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REPORT OF THE

VANCOUVER DOWNTOWN EASTSIDE/SOUTH

MENTAL HEALTH NEEDS ASSESSMENT SURVEY

(OCTOBER 1991 TO APRIL 1992)

L. Ralph Buckley, M.S.W.

Survey financed by BC Mental Health Society in
community partnership with
Greater Vancouver Mental Health Service

FOREWORD

A largely successful shift of care for people with serious mental illness to the community has been accompanied by growing concern that there are significant numbers of people with mental illness in the community not receiving adequate services. This concern is particularly acute in the downtown core of Vancouver where a very high concentration of these people exists.

Riverview Hospital (BC Mental Health Society) and the Greater Vancouver Mental Health Service shared a common concern for those individuals and combined their efforts to conduct a study to improve our understanding of the extent of the problem and, more importantly, the changes to our services that would be required to make them more acceptable and accessible to these individuals as well as more effective in meeting their needs. The collaboration has provided valuable information to GVMHS, Riverview and ultimately to some other agencies on practical steps that can be taken to respond to a serious problem.

The report is also a significant achievement of the team that did the data collection and analysis under the leadership of Ralph Buckley. Paul Choi and Barbara Crozier were seconded from Riverview Hospital to make contacts in the downtown community and to conduct interviews. Ralph Buckley was seconded from the Strathcona Community Mental Health Team to design this study, collect and analyse data, conduct interviews and write the report. A number of other individuals, acknowledged in the report by the author, also helped to design the study and facilitate contacts with individuals to be interviewed.

The research focused on individuals with a serious mental illness which was operationally equated to symptoms of psychosis. It is acknowledged that this is a narrow focus but it reflects the primary mandate of both GVMHS and Riverview Hospital to provide services to individuals with the most serious mental health problems. We acknowledge that the downtown core has a high concentration of individuals with a much broader range of mental health and behavioural problems and that services for these individuals are just as problematic and just as needed as the population on which the study focused.

Housing is a critical issue and the report speaks to the unacceptable conditions that many people must endure as a result of inadequate income and the existence of substandard housing. Needless to say this only exacerbates their mental illness. One option is for Mental Health Services to continue to give priority to the expansion of its housing program. On the other hand Mental Health Services should perhaps focus its resources on the care needs of people with mental illness and municipal and provincial authorities responsible for housing need to give priority to solving the problem. The success of the Portland, Victory, and Hampton Hotels under non-profit management points to one model that needs to be encouraged.

Meeting basic needs for food and clothing must also be a priority. Here the new drop-in, if staffing were increased, could be an effective base for program development. Programs to fill these needs also seem to provide some options for both reaching out to people with mental illness and providing employment opportunities. Other jurisdictions have used individuals who have had a mental illness in these roles and have demonstrated their effectiveness in establishing trust and rapport with individuals

who might otherwise be reluctant to use existing services. Such an initiative would meet the report's recommendations to provide both activities and employment and to better meet basic needs of the target population. Another approach, of course, would be to address the basic issue of inadequate income which the report documents. Mental Health Services, groups representing other individuals with disabilities and Social Services, should be working together to review current policies and support levels for disabled people with a view to establishing more adequate support levels.

The report also speaks to the need for better and more accessible medical services including psychiatric care, dental care, and general medical care. Again the drop-in and outreach services will be a necessary and important bridge between individuals who need services and the service providers. Current services are, however, stretched to the limit. Even if services can be made more accessible, resources will have to be allocated to public health and mental health agencies.

As the data collection phase of the study was coming to a conclusion in the spring of 1992, there was a significant infusion of new, annualized funding from the Health Ministry for the development of mental health services targeted on the most seriously ill. With this funding it has been possible to implement some new programs that will address some of the gaps in service identified in the research.

Most important of these has been new funding to the Lookout Emergency Aid Society to develop a new and larger drop-in in the downtown core. Despite the large number of agencies in this part of Vancouver, there have been few venues where people with a serious mental illness could socialize, feel safe and accepted, and have the option of accessing other services if they choose. The new drop-in will fill these functions and has already proved to be very successful. Unfortunately, current funding has provided space and a skeletal staff. If the center is to meet some of the expectations recommended for it in the report, we will have to find ways to expand its resources.

There has also been some progress on housing. A new Triage facility opened in July, 1993. In addition to its 28 emergency beds the new facility includes a residential component that will provide stable housing to 30 individuals. The housing initiative of the provincial government focusing on the homeless has also resulted in initiatives to develop affordable housing in the area which serves everyone, some of whom will be individuals with mental illnesses.

Funding in 92/93 also permitted expansion of the Supported Independent Living program of Mental Health Services. Some of the living units supported under this program in Vancouver focused specifically on providing options for people in the downtown core to move into market housing in other parts of the city.

The report also points to the problems created by inadequate discharge planning for patients returning to the community. Riverview has established a task force with community representation to develop new procedures for discharge that address this problem. In Vancouver, a sectorization agreement has been implemented which will improve the working relationship between the community teams of GVMHS and acute care hospitals.

Finally, the report recommends that more services need to be provided to people with a mental illness who get caught up in the criminal justice system. GVMHS has designated one new staff member to liaise with the Vancouver pre-trial center and new protocols for meeting the needs of mentally disordered offenders have been developed for BC and are being implemented under the leadership of the Corrections Branch.

Dianne Macfarlane
Chief Executive Officer
Riverview Hospital

John Russell
Executive Director
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Mental Health Service

November 1993

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

I have an extensive list of people I wish to thank for assisting me with this study. They are as follows:

1. *The B.C. Mental Health Society provided funds to make it possible to do the survey and to have Barb Crozier and Paul Choi work on the project.*

2. *John Russell - for making it possible for me to take on this study. Everyone, once in their lives, should have a boss like John. I can approach him over any matter, express negative comments or opinion without fear of censure or reprisal, and come away with a feeling of not necessarily being "agreed with" but certainly being "well listened to".*

3. *The members of my phoning committee for the Residential Snapshot Survey:*

   i) *Nancy Carroll - Interministerial Project*
   ii) *Lily Chow - Strathcona Mental Health Team*
   iii) *Deirdre Evans - Mt. Pleasant Mental Health Team*
   iv) *Jennifer Johnston - Mental Patients Association*
   v) *Barry McArthur - Living Room Drop In Centre*
   vi) *Judi O'Brien - Triage*
   vii) *Ted Osbourne - Ministry of Social Services*
   viii) *Karen O'Shannacery - Lookout*
   ix) *John Richmond - Strathcona Mental Health Team*
   x) *Ted Rowcliffe - Mental Patients Association*
   xi) *Patience Silbernagel and staff - Intensive Community Support Program - Broadway Mental Health Team*
   xii) *John Woods - Lookout*

4. *The members of the Needs Assessment Survey Steering Committee - (see Appendix I) with special mention to:*

   - *Sharon Belli - from Social Services for coming up with the suggestion of surveying all the financial aid workers in the catchment area.*

   - *Dr. Glen Haley - from Riverview Hospital who assisted with compiling the mental status examination in the Mental Health section of our In Depth Survey.*

- Laura Stannard, formerly of DERA, who provided me with the idea of photocopying the $5.00 bill for the "yellow card".

- John Turvey - a measured thanks to John from DEYAS. After attending the first one or two Steering Committee meetings and providing useful information, he stopped coming. I assumed, like the rest of us, he was busy. About a month later John was quoted in the Kerrisdale Courier as saying "The last thing we need in the Downtown Eastside is another survey". At first I was quite upset with John's statement, as I had invested a lot of time and energy on the project. Then I became angry - and that anger has helped to sustain my completion of this task. My hope is that it will be considered a significant study from which the seriously mentally ill in the downtown core will benefit; my fear is that John may, after all, be right.

5. The people who assisted me with conducting the In Depth survey:

- Paul Choi - Riverview Hospital. Paul was assigned to the project and at first I thought because he had no community experience that he would only would get in the way. How wrong I was.

- Barbara Crozier - Riverview Hospital.

6. The people I came to for ideas, editing and assistance:

- Dr. Nicholas Sladen-Dew - Broadway South. Whenever I met with Nick and exchanged ideas, I always came away with a clearer perspective of what I needed to do.

- Dr. Doug Bigelow, Ministry of Health, Victoria - for the ideas, the continued support, and the message that the survey really was worthwhile. And, most importantly, for providing me with that moment of insight when, after 20 drafts, I suddenly knew how it should all come together.

- And to Kaye McMahon - my secretary - for her good humour and extreme patience, despite draft, after draft, after draft.

EXECUTIVE SUMMARY

The Downtown Eastside/South Mental Health Needs Assessment Survey found that there are approximately 200 seriously mentally ill individuals living in the downtown core who are not receiving any mental health services. The Survey makes a number of recommendations which have implications not only for mental health services and its practice but also for a wide range of other community service agencies as well. A summary of these recommendations imediately follows this Executive Summary. The major recommendation made in the Survey, which is not listed in the summary of recommendations, is that a pilot assertive case management project be implemented to serve this population.

COMPOSITE

The major characteristics and needs of this population can best be summarized in the following description of "George" who represents a composite of all the qualitative information obtained in the In Depth Survey. He represents a typical seriously mentally ill person living in the downtown core.

Demographics:

George is a Caucasian male, aged 36 and English speaking. He completed his grade 10. He is single and lives alone in a hotel in the downtown core. He has moved within the area at least once in the last two years from one hotel or roominghouse to another. He has lived in British Columbia over five years. He is attracted to the downtown core because of its low rents, services and the personal attachments he has formed.

Housing:

George does not like his current accommodation because of the lack of cleanliness (i.e. cockroaches), the noise, and the large number of people with severe drug and alcohol problems. He does, however, prefer to live alone. What he would like to have for accommodation is a clean, secure and affordable self contained suite, which is close to amenities and support services. If such housing were to be offered outside of the downtown core, he would likely relocate.

Physical Health:

George's physical health is reasonably good, and he has little problem with his sleeping pattern. He does, however, smoke over a pack of cigarettes a day and this is not healthy. Furthermore, the expense of the cigarettes cuts into the money he should spend on food. He is fairly knowledgeable about AIDS and knows where to go to obtain testing.

Mental Health Services:

At an earlier age George had contact with the mental health system and although he was told what his diagnosis was, it was not explained to him. He feels that perhaps the diagnosis fits, but he has a great deal of ambivalence about it. He also took medication but eventually stopped because of the adverse side effects. George has spent time in a psychiatric hospital on at least two occasions. On one of these occasions he was

feeling suicidal and on the other he was stressed out to the point where he felt unable to cope. On discharge, no follow up plans were made.

George also has had contact with a mental health team and initially he found the experience helpful He eventually dropped out of treatment because he changed his mind and felt he was not being helped. Moving also made it difficult for George to maintain his contact with the people he was seeing at the team. George is ambivalent as to whether he wants help now.

The mental health services George would like to see implemented in the downtown core are drop-in centres, more mental health teams with increased staff to provide more one-to-one counselling, more low rental housing and better emergency help.

Mental Health:

After coming in contact with the mental health system George lowered his goals and ambitions. Occasionally he thinks about committing suicide. This is usually when he has feelings of his life being stagnant and repetitive with no point or purpose and no way out. Alcohol does not help these feelings either. In the last 6 months George has had at least one or more psychotic experiences which were not as a result of the consumption of drugs or alcohol or both.

Alcohol and Drugs:

George drinks but it is not clear how serious a problem this is for him. Generally, he does not do drugs. What he likes most about substances is the relaxation and lowering of stress it gives, the good feeling of being high and the forgetfulness/escape it provides. What he dislikes about substances is the hangover/after effects and the cost. George has attended AA meetings and likes them for the group support, the understanding, the acceptance, and the socialization they provide. On the other hand, he dislikes the preaching and dogma as well as some of the people at the meetings who never change, and always tell the same stories.

Legal:

George has been arrested and convicted and has spent time in jail for minor offences. He liked the food he received in jail better than what he obtained while in psychiatric hospitals. In the past 6 months George has also been victimized both physically (i.e. robbery) and psychologically.

Support Services:

George would go to a drop-in in the downtown core, especially if it were open late every night. He would like to see such a drop- in have television, videos, games and provide free coffee and tea. It should have a relaxed atmosphere where he can meet and talk to people, particularly women. Lastly, it should have trained, experienced staff from whom he could obtain counselling if he chose.

George keeps in contact with his family. Occasionally he has what he considers an intimate relationship, and if he experiences a crisis he usually has someone he can turn to whom he trusts. What he does on evenings and weekends is watch TV,

go for walks and read. He often finds, however, that he has nowhere to go because of lack of money and not feeling safe in the neighbourhood. The places he visits the most are the Carnegie Center, parks and friends' places.

Social Contact:

The most important people in George's life are his friends and family. The four major places in the downtown core where he can go and feel comfortable are the Carnegie Center, parks, the Evelyne Sellers Center and coffee shops.

George believes his life provides him sufficient psychological freedom, but financially he feels he has no freedom whatsoever.

Employment:

George can read and write. His employment history, however, is poor. The longest job he ever held was around 2 years and he has not been employed at anything in the last 6 months. George likes work because it gives him money, a sense of accomplishment and improves his self esteem. On the downside, aside from the general stress of working, he finds the long hours difficult to deal with. In addition, he often receives ill treatment from his co-workers. Poor pay does not help either, especially if it is close to what he obtains on social assistance. George would like to be employed at some general labour job like janitorial work.

Income:

George is on social assistance. He receives $602.48 a month. He spends $315.04 on rent and claims the balance of his money is spent as follows: food $162.00, cigarettes $83.68 and alcohol $69.92. When added up these figures come to $630.64 which is $28.16 more than George has. Since these expenses do not include items such as clothing, transportation, hygiene needs, laundry and entertainment, obviously George's financial situation is grim. George feels that he would be able to get by on $890 a month.

Food:

George eats about two meals a day, not three. The items he consumes the most are sandwiches, soup and vegetables. He generally eats at home, but two weeks after cheque day he runs out of money and then he attends the free food places. George spends $5.63 a day on food. When he has the money, he will often go to the Evelyne Sallers Center as the meals there are inexpensive. George has been losing weight lately as a result of poor nutrition.

Hygiene:

George has to share his toilet and bathtub with others in the same building. He does not like the lack of privacy nor the sanitation problems this presents.

Clothes:

George is in need of clothes, particularly raingear and underwear. He generally buys his own clothing. He will, however, go to some of the free clothes places but finds he often cannot obtain the proper fit.

Conclusion:

On a typical day George will walk around the neighbourhood, watch TV, drink coffee or tea and visit friends. George views his two major problems as obtaining money and food. Occasionally finding accommodation also becomes a problem. By far his major worry, however, is the lack of money. George generally does not find his life very enjoyable.

George, then, is the composite of what a typical seriously mentally ill individual living in the downtown core and not receiving mental health services is like.

RECOMMENDATIONS

I DEMOGRAPHICS *(Results page 12)* None

II HOUSING *(Results page 13)*

The poor conditions of many of the hotels and roominghouses in the downtown core is a long standing problem that organizations like DERA have been protesting against for years. These conditions still exist and pressure for higher standards and more inspections by city staff needs to be maintained.

III PHYSICAL HEALTH *(Results page 14)*

1. Although not a healthy lifestyle, the majority of seriously mentally ill do have access to medical services if they choose. A third (33%) of the respondents indicated, however, some problem with obtaining medical service, and this is an area which should be explored.

2. If community workers do manage to establish a working relationship with any of these individuals, their dental needs should be discussed at some point.

IV MENTAL HEALTH SERVICES *(Results page 15)*

1. We need to place more emphasis on client education especially with respect to their diagnoses and what this means, particularly now as clients have the right of complete access to their files.

2. We need to be more concerned and solicitous about clients' complaints of side effects from the medications as this is one of the major reasons for their dropping out of treatment. We need to explain more about the medications, the various dosages, the risks, and the potential side effects, especially with new clients coming into the system. We must take the time to explain that if they encounter problems with the medications to not drop out of treatment, but rather to return for adjustments or try something else, as there are now a growing number of medications available. We also need to remain flexible enough to retain clients in treatment even though they may not be on medications or have temporarily stopped taking them.

3. Better discharge planning needs to occur in hospitals, and these plans, if they are to be effective, must involve the patients.

4. When clients move from one area to another more effort should be made by both the mental health facility they are moving from as well as the one in the area they are moving to, to ensure that in the moving process the client is not lost to the mental health system.

5. Drop-in Centres for the seriously mentally ill should be established in the downtown core, and since this study was completed two have come into existence: one in the Downtown South and the other in the Downtown Eastside.

6. More mental health centres should be established in the community or the ones which are now present should have their staffing levels increased so as to provide sufficient one-to-one counselling time - a request that many of the interviewees made in various sections throughout this questionnaire. We should add that in the last two years staffing levels have begun to increase. Hopefully this trend will continue.

7. If the seriously mentally ill are going to be helped in a substantive way, then more low rental housing is required. Again, some progress is also being made in this area. More is required.

V MENTAL HEALTH *(Results page 20)* None

VI ALCOHOL AND DRUGS *(Results page 23)*

1. There are many alcohol and drug programs already existing in the downtown core and certainly a significant number of this population have a serious alcohol and drug problem. Sometimes, however, they have difficulty accessing these programs, as many of the staff in them are not familiar with the seriuosly mentally ill and the problems they present. In the last three years we have initiated educational workshops and staff exchanges between GVMHS and Alcohol and Drug programmes. More needs to occur and if it turns out that Alcohol and Drug Programs cannot accommodate the seriously mentally ill, then a separate facility should be considered..

2. The difficulty remains as to how to motivate these people to obtain treatment. It should be noted, however, that the need or desire to socialize is quite high and if there were alternatives to the bars and beer parlours such as the drop-ins already mentioned, the consumption of these substances would likely be reduced significantly.

VII LEGAL *(Results page 25)*

1. More mental health services should be made available to the seriously mentally ill in the criminal Justice system. Some progress is occurring in this area.

2. More outreach services should be made available to the seriously mentally ill who have been victimized.

VII SUPPORT SERVICES *(Results page 26)*

1. A drop-in centre is needed in the downtown core which would stay open late every night and be a safe and secure place. It should have free coffee and tea and offer activities as well as opportunities to meet, relax and talk to people. It should also offer counselling, if desired, by trained, experienced staff.

2. As it appears that the majority of these people do keep in some contact with their families, this should be an area that downtown core mental health workers need to be more cognizant of. How many of us, for instance, know who to call if our client is in dire need of help? Too often, the only time we contact families is to inform them of some disaster which has befallen their loved one.

IX SOCIAL CONTACT *(Results page 28)*

1. Certainly the overwhelming message in this section is to have a drop-in centre in the downtown core where the seriously mentally ill can congregate, feel safe, comfortable and accepted.

X EMPLOYMENT *(Results page 29)*

1. As we know from the demographics, the average age of this population is 36, which certainly indicates that employment is an area which needs exploring. If not full-time, considerable efforts should be made to involve them in part-time or casual work. Perhaps Social Services' new Community Volunteer Program (CVP), which pays $100.00 a month for 10 hours' work at a non-profit agency, could be implemented with many of these individuals. Also some innovative measures could be undertaken in the areas of cottage industry work, or modified, on-site sheltered workshops.

XI INCOME *(Results page 30)*

1. The questionnaire clearly shows that their current monthly income is inadequate for almost three quarters of the interviewees. The social assistance rates need to be raised or else work programs as income supplements need to be implemented such as the CVP program already cited in the Employment section.

2. The results also suggest that some seriously mentally ill individuals in receipt of social assistance or handicapped pension would go on to administration voluntarily if it were advertised or actively encouraged by Social Services. We realize this suggestion goes against Social Service's philosophy which stresses independence, but for some of these individuals administration could prove very beneficial and actually help them maintain their independence.

XII FOOD *(Results page 32)*

1. Ms. Falconer advocates having an outreach worker drop off at their homes a non perishable meal on a regular basis, especially in the latter part of the month. Since the most likely time they will be home is in the morning this non perishable meal would be a breakfast pack. Falconer states "this works out perfectly as it gives them both breakfast and something to get them started nutritionally for their day". It could also assist in getting them into treatment as well.

2. We have already suggested Social Services review their rates, and since the completion of the survey the rates have gone up by $10.00 for the employables and unemployables and $16.00 for the handicapped. The problem is a complex one, however, as just because the rates are revised does not automatically mean that

the interviewees will spend their increase entirely on obtaining food, or if they do whether the food is better and more balanced nutritionally. Also if you raise rates in one area of the province you have to raise them everywhere else as well. Perhaps Social Services could look at the problems of the downtown core specifically and implement programs targeted to this area alone.

3. Given the economic hardships, clearly the free food places in the downtown core are essential. Perhaps, however, they too might look at more innovative ways of delivering their services than simply the traditional ones of lineups and sit down meals established years ago during the Great Depression. If this survey is truly representational, although 90% run out of money before the next cheque day, only 44% take advantage of the free food outlets. That leaves a malnourished or undernourished residue of 46%. With all we hear about competing in a global economy and restructuring, we may be experiencing another Depression and we need to think of new and innovative ways to target those most in need.

XIII HYGIENE *(Results page 35)*

1. It would be easy to recommend that all hotels and roominghouses have private toilets with tubs or showers, but highly improbable that such would occur. We would recommend more practically that hotels and roominghouses either concern themselves more with sanitation and privacy, or the city inspection department set higher standards and have more inspections. Perhaps a combination of both would be in order.

XIV CLOTHES *(Results page 36)*

1. Again, as with food and income, the lack of sufficient clothing shows the need for a review of the current social assistance rates or the implementation of more work type programs as an income supplement.

2. Like the food section, the free clothing outlets could consider a number of options. Instead, for instance, of having all the clothes in a box or pile, they could sort things out and label the sizes. The majority of these individuals are men with an average age of 36 who likely do not have the patience or perhaps the fortitude - for it can be embarrassing - to sort through these items properly. A second consideration would be to take a non-traditional approach, as suggested in the food section, and look at some modified form of outreach service to assist those who truly are in need.

XV CONCLUSION *(page 37)*

1. The recommendations for this section have already been made in previous sections i.e. review the social assistance rates, consider more work type programs as an income supplement, look at an outreach service providing nutritious breakfast packs, and provide a drop-in with extended hours which is safe, easily accessible and accepting.

Purpose:

For years there have been reports in the media or complaints from service agencies in Vancouver's downtown core claiming a considerable number of seriously mentally ill people* live in the area who, despite the existence of community mental health teams, are not receiving mental health services.

The downtown core, which includes the downtown eastside and the downtown south, acts as a magnet for many of the seriously mentally ill because of low rents, free or minimal cost services and a high tolerance for strange or unusual behaviour. Often referred to as "Skid Row", many deinstitutionalized and other seriously mentally ill have drifted into the area from various parts of British Columbia or Canada. Others have come after leaving psychiatric boarding homes, or they have been discharged, or what service agencies and residents alike term "dumped", directly into the area by hospitals who have no other places to send them.

Given this background, the purpose of the Downtown Eastside/South Mental Health Needs Assessment Survey was two fold:

1. To locate and obtain an estimate of the total number of seriously mentally ill persons living in the downtown core who are not receiving mental health services.

2. To obtain information about these unserved seriously mentally ill persons: their background, lifestyle, needs, previous experience with the mental health system and their opinion as to what mental health services would be relevant to them.

Catchment Area (See Map)

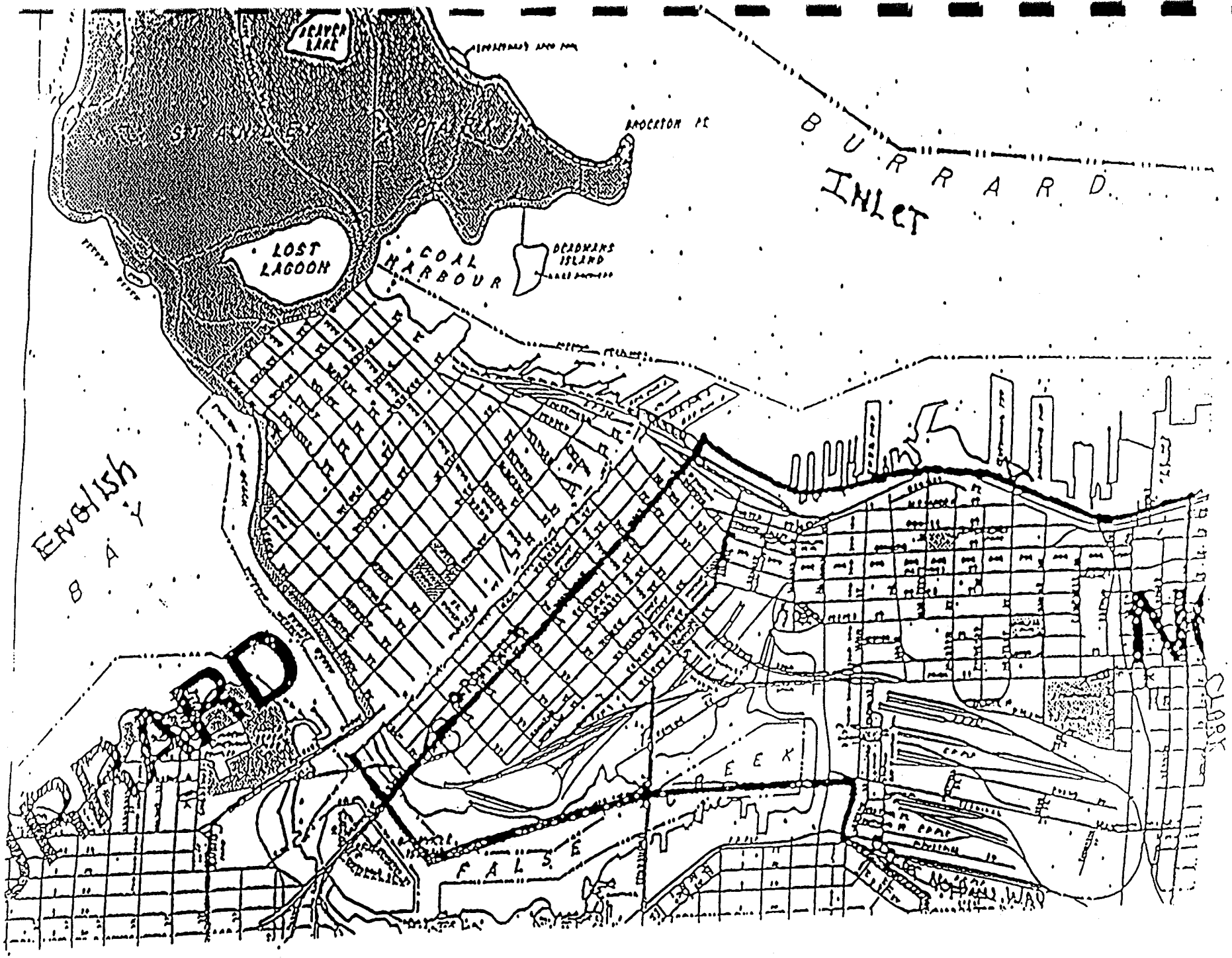
The boundaries chosen for the survey were Clark Drive on the East, Granville (both sides of the street) on the West, the Waterfront on the North, and Great Northern Way which turns into Second Avenue on the South. These boundaries contain an area made up of office buildings, hotels, roominghouses, emergency and residential facilities. There are a small number of single family homes close to the eastern boundary which were not included in the survey as we assumed very few seriously mentally ill would be living in these residences.

The actual population of this area is difficult to obtain as the area we chose does not fit precisely any one given census tract. Our best estimate is a population of between 15-20,000.

Funding and Agency Involvement

The survey was funded by BC Mental Health Society (Riverview Hospital) in cooperation with Greater Vancouver Mental Health Service (GVMHS) as a Community Partnership Project. The survey began in October 1991, and ended April 1992. The Steering Committee for the survey had a broad base which included 23 representatives from treatment facilities, support services, emergency shelters, civic offices and law enforcement agencies. (See Appendix I)

* We wish to make clear that whenever we use the term "seriously mentally ill" we are referring to individuals who display overt psychotic symptoms as you will see by the definitionwe used for the Residential Snapshot, the Short Random Validation, and the Social Services Caseload surveys.


BEAVER LAKE
BROCKTON PT
BURRARD INLET
LOST LAGOON
COAL HARBOUR
DEADMANS ISLAND
ENGLISH BAY
FALSE CREEK

Literature Review:

In preparation for this survey we read a multitude of articles having to do with the homeless mentally ill, the dual diagnosed mentally ill, the programs such as assertive case management etc. designed for the mentally ill, the problems of deinstitutionalization and so on. In all of these we found only two studies which appeared similar to ours. One was done by Dr. Dee Roth and Associates in Ohio State in 1985[1] and the other by Dr. Peter Rossi and Associates in Illinois in 1987[2]. Dr. Roth's study is the largest of its kind. They interviewed 979 homeless people throughout the state of Ohio. Their study had two major objectives: the first was to "determine the mental health status and needs of homeless people"[3], and the second "to determine the extent to which the mental health system in Ohio was responsive to those needs[4]". What they found was that "while some homeless people are mentally ill and require services, the majority are not mentally ill or have had prior psychiatric hospitalizations but are now symptom free[5]. For those that were mentally ill, however, they conclude that the mental health system "has substantially failed to meet or even address the needs of this population"[6].

Rossi and Associates describe their Chicago Homeless Study as "essentially the first rigorous attempt to apply proven methods of social science research to the study of homelessness"[7]. Although their study does not focus specifically on the mentally ill, they do take this population into account. They interviewed a sample of 722 of what they termed "literal homeless persons" i.e. those who clearly have no access to a conventional dwelling. They drew their sample from shelters and systematic street surveys. They came up with a figure of 2,722 literal homeless in Chicago on an average night. They also described this population in terms of age, sex, education, income, employment, social isolation and illness (both physical and mental).

It is difficult and perhaps even misleading, however, to compare and contrast our study with either Dr. Roth's or Dr. Rossi's. We are in a different country with a much more developed network of social services. The people Rossi interviewed, for instance, had an average monthly income of $168.39. In Vancouver, for our population the amount was $602.48. What we can offer for comparison and contrast in a limited manner is the following:

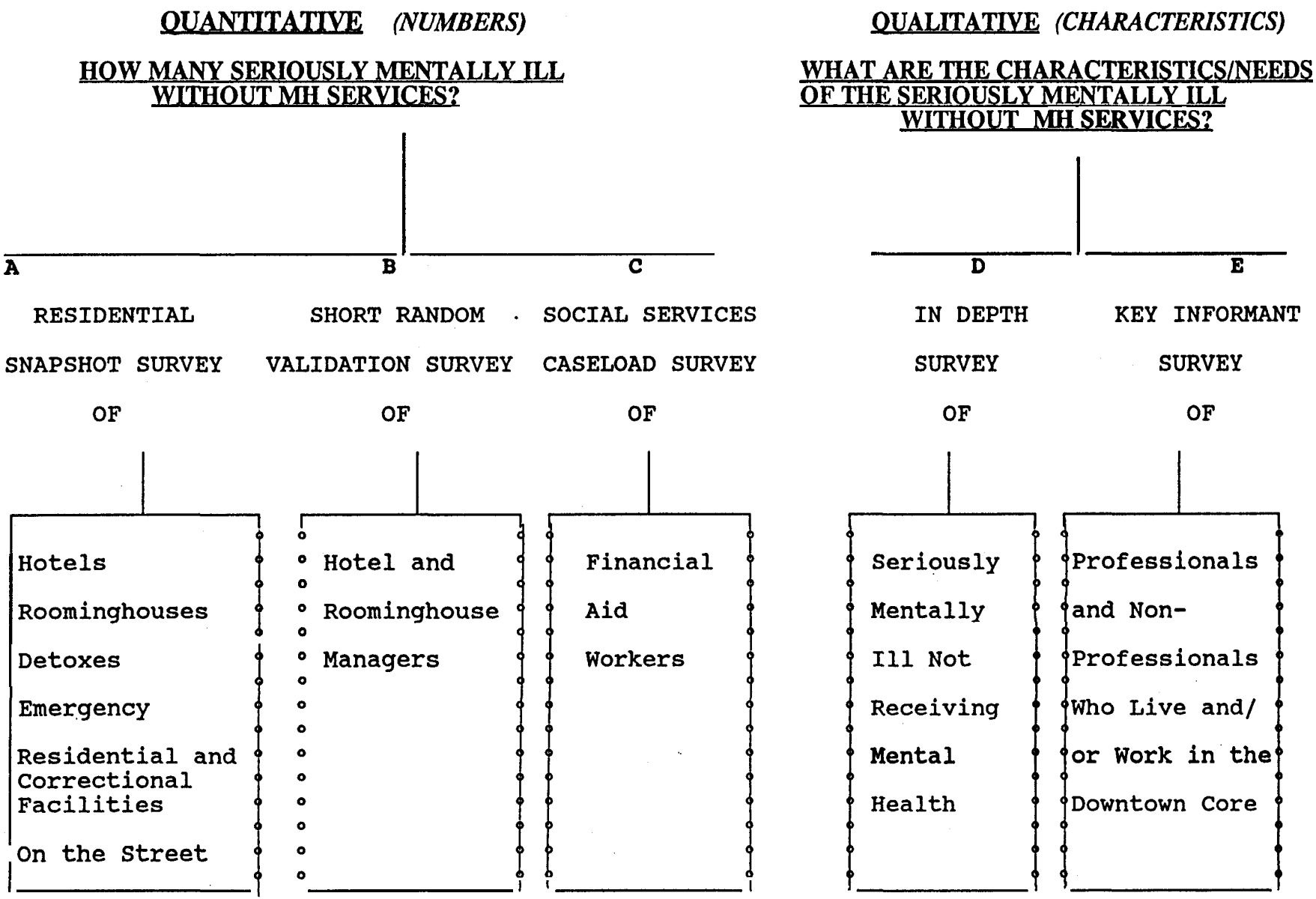
1. We concentrated entirely on the seriously mentally ill which were at least marginally housed in hotels, roominghouses, emergency shelters or residential facilities.

2. Our sample population is much smaller than either Dr. Roth's or Dr. Rossi's.

3. For our estimate of the seriously mentally ill living in the downtown core, we did not have the problem of sampling difficulties which both Roth and Rossi complain about. We canvassed the entire catchment area and obtained the cooperation of the staff of the various facilities and establishments which house these individuals.

1. Roth Dee, MA et al "Homelessness and Mental Health Policy. Developing an Appropriate Role for the 1980s", Human Science Press. 1986.
2. Rossi, Peter H. et al "The Urban Homeless: Estimating Composition and Size", Science, Vol. 35. 1987.
3. Roth, Dee "Homelessness and Mental Health Policy. Developing an Appropriate Rule for the 1980's", Human Science Press, 1986, p. 205.
4. Ibid., p. 205
5. Ibid., p. 212
6. Ibid., p. 212
7. Rossi, Peter "The Urban Homeless: Estimating Composition and Size", Science. Vol. 35, p. 1336.

SURVEY DESIGN



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4. Although some of the demographics and lifestyle data gathered by the other studies are similar, ours are much more extensive.

5. Lastly, the design of our study is much more complex.

Survey Design (See Illustration)

The Mental Health Needs Assessment consists of five separate surveys. The first three are quantitative: the "Resident Snapshot", the "Short Random Validation" and the "Social Services Caseload" surveys (A, B and C). These pertain to the first purpose of the Needs Assessment which, is to locate and obtain an estimate of the total number of unserved mentally ill living in the downtown core. The last two are qualitative: the "In Depth" and "Key Informant" surveys (D and E). These pertain to the second purpose, which is to interview a representative sample of this population to obtain information about their background, lifestyle, needs, previous experience with the mental health system, and their opinion as to what mental health services would be relevant to them.

The Argument:

Before proceeding with describing the five separate surveys with their methodologies and results, we need to address the question which is critical to the Needs Assessment and that is whether the people surveyed really are seriously mentally ill. Since we did not do a psychiatric assessment on each one the answer is obviously not clearly a one hundred percent "Yes". None of the snapshot observations or in depth interviews was done by psychiatrists. In fact, for the quantitative section (surveys A, B and C) we used the observations of hotel and roominghouses managers, emergency and residential facilities staff and social services workers - many of them non-professionals and none directly related to mental health. As you will see when we deal with the methodology, we provided these observers with instructions which were very specific, having to do with counting only those individuals who obviously appeared thought disordered.

We also conducted a short validation study (B) on the hotel and roominghouse managers which confirmed their observations. It is our argument, therefore, that the people counted in the quantitative section of the Needs Assessment are seriously mentally ill. Furthermore, these are the people the community defines as being seriously mentally ill and would refer to a community mental health team or psychiatric hospital in times of crisis.

The qualitative section is more complex. Here we interviewed people who voluntarily came forward and claimed they suffered from a serious mental illness. The following figures give considerable credence to that claim:

- 96% of those interviewed had spent time with at least one psychiatrist, psychologist, physician, mental health team or psychiatric hospital for mental health reasons.

- 82% had taken psychiatric medication.

- 80% had been admitted to a psychiatric hospital and 68% of that group had two or more hospitalizations.

- 60% had previous contact with a community mental health clinic or centre.

- 56% indicated they had psychotic experiences within the previous six months which were not as a result of consuming drugs or alcohol or both.

- 50.5% stated they thought about suicide.

- 34% claimed they were depressed.

It is our contention that although not all of the 89 people we interviewed in the qualitative section were as thought disordered as those counted in the quantitative section, the vast majority suffer from mental illness such that they come in and out of contact with the mental health system requiring treatment for varying periods of time. Furthermore, even though the two groups may not be totally identical, the impoverished lifestyle that the 89 interviewees depict certainly qualifies them as a representative sample of the seriously mentally ill who reside in the downtown core.

PART I: QUALITATIVE

I. RESIDENTIAL SNAPSHOT SURVEY

Methodology:

The Residential Snapshot Survey involved canvasing all the hotels, roominghouses, detoxes, emergency, residential and correctional facilities in the downtown core to ascertain how many seriously mentally ill reside in their buildings. The plan was to extract from this amount the number who were not in receipt of mental health services. For the hotels and roominghouses, we began by contacting the Executive Vice President of the BC and Yukon Hotels' Association to explain our survey and obtain an endorsement statement. We then sent a form letter to all the hotels and roominghouses, with the endorsement statement enclosed, asking for their cooperation in obtaining four snapshot surveys beginning January 1992 and ending in April 1992. The same form letter was sent to the emergency and residential facilities, the three detoxification centres and the Vancouver Pre-Trial Centre -- all within the survey boundaries.

We requested that all managers or responsible staff record the number of residents in their establishment who they believed to be seriously mentally ill on the fourth Monday of each month at midnight. This was two days before Social Services issue day, and we reasoned that at this time people would be short of money and less likely to be on the move than at other times during the month. We gave the managers or responsible staff the following definition:

> We are asking you to identify those who you <u>believe to be seriously mentally ill</u>. We are talking specifically about people who appear to have strange and unusual behaviour. They may talk about strange thoughts, or possessing magical power, or hearing or seeing things that others do not, or they could be extremely suspicious and guarded. Please try to distinguish between someone who is alcoholic versus someone who is mentally ill, as the behaviour of someone "under the influence" can be very similar. Sometimes this is impossible to do and in such cases please mark the individual as being mentally ill. We are not asking that any of you be psychiatrists, just reasonable observers!.

On the same nights the Vancouver City Police and Car 87 (GVMHS' After Hours Emergency Service) were also requested to record anyone seriously mentally ill found sleeping out in alleyways, under bridges or in parks. None was reported.

We had a group of fifteen volunteers who work for the downtown core services phone all the participants on the day of each snapshot to remind them of the impending survey at midnight. They then phoned the following day to obtain the count.

Results:

By the time of the last snapshot in April we had obtained the figure of 610 seriously mentally ill: 477 residing in hotels and roominghouses and 133 in the detoxes, emergency, residential and correctional facilities (see Residential Snapshot and Social Services Caseload Results illus.). For this figure we obtained 100% response from the detoxes emergency, residential and correctional facilities (20 out of 20) and an 87% response from the hotels and roominghouses (147 out of 181). Of the 34 four we did not contact 3 were hotels who refused to cooperate and the remaining 31 were small roominghouses who could not be reached by phone, letter or even by going in person because the premises were always locked. As these roominghouses appeared to lack any supervisory staff, we assumed they catered to a very stable clientele, which likely would not include many of the seriously mentally ill. Interestingly, the 477 mentally ill persons reported by the hotels and roominghouses represents 5% of their total population - a sizeable proportion.

Given the figure of 610, we were then faced with the problem of determining how many were not receiving mental health services. We knew they could receive such services from four sources in the downtown core: the Mental Health Teams (Strathcona and the West End), Forensic Outptient Services, private psychiatrists and family physicians. The role of the physicians would primarily be prescribing medications, and this would include the physicians in the public Downtown Health Clinic, who we canvassed separately. We began by counting the number of seriously mentally ill obtaining treatment from the two mental health teams. Then we solicited Forensic Outpatient Services, the Downtown Health Clinic, and all the family physicians and private psychiatrists in the area and asked them how many seriously mentally ill they were treating who were not being seen by one of the mental health teams. Our plan was to subtract all the seriously mentally ill reported from the above sources from the 610 to find how many were left untreated. This method failed because when we added up the results, we came up with a surplus figure which indicated that everyone who was seriously mentally ill in the downtown core was receiving treatment.

From practical experience we knew this result to be inaccurate and, as we had good communication with all sources other than the family physicians and private psychiatrists*, we concluded they could not process our request accurately. This we attribute to large caseloads and limited information about the lives and circumstances of their patients.

Fortunately, one of the members of the Steering Committee was a supervisor of a downtown social services office. She pointed out that most, if not all, of the reported 610 seriously mentally ill would be on social assistance or handicapped pension and thus known to their financial aid workers. As a consequence, we implemented the Social Services' Caseload Survey (C). Before discussing this survey, however, we will attend to how we validated the hotel and roominghouse managers' observations.

* It should be noted that the vast majority of these respondents were physicians, not private psychiatrists. Actually the area has very few private psychiatrists.

II. SHORT RANDOM VALIDATION SURVEY OF HOTEL AND ROOMINGHOUSE MANAGERS

Methodology:

As we were particularly concerned about the validity of the observations of the hotel and roominghouse managers, we decided to take a random sample of 29 and ask questions as to how they distinguished between someone who was on alcohol or drugs vs. someone who was mentally ill. We also asked each manager for the name of one patron who they had identified as seriously mentally ill. We later checked the name against the records from Riverview, GVMHS and Forensic Services.

Results:

We found in the majority of cases the managers' observations to be surprisingly accurate. When asked what they felt constituted someone with a serious mental illness they cited symptoms such as talking to themselves, hearing or seeing strange things, suspiciousness, rambling and disjointed speech, confused thoughts, pacing, staring, self neglect and isolation. Only 3 out of the 29 interviewed (14%) saw the mentally ill as violent, noisy, threatening and synonymous with drug addicts.

When asked how they distinguished between someone who is mentally ill versus someone who is either alcoholic or on drugs. Their answers were extremely informative. The following are some of the replies:

- Mentally ill behaviour is consistent. Alcohol and drug is erratic, unpredictable.
- Substance abusers tend to be aggressive and fight. Mentally ill generally do not cause problems.
- Mentally ill talk about their beliefs; not so with alcoholics.
- Those who are mentally ill forget disputes or altercations right away, not so with substance abusers.
- Substance abusers often have groups, lots of visitors. The mentally ill, when they drink or do drugs, often do it alone.
- Mentally ill usually listen to you when you talk to them; not so with drunks and drug users.
- You can always tell substance abusers by the glassy eyes and especially the smell.

The majority were quite confident they could easily distinguish between the two groups.

When asked if the seriously mentally ill caused them problems, the majority of managers stated they preferred them to many other resident groups, particularly alcoholics. A common complaint, however, of 34% of those interviewed was that at times the mentally ill yell and scream in their rooms to the point where they have to be evicted due to complaints from other patrons.

When we checked the name they provided of the one patron who they believed to be seriously mentally ill against the records of Riverview, GVMHS and Forensic Services we found that in 23 cases (79%) the person was or had been known to one of these systems.

Aside, then, from also being informative, we concluded from the observations made, as well as the names of the patrons provided, that the information given by the hotel and roominghouse managers was valid.

RESIDENTIAL SNAPSHOT AND SOCIAL SERVICES CASELOAD SURVEY RESULTS*

(April, 1992)

TABLE 1

RESIDENTIAL SNAPSHOT SURVEY

Hotels and Rooming Houses - 147 reporting out of a possible 181	477 SMI
Detoxes, Emergency, Residential and Correctional Facilities (20 out of 20 reporting):	133 SMI
Total	610 SMI

TABLE 2

SOCIAL SERVICES CASELOAD SURVEY

Financial Aid Workers report on the number of SMIs and where they obtain treatment.			Reported Figures From the Treatment Resources Themselves
Downtown Health Clinic	52 SMI	vs.	50 SMI
Forensic Outpatient Services	28 SMI	vs.	35 SMI
Mental Health Teams	215 SMI	vs.	230 SMI
Sub Total	295 SMI	vs.	315 SMI
Faimily Physicians	80 SMI		Could not accurately obtain.
Private Psychiatrists	39 SMI		Could not accurately obtain.
No One	209 SMI		- N/A
Unknown	3 SMI		- N/A
Total	626 SMI		-

* Total of 626 SMI reported by Social Services compared with 610 reported by hotels, roominghouses, emergency, and residential settings.

III. SOCIAL SERVICES CASELOAD SURVEY OF FINANCIAL AID WORKERS

Methodology:

As indicated in Section I above, this Social Services Caseload Survey was not part of our original plan, but arose because we encountered difficulty extracting from the Residential Snapshot Survey the number of seriously mentally ill not receiving mental health services. Since, however, the seriously mentally ill residing in hotels, roominghouses, emergency and residential facilities were quite well known to the financial aid workers, we decided to ask them not only to give us a count of the seriously mentally ill on their caseloads but to also indicate from what source, if any, they were receiving mental health services. In order to remain consistent we gave the same description of the seriously mentally ill to the financial aid workers which we had used in the Residential Snapshot Survey.

Results: (See Residential Snapshot and Social Services Caseload Results illus.)

Social Services came up with the figure of 626 seriously mentally ill which was extremely close to the 610 reported in the Residential Snapshot Survey. As it was impossible to do the two surveys simultaneously, and as they covered the same population living in hotels, roominghouses, emergency and residential facilities, and as both surveys used the same definition, we concluded the two surveys confirmed one another. Furthermore, since the figures the financial aid workers in the Social Services Survey gave for the Downtown Health Clinic, Forensic Outpatient Services, and the two Mental Health Teams were very close to the ones reported by those agencies themselves:

	Financial Aid Workers		Agencies Themselves
Downtown Health Clinic	52	vs.	50
Forensic Outpatient Services	28	vs.	28
Mental Health Teams	215	vs.	230

we inferred, therefore, that the figures they provided for the family physicians and private psychiatrists (119), from whom we obtained an erroneous count, would also be reasonably accurate.If you look at Table 2 in the Residential Snapshot and Social Services Caseload Survey Results, you can see that what is left in the financial aid workers' survey is the category of "no one" which equals 209. These are the seriously mentally ill who, according to the financial aid workers, receive no mental health services. In round figures, therefore, it is our contention that based on the Social Services Caseload Survey there are approximately 200 seriously mentally ill persons residing in the downtown core who are currently lost to the mental health system. It is from this group that we attempted to draw the interviewees for our In Depth Survey IV.

PART II - QUANTITATIVE

IV. IN DEPTH SURVEY OF SERIOUSLY MENTALLY ILL NOT IN RECEIPT OF MENTAL HEALTH SERVICES

Methodology:

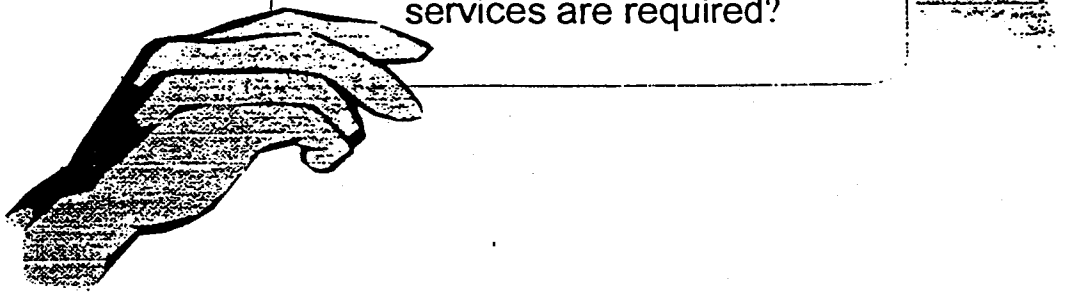
In this survey we approached the problem of how to conduct an in-depth interview with someone who is seriously mentally ill and not in contact with a mental health service. As previously mentioned, in the early stages of planning we came across two studies, by Dr. Roth and Dr. Rossi, dealing with the homeless mentally ill which were similar to ours. In Dr. Roth's study they used incentives such as coffee, cigarettes and an inexpensive meal, but the study did not indicate precisely how they managed to initially contact their interviewees. In Dr. Rossi's study they found their subjects by visiting emergency shelters and also by going into pre-selected city blocks late at night, accompanied by policemen, and interviewing anyone they encountered, even waking them up if necessary. By comparison, as we do not have a large shelterless population, i.e. those who sleep in the streets, we felt Dr. Rossi's approach was not applicable to Vancouver and decided instead to use the "yellow card". This was a yellow card of fairly thick bond paper on which we invited those suffering from a mental illness to participate in a personal interview. (See illustration.) On the front of the card we put a picture of a five dollar bill with the words "$5.00 for 1 Hour's Time - Mental Health Survey". As a further inducement, like Dr. Roth and Associates, we also stated that coffee and cigarettes would be provided during the interview. The cards were distributed to all the hotels, roominghouses, libraries, food lines, drop-ins, emergency shelters, detoxes and social service offices in the downtown core, even places where it was thought people might sleep out. We also produced the same card in blue, written for the Chinese population, and one of our principle interviewers was Chinese himself. Different sections of the catchment area were targeted every week so as not to be overwhelmed with requests. We also met with numerous community groups, explained the survey, gave them the yellow cards and asked that they refer anyone they felt was appropriate. Copies of the interview schedule and money were left with a number of community workers so that they could conduct the interview themselves if they felt they would be unsuccessful in referring.

Those persons who wanted an interview were instructed on the card to take it to one of the numerous community resources listed, or to call us to arrange a convenient time and meeting place which included cafes, emergency shelters, various community resources, the interviewees' own rooms - virtually any agreed upon location. There are a number of agencies in the downtown core that provide free phone service for local calls. Our contact number was a cellular phone which we carried with us at all times, including overnight and on the weekends. The cellular became our main means of screening.

Those who phoned or were referred to us directly were asked three questions:

1. Do you live in the Downtown Core?

2. Have you ever had contact with a psychiatrist, psychiatric hospital, or a mental health team; and do you see any of them currently?



THIS SURVEY WILL HELP DETERMINE:

Are current services working?

How can they be improved?

What additional or different types of services are required?

MENTAL HEALTH SURVEY

If you are living in the Downtown area,

If you have ever had contact with a psychiatrist, psychiatric hospital, mental health team, or mental health service,

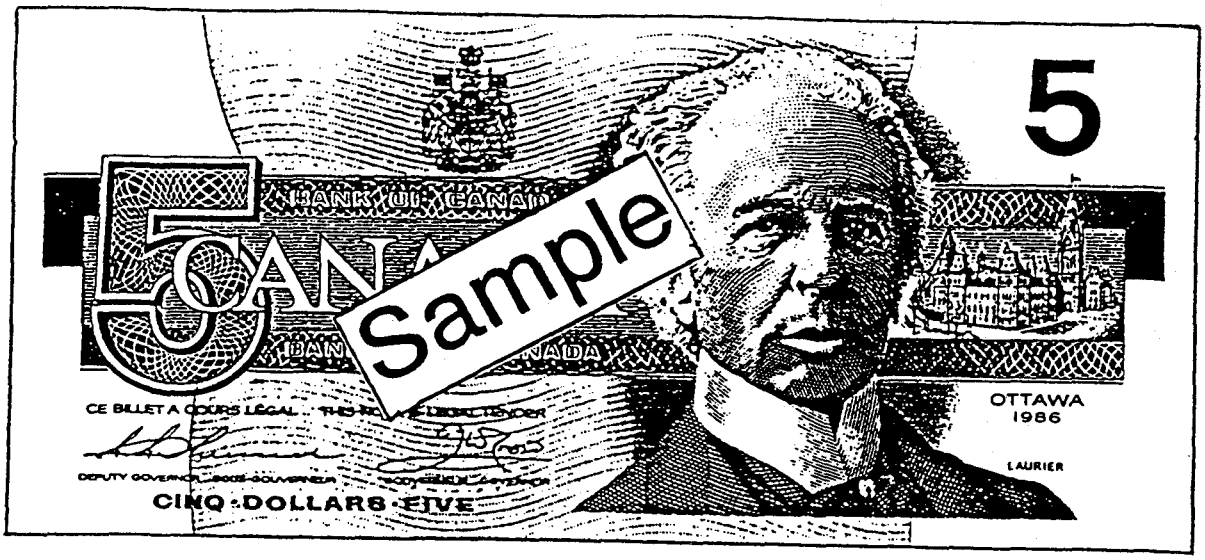
If you are troubled with obsessive or frightening thoughts or visions,

YOUR OPINION IS NEEDED ON
MENTAL HEALTH SERVICES IN THE DOWNTOWN CORE.

Cigarettes and/or coffee will be provided during interviews.

Hi! My name is Ralph Buckley. I have worked in the Downtown area for many years. I have been asked by the Ministry of Health for recommendations regarding improving services to people with mental health problems in the Downtown Core. Your interview can be done at any of the places listed on the back of this card, or in a cafe, or in the privacy of your home or hotel room. I look forward to meeting with you!

Please turn over for more information



$5 for 1 HOUR'S TIME

MENTAL HEALTH SURVEY

(This was folded so that the above was shown first.)

Please take this card to any of the following places and they will contact me immediately to set up an interview time:

Carnegie Centre, Catholic Charities, Crosswalk, DERA, DERA South, D.E.Y.A.S., Downtown Community Health Clinic, Dugout, Dunsmuir House, Downtown Eastside Women's Centre, First United Church, Harbour Lights Detox, Lookout, Needle Exchange, Nexus, Pender Detox, Saint James Social Service, SUCCESS, The 44 (Evelyn Sellers Centre), The Door is Open, Triage, Triage Outreach, Union Gospel Mission, Vancouver Food Bank, any downtown MSSH office.

OR

If you wish to contact me directly to arrange an interview at a time and place of your convenience, please call me at 230-9806.

CONFIDENTIALITY GUARANTEED

3. Do you have problems with obsessive or frightening thoughts or visions?

If we had a "yes" to the first question plus a "yes" to either the second or third, excluding, of course, if they were being currently seen by a psychiatrist, psychiatric hospital or Mental Health Team, we would conduct an interview. We ended up with eighty nine interviewees, all of whom, with a few exceptions, met our criteria.

The questionnaire was twenty eight pages long and lasted between one and two hours. All eighty nine interviewees completed it orally, with many taking numerous smoke breaks. Even though the questions were sometimes quite personal, we consistently found they were very willing to talk. The questionnaire elicited information in the following areas: Demographics, Housing, Physical Health, Mental Health Services, Current Mental Status, Alcohol and Drug, Legal, Support Services, Social Services, Social Contact, Employment History, Income, Food, Hygiene (i.e. current living conditions) and Clothes. Its concluding section had questions such as "A Typical Day?", "Major Problems?", "Philosophy of Life?" and "How Does The Future Look?".

Results:

The following is an extensive summary of each individual section, 15 in all. It should be noted that when we discuss major preferences the responses are listed in descending order of frequency and usually, because of subgrouping problems, the percentages are not given. So when we say the two major reasons stated by the sample population for not working was that they couldn't find work and that they had physical health problems, it is to be understood that the first reason was given more often by the interviewees than the second. Lastly, there was also a sixteenth and a seventeenth section to the questionnaire, both of which we eventually decided not to pursue. The sixteenth section was entitled "For Those Receiving Treatment at Strathcona and West End Teams". For a more extensive discussion see Appendix II. The seventeenth section was a compilation of "Interviewers Observations" about the individuals they interviewed and we have provided a sampling of 10 of these in Appendix III.

I

DEMOGRAPHICS

Results:

The sample population is predominantly male (85%), young (average age 36), reasonably educated (average grade 10.8), Caucasian (90%), and English speaking (99%). 99% have single status especially if the divorced (25%), separated (10%) and widowed (2%) are included in with the singles (62%). 88% live alone.

60% live in hotel and rooming houses, 18% in apartments or suites, 16% in emergency shelters, 4% in supervised living resources and 1% are shelterless and another 1% refused to answer.

This is an extremely mobile population as indicated by the statistic that 60% moved to their current address in the last six months, 68% in the last year and 82% in the last two years. Furthermore, 50% have lived in three or more places within the last year and although mobile they move within the confines of the downtown core as 44% of them stated they have lived downtown for five years or more.

On a broader scale 66% have been in BC over five years and 25% have come from another province. The major attractions of the downtown core are the low rents (31%), the services (16%) and personal attachments (16%).

Summary

If we were to produce a composite from the demographics given above for the seriously mentally ill individuals we interviewed the most predominant one would be a person who is male, aged 36, Causasian, English speaking and has completed his grade 10. He would be single and live alone in a hotel or roominghouse. He would have moved at least once in the last two years and most likely from one hotel or roominghouse in the downtown core to another. He would have been in BC over five years and been attracted to the downtown core because of the low rents, services and the personal attachments he has formed.

We will continue and complete this composite at the end of the fifteenth section in order to produce a portrait of what an average seriously mentally ill person living in the downtown core is like in terms of his background, lifestyle, needs, previous experience with the mental health system and what he wants in the way of relevant community mental health services.

Recommendations: None

II

HOUSING

Results:

The majority of people interviewed (63%) did not like the accommodation they were living in. What they disliked most about it was the following: lack of cleanliness (i.e. cockroaches), too many people with alcohol and drug problems, too much noise and their rooms too small. 66% indicated they preferred living alone. In the last year 37% had been shelterless for at least one night and 11% of that number has experienced shelterlessness over five times.

26% of the sample population had previously lived in a psychiatric boarding home. They left primarily because there were people in the home they did not like.

We asked what was important for them in housing. Their major concerns in order of importance were as follows: cleanliness (no cockroaches), affordability, security, location (i.e. close to amenities and support services), privacy, freedom and mobility (i.e. to come and go when one wants), the people living there and quietness. The housing which the majority (77%) would most like to live in is a self contained suite or apartment. Most (68%) preferred to cook on their own.

We also asked the question that if we were able to come up with an apartment or suite outside the downtown core, would they be prepared to relocate. 69% stated they would and an additional 7% said "maybe". Interestingly enough, however, 23% indicated they would prefer to remain in the area.

Summary:

The majority of respondents did not like the housing they were living in because they were too many people with alcohol and drug problems, cockroaches, lack of cleanliness and too much noise. Two thirds indicated they preferred living alone. In the last year 37% were shelterless for at least one night and 11% of that number were shelterless for over five nights.

What was important for them in housing was cleanliness (no cockroaches), affordability, security, location (i.e. close to amenities and support services), privacy, freedom and mobility, the people living there and quietness. The housing most would like to live in is a self contained suite or apartment. Most preferred to cook on their own.
TCA

If a self contained apartment or suite were offered to them outside the downtown core almost three quarters would relocate. One quarter, however, would choose to remain.

Recommendation:

The poor conditions of many of the hotels and roominghouses in the downtown core is a long standing problem that organizations like DERA have been protesting against for years. These conditions still exist and pressure for higher standards and more inspections by city staff needs to be maintained.

III

PHYSICAL HEALTH

63% of those interviewed stated their health was either excellent or good. 61% said they did not suffer from any disorders or diseases that require medical attention. 25% stated, in fact, that they never saw a doctor. 34% indicated that they suffer from an irregular sleeping pattern. 20% get up in the morning between 10:00 am and 2:30 pm with another 8% reporting no consistency. 24% go to bed between 12:30 am and 4:00 am with another 13% stating that their bedtime varies. 70% of respondents indicated they obtained a reasonable night's sleep.

As far as obtaining medical help, 20% reported difficulties. Another 13% claimed they had problems with eligibility. With dentists, 38% stated they never went.

A major health and economic problem is the large number of respondents who smoke (88%). Of that group, 93% smoke more than 10 cigarettes a day. The average number of cigarettes smoked in a day was 22. 74% of the smokers reported that the increase in the cost of cigarettes had changed their life style by some cutting down on smoking or picking up butts whenever possible, but more sinisterly by many cutting down on the money they used to spend on food. At an average of 22 cigarettes a day, the cost , if you smoke "tailor mades" is around $180.00 a month which is 42% of your income if you are on handicapped pension, 69% if you are deemed "unemployable", and 86% if you are on straight social assistance - in all categories a high percentage of their income literally goes up in smoke! Obviously if you "roll your own", bum, or pick up butts the cost goes down considerably. Unfortunately we did not ask the interviewees whether they rolled their own.

We also asked questions about AIDS. 84% stated they knew about AIDS and where to go to obtain condoms. Only 6% said they did not use condoms. 46% knew where to go for clean needles and 69% where to go for testing. 24% of the respondents claimed they had already been tested.

Summary:

A little less than two thirds (63%) of those interviewed rated their health as excellent or good. Although their sleeping patterns varied considerably, over two thirds (70%) obtained a reasonable night's sleep. Dental problems may exist as over a third (38%) never see a dentist.

A major health and economic problem is smoking as 88% of the interviewees smoke an average of 22 cigarettes a day. Close to three quarters (74%) of the smokers reported that the increase in the cost of cigarettes has changed their life style particularly by taking away from the money they use for food. If you smoke "tailor mades" the cost goes from a little less than a half to over three quarters of your income depending on whether you are on the handicapped, unemployable or the straight social assistance rate. Well over three quarters (84%) of those interviewed knew about AIDS and where to go to obtain condoms. More education, however, could be done in this area.

Recommendations:

1. Although not a healthy lifestyle, the majority of seriously mentally ill do have access to medical services if they choose. A third (33%) of the respondents indicated, however, some problem with obtaining medical service, and this is an area which should be explored.

2. If community workers do manage to establish a working relationship with any of these individuals, their dental needs should be discussed at some point.

IV

MENTAL HEALTH SERVICES

Results:

a) Previous Contact With The Mental Health System:

96% of those interviewed had been in contact with at least one psychiatrist, psychologist, physician, mental health team or psychiatric hospital for mental health reasons. 78% had this contact before the age of 30. 21% stated they still had occasional contact with at least one of these resources. 72% reported they were told by a mental health professional what their diagnosis was and these are some of the responses:

> Yes - first depression, then paranoid schizophrenia, then chronic depression, last boderline personality.
>
> Yes - paranoid psychotic, agoraphobic, claustrophobic.
>
> Yes - paranoid paralogical reaction to stimuli.

When further asked whether the mental health professional explained what the diagnosis meant 58% stated "No". We then asked to tell us what it meant to them when someone used the diagnosis to describe them. Only 13% had an accepting reaction, ie. "the diagnosis fits, I live with it". The rest reacted with silence, neutrality, anger, and non-acceptance. When asked whether they agreed with the diagnosis, however, 55% stated "Yes".

b) Medications:

82% stated they had taken psychiatric medication. Of that group 53% said the medication helped and another 11% were uncertain. 36% were negative.

The following are some of the positive statements:

- Valium helped, made me placid and less tense and less suicidal.
- Cleared my internal dialogue, I could deal with my thoughts more clearly.
- Calmed nerves and helped me sleep.
- Kept me from violent outbursts.

Negative comments were:

- It numbed all my feelings but anger and rage.
- Didn't help, I'm still depressed.
- Made my eyesight weird, no taste buds, spaced out feelings.

We also asked specifically about problems with medication and the major complaints were around feeling drowsy, dull and zombie like as well as having involuntary movements, and erection problems. The major reason for stopping their medication was because of adverse side effects.

c) Hospital Experiences:

80% of the respondents had been hospitalized and of that group 62% had two or more hospitalizations and a further 6% could not remember how many times they had been hospitalized. 45% were hospitalized against their will. 29% had been hospitalized within the last two years and 45% within the last five years. The major reasons for their having to be hospitalized were feeling suicidal or stressed out to the point they felt unable to cope. A significant number (11%) admitted to alcohol and drug problems as well as being suicidal and another 11% stated they could not remember the reasons why they were hospitalized. A majority did agree that they were usually hospitalized for the same reasons. During their last hospitalization 54% claimed that no discharge or follow-up plans were made, while another 1% were uncertain.

Some negative comments were:

Yes - put me on a bus
No - hospital threw me out
No - said find a place

For those who did have discharge planning we asked whether they were in agreement with the plans, and 20% said "No".
The following are some of the negative comments:

- The doctor just walked in and told me there's nothing more they can do for me, and discharged me with no follow-up planning.
- I just played along with their medication scheme, took the pills as given, then they let me out.
- Just told me to get myself a place and to go back to see them if any problems.

- They just let me go when I started feeling better and told me to see them if I had any problems.

- They just told me to go to Strathcona after giving me an L.A. injection.

We asked their overall opinion of psychiatric hospitals and 22% rated them as good or very good, while another 28% said they were okay. 37% stated they disliked psychiatric hospitals, and another 13% did not answer the question.

The following is what they liked about their hospital experience:

- food and rest
- direction
- stability
- comfort
- company
- providing awareness
- stimulated confidence
- provided protection

These are some of the positive comments:

- Kept me from killing myself.

- Helped me to understand and communicate with people.

- Helped me understand my illness.

The major complaints with hospitals were over medicating, too controlling, and hospital staff being too busy to attend to individual needs, particularly doctors.

d) Mental Health Centres/Teams:

60% of those interviewed had previous contact with a community mental health clinic or centre. Out of that group 68% found the experience helpful. By far what they found most helpful (47%) was they felt they were treated kindly, listened to, and had things explained to them. Almost a third (32%), however, found the experience not helpful. Their major complaints were a lack of understanding by staff and the lack of time staff were able to spend with them, the last complaint being identical to that made against hospitals. When asked why they dropped out of treatment the three major reasons were that they felt they were not being helped, they saw no further need for treatment, and that as a result of moving they lost contact. This last reason is significant, as this group is highly mobile.

When asked whether they needed help now 47% said "Yes", and another 3.5% said they were "uncertain". We also asked the question "What prevents you from seeking help now?" The two major responses were: that they did not know where to go for help, and that they were afraid of being rejected.

e) Recommendations of Interviewees:

We ended this section by asking "What mental health services would you like to see which would benefit people in situations similar to yours?" Their major responses in order of importance were: drop-in centres; more mental health centres with increased staff; more low rental housing projects; better emergency help; and more one-to-one counselling sessions.

Summary

Almost all of those interviewed (96%) had been in contact with at least one psychiatrist, psychologist, physician, mental health team or psychiatric hospital for mental health reasons. Almost three quarters (72%) were told what their diagnosis was, but over half (58%) never had it explained to them. Well over three quarters (89%) had difficulty dealing with this information, although over half (55%) agreed with the diagnosis.

Over three quarters (82%) had taken psychiatric medication. Of that group over half (53%) said the medication was helpful, a little over a tenth (11%) were uncertain, and a little over a third (36%) were negative. What they liked about the medication was that it made them less tense and suicidal, more able to prevent violent outbursts, and more able to clearly deal with their thoughts. What they did not like about the medications was that they made them feel drowsy, dull and zombie like, as well as giving them involuntary movements and erection problems.

Over three quarters (80%) of the respondents had been hospitalized, and of that group over two thirds (approximately 68%) had been hospitalized on two or more occasions. A little less than half (45%) had been hospitalized against their will. A little less than a third (29%) had been hospitalized within the last two years.

The major reasons for being hospitalized were feeling either suicidal or unable to cope. While in hospital slightly over half (54%) claimed that no discharge plans were made, and for those that did have plans almost a quarter (20%) were not in agreement with them. When asked to rate psychiatric hospitals, 22% said "good" or "very good", 28% replied "okay", 37% disliked, and 13% didn't answer the question.

Well over a half (60%) of those interviewed had previous contact with a community mental health clinic or centre and of that group over two thirds (68%) found the experience helpful. The remaining third (32%), however, did not find the community mental health clinic helpful and complained about problems with medications, a perceived lack of understanding by staff and the lack of time staff were able to spend with them. When asked why they dropped out of treatment the three major reasons were that they felt they were not being helped, they saw no further need for treatment, and that as a result of moving they lost contact.

The community mental health services which they felt would benefit people like themselves in order of importance were: drop-in centres, more mental health teams with increased staff to provide more one-to-one counselling, more low rental housing projects and better emergency help.

Recommendations:

1. We need to place more emphasis on client education especially with respect to their diagnoses and what this means, particularly now as clients have the right of complete access to their files.

2. We need to be more concerned and solicitous about clients' complaints of side effects from the medications as this is one of the major reasons for their dropping out of treatment. We need to explain more about the medications, the various dosages, the risks, and the potential side effects, especially with new clients coming into the system. We must take the time to explain that if they encounter problems with the medications to not drop out of treatment, but rather to return for adjustments or try something else, as there are now a growing number of medications available. We also need to remain flexible enough to retain clients in treatment even though they may not be on medications or have temporarily stopped taking them.

3. Better discharge planning needs to occur in hospitals, and these plans, if they are to be effective, must involve the patients.

4. When clients move from one area to another more effort should be made by both the mental health facility they are moving from as well as the one in the area they are moving to, to ensure that in the moving process the client is not lost to the mental health system.

5. Drop-in Centres for the seriously mentally ill should be established in the downtown core, and since this study was completed two have come into existence: one in the Downtown South and the other in the Downtown Eastside.

6. More mental health centres should be established in the community or the ones which are now present should have their staffing levels increased so as to provide sufficient one-to-one counselling time - a request that many of the interviewees made in various sections throughout this questionnaire. We should add that in the last two years staffing levels have begun to increase. Hopefully this trend will continue.

7. If the seriously mentally ill are going to be helped in a substantive way, then more low rental housing is required. Again, some progress is also being made in this area. More is required.

MENTAL HEALTH

Results:

This section focussed on the current mental health of the interviewees. We began by asking whether they had ambitions or goals, which changed, and in what way, after they had come in contact with the mental health system. 43% said "Yes, and now not attainable"; with another 8% also saying "Yes" but with the explanation "but now have different goals"; 26% said "No, no change"; 18% said "No, never had goals"; and 5% either did not answer or their answer was not understandable.

The following are some of the comments made:

- Before contact - big/unrealistic goals. After experiencing mental illness and living with it, basic survival - the key, set small attainable goals.
- Was going to go to university, get married and have a good life.
- No, no life, no ambition.
- Yes, goals lessened, felt unable to compete.
- No ambitions, want to relax.

When then asked if they felt they were depressed, 30% said "yes" and another 4% said "at times". 50.5% stated they thought about suicide with 15% of that group indicating "all the time" and another 13.5% of the same group stating "fairly often". We also asked them to describe the feelings they had when they were suicidal. The major one mentioned was the feeling of life being stagnant and repetitive with no point or purpose and no way out. High on the list as well was what they described as "alcohol related" feelings.

The following are some illustrative comments:

- No purpose in life, I'm going to die anyway.
- Yes, when I had an insect in my head.
- 25 seconals and a bottle of whisky.
- I'm not worth it, I'm not salvageable, no chance for me to start a new life.
- Abusive, violent life from parents and some friends, never found any love.

The remainder of this section consisted of a mental status examination which, with the assistance of Dr. Glen Haley, a psychologist at Riverview Hospital, we compiled from a number of standard mental status assessment instruments. We began this section by stating that we were going to ask them about "unusual and sometimes bothersome experiences that people have at least one time or another in their lives". They may have had some of them in the distant past but we wanted to know whether they had experienced any of them in the last six months and how long the experiences lasted and how much they bothered them (see illustration). We asked an

exhaustive list of 13 questions covering the following psychotic characteristics:

1. people following them;
2. people plotting against them;
3. people trying to hurt them;
4. people trying to poison them;
5. people reading their mind;
6. whether they could actually hear what another person was thinking even though he or she was not speaking;
7. whether others could hear their thoughts;
8. whether someone or something could put strange thoughts directly into their minds or could steal thoughts out of their minds;
9. whether they were being sent special messages;
10. whether they believed they were especially important in some way or that they had power to do things other people couldn't do;
11. whether they experienced seeing something or someone that others who were not present could not see, like having a vision while completely awake;
12. whether they heard things other people could not hear such as a voice;
13. whether they had unusual feelings inside their body like being touched when nothing was there or feeling something moving inside their bodies.

Over two thirds (69%) of those interviewed stated they had one or more of these experiences within the last 6 months. Of that 69%, however, 13% stated that they were drinking or doing drugs when they had these unusual experiences and three-quarters of that group felt alcohol or drugs were responsible for these experiences while the remainder said they were "uncertain". This leaves 56% who had psychotic experiences within the previous 6 months which were not as a result of consuming drugs or alcohol.

Returning to the psychotic experiences, the five major ones reported were: feeling someone was following them (37%); plotting against them (36%); hearing a voice which others couldn't (36%); feeling more important or powerful than others (33%); and hearing another's thinking even though they were not speaking (33%). The experiences which persisted the most were those of being sent special messages (11%); following (11%) and feeling more important or powerful than others (9%). The ones which bothered interviewees the most were the feelings of people following them

RESULTS OF COMPILATION OF STANDARD MENTAL STATUS ASSESSMENT INSTRUMENTS

Psychotic Characteristics	% Experienced in last 6 months	How Long Experience Lasted				How Much Experience Bothered			
		No Time Specified	A Great Deal	A Fair Amount	A Bit	Very Much	Fair	A Bit	Bother
Following	37%	0%	11%	15%	11%	10%	4.5%	10%	12.5%
Plotting Against	36%	13%	3%	9%	11%	10%	10%	7%	9%
Hearing What Others Couldn't	36%	11%	4%	0%	18%	9%	4.5%	4.5%	18%
Feelings of Importance and Power	33%	9%	9%	0%	15%	4%	0%	3%	26%
Hearing Another's Thinking Even Though No One Speaking	33%	9%	5%	8%	11%	7%	6%	13%	7%
Seeing What Others Couldn't See - A Vision	30%	4.5%	4.5%	0%	21%	10%	2%	3%	15%
Others Could Hear Their Thoughts	28%	11%	1%	0%	16%	8%	1%	8%	11%
Hurt	22%	8%	4%	4%	6%	8%	3%	4%	7%
Reading Mind	20%	8%	1%	3%	8%	3%	1%	5%	11%
Send Special Messages	20%	4.5%	11%	0%	4.5%	1%	1%	2%	15%
Put Strange Thoughts Into Mind or Steal Thoughts Out	17%	10%	1%	0%	6%	2%	0%	1%	14%
Poison	13%	9%	0%	2%	2%	4%	0%	2%	7%

(10%), plotting against them (10%) and seeing what others couldn't see such as a vision when completely awake (10%) Those that bothered them the least were: feelings of having more importance or power that others (26%), hearing voices others couldn't (18%), and of being sent special messages (15%).

Summary:

A little over half of those interviewed (51%) indicated that their ambitions and goals in life changed by having to lower them after coming in contact with the mental health system. About a third (34%) stated they were currently depressed and half (50.5%) indicated they felt suicidal ranging from "all the time" to "occasionally". A little over a half (56%) indicated they had psychotic experiences within the previous six months which were not as a result of consuming drugs or alcohol. The three major experiences were: feeling someone was following them, plotting against them and hearing a voice which others couldn't. The experiences which persisted the most were those of plotting against, following and feeling more important or powerful than others. The ones which bothered them the most were following, plotting, and hearing what others couldn't. The psychotic experiences which bothered them the least were: feeling more important or powerful than others; hearing a voice which others couldn't and seeing what others couldn't see such as a vision when completely awake.

Recommendations:

None

VI.

ALCOHOL AND DRUGS

Results:

We began this section by asking how often the interviewees drank. We received a range of answers which included: a great deal (18%), binge drinking especially around "Welfare Day"* (23%), and not much (35%). 24% stated they did not drink. We asked the same question with drugs and found the following: a great deal 13%), fairly often (11%), sporadic (6%), a bit, not much (8%) and no answer given (2%). Drugs, however, had a much higher percentage (60%) who claimed abstinence. We also asked about glue and found 4% who admitted to doing glue and another 6% who would not answer the question. What inverviewees liked most about substances was the relaxation and lowering of stress they gave, the good feeling of being high, and the forgetfulness/escape they provide. What they disliked most about substances were the hangover/after effects and the cost. When asked why they used the substances they gave the major reasons as helping them to socialize, to forget/escape and to give them the high. 32.5% stated they drank or did drugs alone while 41.5% did them with people. Another 15% said they did them both alone and with people. One respondent commented, "I drink alone; do marijuana with people". Around 50% of the interviewees go to bars or beer parlours. 29% encountered problems such as fights or arrests within the last 6 months while under the influence. 27% stated they had "the shakes" within the last 6 months and 17% the "DT's". 15% went to detoxes in the last 6 months. Overall, 28% of the "interviewees have experienced detoxes - with 40% of that number claiming the detoxes helped them straighten out their lives. 40% of the interviewees had been referred to an Alcohol and Drug Program and 36% went. The major reason they went was to obtain help; the major reason they did not go was because they felt they had no problem. For those who went to the detoxes, what they found they liked the best was the counselling and support they received.

A.A. an N.A.:

70% stated they had been to an A.A. or N.A. meeting. The things they liked most about these meetings were the group support, the understanding and acceptance, and the socialization. The two major complaints they had with A.A. and N.A. were: (1) that there were people at the meeting who never changed and always told the same stories, and (2) there was too much preaching and dogma involved.

* The 4th Wednesday of every month when Social Services recipients receive their funds for the following month.

Summary:

A little over three quarters of the interviewees (76%) stated they drank in varying degrees. A much lower amount, two fifths (40%) claimed they did drugs. A very small number admitted to doing glue (4%). What interviewees liked most about substances were the relaxation, good feelings and forgetfulness they provide. What they disliked most about the substances were the after effects and the cost. They use these substances to socialize, forget and obtain a high. About a third of the interviewees (32.5%) drink or do drugs alone. About half the respondents go to bars or beer parlours. Within the last six months over a quarter (29%) encountered problems such as fights or arrests. Another just over a quarter (27%) had the shakes and just under a fifth (17%) DTs. Just over a quarter (28%) of the interviewees had experienced detoxes. A larger number (40%) had been referred to an Alcohol and Drug program. The major reason they went was to obtain help. The major reason they did not go was they felt they did not have a problem. An even larger number, over two thirds (70%), had attended an A.A. or N.A. meeting.

Recommendations:

1. There are many alcohol and drug programs already existing in the downtown core and certainly a significant number of this population have a serious alcohol and drug problem. Sometimes, however, they have difficulty accessing these programs, as many of the staff in them are not familiar with the seriuosly mentally ill and the problems they present. In the last three years we have initiated educational workshops and staff exchanges between GVMHS and Alcohol and Drug programmes. More needs to occur and if it turns out that Alcohol and Drug Programs cannot accommodate the seriously mentally ill, then a separate facility should be considered..

2. The difficulty remains as to how to motivate these people to obtain treatment. It should be noted, however, that the need or desire to socialize is quite high and if there were alternatives to the bars and beer parlours such as the drop-ins already mentioned, the consumption of these substances would likely be reduced significantly.

VII

LEGAL

Results:

83% of the interviewees stated they had been arrested and 61% had been convicted. The major arrests were for assaults (19%), theft (12%), breaking and entering (10%) and possession of stolen property (10%).

70% of the interviewees spent time in jail with almost two thirds of that group (64%) incarcerated for less than a year. We than asked the question "how would you compare jail with a psychiatric hospital?" 36% liked hospital better, 24% preferred jail, 2% stated they were equal and 5% were uncertain. The following were some of the comments:

- safer in jail than in hospital;
- prefer jail, at least the food is better;
- the hospital is better but not the food;
- rather be in jail, at least I know what I was doing, knew what was expected of me and when I was getting out;
- jail more freedom.

There did appear to be a consensus that the food in jail was superior to that in hospital. While in jail 39% stated that mental health services were made available to them, and of that group about a quarter (23%) stated the services were helpful.

We also asked whether they had been victimized in the last 6 months and 61% stated "Yes". The three major forms of victimization were robbery, psychological victimization and assault. 54% of those victimized received help. The three major sources from which they did were the police, social services and the ambulance people. We also asked whether they had ever gone to the police for help and 51% replied "Yes". 43% indicated that the police had been helpful with another 2% giving a mixed reaction stating that "some cops are okay".

Summary:

Over four fifths (83%) of the interviewees stated that they had been arrested and a little less than two thirds (61%) of them had been convicted. An identical amount (61%) claimed they had been victimized. The three major forms of victimization were robbery, psychological victimization and assault. A little more than one third (39%) of those who spent time in jail received mental health services.

Recommendations:

1. More mental health services should be made available to the seriously mentally ill in the criminal Justice system. Some progress is occurring in this area.

2. More outreach services should be made available to the seriously mentally ill who have been victimized.

VIII

SUPPORT SERVICES

In the first part of this section we asked questions about what community services the interviewees used and what their opinions were of these services. In the second part we asked about their personal support system and what they did with their time.

Results:

Community Support Services: (See illustration)

We began by asking interviewees their opinions about the following community services: Lookout, Triage, Catholic Charities, DERA, DEYAS, the Evelyn Sallers Centre, the Dugout, the Foodbank, the Downtown Health Clinic, Strathcona Mental Health Team, West End Mental Health Team, the Police, Car 87, and Social Services (see illustration). The major services used were Social Services 100%; the Police (79%); Lookout (69%); the Evelyn Sallers Centre (65%); the Foodbank (63%); and Catholic Charities (61%).

We also asked if a drop-in were put into their area which was open late every night would it interest them and would they come to it. 70% said "yes" and another 6% said "probably". We then asked what they would like to see in such a drop-in. We obtained numerous suggestions with the major ones being: a place that would have television or show videos; that would have free coffee and tea; that would have a relaxed atmosphere where they could meet and talk to people; that would be able to provide counselling from experienced staff; and where also they would have games. Many of the men expressed the desire to have a place to meet women.

Personal Support Services:

70% of the interviewees stated they kept in contact with their family, with 42.5% having contact at least once every 6 months. 47% claimed their family helped them. 55% had a family of their own and of that group almost half (49%) had no contact with them at all. When asked whether they enjoyed intimate relationships, 55% said "yes" and another 3% said "occasionally". Of those who said "no" (41%), a little less than half of that group (44%) also said "no" to the further question "would you like to have an intimate relationship". When asked what prevented them from having an intimate relationship the two major reasons given were: no opportunity to meet the right person and no money.

63% stated they did have someone who they felt comfortable to talk to and 62% also stated they had someone they could trust and turn to in times of crises. Of those who did not have someone to trust or turn to in times of crises (38%), almost two-thirds (62%) of that group stated they would like to have this situation change.

Time Usage:

We then asked questions about what they did during the evenings and weekends. The three major activities mentioned were: watching TV, going for walks and reading. When asked whether they had places to go the largest response was "nowhere". Aside from this, the three major places mentioned were: the Carnegie Centre, parks and friends' places.

Some comments made were the following:

- No, not safe to go out at night.
- Go to bar when have money.

For those who had no place to go, almost three-quarters (73%) of that group stated they would like to have such a place. When we asked what that place would look like the three major responses were: a safe and secure place, a drop-in centre with activities, and a place where they could sit down and relax with people.

Summary:

What does the information in this section imply or suggest? If we look at the stereotype of a lonely seriously mentally ill individual living in a hotel room or apartment with minimal contact with anyone, we see that this is not a precise fit. The majority of these individuals use community support services. On a more personal level we see that over two-thirds (70%) keep in contact with their families, a point many of the workers in the various downtown agencies often forget or overlook. Also, almost two-thirds (58%) of this group have intimate relationships as well as people they can turn to in crises (62%). Furthermore, the overwhelming majority of these individuals claim they would respond to one-to-one counselling from a qualified/skilled therapist. They do, however, fit the stereotype in terms of staying in their rooms a great deal on evenings and weekends, although this could likely be due to lack of money or, like other downtown core residents, they do not feel safe in the neighbourhood after dark. Many would like to have a safe and secure place where they could drop in and have activities, or just relax and talk to other people.

Recommendations:

1. A drop-in centre is needed in the downtown core which would stay open late every night and be a safe and secure place. It should have free coffee and tea and offer activities as well as opportunities to meet, relax and talk to people. It should also offer counselling, if desired, by trained, experienced staff.

2. As it appears that the majority of these people do keep in some contact with their families, this should be an area that downtown core mental health workers need to be more cognizant of. How many of us, for instance, know who to call if our client is in dire need of help? Too often, the only time we contact families is to inform them of some disaster which has befallen their loved one.

Facility or Organization	Percentage of Those Who Used Community Service	Ratings by % of Those Who Used Facility/Organization					
		Excellent	Good	Okay	Poor Didn't Like	Terrible	No Opinion
Social Services	100%	9%	36%	30%	10%	8%	7%
Police	79%	7%	23%	41.5%	21.5%	7%	-
Lookout	69%	7%	39%	38%	11%	5%	-
Evelyne Sallers	65%	10%	55%	19%	12%	4%	-
Foodbank	63%	11%	45%	14%	23%	7%	-
Downtown Health Assoc.	62%	13%	45%	25%	15%	2%	-
Catholic Charities	61%	5%	52%	26%	13%	4%	-
DERA	53%	11%	49%	13%	25%	2%	-
Dugout	49%	7%	48%	32%	13%	0%	-
Strath. Mental Health	43%	10%	38%	21%	23%	8%	-
Triage	39%	11%	40%	29%	14%	6%	-
The Drop-Ins, MPA, Kettle Coast Foundation	33%	24%	21%	17%	21%	7%	10%
Car 87	22%	0%	60%	20%	20%	0%	-
West End Mental Health	18%	6%	25%	31%	25%	13%	-
DEYAS	8%	14%	0%	72%	14%	0%	-

IX

SOCIAL CONTACT

Results:

We started this section by asking if they had any friends and 78% said "yes". Well over half of this group (58%) see their friends daily. They do things together with these friends and view them as being of help. Currently the major people of importance in their lives are friends and family.

We also wanted to test the theory that people who they see frequently such as hotel managers, waiters, storekeepers, etc., would be significant for their daily routine, so we asked the interviewees how important these people were to them. 79% replied they were "not important". It would appear, therefore, that the theory is not reality based.

We proceeded to ask what places in the downtown core they could go and feel comfortable. The four major ones mentioned were: Carnegie Centre, the parks, the Evelyne Sallers Centre and coffee shops. The major services they currently use the most were the Downtown Health Clinic, the Evelyn Sallers Centre, the Carnegie Centre and the Robson Street Library. At Christmas time about half (47%) stay by themselves and about a quarter (26%) go to their parents' home.

We asked if their lives gave them enough freedom and 63% said "yes". A complaint that many made, however, was that because they lacked money and were dependent on social assistance, they had no financial freedom. We then asked if their lives gave them enough privacy just over half (54%) said "yes" and just under half (46%) said "no". Those who responded negatively stated that their hotel rooms offered them no privacy at all.

Summary:

As we indicated in the Support Services section, the majority of these individuals have friends and visit them often. There are, however, limitations to these friendships as almost half of them spend Christmas alone. Although two thirds of the interviewees feel that their lives give them sufficient psychological freedom, a major complaint is that for lack of money they have no financial freedom. Many also complained about the lack of privacy they experience in their hotel rooms.

Recommendations:

1. Certainly the overwhelming message in this section is to have a drop-in centre in the downtown core where the seriously mentally ill can congregate, feel safe, comfortable and accepted.

X

EMPLOYMENT

Results:

We began this section by asking about their literacy, specifically whether they could read a newspaper. 91% replied they could. 98% stated they could write. In terms of employment, 44% stated the longest job they had ever held was two years or less. One rather humorous comment was "My life is a job. I'm still getting paid on welfare". Only 18% indicated they had done any work in the past 6 months. The three major aspects they liked about work were the money, the feeling of accomplishment and the self esteem work provided. What they disliked about work were the long hours, the stress, the ill treatment they received from co-workers, and the often poor pay. When asked why they were not working the two major reasons given were that they couldn't find work and that they had physical health problems. 91% stated they would like to be employed at something. When asked what that "something" might be the five major responses were: janitorial work, anything, cooking, construction and working with computers. When we grouped the various responses into categories the two major ones were general labour (41%) and trades (25%).

Summary:

The vast majority (91%) of the interviewees were literate. A little over three quarters (77%) were unemployed and had been for over 6 months. Many of these individuals had poor employment records. What they like and dislike about work, aside perhaps from the complaint of ill treatment by co-workers, is no different from the general population. Close to everyone interviewed (91%) would like to be employed at something and the majority are quite realistic about the types of jobs they could do, given their employment backgrounds and job availability.

Recommendations:

1. As we know from the demographics, the average age of this population is 36, which certainly indicates that employment is an area which needs exploring. If not full-time, considerable efforts should be made to involve them in part-time or casual work. Perhaps Social Services' new Community Volunteer Program (CVP), which pays $100.00 a month for 10 hours' work at a non-profit agency, could be implemented with many of these individuals. Also some innovative measures could be undertaken in the areas of cottage industry work, or modified, on-site sheltered workshops.

XI

INCOME

Results:

This is one of the more revealing sections of the questionnaire. We began by asking for their current sources of income and obtained the following:

HPIA (i.e. handicapped pension)	30%
Social Assiatance	64%
Pension	4%
Own Savings	2%
	100%

24% stated they supplemented their income in some way, the two major means being casual work and that of a paid volunteer at a non profit agency for $50.00 a month. The average amount received in a month was $602.48. We also asked how long their money lasted for the month and 27% indicated the end of one week; this number increased to 55% at the end of two weeks; 71% made the money last to the end of three weeks; and 27% made it through the entire month. (2% refused to answer.) We then asked what they did to survive if their money ran out before the next payday. 60% claimed they used the free food places. The second largest response was from 38% who refused to answer. We then asked the interviewees to break their monthly expenses down in terms of housing (average rent $315.04), food (average spent on food $162.00), cigarettes ($83.68) and alcohol ($69.92). They had other expenses as well which we did not do averages on. These included clothing, transportation, hygiene needs, medications, laundry and entertainment. If you take all the averages of income, housing, food, cigarettes and alcohol you have the following:

Average monthly rent-	.	$315.04
Food	-	$162.00
Cigarettes	-	$ 83.68
Alcohol	-	$ 69.92
Total		$630.64 vs. average monthly income $602.48.

When you subtract the total of these averages from the average monthly income you obtain a negative figure of $28.16, which makes sense since the majority never make it through the month on their current income.

We also asked whether it would be helpful for someone to administer this money once a week. 20% said "yes", 67% said "no", and 10% were already being administered. The following are some of the comments made about administration:

- Definitely not! Then I would have nothing for days.
- Yes, but I don't want it.
- Yes, once a day.

We finished this section by asking the interviewees how much a month they felt they needed to get by on comfortably. Their answers averaged out to a required monthly income of $890.00.

Summary:

The average monthly income of the interviewees was $602.48. This amount lasted about a week for just over a quarter of them (27%), two weeks for a little over a half (55%) and three weeks for just under three quarters (71%). There were 27% who managed to make the money stretch the entire month. For those who didn't make the money last their major source for food was the free food outlets. When we added up the average monthly costs for rent ($315.04), food ($162.00), cigarettes ($83.68) and alcohol ($69.92), without any additional expenses such as clothing, transportation, hygiene needs, laundry and entertainment, and subtracted them from the average income of $602.48 we wound up with a negative figure of $28.16. A little less than a quarter (20%) wanted to have their money administered. The average monthly income the interviewees stated they required to get by on was $890.00.

Recommendation:

1. The questionnaire clearly shows that their current monthly income is inadequate for almost three quarters of the interviewees. The social assistance rates need to be raised or else work programs as income supplements need to be implemented such as the CVP program already cited in the Employment section.

2. The results also suggest that some seriously mentally ill individuals in receipt of social assistance or handicapped pension would go on to administration voluntarily if it were advertised or actively encouraged by Social Services. We realize this suggestion goes against Social Service's philosophy which stresses independence, but for some of these individuals administration could prove very beneficial and actually help them maintain their independence.

XII

FOOD

For this section we asked the interviewees a number of questions having to do with what they eat, where they eat, how much they eat, and the cost of what they eat. For our analysis, we were fortunate enough to obtain the services of Ms. Carol Falconer, who is the nutritional consultant for GVMHS.

Results:

We began by asking whether they had eaten on the day they were interviewed and 35% said "No". This data is meaningless, however, as we did not record the time of day the interview was done. A much more significant question was "how many meals a day do you normally have?" and 25% said one, 44% said two and 1% said they didn't eat every day. 70% of those surveyed, in other words, did not eat three meals a day. Ms. Falconer points out "This is significant. A good standard in nutrition is that a person eat three balanced meals a day, and 70% have very little chance of meeting these requirements."[8] **Ms. Falconer also commented on the 25% who only get one meal a day and called this "drastic, because they are possibly only getting one third of their** nutritional requirements"[9]. When asked what they usually have to eat the three major items mentioned were Sandwiches, Soup and Vegetables. Most of their eating is done either at home or at free food places. We also asked about the cost of meals per day and the answers ranged considerably with 17% claiming, in fact, that they spent nothing on food at all as they used the free food outlets entirely. We came up with an average of $5.63 a day, which did not include the 17% who claimed they had no food costs. Using a 30 day month this comes to $168.90 which is fairly close to the figure of $162.00 given in the income section where they were asked to break their monthly expenses into various categories, food being one of them.

We then asked if they felt they obtained enough to eat and 29% stated "No" with another 11% who said "Yes, but not all the time". Some of their comments are quite informative:

- I'm not starving, I long for the food that I don't have.
- Yes, quantity wise but not variety and quality.
- Yes, but not the right kind of food.

We also asked whether they used foodbanks, sandwich lineups, soup kitchens, Salvation Army meals, Union Gospel meals, and the Evelyne Sallers Centre. They were ranked as follows:

1.	Evelyne Sallers Centre	- 59%	
2.	Sandwich Line Ups	- 47%	
3.	Foodbanks	-	44%
4.	Salvation Army meals	- 43%	
5.	Soup Kitchens	- 39%	
6.	Union Gospel meals	- 37%	

We continued by asking where they stored their food and 33% claimed they had no fridge or cupboard, and another 6% had a cupboard but no fridge. One interviewee stated his food was

8. Falconer, Carol, RDN "Comments on Food Section in Downtown Eastside/South Needs Assessment Survey" Dec. 6, 1992 Pg. 2
9. Ibid. Pg. 2

"hanging in a bag out my window". 42% have to buy their food every day.

We went on to ask how they managed to eat if they ran out of money before the next payday and only 10% stated this never happens[10]. 44% replied they used the free meal services. We also asked whether any of them had obtained food out of a dumpster and 29% replied "Yes": some occasionally, some often and some daily. Ms. Falconer felt this was also a significant figure and likely an under-estimate as many would not want to admit eating out of a dumpster.[11] 75% indicated they cook, the majority on a stove or a hotplate. One individual claimed he cooked on an iron, turned over. 35%, however, had nothing to cook on.

In the final portion of this section we asked what they had to eat: for the morning of the previous day and 19% indicated "nothing". The three major items consumed by the rest were coffee,toast and cereal. We proceeded with asking about the afternoon of the previous day and learned that 33% ate nothing. The three major items consumed by the rest were sandwiches, soup and coffee. Finally, we asked about the previous day's supper and 17% said "nothing". The three major items consumed by the rest were coffee, meat and sandwiches.

We concluded this section by asking whether the respondents had lost or gained weight lately. 42% replied they had lost. Ms. Falconer states that this indicates they are "not getting sufficient calories in their diet"[12] and that this is "highly predictable from other information in the survey"[13]. She also points out that the percentage of those who lost weight (42%) is almost identical to the percentage who felt they did not have enough to eat most of the time (40%). Falconer concludes "We are looking at a highly malnourished population. Mental illness is difficult enough to deal with without the additional burden of malnutrition."[14]

Summary:

Almost three quarters of the population surveyed (70%) eat two meals or less a day. The major items consumed in their diet are soup, sandwiches and coffee. The average cost of meals per day is $5.63. Over a third of the interviewees (40%) claimed they did not have enough to eat all of the time. In addition, there is ample evidence to indicate that even in cases where the quantity of food is sufficient, there is little variety or quality.

A third of the population (33%) have no fridge or cupboard to store their food and only 10% manage not to run out of food money before the next cheque day: the other 90% do. When they do run out the majority (44%) use the free meal services. A little less than one third (29%) admitted to obtaining food out of dumpsters, which is very likely an underestimate. And close to half of those interviewed (42%) claimed they had been losing weight, which given their diet is predictable according to Falconer. She also points out that the percentage of those who have lost

10. In the Income section 27% indicated their money lasted them until the end of the month. Perhaps this disparity can be explained by many of that 27% occasionally running out of food on some months but not all.
11. Falconer, Carol, "Comments on Food Section in Downtown Eastside South Needs Assessment Survey" Dec. 6, 1992 p. 3
12. Ibid. Pg. 3
13. Ibid. Pg. 3
14. Falconer, Carol, "Comments on Food Section in Downtown Eastside South Needs Assessment Survey" Dec. 6, 1992 p. 3

weight (42%) is almost identical to the percentage who claimed they did not have enough to eat most of the time (40%). She concludes from this correlation "...that we are looking at a highly malnourished population"...Mental illness is difficult enough to deal with without the additional burden of malnutrition".[15]

Recommendations:

1. Ms. Falconer advocates having an outreach worker drop off at their homes a non perishable meal on a regular basis, especially in the latter part of the month. Since the most likely time they will be home is in the morning this non perishable meal would be a breakfast pack. Falconer states "this works out perfectly as it gives them both breakfast and something to get them started nutritionally for their day"[16]. It could also assist in getting them into treatment as well.

2. We have already suggested Social Services review their rates, and since the completion of the survey the rates have gone up by $10.00 for the employables and unemployables and $16.00 for the handicapped. The problem is a complex one, however, as just because the rates are revised does not automatically mean that the interviewees will spend their increase entirely on obtaining food, or if they do whether the food is better and more balanced nutritionally. Also if you raise rates in one area of the province you have to raise them everywhere else as well. Perhaps Social Services could look at the problems of the downtown core specifically and implement programs targeted to this area alone.

3. Given the economic hardships, clearly the free food places in the downtown core are essential. Perhaps, however, they too might look at more innovative ways of delivering their services than simply the traditional ones of lineups and sit down meals established years ago during the Great Depression. If this survey is truly representational, although 90% run out of money before the next cheque day, only 44% take advantage of the free food outlets. That leaves a malnourished or undernourished residue of 46%. With all we hear about competing in a global economy and restructuring, we may be experiencing another Depression and we need to think of new and innovative ways to target those most in need.

15. Falconer, Carol, "Comments on Food Section in Downtown Eastside South Needs Assessment Survey" Dec. 6, 1992 Pg. 3
16. Ibid. Pg. 5

XIII

HYGIENE

Results:

100% of those interviewed had access to a bathtub or shower and 92% of them on a "daily" basis. Only 15%, however, had a private bathtub or shower. We asked what their bathtub or shower was like and 23% indicated either "poor" or "terrible". The following are some of the graphic negative comments:

> Reasonably clean but not enough privacy.
> Terrible, unsanitary.
> Not clean, very seedy.
> Rotten, not clean because of some tenants.
> No hot water in the building.
> Not very good in my building, no privacy, I use 44's shower and Woodwards' toilet.
> Gloomy, hot water faucet busted, have to use screwdriver.
> Not very clean, cockroaches and mice.
> Unsanitary, smell of urine, cockroaches, no privacy, door cannot be closed properly.
> Not clean - syringes in toilet area.

We also asked whether they had a washbasin (93%), hot water (90%) and access to a toilet (99%). With toilet access, however, only 12% were private. When we asked about the conditions of these facilities 12% stated they were "acceptable" and 15% said they were either "poor" or "terrible". 61% for some inexplicable reason, did not answer the question. The following are some of the negative comments which were made:

- very ancient and unsanitary toilets;
- a hotel is a place where you have to watch what you touch, germs, etc.;
- I use the washroom facilities in the 44 a lot, they are cleaner than the hotels.

Summary:

Although everyone had access to either a bathtub or a shower, well over three quarters (85%) shared them with at least one other person. Certainly one has to question how sanitary such situations are. Almost a quarter of those interviewed (23%) rated these facilities as either "poor" or "terrible". The lack of privacy for toilets was almost identical to that of bathtubs and showers (88%).

Recommendations:

1. It would be easy to recommend that all hotels and roominghouses have private toilets with tubs or showers, but highly improbable that such would occur. We would recommend more practically that hotels and roominghouses either concern themselves more with sanitation and privacy, or the city inspection department set higher standards and have more inspections. Perhaps a combination of both would be in order.

XIV

CLOTHES

Results:

In this section we began by asking whether they had enough warm clothes and 21% stated "No". We then asked where are the places they go to obtain clothes and the major responses were that they bought their own or else obtained them at the following: Franciscan Sisters, Free Places*, United Church, St. James Social Services and the Salvation Army. We also asked, if applicable, what prevented them from going to these places. The two major responses were lack of money (for those who bought their clothes) and sizing, i.e. they can't get the proper fit (for those who use the free clothes places). We also asked how they had their clothes cleaned and 15% stated they handwash them in the sink or bathtub.

We continued by asking whether they had rain gear and 57% said "No". As to footwear, especially for rain or snow, 36% said "No". One respondent claimed he obtained his shoes from a dumpster. 59% stated they had no dress clothes.

We ended this section by asking if they had clothing needs now and 63% said "Yes". Underwear, in particular, was a high priority item as this is something they cannot obtain from the free clothes outlets.

Summary:

Like the sections on food and income, many of those interviewed were found wanting when it came to sufficient clothing. Almost a quarter (21%) did not have warm clothes, over half did not have rain gear (57%), and a little over a third did not have proper footwear for rain or snow (34%). Over half (59%) did not have dress clothes and almost two thirds (63%) stated they had clothing needs now. Underwear, for instance, was a high priority item as this is something they cannot obtain from the free clothes outlets.

Recommendations:

1. Again, as with food and income, the lack of sufficient clothing shows the need for a review of the current social assistance rates or the implementation of more work type programs as an income supplement.

2. Like the food section, the free clothing outlets could consider a number of options. Instead, for instance, of having all the clothes in a box or pile, they could sort things out and label the sizes. The majority of these individuals are men with an average age of 36 who likely do not have the patience or perhaps the fortitude - for it can be embarrassing - to sort through these items properly. A second consideration would be to take a non-traditional approach, as suggested in the food section, and look at some modified form of outreach service to assist those who truly are in need.

* "Free Places" includes the Franciscan Sisters, United Church, St. James and the Salvation Army.

XV

CONCLUSION

In this concluding section we attempted to obtain a comprehensive picture of how they spent their time, the major problems they had to contend with, and their philosophical outlook.

Results:

We began by asking them to describe a typical day. The four major activities mentioned were walking around the neighbourhood, watching TV, drinking coffee or tea and talking/visiting friends. One interviewee described his day as follows:

> Woke up, think what I have for cigarettes or coffee, go collecting scrap, come home around 2 pm, look for something decent on TV, wish for somewhere decent to go, wish I had the nerve to apply for a job, go for a walk, read, go to sleep.

We went on to ask what they considered the problems they had to deal with on a day to day basis. The two major ones were money and obtaining food. When we asked what problems they had last week we received similar replies; money, finding accommodation and obtaining food. The problems for the last month were finding accommodation and money. In the last year the most outstanding problem was money.

We asked what their philosophy of life was and received a wide range of answers. We attempted to categorize them in the following manner:

Practical/concrete/cliche	43%
Altruistic/socially conscious	19%
Narcistic/self interest	16%
Spiritual/religious	7%
Not categorizable	15%
	100%

We ended this section by asking how they enjoyed their life. 25% were in the range of "very much" and "I like it", 25% said "It's OK" and 50% felt negatively. One respondent stated "I'd rather be rich and have problems, than poor with my problems".

Summary:

A typical day for the majority of the interviewees involves walking around the neighbourhood, watching TV, and visiting friends. The three major problems they continually have to contend with is obtaining money, food and accommodation with money being by far the most important. 50% of the interviewees felt negatively about their lives, while another 25% stated their lives were "okay".

Recommendations:

1. The recommendations for this section have already been made in previous sections i.e. review the social assistance rates, consider more work type programs as an income supplement, look at an outreach service providing nutritious breakfast packs, and provide a drop-in with extended hours which is safe, easily accessible and accepting.

COMPOSITE

In the first section on demographics we began by providing from the data a composite of what a typical seriously mentally ill person living in the downtown core would look like. 15 sections later we can now complete the task. We will call this individual George and describe him from the beginning.

Demographics:

George is a Caucasian male, aged 36 and English speaking. He completed his grade 10. He is single and lives alone in a hotel in the downtown core. He has moved within the area at least once in the last two years from one hotel or roominghouse to another. He has lived in British Columbia over five years. He is attracted to the downtown core because of its low rents, services and the personal attachments he has formed.

Housing:

George does not like his current accommodation because of the lack of cleanliness (i.e. cockroaches), the noise, and the large number of people with severe drug and alcohol problems. He does, however, prefer to live alone. What he would like to have for accommodation is a clean, secure and affordable self contained suite, which is close to amenities and support services. If such housing were to be offered outside of the downtown core, he would likely relocate.

Physical Health:

George's physical health is reasonably good, and he has little problem with his sleeping pattern. He does, however, smoke over a pack of cigarettes a day and this is not healthy. Furthermore, the expense of the cigarettes cuts into the money he should spend on food. He is fairly knowledgeable about AIDS and knows where to go to obtain testing.

Mental Health Services:

At an earlier age George had contact with the mental health system and although he was told what his diagnosis was, it was not explained to him. He feels that perhaps the diagnosis fits, but he has a great deal of ambivalence about it. He also took medication but eventually stopped because of the adverse side effects. George has spent time in a psychiatric hospital on at least two occasions. On one of these occasions he was feeling suicidal and on the other he was stressed out to the point where he felt unable to cope. On discharge, no follow up plans were made.

George also has had contact with a mental health team and initially he found the experience helpful He eventually dropped out of treatment because he changed his mind and felt he was not being helped. Moving also made it difficult for George to maintain his contact with

the people he was seeing at the team. George is ambivalent as to whether he wants help now.

The mental health services George would like to see implemented in the downtown core are drop-in centres, more mental health teams with increased staff to provide more one-to-one counselling, more low rental housing and better emergency help.

Mental Health:

After coming in contact with the mental health system George lowered his goals and ambitions. Occasionally he thinks about committing suicide. This is usually when he has feelings of his life being stagnant and repetitive with no point or purpose and no way out. Alcohol does not help these feelings either. In the last 6 months George has had at least one or more psychotic experiences which were not as a result of the consumption of drugs or alcohol or both.

Alcohol and Drugs:

George drinks but it is not clear how serious a problem this is for him. Generally, he does not do drugs. What he likes most about substances is the relaxation and lowering of stress it gives, the good feeling of being high and the forgetfulness/escape it provides. What he dislikes about substances is the hangover/after effects and the cost. George has attended AA meetings and likes them for the group support, the understanding, the acceptance, and the socialization they provide. On the other hand, he dislikes the preaching and dogma as well as some of the people at the meetings who never change, and always tell the same stories.

Legal:

George has been arrested and convicted and has spent time in jail for minor offences. He liked the food he received in jail better than what he obtained while in psychiatric hospitals. In the past 6 months George has also been victimized both physically (i.e. robbery) and psychologically.

Support Services:

George would go to a drop-in in the downtown core, especially if it were open late every night. He would like to see such a drop- in have television, videos, games and provide free coffee and tea. It should have a relaxed atmosphere where he can meet and talk to people, particularly women. Lastly, it should have trained, experienced staff from whom he could obtain counselling if he chose.

George keeps in contact with his family. Occasionally he has what he considers an intimate relationship, and if he experiences a crisis he usually has someone he can turn to whom he trusts. What he does on evenings and weekends is watch TV, go for walks and read. He often finds, however, that he has nowhere to go because of lack of money and not feeling safe in the neighbourhood. The places he visits the most are the Carnegie Center, parks and friends' places.

Social Contact:

The most important people in George's life are his friends and family. The four major places in the downtown core where he can go and feel comfortable are the Carnegie Center, parks, the Evelyne Sellers Center and coffee shops.

George believes his life provides him sufficient psychological freedom, but financially he feels he has no freedom whatsoever.

Employment:

George can read and write. His employment history, however, is poor. The longest job he ever held was around 2 years and he has not been employed at anything in the last 6 months. George likes work because it gives him money, a sense of accomplishment and improves his self esteem. On the downside, aside from the general stress of working, he finds the long hours difficult to deal with. In addition, he often receives ill treatment from his co-workers. Poor pay does not help either, especially if it is close to what he obtains on social assistance. George would like to be employed at some general labour job like janitorial work.

Income:

George is on social assistance. He receives $602.48 a month. He spends $315.04 on rent and claims the balance of his money is spent as follows: food $162.00, cigarettes $83.68 and alcohol $69.92. When added up these figures come to $630.64 which is $28.16 more than George has. Since these expenses do not include items such as clothing, transportation, hygiene needs, laundry and entertainment, obviously George's financial situation is grim. George feels that he would be able to get by on $890 a month.

Food:

George eats about two meals a day, not three. The items he consumes the most are sandwiches, soup and vegetables. He generally eats at home, but two weeks after cheque day he runs out of money and then he attends the free food places. George spends $5.63 a day on food. When he has the money, he will often go to the Evelyne Sallers Center as the meals there are inexpensive. George has been losing weight lately as a result of poor nutrition.

Hygiene:

George has to share his toilet and bathtub with others in the same building. He does not like the lack of privacy nor the sanitation problems this presents.

Clothes:

George is in need of clothes, particularly raingear and underwear. He generally buys his own clothing. He will, however, go to some of the free clothes places but finds he often cannot obtain the proper fit.

Conclusion:

On a typical day George will walk around the neighbourhood, watch TV, drink coffee or tea and visit friends. George views his two major problems as obtaining money and food. Occasionally finding accommodation also becomes a problem. By far his major worry, however, is the lack of money. George generally does not find his life very enjoyable.

George, then, is the composite of what a typical seriously mentally ill individual living in the downtown core and not receiving mental health services is like.

V. KEY INFORMANT SURVEY OF PROFESSIONALS AND NON PROFESSIONALS WHO LIVE AND/OR WORK IN THE DOWNTOWN CORE

Methodology:

At the same time we were conducting the In Depth Survey we also sent a short mail-out questionnaire to Key Informants, the majority of whom were service providers living and/or working in the downtown core.

We did this because we felt such a survey would be useful for three reasons:

1. It would provide an additional source from which to obtain information about the lifestyle and needs of the seriously mentally ill in the downtown core.

2. It would advertise the fact that we were doing the survey, and thereby make it easier for us to obtain cooperation for places to conduct interviews and for referral sources from which to obtain suitable candidates to interview.

3. Because they participated in the survey, the community would be more interested in reading the final report, and perhaps even assisting with some of its recommendations.

In the Key Informant Survey we asked about their perceptions of the seriously mentally ill both in receipt and not in receipt of mental health services, what they thought of the current mental health system, and what they would recommend in the way of new services.

Before reporting on the results, we should acknowledge what George Warheit and Associates, in an article entitled "Planning for Change: Needs Assessment Approaches", calls a basic disadvantage of the key informant approach and that is "that it has a built in bias in as much as it is based on the views of those who would tend to see the community needs from their own individual or organizational perspectives".[17] Warheit goes on to point out "It is quite possible that these perspectives, even collectively, may not represent an accurate appraisal of the totality or types of needs which exist in the community"[18]. In order to account for this built-in bias, we will compare the relevant key informant results with those provided by the sample population in the In Depth Survey.

17. Warheit, George J. "Planning for Change: Needs Assessment Approaches", Unpublished NIMH Grant Manual, 1974, Pg. 31

Results:

With the Key Informant Questionnaire we received 51 replies. The average number of years informants had worked in the downtown core was 6.5. The major behaviour, in their opinion, which sets the mentally ill apart from other groups in the area is their "disordered, delusional and paranoid thoughts" (69%). What they talk mostly to these key informants about is their finances and their practical concerns about their daily lives. Finances is by far the dominant theme. According to the informants, the seriously mentally ill spend most of their time smoking, sitting in apartments by themselves, watching TV and drinking coffee. When we asked the same question to the sample population concerning their evening activities, their responses were fairly similar, except that they claimed they went out for walks a great deal.

43% of the key informants felt there were not enough places in the downtown core where the seriously mentally ill could go and be accepted. The major places the informants felt they could go and be accepted were: The Carnegie Center, Triage, Lookout and St. James Social Service. The percentage of the sample population who stated they had "nowhere" to go in the evenings and weekends was (25%) and they included places such as parks and visiting with friends, which the key informants appeared unaware of.

63% of the key informants felt the current housing of the seriously mentally ill in the downtown core was either "poor" or "terrible". The sample population came up with exactly the same percentage. The majority of key informants also felt the following quality of life indicators were either "poor" or "terrible": finances (78%), physical health (64%), nutrition (76%), living stability (68%) and close relationship with others (74%). Interestingly, the sample population agreed with the indicators of finances and living stability but differed significantly on those of physical health, nutrition, and close relationships with others. They saw these indicators much more positively.

76% of the key informants felt the seriously mentally ill did drugs ranging from a great deal to occasionally. This differs from the sample population who for the same range gave 38%. For alcohol abuse the key informants gave the figure of 90% which also ranged from a great deal to occasionally, while the sample population stated 76%.

With legal history, key informants felt that 69% of the seriously mentally ill had previous or current legal involvement. This compares with 83% reported by the sample population. The major services in the downtown core which the informants felt the seriously mentally ill use - not where they can go and be accepted - were Lookout, Triage, Strathcona Mental Health and St. James Social Service.

In the final section of the survey, concerning existing mental health services, the key informants, in the main, felt positive about the mental health teams, but indicated the following areas where they needed to either improve or do differently:

- more programmes employing life skills;
- more cooperation with front line workers;
- more outreach for the non compliant;
- more staff for overloaded teams;

18. Warheit, George J. "Planning for Change: Needs Assessment Approaches", Unpublished NIMH Grant Manual, 1974, Pg. 31

- more services for the dually diagnosed;
- more information sharing;
- provide streetworkers;
- improve emergency response time.

With Car 87, only a few knew about the service. What they felt Car 87 should either improve on or do differently were the following:

- have a closer link with Corrections;
- become a 24 hour, 7 day a week service;
- have more than one car.

As to how the mental health teams could assist the key informants in dealing with the seriously mentally ill, the two major ways were by consultation and outreach.

The 3 major community services recommended by the key informants were: a drop-in, more outreach, and more low cost, secure housing.

Those key informants who worked for a mental health service stated they should do more outreach to engage the seriously mentally ill who never come when referred, or come and then drop out shortly afterwards. Some other novel suggestions were:

- provide rewards for injections;
- create buddy systems with clients;
- provide inexpensive or free nutrition;
- provide mental health financial administration;
- have a satellite office in a hotel.

Summary:

The Key Informant Survey received 51 replies. The major behaviour which they felt set the seriously mentally ill apart from other community groups was their "disordered, delusional and paranoid thoughts". The major topic they talked most to the key informants was their finances. The key informants perceive the mentally ill as spending most of their time smoking, sitting in their apartments by themselves, watching TV and drinking coffee. The sample population gave a somewhat similar picture but indicated they also went out for walks quite often. The key informants also felt that there were not enough places in the downtown core where the seriously mentally ill could go and be accepted. The sample population felt similarly, although the percentage was less.

One major difference between the two groups was that the key informants tended to see the conditions of the seriously mentally ill as being much worse than what they stated themselves. Both groups saw quality of life indicators such as housing, finances and living stability as similar but when it came to physical health, nutrition and close relationships with others, the sample population saw them much more positively. The same disparity continues with alcohol and drugs, with the key informants giving higher estimates than the sample population, particularly with respect to drugs: 76% key informants versus 38% for the sample population.

The legal history section was the only one where the key informants underestimated the sample population: 69% key informants versus 83% sample population. The major services in the downtown core which the seriously mentally ill use according to the key informants are Lookout, Triage, Strathcona Mental Health Team and St. James Social Service.

The key informants felt positive about the existing mental health teams but suggested a number of areas where they could improve or do things differently. Very few key informants know about Car 87, but the ones who did also made suggestions about how they could improve or do things differently. Outreach and consultation were the two ways in which the key informants saw the mental health teams assisting them. The 3 major community services recommended by the key informants were: a drop-in, more outreach, and more low cost, secure housing. The key informants who worked for a mental health service felt they should do more outreach to engage the seriously mentally ill who never come for treatment when referred, or come and drop out shortly afterwards.

Recommendations:

As far as the seriously mentally ill are concerned, all the recommendations have been previously made in the In Depth Survey section. As to the community mental health services, if we made a recommendation for increasing staff levels, this would likely be viewed as self serving. Suffice it to say that the emphasis in mental health is shifting to the community and more money should continue to be spent in this area. For the existing mental health teams, however, we can emphasize the recommendations made by the key informants in the downtown core services which are:

- provide more outreach to the non-compliant;
- provide more consultation to other community services.

DISCUSSION

There are many recommendations coming out of this survey which have implications for a number of community services beside those directly related to mental health: Social Services, Corrections, City Hall, free food and clothing outlets, to mention but a few. For the mental health system itself, however, the question is what should be done about the approximately 200 seriously mentally ill living in the downtown core who are not receiving mental health services. One could argue that even if all of these people are currently symptomatic and in need of treatment that they should simply be left alone. There are services available which they can access if they choose: the two mental health teams, the two new mental health drop-ins, and the various outreach workers which have become attached to downtown core resources such as Lookout, Triage and the Mental Patients' Association (MPA). Our retort to this argument is threefold:

1. despite the best intentions of all these overloaded resources we are told, particularly by the media, that very little is being done for the seriously mentally ill in the downtown core;

2. this survey indicates that there are approximately 200 of them not being served;

3. a recent study at Vancouver General Hospital stated that over a third (43%) of the seriously mentally ill patients that go through their emergency outpatient department are not followed up by any mental health service[19].

All these pieces of information suggest a more aggressive approach be explored. Consider too, that with the recent changes in the Criminal Code (Bill C-30)* along with the upcoming changes in the proposed new mental health act, there will definitely be more seriously mentally ill in the community and a significant proportion of them will likely be attracted to the downtown core. Certainly there will be those who reject assistance, but if the In Depth Survey is at all accurate, about two thirds to three quarters would be receptive.

The major recommendation of this report, then, is that a pilot project be implemented with the specific mandate to serve this population. The necessary ingredients for such a project already exist. We have the knowledge and experience of assertive case management models such as the Bridge program in Chicago or our own Interministerial program in Vancouver. Both programs have small caseloads and commit themselves to providing outreach services to seriously mentally ill persons who for one reason or another have difficulty accessing "mainstream" mental health services. As a result of the Residential Snapshot Survey section, we know where these individuals reside and how to

* Without going into a detailed discussion, the upshot of the new Bill C-30 legislation is that seriously mentally ill individuals who commit crimes, serious or otherwise, will either remain in the community, perhaps on probation, or certainly spend less time incarcerated in institutions than previously.

19. Bilsker, Dan, "A Study of Greater Vancouver Mental Health Services Target Population Admitted to Vancouver General Hospital's Psychiatric Emergency Section", 1990, Pg. 9.

contact them. And from the information obtained in the In Depth Survey section we have a fairly accurate blueprint of their needs and desires. The breakfast pack, for instance, could become part of the service along with on site work programmes, recreational activities and so on. The end result would be a lessening - hopefully an eliminating - of the seriously mentally ill who become lost to the mental health system.

As this province has stated its commitment to downsizing and community mental health programmes, and more recently to the homeless of which the mentally ill are a sizeable portion, it is to be hoped that money will be forthcoming for such a project. For all of us who are involved in the mental health field, as long as there exists this significant number of malnourished, untreated, seriously mentally ill people, many of whom languish in cockroach ridden hotel rooms with unsanitary washroom facilities, often victimized by others or tortured by their own thoughts, we will all share a collective guilt - especially every time a local television station shows the public these deplorable conditions and demands "Why isn't something being done?"

APPENDIX I

NEEDS ASSESSMENT STEERING COMMITTEE MEMBERS *

Alcohol and Drug - Linda Syssoloff

BC Ambulance Service - Glen Braithwaite
BC Corrections Branch - Fred Hitchcock
BC and Yukon Hotel Association - Mario Poharich

Carnegie Centre - Diane McKenzie

Downtown Eastside Residents Association (DERA)
- Jim Green, Laura Stannard

Downtown Eastside Youth Activities Society (DEYAS) - John Turvey

Evelyne Sallers Centre - Ray Stensrud

First United Church - Jim Elliot

Greater Vancouver Mental Health Service (GVMHS)
- Judith McIntosh, John Russell

Lookout Emergency Aid Society
- Karen O'Shannacery, Al Mitchell

Mental Patients Association (MPA) - Barry Niles

Ministry of Social SErvices
- Thelma Barclay, Sharon Belli, Gerry Mignault
Bev Taylor

Ray Cam Co-op. - Carole Brown

Riverview Hospital - John Fox, Barbara Crozier, Paul Choi,
Dr. Glen Haley, Juhree Zimmerman

Sexually Transmitted Diseases (STD) Outreach Clinic
- Linda Manzin, Jacqueline Barnett

Strathcona Community Centre - Dominic Fung

Strathcona Elementary School - Noel Herron

United Chinese Community Enrichment Services Society (SUCCESS)
- Baldwin Wong

* It should be noted that not everyone on this list attended every meeting.

Urban Core Workers Association - Allison Sawyer

Vancouver City Police Department - Inspector Carson Turncliffe
Const. Bob Taylor
Const. Bob Pounder

Vancouver City Social Planning Department - Jeff Brooks

Vancouver Native Health Society - Lou Demerais

APPENDIX II

FOR THOSE RECEIVING TREATMENT AT STRATHCONA OR WEST END MENTAL HEALTH TEAMS

This was a short section at the end of the questionnaire aimed at individuals who already were in the mental health system. These are the five questions we were going to ask:

1. How long have you been in treatment i.e. taking medications and seeing a psychiatrist and mental health worker?

   _____

2. Was there a time in the course of your mental illness when you were not in treatment, not taking medications and not seeing a psychiatrist or mental health worker?

   _____

   a) What was it like? _____

3. What event or occurrence made you decide that accepting treatment was in your best interests?

   _____
   _____

4. Can you comment on the medication you take?

   _____
   _____

5. What keeps you in treatment i.e. continuing to take medication and seeing your psychiatrist and mental health worker?

   _____

The idea was that we would take a representative sample of seriously mentally ill team clients who were in treatment and compare them with the ones we had already interviewed to see what the similarities and differences were between these populations. Unfortunately, we ran out of time and money and could not pursue this endeavour. We would gladly help, however, any individual or agency in the future who might decide to complete this task.

APPENDIX III

INTERVIEWERS' OBSERVATIONS

After the interview was over we asked the person conducting the interview to write a brief description of the individual's circumstances and to add their opinions as to whether they thought the interviewee was thought disordered, whether their answers were genuine, whether they could establish rapport, how they saw the individual's functioning and finally what service they thought would be appropriate for that person. Unfortunately, perhaps because we made these requests in one paragraph rather than requiring separate spaces for each question, we obtained a variety of responses from the various interviewers. Some answered the question partially, some put in additional information, and some never answered the questions at all. We did not, therefore, apply any evaluative process to this section. Some of interviewer's observations, however, were quite descriptive and we have chosen a number for illustrative purposes.

1.

A 39 year old, bespectacled woman, was friendly and open. Asked for cigarettes before the interview started and smoked five cigarettes during the 1 1/2 hour interview. Rapport was established readily, good eye contact. Flow and content of conversation relevant. Answers were genuine. No evidence of thought disorder, although she said she had some unusual experiences such as people were following her and able to read her mind. I feel that all these were actually her own thought because of her own fear and lack of security.

The only problem she has now is that she's on medication for epilepsy which is controlled during day time but she still has seizures while she's asleep at night because she wets her bed a lot and cannot explain why.

Most of the time she's emotionally stable and "happy go lucky" but there were times she thought of committing suicide because being an epileptic is a "burden" to the society and the people she knows. She's on H.P.I.A. and functions quite well independently as long as her money is budgeted weekly for her (she can blow the pension check in 1/2 day), and she smokes up to 4-5 pk/day when she has money. Cigarettes are more important than food.

Although not showing much symptoms/signs for any major psychiatric disorder, she could make use of some support sessions and counselling.

2.

This man is definitely suffering from a major mental illness (paranoid schizophrenia). He is functioning marginally in the community. He is so paranoid that he doesn't get out of his room except to buy food on a daily basis. He firmly believes that people (especially the police and the bikers and the blacks) are plotting against him with people to harass him and one of these days he will not be able to take it and will take his life!! Would be nice to see him in Strathcona Mental Health team if he wishes to, but he said he's too late for any help now. Maybe some home visits could be arranged.

3.

Definitely thought disordered. Concrete thinking. Answers were genuine, easy rapport.

This man has been off meds for over a year and has a marginal existence but is optimistic. He could do with better housing and with a drop-in centre that made little demands on him.

4.

D. presented himself as a harmless individual who has a record of wandering and living by the ocean. He came to the emergency shelter from a Hospital Emergency Department where he went after he could not find a warm place to live. He gets his clothes from people and when they are dirty he gets new ones. He doesn't seem to know of too many downtown services.

D. expressed that he had difficulty sleeping because he could hear and compose music in his sleep. He felt he needed people and professional help, but also felt that he had no say in it. He felt that his activities of daily living were controlled and directed by others, but didn't want help with securing services because he felt people stigmatized him because he's mentally ill.

D.'s last visit was one year ago. Records check showed that he is not under treatment at either of the local mental health teams.

5.

A manic depressive who has been drifting in/out of the system and in and out of the province for the last few years. First psychiatric contact was back East in 1985. Was in hospital 3 times. Also had history of alcohol abuse when he was working for the brewery (for 5 years back East) but has cut down his drinking considerably since referred to and attended the alcohol program.

Has insight about his illness, would seek psychiatric help when he starts to hear voices, not sleeping, and having racing thoughts etc. but would also stop his medications when he feels that he was "doing well". His major complaint is that medications make him too drowsy, although he realizes the need for him to be on medication he doesn't want to be over "sedated" all the time.

Last time at the mental health team was about 2 months ago, and is still taking Chlorpramizine 4X/day. No evidence of thought disorder, was honest and open throughout the interview. Follow up by mental health care to ensure he is on medications. He could use a drop in centre in the area.

6.

Was in a psychiatric hospital in 1990 for (manic depressive illness). Went to a mental health team for 2 months, 1.5 years ago and stopped because he was told to see a drug/alcohol counsellor before he could be seen again. He has difficulties getting to sleep - was on medications but they didn't help and he stopped taking them. (Couldn't remember the names of the meds.) Answer was genuine, easy rapport. I would say he is functioning at the low end of the medium level - he doesn't do much, not many friends, eats whenever he can and doesn't have that many places to go to. D. is a good candidate for the team to assess and may be put on medications (night sedation) if necessary. Needs alcohol and drug counselling and a drop in centre for daily activities/socialization.

7.

A 37 year old caucasian of Dutch origin, lives in Downtown core area over 6 years. Long history of psychiatric illness - 1st contact was at his late teens. Has been in and out of hospitals for at least a dozen times, last time was Jan. - Feb. '92 for 2 weeks and diagnosed as having schizophrenia, paranoid type. He had been on different medications - Lithium, CPZ, Trifluperazine. LA injectables. Stopped taking medication because of side effects.

Has some insight about his illness and knows when he needs help but doesn't like to be "controlled" by medications partly because of the side effects and partly because they take away his independence.

Some thought disorder evident. Able to function at an acceptable level as long as he is not "psychotic" - the term he used to describe why he was hospitalized.

I suggested to him that he should consider to come to the team for follow-up and that taking medication regularly may keep him out of hospitals.

A drop in centre would suit him quite well as he is using the Kettle, MPA, Coast and Carnegie Centre regularly.

8.

D. was approached at the emergency shelter by a staff person who asked him if he would be interested in the interview. D. was not clear on the reason for the interview but he was broke and needed cigarettes. At the time that we arranged to do the interview he attempted to make a bargain with me; he wanted some cigarettes in advance of the interview. I said I could not do this.

The interview took two hours to complete over the course of a single day. D. would lose total interest in the interview after just two or three pages and, therefore, I would give him a 10 minute coffee break. Several times we took extended breaks. When the interviews would break down D. would stare at the walls and simply not answer the questions. He appeared to go into some form of trance.

Several times D. indicated that he thought the questionnaire was some form of test.

In my opinion D. was clearly "schizophrenic". He stated that the voices in his head were continuous, despite medication. D. said that his voices gave him direction, ideas and would not stop even when he was trying to concentrate. He found none of the mental status exam questions odd in any way (a reaction I have noted with other interviewees).

9.

This person is thought disordered. He had a continuing conversation with his "voices" throughout the interview. It was apparent at times that his answers were not genuine. Demographic information is probably totally untrue.

His continued reference to tourists or sightseeing seems to have some meaning to him although at first I thought he was being evasive.

Considering the severity of his mental dysfunction, he maintains himself well and functions at a surprisingly high level, i.e. maintaining living situation, friends etc.

The most important service he needs is decent housing.

10.

The last half of the interview was conducted by another staff member. I already had somewhat of a rapport with client. She has been somewhat of a pain at Triage i.e. demanding, verbal abuse, not following rules. Her primary concern at the point I took over the interview was about the $5.00 fee. I do think her answers were genuine as she thought before answering. She has stayed at various hotels and shelters since 1989. 1985 - 1989 in Calgary. Before that same situation in Vancouver. She was in a provincial psychiatric hospital in 1972. She hears voices but refuses to see a care team. When she is not talking to someone she will come around the office with verbal abuse i.e. what are you are doing working here, who the hell are you. If you talk with her, she can be civil and has a good sense of humour. I think she should be seen by a team. (Her doctor has also suggested this.) I think she could actually be helpful at a place like St. James as a volunteer.

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