HISTORY OF COMMUNITY MENTAL HEALTH IN THE VANCOUVER AREA (1973-2000)

L. Ralph Buckley M.S.W.

Greater
Vancouver
Mental
Health
Service

GVMHS

Symbolizing the process of despair, and then self-realization, hope, and joy, our client's experience is the human shape with the arms raising.

Symbolizing the growth GVMHS has gone through (and will continue to go through) is the tree shape. It also signifies the sheltering aspect of the services provided by GVMHS.

Services provided by GVMHS

Adult

Family and Children

Rehabilitation

Emergency (Car 87)

Multicultural

Outreach

Housing

Client Participation

Providing Service to Community Non Profit Societies, Long Term Care Facilities, Hotel Operators, etc.

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FOREWARD

For some time I have been wanting to capture the story of the development of the community mental health system in Vancouver. It's a story of visionary thinkers, administrators, service providers, clients and family members who, together, created a unique, world-renowned system known as the Greater Vancouver Mental Health Service (GVMHS).

GVMHS pioneered an incredibly wide range of services containing culturally responsive care, focusing on recovery and rehabilitation as its basic principle. It includes initiatives in housing, developing the concurrent disorders of mental health and addiction services, and providing support and direction to related non-profit community agencies and consumer training and art organizations. During its twenty seven years of existence, GVMHS gained international recognition throughout the rest of Canada and United States, and particularly the Pacific Rim Countries where it became known as the "Vancouver Model".

This unique model of truly interdisciplinary involvement (physicians, nurses, social workers, occupational and recreational therapists, artists, addiction counsellors etc.) in services and planning provided a rich legacy which continues to thrive to this present day.

Funding for this work was provided by Mental Health Research, Dept. of Psychiatry, Vancouver Acute, and Community. It is a dedication from several individuals who contributed to Ralph Buckley who wrote it, in consultation with John Russell, the former Executive Director of GVMHS, who over two decades of tireless administration helped to make it a world renowned organization.

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INTRODUCTION

In the 1950s and early '60s the treatment option for anyone having a serious mental illness in Vancouver was a general practitioner (G.P.) or a private psychiatrist. Otherwise it was Riverview Hospital in Coquitlam, with the patient often committed there by the courts. During that period, Riverview had a population of 5,500. Hospital stays were often counted in months and sometimes years. At the present moment (2017), Riverview still exists, but it is a shadow of what it once was, with a patient population of around 100. Most of the buildings are deserted and crumbling, and discussions are underway to turn the beautiful grounds into a park, a museum featuring the history of Riverview, or to prime real estate, or perhaps an amalgamation of all three. People with mental illnesses now are treated in the community, and, if they need to be hospitalized, are admitted to general hospitals, the same as patients with other illnesses. A long stay is now considered anything over a month. How did all this change? When and how did it happen? This is the history of the Greater Vancouver Mental Health Service (GVMHS) from its beginnings in 1973 until its demise in early 2000.

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.
>
> 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

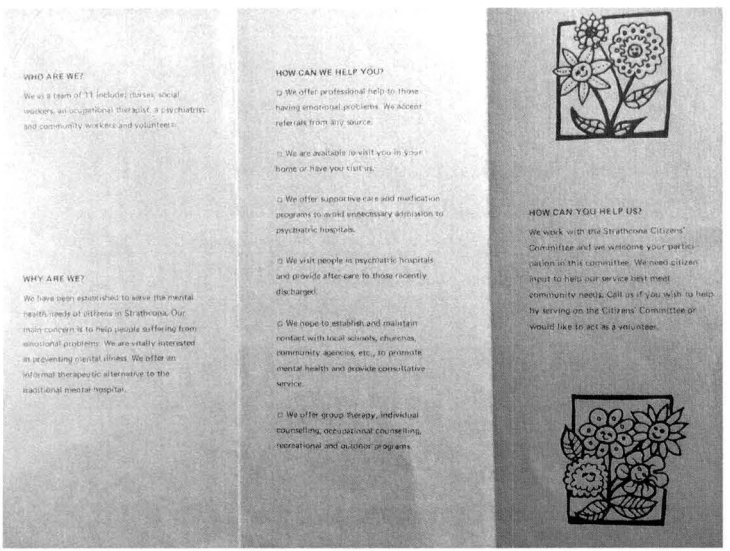
Health Worker, five or six Mental Health Workers (referred to as "Primary Therapists" and now called "Case Managers") made up of psychiatric nurses and social workers, as well as one occupational therapist, and usually two secretaries. The occupational therapist position was in keeping with Cumming's 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.

CHAPTER 2:

THE GROWTH YEARS (1975-1981)

In 1975 GVMHS acquired the Riverview Outpatient Department, along with its seconded staff, which was renamed the Broadway Community Care Team. This brought the number of care teams to eight, and increased the GVMHS client caseload from 1,534 to 4,515. The initial mandate for the care teams, as stated in the Vancouver Plan, was to provide treatment to the chronically mentally ill adult. Cumming realized that his Plan was not a complete system as it did not address the needs of either seriously mentally ill children or the elderly, at least to begin with. Cumming envisaged that this would come later, and it did.

In the meantime, the teams established themselves and became integrated in their designated catchment areas, with the Central Office allowing a great deal of autonomy. At the Strathcona Team, which had a large Chinese population, many of whom had little or no English language skills, a number of Chinese mental health staff were hired to make certain this

ethnic group had access to the new care team. On many teams the staff, as well as providing direct service to their clients, also became helpful to the community agencies in their catchment areas that provided services to their clients. In 1974, the Strathcona Team was instrumental in helping St. James Social Services and Lookout Emergency Aid Society establish Victory House which resulted in Victory House providing all their 47 rooms exclusively to clients of the Strathcona Team. A worker from the Team was then assigned to provide ongoing service to Victory House. The same service was provided to Lookout, as it was an emergency shelter that often housed many mentally ill individuals. The team coordinator became a board member of Lookout and also a participator in committee meetings with other agencies in the area, such as Cordova House and The Urban Core Workers Association. The Broadway Care Team had two members of their staff, one on the board of the Arbutus Work Incentive Society and the other on the Kettle Friendship Society. All of the Care Teams were heavily engaged in providing information seminars and consultations on mental illness to other community agencies within their catchment areas.

In April of 1975, GVMHS acquired two resources from Riverview which included their seconded staff: Vista and Venture. Vista was used as a halfway house for female Riverview patients, and GVMHS turned it into a 10 bed rehabilitation residence for women clients from the care teams who needed a structured supported home environment following a psychiatric crisis or release from hospital. Venture was a halfway house for male Riverview patients which GVMHS changed to an emergency short term facility for male and female clients

from the care teams with problems which, if not attended to, would easily lead to hospitalization. Venture provided a needed time out, a respite, and clients would receive support from professional staff for short periods of time so that they could re-stabilize and make plans, if necessary, for their next steps. When a client was admitted to Venture, although their health record went with them, the Team's psychiatrist and primary therapist maintained clinical responsibility. In addition, until October of 1979, Venture's residential staff responded to all evening and weekend calls that were diverted automatically from the community care team phone lines directly to Venture. Venture also handled its own crisis line. The 1978 GVMHS Annual Report referred to the transfer of Vista and Venture to the GVMHS as "representing the first major step taken by the administration towards support services being available to all Teams". In 1991 Venture moved to a 20-bed facility and also took on being a stepdown resource for early discharge of many team patients, mostly from VGH.

1978:

1978 was a "pivotal" year for GVMHS, as it acquired two more very important support services:

1. **MENTAL HEALTH EMERGENCY SERVICE (MHES):** Prior to 1978 GVMHS staff provided an on-call after-hour emergency service at night during the weekdays and also on weekends and holidays. In February of 1978, the GVMHS administration established a joint after-hours emergency service with the Vancouver City Police

Department called the Mental Health Emergency Service (MHES), which initially had a mobile unit, called "Car 87", staffed by a nurse and a plain-clothed police officer as a partner. The care teams would alert MHES to pending crises among their clients and arrange from them to be seen and assessed during the evening or on the weekend. Psychiatrists from the teams were on call and would come out to do an assessment if it was felt that hospitalization might be required. Venture would handle the after-hours calls for MHES. Once known, MHES would often be contacted for advice and assistance by emergency hostels, long term care facilities, hotel operators, and other community facilities.

2. MENTAL HEALTH LIASON PROGRAM (MHLP):
In July of 1978 GVMHS became responsible for the developing a Mental Health Liaison Program which took on the assessment and placement of all psychiatric referrals, as well as program development within the mental health boarding homes acquired from Long Term Care.

THE FINCH REPORT:

1978 was also the year of the Finch Report, which posed the question of whether GVMHS wished "to remain a clinically based service or take on a more integrated rehabilitation focus by developing support services". The GVMHS administration agreed with the second portion of the question, which was affirmed in the Annual Report of that year, which stated:

> Over the years, GVMHS has recognized the need to expand its services in order to maintain the seriously mentally ill person in the community. There must be not only direct treatment services but vocational rehabilitation, social-recreational, and housing services as well.

STUDENT PRACTICUMS:

1978 was the year when GVMHS began accepting student psychiatric nurses and social workers requiring practicum placements as part of their educational programs. It wasn't until 1988 that GVMHS, in conjunction with the UBC Department of Psychiatry, developed a community mental health training program, fully accredited by the College of Physicians and Surgeons, for residents in psychiatry to come to community mental health teams on a six month rotation basis to expose them to a new form of practice that complimented their hospital-based training.

THE FIRST MENTAL HEALTH CONFERENCE:

To celebrate its fifth anniversary, in September of 1978 GVNHS sponsored: "New Perspectives in Community Mental Health". The goal of the conference was not only to highlight some of the community mental health programs across Canada and United States, but also to expand GVMHS's own profile nation-wide.

By the end of 1978, GVMHS now had as support services the Mental Health Emergency Service, The Mental Health

Liaison Program, Vista, and Venture. The 1978 Annual Report prophesied that:

> When the financial resources become available to complete the necessary teams and support services, the Greater Vancouver region should have a system of mental health treatment programs unequalled in Canada.

1979:

Mental Patients Association (M.P.A.): In April of 1979, GVMHS assumed the responsibility for the care component of the Mental Patients Association residences, which was added to the jurisdiction of the Mental Health Liaison Program.

S.A.F.E.R.: (Suicide Attempt Follow-up Evaluation and Research).

In November 1979, GVMHS was assigned administrative and clinical responsibility of SAFER, a program focusing on providing treatment for non-psychotic people who have made a suicide attempt. This is another example of GVMHS taking on a service that deviated from Cumming's original mandate which, ironically, was in direct contrast to the American scene. The GVMHS debate at that time was not about how to find and provide service to the forgotten chronic mental patient, but rather how much it should expand its mandate to include other groups that also had mental health problems.

AFTER-HOURS PSYCHIATRIC EMERGENCY SERVICE:

In November 1979 the After-Hours Psychiatric Emergency Service came into effect, which amalgamated Venture's after-hours telephone answering service for the Community Care Teams, the Venture Crisis Line, and Car 87 into one after-hours emergency service operation. Car 87, however, was terminated in 1980 as the result of confusion arising between roles of the police person and the nurse, which had not been clearly defined. A Service Agreement was established that when a site visit arose that had doubt about personal safety the police would provide assistance. It wasn't until 1987, after discussions between GVMHS administration and the Vancouver Police Department that the matter was clarified and Car 87 was reinstated.

1980:

1980 was the year that special projects began appearing within the care teams themselves. One, of these was the project in the Strathcona area called: The Vietnamese Boat People Project.

THE VIETNAMESE BOAT PEOPLE PROJECT:

There were approximately 400 Vietnamese refugees in Chinatown who were referred to as the "Boat People". The Chinese component of the Strathcona Team took on a six month project to provide psychiatric services to the Chinese speaking Vietnamese refugees. Aside from individual treatment, they also gave seminars to help orient the refugees to their new country. These services were not restricted to the Strathcona Team's

catchment area, but were made available to all Chinese speaking Vietnamese refugees living in the Vancouver and Richmond areas.

THE STRATHCONA HOUSING PROJECT:

At that time in the Downtown Eastside there were no long term housing available for team clients. As a result, the Strathcona Team approached B.C. Housing and negotiated an agreement whereby three row houses, handling nine clients, were allocated to the Team: two at the Stamps Housing Project and one at Maclean's. In response, the Team guaranteed they would deal with any crises that might arise and this included the After-Hours Psychiatric Emergency Service as well, to deal with any crises arising after regular team hours.

1981:

This was the year that GVMHS became the first community based organization in Canada to receive the Canadian Council of Hospital Accreditation. GVMHS was beginning to be noticed.

CANADIAN COUNCIL ON HOSPITAL ACCREDITATION
CONSEIL CANADIEN D'AGRÉMENT DES HÔPITAUX

certifies that *atteste que*

Greater Vancouver Mental Health Service
Vancouver, British Columbia

has been surveyed by representatives of the

CANADIAN COUNCIL ON HOSPITAL ACCREDITATION

and having met the Standards for quality of care set by Council, has been awarded the status of

Accreditation

This status has been achieved through the combined efforts of the Governing Body and Management, Professional and Supporting Staffs with voluntary assistance from the residents of the community.

a reçu la visite d'évaluation des représentants du

CONSEIL CANADIEN D'AGRÉMENT DES HÔPITAUX

et ayant satisfait aux normes de qualité de soins établies par le Conseil, s'est mérité le statut

d'Agrément

Ce statut a été mérité grâce au travail de coopération du Conseil d'administration et de la direction, du personnel professionnel et du personnel de soutien, avec l'assistance bénévole des résidents de la communauté.

October 6, 1981

Ginette Rodger
Chairman-Président

Executive Director-Directeur général

CHAPTER 3:

THE COMING OF AGE (1982-1986)

The GVMHS Central Office began by having a Research Department which, in the early years, was very helpful in providing internal statistical surveys, but was never able to move beyond to produce papers on clinical matters in conjunction with local universities like UBC or Simon Fraser or other universities either in Canada or United States. Unfortunately, there was never enough money, and it was felt that such research had the potential to distract from client care. The result was that by 1985 the Research Department was disbanded. Other projects flourished, however, and are listed below in yearly chronology.

1982:

PSYCHIATRIC NURSES WIN ARBITRATION AWARD:

In 1982 the psychiatric nurses of GVMHS won an arbitration award which aside from increasing their salaries,

also had the effect of changing the Coordinator's position to Team Director, in order to make certain that the position would not become unionized. It also meant that the Director, rather than the team members, had the final say on hiring new staff. As already mentioned in Chapter One, in the first few years, the teams had been relatively left alone by the Central Office, but as GVMHS assumed more responsibilities, the need for central administration became greater. GVMHS administration, however, never viewed itself as wishing to become a hierarchical organization. In a brochure published in 1990, it clearly stated:

> GVMHS has worked hard to minimize the amount of hierarchy within its organization. Much of the direction and many of the decisions regarding GVMHS are reached by staff committees. Existing committees include: Education Committee, Standards of Care Committee, Audit Committee, Professional Advisory Committee, Health Records Committee, Rehabilitation Services Committee, and Family and Children's Committee.

THE WIDGET FACTORY:

1982 was also the year that The Strathcona Team, after having being told by the only vocational rehabilitation workshop in Vancouver at the time to stop referring their "lower functioning" clients, decided to set up their own sheltered workshop which they named "The Widget Factory". The team canvassed businesses in the neighbourhood and

found many that were willing to supply them with a series of packaging and collating jobs. Clients were encouraged to work a minimum of 10 hours a month, and with the money made, plus some additional grant money, they were paid the minimum hourly wage which supplemented the money they received from their monthly disability pensions. For many clients, it greatly increased their self-esteem by viewing themselves as being employed. In addition, in the work environment they were encouraged to participate in a considerable amount of additional socialization and recreational activities.

1984:

JAPANESE DOCUMENTARY ON GVMHS:

This was the beginning of GVMHS becoming seriously recognized internationally for its delivery of service to the chronically mentally ill, particularly by countries like Japan and Taiwan. In October of 1984, a Japanese television production crew visited GVMHS and spent a week taping various aspects of its services for a documentary for Japanese audiences on community mental health services.

"A TALE OF TWO CITIES":

In 1984 Dr. Morley Beiser conducted a research study entitled "Does Community Care For the Mentally Ill Make A Difference? A Tale of Two Cities". In the study he matched patients with schizophrenia in Portland with a similar group in Vancouver, both of whom had been discharged from their respective hospitals. His research found that Vancouver's

community care was far superior. The Vancouver cohort were less likely to be re-hospitalized, and if they were, they had shorter lengths of stay. Describing GVMHS, Beiser stated:

> Each patient is assigned a mental health worker who provides therapy. The worker is also a client advocate and community broker, who attempts to meet individual client needs such as housing, placement in a sheltered workshop, enrollment in some of the team's social and recreational activities or in one of its group therapy programs designed to develop social and vocational skills. Psychiatrists provide assessment and medical consultation. GVMHS also operates short-term residential activities for patients in crisis, maintains a suicide prevention service, provides a 24-hour emergency service and offers consultation to various community agencies, including an assessment and placement service for psychiatric boarding homes. With its focus on chronic patients, its linkages with other community resources, its aggressive outreach policy, the broad range of services its specially trained staff provide to clientele, and its individually tailored programs of rehabilitation; GVMHS fulfills the criteria, described in the literature for a model program to serve the chronically mentally ill.

CREATION OF MEDICAL DIRECTOR AND AREA CLINICIAN POSITIONS:

By 1984, the psychiatrists from the teams approached the Central Office requesting more input into the administration of GVMHS. A few wanted to take over the Director's position. Discussions were held and an amicable solution resulted in the creation of a Medical Director position at the Central Office for three sessions a week, and the designation of one physician at each team as an "Area Clinician". The Area Clinicians met monthly with the Medical Director to provide psychiatric input into the GVMHS decision process. The Medical Director also took over the hiring of new psychiatrists and physicians to the teams.

1985:

THE MULTI-SERVICE NETWORK (MSN):

As GVMHS moved further into the '80s, by 1985, it was recognized that there were a small number of very troubled individuals with multiple problems, living mostly in the Downtown Eastside area of Vancouver, who consumed enormous amounts of services with no real benefit resulting. Statistical research was done on a few of these individuals using per diem rates from hospitals, ambulance, and correctional services, which found that just one of these individuals in a single year cost the various services over a million dollars. Using this information, it was possible to approach and convince four other major service organizations to fund a project called the Multi-Service Network. The five organizations

were: Alcohol and Drug, Corrections, Forensic Services, Mental Health, and Social Services. Historically, this was the first time these five agencies had ever come together to collaborate on a shared problem. The MSN staff consisted of one coordinator, with a half-time secretary, who brought together workers from the five funding organizations, plus other community agencies in the Downtown Eastside who had dealings with these multi-problem individuals, to help formulate realistic service plans which the workers would agree to provide. The coordinator would then monitor the progress of the service plan, keeping everyone informed, and, if necessary, call another meeting if problems arose.

In 1986, the MSN commissioned a study of the project by the Simon Fraser University Psychology Department, the results of which were later published in an article on the MSN in February 1992 of the Community Mental Health Journal. The study showed:

> Referral agency personnel reported that gaining information on the client and other agencies serving the client were the most important outcomes. Almost as important was developing better strategies and options for dealing with the client. ....The MSN appears to have made substantial progress in coordinating agencies that were duplicating services, working at crossed-purposes, and laboring under false impressions of the client and other services provided. In at least some significant

> instances, MSN seems to have facilitated the development of sufficient structure or external control through agency cooperation to bring about improvement in the lives of its clients.

1986:

THE INTERNATIONAL MENTAL HEALTH CONFERENCE:

Hosting Expo '86 brought Vancouver the international spotlight, as well as thousands of international visitors. 1986 was also the year that GVMHS jointly sponsored with the Health Ministry an International Mental Health Conference where GVMHS and its services were on display, which greatly added to its growing international reputation.

CHAPTER 4:
GVMHS ARRIVES, AND BEYOND (1986-2000)

By 1986, a little over a decade had passed since GVMHS began, and many changes had occurred by this time. The anti-psychiatry movement had all dissipated, and now the GVMHS client brochures describing its services openly used diagnostic terms such as schizophrenia, psychosis, and bi-polar illness. In a client information booklet published in 1992, after the section covering the major mental illnesses GVMHS treated, there was a following section listing the main medications used for treating "schizophrenia, for symptoms such as hallucinations and delusions". It then listed the medications side effects. It went on to do the same for depression. The Care Teams were now called Mental Health Teams. Also during this last time period, many GVMHS staff were invited to visit other cities in Canada, United States, Taiwan, and Japan to describe the GVMHS community mental health services in Vancouver.

In the years between 1986 and 2000 the clientele were changing as well. The new generation of younger clients did not have histories of long hospitalizations. Periodic short stays were the norm. Many of those serious and persistently mentally ill often had more complex diagnoses which included a variety of personality disorders along with substance abuse, diabetes, and HIV-Aids. Starting in the 1990s, team caseloads became larger, with each therapist carrying anywhere from 45 to 65 clients, along with more paperwork demands.

In 1995 the Broadway Team was split into Broadway North and Broadway South. Five years later they were renamed the North East and the Grandview Woodlands Mental Health Teams.

Between the years 1986 to 2000, GVMHS expanded immensely in all five of the following service areas: Family and Children's, Geriatrics, Housing, Rehabilitation, and Special Projects. The expansion in each of these services will be described chronologically for this time period.

FAMILY AND CHILDREN'S SERVICES: (1986-2000)

In 1986 a Director of Family and Children's Service position was added to the management structure of GVMHS. This was a clear statement that GVMHS was fully committed to expanding its original mandate, to provide assessment, treatment, and consultation services to severely disturbed children and adolescents, and their families. By 1990, GVMHS had a family

and children's component of 22.5 FTE's providing service through the eight mental health teams and it had Blenheim House. Between 1986 and 2000 the Family and Children's Service developed a number of small inter-ministerial specialized programs where funding came from a wide variety of sources. In chronological order, they were:

ADOLESCENT OUTREACH SERVICE (AOS): (1986)

AOS was a small group of family and children's workers who, in 1986, set up a service to work with street-involved youth and young adults, many of whom came from abusive family backgrounds and were HIV+, pregnant, involved in substance abuse, prostitution, criminal activity, and had mental health concerns (psychosis, depression, suicidal behavior, self-mutilation and reactions to a diagnosis of HIV+).

SCHOOL MENTAL HEALTH SERVICES: (1988)

In 1988, a school mental health service was implemented to meet the mental health needs of elementary school-aged children in the Vancouver School Board's special education classes. The children either had severe behavioural disorders or were emotionally fragile. Individual and group treatment were provided to the children and to their families. Consultation and support was also offered to teaching and child care staff on a daily basis. A very similar program was developed in 1993 by the Richmond Mental Health Team in collaboration with the Richmond School Board and Richmond Health Department, to provide short-term mental health intervention and treatment for high-risk elementary school-aged children and their families.

YOUTH RESIDENTIAL CONSULTATION SERVICE (YRCS): (1989)

YRCS was another small inter-ministerial F&C program developed in 1989 to provide services to caregivers of "difficult to care for" children in foster homes.

PROGRAM FOR ABUSE REACTIVE CHILDREN (PARC): (1989)

The PARC program was developed in 1989 to assist children (age 6-12 years), who were displaying problematic sexual behavior and had also been sexually abused.

HAMBER HOUSE: (1990)

Hamber House was a day treatment program that first opened its doors in 1990 and provided mental health services to eight adolescents and in 1994, with additional funding, increased the number to ten.

CHILD AND ADOLESCENT RESPONSE TEAM (CART): (1995)

CART was developed in 1995 to provide a quick-response to urgent mental health related crises involving children and youth in Vancouver.

ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD): (1995)

A.D.H.D. was another inter-ministerial program developed in 1995 to provide services for families that lived in Vancouver who had a child or young adolescent with a primary diagnosis of attention-deficit hyperactivity disorder.

GERIATRIC SERVICES: (1992-2000)

The final expansion of the GVMHS mandate foreseen in Cumming's Vancouver Plan came officially in early 1992, when the Central Office established a Director of Geriatric Services. Some teams already had a small number of specially-trained geriatric staff. Once the Director position was in place, however, all teams acquired geriatric staff. The geriatric mandate was to provide care to seriously mentally ill seniors complicated by other medical conditions along with those seniors suffering from dementia who had significant behavioral problems.

THE BRIGHT SPOT: (1995)

In 1995 a Geriatric Rehabilitation Program called "The Bright Spot" was established to provide occupational therapy services to clients of the West Side, Mt. Pleasant (now called Raven Song), and Kitsilano (now called Kitsilano-Fairview) Teams.

HOUSING SERVICES: (1986-2000)

The Mental Health Liaison Program, which in 1978 formally initiated GVMHS into the business of finding housing for clients, had expanded considerably by 1992 and was renamed the Mental Health Residential Services (MHRS). In 1987 GVMHS, which already had responsibility for the Mental Patients Association, took over the funding and monitoring of nine more non-profit community agencies who were providing extensive housing, rehabilitation and drop-in programs for many GVMHS clients. The agencies

included Arbutus Vocational Rehabilitation Society, Canadian Mental Health Association (Vancouver/Burnaby), Canadian Mental Health Association (Richmond), CHIMO Personal Distress Intervention Service, Coast Foundation Society, Kettle Friendship Society, Lookout Emergency Aid Society, Victory House and Triage Emergency Care Society. The Katherine Sanford Society was added in 1990, followed by the Portland Hotel Society, and the Hampton Hotel in 1991, and, finally, Gallery Gachet in 1994. The GVMHS objective was to have these services become a more closely connected system of care and to help them develop their individual services. The Executive Directors from all these agencies had ongoing monthly meetings with GVMHS administrative staff. In the last Spring Edition in 2000 of Connections, the quarterly GVMHS newsletter, the Executive Director of the Mental Patients Association wrote:

> I have always felt that the support I have received from GVMHS staff has been outstanding. From the agencies' perspective, to have GVMHS staff members become knowledgeable of, and champion our programs and initiatives, has resulted in a vastly improved quality of life for our members.

One consequence of these acquisitions, however, was that any of the community team staff who were members on these non-profit boards had to resign due to conflict of interest concerns.

Aside from the community agencies, Mental Health Residential Services developed a Semi-Independent Living Program, which was also used by the community agencies providing housing, whereby clients on disability pensions who were felt ready to assume independent living, were given a rent supplement in order to obtain an apartment or room on their own. The rent would be paid directly to the landlord. A number of GVMHS clients, through agreements made by GVMHS administration, were assisted in finding accommodation through the B.C. Housing Management Commission. MHRS also had five group homes and two more supported hotels besides the Victory: the Portland and the Hampton Hotels. In addition, it had a few family care homes, which were unlicensed and privately owned, offering a family setting for a maximum of two persons.

By the early nineties, GVMHS had much more housing than in 1978 and a wider variety. Nonetheless, it should be noted that in the 1992 GVMHS Adult Information Services Brochure for clients that listed all these services, immediately afterwards added this caveat, "You should know that long waiting lists exist for most housing". There was never enough money to meet all the housing needs.

REHABILITATION SERVICES: (1986-2000)

As previously mentioned, rehabilitation services were provided by occupational therapists from the very beginning of the community care teams in 1973. Their services included individualized rehabilitative assessments and interventions,

group programs and consultation and liaison with community resources within their respective catchment areas. The Widget Factory has already been mentioned and the following are five additional rehabilitation services initiated between the 1986 to 2000 time period:

THE COTTAGE INDUSTRY: (1987)

In 1987 the Broadway Team's rehabilitation staff developed the Cottage Industry which, like the Widget Factory, was for lower-functioning clients who, with staff assistance, produced high-quality products at the Team or in the client's homes. These items were then sold at various locations throughout the city and clients received remuneration for their work. The Cottage Industry provided a wide variety of products geared to different skill levels which maintained client interest and motivation. Both the Widget Factory and the Cottage Industry helped clients with their self-esteem and provided structure where they could socialize and not be isolated. Products from the Cottage Industry won prizes at the Pacific National Exhibition and it was cited by the Canadian Association of Occupational Therapy as a model of patient-centered service.

GASTOWN VOCATIONAL SERVICE (GVS): (1991)

In 1991 the Gastown Vocational Service (GVS), a specialized inter-ministerial project, was established to offer comprehensive vocational assessment and job readiness skills training to higher functioning GVMHS clients and individuals referred by the provincial Vocational Rehabilitation Services. The "broad goal" of GVS was "to improve the individual's job readiness skills

and support network in order to assist them in becoming and remaining functionally independent in the community, based on their abilities and interests".

ART STUDIOS: (1992)

In 1990, staff from the Broadway and South Teams conducted a Needs Assessment Survey of their clients and found that 50 of the 52 consumers surveyed wanted more art activities beyond the pottery group there was running at a community centre. They lobbied GVMHS Central Office for funding and in 1995 they found a rent free space. They started out calling themselves The Fiddle-Faddle-Fingers Group, but as their activities increased to classes on painting, creative writing, drawing, watercolor, sewing , and collage, they changed their name to the Art Studios.

CLIENT ADVISORY COMMITTEE: (1992)

In 1992 in the Annual GVMHS Report, one of the new Service Goals listed was a commitment to "involve clients in program development and evaluation". This led to the establishment of a Client Advisory Committee which became a source of input on new and existing team programs.

GALLERY GACHET: (1994)

In 1994, with financial support as well as assistance from GVMHS staff, Gallery Gachet, another non-profit organization, opened with the purpose providing support to "consumer/survivor" artists. According to the Gallery staff, their

organization was unique and envied by consumer/survivor artists across Canada. Aside from the art works, Gallery Gachet also hosted monthly poetry and performance events.

PEER SUPPORT WORKERS PROGRAM: (1996)

In addition to the Client Advisory Committee in 1992, peer support began with an assertive outreach rehabilitation service called the East Side Rehabilitation. The aim was to give clients the opportunity to create stepping stones to work by providing peer support for those who had been described as "hard to engage" through the use of conventional approaches. The project proved successful and, with the 1992 service goal commitment calling for more client involvement, it led to the establishment in 1996 of the Peer Support Workers Program. It provided an opportunity for clients, former clients, or people who had experience with the mental health delivery system to become involved in providing services to team clients. Peer Support workers were placed in most of the mental health teams as well as the special projects of ACT, Bridging, Dual Diagnosis, and the Inter-ministerial Project.

SPECIAL PROJECTS: (1986-2000)

Between 1986 and 2000 there were many special projects that came into existence which underscored GVMHS'S expanding mandate to provide service not only to the seriously mentally ill, but to other groups with serious mental health challenges as well.

INTER-MINISTERIAL PROJECT (IMP): (1987)

The Inter-ministerial Project was established in 1987, jointly sponsored by Forensic Psychiatric Services, Vancouver Adult Probation, and GVMHS. IMP targeted the same clients as the Multi-Service Network but provided a hands-on approach by a team consisting of a Coordinator (Mental Health), a Probation Officer (Corrections) and four to five case managers. It was an ACT Team in all but name, but the label had yet to be coined in the psychiatric literature. The typical IMP client was young, treatment resistant, and had a diagnosis of schizophrenia or an affective disorder with concomitant personality traits such as those of the borderline or antisocial type. He/she was likely to have a drug and/or alcohol problem and to be periodically homeless. Many of them were also HIV-positive. All IMP clients were bound by a court order, either bail or probation. It was a shared caseload and the IMP staff's job was to attempt to maintain stability of housing, continuity of medical and psychiatric care, and to provide social and recreational support to these clients.

An evaluation was done on IMP and published in 1995 in the International Journal of Psychiatry
which stated:

> The techniques utilized by the IMP reduce the likelihood of the mentally disordered offender coming into conflict with the law. In addition, in those cases where a participant does come in conflict with the law, the advocacy role of the IMP case workers as well as the reputation of

> the program for managing clients successfully in the community, increases the likelihood that the client will be re-released into the community rather than being incarcerated because of a lack of community support.

In April 1995 at a conference in Toronto on Best Practices in Mental Health Care, IMP won the award for the outstanding case management program.

DUAL DIAGNOSIS PROGRAM (DDP): (1989)

In the late eighties, GVMHS was particularly influenced by the writings by Dr. Burt Pepper, a psychiatrist practicing in New York. He was invited as a guest speaker to one of the GVMHS Mental Health Conferences. Dr. Pepper persuasively argued that many individuals with alcohol and drug problems often suffered from a mental illness as well. As a result, GVMHS approached the Alcohol and Drug Program in 1989 to form a partnership called the Dual Diagnosis Project which focused on people with mental illnesses who also had severe substance abuse problems. This was the first such project of its kind in Canada. The DDP offered individual and group treatment for those clients who had the two diagnoses and also provided assessment, consultation, and educational workshops to both Mental Health and Alcohol and Drug staff.

MULTI-CULTURAL PROJECT: (1990)

Vancouver is ethnically diverse, the mother tongue of nearly 40% of the population is something other than English. In

response to their needs, GVMHS developed a city wide Multi-Cultural Program in 1990. The program supplemented the multi-cultural services already being provided by the teams in some of their catchment areas like the Mandarin/Chinese speaking mental health staff at the Strathcona Team. The Multi-Cultural staff languages included Chinese, Punjabi, Hindi, Spanish, and Vietnamese. They assisted the case manager and team psychiatrists and physicians in assessment and treatment of those clients who spoke these languages. In addition, the Multi-Cultural staff presented a large number of community workshops and translated mental health information pamphlets into all of the above languages.

BRIDGING TEAM: (1993)

In 1993 a Bridging Team was formed whose purpose was to work with hard to house clients being discharged from Riverview to support them in their successful integration back into the community.

WELL-BEING PROGRAM: (1993)

Also known as the Deaf, Hard of Hearing, and Deaf-Blind Well-Being Program, but shortened to the Well-Being Program, was established in May of 1993 to provide mental health services to people with the above disabilities who also had mental health problems. The program produced 3 videotapes in sign language, with captioning and voice over: *"Well Being & You"*, *"Caring for Yourself"*, and *"Working with a Mental Health Interpreter"*.

RIVERVIEW DIRECT: THE STRATHCONA PROJECT: (1994)

By the early '90s, the clients from the Strathcona Team when hospitalized, went to VGH, the hospital assigned to their catchment area. If the hospital stay for some became too long, they would be transferred to Riverview Hospital for further treatment. The communication between VGH and the Team was often poor. One of the physicians at the Team also worked at Riverview, and was able to negotiate an agreement with Riverview that they would set aside twelve beds on his ward for Strathcona clients who the Team felt would require longer stays. So instead of going to VGH first when these clients were hospitalized, they were admitted directly to Riverview.

Dr. Cumming would have approved of this project because it required that staff from the Strathcona Team would attend the ward rounds at Riverview concerning their clients and staff from the Riverview ward would come to the Strathcona Team for clinical discussions on the clients, as well as for an orientation to the community team. This sharing of staff with other mental health facilities was one of the major recommendations made by Cumming in his Vancouver Plan in 1972.

The project was evaluated by a Riverview psychologist and three of the major conclusions from his report were:

1. The direct admissions reduced the overall amount of time the patients stayed in hospital.
2. The direct admissions decreased duplication of treatments when transferring from hospital to hospital.

3. The results of a hospital staff questionnaire clearly indicated the Strathcona Project experience improved communication with the Team.

ASSERTIVE COMMUNITY TEAM (ACT): (1995)

In 1995 an Assertive Community Team was formed, involving GVMHS staff in partnership with the psychiatric sections of VGH, UBC, and St. Paul's Hospitals. It was designed to assist clients who were frequent users of emergency sections of the three hospitals, by providing assertive case management to improve their quality of life and consequently decrease their need to use hospital emergency services. In 2000 the ACT and Bridging Team (serving Riverview patients) were amalgamated and called the ACT/Bridging Team.

CHAPTER 5:
THE FINAL CHAPTER

The growth and changes in GVMHS from 1973 to 2000 have been captured in the three previous chapters. This last chapter, aside from describing the events leading to the demise of GVMHS, deals mostly with providing some of the praise GVMHS was given during these years, by experts in psychiatry who came to visit GVMHS to observe the community mental health services it was providing. One of these individuals was Dr. Leona Bachrach, a well-respected Research Professor of Psychiatry from the Maryland Psychiatric Research Centre. In 1992 she spent ten days visiting the GVMHS mental health teams, and special projects and presented her observations at a Staff Day Talk on March 11, 1992. Here are some excerpts from her speech:

> As for high points, I'd be terribly remiss if I didn't share with you my joy at finding a system of care—an entire system of care, not just an isolated program—that sees as its mission

> the enhancement of people who suffer from the most serious mental illnesses. Maybe you don't know how rare this, but I do. And I look upon your dedication to this cause with great appreciation.
>
> In fact, I think that GVMHS is quite exceptional in at least two ways. Not only is it exceptional for the persistence with which it guards and fights for its mandate in an era when champions of seriously mentally ill are hard to find. But it's also exceptional in the persistence with which it pursues and tries to anticipate threats to that mandate. A lot of systems of care that I know produce things like five-year plans—paper documents that talk about today's deficits and tomorrow's needs. But GVMHS is one of the very few systems that go beyond the paper-shuffling.

Dr Bachrach then goes on to talk about GVMHS' crisis services:

> Now, I would say that the crisis services in GVMHS are, in my judgement, among the best I've seen anywhere—largely because they take a very holistic approach to what a crisis is. Too often, in other systems of care, crisis intervention means pharmacological intervention and nothing more.

> Here, in Greater Vancouver, crisis services include crisis beds and a lot of remarkable on-site hand holding. There's also a strong and effective liaison with the police force, and this is quite innovative. .....It's very clear that GVMHS takes crisis care seriously.

Close to the end of her speech she mentions GVMHS' individualized planning:

> I truly believe that it's in this area – the area of individualized planning — that the Care Teams shine. When I think about the way in which this concept is supported by front-line workers here, I begin to understand why so many people in the States view Greater Vancouver Mental Health as a prototype and model. In fact, I've visited a lot of systems of care over the years, and I can honestly say that I've never seen another system in which the notion of clients' individuality is so firmly rooted. Clients here are people ...

In 1993 Dr. E Fuller Tory, another well-respected American psychiatrist, came to British Columbia to do a comparative study entitled "Quality and Cost of Services for Seriously Mentally Ill Individuals in British Columbia and the United States" which was published in the Hospital and Community Psychiatry Journal in October 1993. In the article, he refers to GVMHS by stating:

> GVMHS appears to provide better outpatient care than is available in any urban area in the United States.

In 1994 Dr. Douglas Bigelow, a psychologist associated with Oregon State University, wrote an article on GVMHS which was published in the Spring Edition of the New Directions For Mental Health Services Journal had this to say:

> The Greater Vancouver Mental Health Services Society (GVMHS) provides a rare demonstration of what is possible when the political will, together with certain structural elements, exists to make a long-term, straightforward commitment to a unified, administratively integrated service for seriously and persistently mentally ill people in the community
>
> Like any mental health agency, GVMHS has its deficiencies, problems, and frustrations. However, it has also delivered twenty years of dependable, effective service to people with chronic mental illnesses and has had very low staff turnover — all without the fiscal incentives and contractual pressures mistakenly thought to yield good performances.

There were more articles written that praised GVMHS other than the ones referenced above. But even as GVMHS was receiving international recognition, there were other events occurring at the same time within the larger provincial

health system which GVMHS had no control over. In 1991 the Ministry of Health established a "Royal Commission on Health Care and Costs" called the Seaton Report, after the chair, Justice Peter Seaton. The report was called "Closer to Home" and recommended more home care, more nursing care, the greater use of community clinics, and supported the move of hospital-based services into the community. As GVMHS was community-based, this sounded very favorable. But by 1996 the emphasis had changed to regionalization, and the eventual establishments in 1997 of six Health Authorities throughout British Columbia. The one having jurisdiction over Vancouver and Richmond was called the Vancouver/Richmond Health Board (VRHB). Eventually on April 1st, 2000. GVMHS lost its independent non-profit status and was integrated into the VRHB. Two years later the VRHB name was changed to the current Vancouver Coastal Health.

LOOKING BACK

In reviewing this history, it clearly shows that GVMHS never lost sight of its original mandate to provide service to the serious mentally ill, first with adults, later with families and children, and finally with geriatric populations. GVMHS pioneered community mental health services in the Vancouver area, and in the process, received international recognition as it focussed on individuals who, historically, were left untreated, and which drew interest and accolades from countries around the world.

GVMHS throughout its history, on behalf of its clients, reached out and made agreements with other service organizations such as the Police, Hospitals, Alcohol and Drug Programs, Corrections, Forensic Services, Human Resources (Now called "Employment and Income Assistance"), School Boards, along with a host of community agencies such as MPA, Lookout, Triage, Coast Foundation, and the Kettle.

GVMHS was adaptable and open to change. As the clientele changed from the early years in 1973, GVMHS recognized these changes and responded clinically by creating special projects like the Multi-Service Network, the Inter-ministerial Project, the Dual Diagnosis Program, the Multi-Cultural Program, the ACT, and the Bridging Teams. In the area of Rehabilitation, aside from the work done by occupational therapist and rehabilitation workers at the Teams, GVMHS created the Gastown Vocational Services, Gallery Gachet, the Art Studios, the Peer Support Program, and embraced the concept of consumer involvement by forming the Client Advisory Committee.

GVMHS also remained non-hierarchical, with each Mental Health Team and specialized unit being unique, and operating with a degree of autonomy within the overall policy guidelines of GVMHS. This was a feat for any organization of this size to accomplish and one which fulfilled the Fifth Objective of Dr. Cumming's Vancouver Plan (Decentralizing This New Community Service).

GVMHS pioneered community mental health services in the Vancouver area and left a legacy for future mental health workers and administrators which will be difficult to ever emulate and which should be acknowledged and not forgotten.

TIME LINE

1971	The Foulkes Report.
1972	Home Treatment Project. Cumming Report: The Vancouver Plan. (Blueprint for GVMHS).
1973-74	Establishment of 7 Community Care Teams: West End, Strathcona, Mt. Pleasant, Kitsilano, West Side, South, and Richmond.
1973	Full time Executive Director for GVMHS appointed.
1974	Family & Children's Staff acquired from Maples Family and Children's Clinic in Burnaby. Blenheim House acquired from Riverview.
1975	Venture acquired from Riverview. Vista acquired from Riverview. Riverview Outpatient Department acquired and becomes the Broadway Community. Care Team.

1978 Mental Health Emergency Service (MHES).
Mental Health Liaison Program.
Student practicum placements accepted for psychiatric nurses and social workers.
Finch Report.
First Mental Health Conference.

1979 Mental Patient's Association (M.P.A.) added to the Mental Health Liaison Program.
Strathcona Housing Project.
SAFER acquired.
After-Hours Emergency Service (amalgamation of Car 87, Venture's after-hours answering service and crisis line).

1980 Strathcona Housing Project.
Car 87 terminated.
The Vietnamese Boat People Project.

1981 GVMHS becomes first community based mental health organization in Canada to receive the Canadian Council of Accreditation Award.

1982 GVMHS psychiatric nurses win Arbitration Award.
Coordinator position changed to Team Director.
The Widget Factory.

1984 Japanese Film Crew's documentary on GVMHS mental health services.
"A Tale of Two. Cities". Dr. Morely Beiser conducts a research project comparing Vancouver's community mental health services with Portland's community mental health services.

GVMHS establishes Medical Director Position at Central Office and Area Clinician Positions at each Mental Health Team.

1985 Multi Service Network (MSN).

1986 Expo 86. GVMHS co-hosts an International Mental Health Conference.
GVMHS establishes a Family and Children's Director.
Adolescent Outreach Service (AOS).

1987 Inter-ministerial Project (IMP).
9 Non-profit community agencies added to the responsibilities of GVMHS:
Arbutus Vocational Rehabilitation Society, Canadian Mental Health Association (Vancouver/Burnaby), Canadian Mental Health Association (Richmond), CHIMO Personal Distress Centre, Coast Foundation Society, Kettle Friendship Society, Lookout Emergency Aid Society, Victory Hotel, and Triage Emergency Care Society.
The Cottage Industry.

1988 Community Training for Psychiatric Residents approved by B.C. College of Physicians and Surgeons.
School Mental Health Services. (Vancouver)

1989 Dual Diagnosis Program.
Youth Residential Consultation Service (YRCS).
Program For Abuse Reactive Children (PARC)

1990 Multi-Cultural Program.
Katherine Sanford Society added to the responsibilities of GVMHS.

Hamber House.
Geriatric Program begins.

1991 Broadway Team is split to produce Broadway North and Broadway South, making 9 Mental Health Teams.
Gastown Vocational Services.
Portland Hotel Society and Hampton Hotel added to the responsibilities of GVMHS,
Report of The Royal Commission on Health Care and Costs, named the "Sutton Report" and titled "Closer To Home".

1992 Client Advisory Committee.

1993 GVMHS establishes a Geriatric Director.
Bridging Team.
School Mental Health Services (Richmond).

1994 Riverview Direct.
Gallery Gachet added to the responsibilities of GVMHS.

1995 Assertive Community Team.
The Bright Spot.
Child and Adolescent Response Team (CART).
Attention-Deficit Hyperactivity Disorder Program (ADHD).

1996 Peer Support Workers Program

1997 6 Health Authorities established throughout B.C.
GVMHS comes under the authority of the Vancouver/ Richmond Health Board (VRHB)

2000 Broadway North Team is renamed North East Team and Broadway South is renamed Grandview Woodlands.
ACT and Bridging Teams amalgamate to form ACT/ Bridging Team.
GVMHS is integrated into the Vancouver/Richmond Health Board.

APPENDIX

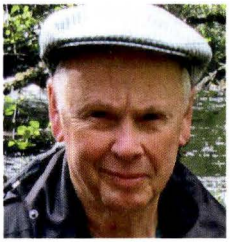
This history was very difficult and time-consuming to write. It involved having to collect notes, annual reports, periodicals, summaries of important presentations, information booklets and brochures, visit various libraries, and sort through old boxes left at Teams, and some in my own storage locker. Then there was the very valuable information I obtained from previous members of GVMHS staff. I ended up with a massive amount of material which I then had to decide how to organize to produce this history. In the process, I may have left out a program and, if so, the reason is that either I did not find it or if I did, there was not enough information to do it justice.

You will also notice that in this history I have left out the names of any GVMHS staff members. There were many who contributed to the success of GVMHS. This was deliberate. I felt that if I mentioned even one, I would never know where to stop.

Instead, I chose to focus entirely on GVMHS alone and tell its story from the early beginnings until its end in 2000.

L. Ralph Buckley M.S.W.

About the author



Ralph Buckley was Director of the Strathcona Mental Health Team from 1980 until 2005. Prior to that time, he worked at Health Sciences Centre Psychiatric Hospital and St. Paul's Outpatient Psychiatry Department in Vancouver. He was instrumental in developing special projects in the Downton Eastside such as the Multi-Service Network, the Inter-ministerial Project, and the Dual Diagnosis Program. He travelled to Japan and to the United States and made presentations regarding the community mental health services provided by The Greater Mental Health Service (GVMHS). He wrote and co-authored a number of articles which were published in various Psychiatric Journals. In 2001 he received the Distinguished Service Award by the Canadian Association of Social Workers "for outstanding contribution for the advancement of social work practice in health care". In 2003, the University of British Columbia presented him with the Unsung Hero Award and in 2004 Ralph was the first person to receive the CBC early morning "Bright Light" radio show interview.