-patient and out-patient services, would improve the delivery of services to mental health service patients.

Recommendations for Change

I asked all 21 individuals in the professional cohort to suggest how community-based mental health services could be improved. The outcome of this survey[10] is an

[9]Nor was he particularly enthusiastic about such a development. In his opinion, "diversity makes for a creative system".

[10]The results are based on the responses of 19 people. Crown Counsel stated that the availability of beds is his main concern. The jail doctor chose not to answer this question, due to his lack of familiarity with the community-based system.

extensive list of proposals (see Table 5.1) ranging from providing more support services to patients' families, to empowering Justices of the Peace to divert mentally ill offenders out of the criminal justice system and into treatment facilities. Several distinct categories of recommendations emerged from the entire list of suggestions.

Ten respondents stressed the urgent need for more housing and/or shelters for psychiatrically disabled persons in the Downtown East Side of Vancouver. As one shelter employee (Community Worker 2) pointed out, "there is a high turn-away rate in a hell of a lot of places but there are no other places for people to go [to] if they are turned away from the shelters". In addition, two participants (Community Worker 3 and Psychiatrist 1) indicated they would like to see more qualified staff in psychiatric boarding homes. Mental Health Coordinator 1 recommended having more highly skilled home-maker services available to mental health clients.

An increased focus on the recreational/social needs of psychiatrically disabled persons ranked as the second most frequent concern among respondents (N=9). One participant maintained that "[mental health patients] need more recreational opportunities, more constructive things to do with their time". Mental Health Coordinator 3 recommended going out and doing activities without turning such events into therapy sessions. In his opinion, community workers "... have to see the clients as having something to give, to contribute in a social situation". Five respondents adamantly insisted that a drop-in centre accessible after-hours and on weekends would make a big difference to mentally disordered people who get into crises at those times. A mental health director at MHES (Administrator 5) suggested that "if we [opened a 24 hour drop-in centre], the downtown area would start to look a lot different at night".

Over half of the professional cohort stated that more financial and human resources are essential, both for improving existing services and for creating new facilities and programs. Three participants wanted more acute care beds available in the Downtown East

TABLE 5.1: PROFESSIONALS' RECOMMENDATIONS FOR CHANGE

RECOMMENDATION	# PROFESSIONALS
More Housing*	10
More Recreational Opportunities+	9
Additional Services	6
More Human Resources	6
Public Education	4
Flexibility in Treatment Philosophy	4
Increased Coordination	4
Acute Care Facility	3
Vocational Rehab. Programs	3
Increased Financial Assistance	3
More Community Involvement	3
More Consumer Input	2
Decentralization/Regionalization	2
Training Programs for Staff	1
Support for Families	1
Divert from Criminal Justice System	1

* Housing entails better quality housing, trained staff in boarding homes and access to home support services.

+ Recreation includes the suggestion to build an after-hours drop-in centre in the Downtown East Side of Vancouver.

Side. One of these (Administrator 4) specifically proposed having a *locked* acute care facility in the area "... to deal with patients who are in crisis, or who engage in violent behaviour and can't be dealt with in a general hospital ...." It is not clear from the data whether other front-line workers would support the idea of a locked facility[11].

Mental Health Coordinator 1 indicated that she would like to see several new services established, including: "[a] variety of drug and alcohol treatment programs for dual-diagnosis individuals; an additional IMP project with a slightly different mandate; [and] a new facility for women that would offer more safety and security for female chronic mental patients". This individual is unique in being the only participant to consider the issue of personal safety for women clients in the Downtown East Side.

A number of mental health workers advocated more staff for existing services. Six persons recommended fortifying the number of employees available for outreach and case-management work. As Psychiatrist 1 pointed out, "building new facilities is one thing, getting personnel to staff the places and provide care is another matter". As an intermediate step, he suggested having "... more outreach workers attached to hospitals and care teams".

Four individuals stressed the need for more public education. As two of the four pointed out, misconceptions about mental illness are all too prevalent in our society (cf., Herman, 1987; Johnson, 1990). Indeed, Community Worker 1 emphasized the importance of teaching the public that "... [mental health clients] are not dangerous, sexual deviants, nor are they stupid". According to a shelter employee (Administrator 2), education aimed at debunking these myths and stereotypes is crucial to garnering widespread support for mental health concerns. As she pointed out, "we can't get housing without public support". She also declared that "... we must make [mental health] a higher priority at the provincial [government] level".

[11]He anticipated a lot of opposition from patients' rights advocates, from residents in the area and, possibly, from other mental health professionals.

In addition to public education, other participants prescribed better dissemination of information to patients and more training for personnel in community facilities. Specifically, the director of a residential facility (Administrator 4) recommended enhancing the repertoire of intervention skills among front-line staff. In his opinion, "... pushing pills is not just the only answer". His comment seems to reflect other professionals' opinions that mental health care, at present, over-emphasizes the clinical aspects of treatment.

Indeed, four of the respondents maintained that greater flexibility in the delivery of treatment services was needed. In one shelter worker's opinion (Administrator 2), the system ought to examine disability issues and make some decisions around such concerns: "... we don't want services that are restricted to diagnosis". Community Worker 1 recommended that mental health workers adopt a "[more] eclectic, holistic approach to helping [people]". According to a Professor of Nursing, "we need to consider that the concept of mental health ... encompasses the whole quality of a person's life". This philosophy is further reflected in the MHES director's (Administrator 5) argument that service providers ought to reconsider the "nine-to-five" approach to service delivery and adapt a bit more to the clients:

> ... service providers [are] trying to get clients to fit this ... agenda and it just doesn't work like that. With the existing approach, we can keep our clients alive and in the community but the quality of life is not there; clients have no-one to talk to after 5 p.m.

Several participants recommended soliciting more input from communities and clients, regarding the provision of mental health services. Two were in favour of encouraging municipalities to identify their service delivery preferences. Others firmly believed that service-dependent populations ought to be consulted about their needs. As Administrator 5 stressed, "... there must be a dialogue between the care-givers and the [clients] ... then they could go to the administrators to suggest changes." According to the

director of another agency (Administrator 6), clients should be taught the skills that would enable them to participate in the decision-making process as equals, rather than as token objects of agency intervention.

The police officer and Psychiatrist 1 maintained that new services ought to be spread out more evenly within B.C.'s lower mainland. According to the police officer, "[the government] should send the money to other areas that they want to send these people to". In his opinion, the Downtown East Side "is past its saturation point; it just can't absorb any more people". Furthermore, he thought that chronic mental patients would find it easier to readjust to community life in quieter, safer suburban areas, rather than in an inner-city neighbourhood. However, he was pessimistic about the likelihood of establishing these resources in other areas. In the following subsection, I consider some of the impediments to change that may be responsible for such a bleak appraisal.

Barriers to Implementing Changes

The data suggest that, overall, participants in the professional cohort recognize that the prospects for change are dependent on both the economic climate and the political will of the governing party. Respondents identified a number of political barriers to transforming the mental health system.

Four individuals noted a lack of interest in mental health issues as one of the major reasons for the deterioration of service delivery. Clearly such concerns were not a priority for the Social Credit Government[12] in 1991. As Community Worker 1 observed, "they were for business, not social services".

The GVMHS manager (Administrator 1) alluded to in-fighting and power struggles within the bureaucratic structure of the mental health apparatus that might have

[12]Although mental health was an election issue for the New Democratic Party prior to its victory in the 1991 provincial election (see Chapter II), there is evidence that this is no longer the case (cf., Watson, **The Province**, March 10, 1993:A32; Rees, **The Province**, February 14, 1993:A10-11).

consequences for the realization of the **Draft Plan**. According to his description, mental health "... is a funny little backwater in the overall provincial system. [There] are a lot of little chiefs who want a piece of the pie". Furthermore, "... at the deputy minister level, you get these creatures called 'politicrats'; they are a cross between politicians and bureaucrats. Some of them are susceptible to the slightest political breeze. It makes it impossible at the lower levels to know what goes on".

It is quite possible that some "politicrats" (Administrator 1) may also be sensitive to the political mood of the public. According to the co-author of the **Draft Plan**, "Cabinet makes its decisions based on public perception and understanding of mental illness ...". Given the uncritical acceptance of misconceptions and stereotypes about mental illness in our society (cf., Herman, 1987), one can easily see why mental health remains a low priority on the funding list.

A lack of political will, most likely based on misinformation about mental illness, also hampers the development of community services and facilities in some residential areas. Politically organized communities are often successful in mounting opposition to the creation of mental health services in their neighbourhoods (cf., Scull, 1984). As the police officer wryly observed, it is the locales with "weak political clout" that become hosts to complex networks of service agencies.

Even if the will to improve the mental health system did exist, the fiscal implications would also have to be addressed. Although the provincial court judge maintained that bureaucrats would happily spend money on treatment facilities if funds were available, other participants were less optimistic. As one outreach employee (Community Worker 1) pointed out, it would be "... naive to believe ... that you can just pull money out of a hat to solve problems ...." The MPA Court Worker believed that even the social democratic NDP "[would not] be able to put that much money into improving services".

Four mental health professionals remarked that even though $20 million has been earmarked by the Ministry of Health as enhancement funds, this represented little more than a "drop in the bucket". According to Administrator 1's calculations, $20 million "... turns out to be not very much, per capita. In real terms, you are not talking about a lot of staff at [the] front line". An MHRS employee (Community Worker 3) questioned whether the services could keep up with the numbers of clients, even with the extra resources that were to become available to the system.

Despite these various obstacles, some respondents nonetheless voiced a guarded optimism about improvements that might be implemented in a different political and economic climate. Mental Health Coordinator 3 predicted that if the government followed through on its funding commitment, the mental health system could be in for better times. However, he balanced this forecast with a certain degree of scepticism, based on the United States' experience with deinstitutionalization.

On the basis of a small cash flow that was made available in the earliest stages of implementing the **Draft Plan**, some participants maintained it was realistic to expect an increase in staffing for front-line services. Furthermore, three respondents anticipated seeing some new facilities, such as a drop-in centre, at some point in the foreseeable future.

Two mental health professionals focused on improvements that might be attained at the (then) current level of funding. Psychiatrist 1 argued that some authority mechanism could be implemented for regulating the quality of residential facilities. The MHES director (Administrator 5) proposed that agencies become less bureaucratized in their approach, and emphasize boosting morale by rewarding mental health workers for what they are able to accomplish with limited resources. It is conceivable that such an enhanced working environment might in turn foster a positive shift in attitude toward mental health patients.

In the remainder of this chapter I review the interview responses of mental health patients themselves.

Consulting the Clients: "What ails thee?"

The following sections canvass four main areas: views on community living; quality of life; opinions about the mental health and social services systems; and suggestions for improving service delivery.

Community Living

I asked several questions pertaining to clients' experiences with community living. While most participants preferred living in the community when they were feeling mentally stable, they stressed the importance of having access to a place like Riverview when the need arose.

Furthermore, respondents' attitudes toward community living were related to the specific area of the city in which they lived (i.e., the Downtown East Side, in contrast to the West side or the West End) and on their perceptions of other people who lived in the neighbourhood. For example, shelter residents perceived their fellow lodgers more positively than other people whom they knew in the Downtown East Side. However, my conversations with several of the tenants also revealed a slight undercurrent of animosity towards some of the more disruptive emergency clients staying at that facility.

Although most of the shelter clients appreciated the increased freedom associated with community living and the proximity of the shelter to other service agencies, very few of them actually enjoyed life in the Downtown East Side. In the words of one individual (Client 7): "I don't like living in this community; it's dangerous in this area. No one wants to live this kind of skid row lifestyle, but I just make the best of my situation".

At least three of the male respondents from the shelter expressed concern about the violence and lack of social conscience which seem to pervade the inner city. One person (Client 8) explained that "in this community, more generally, people are rotten to each other.

They'll kill someone for twenty dollars". One of the female participants I interviewed at the shelter (Client 2) alluded to an incident in which she had been victimized[13]. Another woman (Client 6) voiced her fears about becoming involved in — or victimized by — the drug trade which exists in the area.

In contrast to the shelter residents, eight of the nine *Coast* clients liked the neighbourhoods in which they resided. While they may not have appreciated specific elements of their residence in the West End of the city, such as the volume of traffic or the "... bloody sirens going at all hours ..." (Client 18), they were generally satisfied with their accommodations. Unlike their counterparts in the shelter, the *Coast* clients did not seem to experience a high level of perceived threat to their personal safety on a daily basis.

Quality of Life

The overall quality of life for mental health patients depends on several variables. In addition to shelter, as discussed above, the financial ability to meet other basic needs, the opportunity to participate in social and recreational events, and the chance to engage in meaningful time-structuring activities are important considerations in evaluating the standard of living experienced by psychiatric patients.

Squalid living conditions, high rents, lack of money for food, social isolation and other stresses associated with living in the inner city all contribute to the likelihood of subsequent mental breakdowns among discharged psychiatric patients. In fact, two respondents specifically identified poverty as triggering episodes of acute crises. However, clients' levels of functioning also seem to influence where they end up living, and the kinds of recreational or vocational programs that are available to them. Lower-functioning, less

[13]She was not willing to discuss this experience in more detail; therefore, I was unable to determine (1) the nature of the victimization and (2) how/whether she chose to deal with the situation. I would surmise, based on my interview with Mental Health Coordinator 1, that incidences of violence against female chronic mental patients probably occur more often than they are formally reported.

stable individuals are more likely to find themselves in poorer surroundings and with fewer options.

Overall, the *Coast* tenants I interviewed were generally quite stable and seemed to lead more fullfilling lives than their counterparts in the shelter. For example, two of the female *Coast* tenants (Clients 11 and 12) had both enrolled in community college courses, and several people had volunteer jobs with which they seemed happy. In contrast, many of the shelter residents spent their days playing cards, watching T.V. or wandering around the streets of the Downtown East Side. While some of these individuals (e.g., Client 2) claimed to enjoy their lifestyle, others (Client 3) were dissatisfied with the lack of structured activities available to them.

During my visits to the shelter, I detected an undercurrent of indifference, low motivation and despondency among many of the clients. For emergency clients, a common experience was the lack of stability in their lives. For many of them, it seemed that mere survival was a continuous struggle. Long-term tenants appeared to have resigned themselves to their lot in life. A few of them gave the impression that they had lost the will and the energy to fight for anything more, and that it was futile to question authorities or to demand a better quality of life.

The Patients' Evaluation of the Service Network

All of the mental health clients in my sample were receiving financial assistance at the time I collected my data. Participants from both the shelter and *Coast* articulated two major criticisms of the services provided through MSSH. First, dissatisfaction was expressed with the amount of income assistance they received from the provincial welfare system. Welfare rates varied from a low of $525 to a high of $695 monthly. A married couple in the sample received a combined total of approximately $1,000 per month. Needless to say, these partners had to budget carefully to make ends meet.

One individual (Client 15) pointed out that "the rates are so low, most people are just barely surviving". A *Coast* tenant (Client 11) offered the following opinion of the welfare rates: "[They're] awful, inadequate. The rates for the 1990s are disproportionate to the costs of living. The system is geared toward getting people off assistance and into work programs" One of the shelter residents (Client 3) concluded that "the welfare system in English Canada is too capitalist. I don't think the government in this province cares about people". Others maintained that social services were doing the best they could, with the limited resources available to them.

The second major criticism of the welfare system in this province related to the attitude of social workers towards mental health clients. Almost half the respondents in this cohort were dissatisfied with how they have been treated by financial aid workers[14]. My impression is that they perceived social workers as unhelpful, unknowledgeable, rude, patronizing and lacking in compassion.

I also canvassed opinions on the community mental health system. Overall, participants ranged from describing the care teams as helpful and caring but overburdened with large caseloads, to perceiving the doctors as inexperienced, ineffective, difficult to relate to and lacking in concern for their patients. A widespread complaint was the lack of attention and time afforded to patients by the care team doctors. One person (Client 8) commented that the doctors do not do anything other than administer or adjust medications.

A female tenant from *Coast* (Client 11) argued that, in practice, the treatment provided by the care teams is oriented towards the management and control of psychiatric clientele. She observed that "it is really sad to see some people checking everything with their therapist. It can be really demeaning; most mental health patients accept it even if they don't like it".

[14] At the same time, eight participants did express a positive opinion of social workers, and a few had not given the issue much thought.

A few people (e.g., Client 6) indicated that they would like to see more job training programs. Another individual expressed frustration at the lack of information he received from social workers about the availability of rehabilitation programs.

Suggestions for a More User-Friendly System

I asked what kind of changes clients would like to see in the delivery of mental health and social services. The general consensus was that social workers ought to treat people with more respect and compassion. One individual (Client 1) stated that he would like to see "more down-to-earth human beings in social services; not people who've never been on the skids. [Furthermore], they should spend some time on the skids to know what it's like". One of the males from the shelter (Client 3) recommended assigning one financial aid worker to oversee specific clients' files. In his opinion, it was frustrating having to deal with a different person every time he contacted the Social Services office.

Another participant (Client 18) offered the following opinions on the delivery of social services in Vancouver:

> I ... think there is a real need for widespread re-education of personnel in social services; they tend to be very patronizing. Many people really dislike welfare workers. There are some individuals in the system who try to do a good job with the limited resources available and the large case-loads, but some of the welfare workers really despise the people they work with and they have a bad attitude. You see the same thing in mental health, too, but most of the people on the receiving end of these services are too passive to stand up to these workers.

One of the women tenants from *Coast* (Client 11) believed that the care teams should focus less on management and control and "take a closer look at the family and social background of most of the patients". A male *Coast* resident (Client 18) maintained that mental health professionals: "... need to look at their own system and see what else can be done on tight budgets. The care teams have large caseloads, so how can they be expected to

give all the help that is needed?" Indeed, nearly all of the clients I interviewed appreciated that many of the limitations on the provision of care were due to the imbalance between the caseload sizes and number of staff, and that care teams did not have the financial resources to hire more workers.

Based on my discussions with mental health clients, it would appear that professionals who care about and listen to patients' concerns are also vital to helping clients cope in community settings. This suggests that, as per Client 18's recommendation, mental health professionals may have to reconsider their methods of service delivery, with a view to implementing a more holistic treatment approach on a "shoe-string" budget.

Mental health patients also asserted that safe, affordable housing and a decent amount of money to live on are critical factors in facilitating a reasonable level of mental stability. One shelter tenant (Client 6) stated that she would like to see mental health professionals "get jobs for people, get them off their meds, get them active and motivated, and spend more time with patients".

Prior to these interviews, several of the care providers had led me to expect mental health clients would state their experiences and concerns in very concrete, basic terms — for example, not having enough money to buy cigarettes or coffee. I was also given the impression that these people were unlikely to understand why their needs were not being adequately met by the mental health system. Consequently, I was surprised at the level of political awareness demonstrated by some persons in my sample. Contrary to expectations, they did appreciate the kinds of political-economic and ideological forces that influence the delivery of mental health and social services. As well, they offered informed and practical suggestions for improving service delivery within these two systems.

In retrospect, I would argue that by underestimating clients' levels of interest in and comprehension of social issues affecting their lives, care providers are doing a disservice to

these individuals. I share the view that mental health service patients ought to be encouraged to provic input into the quality and structure of service delivery.

Conclusions

Throughout this chapter, I have considered the efficacy of the mental health system through the eyes of two distinct groups: the front-line workers and the clients. I began by presenting an evaluation of service delivery from the perspective of front-line workers. It appears that most participants in this cohort subscribe to a more or less uniform "party line" on certain issues, ranging from their explanations for the inability of community-based mental health services to provide adequate care to patients, to their identification of specific impediments against improving the system.

Perceptions of clients' opinions of service delivery varied, to some extent, with the workers' proximity to the front-line. Often, those who had the most daily contact with service-dependent populations articulated the most accurate insights into the latter group's needs and opinions[15]. The degree of weight mental health personnel attached to their clients' perspectives, however, is another issue altogether. A few individuals such as the MHES worker (Administrator 5) maintained that mental health patients ought to be consulted on questions of mental health care. The majority of professionals' comments, however, reflected a typically bureaucratic, top-down attitude that the "experts know best". While it may be true that the experts know the most about how the system works, it is doubtful whether they are as well-versed on what it is like to be on the receiving end of mental health care.

In some ways, the themes that emerged out of the interviews with this cohort paralleled the concerns voiced by the care-givers. Clients also expressed concern about the

[15]Based on a comparison of workers' and clients' comments documented in the interview transcripts.

social conditions in which they found themselves, the need for a more holistic approach to community-based treatment, and the lack of financial and human resources required to fortify and improve service delivery. Unlike some of their professional counterparts, mental health clients were quite sensitive to the condescending attitudes that accompanied the delivery of care in both the mental health and social services systems.

It would appear that taking the time to listen to patients' perspectives on the quality of care, and their suggestions for improvements, might prove beneficial for both patients and care providers. Unlikely as it might initially appear, the two groups do share common concerns as well as similar outlooks on certain mental health issues. It might be to their mutual benefit to work together.

Since it is the recipients of mental health services and the front line-workers who are ultimately the most affected, surely both groups ought to be consulted prior to the implementation of mental health policies. Furthermore, it is important to involve clients as equals and to take their concerns seriously. It is also crucial that researchers and/or policy makers who choose to solicit patients' opinions and experiences should do so on the latter's terms. While it will take more than a compassionate inquiry to replenish the depleted state of the service-dependent ghetto, we should, nevertheless, be prepared to meet and talk with them in their own social context, and to ask them "what ails thee?".

In Chapter VI, I summarize and highlight the results of this study, including a brief review of professionals' views on the evolution of a social control network in Vancouver. I conclude by offering some predictions for the impact of the **Mental Health Consultation Report** (1987) on both the criminal justice and welfare systems.

CHAPTER VI

CONCLUSIONS

This chapter provides a summary and overview of the results of this thesis. I discuss my findings in the context of the research questions set out in the Introduction and conclude by speculating about the future impact of the 1987 **Draft Plan to Replace Riverview Hospital** on the three major systems implicated in the service delivery of mental health care in B.C.'s lower mainland.

Putting the Study into Theoretical Perspective

Chapter I of the thesis set out four theoretical models for explaining decarceration: the traditional/clinical perspective; the liberal critique of the anti-psychiatrists; critical structuralist theories; and a fourth approach which considered both Cohen's (1979) and Dear and Wolch's (1987) accounts of deinstitutionalization. The latter framework seeks to understand the shift to community-based mental health care in a spatial context: the inner city. The concepts of a "social control network" (Cohen, 1979, 1985) and a "service-dependent ghetto" (Dear & Wolch, 1987) were used extensively in this thesis to describe the amalgam of criminal justice, mental health and social service agencies which routinely interacted with chronic mental patients in the City of Vancouver. The data suggest that Cohen's extension of discipline thesis has some applicability to the community-based system of mental health care that has evolved in Vancouver over the last 20 years. **First**, although the patient population at Riverview Hospital has decreased dramatically during that period, it has not been completely phased out, despite the proliferation of community alternatives. **Second**, interview data from both mental health workers and patients suggest that some of the agencies responsible for providing mental health and social services do tend to exert both therapeutic and disciplinary control over clients. **Third**, the data analyzed in Chapter IV

indicate that blurring of boundaries has occurred in terms of agency functions, if not in a spatial sense.

One major intention of the thesis was to introduce a human element into both the theoretical and empirical components of the study. At the level of theory, this was achieved by incorporating Dear and Wolch's arguments (1987) that decarceration and the evolution of the service-dependent ghetto must be understood in terms of the interactions between human agency and structure. One theme that emerges out of Chapter II is that human agency indeed played an important role in shaping Vancouver's community mental health system. At the same time, key players' actions were also constrained by larger social forces.

Empirically, I have incorporated a humanistic element through my use of interviews with both mental health workers and chronic mental patients. Where possible I have reported participants' experiences and perceptions in their own words. Although the thesis did consider the consequences of deinstitutionalization from the perspectives of both front-line workers and clients, the emphasis was, in retrospect, more on the former than on the latter.

The Shaping of the Draft Plan

Government initiated actions such as the **Draft Plan** are neither created nor implemented in a social vacuum. Rather, they unfold in a particular context, influenced by political-economic, ideological and cultural forces, and human agency operating at a specific historical juncture. Chapter II provided a detailed account of the development of community-based mental health services in the Greater Vancouver region. This historical review considered in some detail how the aforementioned factors shaped this process. As well, it provided an appreciation of the social framework in which the realization of the **Draft Plan** has been played out.

A review of local reports and news stories highlighted a recurring theme in the mental health system of B.C. Specifically, Vancouver's network of community mental health agencies experienced repeated service delivery crises, from the early 1970s to the present. These periodic crises seemed to stem from a conjunction of two factors: (1) a fiscal commitment to the reallocation of existing resources, and (2) a covert ideological belief that mentally disordered persons are undeserving of adequate social assistance (see Chapter I). Similar to other jurisdictions (e.g., the United States), the deinstitutionalization movement in B.C. has traditionally been couched in humanitarian rhetoric (cf., Cohen, 1985, 1987).

The legacy of these particular themes appears to have been reproduced in both the conception and implementation of the 1987 **Draft Plan to Replace Riverview Hospital**. As mentioned in Chapter II, this document emerged in the midst of the Social Credit government's policy of economic restraint, enacted in the early 1980s. Concerns about escalating health care costs and the impact of increased spending on taxes (Ministry of Health, 1987:19) culminated in a fiscal strategy based on the reallocation of existing resources from Riverview Hospital to finance the development of replacement services in the community. This scheme aimed to placate competing concerns — increased spending versus fears about further cutbacks in social and mental health services — by incorporating observations and recommendations that appeared to please everybody. Statements hinting at providing improvements on a limited budget were juxtaposed with a clearly stated commitment to maintaining existing resources. As Noone (1988) points out, such an approach is inherently contradictory and the **Draft Plan** could not be implemented successfully.

Despite the attempt to satisfy all concerned parties, the data suggest that many front-line workers have concluded that the **Draft Plan** was, after all, primarily concerned with cost containment rather than service enhancement (see Chapters IV and V). Furthermore, as highlighted in Chapter IV, during early 1991 personnel in front-line service agencies

continued to perceive the system as being in crisis: under-funded, short-staffed and stretched beyond its capacity to provide adequate care.

Like its predecessors, the 1987 **Mental Health Consultation Report** is also informed by an emphasis on communitarian ideologies. The continued use of community-based care is portrayed as more humane, and as a more "normalizing" experience. The accompanying rhetoric does not clearly define what is meant by "community", although, typically, the iconography evokes nostalgic depictions of chronic mental patients receiving rehabilitative and clinical services in a supportive, neighbourly setting (cf., Cohen, 1985).

The concept of "community" also elicits expectations that families and relatives will assume the role of primary care providers. However, according to several of the mental health professionals in the sample, patients' relatives are not generally provided with the assistance and resources necessary to successfully carry out this role (see Chapters IV and V; also see Isaac & Armat, 1990). Furthermore, recommendations which emphasize "... the vital role of families in the rehabilitation [process]..." (Ministry of Health, 1987:8) fail to consider the possibilities that: (1) many older, chronic mental patients have few, if any, family ties and (2) having adult patients live with their families may *not* be the best arrangement for either party. Finally, as pointed out in Chapters I and V, the very neighbourhoods which are portrayed as offering a supportive and stable environment for mental health clients are usually the same communities that exhibit the "Not In My Back-Yard" (NIMBY) syndrome and are successful in preventing the development of residential facilities or community agencies in their locales. Consequently, many mentally disordered individuals find themselves residing in the service-dependent ghetto of the Downtown East Side of Vancouver. In this respect, the deinstitutionalization phenomenon in Vancouver has followed a similar pattern to that which has unfolded in the United States – and with similar, albeit less severe, consequences to those discussed in Chapter I.

The Draft Plan Through the Eyes of the Professional Cohort

As indicated in Chapter IV, not all organizations within the social control network have been affected to the same extent by the implementation of the **Draft Plan**. For example, with the exception of the police, respondents from the criminal justice system maintained that this document had not affected the frequency of their interactions with mentally disordered offenders. Unfortunately, no aggregate statistics were made available by these agencies to verify interviewees' observations. Some participants from the mental health system reported pressures from increased caseloads, yet the quantitative data do not necessarily support their perceptions in all cases.

Nevertheless, based on the experiences of mental health professionals and front-line workers, it would appear that some general consequences of implementing the 1987 **Draft Plan** include: pressures from increased caseloads and insufficient services; heavier work demands on staff; and frustration at being unable to hospitalize clients who are experiencing episodes of acute crises. This situation seems to have arisen, in part, as a result of belated efforts to secure both bridge and enhancement funds required to shore up these services before discharging patients.

Furthermore, a number of front-line workers have observed a shift in client characteristics. Both deinstitutionalized and non-institutionalized patients appear to have, in recent years, become more chronic. These individuals need more services and extended contacts over longer time periods. Furthermore, they are generally more time-intensive, exhibiting precisely those qualities that exclude them from many residential facilities and agencies. Many of the community-based services are unwilling to deal with disruptive clients who behave inappropriately and who demand more time and resources than these organizations are able to provide. Additional changes in client characteristics include a decrease in the average age of the mentally disabled; growing numbers of women drifting

into the Downtown East Side; and an increase in the incidence of illicit drug use among chronic mental patients.

The consequences of changing client demographics and caseload sizes are reflected in: (1) the increasing magnitude of the revolving door syndrome; (2) the changing mandate of emergency shelters; and, (3) the expanded role of the criminal justice system as gate-keeper to the mental health system. As pointed out in Chapter IV, a number of mental health clients find themselves circulated between hospitals, shelters, welfare hotels, the streets and occasionally the criminal justice system. The lack of stable, suitable housing for these individuals means that they are periodically homeless, if not shelterless. A vicious circle is created in which chronic mental patients are placed in squalid social conditions and then experience subsequent breakdowns and crises. Compounding these difficulties are the frustration and anger felt by many of these people in response to the apparently rude treatment afforded them by the very agencies on which they depend for assistance. They are hospitalized briefly, often for as little as 48 hours, and then are discharged into the *same* impoverished, alienating environment that had likely precipitated their crises.

In addition, some evidence emerged out of the interviews to suggest that emergency shelters are functioning as "mini-institutions" and/or half-way houses for psychiatrically disabled persons, despite the fact that these facilities are not equipped to deal with mental health crises. In the absence of more appropriate alternatives, the shelters have stepped in to provide a safety net for individuals who have fallen through the service cracks. Places such as Lookout are often the last resort before a person finds him or herself on the street.

The criminal justice system has also been recruited both as a gate-keeper for the mental health system and as a provider of services. On some occasions, an encounter with the criminal justice system is the first indication that a person may have mental health difficulties. In other situations, a chronic mental patient might act out as a means of getting the help she or he requires. In an effort to provide services, the Pretrial Detention Centre has

established a special unit for mentally disordered offenders. Probation also offers programs for this group of offenders through IMP. Even one of the authors of the **Draft Plan** admitted that increasing numbers of mentally ill persons are being shunted into the criminal justice system. Indeed, the **Draft Plan** specifically identifies the Ministry of Attorney General as a player in the delivery of mental health services.

The Social Control Network

It appears that approximately 10 to 15% of chronic mental patients are caught up in the criminal justice system and social services, in addition to the mental health system. The very existence of services such as IMP, MSN and the MPA Court Worker Project attests to the reality of a growing trend toward the transcarceration of mentally disordered persons in the service-dependent ghetto.

Mental health and criminal justice professionals varied in their explanations of this phenomenon. For example, one individual (Administrator 1) perceived this trend as a casualty of the post-deinstitutionalization era, and as applicable mostly to the new young chronics. Others conceptualized transinstitutionalization at a more structural level. An employee at one of the shelters (Community Worker 2) maintained that poverty and a lack of adequate resources played a role in determining which mental health clients are more likely to come to the attention of the criminal justice system: specifically, those individuals who are on the streets are more likely to be picked up by the police. Other community employees (Administrator 2) maintained that some mental health patients act out and come to the attention of the criminal justice system as a coping strategy. In other words, psychiatric patients know that if they "... act really crazy and do something either to themselves or others, they will get the help they need".

Opinions as to whether mentally disordered persons should be dealt with in the criminal justice system varied widely across the professional cohort. On the one hand, some

criminal justice and mental health professionals adamantly believed that the criminal justice system is a totally inappropriate arena for dealing with mental health-related problems. On the other hand, several front-line workers maintained that such individuals should be held accountable for their actions if they are taking their medications and know that their actions are wrong. However, these same community workers also expressed ambivalence as to whether jails are really the best place for mentally disordered offenders, at least as such facilities are currently structured and organized.

At a more general level, one participant, the Professor of Nursing, remarked that it is both a waste of resources and counter-productive for mental health clients to be "... bouncing from one system to another in order to get their needs met". Another individual (Administrator 5) concluded that psychiatric patients would not have to act out and seek help from other systems if they had not been failed by their own system of care.

Mental Health Professionals' Evaluation of the Draft Plan

According to one mental health professional (Psychiatrist 2), the recommendations outlined in the **Draft Plan** must be evaluated in light of the true intent of the document: namely, cost containment or system enhancement. Based on the responses of 14 of the participants in this cohort, one can readily conclude that, within the sample, a majority of these respondents were dissatisfied with how this initiative was unfolding in the early stages of implementation. As indicated in Chapter IV, a number of interviewees were disappointed with how poorly organized the government seemed to be with respect to shoring up existing services and housing, in fostering public acceptance through education, and so on, before discharging more patients from Riverview Hospital. Two individuals conceded that some funds had been loosened up and that a few recommendations were being implemented on a haphazard basis. But, overall, there was a general consensus that, at the time, the process was disappointing at best and a complete disaster at worst.

Many of the front-line workers and professionals within the mental health system have concluded that the true intent of the **Draft Plan** was, after all, cost containment rather than service enhancement. From the perspective of the community workers, it is difficult to believe that the intent could be anything else, given that so few of the recommendations were put into place prior to discharging additional patients from Riverview Hospital. Follow-up data to determine whether interviewees have revised their opinions as this process continues to unfold would provide a useful resource for on-going assessment.

While evaluating the service principles espoused in the **Draft Plan**, several recurring themes emerged from the data. **First**, a number of respondents from the professional cohort criticized the lack of adequate housing, financial support and other non-clinical services available to chronic mental patients. Furthermore, accessibility to existing programs is limited to mental health patients who are stable, medication compliant and relatively high functioning. **Second**, some mental health professionals berated the lack of accountability in providing continuity of care within and across systems. In situations where mentally disordered persons are involved in more than one system, there is a tendency to evade responsibility, particularly if such organizations are not equipped to deal with mental health concerns. **Finally**, when assessing the level of coordination between agencies and systems, participants' opinions were quite divergent. While some thought that the level of communications between agencies is quite good, given the constraints on resources, others maintained that hospitals ought to consult with community-based services on a more consistent basis.

Overall, the data suggest that although there is certainly room for improvement in Vancouver's community mental health system, the situation here is not as dire as it is in some cities in the United States. Nevertheless, shortages in human and material resources have resulted in yet another crisis in service delivery. Clearly, these crises do have profound

consequences for the mental health patients who depend on this service network for their survival outside of a hospital setting.

The Impact of the Draft Plan on Mental Health Clients

Based on the interview data, the following observations can be stated about the **Draft Plan**'s impact on the lives of mental health patients. **First**, it is questionable whether increased freedom in the community is an acceptable trade-off for not having their needs adequately met. Indeed, one must question whether such individuals do have any real freedom, given that they must rely on mental health and social service agencies if they are to survive in the "community". Quite often mental health clients must endure what they perceive as brusque, patronizing attitudes by the personnel in some of these organizations. About half the respondents in the client cohort expressed their dissatisfaction with the poor treatment afforded to them by social service and mental health workers. Another common complaint was that the care-team doctors seemed preoccupied with prescribing medications and apparently had little time to listen to patients' concerns. Many clients did recognize that mental health and social services workers were doing the best they could, given that such agencies lacked sufficient funding and staff .

Second, many of the chronic mental patients living in the Downtown East Side are oppressed by their impoverished living conditions (see Chapters IV and V). It requires a great stretch of the imagination to accept that such individuals are revelling in their increased freedom, given their bleak social environment. According to an outreach employee (Community Worker 1) and MHES personnel (Administrator 5), mentally disordered persons who have fallen through the service cracks struggle to survive. Often they are victimized by others and/or exploited by drug dealers in the area. Indeed, both males and females from the emergency shelter reported fears of being victimized on the streets in the Downtown East Side.

Very few of the participants from the emergency shelter actually enjoyed living in the Downtown East Side, yet they had resigned themselves to their lot in life. They had learned that it was futile to stand up for their rights or to hope for any improvements. Interestingly, the *Coast* clients seemed to have a better quality of life, although they also had to struggle to make ends meet financially. Overall, the clients in this latter group were more stable and secure; they were more involved in social activities and volunteer work; and several of them took a proactive role in determining the course of their treatment plans. The differences in the quality of life – and standard of living – between the *Coast* tenants and shelter residents highlight the heterogeneity of mental health patients and their life experiences. These differences also raise pertinent questions about why and how some mental health patients are able to avoid becoming ghettoized in the Downtown East Side.

Toward a More User-Friendly System of Care

As set out in Chapter V, both mental health professionals and patients were canvassed for their recommendations and suggestions for improvements. Mental health and criminal justice personnel offered a wide array of proposals, ranging from the need for more housing to diverting more mentally disordered persons out of the criminal justice system. Over half the participants in this cohort stressed that the availability of additional financial and human resources was crucial for improving current services and creating new programs. However, these respondents also recognized the existence of a number of political and economic barriers to transforming the mental health system in the lower mainland of B.C.

Mental health clients indicated they would prefer to deal with social workers and mental health workers who displayed more empathy, compassion and respect for patients. They also expressed an interest in receiving more financial support and more non-clinical programs. Furthermore, some of these participants were cognizant of the economic, political and ideological impediments to achieving such improvements.

Both clients and mental health workers emphasized the critical role of safe, affordable housing and a decent monthly income in facilitating mental stability. Supportive professionals who care about and listen to patients' concerns are also crucial to helping mental health patients cope in a community setting. The implications of these findings are clear. Ensuring that mental patients' basic requirements – e.g., shelter and food – are met should be one of the highest priorities in the process of implementing the **Draft Plan**. Furthermore, given the apparently increasing numbers of women mental health clients who are drifting into the Downtown East Side, there is a pressing need to establish more facilities and programs that consider the personal safety of these women.

Re-education of social services and mental health personnel vis-a-vis their interactions with clients should also be a priority in transforming the mental health system. It is time to move beyond the "expert knows best" approach to mental health service delivery. Steps must be taken to solicit clients' perspectives on the quality of care they are receiving, taking their concerns seriously and involving them as equals. Furthermore, such consultations ought to be conducted within the clients' own social habitat.

Since many of the clients and front-line staff appear to share similar perspectives and concerns about service delivery and specific mental health issues, it may be advisable for these two groups to work together and lobby for change. Here, too, clientele need to be treated as equals and taken seriously. At a more general level, policy makers should be consulting both clients and community workers prior to implementing mental health initiatives, as it is ultimately these two groups who are most affected by such actions.

Looking into the Future

As previously mentioned, the data for this thesis were collected in 1991 – during the earliest stages of implementing the **Draft Plan**. Although it is difficult to predict the future, I asked respondents in the professional cohort to speculate on the prospective impact of this

initiative on various social services, mental health and criminal justice agencies. Eleven of the 14 individuals who responded to this question thought that unless more resources were made available, the situation would deteriorate; that is, they expected to see further increases in caseload sizes and work stress, fewer services for clients, and more clients getting caught up in the criminal justice system. Only two individuals saw any glimmer of hope for a better system, and even then it was conditional on receiving more funding and establishing more coordination within the mental health system and with the criminal justice system. In short, the prognosis for an improved, adequately funded service network in the Downtown East Side does not look promising. There appear to be no easy formulas for removing the ideological and political-economic barriers to establishing a satisfactory community-based system of mental health service delivery. If these issues are not afforded a higher priority in developing social policies, we can expect to see the profound human costs of the deinstitutionalization movement so graphically depicted in the prevailing literature (see Chapter I) manifesting themselves in Vancouver over the course of the next decade.

APPENDIX A: TABLE 1
LIST OF RESPONDENTS

1. Provincial Court Judge (male)
2. Administrator 1 (Program Manager, community mental health service: male)
3. Administrator 2 (Director, emergency shelter: female)
4. Administrator 3 (community care team: male)
5. Administrator 4 (residential facility director: male)
6. Administrator 5 (Director of emergency services: female)
7. Administrator 6 (Director, self-help/advocacy organization: female)
8. Crown Counsel (male)
9. Mental Health Coordinator 1 (community mental health service: female)
10. Mental Health Coordinator 2 (outreach program: male)
11. Mental Health Coordinator 3 (community mental health service: male)
12. Community Worker 1 (outreach worker: male)
13. Community Worker 2 (emergency shelter: male)
14. Community Worker 3 (residential services: female)
15. Police Officer (Vancouver City Police: male)
16. Court Worker (female)
17. Nursing Professor (female)
18. Psychiatrist 1 (male)
19. Psychiatrist 2 (male)
20. Jail Doctor (male)
21. **Draft Plan** Co-author (male)
22. Client 1 (Emergency Shelter client: male)
23. Client 2 (Emergency Shelter tenant: female)
24. Client 3 (Emergency Shelter tenant: male)
25. Client 4 (Emergency Shelter client: male)
26. Client 5 (Emergency Shelter tenant: male)
27. Client 6 (Emergency Shelter tenant: female)
28. Client 7 (Emergency Shelter tenant: male)
29. Client 8 (Emergency Shelter tenant: male)
30. Client 9 (Emergency Shelter client: male)
31. Client 10 (Emergency Shelter client: male)
32. Client 11 (Satellite Housing tenant: female)
33. Client 12 (Satellite Housing tenant: female)
34. Client 13 (Satellite Housing tenant: female)
35. Client 14 (Satellite Housing tenant: male)
36. Client 15 (Satellite Housing tenant: male)
37. Client 16 (Satellite Housing tenant: female)
38. Client 17 (Subsidized Independent Housing: male)
39. Client 18 (Subsidized Independent Housing: male)
40. Client 19 (Subsidized Independent Housing: female)

APPENDIX A: TABLE 2
PARTICIPATING ORGANIZATIONS

Greater Vancouver Mental Health Services Society
Regional Crown Counsel, Ministry of Attorney General
Multi-Service Network (MSN)
Saint James' Social Services Society (SJSS)
Lookout Emergency Shelter
Strathcona Community Care Team
Mental Health Residential Services (MHRS)
Union Gospel Mission (UGM)
Inter-ministerial Project (IMP)
Cordova House (CH)
Vancouver City Police
Mental Patients' Association, Court Worker Project
Coast Foundation
Vancouver General Hospital, Psych. Assessment Unit
Mental Health Emergency Services (MHES)
B.C. Mental Health Society
Riverview Hospital
B.C. Schizophrenia Society (formerly B.C. Friends of Schizophrenia)

APPENDIX B

ETHICS PROTOCOL

Hi, my name is Sue Chambers. I am a second year M.A. student in the School of Criminology at Simon Fraser University. I am conducting research for my thesis project, entitled "Implementing The 1987 **Draft Plan** To Downsize Riverview Hospital: Expanding the Social Control Network". This project has the approval of my thesis committee and the University Research Ethics Committee. If you have any questions or concerns about the research, you may contact my supervisor Robert Menzies or myself.

One of my research questions focuses on the impact of this policy decision on community agencies and their clients. The purpose of this interview is to learn about **your** experiences with, perceptions of and responses to the impact(s) of implementing this policy. While you may not be able to answer all of the questions, your honesty and accuracy in answering the questions would be greatly appreciated.

I will not be taping this interview; rather, I shall be taking detailed notes. The information that you share with me will serve as my data and excerpts may be included in the final report of my thesis, but **under no circumstances** will your name or identifying characteristics be included in this report.

Thank you for your willingness to participate in this research project. Although your participation will not result in any personal benefit, your participation will contribute to a greater understanding of these issues and is very much appreciated. If you are interested, I will be happy to supply you with a copy of the results of my study, when they become available. Just before we start the interview, I would like to confirm that you are aware of your rights as a participant in this study:

1. Your participation in this interview is entirely voluntary and will carry no risks or harm to you.
2. Your decision to participate or not will have no effect on your relationship with your agency.
3. You are free to refuse to answer any question at any time.
4. You are free to terminate participation or to withdraw consent at any time.
5. You are welcome to ask me any questions desired at any point during the interview. I will make every effort to answer your questions as best as possible to your satisfaction.
6. You may bring any queries or complaints about the research to my thesis supervisor, the Director of the School of Criminology, or the Chairperson of the University Research Ethics Review Committee.

I would appreciate it if you would sign this form to show that I have read you its contents.

(signed)

(printed)

(dated)

Interview Guide: Professionals' Experiences and Perceptions

I. History

I would like to begin the interview by asking you some questions about yourself. Please tell me a little bit about your personal background? (Where were you were born? How long have you lived in Vancouver?)

1. a. Please tell me about your educational background?
   b. What factors led you to pursue a career in this field?
   c. When did you first become interested in the idea of a career in this field?
   d. Where did you work before you joined this organization?
   e. How long have you been working for this organization?
   f. How would you describe your role in this organization?
   g. Could you please discuss the history of this organization?
   h. How would you describe the mandate of this organization?

Based on your background and experiences, I would now like to ask you some questions about the attributes of your organization's clientele and some questions about your knowledge of other available resources for your clientele.

2. Could you identify any general characteristics across this group of individuals in terms of:
   a. Gender?
   Race?
   Age Group?
   Occupation?
   Educational Level?
   Income?
   Welfare?
   Housing?
   b. Are there any other characteristics across this group of individuals that stand out in your mind? If yes, how did you first come to notice this/these characteristic(s)?
   c. In your opinion, have there been any changes in the characteristics of this group in recent years?
   d. What factors might account for these changes? Social? Legal? Medical? Economic?
   e. Could you indicate the approximate size of your case-list? The total number of clients?
   f. In your opinion, have there been any significant changes in the size of this group in recent years? Since 1987?
   g. What factors might account for these changes?
3. a. What proportion of your clientele have a history of mental disorder? Of hospitalization?

b. Have there been any significant changes in this pattern in recent years? What factors might account for this trend?
c. Do you have any clients who are not involved in the mental health system? If yes, how do these clients differ from the mentally disordered clients?
d. Do you have any clients who are especially difficult to interact with?
If yes, what factors might account for these difficulties?
How does your organization respond to such clients?
What resources are available for these people?

4. a. Would you happen to know, overall, what resources are available for your clients in terms of:
Legal resources?
Social?
Medical?
Economic?
Vocational?

II. Impressions of Policy Implementation

***I would now like to ask you a series of questions about the 1987* Draft Plan to Replace Riverview Hospital.**

5. a. What do you know about this particular policy?
b. Could you tell me what your source of knowledge is, with respect to this policy?

6. a. Were you invited to participate in the consultative stage of the 1987 **Draft Plan to Replace Riverview Hospital**?
b. What has your response been to this involvement? Do you see this as positive? Negative?
c. Would you happen to know whether any other representatives from your organization were invited to participate in the consultative stage of the 1987 **Draft Plan to Replace Riverview Hospital**?
d. Would you happen to know which other groups were involved in this stage of the **Draft Plan**? Representatives from other community agencies? Mental health system? Social Services? Criminal justice system?

7. a. In your opinion, how well organized was the implementation of the **Draft Plan**?
b. What is your general impression of the implementation of this policy?
c. In your opinion have there been any successes? Could you discuss these?
d. In your opinion, have there been any failures? Could you discuss these?

8. a. What reasons would you attribute to a decision to de-institutionalize psychiatric hospitals?
b. Why do you think these hospitals close?
c. How do you view this trend?

9. a. In your opinion, how has the decision to phase out Riverview Hospital affected your organization's ability to operate efficiently?
b. Is the organization able to meet the needs of its clients?

c. In your opinion, what impact has this policy had on your clients?
d. What is your perception of the treatment needs of ex-psychiatric patients? Other needs?
e. In your opinion, what is the most appropriate arena for meeting the treatment needs of ex-psychiatric patients? Other needs?
f. In your opinion, are these needs being adequately met?
g. Would you happen to know whether any of your clients are also involved in the criminal justice system? The welfare system? Are clients often involved in more than one system (i.e. mental health - criminal justice/mental health-welfare)?
If yes, what are your thoughts on this phenomenon?
h. In your opinion, is this a psychiatric problem? A legal problem? A welfare problem? A combination?

10. a. Could you speculate on the implications that this policy decision may have for the practices of community agencies /services in relation to their clientele?
Other mental health services?
Social services (i.e. welfare)?
the criminal justice system?

III. Policies and Practices

I would now like to ask you some questions about the policies and practices employed by your organization, in relation to carrying out its mandate.

11. a. Could you explain your organization's policy on accepting new clients?
b. Are your clients referred to this organization? By whom? What role(s) do they play in the referral process? In establishing a suitable program to meet the needs of the client?

12. a. Is there a standard policy pertaining to the provision of services to clients? A standard practice? Is it applied in a uniform fashion by all of the case workers here?
b. Conversely, is there any discretion among case-workers?
c. Is it a flexible policy? Do decisions vary with the circumstances of the case?
d. Does this policy/practice work? What criteria of success would you employ to determine this?
e. Are there any constraints on the organization in terms of its ability to take on new cases, provide services?
If yes, please describe? Legal? Social? Availability of resources?

13. a. In general, how much knowledge does your organization have about other resources, social services, mental health services in this area?
b. Could you please indicate your familiarity with these other services?
c. Would you please discuss your opinion of these other services? In terms of effectiveness? Availability? Accessibility?

14. Do you think these services have been influenced at all by the decision to phase out Riverview Hospital? If yes, please explain how.

15. a. Are you satisfied with the range of services available to ex-psychiatric patients in the community? The quality of services? In your opinion, are other employees in your organization satisfied with the range of services available? What about administrators? Clients? Personnel in other organizations?
    b. If no, in your opinion, what changes could or should be implemented to improve on the present situation, vis-a-vis meeting the needs of chronic mental health patients in the community? What about increased coordination between services? Other suggestions?

IV. Suggestions for Changes

The remaining set of questions focuses on the kinds of changes you would like to see in this area and your overall assessment of the issue, as well as any additional comments or concerns.

16. a. Ideally, what factors would you like to see changed in order to increase the availability of services to mental health patients in the community? Accessibility? Accountability?
    b. How would you implement these changes?
17. Are there any other local social issues related to the downsizing of Riverview that you would like to see addressed?
18. a. At a pragmatic level, what changes could be realistically implemented? What type of treatment facilities/resources would you like to see established? Made better use of?
    b. Would you speculate on the political issues and implications of such changes? Would these be negative? Positive?
    c. What about fiscal considerations? Limitations on resources?
    d. In your opinion, how effective do you think such changes would be?
    e. How likely is it that such changes would be implemented, even if they could be implemented?
19. Overall, how would you assess the present ability of community services and agencies to meet the needs of their clients? The increased number of ex-mental patients getting caught up in the criminal justice and welfare systems in addition to the mental health system?
20. Are there any issues or concerns which you see as significant that I have overlooked?
21. Do you know of any individuals or organizations whom I should approach for additional information? Would these people be interested in talking to me?
22. Would it be possible to have access to any additional information about your organization (e.g., policy documents, statistics kept by the organization)?

V. Closing Statements

23. Before we conclude, I am interested in getting some feedback on your feelings about this interview. I was wondering if you could comment briefly on:
    a. The overall tone of the interview, from your perspective.
    b. The clarity of the questions.
    c. The order of the questions.
24. Is there anything else you would like to say to me before we conclude this interview?
25. Do you wish to ask me any questions?

Thank you for your patience and time. I appreciate your willingness to share your knowledge and experiences with me. If you wish, I will be happy to provide you with a summary of my research findings, when these become available.

Interview: Community Living Experiences of Ex-Mental Patients

The following questions will focus on your experiences with community living and your thoughts about social service agencies in the community mental health system.

I. Personal Background

I would like to begin the interview by asking you some questions about your personal history.

1. What is your present age (i.e., how old are you)?
2. Were you born in Vancouver? If no, where were you born?
3. Have you always lived in Vancouver? If no, where did you live before you came here? How long have you lived in Vancouver?
4. Do you have any family (i.e., parents, siblings) or other relatives living in Vancouver? If yes, do you have any contact with your family or relatives? How much contact do you usually have with your family? (i.e., Do you see them weekly, monthly, only rarely?)
5. What is your marital status, at present? (i.e., married, single, separated, divorced)
6. Do you have any children? If yes, how often are you able to see your children?

II. Mental and Physical Health

I would now like to ask you some questions about your medical history and mental health history. You may choose to tell me as little or as much as you feel comfortable telling me. Whatever you tell me will remain confidential.

1. How is your general health? If poor, what factors do you think contributes to your state of health?
2. How would you describe your current state of mental health?
3. Have you ever been diagnosed as suffering from a mental illness? If yes, would you be willing to discuss your diagnosis?
4. Are you currently on medication for this illness? If yes, what kind of medication ("meds") have been prescribed for you?
5. Have you ever experienced any side-effects from the medication? If yes, could you describe these side effects? Are you currently experiencing any side-effects from your medication? If yes, how do these side-effects affect your lifestyle?
6. Are you receiving any other types of treatment for your illness? If yes, could you discuss this with me? If no, do you think other kinds of treatments would be helpful?

7. Have you ever been hospitalized for your illness? If yes, where? In a general hospital? If yes, what was your impression of this place? In Riverview Hospital? If yes, what was your impression of this place?
8. What did you like about the hospital? What did you dislike about the hospital?
9. What do you like about being in the community? What do you dislike about being in the community?

III. Living Arrangements

I would now like to ask you some questions about your living arrangements, and how you feel about these arrangements.

1. Do you presently live in the Downtown East Side community? If yes, how long have you lived in this community? If no, in which community do you currently live? How long have you lived in this community?
2. What do you like about the community in which you live? What do you dislike about this community?
3. Where were you living/staying before you came here? How long did you stay there? Did you like living there? What did you like about it? What did you dislike about it?
4. Could you please describe your current living arrangements? (i.e., shelter, boarding home, hotel room, subsidized housing) How long have you been here? Are you happy with your present living arrangements? If yes, what do you like about your place? If no, what do you dislike about your place? What kind of changes would you like to see? What kind of housing arrangements would you like?
5. How much rent do you pay per month?
6. How much time do you spend at your own place? Per day?
7. How much social contact (i.e. talking, meeting for coffee, etc.) do you have with your neighbours? Other individuals in the community?
8. What other kinds of social contact can you think of? What is possible in your present living arrangements?
9. In general, how do you think people treat each other in this community? How would you describe the people **you** know in this community?

IV. Money

I will now be asking you some questions about your source(s) of money, and whether you think it is enough to live on per month.

1. What is your major source of income? Do you have any other forms of income? If yes, please list these for me.
2. How much money do you receive per month from **all** of your sources of income?

3. In your opinion, is this enough to meet your basic needs? What do you consider to be your basic needs? Could you list these needs from most to least important? What amount of money per month do you think would be reasonable?
4. Do you manage your own money? If yes, what do you like about this arrangement? Is there anything you dislike about this arrangement?
5. If you do not manage your own money, who does this for you? How do you feel about this arrangement? What do you like about this arrangement? What do you dislike about this arrangement?
6. How is your money allocated to you? (Daily? Weekly?) How do you feel about this arrangement?
7. Are there any changes that you would like to see in this arrangement? If yes, please describe.
8. Do you receive any other kind of assistance? (e.g., food vouchers, bus tickets, other)

V. Local transportation

I would now like to ask you some questions about local transportation.

1. Do you use any form of transportation, other than walking? If yes, please describe. How often?
2. Do you take buses, at all? If yes, how often? If no, for what reasons?
3. Do you feel that transportation is a problem for you? If yes, please describe.
4. What changes would you like to see? What do you think would be most helpful?

VI. Level of Education

1. How much formal education do you have? (i.e., level of school reached) What factors contributed to this?
2. How does your level of education compare with other people who you know in this community?

VII. Employment

This set of questions deals with your employment history and current employment status.

1. Did you ever work as a teenager? If yes, how old were you when you first started working (either part time or full time)?
2. Are you currently working? If yes, where?
3. Are you currently working at a regular job? If yes, please describe. What do you like about this job? What do you dislike about this job?

4. Are you currently working in a sheltered workshop? If yes, how do you feel about this? What do you like about it? What do you dislike about it? What changes would you like to see? What kind of job would you like to have? Where?
5. Are you currently able to work? If yes, would you like to work? If no, what factors account for this? Do you have any disabilities which prevent you from working?
6. If you are unable to work, are you currently involved in a program for vocational rehabilitation?

VIII. Recreation/Social Life

1. In general, what has your social life been like over the past few months?
2. How often do you see or talk with your friends?
3. What do you do for recreation? What do you like to do?
4. Do any of the agencies that you are involved with provide recreational activities/outings for the clients? If yes, please give some examples?
5. Do you participate in these plans? If yes, how often? What do you like about these outings? If no, what factors account for your decision to not participate?
6. Do you prefer to spend your recreation time alone? With others?
7. In your opinion, are your recreational needs being adequately met? If no, what changes would you like to see?

IX. Involvement with Other Agencies

This set of questions is about the number of service agencies you are currently involved with and your views about these agencies.

A. This Agency:

1. How did you hear about this organization?
2. Were you referred to this program? If yes, by whom?
3. How do you feel about being in this program? What do you like about this program? What do you dislike about this program?
4. How long have you been a client in this organization?
5. How well do you know the other clients in this program? How would you describe the general characteristics of the other clients in this program? Have you noticed any changes in these characteristics since you started in this program? If yes, could you describe these changes to me?

B. Other Agencies

1. Have you sought help from any other social agencies? If yes, which ones?
2. Have you been referred to any other social agencies? If yes, which ones? By whom?

3. Approximately how many social agencies do you receive help from? Could you specify which agencies?
4. Approximately how much contact do you have with each of these agencies?
5. Are you satisfied with this level of contact? If yes, why? If not, why?
6. How do you feel about these social service agencies? What do you like about them? What do you dislike about them?
7. In your opinion, are your needs being adequately met by these agencies? If yes, what do you think accounts for this? If no, what do you think accounts for this? What changes would you like to see? What would you like to see improved?
8. Would you happen to know which community agencies a person could go to if she/he needed the following kinds of services? Legal services (i.e., a lawyer or advocate)? Social services (e.g., food, clothes)? Medical services? Housing? Economic services? Vocational Rehab. services? Recreational services?
9. In general what do you think think about the welfare system? What do you like about it? What do you dislike about it?
10. Overall, what is your impression of the community mental health care system? What would you say about:

    The availability of services?

    The accessibility of services?
11. In your opinion, is there anything that needs to be improved? Modified?
12. What kind of changes would you suggest? How would you prioritize this list? (i.e., list in order of most important to least important, in **your** opinion.)

X. Social Issues

I would now like to ask you a set of questions about your views on a few social issues related to the mental health system. There are no right or wrong answers to these questions. If you are unsure about the meaning of the question, please feel free to ask for further explanation. You may choose to say as little or as much as you want to on these topics.

1. In general, are you interested at all in local politics? Are you interested in social issues that may affect you?
2. What do you know about the downsizing of Riverview Hospital? What have you heard about the downsizing of Riverview Hospital? What do you think about this issue?
3. Do you prefer to be on the street (i.e., in the community) or in a hospital? What do you think are the good points of being on the street? What do you think are the bad points of being on the street? Where would you prefer to be? Why?
4. Do you happen to know anyone who is homeless? Shelterless? What do you think about this?

5. Why do you think people become homeless/shelterless? Do you see this as a problem?
6. How do you think this problem should be solved? What would you suggest?
7. Are there any issues that are important to you that I have not covered? If yes, do you wish to tell me about them?

XI. Conclusion

1. Is there anything else that you would like to say to me?
2. Do you have any questions that you would like to ask me?
3. How did you feel about doing this interview?

Thank you for your time and patience in answering my questions. I have appreciated hearing about your experiences and views on living in this community, and your willingness to share these with me.

APPENDIX C
JAIL DATA: VARIABLES AND CATEGORIES

YEAR
01 = 1989
02 = 1990
03 = 1991
04 = 1987
05 = 1988

OFFENCE
01 = Non-violent offences against a person
02 = Violent offences against a person (e.g., murder, aggravated assault, sexual assault)
03 = Mischief and public disorder offences
04 = Property and fraud offences
05 = Weapons and firearms offences
06 = Driving offences
07 = Drug offences
08 = Non-violent sex offences (e.g., indecent exposure)
09 = Administrative offences (e.g., breach of probation, Failure to Appear)
10 = Immigration and miscellaneous offences
11 = Missing information
12 = Violent property offences (e.g., robbery, arson)

PRIOR CRIMINAL RECORD
01 = Yes
02 = No
03 = Denies (i.e., would not divulge information)
04 = Missing data

PSYCHIATRIC HISTORY
01 = Yes
02 = No
03 = Denies
04 = Missing data

SEX
1 = Male; 2 = Female

Appendix C (Cont'd)

AGE
No special code

RACE
1 = Caucasian
2 = Native
3 = Oriental
4 = Other
5 = Missing data

EMPLOYMENT STATUS
01 = Yes
02 = No
03 = Other
04 = Missing data

RECEIVES WELFARE
01 = Yes
02 = No
03 = Other (UIC, pensions)
04 = Missing data

MARITAL STATUS
01 = Single
02 = Married
03 = Divorced
04 = Other (Widowed, Common law spouse)
05 = Missing data

PLACE TO STAY
01 = Yes
02 = No
03 = Missing data

DOCTOR'S OPINION
01 = No evidence of psychiatric disorder
02 = Alcohol or Drug Dependency
03 = Mentally disordered, but fit
04 = Mentally disordered, not fit
05 = Immigration hearing; disordered, would be a social burden
06 = Immigration hearing; not disordered, not a social burden
07 = Serious personal problems, but no major psychiatric disorder

APPENDIX D
GLOSSARY OF ORGANIZATIONAL MANDATES

GVMHS – To focus on providing services, through a multi-disciplinary team approach, for chronic and seriously mentally disordered persons.

MSN – To coordinate services between agencies for multi-problem people. To identify gaps in services.

SJSS – To provide support for anyone who is mentally disordered and living independently. Support includes: emotional support; friendship; assistance with medications and advocacy work.

LOOKOUT – To provide emergency accommodation and services for people with few or no alternatives; to identify and address their needs; to identify service gaps; to do advocacy work.

CARE TEAM – To provide clinical and rehabilitation services to seriously mentally ill persons living in the community.

TRIAGE – To provide a secure place for clients to have their basic needs met while they try to arrange their long term plans, treatment strategies.

MHRS – To screen clients and match them up with an appropriate residential placement.

UNION GOSPEL MISSION – To provide a supportive program for male transients who may have difficulties with alcohol or other substances who want to straighten out and stabilize their lives; Running an outreach program to maintain contact with clients.

IMP – To work with mentally disordered offenders in an effort to prevent institutional recidivism; to maintain individuals in the community so that their dignity and quality of life goes beyond survival.

CORDOVA HOUSE — To provide care to residents with chemical/alcohol dependencies, behavioural disorders, mental illness, and people who are hard to house by virtue of their dysfunctional behaviours.

VCP — The community liaison program provides a means of maintaining contact with and sharing information of relevance to both the Vancouver City Police and the network of community services in the Downtown East Side of Vancouver.

MPA COURT WORKER PROJECT — To locate psychiatric patients appearing in court, provide them with on-site assistance and support in in the court, refer them to counsel and/or other services, insure that they are aware of their rights.

Glossary of Organizational Mandates (Cont'd)

MHES — Responds to any request from any individual with a mental health crisis and in need of assistance after hours. "Crisis" is defined broadly to avoid placing too many limits on the program and frustrating the general public.

BC MENTAL HEALTH SOCIETY — To develop the overall strategy mechanisms for implementing the 1987 mental health initiative. The Society is has also been responsible for the operation of Riverview Hospital since 1988.

RIVERVIEW HOSPITAL — To provide specialized services to adult and geriatric patients suffering from serious psychiatric disorders which cannot be managed effectively within the community (**BCMHS**, 1990:2).

B.C SCHIZOPHRENIA SOCIETY. — To alleviate the suffering caused by schizophrenia. The organization has four main objectives: 1) To provide support for schizophrenic persons and their families; 2) to educate the general public as well as those who are affected by the disease; 3) to advocate for better services and better mental health legislation; and, 4) to actively promote research by fund-raising and soliciting funds from member donors.

* Also see the **Directory of Mental Health Services for the Lower Mainland** (Inter-Agency Mental Health Council, 1986).

APPENDIX D
LIST OF FREE OR LOW COST GOODS & SERVICES*

FOOD
The Dugout
First United Church
Harbour Light
Union Gospel Mission
franciscan Sisters
New Hope Centre
Food Banks
Evelyne Saller Centre
Carnegie Centre
Downtown Eastside Community Health Clinic
Kettle Friendship Society
Coast Club House

CLOTHING AND OTHER GOODS
First United Church
Franciscan Sisters
Evelyne Saller Centre
Downtown Eastside Women's Centre
Pilgrims Market
Hang-ups Thrift Stores
Thrift Store
St. James Clothing
St. James Second Hand
Salvation Army
St. Vincent de Paul

MEDICAL AND DENTAL SERVICES
Downtown Community Health Clinic
Needle Exchange Program
Downtown Eastside Youth Activities Society
Pine Free Clinic
Emergency Services Medical Clinic
Vancouver General Hospital (Outpatient Dept.)
V.D. Clinic
Dental Outpatient Clinic
Reach Dental Clinic

APPENDIX D (Cont'd)

FREE SHOWERS, LAUNDRY, DE-LOUSING
Evelyne Saller Centre
First United Church
Coast Foundation
Mental Patients' Association

LEGAL SERVICES
Legal Services Society
U.B.C. Legal Clinic
Vancouver Community Legal Assistance Society

*Source: **Help in the Downtown East Side (#4)**, Carnegie Newsletter, May, 1991.

APPENDIX E
TABLE 1: SHELTER DATA

	1987	1988	1989	1990
Numbers Aided				
Men	1473	1480	1225	1418
Women	491	441	374	467
# New Referrals	900	938	1186	975
Referral Source				
Police	22	33	35	46
Emergency Services	1016	606	307	238
Welfare	680	586	363	364
Mental Health	30	24	42	51
Self/Street	155	288	537	734
Referral Reason				
Emotional Support	843	878	829	927
Violent	95	130	82	79
Psychiatric Problems	854	790	583	622
Drug/Alcohol Abuse	518	474	534	618
Transient	420	550	465	527
Other	904	494	278	267
Out of Funds	—	—	1114	1156
Prior Accommodations				
Independent	—	224	389	420
Hotel	—	196	345	415
Hospital*	—	107	192	248
Rehab. Group Home	—	17	19	25
Medical Boarding Home	—	10	6	11
Psych. Boarding Home	—	29	35	38
Hostel	—	60	101	160
Jail	—	45	31	36
Street	—	160	220	221
Placement				
Independent	635	445	309	319
Hospital	100	85	88	67
Psych. Boarding Home	23	27	30	29
Incarcerated	—	6	12	12

APPENDIX E
TABLE 1: SHELTER DATA (Cont'd)

	1987	1988	1989	1990
Source of Income				
Welfare	1355	1116	1069	
Handicap Pension	155	108	124	1327
Gov't. Pension	124	119	101	146
Veteran's Pension	29	23	30	111
U.I.C.	16	25	20	10
Own	32	31	49	31
Nil	204	219	188	57
Other	—	48	29	67
Administered	—	13	18	118

*May include Riverview Hospital.
Source: Lookout Emergency Shelter, 1991

APPENDIX E
TABLE 2: SERVICES FOR MENTAL HEALTH PATIENTS*

EMPLOYMENT/WORK

Arbutus Vocational Rehab. Society — Achievement Centre Program
Arbutus Vocational Rehab. Society — Building Service Worker Program
Arbutus Vocational Rehab. Society — Work Activity Program
Canada Employment Centres — Special Needs Employment Services
Canadian Mental Health Association — Work Readiness Program
Coast Foundation — Day Vocational Program
Coast Foundation — Outreach Program
Coast Foundation — Transitional Employment Program
GVMHS — Employment Programs
GVMHS — Therapeutic Volunteer Program
Kiwassa Neighbourhood Service Assoc. — Career Access Program
Mental Patients' Association — Training & Employment Program
Ministry of Labour — Personal Placement Program
Ministry of Labour — Training Program for Disabled Persons
St. James Social Service Society — Gastown Workshop
Strathcona Community Care Team — Widget Factory

SOCIALIZATION PROGRAMS

Canadian Mental Health Association — Activity Centre
Coast Foundation — Club House
Coast Foundation — Residential Integration Program
GVMHS — Socialization Programs (through Care Teams)
GVMHS — Venture
Kettle Friendship Society — Drop-in Centre
Mental Patients' Association — Drop-in Centre

ADVOCACY/EMOTIONAL SUPPORT PROGRAMS

B.C. Schizophrenia Society (Formerly B.C. Friends of Schizophrenics)
Canadian Mental Health Association
Mental Patients' Advocate Project
Mental Patients' Association — Court Worker Project

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* Source: **Directory of Mental Health Services for the Lower Mainland** (Inter-Agency Mental Health Council, 1986)

APPENDIX E
TABLE 3: PROFESSIONALS' PERCEPTIONS OF CLIENT DEMOGRAPHICS

RACE — Primarily Anglo-Canadian; Whites comprise from 67% to 81% of caseloads; visible minorities generally under-represented according to a GVMHS manager (Administrator 1), although others suggest this is changing (Mental Health Coordinator 3); Chinese, other Asian clients make up approximately 5 – 25% of some caseloads; less than 25% of clients are Natives (Mental Health Coordinator 1) — in some cases, less than 3% (Jail Doctor).

AGE — Ranges from 18 to 80 + years, depending on agency; majority of clients apparently between mid-twenties and mid-forties; average age of clients perceived to be between 30 – 35 years.

GENDER — Fourteen respondents commented that clients were mostly male. Proportion of male clients comprises from 49% (GVMHS) to 90% (IMP) of caseloads, depending on the organization. Women constitute from 10 to 51 percent of agencies' clientele. Two respondents (Mental Health Coordinator 1 and Administrator 3) commented on the growing numbers of female clients. According to Mental Health Coordinator 1, the ratio of women clients at MSN has increased from 23% in 1986 to 50% in 1991.

SOURCE OF INCOME — All participants who answered this question reported that "almost all clients receive social assistance" (Mental Health Coordinator 1). Of this group of mental health patients, "... about 40% are on regular social assistance, 60% are on the handicap pension" (Mental Health Coordinator 3). Some individuals rely on other pensions for income (Administrator 4), a few receive money from their families (Crown Counsel), and others have no money at all (Administrator 2).

ACCOMMODATION — Eleven respondents commented that most of their clients live in welfare hotels or shelters in the Dowtown East Side. A provincial court judge observed that most mentally disordered offenders have addressed within a ten block radius of the Court house. Two participants (Mental Health Coordinator 1 and Mental Health Coordinator 3) remarked that clients circulate between hospitals, shelters, welfare hotels, the street and sometimes jail.

Note: I have omitted the educational and occupational histories of clients, as very few agencies kept data on these characteristics.

APPENDIX E
TABLE 4a: PROFESSIONALS' KNOWLEDGE OF DRAFT PLAN

Provincial Court Judge — Very little.

Administrator 1 — My knowledge is a combination of reading the document and [participating] in the consultative process. People thought it was a good idea to seek community input.

Crown Counsel — Very little. I heard on the news that there were plans to replace Riverview with community facilities.

Mental Health Coordinator 1 — I read the policy. There are plans to replace each bed with one in the community.

Community Worker 1 — I was handed a copy [of the Draft Plan] the week it was released, so I read it and made extensive notes.

Administrator 2 — I participated in the consultative process and I've read the document. The **Draft Plan** sets up a framework for community mental health. It's an excellent blueprint.

Administrator 3 — The [document] is a set of principles. The significance of the plan is [that it] puts mental health care squarely in the community.

Community Worker 2 — Not very much. All I know is that they have emptied out Riverview Hospital.

Community Worker 3 — I don't know that much about it. My perception is that the intent is to eventually close down Riverview and put in more community services.

Mental Health Coordinator 2 — Really nothing very much. I occasionally hear a bit about it from other community service workers.

Mental Health Coordinator 3 — I've read it. It's just a collection of broad statements. I don't think it's anything profound, although the statements all seem like good ideas.

Administrator 4 — I know all about it. I've read it very thoroughly.

Police Officer — "Dick". As far as we're concerned, downsizing happened a few years ago, but they're arguing it's only just happened so who knows what's going on.

APPENDIX E, TABLE 4a (Cont'd)

Court Worker — My understanding is that] they were going to replace the hospital with outpatient services in the community.

Professor of Nursing — I read it a while ago. I have a copy of it.

Psychiatrist 1 — My knowledge is not that extensive. My understanding is that they are downsizing without [?] increasing the capacity in the community.

Jail Doctor — Not very much in terms of the details. I knew they were going to downsize and I wondered what would happen to the people.

Administrator 5 — I read the document. Basically, what I know is that it sounded like a good concept. ... haven't benefitted from the idealized version; ... never followed through ....

Psychiatrist 2 — Quite a bit. I was one of the people consulted. I acted as a consultant for community mental health.

Administrator 6 — I've read the document in great detail.

APPENDIX E
TABLE 4b: PARTICIPATION IN CONSULTATIVE PROCESS

Provincial Court Judge — None. As judges, we wouldn't have considered it inappropriate not to be included in the process.

Administrator 1 — I set up a committee and we made submissions.

Crown Counsel — None, personally. My superior ... would know whether anyone from the Attorney-General's office was involved.

Mental Health Coordinator 1 — I was invited as a board member of ... to write in about issues of concern to the agency.

Community Worker 1 — None, personally.

Administrator 2 — I chaired a committee comprising all of the mental health agencies in the Interagency Mental Health Council.

Administrator 3 — Yes, I wrote numerous drafts for written submissions.

Community Worker 2 — I don't know. I never heard anything about it. I'm not surprised by it; we're not connected with Riverview ....

Community Worker 3 — I don't know if anyone from this office participated. It's more likely that someone from our central office would have been involved at that stage of the Draft Plan.

Mental Health Coordinator 2 — I wasn't here at the time but I don't think [we] participated in that process.

Mental Health Coordinator 3 — I don't know how [the process] worked if all participated ... a committee [would have] been good ....

Administrator 4 — I think somewhere along the line I submitted a letter to them.

Police Officer — None that I know of. They might have had some input from the RCMP, but I think we should have had some input.

Court Worker — The organization was involved in the process. I made a written submission.

APPENDIX 5, TABLE 4b (Cont'd)

Professor of Nursing — I don't know if the Nurses' Association participated in the consultative stage, but I do know that they [submitted a report in response] to the **Draft Plan**.

Psychiatrist 1 —It would probably be quite likely that someone from this department participated, but I wasn't involved in it.

Jail Doctor — Did not participate in the process.

Administrator 5 — Not personally. Well, basically ... it's bureaucratic and typically it's not going to go to the front line.

Psychiatrist 2 — It was a very extensive consultation and very helpful, but it was edited politically and, ultimately, that was a disadvantage.

Administrator 6 — Several branches submitted their concerns and suggestions in writing. We also had a meeting in which our consumers presented their point of view on the **Draft Plan**.

APPENDIX E
TABLE 5: FAMILIARITY WITH COMMUNITY RESOURCES

I.D.	Level of Familiarity
Provincial Court Judge	Very limited
Administrator 1	Extensive
Crown Counsel	Did not ask question
Mental Health Coordinator 1	Extensive
Community Worker 1	Extensive
Administrator 2	Extensive
Administrator 3	Did not ask question
Community Worker 2	Moderate
Community Worker 3	Extensive
Mental Health Coordinator 2	Fairly extensive
Mental Health Coordinator 3	Fairly extensive
Administrator 4	Did not ask question
Police Officer	Fairly extensive
Court Worker	Extensive
Professor of Nursing	Somewhat limited
Psychiatrist 1	Fairly extensive
Jail Doctor	Very limited
Administrator 5	Extensive
Draft Plan Co-author	Did not ask question
Psychiatrist 2	Did not ask question
Administrator 6	Did not ask question

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