PLAN FOR VANCOUVER

Dr. John Cumming

This paper is concerned with the development of a plan for additional psychiatric services to the people of the Greater Vancouver district. It should be read with the following important caveats in mind.

1) The plan at the moment includes only Vancouver City. Currently separate planning is proceeding in Burnaby and it is our intent to consider the North Shore and Richmond in the near future.

2) While this paper reflects the position of the Mental Health Branch, we are acutely aware that the success or failure of a plan depends on substantial agreement between the provincial government, local governments, agents and agencies already involved in Mental Health problems, and representatives of the community at the local level as to the specific needs to be met and the method of alleviating them.

3) The service system suggested here is not a complete system. Especially is this true for groups such as children and the elderly.

This plan is aimed at alleviating some of the problems which we meet in the operation of the present non-system. These problems, with brief comments on them, follow:

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

are aimed at this;

b) the problem of two kinds of psychiatry: public and private psychiatry - while they are overlapping fields, differ greatly in the therapeutic style used, in their patient mixes, and in their perception of "what psychiatry really is." This dichotomy works against optimal patient care since the use of a complete range of resources is not available to either group. We believe that this situation came about not because one group of therapists was morally superior to the other or that one group was vigorous while the other was apathetic but by misguided administration which by regulation and the management of funds divided these groups to the detriment of patient care. The current plan hopes to provide a setting in which this rift could begin to be solved;

c) problems of continuity of treatment and finding treatment - in the current situation getting treatment is a matter of having the energy or competence to seek it out and demand it for oneself. This is not appropriate for a class of illnesses, some of which manifest themselves through lack of competence. While our system is fragmente in order to minimize over-placement and over-use of facilities, it has as a central principle the organization and coordination of treatment facilities.

There are a number of what might be referred to as sub-problems, since they derive in large part from the previously cited difficulties. We could list briefly what is currently referred to as "professionalism," the opposition of established agents and agenci to the process of change, and the effect of public expectations and attitudes on the process of change. All these seem to derive

from practitioners being forced into less than optimal patterns of practice, then finding it necessary to defend these ways, and finally having to deal with a public who have come to believe that their defences were accurate. The inaccessibility of some therapeutic modes to some agents with inadequate referral methods makes inevitable the use of inappropriate methods of care. Finally, the problem of cost is assuming more and more importance. We have in the past developed a very expensive system. Before we extend what we currently offer, we will have to consider how to make what exists less expensive.

A Proposal.

We should emphasize that what follows is a description of a group of services to be offered in the community and by which we hope to change the service patterns to a majority of patients who without these services would be considered proper for treatment in a large mental hospital.

Disadvantages of the system.

We will not belabor the inhumanity of the traditional system. We state as a premise that treatment for mental illness should be humane, as effective as our knowledge permits, and readily available with a minimum of environmental dislocation. Nor will we recapitilate the arguments that large institutions are harmful, per se. We will rest our case on the twin arguments that these forms of treatment are relatively ineffective and that they are very expensive. They are expensive because of the generally high chronicity rate, that is, the number of persons who are not

Patronizing but we can expect on principle

discharged and whose hospital stay comes to be measured in decades. This is a minor but fiscally most important group.

To understand this situation better we must consider again the nature of much serious mental illness, particularly schizophrenia. These illnesses are inherently chronic and remain a powerful influence on the person between the more flamboyant episodes. The major symptom of the chronic state is a relatively pervasive lack of competence which makes normal life stresses become a crisis situation for such a person. In a crisis situation they tend to decompensate and have recurrences of their acute symptoms. Acute episodes are relatively easy to deal with by use of drugs and a structuring of the environment. To improve the stability of the chronic patient we can change his reaction to crisis, increase his competence, or both. Even before the advent of modern drug treatment, about 1954, most patients (perhaps 75%) were discharged from hospital. Today, an acute hospital which says that it only sends 15% of its patients on to a large hospital should be regarded as useless since it is only about 15% of patients who pose a substantial therapeutic problem. However, if as few as 6 - 8 % of patients move into the really long-stay category the hospital population will probably increase and with it the treatment cost.

The Needed Elements of an Alternative System.

The first element of an alternative system should be problem solving help, easily and quickly available when needed. Not only should help be available but the patient must feel and

believe that it is available. Help would be defined here as any manoeuvre which will alleviate a crisis situation. It is down to earth and practical. The second element should be some sort of learning situation where either the patient is made more competent and thus less subject to crisis or the patients reaction to crisis is changed.

The core of our system we will call the Community Care Service. A Community Care team would take primary responsibility for the care of serious mental illness from an area whose population ranged from 50 - 100,000 depending on the rate at which the area generated serious illness. Those who are familiar with the current Home Treatment Experiment will see similarities between the functions of the Home Treatment Team and the Community Care team. We have given the group a new name to indicate that in this plan they play a wider and more general role than they were able to play in the absence of a system of service alternatives to hospitalization. It might consist of an administrator, a psychiatrist, a senior mental health worker (i.e. a qualified and experienced social worker, psychologist or graduate level trained psychiatric nurse) and five or six basic mental health workers (in our experimental studies we have used psychiatric nurses, elsewhere psychiatric aides with special in-service training have been used). Any person who was considered seriously mentally ill would be referred to this team and team members

would quickly assess him, usually by a home visit made by one or more team members. If upon assessment the person seems to need treatment he is accepted by the service, if not he is placed with the most suitable alternative help available. The most common reason for non-acceptance will be that the person is not sick enough. If he is accepted he will be assigned to a basic worker who will be his helper, advocate, therapist and friend until he is discharged from the system of services. This is the core linking service and a patient must be accepted into it before he can use any of the specialized services ancillary to it. The task of the basic worker is to see that the patients problems are solved, through his own efforts if possible, but with guidance and outright assistance if that is necessary. Over time we would expect the basic workers to become proficient in working with therapeutic groups and to understand drug therapies. While in some cases the patient might be managed by the Community Care Services alone, it would be more usual that responsibility would be shared by a referral to one or more specialized services. We would emphasize that the basic worker-patient relationship would be maintained throughout these additional contacts and that the patients final separation from the system of services must be effected by the Care Service.

The Ancillary Services and their Functions.

We must recognize that usually the initial contact with a patient will have been preceded by crises which they have been unable to resolve, and a subsequent decompensation. For many of these people who live a life of marginal financial as well as interpersonal adjustment the crisis may well concern itself with practical matters such as shelter, food, or medical care. Therefore, the system must contain the means of often solving these problems on a short term basis and occasionally solving them for considerable periods of time, although for the most part long term solutions already exist in our society. In the short term then, we will need instantly available hostel places, and since some of these patients will be moderately disturbed or confused, we would want these hostels to be staffed by persons experienced in and competent to manage this sort of mentally ill person. This would be a short term placement since in a short time the person should be able to return to his own home or if he has no home, move on to less supervised accommodation.

Agree in principle - No

Having hopefully solved the problem of the patients immediate basic needs we should be able to move on to strengthening his ability to deal with future crises. As we have mentioned earlier, an important part in this process will be played by the basic worker in dealing with recurrent problems of living with the patient. We will also need more specialized services. The problems which these services (which we have called "competency training services") will deal with fall

All the contradictions of opposing a medical to a social explanation

largely into three groups;

a) problems of goals, norms and values

b) problems of instrumental skills

c) problems of inter-personal relationships

The first and third of these are best dealt with in a day hospital sort of setting, the second in a rehabilitation and sheltered workshop complex. To deal with the instrumental problems first: anyone who has worked in a large hospital is probably aware of the very inadequate work histories of many patients. This is often blamed on the patients eccentricity. Yet we know that employers will accept a good deal of unusual conduct among their employees if they are efficient workers. Rehabilitation services will have to be of a much broader range than is usually conceptualized, they may include training in using transporations systems, using a telephone, the meaning of pay-roll deductions, as well as more focussed skill training. Often key inadequacies will appear in areas where they are not usually expected and part of the skill of workers in these areas will be in finding the crucial area of incompetency.

Often however, defects will be found in the area of inter-personal relations, and of goals, norms and values. A person must be able to set goals for himself which are culturally tolerated and be able to pursue these within the accepted rules of his society. Some mentally ill persons have simply never learned these rules. Further, as we move through life all of us have to maintain at least a minimum of satisfactory interpersonal relationships. The person who is unable to participate in a work group will have difficulty in holding a job. Many people have difficulty with authority relationships; the mentally ill perhaps suffer these in exaggerated form. Both of these problems

can be dealt with in day hospitals, mainly through a number of forms of structured group activities ranging from conventional group therapy, through work project groups, to the discussion of current events. The day hospital must not be just a baby-sitting service. Its staff must clearly delineate what they hope to accomplish and what means they will use to attain their ends. If they do so they can be an invaluable specialized resource. Day hospitals may have to be specialized in function to deal with various age groups whose problems differ sufficiently to merit programs adapted to their particular needs. Finally, a certain portion of patients will be so disturbed at the time of first contact or may through mishap or error in the course of their treatment become so disturbed that hospitalization becomes a necessity. Hospital care, whether in a large hospital or in a ward of a community general hospital should, however, be much less frequently used than is the case traditionally and should be for shorter periods of time than we usually expect. It should be emphasized that it is highly desirable to have the inpatient service organized into units which deal with patients from a given geographic area which would coincide with that served by a Community Care team. The Care team should be involved in the process of hospital care and the hospital staff should serve part time in the community services. It is only through each part becoming sharply aware of the system nature of this care pattern that it can function adequately. Staff sharing will be a major device used in integrating this system.

So far we have ignored the possibility of dealing with patients problems through traditional psychotherapy. We believe that this form of therapy is not regularly indicated with this population. However,

there will be cases where it is indicated and in these infrequent cases it should be available. While some of these patients might well be referred out of the system to the private sector some workers will want to maintain or increase their skills in this area. The system should provide some time for this purpose and proper organization and supervision so that it can be properly carried out. It would, however, be a perversion of the system as we conceive it if a major part of the time of treatment personnel were spent in this way. We have attempted to show the relationships which we have described in diagrammatic form. These represent the internal relationships within the treatment system. We will now turn to the problem of relating this system to other helping organizations in the much larger non-system.

Relating and coordinating the system with the non-system.

The devices which are used to link this treatment system with other agents and agencies might be classified as follows:

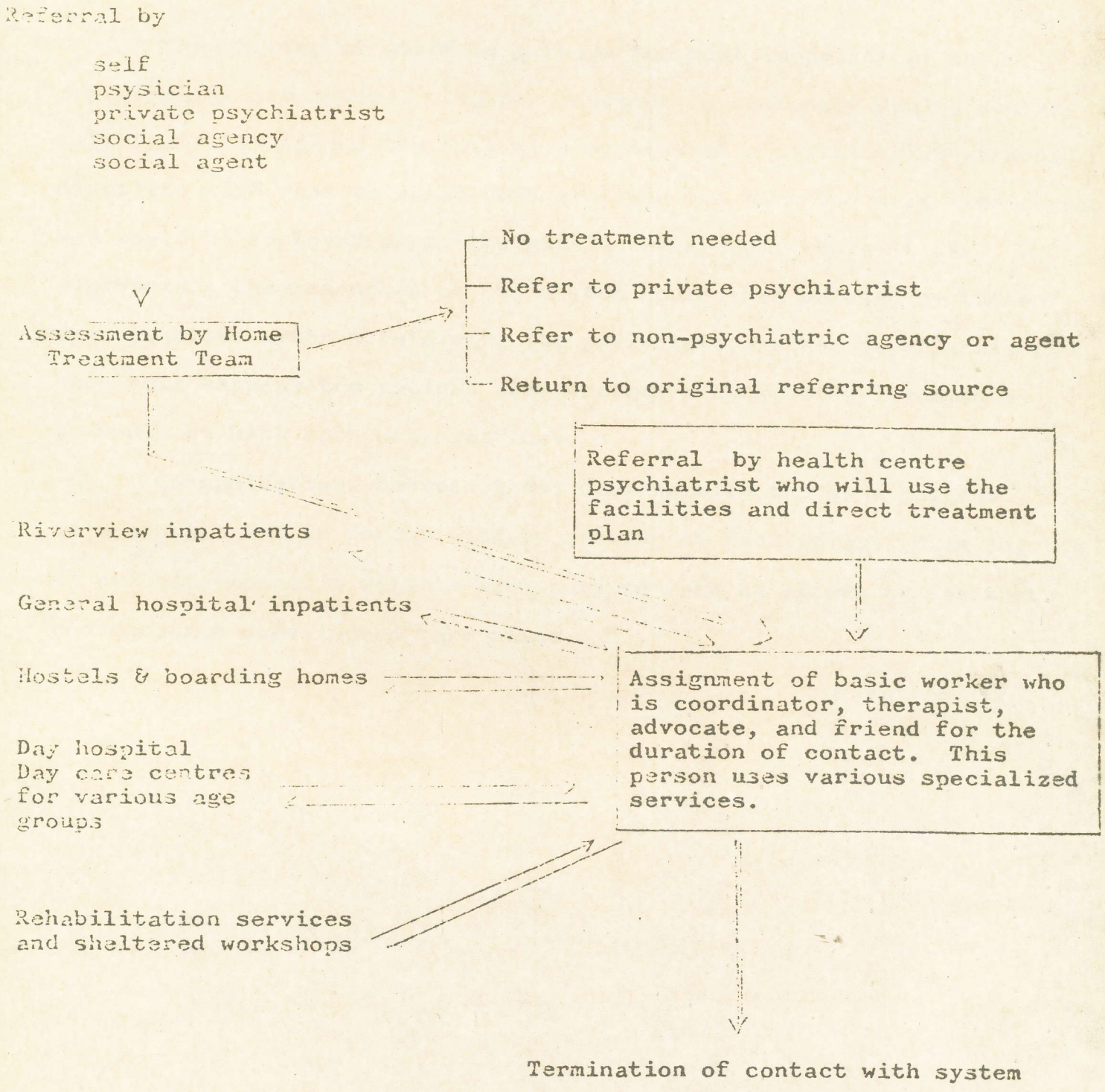
a) the sharing of staff
b) the sharing of work space
c) the sharing of organizational sponsorship
d) agreements on division of labor or the sharing of the client
e) consultation both ways - or the sharing of skills and information

We would find it most important to link this system with, among others:

1) the general medical care system, with special emphasis on community health clinics as they develop
2) the welfare system, including job placement agencies
3) the systems devoted to controlling behaviour - especially police and probation
4) the educational system

RELATIONSHIPS OF TREATMENT SERVICES

- THE PATH OF THE PATIENTS -

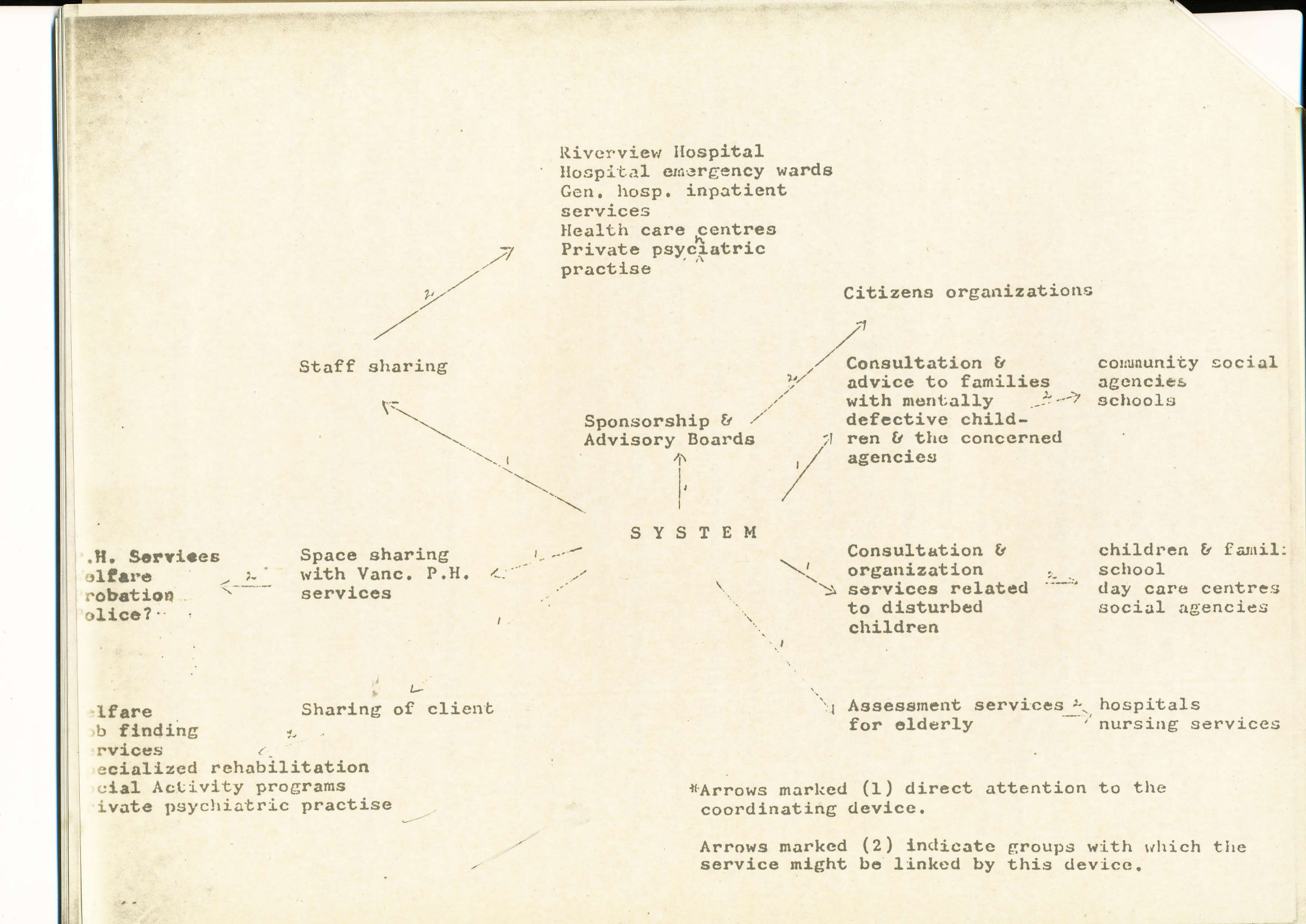


5) the network of community groups and agencies who define needs and monitor services

6) the private psychiatric practise system

The sharing of staff is perhaps the most important of our coordinating mechanisms. If, for instance, a community health centre felt that they needed the full time service of a psychiatrist we would negotiate with them to split this position and hire two half time persons who would be employed part time within the system. When it was appropriate the resources of the system could then be used by these psychiatrists without referring the patient to another psychiatrist. When this happens the patient also becomes a link, being involved as he would be with both organizations.

Communications between those dealing with the same patient is essential and is facilitated by sharing of facilities. Even so, in our experience it will be necessary to make an effort to see that coordination does indeed take place.



*Arrows marked (1) direct attention to the coordinating device.

Arrows marked (2) indicate groups with which the service might be linked by this device.

By the sharing of organizational sponsorship we refer to the possibility that a hospital might provide space, administrative support services, and perhaps a noon meal for patients to enable a day hospital for the elderly to be established. Personnel for the centre might be recruited, trained, and supervised by some part of the system of service. The single administrative auspices should make it easier to use other services of the sponsoring hospital such as physical diagnostic facilities in a health care program for the clients.

By and large these devices are self-explanatory and some of the specific targets for specific devices are set forth in the accompanying diagram. We will not labor the argument here. Sufficient that we recognize that our system can be neither self-contained nor self-sufficient and that we consider it essential to integrate it with other helping agencies. We might, if we are fortunate, succeed by means of this device in improving the coordination between groups of agencies outside of our system who might be brought closer by their joint involvement in our service.

Integration (w. MAA)

A Description of the Elements of Service and their Impact on one Another.

A list of community services which would seem to be reasonably comprehensive follows:

1) A Community Care service - this is central to our concept because it is aimed at replacing expensive inpatient services with less expensive community services and thus hopefully releasing resources either for the improvement of necessary hospital services or building services in other areas where none exist at present.

emphasis on cost reduction

2) Advisory services to those providing services to children - this

is advocated rather than extensive additions to inpatient services because of the high cost and equivocal results of present inpatient services. Many minor disturbances can be dealt with in ways that alleviate the distress of children and parents. It may be that this sort of crisis would spontaneously resolve in time. This, however, does not prevent us giving treatment to shorten the duration and alleviate distress in these conditions. We spend considerable amounts alleviating distress in physical illness with similar prognoses.

what ways?

3) Day care and activity centres for the elderly - these centres which should provide diagnostic work-ups, treatments such as Folsom's "reality therapy" and social problem solving assistance have demonstrated their ability to solve many problems of the impaired elderly person and to reduce the use of hospitals and nursing homes.

4) Day hospitals for full day treatment of patients who would otherwise require inpatient care - these facilities can also be used in shortening hospitalization and in providing programs to help re-introduce those in family care into fuller participation in the community.

5) Sheltered workshops and rehabilitation centres - to provide those much-needed skills to stabilize the inadequate mentally ill person in the community.

6) Hostels staffed with experienced help who can handle a moderate disturbed psychotic for a few days who with this assistance could obtain treatment in the community.

7) Living accommodations - probably both family care and hostels which are not so well staffed as those above for longer term accommodation of minimally disturbed persons.

8) Emergency or crisis centres.

9) Advisory and consultation service to families with mentally defective children.

10) Diagnostic assessment and counselling for disturbed persons who might in many cases obtain longer term help from private practitioners. This might well be provided by part-time involvement of private practitioners on a sessional basis.

11) Boarding home care program workers.

We will now consider the more important of these services in greater detail.

Community Care Program Team

This team will consist of:

1 administrator

1 psychiatrist

1 senior mental health worker (i.e. qualified and experienced Social worker, psychologist or graduate level psychiatric nurse)

6 basic mental health workers (in our experimental study we have used psychiatric nurses, elsewhere psychiatric aides with special in-service training have been used)

1 occupational therapist

2 stenographers

12

On the basis of our experience to date we estimate the case load of such a group as about 180 patients with an average period of time in treatment of about a year. They would thus receive about 15 new cases a month and terminate a similar number. At the present time Riverview receives about 60 cases a month from Vancouver city. We know, however, that this is not meeting current needs. Several years ago the intake was about twice the present figure (too high for Riverview to handle adequately even with minimal staff vacancies). Since few new services have been added

in Vancouver we must guess that while a few may have been sent to hospital unnecessarily it would be wiser to assume that the figure of 120 admissions per month reflects a reasonable estimate of legitimate demand. If this is true it would need eight teams to serve Vancouver city. We envision that there would be staff-sharing between the Community Care team and the Riverview service which serves the same area as they do. Since they will serve the patient from the moment he enters the service until he terminates his connection with the service, the need for an outpatient clinic would gradually be eliminated. Also, they would in time come to have all boarding home patients in their case load so that they would then provide the much-needed emergency backup for this service. Their activities would provide the necessary cohesion between the various elements of the service system.

The next elements.

The next most important elements of the treatment system in order to maximize the usefulness of the home treatment teams would be hostels for moderately confused or disturbed persons and day hospitals to provide programs similar to those which could be expected from a good inpatient service, but on a two work-shift basis. There will be many patients who will not need the degree of control which can be provided in an inpatient service but who yet need a certain amount of supervision during periods when partial care services are not in operation. While hospital beds in the community could be used for this purpose it would consititute overplacement. At any rate, a hostel with a

competent but minimal staff could provide two-shift coverage for moderately disturbed patients where this could not be provided by his family or friends. Probably about eight places might be needed for the above-noted purpose. Since a hostel for about 12 persons can be operated with little more expense than one for four the remaining four places might be used to assist persons who have left hospital over acute crises and to facilitate shortening of inpatient stays.

The day hospital provides another core element of this system. It would provide a strong emphasis on group interaction. One of the two which are proposed might focus on a therapeutic community type of organization while the other might be more overtly aimed at skill training. This element will replace the ward program of an inpatient service and will be used both for those who have never been hospitalized and as a continuation of treatment for those who are discharged from inpatient services. The staff for the hostels would be about six persons, for each, probably psychiatric nurses. The staff of a day hospital might be:

1 ½-time psychiatrist

1 ½-time social worker

1 occupational therapist

1 occupational therapist assistant

1 basic mental health worker

We propose that we set up two hostels and two day hospitals and tha these facilities should be used by all teams.

Third level elements.

These services are the remaining listed services for the

adult mentally ill. We will consider services for children and the elderly separately.

1) sheltered workshops and rehabilitation centres

2) emergency and crisis centres

3) living accommodation

4) family care program workers

Sheltered workshops and rehabilitation centres have two important aspects. Many mentally ill persons have few work and adaptive skills. The lack of such skills means that they are more often than others caught up on social crisis situations with the attendant stress that these produce. We think it has been demonstrated that training in vocational skills decreases the numbers of such critical situations and at the same time makes the mentally ill person more competent in dealing with the crisis. Looked at in another way, if the mentally ill person is going to require transfer payment support in order to live in the community, this subsidy costs little more to deliver through payment for work, however inefficient, than through normal welfare channels. It has the advantage, of course, of adding dignity to the process. It may not be too long before we are engaged in a process of finding ways to keep a larger part of the population out of the work force. When and if this occurs this part of the treatment system would have to be rethought. Sheltered workshops and day hospitals might well be operated in close conjunction with work providing an important activity for the day hospital. We have at this moment not fully investigated the facilities now available in the community for these purposes. In the first two years we would contemplate using the existing assessment facilities at Riverview to provide

the rehabilitation function and to set up no more than two sheltered workshops (or to use funds to expand already existing community facilities). Capacity of each workshop would be about 30 persons with a staff of three;

Emergency and crisis centres.

Currently crisis centres are generally operated by volunteers. We would not interfere with this arrangement except perhaps to plan to meet any requests for training and consultation and to accept referrals as appropriate. An important and overworked community service at the moment is the hospital emergency service of Vancouver General Hospital. The proposed network of services should do much to alleviate their problems. Based as they are on the idea that if service is needed for a serious mental illness that the home treatment team is responsible for offering such a service or of obtaining it from other agencies the problem of disposition of patients should be greatly reduced. This should leave time and resources to improve the assessment process part of the total services. The need here is not so much for new resources but for a reorganization of the present functioning so that it can efficiently coordinate with the network of community services. It may be necessary to have a coordinating person in attendance at V.G.H. during the evening hours so that efficient coordination results and that delays in the transfer of responsibility are obviated.

Living accommodation.

As a mental health expense we would presumably only be

responsible for finding accommodations if this function is not being performed elsewhere. We would, of course, anticipate that there would be an increase in welfare costs as the result of the policy of keeping people in and returning people to the community. No costs are estimated here.

Family care program workers.

As we have mentioned previously this is a function that would be taken over by the various other parts of the network as it becomes developed. Thus the provision of such workers would be a temporary expedient in order to make this program more acceptable in a short period of time. Thus, they would not increase the overall cost of the program but they will increase the amount spent during the developmental phases.

Advantages of the proposed new system.

The prime advantage of the new system is that it proposes to incorporate a component aimed at ensuring that the services remain available to those for whom they are devised. 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.

the system needs most of its elements to be effective. It should, therefore, be introduced region by region rather than introducing one service and then another. This approach in other places has led to situations which have resulted in justifiable criticism. If we are going to reduce hospitalizaiton we must substitute a service which is at least as effective.

not an overly ambitious aim

Services for special groups.

In naming services for children, the elderly and the mentally retarded as part of this system we are under no illusion that what we propose is a definitive system for these groups. The services which are proposed would not conflict with current services, they would add needed elements of service and they would provide a focus for further study and development.