CHAPTER 1:
THE EARLY YEARS (1971-1974)

A profound change occurred in the mid-60s with the advent of mood stabilizers like lithium, and particularly with an anti-psychotic medication called chlorpromazine. The impact of chlorpromazine on psychiatric hospitals has been compared to the impact of penicillin on infectious diseases: it transformed mental health care. Chlorpromazine made it possible for shorter hospital stays, but also resulted in large numbers of patients being discharged into the Vancouver community with very little in the way of adequate discharge planning. The community was not prepared. The existing services were overwhelmed as there was no one agency or facility to take on the responsibility of dealing with the problem. The local newspapers, *The Vancouver Sun* and *The Province*, ran stories and editorials about the problems many of these mentally ill people were presenting and encountering. After years of being in power, the Social Credit government in 1971 was replaced by the New Democratic Party (N.D.P.).

One of the first initiatives made by the new N.D.P. Minister of Health was to commission a report by a Dr. Richard Foulkes concerning Riverview Hospital. The Foulkes Report, as it was called, was extremely critical of Riverview and called it a "barbaric, antiquated institution which needed to be destroyed as quickly as possible". His report was considered too radical, but two of Foulkes' recommendations were implemented:

1. The transfer of the mentally retarded (as they were called at that time) out of Riverview to Woodlands, another large institution in New Westminster.
2. The setting up of a commission to administer Forensic Psychiatric Services.

Following the Foulkes Report, which encompassed the entire province, in 1972 the Ministry of Health hired Dr. John Cumming (a Canadian psychiatrist who had just returned to Victoria from the United States, where he had left his position as head of the New York State Mental Health System) to produce a plan for patients being discharged from Riverview into the Vancouver area where the number of mental patients was highest and the newspapers most critical of the situation.

Like Foulkes, Cumming, in his report, was also critical of "the inhumanity of the traditional system", and made brief reference to large institutions such as Riverview being "harmful" and that "the forms of treatment in these institutions are extremely ineffective and very expensive". Cumming favored treating individuals with mental illness in the community and in order to prove the viability of this opinion, he put together

the "Home Treatment Project" consisting of a Team composed of a psychiatrist and a small number of psychiatric nurses. The Team was assigned to follow patients being discharged from Riverview into the Vancouver area, and assist them with finding shelter, arranging for social assistance, providing medication, counselling, and being proactive in helping with any problems or crises they might encounter. The results arising from the Home Treatment Project showed that 60% of patients discharged from Riverview could, instead, be treated in the community. Based on the success of the project, Cumming produced the Vancouver Plan in late 1972. The Plan had a strong humanitarian component to it and, at the same time, Cumming convincingly argued that care teams, similar to the Home Treatment Project, would significantly reduce health care costs by reducing the long hospitalizations of many of the mentally ill, and also reduce the need to renovate and rebuild many of the 60-year-old buildings on the Riverview site.

The Cumming Plan for Vancouver stipulated that care teams would provide free medication to their clients. It also outlined most of the basic guidelines for how teams would function in the community. These guidelines were contained in the report's six key objectives:

1. Treating the mentally ill within their own communities.
2. Treating the adult psychotic (later changed to the "seriously and persistently mentally ill") as a first priority.
3. The integration/cooperation of mental health services.
4. Developing new roles for mental health workers.

5. Decentralizing the community service.
6. The community care teams would result in a less costly system of mental health care.

OBJECTIVE 1: TREATING THE MENTALLY ILL WITHIN THEIR OWN COMMUNITIES

Cumming foresaw that community work demanded new approaches to resolving problems associated with mental illness. He stated that much of community work would revolve around teaching clients how to adequately survive within the community. The therapy required would be less abstract and more practical than traditional forms of psychotherapy. In community practice, the client must give consent to treatment by the mental health team, except in those instances when committal is required. This reduced the coercive aspect of treatment often associated with hospitals. It also required new attitudes for psychiatric workers to convince or demonstrate the worth and advantage of accepting treatment. Each mental health worker had to "sell" the services offered to those who could utilize them. Extended Leave, whereby a client with a long history of hospitalizations, refusals to take necessary medications, and acts of harm either to self or others, was not an option at that time, and did not arrive until changes were made in the Mental Health Act in 1998. Prior to 1998, if a seriously mentally ill client who needed ongoing treatment decided to withdraw from the services of a community care team, he or she would then have to become extremely psychotic before they could be committed to hospital under the Mental Health Act.

In those cases where persons required hospitalization, Cumming stated that the community care team would provide follow up to help re-integrate them back into the community. Rehabilitation, Cumming stressed, "must take place in the community and could not be accomplished outside of the community".

OBJECTIVE 2: TREATING THE ADULT PSYCHOTIC (LATER CHANGED TO THE SERIOUS AND PRESISTENTLY MENTALLY ILL) AS A FIRST PRIORITY

Cumming pointed out that the psychotic person in the community is too often the person least capable of securing treatment for himself, and as a result needs a service which will reach out to offer the help needed, and that the focus of the care teams should initially be on the "most seriously mentally ill population". In the report he wrote:

> The dreary history of innovations in the mental health field is that new services are set up, usually with the purpose of replacing less effective ones currently in use. However, since there is usually no built-in way of ensuring that the people who need the services find the sources of help and since those who need the services most are by definition not very competent at seeking them, there is a strong tendency for the service opportunities to be found and used by the less impaired and more vigorous component of the

> society. Since this latter group are often more gratifying to treat, little opposition to their monopolization of available resources is made by those who purvey them. By defining a group whose task is at least in part to ensure that the most helpless get their fair share of available services we have at least introduced a device to minimize this common tendency.

OBJECTIVE 3: THE INTEGRATION/ COOPERATION OF MENTAL HEALTH SERVICES

Cumming envisaged that the community care teams would be assisted by sheltered workshops, rehabilitation services, and psychiatric hospitals, and that there would be a sharing of staff among these facilities. The integration and the sharing of staff within any of these facilities rarely occurred to any significant extent.

OBJECTIVE 4: DEVELOPING NEW ROLES FOR MENTAL HEALTH WORKERS

As stated previously, Cumming suggested that the traditional psychotherapeutic role was not that applicable to community mental health work. Although he did not totally exclude this modality of treatment, he felt that psychotherapy would be more appropriately accomplished through private psychiatry. Working in the community often meant visiting clients in their homes, especially in the West End and

Strathcona areas. This was an entirely new role for the delivery of mental health services, which set up new expectations for community mental health workers. Cumming elaborated on the new therapeutic roles for workers, which would involve the teaching of skills required to survive in the community on a day-to-day basis. Special emphasis was given to resolving clients' crisis situations and simultaneously helping them to either prevent or resolve future crises. Since most of the new community workers came from traditional settings, such as mental hospitals, many of these roles were new to them. Cumming specified, in particular, two major roles for mental health workers: the advocate and the friendship role.

(a) The Advocate Role:

Cumming pointed out that very often individuals with mental illness lack the ability to "advocate" on their own behalf. This is especially true of those clients who have spent long periods of time in institutional settings, which certainly was the case in the mid-seventies. Since community mental health professionals often had a good deal of knowledge and power in terms of dealing with the "systems", Cumming felt they could do a great deal to sensitize the community at large to be supportive of the mentally ill.

(b) The Friendship Role:

Cumming did not elaborate as to what the friendship role entailed. In more modern mental health practice, it is likely that he was advocating the need to develop the much needed therapeutic relationship with the client.

OBJECTIVE 5: DECENTRALIZING THE COMMUNITY SERVICE

Cumming's plan insisted that the overall administration of the care teams be set in the community, apart from the mental health branch and from other mental health services. He felt that the community care system was new and unique, and needed to begin in a developmental way, not chained to a massive structure of inherited rules and policies inherent in existing mental health programs.

OBJECTIVE 6: THE COMMUNITY CARE TEAMS WOULD RESULT IN A LESS COSTLY SYSTEM OF MENTAL HEALTH CARE

This never happened. The creation of Community Mental Health Centres in both Canada and the United States in the early 1970's did not bring about a less costly system of care. In New York State, for instance, although deinstitutionalization reduced 60 to 80% of the patients in the state's 37 psychiatric hospitals, despite this massive exodus the hospitals claimed to have inadequate resources and none of them were shut down. This happened in Vancouver as well. The establishment of the community care teams, plus the increase of psychiatric beds in general hospitals, raised the overall cost of mental health care, but older facilities such as Riverview required as much capital as before, and even more in order to provide specialized care, to keep on operating. In 1979 GVMHS had a client population of 4,796 and a total expenditure of $5,230,575. In contrast,

Riverview, with a population of 1100, had a total expenditure of $33,687,213.

Putting aside the Cumming Report, the late '60s and early '70s was also a time of a strong anti-psychiatry movement ,which is reflected in the reports of both Foulkes and Cumming. There was an explosion of alternative therapies to the medical model of psychiatry, which was characterized as consisting of lobotomies (which was used on one of John F. Kennedy's siblings), electro-convulsive therapy (E.C.T.), psychoanalysis, and long hospital stays with large doses of medication. These alternatives included Gestalt Therapy, Reality Therapy, Transactional Analysis, Psychodrama, Rolfing, Paradoxical Intention, The Double Bind Theory (where the "schizophrenogenic" mother was made responsible for producing schizophrenia in her child), and Encounter Groups. There were also a number of popular books available that were quite critical of psychiatry, such as Thomas Szasz's *The Myth Of Mental Illness*, R.D. Lang's *The Divided Self*. Erving Goffman's *Asylums* and Ken Kesey's *One Flew Over the Cuckoo's Nest* which in 1975 was made into a movie that won five Oscars including the Best Picture award.

This outpouring of patients from psychiatric institutions similar to Riverview into the community was not unique to British Columbia. It was happening throughout Canada and the United States during the same time period. The psychiatric literature labelled the process "deinstitutionalisation", a term that was actually coined 15 years after the fact. As Dr. John Talbot, a noted American psychiatrist stated, "It was not a policy.

It was something that happened and there was no planning pertaining to it". What was unique about Cumming's Vancouver Plan, however, was that it targeted the most seriously mentally ill; whereas in most jurisdictions in Canada and the United States, patients were discharged from large institutions like Riverview into heavily populated cities where they became lost to treatment.

In 1998 in a GVMHS quarterly newsletter called "Connections", Dr. Cumming, in a Guest Editorial reflecting on 25 years of GVMHS service, wrote:

> 25 years ago Vancouver Services for the seriously mentally ill were in a state of crisis. No inpatient services would accept such patients, as a result, the emergency services of Vancouver General Hospital were discharging actively psychotic patients into the community. This, the local press was delighted to highlight, to the embarrassment of the Provincial government.
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> The alternative.....was simple, but as far as I know without precedent on this continent, namely to turn the system on its head and make the community services the primary service for the chronically mentally ill rather than merely an adjunct.

Cumming's Vancouver Plan was accepted in late 1972 by the Metropolitan Board of Health of Greater Vancouver which created a Mental Health Advisory Board to oversee it. The

Vancouver Plan became the blueprint for the Greater Vancouver Mental Health Service (GVMHS).

Thus began the setting up of multi-disciplinary mental health teams in different catchment areas, six in Vancouver and one in Richmond. (Richmond was a late addition. Originally the focus was entirely on Vancouver.) The teams varied considerably in their population, social and economic characteristics, and had different psychopathology rates. They were established one at a time between 1973 and '74, some in houses and others in small offices. They were located in the West End, Strathcona, Mt. Pleasant, Kitsilano, West Side, South, and Richmond catchment areas. The West End team worked out of the church basement of St. Andrew Wesley's United Church on the corner of Burrard and Nelson. A staff member from that time recalled that "most clients were seen outside the office...staff went out in pairs for support and safety. The definition of an intervention seemed to be a broad one including helping clients do laundry, catch a bus, and participate in a hobby. Often supportive counselling was done in a coffee shop". This was a similar experience by staff at the Strathcona Team who started out in the top floor of a public health building across from Woodward's Department Store.

In keeping with the anti-psychiatry movement, the community teams were originally called Care Teams, in keeping with the the Cumming Plan which distanced them from the medical model. The staff of each Team consisted of a Coordinator, a Psychiatrist or a General Practitioner (as at that time the teams had great difficulty attracting psychiatrists) who were consulting on a part time basis, a Senior Mental

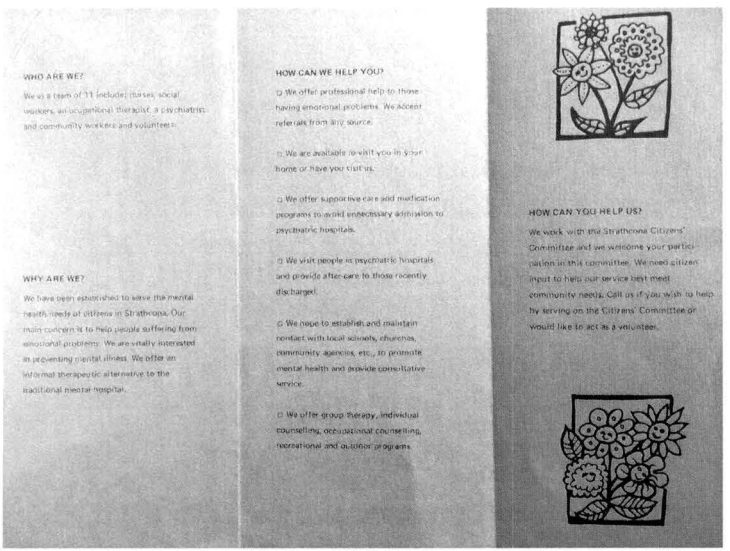
Health Worker, five or six Mental Health Workers (referred to as "Primary Therapists" and now called "Case Managers") made up of psychiatric nurses and social workers, as well as one occupational therapist, and usually two secretaries. The occupational therapist position was in keeping with Cumming's belief that rehabilitation must be done in the community. The OT position was also unique and not included in any other community mental health team in Canada or the United States at that time. One of their simple, but very practical, activities was for clients who had a fear of being with other people. The OT would accompany them on buses to help them overcome the fear so that they would be able to use public transportation to get around in the city. The Coordinator was not a psychiatrist, which was the first time that a different mental health professional held such a position. As well, the designation of "coordinator" was chosen to underscore a more democratic working environment, differing from the medical model found in hospital settings. In addition the targeted mentally ill population were to be called "clients", not "patients".

Another interesting piece of history in this early period was the brochures made by the Care Teams to advertise their new community service. The Mount Pleasant Care Team Brochure opened with:

> We offer professional help to those have emotional problems. We offer supportive care and medication programs to avoid unnecessary admission to psychiatric hospitals. We are vitally interested in preventing mental illness.

> We offer an informal therapeutic alternative to the traditional hospital.

See some of the pages of the Strathcona Care Team's brochure below.



WHO ARE WE?

We as a team of 11 include: nurses, social workers, an occupational therapist, a psychiatrist and community workers and volunteers.

WHY ARE WE?

We have been established to serve the mental health needs of citizens in Strathcona. Our main concern is to help people suffering from emotional problems. We are really interested in preventing mental illness. We offer an informal therapeutic alternative to the traditional mental hospital.

HOW CAN WE HELP YOU?

- We offer professional help to those having emotional problems. We accept referrals from any source.
- We are available to visit you in your home or have you visit us.
- We offer supportive care and medication programs to avoid unnecessary admission to psychiatric hospitals.
- We visit people in psychiatric hospitals and provide after-care to those recently discharged.
- We hope to establish and maintain contact with local schools, churches, community agencies, etc., to promote mental health and provide consultative service.
- We offer group therapy, individual counselling, occupational counselling, recreational and outdoor programs.

HOW CAN YOU HELP US?

We work with the Strathcona Citizens' Committee and we welcome your participation in this committee. We need citizen input to help our service best meet community needs. Call us if you wish to help by serving on the Citizens' Committee or would like to act as a volunteer.

No mention is made of any of the diagnostic labels of mental illness such as psychosis, schizophrenia, or manic depression (now called bi-polar illness). This again reflects the anti-psychiatry movement at the time.

At the very beginning of establishing the care teams, the Mental Health Advisory Board decided that citizen groups for

each of the catchment areas should be involved in the process, which was also recommended in Cumming's Vancouver Plan. This resulted with many of the staff of the first three teams, the West End, Strathcona, and Mt. Pleasant, being hired by citizens from the catchment areas rather than by mental health professionals. But when it came to the fourth team, the Kitsilano Care Team, the invitation for the citizen committee was taken up by a group of people who were strongly anti-psychiatry. They sent out an advertisement to the Kitsilano community which read:

> Some attitudes remain about mental illness which are shameful and in some cases barbaric. Mental illness, in most cases, is differences, and to be extremely different from the "average" is to ensure one's committal. The vast majority of people committed to mental hospitals or given drugs are not "sick", but, rather, they are socially disabled. Mental illness is not some weird disease. It happens to people, to anyone, when the pressure gets a little too hard to take.... We want a special kind of person unfettered by the old methods, and willing to try new ones to meet new problems.

The advertisement concluded by asking any interested citizen in Kitsilano to "Join the Citizen's Committee to do something about it". This was felt to be too radical and resulted in the Minister of Health stepping in to put a halt to the process. From that point onwards, Kitsilano and the remaining three

teams hired their own staff, with the Coordinator being chosen by the GVMHS Central Office and the Senior Mental Health Worker being selected by the team members themselves. The citizen committees disappeared shortly afterwards, and by 1977 were completely gone. It should be noted, however, that in some catchment areas the citizen committees had been quite helpful. The Coordinator of the Strathcona Care Team in 1975 wrote:

> The citizen sub-committee, in particular, did a great deal of work in introducing the team and the concepts of community mental health to the Strathcona Community at large. The committee not only identified many of the basic gaps and needs of the mental health network in Strathcona, but also articulated many of the expectations the community had of the team. They helped to sensitize and familiarize team members with many of the basic problems, situations, and lifestyles characteristic of the area. Had such a process not occurred, the Strathcona Team's positive impact on the community might have been far less than was actually realized.

A central administration office for the community care teams was also established in 1973 and similar to the Coordinator position, the Executive Director was not a psychiatrist.

As the community care teams were being established in the early years, three events occurred in 1974 that illustrate, even at this early stage, GVMHS being asked to take on services which

deviated from Cumming's original mandate. Two of them opened the door for providing a limited service to families and children. The first was a secondment of staff from the Maples Family and Children's Clinic in Burnaby to the South and Mt. Pleasant catchment areas of Vancouver. The Maples staff going to the South area were housed in a building shortly before it became populated by adult mental health staff which became the South Community Care Team. The second event was a transfer from Riverview to GVMHS of Blenheim House, a day program for emotionally disturbed preschool children.

The third event was a transfer of a very small one-person program called Se-Cure which provided a province-wide phone, pamphlet, and travelling lecture service to assist people suffering from Agoraphobia. By 1978 a number of the care teams had at least one family and children's worker, but they provided a very small service. The GVMHS Annual Report for that year stated:

> As resources have been made available, efforts have been made to broaden the mandate of GVMHS to include direct services to children, adolescents, and their families. Within the last three years, limited progress has been made in providing some services to families and children. Many of the Teams have limited capacity to accept patients in this category.

It wasn't until 1986 that this changed, when GVMHS made a major step in addressing the needs of children by establishing

a fully functional Family and Children's component. More on this later.