GENERAL MEETING OF THE CITIZENS' COMMITTEE
OF THE GREATER VANCOUVER MENTAL HEALTH PROJECT

Tuesday, June 5, 1973.

AGENDA

(1) Presentation of minutes of last general meeting.

(2) Report by Steering Committee on progress to date.

(3) Recommendations and Discussion.

(a) That a 3-person Personnel Committee be struck to act in concert with the Project Personnel Committee in the selection of members to the Team.

(b) That one member of the Citizens' Committee be elected to sit on the Coordinating Committee of the Project from the Kitsilano area.

(c) That the Steering Committee be empowered to consult with legal and other counsel re our legal structure.

(d) That the Steering Committee be empowered to look into budgetary requirements for the Kits Team.

(e) That it be recommended to locate the Team in a more hospitable location than the regular institutional building (in concert with principles delineated in the Policy Guidelines document).

(f) That discussion in this meeting and further meetings in the near future determine the actual makeup of the Team so that activity in relation to Rec. (a) abovemay proceed.

(4) Further Business.

(5) Adjournment.

June 19, 7:30 Kits House

Butch Leslie
Nick Zepantis

POLICY GUIDELINES

CITIZENS' COMMITTEE OF THE KITSILANO MENTAL HEALTH PROJECT

A. PREAMBLE

The Citizens' Committee of the Greater Vancouver Mental Health Project in Kitsilano was formed, in part, to ensure adequate nonprofessional citizen involvement in the broad program being formulated. It had become clear, by Fall of 1972, that a major restructuring of the mental health program was being enacted on the basis of a report written by Dr. John Cumming for the new NDP government (see attached document). This, in concert with proposed changes in the provincial Mental Health Act (see Appendix A) suggested a radical departure from former practice. The idea, clearly, was to extend treatment into the very homes of the citizenry.

While this has potentially positive characteristics, many citizens in Kitsilano felt the need for further information. It was believed by some that, because of their past experiences with the mental health establishment, this plan was a further encroachment on their daily lives without necessarily benefitting, nor more importantly being controlled by, them. Investigative research conducted in the main by the Mental Patients' Association supported the contention that a far-reaching bureaucracy had already been set up, making any forthcoming "citizen participation" rather meaningless, and quite obviously providing the stamp of approval required by this politically-sensitive program.

While this may be true (and there is evidence from the West End situation to verify the contention) the citizens of Kitsilano expressed, in a number of well-attended and broadly-representative meetings, their desire to at least get a foot in the door. This Citizens' Committee and its related documents are results of the expressed desire of residents in this and surrounding communities to have a large say, if not control, in the mental health program affecting them.

B. TREATMENT PRINCIPLES

The total membership of the team as it is presently conceived by the Coordinating Committee (see Appendix B)and its related Planning and Advisory Committee is totally "professional". It is not an exaggeration to state that many individuals who have been through the large public mental health system distrust professionals. This is due in part

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Set up grievance committee
All clients given full info about program + role of grievance committee

to treatment methods, in part to general attitudes of nurses and doctors, and in part to the whole fabric of mental health philosophy guiding the program. In any case, many former patients, as well as other interested citizens, want a say in the program; more importantly, they expect better and more humane treatment when in need. The dignity of the person seeking help should be the paramount concern of the Team. The following principles can serve as a guide to the type of treatment expected:

(i) People should be treated with respect as the individuals they are and not solely on the basis of arbitrary classification (ie. this sort of patient as opposed to that sort of patient requiring some specified rigid treatment);

(ii) As many of the problems confronting the Team include physical, emotional and intellectual elements, sensitive individuals are needed who can adapt to their patients, as opposed to forcing their patients to adapt to them or their ideas of what is normal;

(iii) It must be recognized that an essential element of any "treatment" is the subjective bond formed between the person seeking help and the Team member. This relates to (ii) above, and emphasizes the need for a new approach to treatment.

(iv) Occupational therapy is valuable if it teaches the person a useful skill. It is a waste of everyone's time to attempt to evaluate a person's ability by grading his interest in making wallets;

(v) In the case of "freaking out", intensive efforts must be made by staff and volunteers to help the person deal with the shame he/she feels at freaking out. He/She must be helped to deal with the terror experienced at the thought of freaking out again (by recognizing the relevant physical symptoms and deal with them consciously, etc.)

(vi) People coming for help must be encouraged and aided to take up the threads of their life again and contribute to the community in a meaningful way.

(vii) Drug therapy should be kept to an absolute minimum, for too often it has been used as a method of keeping the person quiet as opposed to functionally helping him/her. If a person is depressed, there is usually good reason for it, such as unemployment and poverty, family hassles, etc.

(viii) Embodied in (vii) above is the recognition that humane "treatment" on an individual basis is no substitute for widespread social reform at every level.

(ix) It should be obvious that ongoing consultation and cooperation between staff and people seeking help is a necessary prerequisite to a successful and meaningful program. Grievances should be dealt with democratically, either through an advisory executive and then to a general meeting of staff and recipients, or through some other mechanism jointly determined.

(x) It is felt that constant followup work is important, not only from the point of view of funding, but for the general interest and morale of all participants.

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(C) TEAM OBJECTIVES

Generally, the objectives of the Team are to provide better health care for those who want it. Specifically:

(i) To treat in the community people who would ordinarily require hospitalization, and to shorten hospital stays of those who require in-patient care;

(ii) To provide alternatives to rehospitalization of those recently discharged from hospital;

(iii) To provide an organizational base for a variety of community mental helath programs for all ages and for the necessary pre-planning of these programs;

(iv) To assist other agencies, community groups and associated personnel to deliver better care to the mentally disabled.

While these are the prescribed objectives of the Team, it is obvious that without community support there is very little chance of real success. Therefore, it is further suggested that:

(v) The team work in partnership with community representatives in order to ensure that it is responsive to community needs and that community resources are used to best advantage; and

(vi) Citizens be encouraged to participate in all phases of the team's work, including planning of services, evaluation, and direct service to the people. (In this regard, it is anticipated that some citizens will become paid members of the team.)

(D) CITIZENS' COMMITTEE

Throughout this document, and as has been expressed in the extensive community activity surrounding this program, citizen input, if not control, is a key element. If this is to become a reality, this body must be broadly representative of all classes and interests in the community, must conduct itself democratically and responsibly, and must encourage the voluntary association of people interested in its work.

Eventually, the Steering Committee as presently constituted must give way to a more formal elected Executive with clearly defined powers. The details of the actual organization await further consultation;however, in the meantime as later on, some formal liaison must be developed with the Program's apparatus as is presently conceived. Therefore, it is necessary to have elected citizens on the Personnel Committee (responsible for hiring staff), on the Budget Committee (responsible for determining finances), and on the Coordinating Committee of the Greater Vancouver Mental Health

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Project, as well as any other bodies charged with the continuing planning and management of the mental health team in Kitsilano. In terms of hiring, it is further felt that while professional training does confer useful knowledge and skills, previous experience and capability are more important than professional qualifications. Specifically, the Citizens' Committee should be charged with:

(i) Reviewing on a regular basis the work of the team;

(ii) Providing organized channels wherein effective citizen input can be realized;

(iii) Actively publicizing the work of the Team and of other groups that offer mental health services in Kitsilano so that

- people who need the services can find out where and to whom they might go in trying to resolve their problems.
- the community can begin to have information that is necessary for determining the mental health needs of Kitsilano and the range of services that are needed.

(iv) Acting in a liaison and organizing capacity to coordinate relations with other groups in the Kitsilano area whose interests impinge on mental health.

These objectives can be reached only if there is effective citizen voting power on the bodies determining the goals, orientation and practice of the program, including the committees mentioned above (also refer to Appendix C below).

(E) LOCATION

Not insignificant in the method of service delivery is the location of the Team offices. This location should not be situated in the sterile conditions reminiscent of impersonal institutions, but rather in a warm, home-like setting (Kitsilano House is a good example). Setting is important in creating the atmosphere of humane-ness, sensitivity and involvement which is at the very core of our wish for better treatment.

(F) CONCLUSIONS

This document, by no means complete, has attempted to formalize the history, desires and goals of the community Citizens' Committee, and to help guide its future direction. It cannot be too strongly emphasized that a community health team without extensive community support and involvement is a mockery. We feel that our proposals are realistic, sensible, and totally in keeping with the more progressive philosophy embodied in a community approach to community problems.

client participat

The time for involvement is now.

Appendix A

Mental Health Act - proposed changes

During the fall '72 legislative session, the N.D.P. government introduced Mental Health Act ammendments. These proposed changes were later withdrawn. However, most information indicates that they will be reintroduced next session.

The most salient features of this legislation are as follows:

(i) Decentralization of facilities - any building may be designated as a Provincial Mental Health facility. Any hospital or part therof may become an observation or psychiatric unit. This is an attempt to expand as well as decentralize.

(ii) Centralization of power - the cabinet or government-created societies (see Appendix C: Community Care Services Society) may administer funds and develop new facilities. The cabinet and the Ministry of Health will have more direct responsibility and control.

(iii) Increased detention periods - a person may be confined in a psych unit for up to 60 days (formerly 30) before release or transfer to a Provincial institution (e.g. Riverview)

(iv) Easier involuntary committal - a police officer may initiate committment proceedings against a person on the basis of "information received by him" (the officer). Formerly this could be done only on the basis of the officer's own observations.

While some of the decentralized features of the proposed changes are progressive, the more centralized ones pose a potential threat. They consecrate power in the hands of a few (i.e. The cabinet, the Health Ministry, Directors of facilities, the police and, at least by implication, Mental Health workers.) It seems that the only way for citizens to limit or eliminate abuses of power in their own neighbourhoods is to organize with the objective of determining that the people who work within the Mental Health system will not choose to impose their power upon their patients or upon the community.

APPENDIX A (i)

MENTAL HEALTH ACT

NEW

24 A (1) Where the requirements for the admission of a person under section 23 have been fulfilled, the officer in charge of a psychiatric unit may admit that person to the psychiatric unit and detain him there for a period of thirty days after his admission, or for such longer period, not exceeding a further thirty days, as the officer in charge of the psychiatric unit may authorize, within which period he may be transferred to a Provincial mental health facility.

OLD

24 (3) Within a period of two months ending on the day on which a patient who has been detained in a Provincial mental health facility would cease under this section to be liable to detention in default of renewal under subsection (2), the Superintendent of the Provincial mental health facility, or a physician authorized by him to do so, shall examine the patient and either discharge the patient or record a written report of the examination and include therein his reasons for concluding that the detention of the patient should be renewed, and the report is a renewal of the authority for the detention of the patient.

NEW

18 Subsection (1) of section 27 is amended by adding, after the word "observations" in the second line, the words "or from information received by him".

OLD

27 (1) Where a police officer or canstable is satisfied from his own observations that a person in a public place

(a) is acting in a manner likely to endanger his own safety or that of others; and

(b) is apparently suffering from mental disorder,

he may take such person into custody and take him forthwith to a physician.

SCHEDULE B

APPENDIX B

GREATER VANCOUVER MENTAL HEALTH PROJECT

BUDGET ESTIMATE - April 1, 1973 - March 31, 1974

BURRARD SERVICE AREA - WEST END COMMUNITY CARE TEAM

Personal Services

Psychiatrists* @ $87.50 per session			
1 @ 250 sessions (½ time)		$21,875	
1 @ 250 sessions (½ time)		$21,875	
		$43,750	$ 43,750
Team Administrator **	1 @ $19,812		$ 19,812
Senior Mental Health Worker ***	1 @ $14,880		$ 14,880
Community Psychiatric Nurses			
Grade III	2 @ $10,620		$ 21,240
Grade II	4 @ $ 9,840		$ 39,216
Occupational Therapist Grade II	1 @ $10,620		$ 10,620
Stenographic - Clerical Staff:			
Clerk-Steno III	1 @ $ 7,908		$ 7,908
Clerk-Typist II	1 @ $ 6,624		$ 6,624
			$149,518
Associated Benefits:			
B. C. Medical Plan	@ $75/person (11)		$ 825
U I.C	@ $63.36/person (11)		$ 696.96
			$ 1,521.96
TOTAL			$151,039.96

100% Admin

BUDGET ESTIMATE (CONTINUED)

BURRARD SERVICE AREA - WEST END COMMUNITY CARE TEAM

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Travel	b/f		$151,039.96
For 9 staff @ $650		$ 5,850 *	
Accommodation			
2000 square feet @ $6.00 per sq. ft.		$ 12,000	
Utilities			
Telephone installation and rental Answering service and pagers		$ 3,000	
Equipment & Furniture			
Office, waiting room and O.T. area		$ 7,500	
Supplies and Materials			
Office and O.T.	$ 2,000		
Medical	$ 6,000	$ 8,000	
General Expenses			
Petty Cash, patient transportation, in-service education, purchase of ancillary services, e.g. homemaker		$ 2,200 *	38,550.00
			189,589.96
	Budget Total	$189,589.96	
LESS: Sessional services recoverable from B C Medical Services Commission		$ 43,750.00	
		$145,839.96	
BUDGET TOTAL			$145,839.96

* Recoverable from B C Medical Services Commission

** Based on Psychologist III maximum salary level plus $100 per month for administrative responsibility.

*** Based on Social Worker II maximum salary level

April 11, 1973

COMMUNITY CARE TEAM OBJECTIVES

Initial community care team objectives shall include:

1. To provide a better service to the seriously mentally disabled in the community.

2. To treat in the community patients who would ordinarily require hospitalization.

3. To shorten hospital stays of those who require in-patient care.

4. To provide an alternative to rehospitalization of those who are discharged from hospital.

5. To provide an organizational base for a variety of community mental health programs for all ages and for the necessary pre-planning of these programs.

6. To assist other agencies to deliver better care to the mentally disabled.

Description of Service

The personnel of the Community Care Team will be considered as a unit with the staff at Riverview Hospital and other specialized services which they use. They will have access to beds at Riverview and in community hospitals wherever possible. Their services will be available to the seriously mentally disabled of the region which they serve. Arrangements will be set up to enable them to assess all persons who are considered to have a major illness and to treat as many as possible. If a person is hospitalized they will maintain contact with him during his hospital care and obtain his discharge into their care as soon as his illness has abated sufficiently to allow this step. They will give service as needed to those who have been discharged from hospital. They will endeavour to help the mentally ill person to solve his social, personal medical and other problems by his own efforts, but if these are thought to be beyond his powers they will seek solutions for him through their own efforts or by use of other agencies. They will routinely assess other members of the patient's family in search of disabilities in functioning which indicate potential future troubles and move to strengthen the family against overt illness. If they find on assessment that a person is not ill enough to warrant their services they will be responsible for the completion of a referral to an appropriate agency. They will work with other agencies in a consultative or educational capacity where it is appropriate in order to strengthen that agency's ability to handle more effectively mental disorders among their clients. They will work cooperatively with other agencies who serve the mentally ill in the community and to help them make their efforts more productive. They will serve through their area committee or board as a community focus for planning for an extension of services into areas which are presently ill-developed. They will regard themselves as the centre and basis for a system of services for the mentally ill and will normally provide the means for a person's use of any of the ancillary services which are developed.

Initially the team will provide basic individual treatment and supportive services and as necessary they will set up occupational, recretational, group, family, and other therapeutic modalities.

COMMUNITY CARE TEAM OBJECTIVES (CONTINUED)

Steps to ensure control

An effective record system will be set up to collect such data as may be needed for effective planning and evaluation.

Data routinely collected

Sufficient data will be collected to enable the team to describe the population which they serve and to record the opening and closing of each case and the number of home, office or other visits.

April 11, 1973

Attendance

May 22, 1973

Name	Address	Phone	Group
Jan Aske Dermott	2880 Oak	732-0855	Home Treat
G. Ferryman	2716 W. 10	738-7688	KARA
Ms Frances Moody	841 West Broadway	879-8821	Ch. A. Soc
B. Vogelsang	602-2323 W. 2nd	732-0588	Public He
		736-9844 Work	
Rhoda D. Mirras	02-2265 West 3rd Avenue	736-4670	VSB
		Work 731-1131 local 324	
Carolyn Reynolds	5256 Prince Edward	327-3196	
		224-1374 work	
Larry Green	3255 W. 3rd ave	731 5986	Maples
Judy Abbott	3741 W. 4th	736-3431	
Gordon Reynolds	5256 Prince Edward	327-3196	—
R. John Evans	1807 Collingwood	733 6988	Crisis Centre
Carol Leslie	2424 Cornwall	738-0285	—
Bill Wine	2386 W 8th	682-4857	Farmer
Dick Betts	3375 Arbutus	736-4840	MPA
Stan Persky	2504 York	738-9429	MPA
Jeff Marsh	3472 W 1st	736-5839	CIT
Hugh Parfitt	4455 W 2	224-1730	HTS
Peter Lontinsen.	40876 East 18th.	8792363	CFS.
Danielle Delafe	8505 Osler	263-6154	
Sid Fikkow	1414 Laburnum	732-6659	
Barry Lord	1982 W. 6th	738-1422	M.P.A
Evelyn Pastorino	2961 W 23	689-4939	
Janet Carruthers	1626 Trafalgar	733-8095	

✓ - elected members of steering committee