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In Pursuit of the Golden Mean: Experiences of Frontline Workers in the Mental Health System

by

Crystal Hincks

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CHAPTER ONE: INTRODUCTION

A number of disturbing, gruesome and often inexplicable crimes garnering national media attention over the last few decades has moved mental illness to the forefront of the agendas of researchers, medical professionals, justice organizations, interest groups, and politicians. Canadian cases such as Vince Li, who beheaded Tim McLean on a Greyhound bus in Manitoba in 2008 because he thought McLean was an alien, and Justin Somers, who viciously murdered Barry Stewart at the Edmonton Remand Centre in 2011 because he thought Stewart had green smoke emanating from him and was eating peoples' heads, has prompted increased societal awareness of mental illness and its deleterious effects. Obviously these cases are outliers and most mentally ill individuals are neither violent nor dangerous. However, serious and chronic mental illnesses are of particular concern in that they can lead some sufferers to exhibit unpredictable behaviour with tragic consequences. There are often significant challenges in diagnosing, treating, and managing individuals who suffer from mental illness; the continuum of mental illness is vast and includes individuals at one end who are able to be successfully treated and who manage their mental illnesses reasonably well, in contrast to individuals at the other end who are resistant to treatment for one reason or another (such as, for example, refusing to take medication, or the medication they are prescribed does not successfully treat their illnesses).

Since the movement towards deinstitutionalization in the late 1970s, where thousands of psychiatric patients occupying asylums and hospitals were moved from institutional settings into the community, many of the problems in managing the care of these individuals have increased. Following the shift towards deinstitutionalization, the ability to coordinate care in a centralized institutional setting was diminished, yet it was anticipated that patients suffering from mental illnesses would experience better quality of life outcomes and would receive new types of treatments and care while in the community. With the development of the community-based model came the need for multidisciplinary teams of professionals from a variety of fields to care for the individuals now living in the community. Individuals suffering from mental illnesses were historically cared for only by nurses and doctors during their stays at asylums and institutions, however, over time it was recognized that the contributions of other

specializations were necessary for the successful transition of patients from asylums to the community. As a result, the expansion of such frontline roles as social workers, addictions workers, outreach teams, case managers, occupational therapists and various other clinical roles has grown exponentially. These types of workers, along with psychiatrists, medical doctors, nurses and other 'traditional' medical staff, work collaboratively to offer community-based care to individuals with a variety of mental health issues.

Caring for individuals with mental illness under the current community-based model has been both rewarding and challenging for these frontline mental health workers. Institutional care, although rife with problems throughout its rise and fall, came with seemingly consistent policies for the narrow scope of their medical staff; the divide between the larger, macro-level mental health system and micro-level individuals which it served was generally less ambiguous. The decentralized community-based care policies, on the other hand, have created a type of 'meso-level' between the macro- (institutional) and micro-(individual) levels of mental health care, which is occupied by frontline workers working between these larger mental health structures and specific individuals requiring services.

This thesis investigates the role of frontline workers, particularly their attitudes and opinions, about, first, their perceptions and understanding of their delivery of treatment and services to individuals in the community on behalf of the mental health system and, second, their perceptions of the success of this delivery. Considerable research on the shift towards community-based mental health services has been conducted; however, it has generally focused on mentally ill individuals and the consequences of deinstitutionalization for them. Little research has been done examining the impact that this systemic policy shift has had on the frontline workers occupying the new 'in-between' or meso- level that has consequently emerged within the mental health system. This research intends to fill that gap, or at least offer a starting point for future studies on the central role that frontline workers play in the delivery of mental health services.

Looking Forward

In order for the reader to fully understand the vital and challenging role that frontline workers have, Chapter Two begins with a brief overview of mental illness in terms of definitions and components. This overview offers a summary of the current Canadian mental health service delivery model to provide the reader with an understanding of the system that dictates the policies and practices of frontline mental health workers. The latter part of Chapter Two reviews the literature, centered largely on the history of mental health care discussed over three main periods: the rise of the asylum, the decline of the asylum, and the emergence of community-based care. This historical account is intended to provide context for how the current mental health system developed and how the role of frontline workers has become central to community-based care. This section will also define and discuss the role of frontline workers, as well as introduce the reader to the research questions that this thesis intends to answer.

Chapter Three highlights the methodology used to carry out this research. In addition to the recruitment, sampling and data collection aspects of the research design, this chapter discusses the role and reflexivity of the writer, addresses ethical implications, and offers a commentary on the generalizability and representativeness of the research.

Chapters Four and Five present an analysis of the data. The data were divided into two chapters. Chapter Four discusses the attitudes and experiences of frontline workers whose role is to bestride the line between the larger macro-level mental health system and the mirco-level. Chapter Five considers the smaller micro-level consisting of individuals suffering from mental illnesses.

Chapter Six provides a summary and discussion of these findings as they relate to the proposed research questions. Specific attention is paid to how the experiences and attitudes of frontline mental health workers highlight the challenges of implementing a community-based mental health care model. This chapter concludes with comments on the limitations of this study as well as possible future research implications.

CHAPTER TWO: OVERVIEW OF MENTAL ILLNESS

Definitions of Mental Health and Mental Illness

The definitions of mental health, mental illness, and addiction differ across countries, and within each country various organizations, groups, and associations define these terms differently. The World Health Organization (WHO) describes mental health as "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community" (WHO, 2010[1]). A report presented to Canada's parliament by Kirby and Keon (2004) entitled 'Mental Health, Mental Illness and Addiction: An Overview of Policies and Programs in Canada', refers to mental health as "the capacity to feel, think and act in ways that enhance one's ability to enjoy life and deal with challenges. Expressed differently, mental health refers to various capacities including the ability to: understand oneself and one's life; relate to other people and respond to one's environment; experience pleasure and enjoyment; handle stress and withstand discomfort; evaluate challenges and problems; pursue goals and interests; and, explore choices and make decisions" (Kirby & Keon, 2004, pp. 67[2]). Most definitions of mental health conclude that one's 'good' mental health hinges on the ability to participate in, and enjoy, all areas of life that promote happiness, self-esteem, and satisfaction with their inclusion in society. Alternatively, 'poor' mental health, or mental health problems as they are often called, refers to "diminished capacities - whether cognitive, emotional, attentional, interpersonal, motivational or behavioural - that interfere with a person's enjoyment of life or adversely affect interactions with society and environment" (Kirby and Keon, 2004, pp. 68).

Nearly all individuals will experience poor mental health at some point in their lives, however, it is usually a short-term reaction to life stressors and is expressed through low self-esteem, frustration, burn out or stress. Additionally, most people cope in a variety of ways, including

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[1] http://www.who.int/mediacentre/factsheets/fs220/en/, [accessed March 14, 2012]
[2] http://www.parl.gc.ca/Content/SEN/Committee/381/soci/rep/report1/repintnov04vol1part2-e.htm [accessed January 17, 2012]

the utilization of family and community supports or through internal resilience (Stephens et al, 1999). Mental illnesses or disorders, on the other hand, are "clinically significant patterns of behavioural or emotional function that are associated with some level of distress, suffering (even to the point of pain or death), or impairment in one or more areas of functioning such as school, work, social and family interactions" (Kirby & Keon, 2004, pp. 68). Within Canada, classification and diagnoses of these types of mental illnesses are made using the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is published by the American Psychological Association (APA). There are a number of characteristics within the DSM that differentiate a mental illness from poor mental health:

- Mental illnesses vary considerably in their courses, patterns, type and severity of symptoms, and degree of disability that results
- Individuals may have only one episode, or can experience more frequent episodes of mental illness followed by long periods of wellness
- Some individuals suffer from lengthy and persistent or frequently recurring episodes

The severity of one's mental illness is influenced by any combination of social, psychological, and biological factors; socio-economic pressures, rapid social change, stressful work conditions, gender discrimination, social exclusion, unhealthy lifestyle, exposure to violence, poor physical health, human rights violations, personality factors, genetic factors and chemical imbalances in the brain are just some of the risk factors that make individuals vulnerable to mental illnesses (World Health Organization, 2010). Individuals within Canada, particularly given Canada's diverse cultural background, are susceptible to experiencing any of the above risk factors for mental illness and therefore it is argued that a comprehensive and wide-range of services is required to meet the needs of individuals with mental illness.

Service Delivery in Canada and Alberta

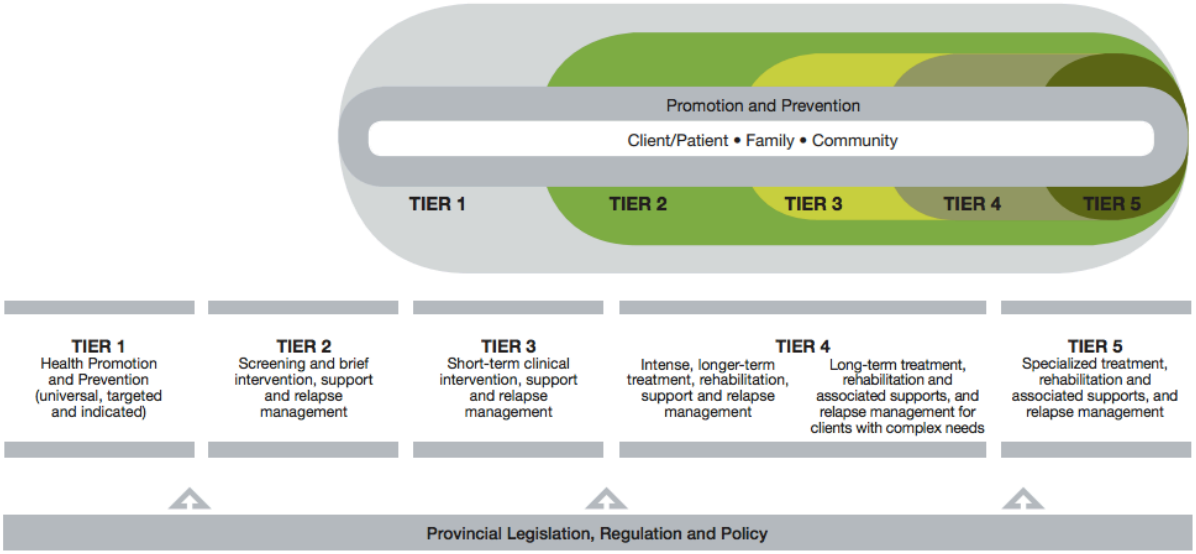
Mental health service and treatment delivery in Canada has largely paralleled the systems in Europe and the United States. The movement away from institutional care in favor of a model centered on community-based services has dominated the ideologies of these regions for over

five decades (Kirby & Keon, 2004). Over the past 50 years, Canada has focused on developing a broad range of initiatives centered on coordinated community services for mental health treatment. Operating alongside supports from psychiatric units at general hospitals as well as forensic psychiatry services, community treatment is the primary, and preferred, model of service delivery (Kirby & Keon, 2004). As the community-care model was implemented in Canada, the federal government transferred responsibility for the organization, funding, delivery and governance of mental health services to the provincial and territorial governments.

During the initial phases of this transfer of responsibility, the delivery of mental health services and the provision of addictions services remained separated. However, over the past decade in Canada there has been an effort to integrate these two systems in order to address the persistent overlap of mental health and addictions, and currently all provinces have adopted service models that provide services for both disorders (Alberta Health Services, 2011). In response to the need to offer comprehensive services to individuals with mental health and addictions issues in Alberta, the Government of Alberta and Alberta Health Services collaborated to release an addictions and mental health strategy that would dictate how services are delivered to Albertans. This Integrated Mental Health and Addictions Service Model (below Figure 1) offers an illustration of the continuum of care that the Government of Alberta offers individuals with mental health and addictions issues. This service model, or 'continuum of care' as it will be referred to throughout this thesis, dictates the type of care that is provided based on the nature of the illness an individual is experiencing (or which level an individual may be presenting on). For example, an individual on Tier 1 may not be experiencing any mental health issues but would still benefit from increased wellness and health interventions, such as self-care or stress management. Each ascending Tier offers more comprehensive and specialized mental health and addictions interventions to correspond with worsening or more severe disorders. For example, individuals suffering from severe and persistent mental health issues would require Tier 5 services and supports, which includes specialized treatments (such as inpatient hospitalizations, assertive community treatment (ACT), or supportive housing). This is not to suggest that once an individual requires services from a certain Tier that he or she will remain there; rather, individuals will often move up and down among the Tiers depending on what stage of wellness they are in. Many individuals with

severe mental health issues may consistently require services among Tiers 2 and 3, but if their mental health deteriorates, they may require Tier 5 services for a period of time.

Figure 1. Integrated mental health and addictions service model



Source: Government of Alberta, 2011, p.9

In order to determine which Tier an individual falls within, level of need is first established based on certain criteria. In Alberta, the guidelines set out by the federal government are used to assess the individual, at which time the characteristics of identified needs are determined before it is decided which Tier of service is required. The table below (Table 1) offers an overview of the varying levels of the characteristics of needs for individuals with mental health and/or addictions issues. These characteristics of need are divided into three groups: first line, intensive and specialized. Additionally, a fourth group of cross-level needs spans across the three primary groups and may or may not apply to a given individual.

Table 1. Characteristics of the Levels of Need

First Line	Intensive	Specialized
•Prevention, assessment, treatment by frontline healthcare providers, including family doctors, mental health services, social services, hospital emergency services and primary care clinics •Target population is people with serious mental illness •Services: information and referral, crisis lines, mobile crisis teams, mental health counseling, hospital emergency services, community health centers	•Assessment, treatment and support services provided in the community or hospital settings •Target population is people with serious mental illness who do not have an ongoing need for services provided in the specialized level of care •Clients typically have complex needs and repeat contact with institutions •Services: intensive case management, psycho-social rehabilitation, medication clinics, psychiatric inpatient and outpatient services	•Highly specialized mental health programs in the community or hospital settings for people with serious, rare, complex or unstable mental illness •Treatment, rehabilitation and support services are provided through multidisciplinary teams •Target population cannot be managed with the existing array of first line and intensive services. They require on-going support, more structured and intensive treatment and higher security •Services: Assertive community treatment teams, residential treatment facilities, regional forensic services
Cross Level		
Cross-level services refer to those services and supports that may be needed regardless of whether someone is being served at the first-line, intensive or specialized level of the mental health system. They include housing and housing supports, educational and vocational services and supports, drop-ins and other social/recreational supports, as well as consumer and family peer/self-help supports. Cross-level services and supports are typically — and most effectively and efficiently — delivered in the community, and are amongst those services and supports most often identified by people living with mental illness and their families as being fundamental to the recovery processes.		
Source: Ontario Government, 1999; Kirby & Keon, 2004		

Each organization, program, and service provider determines the level of needs of clients differently; the table above is simply meant to offer the reader further understanding of what criteria are used to decide where on the continuum of care an individual falls. Individuals in the

‘First Line’ of need may fall within Tier 1 or 2 on the care continuum while individuals within the ‘Specialized’ level would require supports offered on Tier 5.

For an average mentally ill individual (i.e. one suffering from depression, anxiety, a mild mood disorder, etc.), the services offered on the first-line and intensive levels tend to adequately meet their needs and provide the support needed for them to maintain a reasonably high quality of life in the community. For the frontline workers who this research is centered on, specifically those responsible for working with the severely and persistently mentally ill, the majority of their work involves delivering specialized-level and Tier 5 services. As will be discussed further in the data and discussion sections of this thesis, the specialized and Tier 5 services available are less abundant and therefore the outcomes for service users are generally less positive.

The improvement of needs-identifiers and care continuums like those above continue to be developed and refined. Subsequently, for both the federal and provincial mental health systems, frameworks like these are merely ideal directives for providing care and are simply intended to offer service providers some consistency in assessing the needs of clients in the community. The need for such tools and frameworks serves to emphasize the ongoing challenges of implementing a model of community-based mental health care in that determining the needs of a given individual is subjective and is at the discretion of any number of mental health professionals, including frontline workers. The next section will offer a history of mental health care in order to explain how the need for frontline workers arose and how they have inadvertently become the middleman between the mental health system and its service users. The necessity for the inclusion of frontline mental health workers arose during the shift away from institutional care and towards a community-based model of mental health service delivery. While asylum care was historically provided by psychiatrists, medical doctors, nurses and care aides, community care is now provided through the collaboration of a number of fields, including medicine, psychiatry, social work, outreach work, and legal services (Thornicroft & Tansella, 2002). The deinstitutionalization of the mentally ill has been a major transition for both patients and the workers tasked with caring for them; in order to understand the challenges of frontline workers in their caring for the mentally ill, it is important to look at how the mentally ill were traditionally cared for.

The next section begins with an overview of the three historical periods of mental health care: the rise of the asylum, the decline of the asylum, and the balancing of mental health services via community care. In offering a history of these three periods, the nature of the needs of the mentally ill, as well as the challenges for care givers in meeting those needs, will be discussed. For frontline workers, many of the challenges they face lie not only in treating the mentally ill, but working within the parameters of the larger systemic care models that have been implemented over time.

The Rise of the Asylum

The mentally ill in modern society are highly visible and therefore often of significant concern to the public; just two centuries ago, however, the mentally ill, who were often described as 'distracted', 'insane', or simply as 'lunatics', were of much less interest to greater society (Grob, 1994). Prior to the early 1800s, society was generally made up of sparsely populated agricultural and rural communities that viewed mental illness as having social or spiritual implications (Breakey, 1996). Families and communities took responsibility for caring for these individuals, which often had devastating economic consequences if the person was unable to work or if he or she disrupted the household (Grob, 1994). There was further detriment for individuals who were ill but who had no family, as support was inconsistently offered on an ad hoc basis by other families in the community. Although the mentally ill were deemed a burden for families and communities both economically and socially, the proportionately small number of these individuals did not involve structured state intervention.

With the rise of urbanization in both Europe and North America came new awareness of the mentally ill and their afflicted families and communities. As towns grew larger, so did the relative proportion of sick and dependent persons (Grob, 1994). Characterized by immigration, economic development, and subsequently more densely populated city centers, urbanization altered the structure of society and with it came the necessity to find new ways to care for the mentally ill. From the rise of capitalism emerged a new system of wage labour in which the mentally ill did not function well. As most members of the household sought employment in the labor force, the mentally ill were unable to work and were also no longer sufficiently cared for. Although the informal system of care for the mentally ill by families in smaller communities was

once sufficient, in larger cities the presence of the mentally ill, coupled with their lack of integration into greater society, began to create concerns for public security. As Grob (1994) explains, "the spontaneous and informal manner in which most rural communities dealt with sickness and dependency did not operate well in urban areas. High rates of geographic mobility tended to weaken social cohesion as neighbors became more anonymous, and the efficacy of informal and traditional means of alleviating distress diminished" (p.24). The responsibility of caring for affected persons during this time unfortunately led to the exploitation and mistreatment of many of them who were forced to work as slaves or who were sold at auctions or expelled from towns and cities. With fewer familial and community supports, mentally ill individuals were either victimized or left to fend for themselves (Breakey, 1996). As the reliance on families and communities for the care of the mentally ill became less viable, the movement towards systematic mental health policies and interventions began to develop.

In conjunction with changes in the economy and social structure, European Enlightenment values played a role in the responses to caring for the mentally ill (Grob, 1973). A dichotomy of intellectual and scientific currents led to beliefs that disease, including mental illness, could in time be managed and even cured. These newfound ideas emerged in tandem with a growing consensus that the government had a responsibility to develop new welfare functions through the creation of asylums, schools, prisons, and almshouses (Grob, 1994). Influenced heavily by the progressive movement towards institutionalization in Europe, Canada and the United States followed suit and began developing mental hospitals to assume the functions that were once the responsibilities of families (Grob, 1973). With the restoration of sanity and prevention of chronicity[3] in mind, institutions were constructed in remote areas and provided basic needs through custodial care by nurses and psychiatrists. The presentation of a variety of disorders formed an eclectic clinical practice within various institutions; some doctors preferred to offer mild cathartics, warm baths and recreation, while others favored more hostile treatments such as bloodletting, sedation, solitary confinement and restraint (Grob, 1994).

Overall, the confinement of the mentally ill to asylums proved to be a practical solution to the problem of caring for them; small numbers of severely affected individuals were placed in

[3] Chronicity refers to a chronic state or having a long duration. With respect to mental illness, it refers to the length of time that an individual suffers from a mental illness or from symptoms of a mental illness.

mental hospitals, which seemed to alleviate the burden for some families while protecting society from victimization by the more violent individuals. But although proponents of asylums insisted that superior care could be provided in mental hospitals, many family members insisted on keeping their ill members at home, despite the care being minimal at best. An 1824 report commissioned by the government of Lower Canada outlined the role that institutions would play in the care of the mentally ill as well as encouraged hesitant families to relinquish care of their "distracted" family members: "It is almost impossible in private families with a mentally deranged member to provide the supervision his condition requires, for his own sake and for the well-being of the family and society in general. It therefore is necessary in almost every case to remove him from the home" (as quoted in Goodwin, 1997, p.97). Although asylums and their proponents offered a hopeful prognosis for the families of the mentally ill, many families were unable to afford to transfer the care of their ill members to government care. Although mental hospitals were built with the intention of admitting a heterogeneous patient population that would serve the entire community, economic realities resulted in a more elite clientele (Grob, 1994). And even though disadvantaged members of society could still be admitted without an expectation to pay, the limited financial base of early asylums eventually left operators with little choice but to decrease the frequency with which they would accept such patients.

The reality that early mental hospitals catered to affluent patients was not purely a function of economics; the influx of immigrants from various countries during the period of urbanization only served to increase the societal division between the prominent Caucasian elite and minority groups based on class, race, status and educational level; as a result, affluent white families sent their members to asylums for private care with the expectation that they would not mix with ethnic or racial minorities (Grob, 1994). As expected by the elite members of society with mentally ill family members, there was little opposition from hospital superintendents to creating a class-based system of private institutions, as the high costs of protracted confinement of the patients were mounting. Yet the limited resources of private philanthropy, prominently religious-based ideology, and exclusive admission criteria all but destroyed the success of such asylums and ultimately allowed for the emergence of public mental hospitals that would be better able to serve social need.

A number of factors influenced the development of public mental institutions; their founding was seen as "an expression of the growing conviction that population growth, depression and unemployment, widening class distinctions, and immigration of minority ethnic groups – all of which were accompanied by a seeming increase in poverty, indigency, disease and crime – required the creation of formal institutions to replace older ad hoc mechanisms that were ill-suited in a rapidly changing society" (Grob, 1994, p.40). Unfortunately, the development of mental health policies at the legislative level was piecemeal and haphazard at best; little consideration was given to the complex relationships between mental illness, dependency, economic systems and social and class structures. These considerations were instead overshadowed by petitions from private individuals and organizations, informal committees, and short-term political platforms (Grob & Goldman, 2006). Despite these challenges, legislative progress finally led to mental health policy that was underpinned by public institutional care. Unfortunately, the unsystematic manner in which this policy was implemented would ultimately lead to unanticipated outcomes and profound consequences.

The Decline of the Asylum

The growth of mental hospitals, at first accelerated by enthusiasm and dedication to these establishments, eventually slowed in the early nineteenth century. A number of factors contributed to this shift, including concerns around the skewed interpretations of moral treatment and inconsistencies in the new field of psychiatry, post-war restructuring within the field of psychiatry, subsequent changes within political and fiscal environments, and the introduction of psychotropic drugs.

The inconsistent and unscientific provision of mental health treatment was a major element in the decline of asylums. Early psychiatrists insisted that insanity was the result of an interaction between individual predisposition and psychological and environmental factors, and in response they often developed holistic treatments rooted in faith and occasionally infused with subjective medical knowledge (Grob, 1994). Because the pathology underlying mental illness was still a conundrum for most early psychiatrists, patients were diagnosed and treated in an informal manner with little success. Both private and public mental hospitals were primarily

developed based on assertions that diseases of the mind could be cured if the individual was placed in an environment that was humane and therapeutic in nature; however, psychiatrists and other asylum staff immediately recognized the difficulty of treating mental illness simply by offering moral treatment. Furthermore, the very notion of what constituted moral treatment was left open to interpretation by individual psychiatrists; while some believed that group activities, calming baths and therapeutic isolation would restore morality and heal the mind, others subscribed to methods of solitary confinement, bloodletting, and restraint (Grob, 1994).

Yet regardless of the inconsistent diagnoses and questionable treatments employed, the major concern for advocates of asylums was that the initial objective of finding a cure was not being met (Cellard and Thifault, 2006). This was of particular concern given the increasing admission rates of new individuals and low discharge rates of existing patients; the intentions of curing individuals and releasing them back into the community were quickly overshadowed by the high needs and low treatability of the chronically ill and eventually the custodial needs of this population overwhelmed the therapeutic goals of psychiatrists (Davis et al., 2012). Thus began the deterioration of treatment, which was ultimately replaced by the need to simply warehouse the mentally ill. And rather than recognize and address the mounting challenges of treating patients with varying levels of acuity, the optimistic rhetoric of physicians and early psychiatrists instead tended to minimize the challenges of treating the insane, specifically those who were chronically and acutely ill.

Although the claims of curability that once drove public policy were contradicted by the persistence and chronicity of various disorders, asylums continued to offer centralized mental health treatment until the early 1940s. However, care continued to deteriorate in nearly all institutions; with financial and political resources being directed towards war efforts, staffing was decreased and training was poor, ineffective administration and leadership replaced any existing system of management, and inspection and quality assurance procedures became inadequate (Thornicroft & Tansella, 2002). Despite awareness of these conditions by hospital staff, little was done to rectify them until the end of WWII. The successful outpatient treatment of military personnel throughout the war began to legitimize the possibility of treating individuals with manifesting psychiatric symptoms outside of institutions using new psychodynamic therapies (Grob & Goldman, 2006). Many military psychiatrists who had

experienced firsthand the importance of life experiences and social-environmental factors were beginning to subscribe to new theories of early intervention treatment as they saw individuals responding positively to a variety of therapies rooted in scientific medicine. Additionally, many psychiatrists throughout the war were seeing the effects of general medicine in treating diseases and increasing life expectancy, and therefore they began to shift the foundations of psychiatric practice towards a similar medical model (Grob & Goldman, 2006). As a result, institutions saw a mass exodus of psychiatric staff who were eager to branch out and focus on private practice in community and general hospital settings.

The post-war emergence of community psychiatry did not evolve without challenges. There was little consensus among psychiatrists with respect to theory and practice[4]; the medical model endorsed a number of potential explanations for mental illness, including brain pathology, focal infections in any part of the body, the endocrine system, and individual maladaptive traits and, as a result, there was a similar number of eclectic and differentiated treatments and therapies (Grob & Goldman, 2006). Insulin and shock therapies, psychosurgery, and the use of various medicines were widely and enthusiastically accepted into practice, despite there being little empirical evidence of their success other than "clinical impressions" (Grob, 1994). Furthermore, studies of these treatments were being conducted in the setting with the easiest access to control and test groups: mental hospitals.

Although the post-war scientific and medicinal ideologies of younger and progressive physicians and psychiatrists differed starkly from the antiquated ideals of their early asylum confederates, the population of mentally ill remained relatively stable. The criticisms of early asylum treatment of the incurable and insane did not negate the fact that a large proportion of individuals were, in fact, acutely and chronically ill and therefore still required intervention and long-term care. This fostered a merger between new psychiatry and existing institutions, whereby research on new methodologies and practices could be scientifically researched using the individuals who required these treatments the most (Klerman, 1977; Grob, 1994). The results, however, legitimized the assertions that institutions were outmoded warehouses

[4] Thomas Szasz, a psychiatrist and academic, controversially argued that in fact people may exhibit questionable and inexplicable behaviour however they should not be diagnosed as having an illness or disease the way that a medical condition would be described. He instead argued that mental illness was developed as a means of social control. For further information, see his books "The Myth of Mental Illness" (1961) and "The Manufacture of Madness" (1970).

with little more than custodial and care functions. As research on the effects of new treatments and therapies increased, so did research that highlighted the poor treatment and deteriorated conditions that persisted within asylums. Despite their prevailing notions that institutions were quickly becoming obsolete, younger psychiatrists sought to radically reorient the model of care provided in institutions to one of 'dynamic psychiatry', characterized by a sharp modification in the traditional model of disease (Grob, 1994). Yet the innovations of new psychiatry once again highlighted the traditional problems within institutions; family members, social scientists, and patients, both acutely ill and not, were critical of the crude and ad hoc methods of centralized care and treatment previously implemented in asylums and their opinions of care under new psychiatrists was equally as pessimistic[5]. Research into patients' accounts of their experiences in institutions following the implementation of new treatments and therapies continued to indicate little improvement was being made to patients' mental health and overall well-being (Klerman, 1977; Davis et al., 2012). Unfortunately, the problems and tensions within institutions during this time were overshadowed by preoccupation with the problems of depression and war. It was not until the end of WWII that radical new policies for treating the mentally ill would be adopted.

Despite prevailing suggestions that poor conditions and overuse of asylums were the primary reason for their decline, it was World War II that was the catalyst of change: "during that conflict, military psychiatrists found that neuropsychiatric disorders were far more pervasive and serious than had been previously recognized, that environmental stress associated with combat contributed to mental maladjustment, and that early and purposeful treatment in non-institutional settings produced favorable outcomes" (Grob, 1994, p.191). The recognition that mental illness could be prevented or adequately treated without prolonged institutionalization ultimately fueled the aspirations of a new mental health system. The desirability of treating individuals before their symptoms became acute transformed the specialty of psychiatry in that there was a sharp increase in the cohesiveness between asylum proponents and new psychiatrists. Yet it immediately became clear that the development of innovative new policies and practices would require an organization to oversee the process and subsequently the

[5] Erving Goffman offered a more detailed sociological critique of mental institutions and the practice of psychiatry in his book Asylums: Essays on the Social Situation of Mental Patients. See: Goffman, E. (1961) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. New York, NY: Doubleday

American Psychological Association (APA), which at the time was the oldest medical specialty association, was the obvious choice (Grob & Goldman, 2006).

The APA was tasked with reconciling the varying ideologies of old and new psychiatry in order to reform the prevailing institutional model of mental health care. In order to do so, it was determined that a mental health commission would be developed to replace the existing system of mental health agencies and asylums independently headed by psychiatrists. In an effort to bridge the gap between the professional autonomy of psychiatrists and public accountability, the Joint Commission on Mental Illness and Health (JCMIH) was formed in 1955. Following an environmental scan of the existing mental health system, the JCMIH presented a report entitled 'Action for Mental Health', which outlined the commitment to new policies based on a comprehensive national program comprised of four main elements: a greater investment in research, recommendations for the adoption of a national recruitment and retention strategy, the need to disseminate mental health information to the public, and the critical issue of funding (JCMIH, 1961). Although the report offered a direction for the provision of services rather than a blueprint, stakeholders generally embraced its principles and over the next decade the JCMIH and both state and federal governments would collaborate to develop a community-oriented mental health system.

Although much of the focus remained on transferring fiscal responsibility to the federal government for the new mental health system, the JCMIH's recommendation to further invest in research was creating a psychiatric revolution that would assist in legitimizing community care for the mentally ill (Grob, 1994). The increase in research, particularly on the treatability of patients, was yielding a number of studies highlighting the advancements in new drug therapies. Developed in the early 1950s, the use of major tranquilizers became common and the optimism of their effects was expressed by the JCMIH: "Drugs have revolutionized the management of psychotic patients in American mental hospitals, and probably deserve primary credit for the reversal of the upward spiral in the state hospital in-patient load" (1961, p.14).

Although advocates of psychotropic drugs were insistent that patients could now effectively be treated and then transitioned from custodial care to a community environment that was rehabilitative in nature, the overall opinion of the rest of the mental health community on their

effectiveness was divided. A number of studies throughout North America and Europe gave only guarded support for the use of psychotropic drugs with many of them suggesting that the effects of these medications were not significant and did not even meet the minimal requirement of a scientifically acceptable research design (Scull, 1984). Despite the contradictory research offered by these evaluative studies, the policy-making community generally ignored their findings in favour of the studies that purported to demonstrate the therapeutic effects of psychotropic drugs. The introduction of drug therapies offered psychiatrists and policy makers a tangible treatment component that would make the shift from institutional to community care possible. However, Goodwin (1997) adds that while the impact of psychotropic drugs was profound, there were no intrinsic effects that made them directly responsible for the policy shift towards deinstitutionalization. They simply added support to the growing interest in and advocacy of a community-based model of mental health care.

Lessons from wartime experiences, a century of fiscal neglect of institutions, dedication to advancements in psychiatry and innovative policies collectively underpinned the belief that community care and treatment of the mentally ill, including those who were chronically and severely ill, could be achieved (Klerman, 1977; French, 1987). So began the movement towards the deinstitutionalization of the mentally ill and the expansion of balanced mental health services characterized by a number of elements as identified by Thornicroft and Tansella (2002, p.84):

1. Asylums being replaced by smaller, localized centers;
2. Increasing focus on cost-effectiveness and cost containment;
3. Emphasis on multidisciplinary teamwork;
4. Evidence-based psychiatry (pharmacological, social and psychological treatments);
5. Concern about the balance between control of patients and their autonomy.

The expectation of balanced services, rooted in these elements, was that they would preserve the positive functions that asylums served while ensuring that the negative aspects would not be perpetuated. The reality, however, is that these objectives were overly simplistic and that

deinstitutionalization has not led to the utopian community care model that the policy-makers had envisioned.

Community-Based Mental Health Care

As policy began to shift in the early 1970s, it was clear almost immediately after the adoption of new community-based mental health policies that there were a number of weaknesses and deficiencies in the framework, and the effects of these weaknesses have continued to persist. Trans-institutionalization[6], poor release planning, limited community resources, a disconnect between services and changes in the pathologies of the mentally ill have all plagued the community care model since its inception (French, 1987; Ozarin & Sharfstein, 1978; Goodwin, 1997; Davis et al., 2012).

Despite the reduction of admissions and the discharge of existing patients from public and private mental hospitals, many individuals were not actually transitioned into the community under the decentralized model (Grob, 1994). The expansion of community mental health centers (CMHCs) was seen as a new concept that would offer new possibilities:

> Such centers, replacing the traditional institutions, should be the foci of future mental health activities. They would be close to the patient's home, and would provide preventative, early diagnostic, outpatient and inpatient treatment, and transitional and rehabilitative services. They would include psychiatric units in general hospitals, thereby providing the patient with the opportunity of being treated within his community environment. These facilities would be conveniently located in population centers and could provide patients with a continuity of care not now available. As his needs change, the patient in such a center could move quickly to appropriate services such as those for diagnosis, treatment, and rehabilitation; inpatient, outpatient, day or night programs; foster care, sheltered workshop, industry (Grob, 1994, p.255).

Although the creation of CMHCs presented as an exciting, comprehensive alternative to the traditional asylums, the plans for the development and implementation of these new care

[6] Trans-institutionalization refers to the movement of one institution to another. For the mentally ill, many of them were deinstitutionalized only to wind up in jails or other care facilities.

programs were ambiguous at best. Policies for community care had underlying expectations: that patients had a home, that they had family members or other people willing to assume responsibility for their care, that the patient's household would positively influence rehabilitation and that the patient would not create strife or hardship for other family members (Wright et al., 1999). Unfortunately, these assumptions were not supported by findings that over half of the patients being prepared for discharge did not have families to care for them (Pollack et al., 1959). Policy-makers, however, disregarded the data indicating a lack of familial supports and housing programs in the community, and instead forged ahead with the intended departure from traditional asylum care.

Patients who could not be discharged into the care of family members or other sympathetic caregivers were ultimately moved from older mental hospitals to the new CMHCs, with a number of negative consequences. Trans-institutionalization often led to the deterioration of mental health and the decline of functioning in a number of patients, and in some cases patients were discharged and then eventually incarcerated (Goodwin, 1997). The latter outcome has continued to create concern; the relocation of institutionalized patients into the community with limited supports has led to a significant increase in the number of mentally ill having contact with the justice system (Sapers, 2011; Sinha, 2009). Within a decade of the policy of deinstitutionalization taking shape, there was a noticeable increase in the number of discharged mental patients who were ultimately reinstitutionalized in prisons (Rollin, 1969). Although Canada lacks additional and comprehensive data on the status of the mentally ill in contact with the law, the involvement of persons with mental health issues with the criminal justice system has been identified as a major issue; the proportion of offenders in federal institutions nearly doubled between 1997 and 2008 alone (Sapers, 2011). A number of factors contributed to the increase in the number of mentally ill having contact with the criminal justice system, many of these factors were present during the initial policy shift towards deinstitutionalization: the limited availability of mental health services in the community (particularly the prevalence of mental illness not being matched with appropriate and available services), inadequate social service resources (for housing, employment, substance abuse issues), and a lack of information sharing between agencies (creating overwhelming systemic barriers to services for clients) (Sinha, 2009).

The discharge process of the mentally ill has continued to be described as poorly planned and implemented (Goodwin, 1997). Citing differences in the degree of planning by the discharging facility among patients as a major factor, researchers suggest that outcomes for discharged patients are therefore highly variable (Kovess et al., 1995). Patients were often randomly discharged with little effort being dedicated to the ongoing monitoring of their quality of life and level of functioning in the community. The unsystematic manner in which patients were discharged from traditional mental hospitals has persisted over the last four decades as even today there is evidence indicating that release planning continues to be unorganized and in many cases ad hoc (Kay & Legg, 1986; Kovess et al., 1995; Noseworthy, Sevigny, Laizner, Houle & La Riccia, 2014; Nurjannah, Mills, Usher & Park, 2013). For many discharged patients, the challenge of their release planning lies in arranging services for their individual needs; because all of the social and medical needs of patients were traditionally provided by mental hospitals, creating a network of decentralized programs and services to meet patients' specific needs in the community requires considerable effort on the part of the staff in the discharging institution, and this has remained an ongoing issue. The sickest patients, who often require assertive treatment, housing, financial assistance and other services, are often discharged with the expectation that they will be able to navigate each individual system once in the community, yet many patients are simply unable to do so (Miller, 1971). Meeting with psychiatrists, attending life skills programs, managing finances, and connecting with other necessary services often proves overwhelming for discharged patients, and while some of them have the benefit of family members to assist them, many others struggle to reintegrate and subsequently find themselves homeless or incarcerated; as Grove (1994) states, "this group, who were supposed to benefit most from the closure of institutions, have in many cases fared the worst" (p.433). The pervasive challenge in release planning is often attributed to the difficulty of coordinating outpatient mental health services coupled with the lack of social resources in the community, both of which have proved detrimental to the deinstitutionalization movement.

The enthusiasm and rhetoric surrounding early community-based mental health policy largely masked the reality that few community mental health services were put in place for discharged patients. Although CMHCs were intended to be the catchall service provider for individuals who were acutely and chronically ill, these centers were ultimately ill-equipped to provide for

the needs of these patients. And given the lack of consensus about what types of patients and what levels of acuity they could accommodate, many CMHCs were able to effectively handpick clients that were most likely to respond to the types of treatments offered within these centers (Grob, 1994). Chronic patients who were identified as needing the most care for the longest period of time were generally labeled as unresponsive to treatment and therefore unattractive to these units. Furthermore, even when more severely and persistently ill individuals were admitted to CMHCs, they were often discharged with little to no aftercare plan in place. There were a number of other proposed mental health interventions that have been expanded under the new community care policy, including home visits, mobile units, crisis outreach services, self-help groups, and culturally appropriate programs (Kirby & Keon, 2004).

Rather than develop and establish social resources prior to deinstitutionalizing patients, many governments inexplicably did the opposite. Perhaps it is because there was an underlying assumption that many discharged patients would live with and be cared for by family members, initial community-care policy offered only sporadic administration of necessary programs and services such as housing, employment, and education (Goodwin, 1997; Sinha, 2009). Despite the lack of new community-based care and support systems, the accelerated discharging of patients from mental hospitals continued. However, the provision of imperative social welfare resources has continued to lag behind the needs of discharged patients, which undoubtedly has contributed to the high rates of homelessness and poor integration among the mentally ill (Tessler & Dennis, 1992). And as the outpatient population continued to grow after the 1970s, it became increasingly clear that "the policy of deinstitutionalization had created a system that often lacked any clear focus and diffused responsibility and authority" (Grob, 1994, p.300). For example, many urban governments were forced to deal with homelessness, welfare, and housing provisions despite lacking formal responsibility for mental health services. The failure of local governments to fully assume the burden previously shouldered solely by federal institutions eventually resulted in a fragmented system of scattered and limited services and resources for the mentally ill. Additionally, the challenges of providing coordinated wraparound care in the community were compounded by the emergence of a new group of young chronic persons who would ultimately prove difficult to treat and care for.

As mental health policy underwent fundamental changes, so did the pathology of the mentally ill population. Prior to the shift towards deinstitutionalization, the cohort of custodial patients who had received centralized asylum care had generally been institutionalized for decades and had therefore adapted to receiving care. Following the departure from institutional policy, a subgroup of young, severely mentally ill adults were found to have been adversely affected by the transition towards community-based care:

> Young chronically mentally ill persons were rarely confined for extended periods within mental hospitals. Restless and mobile, they were the first generation of psychiatric patients to reach adulthood within the community. Although their disorders were not fundamentally different than their predecessors, they behaved in quite different ways. They tended to emulate the behaviour of their age peers who were often hostile towards conventions and authority. The young mentally ill exhibited aggressiveness, volatility, and were non-compliant. Above all, they lacked functional and adaptive skills… Complicating the clinical picture were high rates of alcoholism and drug abuse among these young adult chronic patients, which only exacerbated their volatile and noncompliant behaviour" (Grob, 1994, p.296).

The combination of the emergence of this population and the decentralization of mental health services had profound consequences; the plight of this young and chronically ill subgroup was characterized by their tendencies to drift, their pervasive cycling in and out of emergency and psychiatric wards after brief stays, their incarceration in correctional centers, and their high rates of homelessness (Bachrach, 1984). It became clear almost immediately that professionals in the community were not prepared for such a clientele; the management of their care was often frustrating and perpetuated compassion fatigue, anger, bitterness and helplessness (Schwartz & Goldfinger, 1981). As Grob's (1994) analysis suggests:

> [Young patients] had little or no experiences with prolonged institutionalization, and hence had not internalized the behavioural norms of a hospital community… Lacking such guidance, many young chronic mentally ill patients – especially those with a dual diagnosis – developed a common cultural identity quite at variance with the society in which they lived. The mobility of such individuals, the absence of a family support system, and programmatic shortcomings complicated their access to such basic

> necessities as adequate housing and social support networks. The dearth of many basic necessities of life further exacerbated their severe mental disorders (p.300).

This population of young chronically ill persons has continued to increase, and while there have been efforts to implement programs and services to meet their dynamic needs, the challenges of their maladaptive behaviours and complex mental health and addictions issues have demanded ongoing efforts to find innovative ways to provide treatment and services under the community-care model. Consequently, there is a growing body of evidence to suggest that the needs of chronic and severely ill individuals have become particularly difficult to meet in the community, which serves to highlight the overly simplistic and misplaced assumption that highly-structured institutional care could effectively be substituted with community care (Lamb & Shaner, 1993; Goodwin, 1997). Controversially, the problems of community care have led some researchers to suggest that a return to institutional care for a small but severely and persistently ill population of individuals would not be a defeatist and retrograde step backwards, but rather would serve to provide a level of care that more closely addresses the needs of this population.

The Role of Institutions in the Community-Care Model

The successes and advantages of community care for the mentally ill continue to be disputed by both professionals and researchers; some research in Western Europe highlights the positive outcomes of limiting inpatient hospital stays while other research in North America insists that treatment in the community has neither improved the clinical condition or quality of life for many mentally ill persons (Goodwin, 1997). Interestingly, there is a body of research that suggests mental health outcomes have improved for the general public in the middle and upper classes, but has deteriorated significantly for the poorest and most impaired populations (Grob & Goldman, 2006; Goodwin, 1997; Frank & Glied, 2006). Perhaps it is important for researchers and stakeholders to acknowledge that there is no ‘one size fits all’ model of mental health care, and therefore adopting one model over another is not going to adequately meet the needs of all users. Policy makers appear to want to simply substitute institutional care with community care despite studies indicating that this cannot be so easily achieved and

may not even be beneficial for many individuals. Lamb and Shaner (1993) found that at least 15 patients per 100,000 population were too aggressive, disturbed or damaged to survive in surroundings other than the controlled setting of a mental hospital and offered a valuable observation:

> We all wish that intermediate and long-term 24-hour, highly structured care would not be necessary, especially with modern antipsychotic medications and our broad array of psychosocial treatments and rehabilitation. We may even wish that all the vast numbers of persons who populated our state hospitals in the past did not need acute long-term care but were simply victims of the poor system of mental health care at the time, of the lack of modern treatment, and of the nature of the hospitals themselves. Unfortunately, our clinical experience does not allow such an easy explanation (Lamb & Shaner, 1993, p.973).

Policy also seems ill-equipped to deal with the wide range of diagnoses and needs of the mentally ill as there is a continued move forward with community care policy. The negative consequences of early mental hospitals have unfortunately created polarized ideologies of institutional care and community-based models, which leaves little ability for policy makers and stakeholders to reconcile the two into a model of care that meets the needs of all individuals with diverse diagnoses and treatability levels. Early mental health policy was underpinned by an assumption that individuals would either be cured and discharged into the community or their conditions would be chronic and they would remain the same or even deteriorate, resulting in their becoming long-term patients; these ideals still appear to be held within the community care model, however, there is ongoing resistance to accepting the latter outcome for some individuals (Barham, 1993). Any researcher, policy maker or mental health professional would concede that there are some severely mentally ill individuals who are simply not thriving in the community and probably require long-term institutional care, yet these observations are overshadowed by a number of assumptions held by these stakeholders.

First, there is an underlying assumption that people with mental health problems are unfairly stigmatized by an intolerant and prejudicial society and that this stigmatization, and not the shortcomings of community care policy, are what creates challenges for them (Goodwin, 1997). Sayce (1994) suggests that discrimination against the mentally ill needs to be explained

within a larger context of patterns of inequality within societies; because of long-held and generally negative opinions towards the homeless, poverty-stricken and lower class populations, singling out and reducing the stigma regarding mental illness is not so easily achieved. Additionally, Philo et al (1993) note that the majority of negative public attitudes towards mental illness are derived from media images and stories and not the experiences of the mentally ill.

A second assumption about the best model of care is that policy makers assume that they know what the mentally ill actually want in terms of care options. While the ability to feel included in every aspect of society is of primary importance, policy makers must understand that a number of the mentally ill do not want community inclusion, but would instead prefer the sanctity of a care facility where they are among others with whom they can identify. As Goodwin (1997) aptly notes:

> The role of people with mental health problems in the making of mental health policy has been minimal, and the extent to which we should expect service users to be the foot-soldiers of a conflict in which their views and their experiences are deemed secondary to a set of ideals propounded by others is a matter of considerable moral difficulty (p.153).

While the needs and concerns of the mentally ill are often addressed through patient advocate groups and associations[7], these services generally offer support and information as opposed to lobbying for policy changes.

Finally, there is legitimate concern regarding the rights of the mentally ill as well as an assumption that institutional care would immediately revoke or infringe upon those rights. The current medical system is based on autonomy and self-determination as it pertains to an individual's own care, however sections of the Alberta Mental Health Act (and others in differing provinces) allow medical doctors, psychiatrists, peace officers and police officers the ability to certify individuals if it is believed to be in their best interests. These certificates range in length from 24-hours to six months, however some chronically and severely ill individuals have been repeatedly certified for years at a time if they are not deemed stable enough for

[7] In Alberta we have the Mental Health Patient Advocate Office, which provides information, investigative services and resources to the mentally ill and the general public. See: https://www.mhpa.ab.ca/Pages/Default.aspx

discharge. Baldwin and Twigg (1991) argue that there are a number of populations in addition to the mentally ill that require ongoing and often long-term care, such as the disabled and elderly, and that there is a collective responsibility for meeting the needs of these groups. The question then becomes, why do we decide to place elderly family members in care facilities and disabled children and family members into group homes and care facilities without much concern, yet when it comes to the mentally ill, their rights are believed to be taken away if they are put into an institution that will care for them?

The Role of Frontline Mental Health Workers

The historical outline above serves to illustrate that over the past few centuries there has been a concentrated effort to care for the mentally ill in the best manner possible. The movement away from institutional care towards a community-based service delivery model was merely a continuation of these efforts, though it appears that this policy shift has had unintended consequences for both the mentally ill and the professionals who care for them. The swift decline in the legitimization of institutions, followed by the hasty and poorly planned adoption of community care policies, has led to a fragmented mental health system in which adequate care often eludes the clients who need it most (Goodwin, 1997).

The expansion of the use of frontline workers from various agencies was intended to rectify this dilemma and create cohesion within the larger system; through case management and collaboration among programs and agencies, professionals working on the frontlines in the community have shouldered the burden of providing care to a large number of mentally ill individuals with varying acuity levels and diverse social adversities. As such, frontline workers play a pivotal role in the care of the mentally ill for a number of reasons: they are often the first point of contact for individuals accessing mental health services, whether their experience is during a crisis or is the result of a referral from another service (i.e. a family doctor); they often provide social services that are outside of their scope of care (i.e. many community mental health clinicians complete housing assessments or assist individuals with accessing financial assistance, which is generally not the job duty of a clinician); they provide long-term care for clients who are acutely ill and who require ongoing intervention or supervision; they are

typically responsible for referring individuals to specialized mental health services (i.e. counseling or therapy groups, brain injury clinics and outreach programs); they work closely with other care providers, such as families and group homes; they work alone in outreach capacities in the community, often with unstable and potentially violent individuals, and; they provide various levels of dynamic care based on the presentation of the client (i.e. some clients function well in the community and require minimal support, while others require hospitalization and intensive stabilization). The variation of job duties for many frontline mental health workers therefore requires adaptability, improvisation, and discretion to find ways to provide individualized care within the boundaries of systemic policies.

Lipsky's Concept of Street-Level Bureaucrats

In 1980, Michael Lipsky first published a groundbreaking paper entitled "Street-Level Bureaucrats" which sought to examine and explain the relationship between the place of individual workers within the larger social systems that dictate the public policy these workers put into practice. Lipsky's concept is best explained in his own words:

> These are the schools, police and welfare departments, lower courts, legal services, and other agencies whose workers interact with and have wide discretion over the dispensation of benefits or the allocation of public sanctions… interactions with street-level bureaucracies are places where citizens experience directly the government they have implicitly constructed. Unlike these other experiences, however, citizen encounters with street-level bureaucracies are not straightfoward; instead, they involve complex interactions with public workers that may deeply affect the benefits and sanctions they receive (2010, p.xi).

Lipsky (2010) insists that there are two distinct characteristics of the roles of these street-level bureaucrats; first, that discretion is a 'critical dimension' of much of the work that these individuals do and, second, that these types of jobs cannot typically be performed with the highest possible level of decision making because there are too many mitigating factors (i.e. time constraints, limited information, lack of resources, etc.). The result, he claims, is that "street-level bureaucrats manage their difficult jobs by developing routines of practice and

psychologically simplifying their clientele and environment in ways that strongly influence the outcomes of their efforts. Mass processing of clients is the norm, and has important implications for the quality of treatment and services" (Lipsky, 2010, p.xii).

Lipsky's article was originally published in 1980, just as deinstitutionalization was being implemented, and so although he is not speaking directly about frontline mental health workers, his framework applies to this population of service providers. As a result, the notion of frontline mental health workers as street-level bureaucrats will be explored in this thesis, however it should be made clear that the intent is not to primarily underpin this research with Lipsky's work in terms of a theoretical framework. Rather, frontline mental health workers who are in a role likened to the notion of street-level bureaucrats will be considered. As such, the concept of the street-level bureaucrat will be used conceptually to illustrate the role that frontline workers play as the middleman between the larger mental health system and its mentally ill clients.

In reading through the introduction to mental illness, as well as the literature highlighting the tumultuous history that the mental health system has experienced, one should have a deeper understanding of the challenges that frontline mental health workers face. On one hand, the mental health system has undergone fundamental changes that are both exciting and promising; with the continued progress made towards developing new treatments and therapies, coupled with a number of vital social support initiatives, the direction of mental health is certainly encouraging. On the other hand, and perhaps more pessimistically, the challenges that have come with implementing new policies and frameworks in moving towards the creation of a better and more effective mental health system have undoubtedly created some frustration for professionals across all levels of the system. It is for these reasons that it is important to research and understand how these professionals, and specifically frontline workers, cope with working as meso-level, street-level bureaucrats within the macro-level mental health system.

While the experiences of individuals, families and communities are often the focus of research, a group that is less often studied but is critical to dealing with mental health issues is the frontline workers who provide care on a number of levels. My research is intended to address this gap by highlighting the experiences of frontline workers who work with chronically ill

clients. Although the mentally ill and their experiences are crucial in assessing the success of community care, those experiences may be largely influenced by the quality of care offered by frontline workers. Frontline workers often serve as the linchpin between the mental health system and the individuals who require mental health services. My research questions are intended to explore workers' feelings about their pivotal role as street-level bureaucrats:

i. What are the challenges faced by frontline mental health workers whose role is to deliver community-based services as dictated by macro-level healthcare policy?

   a. Are policy and practice working effectively together?

   b. What are the challenges associated with implementing services dictated by the healthcare system itself?

ii. Do frontline mental health workers believe that they are effectively providing services and care on the individual-level based on the needs of clients?

   a. Are there appropriate and adequate services provided by frontline workers that are available for all clients with varying mental health problems?

   b. What outcomes do clients experience as a result of the services provided by frontline workers?

In order to answer these questions, I conducted informal interviews and open-ended surveys to collect qualitative data from frontline workers in a variety of frontline mental health services. These two approaches, which will be discussed further in the methods chapter, allowed me to highlight the experiences, attitudes, and feelings of frontline workers who routinely treat the chronically mentally ill in the community based on the community care approach.

CHAPTER 3: RESEARCH METHODS

> "The serious underfunding of mental health research must be corrected and a research agenda developed to enable research funding to be put to the best possible use. In addition, the development of a range of guidelines and standards is needed to help accelerate the translation of knowledge into action and enhance quality. Better planning to address mental health resource shortages and to help the mental health workforce adapt to new and expanded service requirements will also be critical to achieving change".
>
> -Changing Directions, Changing Lives: The Mental Health Strategy for Canada (Mental Health Commission of Canada, 2012, p. 18).

Introduction

The literature reviewed in the previous chapter offered a brief overview of the history of the mental health system as a whole, and how it has gone through significant changes in both Europe and North America over a number of decades. Unfortunately, examining the role of the professionals who provided the care in each respective period is limited. This is mainly the case due to the lack of research and literature available on the experiences of these professionals; while some literature considers the struggles that families endured in trying to care for mentally ill relatives, subsequent worker-based research was dedicated to the emergence of psychiatry and the doctors who practice it. This research provides some insight into a very limited body of literature on frontline mental health workers and their experiences, therefore contributing to a better understanding of the structure of mental health initiatives and policy implementation. Furthermore, it is the absence of existing research in this area that provided motivation to look more closely at the professionals in the mental health system that have the most contact with the severely mentally ill in the community. I believe that the role they play in navigating the demands of the structure of the mental health system and the

individual clients is paramount to understanding the relationship between system and clients and therefore requires specific consideration. This chapter will outline the methods that I employed to carry out this research, starting with a brief but important discussion on reflexivity, followed by a detailed overview of the research design used to capture the voices of frontline mental health workers.

Reflexivity

Finlay and Gough (2008) assert that "reflexivity requires critical self-reflection of the ways in which researchers' social background, assumptions, positioning and behaviour impact on the research process" (p. ix). This notion is particularly important to my research given my background in the mental health system. For six years I have maintained a role on the frontline of the mental health field and, as expected, this has fostered my interest in carrying out this research. This may be an advantage, as Moustakas (1990) points out: "the task of the initial engagement is to discover an intense interest, a passionate concern that calls out to the researcher" (p.27). It is because of my concern for the current state of the mental health system that I have become increasingly passionate about creating awareness and facilitating discussions about the problems faced by both frontline workers and their clients.

Maslow (1966) insisted that "there is no substitute for experience, none at all" (p.45) and this can be especially true when working in the mental health field. For over five years I worked as a Community Peace Officer (CPO) and no amount of formal education is comparable to the hands-on experience I have gained. My role was to assist in the management of mentally ill individuals and offenders both in the community as well as in remand centers and other institutions. If you can think of it, I have seen it, heard it, been called it, had it thrown at me, seen someone eat it or seen someone do it. Expectedly, since I have worked in this role I have often been asked about the 'craziest things I have seen at work' or people will ask me how I manage to work in a field that they 'could never work in'. And as more and more people are often fascinated by the things I have seen or had to do, it becomes apparent that lay people care more about the bizarre things I am exposed to as opposed to the larger social effects of extreme mental illness. For example, there are countless times that I have seen people eat

their own feces or have had them throw it at me; friends, family members and acquaintances always have the same mixed reaction of disgust and interest in how I manage to deal with those situations. But little consideration by these curious lay people is given to how individuals with mental illness deteriorate to a point where that type of behaviour is exhibited for whatever reason; instead, they only want to hear about the interesting or bizarre aspects of the behaviours of severely mentally ill individuals. I often try to explain that sometimes individuals are so psychotic that they do not understand the social taboo associated with their behaviours; in other cases, the individuals are attention-seeking or volatile and they realize that throwing feces will be more insulting or offensive to an officer or nurse than something like name calling or assaultive behaviour.

Regardless of the reason for the behaviour, the larger impact for me is the realization that we have a mental health system that does not equip individuals with the tools to effectively manage their illnesses; they cycle through hospitals and jails at an alarming rate, have limited access to services and resources, and are regularly homeless and vulnerable. Many 'frequent fliers', or individuals who regularly have contact with police, emergency services and hospitals, become the ultimate paradox for people like me; on one hand, these individuals are extremely frustrating to deal with because we (front-line workers) apprehend them on a weekly basis for the same reasons each time and these individuals have little regard for how their behaviour is burdening social systems and limited resources. On the other hand, to look past their behaviour is to see their underlying mental illnesses. Many of these clients often know what they are doing is wrong or unacceptable, however they do it anyway because of low impulse control or limited insight often stemming from an organic mental illness. For example, there is one well known client who makes over 1,000 calls to the Distress Centre every year claiming she is suicidal and is going to kill herself if the police do not show up. When the police show up, she holds a knife to her wrist and threatens to hurt herself if they approach, or she barricades herself in a room which results in the police breaking the door down before having to physically restrain her and transport her to a hospital where she continues to be verbally and physically assaultive with nursing staff, doctors, and security. This particular individual is a known alcoholic and has burned her bridges with every emergency and social service in the city. The result is now a client who is clearly mentally ill and requires services but who has established herself as difficult and frustrating to manage and so efforts to find her treatment to

control this behavior are increasingly limited. Furthermore, her behaviour extends beyond the continuum of care (i.e. Tier 5 supports such as hospitalizations, assertive community treatment, or other services outlined in Figure 1 and Table 1 on pages 12 and 13, respectively) available to individuals who are persistently and chronically ill but for whom there are limited long-term resources such as institutions or mandated addictions treatment.

The reaction I get most when I discuss the trials and tribulations of working with these clients is that people tell me I am now jaded; I do not believe this to be the case as I do not see the negative in all of these clients. I recently quit my job as a CPO and I am now an outreach worker on a Corrections Transition Team; in this role I am tasked with assisting offenders with mental health and addictions issues in accessing treatment, housing, and psychiatric resources in order to prevent them from reoffending and cycling through the justice and medical systems. Many of my clients now are those who I had previous contact with as a CPO and so I have experience working with the chronically mentally ill in both enforcement and treatment capacities. While my new role allows me to see how some clients can be successful and 'do well' in the community, the gaps in service and barriers to resources remain prominent. I do not believe it is jaded to feel that some mentally ill clients will never function in society; to me this is simply a reality of the unfortunate combination of crippling mental illness and a system ill-equipped to treat it. I will not deny that having worked with the 'worst of the worst' and lowest functioning members of society has diminished the hope I may have had for these people, however, I also realize that many of these people did not choose their lives and are instead unequivocally the products of their individual and social environments. It is for this reason that I am interested in researching mental illness and those who work within the system. I have been able to identify a number of problems with the current mental health system and I have a vested interest in identifying solutions that would create a better system for clients and workers and society more generally.

I am of the opinion that frontline workers have the valuable input regarding the shortfalls of the mental health system and accordingly what changes need to be made to successfully treat the mentally ill. Policymakers are often far removed from the individuals they make decisions for, with the result a severe disconnect between the larger systems and the clients they are intending to serve. Policymakers however are, by default, the ones with the 'voice' when it

comes to mental health; the policies they implement is evidence of their opinions about how the mental health system should be organized and what is best for the clients. As a frontline worker with my own opinions, I decided to address the attitudes and opinions of other frontline workers in order to determine if there is a consensus among them with respect to the challenges of working within the community-based care model. I have made every effort to remain objective and unbiased in my research, however, given the nature of reflexivity in research, undertones of my personal opinions may be present, and this will be further discussed in the limitations in the concluding chapter.

Sampling

The participants included in my research are all frontline workers who have, at some point in their careers, worked in a role that required them to treat mentally ill patients in an emergency or crisis situation[8]. While some community mental health workers treat patients in clinics where the patients are generally stable in their behaviour, emergency services are far more dynamic in that patients are often extremely sick, are under the influence of drugs or alcohol, and are generally resistant to treatment and require forced stabilization. It is these emergency service workers who I recruited for this research. I wanted to speak with the workers who most frequently interact with these clients and who could offer the experienced insight into the needs of this population.

Below, I outline the general titles and duties of the frontline workers most often tasked with assessing and treating those in crisis and who participated in this research:

- Registered Psychiatric Nurses (RPN): these nurses have all of the medical training of Registered Nurses (RN) but have additional training in psychiatric disorders, treatments, medications, as well as social aspects associated with mental illness. They work in a number of emergency service capacities, including in Emergency Departments in hospitals and on community outreach teams (locally, these include

[8] A crisis or emergency situation is defined as one in which the client requires immediate intervention in order to prevent harm to the individual or to others. In these situations, the individual is often in severe distress, i.e. actively suicidal or is experiencing a psychotic break with reality, which is impairing the ability to make decisions for him or herself.

Police and Crisis Team, Assertive Community Treatment Team, SafeWorks Initiative, Community Treatment Order teams, and so on).

- Police Officers and Peace Officers: police are now receiving mental health awareness and intervention skills as part of their training. Because many offenders have mental health issues, it is critical that officers are able to identify when someone is in crisis and requiring hospitalization in contrast to someone who is under the influence of a substance or who is simply behaviourally defiant. Also, a number of specialized community peace officers work in community settings to assist staff in providing mental health care, as well as to maintain custody and control of mental health patients on psychiatric units, in hospital settings, and wherever else they may be required.

- Psychiatrists: not all psychiatrists work in emergency situations, however, the majority are trained in this area as part of their residencies. While some remain in emergency psychiatric services, many work on an outpatient basis with clients who are generally stabilized and not continually in crisis.

- Social Workers (SW): nearly all emergency mental health departments and initiatives have a social worker on their team who is able to assist in addressing the needs of the client outside the realm of medical treatment. This often means that clients need assistance in finding shelter, getting funding for medication and treatment, or accessing services to address stressors in their lives such as addictions, domestic violence, family strain, etc.

- Nurse Educators (NE): individuals who work in this role are often the only source of new training, policies or practices for their respective areas. A mental health NE would therefore attend conferences and meetings relating to the direction of mental health and is then responsible for cascading the information to all other frontline workers. Additionally, NEs are able to act as a source of information for frontline workers who may have questions about their roles and responsibilities.

- Agency Staff (AS): agency staff, including outreach workers, are those individuals who work in community and non-profit agencies and organizations who serve a large

number of clients with mental illness but who may not have training or education specific to mental health. This can include workers in shelters and drop-in centers, inner-city housing associations, and recreational centers. Since deinstitutionalization, many of these agencies have seen an increase in the number of clients who are acutely ill and who require crisis intervention.

I conducted 6 interviews and collected 14 surveys with both men and women (5 and 15, respectively) for this research. I ceased data collection after having recruited 20 participants as themes were consistently emerging from the data and little new information was identified in terms of attitudes, experiences, etc. Participants included a psychiatrist, several registered psychiatric nurses, a social worker, police officers, peace officers, outreach workers and an executive director of a homeless shelter; most of these participants had worked in more than one area of mental health throughout their careers and therefore had an array of experiences to draw on.

Recruitment

Because I have worked in the mental health field for the past six years, I had access to a large number of potential participants. In order to recruit participants, I used three snowball methods: email, posters, and face-to-face interactions (see Appendix A for recruitment materials). First, I had clinical mental health managers email their respective teams with a template that I forwarded to them. I also sent emails to frontline workers that I know on a more personal level and asked them to forward my recruitment information to any of their co-workers who fit the participant criteria[9]. Second, I made posters that included the same recruitment information as the emails and posted them in the psychiatric offices in the emergency department of the three major hospitals in Calgary. Lastly, I capitalized on my daily face-to-face interactions with mental health workers by telling them about my research and

[9] The criterion for participation was that the individual had to have frontline experience with the severely and persistently mentally ill in any capacity. For some, this may have been crisis work, while for others it could be institutional in nature. Participants did not need to be currently working in this capacity, but only had to have some experience in providing mental health care.

giving them my contact information if they wanted to participate. Potential participants were given the option of either doing an interview or completing a survey; I opted for these two methods as it would give participants the ability to choose the manner that would create the highest likelihood of completion. Because mental health services operate on a 24/7 schedule, many frontline workers prefer to work night shifts, and therefore those participants felt that they would be able to complete a survey during their down time at work rather than do an interview during their personal time off.

Overall, the recruitment process for my research was challenging despite my many personal and professional connections to frontline workers in the mental health field. First, the notion of how to provide adequate community-based care is quite controversial and political, particularly with respect to where institutions fall on the continuum of care. While I was told in many casual face-to-face interactions by a number of people that they believe that a small proportion of the severely mentally ill are not being adequately cared for in the community, there is clearly a separation between idle office conversation and formally documenting one's opinions because I did not receive as many respondents as I had hoped. For some, I believe that they are very passionate about mental health and wanting to better the system, but they prefer to keep their opinions and attitudes quiet for fear of being ostracized by colleagues or management. For example, I currently work on a mental health team that transitions mentally ill and addicted offenders from jail into the community, and I am aware that my opinions of the mental health system are not in line with the mandates of the program and the ideals of our management. The way that I view crime, offenders, and mental health, are somewhat removed from strict 'compassion and care' ideals[10] that the rest of the team subscribes to. As a result, I often prefer to keep my opinions to myself with respect to how I truly feel about what our team is attempting to do for the population we work with. Second, as will be discussed in the following data chapters, mental health workers often feel over-burdened by their caseloads, and therefore finding time to participate was difficult for many of them. For example, all of the interviewees rescheduled their meetings with me at least once because their schedules had

[10] This refers to the notion that all mentally ill individuals deserve the same care and compassion regardless of their behaviour, symptoms, or diagnosis. For example, if a mental patient attacks a police officer, the compassionate and caring explanation may be that the individual is simply very sick and does not intend to exhibit such behaviour. However for the police officer, the behaviour is seen as deliberate and aggressive and is not to be tolerated, which results in the individual being forcefully restrained or arrested.

changed or they did not have the time to meet as originally planned. Also, I had recruited an additional two interviewees who rescheduled their interviews a number of times and then ultimately did not follow through with participation because of their inability to find a time to meet with me.

A similar trend occurred with the administration of the surveys; only four of the fifteen respondents returned their surveys to me without a follow-up email prompting them to complete the survey. Another three participants were recruited and were sent the surveys but they did not complete them and did not respond to my follow-up emails inquiring about their willingness to continue participation and complete the surveys. This was frustrating as a number of participants opted to complete the survey rather than an interview because it would be a more flexible option for them in terms of being able to complete it on their own time.

Representativeness and Generalizability

While the goals of my research were to capture the experiences of frontline workers and explore their attitudes about the challenges of providing community-based care, I realize that my findings may not represent the attitudes of the larger population of mental health workers. Because of my personal and professional connections to many of the participants, there may be some 'volunteer bias'[11] that limits the generalizability of my research. For example, many of the individuals I know in the mental health system work with the most acutely ill and may have experienced burnout more so than practitioners in other areas of the field. These individuals therefore may have stronger negative opinions about their roles, their clients, and the policies of the mental health system than workers who are new to the system and have had limited experience. Many of the participants who were successfully recruited for my research may fit this profile and so volunteer bias may be present in that they participated partly to vent about the stresses of their jobs or the frustration they feel with the mental health system.

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[11] According to Palys (2003), volunteer bias is the notion that "the people who volunteer to participate in research are often different in a number of ways from those who don't. Thus, if we select a random (and hence representative) sample of some population, not everyone participates (as is usually the case), we cannot simply generalize the results from the sample who participated to the broader population unless we have some understanding of how, if at all, those who participated are different from those who don't" (p.439)

Additionally, my research findings may not represent mental health practitioners who have many positive experiences with their clients and who feel that community care is sufficiently balancing the needs of clients with the availability of services. This limitation and others will be discussed in a later chapter. It is important to note that my intentions are not to suggest that all mental health workers have the same opinion about the challenges of providing community-based mental health services. My research is meant to give a voice to a specific group of frontline mental health practitioners and to explore their opinions about their roles in serving the severely mentally ill.

Interviews

Each of the six interviews lasted from forty minutes to nearly two hours in length and was conducted at the workplace of the participants. This was convenient for participants in that they could participate while at work rather than having to find time in their personal schedules. Additionally, many of the participants and I share the same work environment and so it was easy for me to meet them at their offices which was more comfortable and confidential than a public place.

An interview schedule was prepared to cover five main topics: background and experience; current mental health policy; attitudes towards current practices; institutionalization; and the future of mental health. A number of questions were prepared for each domain in order to answer the research questions, however, a semi-structured and open-ended format was used in place of a strict interview plan. This allowed the interviews to flow and for some questions to be explored in greater depth depending on the participant's experience or opinions. In order to accommodate this, some questions were omitted or added depending on the direction of the interview. By being flexible in my interviews, I was able to capture each participant's distinctive personal experiences and attitudes.

Surveys

Surveys were included as a data collection method in order to accommodate those who were constrained by shift work schedules that are oftentimes inconsistent, or who were unwilling to be interviewed for whatever reason. The questions were typed into a Word document with a brief set of instructions at the top of the survey and the document was emailed to the participants. The participants were then able to complete the survey on their own time and email it back to me when it was complete.

The questions on the survey were identical to the questions in the interviews in order to standardize data collection and enhance the reliability of the data. Additionally, this method was used rather than a survey with closed-ended questions or opinion scales in order to obtain richer data from the participants. Because my thesis is centered on the experiences and opinions of frontline mental health workers, a survey design that included closed-ended questions and opinion scales would likely not capture the essence of what the participants were trying to convey.

Just as some questions were not applicable in the interviews, participants who opted to complete the surveys were able to skip questions that they were unable or unwilling to answer. Participants ultimately answered all of the opinion-based questions, however, some questions assessing their knowledge of mental health policy were skipped because many frontline workers were unfamiliar with the policies that I was inquiring about. It could be assumed that this would hinder the data but instead it is a finding in itself; frontline workers who are not familiar with the mental health policy that they are implementing is not an indicator of worker incompetency, but is instead an illustration of the disconnect between the macro and micro levels of the mental health system as a whole. Workers may feel that they should not necessarily be expected to enquire about policies outlining the direction of mental health as it is the responsibility of the policy makers to ensure information is cascaded down accordingly. On the other hand, policy manuals are available in each unit or department and staff is generally expected to be familiar with the information.

One challenge of the surveys was collecting rich enough data. Because the questions were open-ended and required the answers to be typed in, the opportunity for participants to simply

answer with short and concise responses was increased. Participants who elected to do an interview could speak freely without concern for how much time it would take me to transcribe it, while those who completed surveys may have had time constraints or a general reluctance to type an extensive answer to each question, potentially limiting the comprehensiveness of their answers. The data collected, however, was able to sufficiently address the research questions and offer insight into the attitudes of frontline mental health workers.

Confidentiality

All participants, both interviewees and those who completed surveys, were offered the option of remaining anonymous with respect to their identities and comments. This option was offered on the consent to participate form. All respondents elected to remain anonymous, and therefore all of the names used in the following data chapters are pseudonyms.

Ethics

There are certain ethical considerations that must be acknowledged when discussing mental illness and the opinions of frontline workers. For the most part, frontline workers are governed by various confidentiality and privacy acts that require they keep patient information protected and they take these acts seriously. There are, however, some cases well known within the mental health system that are discussed in a general sense throughout the data chapters. Every effort has been made to protect the identities and privacies of these individuals; they are discussed strictly to provide contextual examples of the experiences that some frontline workers have with particular complex, severely mentally ill clients.

CHAPTER FOUR: LITTLE FISH IN A BIG POND: PROVIDING CARE FROM THE MACRO LEVEL

Because the intentions of this research are to gather and understand the experiences and perspectives of frontline workers who work between the macro-level mental health system and the individuals who occupy the micro-level, the next two data chapters are divided into two parts. First, the macro-level chapter (Chapter Four) will discuss the challenges for frontline mental health workers of being at the bottom of a top-down mental health system that is administrated by far-removed policy makers and government officials. In order to answer the first research question for this thesis, Chapter Four offers insight into the role that frontline workers see themselves in, their attitudes towards the overarching system that dictates the services they provide, and their opinions as to what is lacking within this system. The micro-level chapter, Chapter Five, instead answers the second research question by looking at how the challenges of the larger mental health system may cascade down to the mentally ill clients who utilize its services, and how effectively the frontline workers are able to provide care to this population using the resources available.

THE MACRO-LEVEL

> "A transformed mental health system should primarily be based in the community, because obtaining services, treatments and support in communities improves quality of life and leads to spending less time in hospital. De-institutionalization—when Canada, along with many other countries, moved away from a long tradition of warehousing people with mental illness in institutions (or 'asylums')—was the right policy. Our failure was in not replacing institutional care with sufficient services and supports in the community. This failure has contributed significantly to the proportion of people living with mental illness among the homeless population and in our jails and prisons, turning them into the 'asylums' of the 21st century. Lack of access in the community to crisis support, mental health and primary care services also drives people to emergency rooms for help, increasing waits and stretching resources. Many community services do not

> even keep waiting lists because it might give false hope to people in need that eventually their time will come".
>
> -Changing Directions, Changing Lives: The Mental Health Strategy for Canada (Mental Health Commission of Canada, 2012, p. 60)

Introduction

The above quote from Canada's mental health strategy offers a stark summary of the state of the current community-based Canadian mental health system. Although this strategy was developed to identify issues and make recommendations to address these shortcomings, the reality is that it primarily legitimizes the assumed failings of the community-care model and substantiates much of the current and past research that criticizes the manner in which community-based care has been implemented.

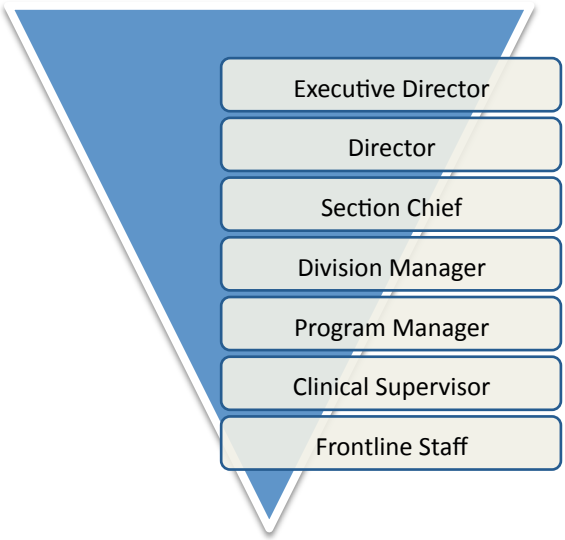
The administrative and organizational processes of community mental health care have had a profound impact on the frontline workers who are responsible for implementing this model. Providing individualized care to the mentally ill within the policy-driven confines of federal and provincial mental health systems can be a challenging task for frontline workers. In this chapter, participants discuss their opinions and experiences of trying to provide care within a larger systemic framework in order to address my first research question. This section will begin with a contextual overview of the mental health care system in Alberta, followed by a look at participants' attitudes about current policies, their opinions of the inadequacies of the system as a whole, and their perceptions of the limitations of the community-based care system under which they work.

Health Care Structure in Alberta

The structure of Alberta Health Services (AHS) appears to play a role in the opinions of how frontline mental health workers view their roles and abilities, as well as the service levels that they are able to provide to clients. In 2008, a controversial decision was made to abolish each of the existing nine regional health authorities and three overarching health organizations and

replace them with a "superboard" that would be known as AHS[12]. While most of the 105,000 AHS staff members have adapted over the past five years, it has been argued that frontline workers may have become marginalized with respect to their inclusion in the daily operations of AHS[12]. For example, most frontline workers have a clinical supervisor, a program or unit manager, a regional manager, and then a number of zone directors above them. The result is a top-down hierarchy that has many levels, with participating frontline workers reporting that they feel they are often unheard or dismissed when they have opinions about how the services they are offering could be improved. To highlight this, Figure 1 (below) is a general organizational chart for AHS psychiatric services in Calgary. This chart illustrates the various levels within the hierarchy of AHS for the department of psychiatry alone, although other sectors tend to look similar in structure. It is therefore easy to see how easily it can be for frontline workers to feel that their opinions and attitudes are dismissed when they are so far removed from those who are in decision-making roles (typically at the executive section chief level and above).

Figure 2. Example of the organizational hierarchy for a mental health department



[12] See: http://www.canada.com/edmontonjournal/news/story.html?id=4b0743f0-2046-4b13-8be7-7e2e4ca7e10d (accessed January 23, 2014) and http://www.edmontonsun.com/2012/01/21/gap-between-frontline-workers-and-ahs (accessed January 23, 2014).

Mental Health Policy

Mental health policy, both nationally and provincially, has generally been developed at directorial levels that are far removed from both frontline staff and the clients that policy serves. In adopting a community-care model for Canada's mental health system, little consideration seems to have been given for how frontline workers would implement new policies and frameworks that are contradictory to what were traditionally in place under the institutional care model. For example, one participant described how in many instances nurses on psychiatric units are now responsible for coordinating a patient's release plan, whereas this is not a job duty of a nurse. She explained that this work would typically be done by a social worker or a transition planning coordinator, however these tasks are now often shouldered by various frontline staff who have little to no training in such work.

Goodwin (1997) explains that there was, and still is, considerable support for the underlying community care model among frontline workers and therefore the criticisms lie in the implementation of this model. As will be expressed throughout this section, participants tend to agree with this notion. Participants echoed Goodwin's sentiments that the lack of funding for community initiatives, the lack of imagination regarding their development, and a lack coordination between institutions and community programs have all resulted in poor outcomes for the mentally ill, such as homelessness, deteriorating mental and physical health, and the inability to successfully integrate into society. For example, with respect to deinstitutionalization, clients who have spent several years, and in many cases several decades, in institutions were transitioned into the community with few supports in place.

Furthermore, it seems that frontline workers feel that they were not adequately equipped to deal with this population, as the mentally ill had generally been under the care of experienced teams within institutions. When asked about this, James spoke about the effects that the policy shift has had on frontline workers:

> …it was definitely a direction that they [policy makers] wanted to go and it was clear, you know and in a lot of ways, we needed to do that cause what they did when Kirby[14] wrote

[14] This refers to a mental health report titled "Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addictions Services in Canada", written by Michael Kirby (chair) and Wilbert Keon (deputy chair) from the Standing

> that report, in going through cross-country cutting of inpatient resources and saying, you know, we can't do inpatient acute care as much, right, so we've gotta cut those tertiary care hospitals. But they didn't beef up the community resources to manage a lot of those people. So that was necessary for sure. Um, what your project's talking about is what they neglected to do is that there's a small population that really needed ongoing long-term wrap around structured care, and that was not, as far as I remember, that was not addressed in the Kirby report.

James is referring to how the Kirby Report did little to directly address the issues facing individuals who are chronically and acutely ill. The report suggests that these individuals may need specialized services, but only goes so far in defining these types of services:

> "highly specialized mental health programs provided in community or hospital settings that focus on serving people whose serious mental illness is characterized by complex and unstable mental disorders. Only those very few people with serious mental illness who require ongoing, daily contact with service providers will need to access such specialized services and supports" (Kirby & Keon, 2006, p.104).

The report does not elaborate on what these types of services and resources are, and how they would be implemented. What the report does assert regarding these services is that "specialized services are not synonymous with long-term, institutionalized care. Rather, treatment, rehabilitation and support services can be provided by multi-disciplinary teams that work in ways to enable many people living with these illnesses to continue to live in the community" (Kirby & Keon, 2006, p.104). The unyielding shift to community-based care seemed inevitable based on these comments, however the challenge for frontline workers has since become how to appropriately and effectively treat clients who are not benefiting from, or responding to, the types of community treatments and support services available.

Prior to the shift towards the balancing of services, certain mental health workers were often accustomed to seeing clients with a particular acuity. For example, institutions were generally reserved for treatment-resistant and chronically acutely ill patients, whereas clients in the

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Senate Committee on Social Affairs, Science and Technology. This report can be found at: http://www.parl.gc.ca/content/sen/committee/391/soci/rep/rep02may06-e.htm

community were generally lower on the acuity scale for mental illness, for illness including depression, anxiety disorders and personality disorders (Goodwin, 1997). Frontline workers in the community were therefore less experienced in treating high-needs clients and so when the policy was changed to deinstitutionalize these types of clients, little consideration was given to the training and expertise of the frontline workers that would end up taking over care of these individuals (Grob, 1994).

The disconnect between policy and practice within the mental health system is highlighted through the participants' responses to questions about their knowledge of the current mental health policy that they are expected to put into practice. The majority of participants acknowledged that they are unfamiliar with the direction and strategic policy of mental health both Canada-wide and in Alberta. For example, when asked how familiar she is with Canada's mental health policy report, Mel stated:

> I don't know, I don't officially know it but I'm assuming it's about creating mentally healthy workplaces, like this is probably stuff that gets spoken about on a daily basis with us. Like the increased awareness about how to promote mental health, prevent illness and suicide, and reduce stigma, we talk about it a lot and then obviously we have mental health week and during our staff meetings we talk about this kind of stuff. But officially I don't know.

When participants were asked if they felt they have the ability to influence policy as frontline workers, respondents reported that their knowledge of service delivery, coupled with the need they see for particular services or resources, are largely ignored. Hayley asserts that, "Policy is largely influenced by demand and not by true experiences of clients, families and caregivers", suggesting that many of the decisions made with respect to mental health policy are centered on available resources as opposed to looking at what the clients truly need. This can potentially be attributed to the manner in which policy is developed. In discussing how mental health policy is developed, Mel pointed out that because policy is often made at a level far-removed from the frontline, a disconnect seems to have developed between the policy itself and the frontline workers trying to put policy into practice:

> I think what ends up happening is that lots of policies get made by people who have never worked the frontlines. They've never worked with these people. And so I think it's

> unrealistic to think that you're going to do this. And then also, in terms of communication, stuff doesn't get communicated, so for instance if you discharge somebody against clinical advice, there's a policy around it but it never gets said to anybody and then all of a sudden you get in trouble for it. So I think that policies are sometimes created by people who actually have no idea about what the hell they're talking about.

Additionally, Katie felt that there is little ability to influence policy "in the current workforce, because the acuity is increasing so you're just bogged down having to deal with case by case by case by case. So to step out of the box is really hard to do". Katie elaborated on this by discussing how many of the clients she sees who are becoming more and more complex in their needs yet the mental health systems are not adequately equipped to effectively and efficiently give them the best care possible. She stated that many clinicians are then left to focus their efforts on giving even the minimum care required, which leaves little time to advocate for better policies and changes to the larger mental health system.

Participants unfortunately did not offer additional opinions regarding mental health policy, presumably because of their unfamiliarity with such policies, reports and strategies. For example, all participants were asked about their knowledge of Canada and Alberta's mental health policies, and only one participant could confidently comment on the strategic direction of the mental health system either federally or provincially. Interestingly, James is the only participant who is employed above the 'Clinical Supervisor' level of the AHS hierarchy, which may explain why he is more knowledgeable about the policies and strategies than the other participants. Most of the other comments about policy offered by participants simply reflected their opinions of the poor systemic outcomes that have been produced by the community care model and its policies, such as limited resources and a lack of services. There was no question that frontline workers are familiar with the policies for their respective job roles and what types of services they are required to provide, however the concern apparently stems from the frustration of the policies not allowing frontline workers to provide the level of care that clients may need.

McKenzie and Wharf (2010) explain that frontline workers often default to exercising discretion when putting policy into practice, and while this allows for frontline workers to adapt to the

often dynamic needs of clients, it can also lead to inconsistencies within the service delivery model. For example, the Mental Health Act limits the treatment that can be 'forced' on a patient to the minimum amount needed to provide care and the basic necessities of life; however for some frontline workers, this may mean that they feel the client needs to be physically coerced to attend to hygiene as part of the treatment (such as being physically placed in a shower by staff), while another clinician may leave the patient until he or she has the capacity to make decisions regarding hygiene (which for some patients can be weeks). There have been a number of instances when I was working on psychiatric units that I was required to physically hold patients in a shower while a nurse washed them, and in other cases we would be advocating to the nurse to physically make patients shower and they would refuse, stating there is no policy outlining where personal hygiene is part of the treatment plan. It is these types of discrepancies that lead to the need for discretion, but which also do not ensure consistent care for all patients.

Lack of Resources

The funding of community mental health services emerged as an ongoing theme throughout the interviews and surveys despite the fact that no direct questions were asked regarding the impact that funding has on the successful delivery of services. The inability of frontline mental health workers to offer high quality care to the mentally ill is, according to nearly all of the participants, solely based on the limited resources available for mental health services, programs, and resources. Despite the fact that the Alberta government allocated $753.8 million dollars in the 2010-2011 fiscal year on mental health and addictions programs, services, and initiatives (Wild et al., 2014), all of the participants who completed interviews expressed their frustrations when discussing how client care has diminished because funds are not adequately diverted to mental health.

According to Hayley, "community care provision needs more money/funding if it is to be successful. As it presently stands, mental health professionals in the community don't have the man-power, time, training or mandates to care effectively for those clients with serious and persistent mental illness". Despite the fact that Hayley's opinion and others like it may be reiterated across the frontlines of the mental health system, policy makers have habitually

disregarded these opinions and attitudes in favor of making decisions based on public opinion and fiscal guidelines (McKenzie & Wharf, 2010; Anderson, 2014). Mel reiterated Hayley's sentiment in discussing the limited resources available to effectively give clients the care they need:

> There just isn't enough [resources]. Any way you look at it, there just isn't enough, because there isn't enough money. So you can't expect a schizophrenic to hold down a full time job because they're not going to be able to. And then those are the people that end up living at the Mustard Seed or the Drop In Centre, which still isn't appropriate either, because they're not getting their medication and then they deteriorate and become another strain on the system or within the police and medical services. So there just isn't enough money for mental health.

Situations like the one Mel describes above are common for the mentally ill (Kirby & Keon, 2004; Wild et al., 2014); ideally, an individual with schizophrenia would present to the hospital and depending on the severity of his or her symptoms, may be admitted to the hospital for stabilization (which can take any amount of time from days to months). However, according to participants, given the current shortages of psychiatric beds available, many people are given a dose of medication and a prescription and are told to follow up with a clinic or with their family doctors, but they ultimately end up in shelters or jail. Yet contrary to the assertions of frontline mental health workers that the shortage of funding is continuous and is hindering the ability to offer quality care, the GAP-MAP report (Wild et al., 2014) for 2010-2011 states that approximately 80% of direct mental health service costs in Alberta were spent on Tier 3-5 services (such as inpatient, residential and crisis services), which are reserved for individuals who are more acutely ill (i.e. mood disorders, substance-related disorders, psychosis, schizophrenia, etc.). Importantly, acknowledging that these financial resources are invested in these care levels does not equate to adequate care and enough services to treat everyone who requires such intensive care. In fact, the necessity of diverting 80% of the resources to Tiers 3-5 illustrates the overwhelming need for these types of services and resources, and so frontline workers may not be exaggerating the shortages that they describe.

Participants did not only emphasize the lack of resources for the acutely ill, but also discussed how the lack of funding for mental health services in Alberta has had a detrimental effect on all areas of community care. A number of participants explained that even when a bed is available in the hospital for a client, once it is time to discharge that individual back into the community, a number of barriers then face the client in the form of housing shortages, program waitlists, and limited financial assistance. Katie explained the difficulty in finding appropriate and timely services for clients once they leave the hospital:

> [We need] places to refer to. And even if you have places to refer to, your waitlist times don't, um, don't match up with need. So it's great and dandy that you have these potential community services and that you make a referral and there's a 3-6 month waitlist and then your patch work-up for that is that you make a referral, say, from any emergency department to an emergency room outreach team, so they'll follow them in the interim but they get bogged down cause now everyone is having a referral to your service, so really you're just doing patchwork after patchwork after patchwork when you don't have enough supports out in the community for these people. And everything has a long waitlist. Everything.

Katie explained that while the outpatient and outreach programs may have at one time been able to sufficiently provide service to individuals requiring community follow-up, it seems that the needs of clients are not being matched with an increase in resources to provide adequate service. Thornicroft and Tansella (2002) assert that when the provision of day programs and outpatient services were decentralized and transferred from institutions to community-based care service providers, the functions became at risk of deterioration unless resources were directed into these types of services in the community setting. While these services were certainly developed within the community setting, the capacity for them to effectively and efficiently provide service for the increasing number of clients is diminishing (Kirby & Keon, 2004), a sentiment that echoes the comments that Katie offered above. The lack of these services and resources appears to be getting the attention of politicians and, hopefully, policy makers. In a TV interview with Global News, Alberta NDP health critic David Eggen referred to Alberta's mental health system as a "mess" and with respect to the overall delivery service

model, stated, "[this mess] just shows the depth to which our mental health system has not been properly organized" (Ramsay, 2014).

The Silos of Community Care

With the increased strain put on community resources in Alberta, a number of programs and agencies have redefined the criteria that a client must meet in order to be eligible for services. For example, some housing programs will only take individuals who have an Axis I diagnosis (i.e. schizophrenia, bipolar, psychosis) AND who have been homeless for more than two years. Other programs will only house individuals with chronic addictions issues as a harm reduction measure. A number of community treatment programs will not work with individuals who have been charged or convicted of certain crimes (i.e. assault, robbery, break and enter, etc.), while others will only take clients with those types of offences on their criminal record. While it would then seem that there are programs out there for each type of person, the reality is that many individuals meet some of the criteria of one program, and some criteria of another. Katie discussed the difficulty in navigating the criteria of programs and services in the community:

> Yes, every, so every team has its own kind of criteria, client criteria, so you can think that somebody would be appropriate for, say the Assertive Community Treatment (ACT) team or the Active Treatment Team (ATT) and then you make a referral but they don't actually meet their criteria, and really what you're talking about is the chronically acutely ill that don't actually fit the criteria for any of the existing community resources, so that's a roadblock because they don't fit anywhere. So then you have to start negotiating, "well I know they don't fit, but they don't fit anywhere else so who's going to take them?" Or having, say, chronically ill, older patients that are also verbally aggressive and need home care but are burning through their home care, their bridges. And so there's that. So then you can't, these are obviously challenging patients that are burning their own bridges or don't fit into a specific category. And so what do you do with them? Yet they're the most challenging ones.

Whereas hospital-based psychiatric units and the remaining institutions generally accommodate individuals presenting with any number of symptoms, illnesses, social concerns

and legal issues, the criteria set by the mandates of community programs and services allows for the disqualification of many individuals who require intensive and ongoing care (Goodwin, 1997). Ryan also spoke to the difficulties in navigating appropriate services for clients in the community:

> I'm not sure what we're supposed to do anymore. We'll have a guy who is so sick and who has crazy addictions issues, and you'd think there would be a ton of services available for him. So we call around to housing programs, but they won't take him because he once set a garbage can on fire and racked up fed [federal] charges for arson for that. So he's seen as some big pyromaniac danger when in fact he's homeless and wanted to make a fire on a cold night. Is that really a good reason to not work with someone? Absolutely not. Then we call another agency, and they're okay with the charges, but they don't work with people who have the mental illness he does. Like what are we supposed to do here? We just end up discharging him into homelessness at a shelter and tell him to try to connect to services. It's absurd.

Fortunately, the frustrations of frontline workers like Ryan are being heard at a government level; the report by Kirby and Keon (2004) to the Standing Senate Committee on Social Affairs, Science and Technology highlighted the inadequate services for individuals with mental illness and specifically touched on the concerns for the specific needs of individuals with concurrent disorders, the barriers to services for clients with dynamic needs, the lack of specialized services, and the existence of silos within the greater network of services and resources.

It appears that one response to these challenges has been to create various community programs with catch all mandates and less stringent criteria for access. Participants acknowledged that this was a move in the right direction, however, their collective concerns were that it has led to a duplication of services across several programs. For example, services like the Assertive Community Treatment team (ACT), the Corrections Transition Team (CTT), the Community Extension Team (CET), the Community Geographical Team (CGT) all have similar mandates in that they manage high-needs clients in the community. When an individual is on the caseload of one team, they are generally not able to work with another team, however clients are often moved among programs for various reasons. As Ryan explained,

> So you have a guy in jail and he's seen by CTT. Well, they're only transition, so they can't manage the person long-term in the community. So then the person goes to ACT 'cause he's high needs and no one else can take him. But oh look, he's transient so he takes off to Red Deer. Well, better refer him over to CGT who can follow him there. And it just goes on like that… Sure, um, it seems like it's good that the guy is being taken care of wherever he goes, but in reality he's been connected to three different programs, three different case managers, we're lucky if they communicate with each other, and nothing can get done effectively. Or they're all working on housing things for him and then the housing places never know who to contact for information and stuff. So it's definitely not the best set up. There are too many people doing too many of the same things and it creates confusion. And that's just AHS. That doesn't even include the other community agencies who have their own thing going on and who have all kinds of confidentiality barriers in place, so sometimes we can't even find out if we're duplicating services 'cause they won't tell us.

Goodwin (1997) asserts that the lack of coordination of mental health services has been a major impediment to delivering effective treatment for the mentally ill in the community and has ultimately led to the duplication of services dilemma that we see today. While each of the teams discussed above offer a slightly different specialty service, the reality in Ryan's comment is that most people fit the criteria of several of those programs, and so how each individual is connected to each service is inconsistent. James' discussion of this dilemma touches on these challenges:

> My hope is that, I think what I would like to do is try to coordinate resources better, cause I think there's a lot of duplication of services. I think that if we can coordinate and make a strategy much more like what you referred to as a continuum of care, um, I think we would do a lot better in helping people. We would be a lot more efficient in helping people. Which also includes having family doctors take over patients' care once they're stable. We are a limited resource. We have to recognize that. We can't keep just throwing money at it. That's not the answer. We can't keep hiring, that's not the answer either. Yet the population keeps growing, right, so we have to figure out a way that we can make less resources be more efficient with what we are. And part of that is we're

> just not talking to each other. Like when I took over this portfolio it dawned on me that in one clinic across in the northeast they have no clue what the clinic downtown is doing. Their policies, who they take, how they take them, like, there's no connection. And yet if a patient moved from there to the other clinic, like a different geographic zone, they get a completely different level of care. That isn't right either. So I can foresee us moving towards that. A little bit better integration of services, like some of what AHS is talking about is tearing down silos, so the way our system's developed, we've developed all these silos of care. Which once you're in the silo it's very good care. But if you've gotta jump between silos you're probably gonna crash and fall. And then the only catch net is emerge[ncy].

James' comments above were in response to questions about the future of the mental health system in Alberta, and what he thinks needs to be addressed. Other participants also addressed concerns regarding the coordination of services. As Krista said:

> I think it's gonna get worse before it gets better. That's really depressing to say, but I mean, it's almost going to have to take a bunch of frontline staff to like, organize their own thing. I think what our big crutch is right now, or our big roadblocks, huge roadblocks, is FOIP and HIA, because we can't communicate with other services, only within AHS and even then, only sometimes, and so we're 4 blocks away and I'll know of someone about Alpha House but I can't tell my co-workers here because Alpha House has their own confidentiality policy and we have our own, and so it's really unfortunate. Um, so once we deal with some way of having, that we can get consents from everyone who are vulnerable so we can kind of work together and case manage, that's the only way we're gonna make community mental health and addictions better. But until then, it's just gonna keep having gaps in service, and we're gonna keep implementing these programs that are supposed to deal with the gaps in service, that aren't gonna get, be quite equipped to deal with the gaps in service and so it's gonna continue until maybe we start an institution or create a new community model somehow.

Kirby and Keon (2004) addressed these concerns a decade ago in their report where they noted that the mental health system, both federally and provincially, is comprised of a complex array of unevenly distributed services that often operate in silos. They noted that most of these

services are disconnected and often duplicated, which is a challenge for both service providers and clients. The lack of coordination among services and the duplication of programming have undoubtedly left many chronic and acutely ill individuals with little ability to successfully navigate the system and connect to the appropriate resources. These systemic barriers have manifested what is one of the major challenges for both participants and professionals on all levels of the mental health system: the revolving door (Kirby and Keon, 2004).

The Revolving Door of Services

Goodwin (1997) states that there is a correlation between the lack of available community mental health supports and the tendency for re-admittance to psychiatric units, however he admits that the nature of this link is difficult to specify. Early studies following deinstitutionalization found that the only variable that consistently predicted readmission was the number of readmissions that an individual had already had (Rosenblatt & Mayer, 1974). More recent research indicates that readmission rates have continued to rise, with a tendency towards shorter yet more frequent patient admissions (Donnelly, 1992). Overall, most mental health researchers tend to agree that the changing nature of mental health policy has manifested a population of young, chronically ill individuals who are increasingly experiencing a 'revolving door' pattern of admission, discharge, relapse, readmission, discharge, and so on (Goodwin, 1997; Grob, 1994).

Nearly every participant I spoke with for this thesis touched on the concept of the revolving door within mental health services, social services, and justice system services in Alberta. A number of participants stated that human rights have played a role in the way that individuals access acute mental health services. Since the pendulum has swung away from a model of institutionalization in which human rights took a backseat to treatment as a primary concern (Grob, 1994) and towards a community care model based on autonomy and patient rights, mental health services have become largely voluntary. This model has benefited the majority of the mentally ill who are capable of making care decisions for themselves in consultation with the appropriate professionals. The chronic and acutely ill individuals, however, are often too sick to make informed decisions for themselves and occasionally need to be certified under the Alberta Mental Health Act, which then allows a psychiatrist or medical doctor to make

decisions on behalf of that individual. Some participants, however, were critical of the extent to which the policy underpinning the Alberta Mental Health Act assists in treating the individual. Megan emphasized the shortcomings of its provisions:

> Sure, it's nice that when these people are cycling through the system we can certify them as needed and force treatment, but that only works in the hospital. So what the policy is saying is that we can do what we need to do to stabilize them, but once they're fine, and I use that term loosely, we discharge them and can no longer make decisions about how to best care for them. So they go out into the community and stop taking their meds and deteriorate and then come back in again a few days or a few weeks or sometimes a few months later, and they're a mess again. So if we're saying that they are routinely incapable of making decisions for themselves and their mental well-being during their weekly crisis, why aren't we able to continue to say that when they're in the community? It's such a challenge, because then they become frequent fliers and burn their bridges because we aren't allowed to treat them unless they consent. We just chase our tails.

The American Psychiatric Association (APA) recognized this challenge almost immediately following deinstitutionalization. In 1982, the APA insisted that many people living in the community with mental illness were in need of compulsory treatment and were likely to deteriorate if no intervention was provided (Goodwin, 1997). Subsequent programs centered on involuntary outpatient treatment were developed, however human rights watchdogs were, and still are, skeptical of the benefits for ill individuals (Lamb, 1984; Grob & Goldman, 2006).

The frontline mental health workers who participated in this research acknowledged that human rights are necessary for protecting the vulnerable, however, they noted that this simply leads to a pattern of discharge and readmission for many people. Katie, for example, discussed how limiting the current measures are for managing revolving door clients in the community:

> The problem is that most community services are voluntary so we have CTOs[15] but those don't apply to everyone and there's specific criteria and even with a CTO you basically

[15] A Community Treatment Order (CTO) is a treatment and care plan that an individual is expected to comply with in the community. It usually dictates that the individual takes medications as prescribed and follows up with specific services in

> can't make somebody do anything. And you can, essentially, by using CPS, using another resource, bring them to emerge, get them medicated, potentially admitted, potentially discharged after an IM (intramuscular injection), whatever happens, but it's, it's a huge drain on resources so um, no, because they're voluntary they're pretty much impossible to treat effectively. So I think for the revolving clients, institutionalization is usually best if we can ensure that strict guidelines are in place for what's acute, what's chronic, and so on.

CTO's have become a significant component in the community model of mental health, and are intended to work as a contract for the individual. Generally speaking, the individual must consent to the CTO, and treatment cannot be forced under it. Katie's comments therefore suggest that a CTO may appear to be a good management tool for both practitioners and the individual, however if the individual is not compliant, there are few consequences. Ryan also spoke about the use of CTOs as tools for mitigating the revolving door problem:

> CTOs are a joke, honestly. The idea seemed to be good in theory because we're saying that someone has to follow through with their treatment. But what we're also saying is 'but if you don't, hey, whatever, we'll figure it out after'. I know people who are responsible for checking on clients with CTOs and they aren't even enforcing them. If they see a client who hasn't been taking their meds, they just try to talk to the person about it and then will go back a day or two later, or sometimes one or two weeks later, to try again. Well by that point the person has begun to deteriorate. And what if they don't comply? They go to the hospital to be checked out by a doc? Big deal. If they deteriorate, that's bound to happen anyways because they're the people that are always cycling through the system anyways. So would a CTO prolong it? Maybe a little. But it sure doesn't stop it.

It seems that participants are not the only ones who scrutinize CTOs. In 2012, the Mental Health Commission of Canada issued a position statement regarding CTOs, stating, "While community treatment orders may have utility with a small number of severe and persistently ill people, the potential for abuse, the lack of clear outcome evidence and the availability of less

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order to continue living in the community. For more information, see:
http://www.health.alberta.ca/newsroom/community-treatment-orders-MHA.html

coercive options would indicate that there should be a far greater priority in improving community resources than putting in place community treatment orders. Community treatment orders may be effective in some very specific circumstances but they must be introduced at the end of a continuum of other, demonstrably effective protocols and community supports that have already been put in place. This is not yet the case currently in Alberta or, to our knowledge, elsewhere in Canada." (Mental Health Commission of Canada, 2012, n.p.). CTOs may have their place in the spectrum of mental health services, however, participants suggested that they are not effective for managing chronically ill individuals who regularly cycle through the system. As Krista pointed out:

> So, and I do know that, like, the Sheldon Chumir Urgent Care had a list of the 100 most vulnerable in the city, so they were trying to allocate them services, but like, how do you find them, how do you sustain it, how do you keep them continued on their medication? So, that problem was supposed to go away with Community Treatment Orders, but Community Treatment Orders are practically like a restraining order. They're a piece of paper that says a whole bunch of stuff but really doesn't do anything, right? 'Cause they stop taking their meds, they disappear, they're transient, no one can find them, and there's no communication, cause we're not allowed to tell who, tell police who has a Community Treatment Order until police pick them up and call one of us, then we can say. But like, it really, there is very little communication when someone is on a Community Treatment Order, and so they find them like two weeks later, well they've been off their meds for two weeks already, so it's just...it's kind of depressing.

In discussing the revolving door of mental health services, another theme that emerged was the amount of justice system resources which are utilized by the chronically mentally ill. Since deinstitutionalization, research has long indicated that jails have become the new institutions for the mentally ill (Lamb & Weinberger, 1998; Prins, 2011; Stern, 2014). Participants reiterated this, noting how the persistently mentally ill are not only cycling through the medical system via emergency rooms and psychiatric wards, but also through remand centers and correctional institutions. As a clinician working for over a decade with forensic populations, Krista explained:

> Now that we've seen it (the cycling) in the community, we all know. Like most of the homeless people are ill and so in a way jail has become the new institution. And this is where they come and they get their dental dealt with, and on the mental health unit in remand, they do cooking classes, they do outreach, like, um, activities and daily living classes, they do counseling classes, they do all kinds of little classes. So jail really is the new institution. And they treat them very well, and they, some of them thrive in there. Which is really unfortunate, cause then they get a record and then come out here and they can't get housing because they have a record, so...maybe eventually all of them will land in jail and we can just take care of them in jail.

Some participants echoed Krista's sentiments that it is unfortunate that jails are housing the mentally ill but at least there are programs and resources being put in place to offer services to these individuals while they are incarcerated. For example, Chelsea stated:

> Jails aren't ideal because they are generally meant to punish people, or at least control people. And so when our guys are in there, sure they're getting their meds most of the time and three meals a day and stuff, but they're still ultimately being punished for being mentally ill. They're in there because they didn't show up for court and got a failure to appear breach charge for a mischief charge from last year. Lots of these guys get these petty charges and then don't remember when court is and then they get breached, so they're constantly in and out of jail. Sure they might get some help while they're in, but we all know they're gonna be back out without those services, so then what do they do?

Despite the fact that the media tends to sensationalize high-profile crimes that involve a mentally ill perpetrator, many of the mentally ill individuals occupying jails are there for a variety of less serious offences, such as thefts, nuisance charges, fines, and drug-related charges (White et al., 2006). Eva touched on this in her responses to questions about the current challenges of community care:

> We see so many clients that are self-medicating with drugs and alcohol. So many. And so what happens? They can't maintain their housing, so they lose that and have to go stay at the D.I. (Drop-In Centre) or The Mustard Seed or whatever shelter, and it isn't long before they realize they need money for food or more drugs or whatever. So they go out and steal stuff and ride the C-Train and get busted for fare evasion and possession

> of stolen property. Obviously we can't just say 'oh he's mentally ill so just forgive that behaviour', but do we really need to remand him for 60 days for that? It then costs the system money. I would rather use my tax money to just give the guy a free transit pass. This in-and-out of jail situation is a total drain on resources.

What seemed to be most defeating for participants was that this revolving door epidemic does not need to continue.

Concerns over the increasing number of incarcerated individuals with mental health problems were voiced to governments within a decade of deinstitutionalization policies being implemented (Goodwin, 1997). The failure of policy makers and governments to appropriately respond to these concerns has resulted in a current system of transinstitutionalization in which the mentally ill have simply been displaced from one institution to another. The potential solution to this predicament is to re-open institutions that are actually meant to treat the mentally ill rather than warehouse them while their legal matters are addressed. This controversial suggestion will be discussed further in the next data chapter.

Jamie: A Case Study in Systemic Shortcomings

To highlight some of the challenges within the larger mental health system that participants have voiced, we can consider the challenges in treating a client named Jamie:[16]

Jamie is 28 years old and is currently homeless with few family supports. He has been in and out of psychiatric units and jail over the past 15 years. He has been diagnosed with schizoaffective disorder[17] and psychiatrists have queried whether or not his level of functioning is somewhere along the autism spectrum. Additionally, he self-medicates with crystal methamphetamine, crack, alcohol and other drugs. He routinely gets into trouble with the law because he is impulsive and winds up breaching his conditions, assaulting people, and not following through with mandated treatment. The number of agencies involved in Jamie's care is complex. He was previously connected to a program tasked with managing the most sick

[16] The client's name and details have been changed to protect his privacy and confidentiality.

[17] Schizoaffective disorder is a condition in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms, such as mania or depression.

and difficult clients. However the last time that Jamie wound up in jail, it was decided that he no longer fit the program because he is in trouble with the law too frequently. He had also been on a Community Treatment Order (CTO) but it was not renewed and therefore it expired, making Jamie no longer responsible for adhering to treatment in the community. While incarcerated he was connected to another program in order to find him housing, help him access mental health services, and ensure he is staying clean in the community. This is a short-term transition program, and for a client like Jamie, he would ultimately be connected back to the first program; however, this program will no longer work with him. His legal aid lawyer, who works primarily with homeless clients, has been attempting to help him apply for housing and other programs. A former social worker of Jamie's has applied for him to be housed in a longer-term type of institutional care that focuses on clients that have a dual diagnosis (mental health and an addiction). Jamie, however, attended this facility but was asked to leave upon intake after his urinalysis was positive for drugs. Jamie has also been referred to a long-term justice program, which offers probation services along with mental health and addictions supports. This program will follow him in the community for the duration of his probation sentence, after which it is unknown what service will work with him next and ensure that he is being treated appropriately in the community. Furthermore, no single program or individual is coordinating his care.

Jamie's story is a stark illustration of the difficulties involved in treating the severely and persistently ill in the community; yet Jamie's story is not unique in that there are many clients who face the same challenges. Coordinating services for clients like him is not only challenging because of the number of agencies involved, but it often requires a number of consent forms to be filled out by the client, and so each time that a new program or agency needs to be contacted, the client needs to consent. This is difficult for clients who are transient and homeless and are not immediately accessible to sign these forms. Additionally, a large number of these clients experience paranoia and distrust of people they feel are interfering or trying to control them, so they may not always be willing to sign the consent forms regardless. Jamie's story not only offers some insight into the difficulty in coordinating community services for acutely ill clients, but also confirms what participants have stated about the overall mental

health system: that services are fragmented into silos; there are not adequate and appropriate services available for clients who are severely and acutely ill; and clients ultimately become caught in the revolving door of services.

Summary

Participants offered a perspective on the mental health system that could best be described as pessimistic. According to the comments offered in this chapter, the overarching opinions of participants indicate that the systemic fragmentation that followed deinstitutionalization has continued to plague the community-based mental health model. In some instances, there are gaps in services, while in others there is a duplication of services. In both cases, it is having a detrimental effect on the severely ill clients as frontline workers struggle to offer the best care possible in a piecemeal fashion using the resources available. Unfortunately, clients still appear to be falling through the cracks which is leading to their cycling through various services and systems (medical, justice and social), and these challenges will be discussed further in the next chapter.

CHAPTER FIVE: IMPROVING THE PROGNOSIS: PROVIDING MENTAL HEALTH SERVICES ON THE MICRO LEVEL

> "For those needing assistance, the current system can feel like a maze, as it can to the thousands of dedicated people who provide the services, treatments and supports that people need. Unfortunately, there is no simple formula for creating a system that is truly integrated around people's needs and draws fully on their strengths"
>
> -Changing Directions, Changing Lives: The Mental Health Strategy for Canada (Mental Health Commission of Canada, 2012, p.52)

Introduction

Frontline mental health workers, and professionals on other levels for that matter, are responsible for providing services and treatments to individuals in a variety of settings and circumstances. The interactions that occur on a daily basis between service providers and those needing assistance are the foundation of mental health care. Mental illnesses are generally attributed to the pathologies of the individuals who experience them and therefore frontline workers are tasked with offering treatment at the individual level on a case-by-case basis. With this role comes the realization that frontline workers face unique and often challenging circumstances in their efforts to provide mental health treatment. The macro-level obstacles discussed by participants in the previous chapter compound these challenges. This chapter aims to capture the experiences and opinions of frontline mental health workers specifically in relation to the one-to-one care that they provide for individuals suffering from mental illness.

The Revolving Door of Resources

The majority of mentally ill individuals who have been previously institutionalized have been able to adjust to being cared for through community-based mental health services (Grob, 1994). Some still require intermittent inpatient stays on hospital psychiatric units, however most of these clients can be discharged within 30 days of first being admitted (Alberta Health

Services, 2011). Other clients, such as individuals who have not experienced institutionalization for mental health treatment, have not known any other system except that which is presently in place. For both of these previously institutionalized and never institutionalized client populations, as well as individuals who are experiencing their first contact with the mental health system, community-based services have provided some adequate support both during crises and for longer-term care. There is, however, a specific population within mental health whose acuity is severe and persistent and it is these individuals that the current mental health system is seemingly unable to adequately treat. Although there is no national database on mental health in Canada that can offer accurate prevalence rates on mental illness, it is estimated that these individuals make up less than 10% of the mentally ill population (Wild et al., 2014), however, their needs are often exponentially higher than others and therefore they tend to utilize more services and resources than the rest of the population (Kirby & Keon, 2004). These individuals typically have Axis I disorders such as schizophrenia, psychosis or bipolar disorder, all of which are generally the most difficult to diagnose, treat, and manage. Furthermore, over 50% of these individuals have concurrent addictions issues and an even higher number of them have had contact with the criminal justice system, all of which makes them considerably more difficult to treat (Canadian Mental Health Association, 2013).

When asked how the current mental health system is working for this concurrent-needs population in the community, James replied:

> I don't think it's doing well at all. It's extremely expensive, I mean you've talked to PACT[18] so you know the frontline, we see the same people getting kicked out of emerge or inpatient units barely stabilized, discharged, they just need much more than even the super assertive community treatment team that we've put in place. Um, granted, it's not a large population, but you know talking to PACT I think, I have no stats to back this up, but I wouldn't be surprised if I can name off 10 people off the top of my head that would be utilizing at least a million dollars worth of resources a year each. If you collect the EMS, the medical systems and so on, that's definitely a lot of resources and we're not even really helping those people at all. I mean we have a couple now, but it's still early,

[18] The Police and Crisis Team (PACT) pairs a mental health clinician with a police officer, and this team responds to crisis calls involving individuals with mental health issues.

> that we're following or I'm following with PACT and CTOs and we're clamping down really hard and it's keeping them out of emerge. Are they doing as well as they could be? Probably not. But they're housed and off the streets and not in hospital and not in jail, so yeah.

The majority of participants offered similar commentary with respect to the overwhelming amount of resources that this particular population utilizes. There seemed to be a consensus among frontline workers that a small proportion of the mentally ill are so acutely ill that they consistently use more resources than the rest who require low to moderate access to services. According to Matt:

> The difficulty is that there's that small population that use, just like the rest of medicine, 10% of the population uses 90% of the resources. Well mental health is the same, I mean, it's probably even more so, like 10% of the mental health population uses probably 99% of the resources, mental health and otherwise. And those are expensive resources, so how can we do that better would be more the question.

The participants in this study work mainly within health specialties, and so the resources that they speak of are often referring to those provided by Alberta Health Services, with funding going toward psychiatric units, outpatient clinics, and community mental health teams. However, because most of these clients are considered complex based on their diagnoses, addictions and support needs, their mental health problems are compounded by social and legal issues which then take up even more resources. Speaking from a medical standpoint, Hayley states:

> The demand for hospital beds can often mean that acutely ill individuals are not admitted because of chronic 'bed blockers' who lack appropriate long term care or placement. For example, too few programs meet the ever-increasing demand of the chronically mentally ill, especially because community care generally only works on a Monday to Friday office hours basis.

Because there are not enough resources and supports in place for the chronically ill, they tend to be admitted to hospital units, which subsequently reduces the availability of resources for others that the units are actually meant to be serving. Participants were asked about the

adequacy of the resources within the community for mentally ill individuals with varying acuity levels. Michelle explained that although most of the resources available are for individuals who are not chronically or severely ill, frontline workers are still utilizing what services they can to provide care for that population:

> I think we actually do have that [appropriate care] depending on what stage of your illness you're in, but again, so within a person there's gonna be that spectrum and I think in general we do pretty good. But I think that the part that you're talking about and the part that I'm talking about is that there's this group of people that for whatever reason are just so on the far end of the spectrum that we're not structured to help them. That's more the case. Like 90% of the mentally ill, we're giving them pretty high end treatment. You know, whether it's in a family doctor's office or in shared care or in clinics, it's pretty good care I think overall. Unfortunately when you get to certain extremes, that's where a lot of our resources are limited.

While most participants are speaking directly to the resources being utilized from a health care perspective, Gail, who works with the homeless in a non-profit capacity, offered commentary on the social resources being utilized in the community by the chronically mentally ill:

> We took on some money as an agency from the Homeless Foundation to look at housing 50 of the most difficult, hard to house people, right? So when you say hard to house, it's, they've been in a shelter for more than a year. And there's a certain acuity level that they fall into, and we're having a really tough time. There's a lot of people that you can't force compliance on and if you choose to put them in housing, how do you then deal with all of the problems that happen? It becomes an expense to the agency when somebody trashes the apartment, when they start making threats to other residents. It's okay maybe if you own the building, but if you're subletting or leasing from another landlord, you have to incur the costs for the damage. It gets very complex.

The result for the medical, social, and legal systems when many chronically ill individuals access services and resources so frequently, although with little success, is that they become a burden and ultimately 'burn their bridges' within the already limited mental health system. Psychiatric units will not admit them, housing programs will not house them, community treatment programs struggle to assist them and other agencies simply refuse to even attempt

to help them with simple things like giving them clothing or meals. The notion of these persistently ill individuals burning their bridges was perhaps the most common theme identified through both the interviews and surveys. Nearly every participant discussed how these individuals, who ultimately require wrap-around resources[19] and services for them to sufficiently function in the community, are generally so ill that most frontline staff are not equipped to properly assist them and so the service agencies will simply refuse to help. The main reasons that individuals burn their bridges are because they refuse medication; they are often extremely aggressive and violent; they have criminal histories that exclude them from the criteria necessary for a given service to work with them; they are transient; and they cycle through the legal system so frequently that they cannot be appropriately monitored. When asked about how to best treat these individuals, Ryan insisted:

> They need some sort of high intensity, assertive community care, and a lot of these guys, the other problem is that they've burned so many bridges, right? People don't want to deal with them anymore. It's a headache dealing with some of these guys. They don't want the help, they yell at you, they threaten you, there's very few people that are willing to work with them.

One such example is Kenny[20], a well-known individual in Calgary's mental health system. He is a middle-aged man with a lengthy history of chronic and severe mental health issues, addictions, aggression and violence and criminal activity. Kenny was specifically mentioned by five of the six participants who completed an interview for this research, mainly because he so easily serves as the 'poster child' of the types of individuals who are severely ill but for whom there are limited resources. For example, here are just a few comments made about the difficulty of trying to treat him in the community:

> "Like, everyone knows Kenny. We know him in addictions, we know him in mental health, we know him in corrections, we know him in forensics, we know him inpatient, we know him in outpatient psych."

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[19] Wraparound services are intensive and individualized and are intended to provide everything an individual needs to be successful in the community. In this case, these services would include supportive housing, a case manager, ongoing mental health support, financial assistance, etc.

[20] This individual's name has been changed to protect his privacy.

> "And even in jail, he's only there for fines usually, so he's there for like 3 weeks, we get him back on track, he goes back out, smokes crack, he gets agitated, hits someone and he's back again for a few weeks. So unfortunate. And like how many times has that guy been beat up, or, you know, beat up other people? Who knows."
>
> "Yeah Kenny is, my guess with Kenny, a guy like Kenny, you wait until he's incompetent and then you can place him. But you're right, he's a good example of people who don't wanna work them anymore. They patch him up in hospital and discharge him right away, for what? So that he can get sick and call 911 or have someone call 911 on him in a couple days? We patch him up and discharge him and he'll be right back to where he is. We just don't have the resources in the community."
>
> "And that small population is using up so much resources because we're just kind of scrambling after them, like the Kenny's. Well if Kenny was somewhere that he didn't require as much resources and he was cared for and he was taken care of it would help on both sides from my perspective. Kenny gets care which frees up the rest of the system. He's not taking anymore."

This is a major concern within the mental health system because there are a number of teams that have been developed specifically to deal with individuals like Kenny. For example, the Police and Crisis Team (PACT) responds to emergency situations involving the mentally ill, and they generally treat and attempt to manage the most chronically and severely ill. The Assertive Community Treatment (ACT) team was developed to treat the same population, who are almost always treatment-resistant, mainly because of non-compliance (i.e. refusing medication, inability or unwillingness to attend appointments, and so on). The Community Extension Team (CET) offers support to mentally ill individuals once they are released from psychiatric units so that they can be closely monitored in the community. There are a number of other teams who offer similar services for this difficult to manage population, however, participants stated that the chronically ill individuals have burned their bridges with these very teams that were designed as a last resort to help them, and therefore there are no other resources available.

Compassion Fatigue

A consequence of the burdensome negative effects that the chronically ill have on frontline mental health workers is that frontline workers eventually experience compassion fatigue. Defined as the emotional and physical 'cost of caring' that workers experience over time when working in certain fields (Figley, 1982), compassion fatigue is particularly prominent within the mental health field. As previously mentioned, the majority of individuals who present with mental health issues also tend to face a number of other social and legal issues that complicate their cases further. Frontline workers who are tasked with assisting these individuals will then experience an erosion of their own ability to consistently be compassionate, empathetic, and optimistic. The small population of the persistently mentally ill are generally impoverished, low functioning, aggressive, and quite simply, frustrating. It then becomes easy to adopt the mentality that 'nothing is going to change' or 'there's no point in trying to help him' when you are constantly working with the same individuals who refuse your help, assault you, and who have a long history of cycling through the various services and resources. For individuals like Kenny, there is little tolerance left for them and their behaviour among programs and services; despite the fact that they often require the most help and compassion, few mental health workers are willing to offer it given the history of certain individuals. Kristen identified the mentally ill population itself as a major factor in the development of compassion fatigue:

> You know the worst part about it? I think it actually creates more compassion fatigue and staff fatigue because when they're out in the community, there's not a single security staff around, so there's no help, and so they get kicked, they get punched, they get verbally abused, and so on. How can we be expected to try to help these people when our resources suck and these guys don't want our help?

When discussing the impact that the current system has on frontline workers, all of the participants who completed interviews eventually arrived at a point where they acknowledged that their own levels of compassion fatigue eroded their attitudes towards their clients, co-workers, and the overall mental health and social systems that they work within. For example, in discussing her frustrations with the current system, Tracy identified both systemic and

individual client issues as reasons for her current attitudes and opinions of the community-care model:

> We don't have the resources in the community and so we have, you know, a bunch of the same people coming through needing services but what do we do for them? We usually just stabilize them and try to refer them somewhere else. Like there are guys like Kenny who no one wants to work with anymore. The [psychiatric] unit staff [in hospital] don't mind taking him 'cause they have security and treatment orders and whatever else they need to control him. But the rest of us don't have that luxury. So when we can we try to get him admitted to hospital, but other times all we can do is offer him meds and hope he'll take them. And I guess it sounds like we're pawning him off, and maybe we are, but what else are we supposed to do? There aren't resources for him or anyone else like him.

The situation that Tracy is referring to appears all too common on the frontlines of these frontline workers' experiences with caring for the mentally ill health. Working within a fragmented system with clients who are difficult to manage seems to result in a major depletion of both the willingness, and ability, to offer the level of care that is mandated by organizations such as Alberta Health Services. James offered a similar account of the frustrations that workers like him feel:

> I mean one of the struggles is that, you know, as a frontline worker, there's so much energy in trying to stabilize a person, and once they're stable, there's a natural human tendency to want to keep that person well. But, which isn't a bad thing. The problem is if you do that then you can't take the next person that needs your help, and it's draining. It gets constantly tough moving through these people, but that's what we need to do 'cause the population's grown so much. Um, you know, we're limiting service because we're limited to the amount of funding that the government gives you. Perhaps if it was connected to the population then it might be easier, but, you know, as an example, I was looking at the demographics recently and for Calgary alone, it's increasing in population by 30,000 people a year, and so 30,000 more people are entering the city. If we look at general statistics, probably 1% of them are mentally ill to the point of requiring some sort of help, so that's 3,000 people entering our acute mental health services a year in

> addition to the people we already have. We don't have those kinds of resources ready for them. So how do we deal with that? It just wears you down.

There seemed to be undertones of pessimism for the future of mental health in Alberta by the participants, which may be influenced by the levels of compassion fatigue that frontline workers experience. What can reasonably be expected from workers in terms of their ability to give care and not become frustrated when they deal with the same individuals on a daily basis? While the ideology may be for all workers, frontline or otherwise, to treat all mentally ill individuals with compassion, dignity and respect, the reality is that the complexity of mental health issues is increasing, the number of mentally ill individuals is increasing, at the same time the amount of resources is decreasing. The notion of having to do more with less is a very real challenge for frontline mental health workers, and unfortunately, when they experience compassion fatigue, it is the mentally ill population who also suffer.

Quality of Life in the Community

Since moving towards community care from the period of the asylum, the lives of many previously institutionalized individuals have improved; they have been able to reintegrate into society, access appropriate supports, and lead fulfilling lives (Grob, 1994). However, with respect to the small, chronically and severely ill population that has been frequently referenced throughout this research, their adaptation to the community mental health model has been less than successful according to participants in this study.

Despite the fact that nearly all frontline mental health workers experience compassion fatigue at some point in their careers, many of them realize that it is their frustrations with the overall system that cause them to take those frustrations out in their dealings with clients. It is not uncommon to hear someone comment about how frustrating or annoying a client is, but in the same breath recognize that the client did not ask to be that way. It can be difficult to remember that most of these clients may come from dysfunctional families, and/or may be genetically loaded and predisposed to mental illness and not exactly given a good start in life. Although no direct questions were asked about participants' perceptions of these challenges

faced by the severely ill population, nearly every participant mentioned the effects that the community care model has had on the quality of life for the mentally ill.

Gail, for example, who has worked in a number of roles within the non-profit system, currently works with the homeless. When discussing the current issues faced by the clients she sees, she had a considerable amount to say:

> Traditionally the burden fell on the family and community to take care of someone with a mental illness but back then I think the acuity was a bit different. But now you have people who don't have the time, resources or ability to do that. People are just not equipped to do it and so who will? And so many people that have a mental illness come from families where there's poverty, addiction and mental health [issues] already, and so asking a population like that to then take care of another family member with the same issues is just unreasonable. They can't help themselves, so how can they help others? They don't always have those connections because their family members are in jail, in hospital, and so on. It's very generational.

According to participants, being born into dysfunction is the first major barrier that the mentally ill experience. As Gail explained, family members were once responsible for the care of their mentally ill family members. Today, however, it has become far too difficult for most families. And in many of the cases of the sickest individuals, it may have been their family dysfunction that manifested the mental illness in the first place, and therefore it is unacceptable to assume that family networks are in place for people that need them. The result is that most of the severely mentally ill have become homeless.

Housing for all populations, mentally ill or not, is generally limited; market rents are extremely high and there is often a shortage, and so finding housing for vulnerable populations like the mentally ill is an even bigger challenge. A number of cities have adopted "housing first" models, which essentially suggests that if individuals have housing, the rest of the needs in their lives will more easily be met. Unfortunately, these models have not been successfully implemented due to limited housing resources, availability of other necessary services, and a number of other factors. Gail, who has worked with the homeless and vulnerable populations for nearly three decades, insists that these models have a number of shortcomings:

> So you have housing first programs that were adopted. There was a fellow in the US who worked under George Bush who was his housing guru, and he had this idea based on the housing first model out of New York that all states and the provinces in Canada could adopt this and we could eliminate poverty and homelessness throughout the US and Canada. And there were a lot of people that bought into it. They developed plans and there were action committees that were formed and foundations where municipal governments took it on. And on paper it looks great, but in reality there's a lot of problems that are attached to it and there's a tremendous amount of money, billions of dollars that have probably been spent in the first 6 years. And they claim that there's been between 4000-5000 people that have been placed, but I don't know if they've come from shelters. 'Cause I've often said, 'well who are these people? And are they, were they truly homeless or did they, were they on waiting lists for subsidized housing? Were they couch surfing? Like, can you prove that they came from shelters?' And there's not been a lot of research after the fact to back up their findings. So, while I think housing, everybody should deserve housing, but there's different types of housing for different types of people. I think that there's a recognition that we need to revisit the plan and we are doing that.

While many people would agree that a housing first model is an initiative that should be implemented, Gail's suggestion that additional research is required on the outcomes for the individuals being placed is an important one. Whether severely mentally ill individuals are housed in their own apartments or staying in shelters, there are still concerns around the management of their illnesses. For an individual who is a paranoid schizophrenic, he or she may become secluded at home unless there are family members or agency workers checking on the welfare of that person, he or she is susceptible to severe deterioration. For example, some individuals with this form of schizophrenia may barricade themselves into their apartments, not even willing to leave for food or other necessities; they would rather stay hidden and unknowingly succumb to their mental illness than risk leaving. Housing first models therefore must consider what kinds of supports need to be put in place for homeless individuals who have severe mental illnesses.

In other instances, some homeless individuals have simply lived in shelters or have slept rough (in tents or makeshift camps) for long enough that they do not adjust to being housed. Many housing programs that attempt to provide resources for the 'hard to house' chronically mentally ill have a number of strict guidelines that are difficult for some of these individuals to adhere to, such as curfews, visitation rules, structured meal times, and so on. Kristen, who has considerable experience working in community mental health, described her frustration with the various housing first programs:

> There's the ten-year plan to stop homelessness. Well, how are we supposed to stop homelessness when 30 years ago we threw all of the mentally ill onto the streets and said 'fend for yourselves'? They've burnt all their bridges so now they're homeless. They're accustomed to being homeless. You can't put someone who is used to not having four walls and no structure and no, like, responsibilities, into a house with four walls and give them a case manager that might visit them once a week that goes "Hi, and are you okay?" And if it's a brand new nurse that doesn't know how to engage, it becomes, "Oh well this is my half hour that I get to visit you, and by the way you're not allowed friends over, you're not allowed this over, you're not allowed that over, and then they suicide and then we're like ohhhh, why did the system fail?" It's so bad, housing the homeless is just such a stupid battle...we keep talking about making their needs come first but maybe they don't wanna be housed and now we can't really blame them.

What Kristen is describing is a common occurrence and one which financial resources simply cannot fix; many mentally ill individuals do not want to live somewhere that is overly structured, despite the fact that structure could potentially benefit them the most. However if they have adjusted to being transient and doing what they want, it becomes difficult to then take these people and put them in housing and expect them to immediately have a better quality of life.

Another factor that reduces a severely mentally ill individuals' quality of life, under the community-based model, is the potential for victimization; some individuals deteriorate so badly that they end up harming others, while others are at extremely high risk of being victimized themselves. For example, prostitution is quite prevalent among the mentally ill population, particularly those individuals who have concurrent addictions issues. As Katie points out:

> I've met a couple of clients who are quite young but persistently unwell, and who put themselves at risk because of impulsive behaviours and because they're just unwell and paranoid and a whole bunch of stuff. And we have girls that will prostitute themselves consistently and if they were in their right mindset wouldn't do it otherwise, so they're putting themselves at risk to be assaulted in many ways, and the STI's and a whole bunch of stuff, so...

It is not uncommon for mentally ill females to become involved in prostitution, particularly those with concurrent addictions issues. The limited availability of social supports, coupled with a high level of vulnerability makes mentally ill women and girls more easily susceptible to becoming entrenched in a high-risk lifestyle filled with substance abuse, violence, sexual assaults, unplanned pregnancies, and other varying degrees and types of victimization. And because these women and girls are often acutely ill and under the influence of a number of substances, their ability to seek out assistance is generally limited. Trish asserted that if there were appropriate community services available, "...they wouldn't be deteriorating and living on the street and doing sex trade and being raped and vulnerable just for their addiction."

Men, however, are equally susceptible to victimization when they are homeless, mentally ill, and have addictions issues. More often the victims of assaults, bullying, and other forms of violence, men are also vulnerable and at risk for victimization. Mel explained why the combination of mental illness, addictions and homelessness reduces the quality of life for many individuals:

> But, um, the very chronically acutely ill I think it does them a disservice. They're actually more at risk to themselves out in the community. Very often they're the homeless person that is at risk to be hurt by other people because they're not in, their mind is playing tricks on them, they're paranoid, they're out in the community without any support and they're homeless and they can't even function. And we all know that the stress, stress really affects somebody's mental health whether you're well or not. And if you're unwell it really does do a number, and so those people should have the right to be housed appropriately and to have all their basic rights, human rights, met. Which is housing and access to everything else and an environment which is less stressful than being out in a shelter or homeless on the street.

Similar sentiments were expressed by other participants concerning the vulnerability of the homeless mentally ill, which has a direct impact on the quality of life these individuals experience. Particularly, the notions of dignity, humane treatment, and inclusion were discussed. James, for example, described how deinstitutionalization has affected the well-being of the mentally ill:

> ...in my experience, what I've seen is that deinstitutionalization, that's exactly what it's done. It's taken away peoples' dignity. As ironic as that sounds, when we release them into the community and we hide them in these houses, we've taken away their dignity. They can't work, we just give them AISH and tell them you're so sick you can't ever work or do anything, and then they're sitting there and they can't even take care of themselves or their homes and they're living in squalor and their hygiene and nutrition, they're not equipped to take care of. So as ironic as it is, deinstitutionalization has taken away their dignity...

The idea of institutionalization of the mentally ill was a major issue of contention among human rights activists and policy makers, and during the periods of asylums where conditions were poor, it is understandable that confinement was considered inhumane. What participants like James point out is that there is an equal, if not greater, amount of inhumane treatment that is present in community mental health care. And while this may not have been expected when the shift towards deinstitutionalization began, the outcome has been such that the mentally ill, particularly the severely and persistently ill, are experiencing a quality of life that has not been any better in the community. Proponents of deinstitutionalization have long insisted that autonomy is directly correlated with quality of life, however, the current conditions that the mentally ill are forced to live in under the community care model is an illustration of the poor quality of life that many individuals are experiencing. A common theme among participants was how quality of life is diminished for the mentally ill because of exclusion from the rest of society and the community.

The stigma of mental health has been an ongoing challenge for both the mentally ill and mental health professionals. Unless someone has direct experience with mental health, either as a sufferer, support person, or professional working in the field, the public appears to have little

knowledge about mental health in general. Gail discussed how the majority of people tend to have a skewed image of the mentally ill:

> People live in this fantasy world. They watch too many movies like "One Flew Over the Cuckoos Nest", and think everybody is like Jack Nicholson, crazy, and 'here's Johnny' a million times over. And it's, you know, there's so much more we could do better by these people and they're human beings. And yes, they have severe mental illness, but they need to be treated with dignity and respect and we need to be able to identify worthwhile things that include them, that empower them, and build their self-esteem. We need to look at how we can make their lives a lot more comfortable and inviting and productive.

Unfortunately, the media and entertainment industries have created unrealistic perceptions of the mentally ill and therefore the general public's attitude towards this population is generally negative (Grob, 1995; Grob and Goldman, 2006; Mental Health Commission of Canada, 2008). This ultimately diminishes the quality of life that the mentally ill can experience as they are often viewed as dangerous, burdensome, or just simply a nuisance. Megan spoke to the feelings of the clients she works with in the community when asked about what she sees as a major detriment to their level of inclusion in society:

> What they report most is loneliness. They have no one. Absolutely no one. And all they want is someone that cares that they can talk to. People that have been disruptive in the past, you pay attention to them, you give them your time and the behaviours dissipate. So it speaks to then a different type of community that cares. It speaks to inclusivity. It speaks to maybe providing more programs that help them to feel a part of a community, because their reality is that nobody wants them in their community. Nobody. We have something that everybody talks about and that's NIMBY-ism[21], and as long as the community will be up in arms about day cares and hospices for the dying or it doesn't matter what it is, but God help you if you want to put low income housing in somebody's neighbourhood. You are going to have people that will fight you tooth and nail because they don't get it and they don't understand and they don't want to understand. It's so

[21] NIMBYism refers to the Not-In-My-Backyard syndrome "which undermines the public support for the transitional and supportive housing important to a wide variety of needy groups" (Travis, 2005, p.242).

> sad to see people that are so selfish and just feel that there is a segment of our society that should be excluded. And I think they would honestly prefer for them to be sent off to some island with a barbed wire fence and just left to be cared for. It's kind of like when there was an AIDS epidemic in Africa. There were sites that were created for people that had AIDS and it was horrible, absolutely horrible. And yet we live in a civilized society where you'd think that there would be an element of people that care and should care but that doesn't happen. So we'll never, you know unless people's attitudes change, we're not going to move very far in the path to happiness.

Megan spent a significant amount of time discussing the disconnect between the attitudes and actions of the lay public when it comes to policies and practices around mental health and the homeless. For example, the attitudes of Canadians when it comes to punitivity indicate that we live in a society that values rehabilitation and reintegration for offenders. However, when it comes to the placement of halfway houses and other social programs for that population, most people maintain a NIMBYism mentality and subsequently fight against having those resources set up in their communities (Travis, 2005). Now, with the sensationalization of many high-profile crimes committed by mentally ill individuals, it appears that the public views the mentally ill increasingly negatively and so many communities do not support the establishment of mental health resources in their areas either. This ostracizes the mentally ill from certain communities and subsequently social settings, which does little to give them a sense of belonging. Gail also touched on this issue, explaining how members of particular communities react to the actions of her clients:

> I deal with it every day. We want to try to keep the bad guys out and we try to get the support of police and police get yelled and screamed at by neighborhoods when you get displacement of people moving into their neighborhoods and they get upset when someone goes through their garbage looking for cans. It's never ending. And yes there are some behaviours that are not particularly in line with good social behaviours, but they have something wrong with them, so I don't know people are expecting... And that happened during the flooding where we were displaced... we have a hotel that's sitting on Edmonton Trail and McKnight so we had upwards of probably 800-900 people sleeping in that hotel for 4 or 5 days. You can't contain people, so there were people

> that were mentally ill and mentally challenged that were wandering in the neighbourhood. People were just freaking out because they don't understand. They've never seen somebody talking to themselves or acting bizarre. Um, so it speaks to a level of peoples' fear of the unknown and their lack of understanding.

When the mentally ill are forced to try to integrate into a society that does not accept or understand them, they will inevitably be limited to certain areas or communities where they feel some degree of acceptance and safety. In Calgary, they are generally found in the downtown core, drifting between shelters and green spaces. Because of the limited space and resources for the mentally ill, coupled with the lack of acceptance by greater society, much of the mentally ill population tend to isolate themselves and self-medicate with street drugs, which often exacerbates their symptoms and behaviours. Having a severe mental illness, combined with the often-unpredictable side effects of street drugs, results in many individuals ending up either in the hospital or in jail.

Addictions and mental health were at one time two separate fields with their own diagnostic and treatment models, however, a number of studies on the concurrence of mental health and addictions suggested that the two are more closely related than previously thought (Rush et al., 2008; Kessler et al., 1996). For example, Garfinkel (2009) stated that "the likelihood of having a substance use disorder was four times higher for those with schizophrenia than for the population at large, and those with bipolar disorder were five times more likely to develop these problems" (n.p.). The outcome of such research findings was the movement towards integration of addictions and mental health into one concurrent-capable system in which diagnoses, treatment and management of either or both issues could be effectively managed together. Although most working professionals in either field would agree that addictions and mental health belong under one umbrella of care, there is ongoing concern for mentally ill individuals in the community who are inadequately cared for and who have severe addictions issues. Tracy discussed the challenges of serving members of the mentally ill population when they are seeking treatment for their addictions:

> They can go to detox at Alpha House or detox at Renfrew, but so if I was an active user right now, and I was like "I wanna quit", I would have to check into Renfrew tomorrow morning with everyone else in the city that wants to do that, and keep checking in every

> day, every day, every day. Then I have to be there for at least 5 days because I have to be sober for at least 5 days before a treatment centre will take me. So you're pretty much set up to fail. You're expected to stop on your own for at least 5 days, some of them up to two weeks, and then you can go [to treatment]. So how do you do that when you're homeless, living on the streets, have mental health issues, and trying to quit drugs? So it's just ridiculous. They're set up to fail before they start.

The reality is that for most individuals with concurrent mental health and addictions issues, they will not initiate treatment for themselves for either disorder. And so unless there is an agency or individual looking out for people who need help and who can assist them in successfully navigating the system, the severely concurrently-ill clients will continue to deteriorate in the community. When looking at the notion of quality of life, it cannot be fathomed that most sick individuals would prefer to live a life where they constantly cycle through periods of decompensation[22] followed by brief periods of wellness. All participants who completed an interview and nearly half of the participants who completed surveys made reference to the poor quality of life that the mentally ill experience because of the complexities of their issues and the limited resources available to address them. Perhaps the best summation of the current state of the mental health system and its effect on the quality of life for the mentally ill was offered by Kristen:

> But you know what, like, okay human rights, fair enough, but giving people rights to be homeless, there's no rights in that. There's nothing human about being vulnerable, and the thing is, everyone intrinsically wants to part of a community, so our mentally ill, we don't get it, get pushed into the community and the first thing is they get predators that come out, or they learn that they then need to survive by being predators. So either they're victims or they're predators, so it just perpetuates this disgusting situation. And they're too vulnerable to recognize this, and they have no insight to recognize that they make bad choices. They just survive until they die.

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[22] Decompensation, also known as the prodromal stage, refers to the onset or worsening of symptoms that precede a mental illness. For example, an individual will often exhibit symptoms of bizarre thoughts, sleep disturbance, withdrawl from people, etc., before having a full-blown psychotic break. See http://www.cmha.ca/mental_health/early-psychosis-intervention/#.UwQBgUJdU4Q for more information.

Institutionalization

Attitudes towards institutionalization vary greatly among frontline workers, other mental health professionals, stakeholder groups, clients, former institution staff, and the general lay public. However, the general attitude towards institutions has generally been negative, an outcome that has largely been prompted by institutional shortcomings (Thornicroft & Tansella, 2002). A large portion of time during the interviews with participants was spent discussing their attitudes towards institutions and, similarly, participants who completed surveys were also asked a number of questions about their attitudes and opinions. All participants who completed an interview noted that the very mention of institutions is controversial, however, they were all eager to discuss their feelings towards them and their role in mental health treatment. It was noticed throughout the data collection process that the participants seemed to feel an obligation to first acknowledge the negative aspects of institutions before offering any favorable opinions of them. For example, Kristen stated that "…yes, there was definitely, like, the nurse Ratchetts in there and people that were burnt out and whatever, but there is everywhere you go," before going on to state "I feel like institutions got a bad rap and I feel like now that we've learned what's going on in the community, I don't think you'll find very many mental health workers that actually think that institutions are a bad idea." Gail also opened the discussion about institutions by recognizing their failures:

> Things have changed drastically in the hundreds of years and there were some horrible things that did happen. There's an institution in Montreal that took the mentally ill and did, I think under the US government, did a lot of testing on their brains, you know, electro-shock therapy and, you know, took away their ability to have children. But those days are long gone.

Once participants had briefly discussed the shortcomings of asylums in earlier years, they held little back when discussing their opinions of how deinstitutionalization has been implemented. James' tone was one of frustration when discussing how the idea of human rights has so significantly affected people's perceptions of institutions:

> I do recognize that in the past institutions were horrible. They treated people horribly. Everyone and their dog was sent to an institution. I think we're beyond that now. You know, like, the pendulum has swung the other way, but it's like, not everyone can survive

> on their own. If people saw, as you've probably seen, the squalor that people live in, just because they're not in an institution...they're living horribly. That's not humane either.

There seems to be a general consensus among participants and within the mental health rhetoric overall that deinstitutionalization was not necessarily an inappropriate or poorly designed model, however, it has been consistently suggested that it is the implementation that has fallen short (Grob, 1994; Moran & Wright, 2006). James, for example, expressed his disdain for the manner in which long-term care clients were being transitioned into the community:

> We've seen people given Greyhound tickets after being institutionalized for 60 years show up on a Friday afternoon and who were told to go to a mental health clinic on Monday. That's happening less now, but it did initially during deinstitutionalization here in Alberta. But now it seems like they're doing it a lot better. They're at least calling the Community Extension Team[23] or will transition people to the community somehow. It's just that it's not easy if you don't have a receiving housing place that can receive them. But it's getting better.

According to Grob (1994), the accelerated discharge of the mentally ill from hospitals and institutions had major repercussions for these individuals. The decentralized care model, or community care model, was barely an enacted policy before large numbers of mentally ill were deinstitutionalized, and so many of them were released with little or no support in place. Despite the research indicating that outcomes for the mentally ill are favorable when their discharge is carefully planned, there is still a percentage of individuals with a severe mental illness who do not improve when moved to the community, regardless of the level of planning and management (Thornicroft & Tansella, 2002).

Participants tended to reiterate these ideas when speaking of institutionalization; they all suggested that the majority of the mentally ill have reasonably good outcomes in the community when their discharge plans are successfully implemented, however, this is not

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[23] The Community Extension Team (CET) is responsible for assisting discharged mentally ill patients with accessing transitional supports, such as housing, mental health resources, social programming, income support, medication management, etc.

always a reality for some individuals. Ryan explained the limited resources for clients when they are discharged from hospital:

> I mean the problem is after. So I mean Community Extension Team [CET] is a good example. The amount of work that our team does post-discharge is huge. Um, ideally, I mean, if every patient leaving hospital can get that much care that would be great, but we don't have those kinds of resources. And I mean the small population we're dealing with that you're talking about, CET can't manage that, it's either that they're too violent or too aggressive or we can't find them…I think outreach teams have been very effective, there's just not enough pull.

It is concerning that the deinstitutionalization of the mentally ill began nearly five decades ago but the challenges of implementation are still lingering today. While the development and implementation of institutions took several decades to peak, the undoing of their existence in the history of mental health treatment was exceptionally quick. Tracy, whose father worked at a long-standing provincial facility several years ago, discussed her father's experiences with the clients:

> …when we talk about the decision to deinstitutionalize, and what my dad witnessed living there, it was very, very sad. And he has no mental health background, um, but because he worked up there and he's seen these people for many, many years because he worked there for many years, he would see them walking downtown disheveled and mumbling to themselves and clearly not doing well. It was hard for him. He didn't know what to do. He's a plumber, no problem, but it broke his heart actually because he saw the side of these people that, you know, they'd always say 'Hi Carl,[24] I like your hat today' because my dad always wore these crazy hats. And so he had that relationship with them. Like he didn't have a nurse-patient relationship, he had kind of the maintenance plumbing guy on the grounds and social relationship and you know, he knew they all had their demons, if you will, but saw them as a person and then to see them not well, was you know, that was hard for him when they did that. And like I said, their plan wasn't very good. And this is third hand, I don't know exactly what they did, but my understanding from my dad is basically they moved them out of a very structured

[24] Name has been changed

> environment where they had work programs and like the snack bar and all that kind of stuff, to a hotel with a bar. And they were in a room with like nothing. So that's the other thing, they put them in an environment that's not even a home environment. There's no kitchen, there's no way for them to cook, so they're basically in a hotel room with a bathroom. And here's your blister pack of meds, someone will be here in a month to check on you. And I don't know what the plan was obviously, but it was poorly executed and it was very unfortunate for those people because again, they were probably being taken advantage of… there were still probably people that preyed upon them.

As Goodwin (1997) points out, "the discharge process has sometimes been found to be poorly planned and implemented. Decisions over who is suitable and ready for discharge, for example, have often been found to proceed in an unsystematic manner" (p.122). Lightman (1986) adds that in Toronto, many individuals were discharged either directly into homelessness or into the poorest districts with the worst housing and limited services. A 1971 study by Miller, which looked at reintegration into the community of over 1,000 ex-mental patients, indicated that there were four factors that determined an individual's chances for success in the community: sufficient material support, sufficient care and emotional support, an accepting social network, and a sense of mastery. According to Miller (1971), these factors were absent in the majority of cases, and therefore a large proportion of the mentally ill were unsuccessful in reintegrating into society. Although Miller's study was conducted during the implementation of deinstitutionalization and therefore may not offer contemporary trends, Goodwin (1997) asserts that a number of studies have since been conducted and many of them found that social conditions for the discharged patients have not improved the mental health of these individuals, while others offered only a heterogeneous pattern of outcomes for discharged patients. As Goodwin adds, "the assumption underlying the movement towards deinstitutionalization, that patients would receive support in the community and would thereby benefit from being discharged, has proved overly simplistic and sometimes erroneous" (p.124). Regardless of the amount of discharge planning, a large portion of the previously institutionalized population was discharged into homelessness or into the care of family members who were unequipped to provide adequate care, particularly for the individuals who are chronically and acutely ill (Grob, 1994). Katie described the case of a former adolescent patient that she worked with:

> We had a patient that was here probably 6 or 7 years ago that met full criteria for schizophrenia, including classic symptoms like catatonia and everything that you don't see nowadays at all. So at the age of 17 he was your classic schizophrenic which you don't even see in classic schizophrenics, and there was no way that you could discharge him, (a) because he came from a genetically loaded family where mom was bipolar and dad was just not unwell per se, but not able to care for him, so he came from a family that couldn't care for him. He was very unwell, he even had olfactory hallucinations which you don't see, um, and so we had him here for over a year because [institution] at the time was still doing longer term care, and they wouldn't take him until he was 18. So he was here for a year, we sent him there, he was there for a couple years and he's a revolving door, he gets admitted in and out of [institution] so he has been part of the mental health system for the last 7 or 8 years and will never be able to be on his own. He still phones us, he's still unwell, he's so unwell and he never will be well. He's 26 years old or however old he is and he'll never function in society.

Frontline workers rarely see the mentally ill individuals who are doing well in the community, as that population tends to access clinic services on their own or receive the appropriate ongoing care from their family doctors (Goodwin, 1997). Instead, frontline workers are tasked with the management and treatment of the severely and persistently mentally ill, which perhaps gives them a different perspective on the lack of resources required to appropriately treat these individuals. Consequently, frontline workers appear to be the biggest proponents for the revisiting of institutions as a care option for the most severe mentally ill.

All of the individuals who participated in this research passionately commented on the need for institutions in order to offer care for those individuals who are not being adequately cared for in the community. Gail was particularly frustrated with the current lack of institutions:

> There are too many people with mental illness that are filling up shelters, they're being problematic in the community, they're being placed in houses that are creating unsafe housing and that's creating problems for communities. And the solution I think is simple. I don't understand why they chose to close the facility that provided quality care to the long-term clients. Mental illness is not going to disappear, it's not going to go away, so if they cannot function, if they can't socialize, if they can't enjoy life to the fullest, and if they

> were able to do that in an institution, why not put them back there? You know, I said to somebody the other day, we all have the ability, we all pick the people in our lives that we have an affinity to, that we think the same, that we enjoy the same activities, and we somehow, it's no different for our [mentally ill] population. There are some mentally challenged people that prefer to be with people that are of their same IQ level, that have the same afflictions. Why do we make it difficult for those people? There's a certain comfort zone and level of acceptance in that group. It's a community, this is a community at our shelter. We develop a community because people feel a level of comfort, they feel safe, there's, they know that there's gonna be staff that will support them in their journey and that we'll be here to provide them with all the resources that they need. It should be no different for the mentally ill. I just think there was nothing wrong with where they were. Why was the decision made to discontinue the services? Was it strictly a money issue? Or the fact that they think they'll be better off in the community?

Perhaps the most prominent notion of Gail's comment is the suggestion that we as policy makers and practitioners in the mental health system assume that by placing the mentally ill into the community that they will naturally assimilate into it, and even more so, that they want to. It is a strange paradox that a major factor in the decision to deinstitutionalize the mentally ill was the intent to offer these individuals some autonomy, however, even in the community treatment model, efforts are made to push these individuals into a community that they may not even want to be a part of or ever feel that they are a part of.

Other participants discussed the benefits that institutions would have for the mentally ill in terms of structure, adequate personal care, the availability of programming; James discussed his long-standing attitudes that favour the revisiting of institutions:

> …in the 60s and 50s when there was institutions we had personality disorders thrown in there, if you had alcohol induced psychosis you were thrown in there, and it was like, well that's not right either, but at the same time, we aren't working in the 60s. We have much, much better understanding of mental illness, what's illness, what's not. And that's not to say we get it all right, but…I've been saying we need institutions for years. Not the way that they were. So maybe institution isn't a good word, maybe care centre or

> something. But yeah, it's inhumane the stuff that I see and where people are at now. I can see it being, you know, kind of like Ponoka used to be. Staged units, eventually a self-contained community, um, where they have access to therapy, people watching and making sure they're not deteriorating, stuff like that. Um, and just better controls with who gets admitted in there. You can't throw everybody in there. It's gotta be monitored and watched the way it should be, that they're using standards of care that are appropriate and humane.

Participants were consistent in their assertion that the word institution has a negative connotation (such as James' comment above), and therefore any new potential long-term care facility would perhaps need to be referred to by a name that suggests compassion and caring. Seniors' homes, for example, are referred to as care homes and they care for the elderly individuals who cannot care for themselves; a care facility for the mentally ill would be no different in that the goal is always ultimately to look after people who are incapable of taking care of themselves.

A common theme amongst the discussion about institutions should be mentioned, and that is who the institutions would benefit most: the clients. None of the participants suggested that institutions would make their jobs and lives easier, or that they would like institutions so that they would not have to struggle to continue treating the severely mentally ill in the community. A major component of the Alberta Health Services mandate is to offer client-focused care, and this appears to be an important tenet that mental health workers live by. Throughout the interviews and within the surveys, it was clear that participants felt the lack of institutions or long-term care facilities was a disservice to the clients. Participants spoke about the detrimental effects that some mentally ill have suffered since being deinstitutionalized and how they could benefit from the availability of long-term care facilities. The fact that participants want to see changes in the mental health system so that the clients can thrive, rather than because it would be 'easier', emphasizes the care and compassion that mental health workers feel towards the individuals they work with every day. Tracy discussed her view on the potential impact institutions could have if their focus was on client wellness:

> I think that comes back to institutionalization vs. deinstitutionalization and I think if we could actually find that balance [of care]. And I think rehab is so critical and I always

> appreciated it, but working here we have access to the most amazing recreational therapists ever, and I think people de-value leisure and rec-therapy as 'that's just a luxury or is nice to have', but it's actually what keeps people, people. And everybody is different, not everyone can go to a 4-week program and sail on through and never have to come back and access mental health services. Like some of the people we talk to, they might need six months, a year, or two years even to really live that life and feel the difference, see the difference and start to build some inroads or bridges to that healthier lifestyle. 'Cause I don't think they're given enough time, and like I said, Claresholm[25] tries, but they're only servicing 4 or 5 people at a time for 6 months in that nice little place, its beautiful there, but we need more of that. And then if you look at the cost...the costs of inpatient actually putting in resources, the return would be huge. And then that person has a quality of life and really, if we're all in mental health, that's technically what our goal is, is to give people back that quality of life.

Kristen also echoed this sentiment by describing the challenge in offering the mentally ill the same type of care on hospital units that would otherwise be offered in an institution:

> So, and they likely wouldn't have to deteriorate to the point where they're selling their body and stealing and whatever. So that's one thing. But mental health wise, um, on all of the teams I worked on, there's always this standard handful, actually it's larger than a handful, that come in and they've been coming in and out of the hospital system for 25 years, ever since the institutions stopped, and they don't get better. They get better enough that we can, um, release them, usually to the Drop-in Centre or the Centre of Hope because by then, by now, they've burnt every bridge because they're mentally ill and they can't manage their rent, and then can't manage their payments and they can't manage living on their own so they burn their houses down or, or figuratively, or literally, burn their bridge. Or they start using drugs to self-medicate. So, um, I wish we had the institutions, perhaps in a different way because, like, look at one of our clients in Alberta at [hospital]. He's been there for like two and half years. Well that's not a good thing. I saw him this weekend, and he was like Kristen! Why aren't you doing bingo anymore?

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[25] Claresholm Centre for Mental Health and Addictions is a 100-bed long-term care facility for the mentally ill and individuals with concurrent mental health and addictions issues. It offers a number of therapeutic programs and services for individuals who are unable to be transitioned into the community.

> And I was like "Well Matt, we don't do bingo unless the nurses have time", and he was like "well you used to do bingo with us all the time and movie nights and we don't have that anymore. When you left the whole place went downhill". And I was like "Well that's because I made a point of taking time out of my shift and I would run my ass off for my shifts to do that. Whereas now, it's even more short-staffed than when I was there, and it's a lot newer staff, so they don't know how to manage 5 heavy patients and do a bingo. But like, it's so true that in-patient psych units don't have enough budget to do any activities for the people. Whereas if we had an institution, like even Ponoka, they have a swimming pool, they have a leather working class, they have woodworking class, they take them out bowling every Wednesday or every Friday. Um, they get activities, and it kind of stimulates them. But really in the hospitals, all they really get is their smoke breaks every hour.

What Kristen and Tracy have described above is commonplace in the current mental health system; it would seem that the very word institution has become so negative, however, our mentally ill have now simply become warehoused in hospitals, jails, and shelters. And in these settings, they receive limited therapeutic care and instead are simply stabilized and re-released into the former circumstances that expedited their deterioration. It is for these reasons that mental health clinicians are often proponents of revisiting institutionalization; it is not to punish or hide these individuals, but instead it is intended to give them the care that they cannot give themselves. As James summarizes:

> But overall, we're all trying to help this population. And we have all ranted about how hard it is on this population to be dragged into emerge and injected and then cycle through so often, it's hard on them. So I feel like if we had dollars and cents to indicate the costs combined with the life outcomes for these clients, we would see that other resources need to be developed…If you had a bigger setting you could set up a workshop or a woodworking shop or a mechanic shop or a, you know. But you can't do that with a housing project or hospital unit.

In reviewing the data collected in the previous two chapters, participants offered a sobering yet insightful perspective on the state of the mental health system. Frontline mental health workers appear to face a number of difficulties in their roles as defined by the larger macro-level system

and in practice with the clients with whom they interact daily (the micro-level). The next chapter will discuss these findings in more depth while also offering some larger implications for the future of the mental health system.

Summary

The comments offered by participants throughout this chapter arguably validate those made about the mental health system in the previous chapter; in chapter four the participants discussed the shortcomings of the mental health system in terms of its function, and in this chapter their comments have explained how these shortcomings have affected the individual clients. Many of the severely and persistently mentally ill lack the adequate resources to successfully integrate and function well in society, which ultimately leads to a number of problems for them; many wind up housed in correctional institutions, while others become homeless and cycle through homeless shelters and hospitals. For frontline workers, these problems exacerbate the challenges they already face in trying to care for the severely mentally ill in the community.

CHAPTER SIX: DISCUSSION AND CONCLUSIONS

> "We have made, and continue to make, progress in dealing with mental health problems and illnesses in Canada. Still, fragmented and underfunded mental health systems across the country are far from able to meet the mental health needs of Canadians. People living with mental health problems and illnesses – whatever their age and however severe their mental health problem or illness - and their families should be able to have timely access to the full range of options for mental health services, treatments and supports, just as they would expect if they were confronting heart disease or cancer"
>
> -Changing Directions, Changing Lives: The Mental Health Strategy for Canada (The Mental Health Commission of Canada, 2012, p. 12)

Introduction

The findings presented in the previous two chapters have offered some insight into how frontline workers perceive their roles as street-level bureaucrats who mediate between the larger mental health system and the clients it serves. This chapter will look at how the experiences of these frontline workers and the input they have shared can provide greater understanding of some of the challenges in providing mental health care in community settings, as well as some guidance for policy makers in terms of what can be done to improve services. In order to do so, it is important to keep in mind the research questions guiding this thesis:

i. What are the challenges faced by frontline mental health workers whose role is to deliver community-based services as dictated by macro-level healthcare policy?
   a. Are policy and practice working effectively together?
   b. What are the challenges associated with implementing services dictated by the healthcare system itself?

ii. Do frontline mental health workers believe that they are effectively providing services and care on the micro-level based on the needs of clients?

a. Are there appropriate and adequate services provided by frontline workers that are available for all clients with varying mental health problems?

b. What outcomes do clients experience as a result of the services provided by frontline workers?

The following discussion will use the information provided by the 20 participants to offer some answers to the above questions as well as discuss the broader implications of mental health policy in Alberta.

Providing Care under the Current Mental Health System

There is a significant challenge in providing care to the mentally ill under the community-based model. In Canada, the federal government offers a number of strategic directions that it would like to see implemented, however, the provinces vary greatly in the way in which they implement these directives. The data suggests that participants of this research study strive to provide care on behalf of Canada's larger strategy, for AHS, and for their own personal and professional satisfaction. However, their experiences indicate they face a number of challenges in doing so. Overall, participants' attitudes about working with acutely mentally ill had consistent undertones of frustration. In Alberta, being one frontline worker out of 105,000 staff members in an enormous and complex hierarchical organization like AHS offers little ability for an individual to feel as though he or she is valued and is heard. When the federal and provincial governments implement mental health policy for frontline workers to follow, it could be expected that there are difficulties in putting these policies into practice.

Policy makers obviously need to develop policy that will serve the mentally ill across the spectrum of symptoms and diagnoses, yet it is abundantly clear that frontline workers have more intimate knowledge of the clients, including their histories and needs, which they would argue needs to inform policy. It becomes difficult when frontline workers see something that could be changed to better provide service on behalf of the system yet they claim there are

few opportunities to be heard. The resulting feelings of helplessness and the subsequent bitterness that may accrue from eventually adopting a “nothing will ever change and they won’t listen to me anyway” attitude ultimately breeds a population of frontline workers who do not feel valued. This is not to suggest that frontline workers do not take pride in their work and provide quality services, but rather it is intended to speak to the frustrations of frontline workers and how these frustrations may then change the attitudes of the workers. As service providers to some of the most vulnerable individuals in society, the negative attitudes of frontline workers that are manifested may cascade down to the clients. Frontline workers who feel that they are not given the tools, support, and ability to do a good job may simply become defeated and cease to believe that it is worthwhile to do a good job. As a frontline worker myself I have seen countless colleagues develop these attitudes despite entering the mental health system with positive outlooks and admirable work ethics. Obviously there are many people in many professions and sectors outside of the mental health field who are in a frontline or ‘bottom of the totem pole’ position and so one might ask what’s so seemingly unfair or challenging for mental health workers under the larger mental health system structure?

Primarily, it is because the nature of mental health is such that frontline workers are doing their best to care for very sick, unpredictable, and difficult to manage clients with limited resources. Very few individuals who do not work in healthcare, let alone mental health, can say that they spend their days at work being verbally and physically assaulted, constantly having to anticipate the actions of an unpredictable individual, having feces, urine and other bodily fluids thrown at them, and then having to look past that behaviour and treat the individual with care and compassion. So, as most of the participants alluded to, there is a strong sense of the importance of input into the policies that dictate how the mentally ill are to be treated in the community and in hospital settings. Overall, frontline workers appear to be suggesting that the challenges are not rooted in treating mental illness itself, although this definitely has an impact; instead, they are frustrated because they feel they could provide better service to their clientele if they were working within a system that provides appropriate resources to meet the required needs. Yet the mental health system is in the predicament of determining the amount of resources that are allocated for services in the welfare sector but without the same level of experience that the front-line workers have. For example, in revisiting the care continuums on pages 12 and 13, most frontline workers who directly work with the most severely mentally ill

offer services on Tier 5 and on the specialized level. The challenge appears to be that people with mental illness have complex needs that are unable to be adequately serviced at these levels.

Figure 3. Range of acuity and range of services

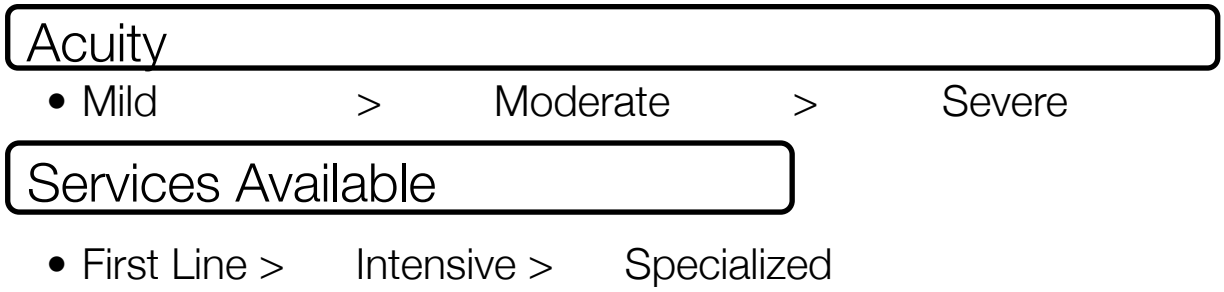

Figure 3 (above) illustrates how the needs of clients extend beyond the range of available services. Most clients suffer from an acute mental illness that is adequately treated somewhere on the service continuum. However, frontline workers who serve the chronic and persistently ill often do so in the gap that extends beyond the range of services available with clients who fall on the far (severe) end of the acuity spectrum. At one time, institutions would have filled that gap and would have been the most extreme option to correspond with the most extreme cases of mentally ill individuals, however because the larger mental health system favors a community-based model, frontline workers are required to treat these cases with the resources available.

Lipsky (1980) explains that the demand for services will always meet the supply, if not exceed it. As such, even if governments directed additional resources towards mental health services, the demand for those services would increase to match the supply. In other words, any available resources will always be consumed. If this is the case, front-line workers may be better utilized when they have more direct input into the policies that they must work with.

Systemic Barriers

A portion of frontline worker disdain towards mental health policy is the result of confidentiality protection and the inability to share information. Since the mental health system was decentralized, the network of services both within AHS and outside of it continues to become fragmented, and just like the pendulum swing from deinstitutionalization towards community care was extreme in nature, so was the development of privacy and patient information acts. Frontline workers expressed overwhelming frustration with the manner in which information is shared about clients, particularly because the majority of severely and chronically ill clients are required to access a number of different services to meet their needs. It is perhaps appropriate to return to Lipsky's (2010) concept of the street-level bureaucrat, as it is closely tied to the adaptations that frontline workers make when dealing with clients like Jamie. Lipsky (2010) explains that street-level bureaucrats govern the effectiveness of public service delivery, yet performance is greatly affected by the limitations (time, information, and resources) of the larger system. Workers therefore respond to individual cases and use their judgment to determine the best way to find and allocate services; this directly applies to frontline mental health workers, as they are often required to improvise when developing care plans for individuals with severe mental illnesses and who have other complex needs. Frontline workers are tasked with identifying the resources available and then connecting the mentally ill to the appropriate resources and services to meet the needs of the client. Individuals like Jamie are therefore reliant on frontline workers to find the best ways to provide care with the services provided by the larger system.

Even for the services that exist, the agencies and organizations providing them are often overwhelmed with long waitlists and exhausting caseloads. I asked an ACT staff member how long it takes for a client to get a worker with their program, and I was told the wait is typically six months. In order for a new client to receive a worker, other clients need to be transitioned to other services or dropped from the program. However, because most of the individuals with higher acuities tend to get referred to ACT for long-term care, there is often little turnover. For other programs, such as Pathways (which provides intensive and supportive housing), the wait can be up to a year; that is a whole year that severely mentally ill clients are expected to couch surf, stay at shelters, cycle through jail, survive on the streets or live with family until they can

be housed. In the meantime, frontline workers are expected to provide as much mental health treatment as possible for these clients, which proves difficult, if not impossible, in most cases.

Institutional Care

One of the major themes that emerged was the lack of long-term care facilities for individuals who do not function well in the community. While most mentally ill individuals have arguably been able to transition to community care relatively well, the severe and persistently ill have not adapted as successfully. The movement away from institutional care, coupled with the emergence of a younger and more chronically ill population, has had overwhelming consequences for both the clients themselves and the frontline workers trying to treat them. The chronicity and high prevalence of substance abuse of this population makes a strong case for at least discussing the feasibility of maintaining some long-term institutions, however, it appears that politicians and policy makers continue to avoid such conversations.

Institutions emerged with the intention of curing the mentally ill, an outcome which has obviously not been achieved. Yet this does not mean that institutions cannot effectively treat the mentally ill and provide the care they need. Policy makers and other individuals and agencies who often champion the human rights of the mentally ill in terms of their autonomy and the right to live a high-risk lifestyle in the community are quick to dismiss the benefits of institutional care by pointing out the negative aspects of institutions from two to three centuries ago: overcrowding, harsh treatments, the inappropriate use of institutional care for those who did not require it, etc. What these policy makers and activists may overlook are the current ethical and moral considerations for a specific population in today's society; the serious mental disorders that the severely and chronically ill population suffers from are often exacerbated by a number of social problems such as homelessness, poverty, substance abuse, and repeat contact with the criminal justice system. As noted by a number of participants, leaving incapacitated individuals with severe mental health problems and ongoing social needs to fend for themselves, and bounce from service to service in a community-based care system that most professionals struggle to navigate themselves, seems considerably harsher than providing ongoing care in a long-term care facility.

The prolonged disillusionment of policy makers and mental health think-tanks who fear the public backlash of reopening discussions about the need for institutions only allows for further deterioration of the mental health system and its ability to treat the most chronic individuals. It also continues to put frontline workers in the precarious position of having to improvise community-based care plans for these chronically ill clients who clearly need institutional or long-term care. Policy makers, and even the lay public who disagree with using institutions for the severely mentally ill, seem generally unaware of the challenges that frontline workers face every day trying to alleviate the individual conditions for society's sickest and complex individuals, all while feeling that they have no ability to influence the conditions of the larger mental health system. Even the most intensive community supports are not enough for a number of clients, and so there are no illusions on the part of frontline workers that these clients will ever get better under the community care model. The sentiment of frontline staff often then becomes "well, if we can keep him out of jail for a month then we're doing a good job" or "he's in the hospital for a short stay so at least he will get treatment for a while". Frontline workers who participated in this research made it clear that working with such a low benchmark for success should not be the standard of care that policy makers deem acceptable. As such, revisiting institutional care as an alternative to the poor quality of life that most of these severely ill individuals experience within the community-based system is one that all participants in this study would urge policy makers to consider.

Caring for Clients

Because of the systemic challenges discussed above, it follows that frontline mental health workers struggle to provide quality care for clients in the community. The personal challenges for frontline workers in caring for the severely mentally ill are twofold; first, providing care within systemic boundaries can create frustration for frontline workers and those frustrations are potentially passed on to the clients through inconsistent treatment efforts. Lipsky (2010) explains that "street-level bureaucrats often spend their work lives in these corrupted worlds of service. They believe themselves to be doing the best they can under adverse circumstances, and they develop techniques to salvage service and decision-making values within the limits

imposed on them by structure of the work" (p.xv). For frontline mental health workers, this may mean that they simply adjust and find their own ways of providing care within the parameters of the larger system. And although their individual efforts may not always meet the ideal level of care that is outlined by policies, frontline workers are able to accept that clients receive the best care that can be provided under the circumstances.

Second, this client population is extremely exhausting, and so compassion fatigue may develop and potentially lessen the care that an individual receives. Lipsky (2010) insists that street-level bureaucrats" consistently favor some clients over others, despite official policies designed to treat people alike. To understand how and why these organizations sometimes perform contrary to their own rules and goals, we need to know how the rules are experienced by workers in the organization, what latitude workers have in acting on their preferences, and what other pressures they experience" (p. xiii). Simply because frontline mental health workers experience compassion fatigue and burn out does not mean that they no longer want to care for their clients. Rather, they adapt and routinize their roles so that their clients might generally experience positive outcomes, however they may not be as numerous or positive given the adjustments that workers make to their practices.

It is important to remember that frontline workers are in the roles that they are largely because they enjoy the work and want to help people. When they experience frustration with the larger mental health system, it seems that the frustration lies in seeing clients not respond well to treatment or not get the treatment that they need. All too often the same clients repeatedly cycle through services, and most frontline workers develop a sympathetic and compassionate view of them; participants in this study often referred to the circumstances of clients as 'sad' or 'unfortunate' because there was little that the worker could do to make the client's prognosis or quality of life better. Over time, frontline workers seem to experience a shift in their outlook of clients from one of sympathy to one of helplessness; to compensate for the feelings of helplessness, frontline workers appear to cope by resigning themselves to the fact that these clients simply won't do well in the community, and so they provide the minimal care necessary to treat the client and discharge them into the care of another service. A number of comments by participants seem to reflect this sentiment as several of them expressed frustration; participating frontline workers feel that under the current mental health system

there are so many limitations to the services available that most clients will not receive the care they need and therefore there is little point investing time and effort into a client who will not get better. The frustration that comes from repeatedly providing care with little to no positive outcome or reward undoubtedly takes a toll on the worker and, sadly, it is the client who suffers the most consequences because of this. It would perhaps not be going too far to suggest that after a while, frontline workers reduce their efforts with clients who they feel are a 'lost cause' and who are not worth investing the time and energy into. However the investment in time and energy for the 'frequent flier' clients that are repeatedly being referred to services that will not provide adequate care is presumably diminished over time. For example, in the case of Kenny (discussed in a previous chapter), it could be argued that there is no service that is appropriate for him except for an institution. If frontline workers adopt the mentality that he needs an institution and no other service will suffice, are they still willing to provide the care that they can, or do they simply offer the minimum and then discharge him back into homelessness because they cannot offer him the institutional care that he needs?

When discussing the potential benefits of institutional care for the severely ill clients that they repeatedly encounter, frontline workers' attitudes were that they felt clients such as Kenny could finally get the care they needed if long-term care was available. None of the participants (and possibly most frontline workers) want to see the mentally ill institutionalized because it will be easier or because it will lessen their own feelings of helplessness. They want to see certain clients institutionalized because community care is failing them and frontline workers only want to see those individuals live healthy, productive and rewarding lives. Participants enthusiastically talked about how much programming could be available in an institutional setting, about how clients would no longer be vulnerable to the predators they encounter while living on the streets, and how they would experience a higher quality of life overall. Furthermore, many participants expressed a desire to work in an institutional setting in order to provide the level of care that they feel cannot be delivered in a community setting.

Although frontline workers care for their clients and want to see them do well, they still regularly see clients who are simply draining, both emotionally and physically. These types of clients significantly diminish a frontline worker's ability and desire to provide care because these clients are violent, needy, or their symptoms are so severe that they require a worker's

full attention at all times. Compassion fatigue and burnout can therefore develop quickly, particularly for workers who are in roles that continuously work with the most chronically and persistently ill. It is in these cases that treatments may be administered based on what makes the worker's job easier rather than what is best for the client. For example, some clients with known serious mental health problems may present with drugs or alcohol in their system, at which time service providers will attribute their behaviour or symptoms to the substance rather than the underlying mental disorder. As long as the individual does not require medical care, he or she can be discharged or refused service. In other cases, clients are simply medicated until the symptoms decrease enough that they do not require further care. This is not to suggest that frontline workers are trying to make clients' lives more difficult by only providing the minimal care required to be able to move them along to another service. Unfortunately the constant challenge of these types of clients may eventually wear down even the most caring and compassionate worker, at which time making the client someone else's problem may trump ensuring the client is receiving the best care possible.

One might read this and suggest that frontline workers are in charge of their own emotions and should not develop disdain towards clients or that they should be putting their personal biases aside in order to offer consistent and high-quality care each and every day to each and every client. Yet the reality is that this is easier said than done in any role where an individual is caring for others. The reason that family members bring their mentally ill loved ones to emergency rooms, family doctors, community services and long-term care facilities is because they realize they cannot shoulder the burden of caring for family members with needs that are far different than other populations who require care. Frontline workers shoulder this burden each and every day with innumerable clients with varying acuities, and so one cannot expect these workers to maintain compassion at all times, particularly given the systemic barriers and challenges that dictate how services are provided.

Quality of Life

The intention of providing care for any individual is to give him or her the best quality of life that can be attained, a notion that frontline mental health workers subscribe to. Much of the mentally ill population can experience reasonably good outcomes with various treatments and

supports provided by frontline workers, however, other individuals with severe mental health issues are already so disadvantaged by societal standards (poverty stricken, uneducated, unemployed, homeless, etc.) that living a life that is fulfilling and rewarding can seem unachievable. Policy makers and some members of the public believe that giving individuals the autonomy to live their own lives equates to promoting a high quality of life, yet the frontline workers who participated in this study offered a conflicting analysis of the quality of life that the severely mentally ill are experiencing.

Overall, frontline workers seemed to feel that they are unable to provide the care necessary to adequately help the severely mentally ill thrive in the community because of such barriers and constraints as systemic service ideals and the chronic shortage of resources. Providing the basic necessities of life and providing experiences that will enrich the lives of others are two very different concepts and, unfortunately, the current mental health system appears not to focus on the latter. For frontline workers, however, there is an expectation by the larger system that they provide services that will enhance an individual's quality of life, so long as the services are within the scope of mental health policies. However, as some participants discussed, policy makers often make assumptions about what clients want or need or what will enhance their quality of life. For example, in order to counter the stigmatization that the mentally ill may feel, policies and initiatives are developed to attempt to 'force' this population to assimilate into mainstream society. For some individuals this pushes them out of their comfort zone and they integrate well; for others, they become even more aware of their disadvantaged social position and this creates negative feelings towards society; further, others simply do not want to interact with the rest of society and instead prefer to be with likeminded individuals in a setting such as a psychiatric unit or a homeless shelter. Governments and policy makers may be able to provide guidance and make decisions with respect to the medical and mental health interventions that an acutely ill individual would benefit from, but it cannot be expected that the individual will simply integrate into the rest of society after treatment is complete. The result is that frontline workers are left trying to find ways to balance the care for these individuals who have been pushed into the community by the deinstitutionalization policy but who do not fare well in such settings.

For many individuals who were deinstitutionalized and continue to be transitioned into the community, this meant being discharged from care directly into a life of homelessness (Gillespie, 2010). Speaking firsthand, I have seen countless mentally ill individuals released from hospitals or institutions with nowhere to go, and participants echoed this in their discussions with me. Acutely ill individuals who are discharged are often given a transit ticket along with a street guide that provides information on various social services and resources available in the city and told that they can go to the Drop-In Centre, Mustard Seed, or other homeless shelter to sleep. Frontline workers tend to respond to these situations in a manner that parallels Lipsky's (1980) notion that workers will improvise solutions using available tools and resources. This may include contacting homeless shelters in an attempt to secure an emergency bed[26] or having the client admitted to hospital if their mental health issues are serious and persistent. While these actions are admirable in that they demonstrate the commitment that frontline workers have to seeing their clients b well cared for, these situations also further illustrate how frontline workers are forced to find creative solutions to fill the gaps in service that have been created by the piecemeal organization of the mental health system.

Implications and Conclusions

Despite all the frustrations of both the larger mental health system and the clients it serves, frontline workers are quick to remind anyone who asks that at the end of the day, they are concerned for their clients and feel that they are not being adequately cared for. As previously discussed, the addiction-riddled and severely mentally ill often cycle through services and resources, and the prevalence of such a phenomenon should itself speak volumes about the shortcomings of the community care model. The outcomes for any individual who is chronically schizophrenic and addicted to crystal meth quickly undermine the sunshiny prognosis that is promoted by community-based mental health policy. Mentally ill individuals who are thriving in the community and who have a high quality of life are not presenting to the emergency room of hospitals two or more times per week, frequently being admitted for stabilization on psychiatric units, cycling in and out of jail, or sleeping under bridges in the

[26] A number of shelters and housing programs tend to have emergency beds available that can be reserved for high needs clients or individuals with extenuating circumstances. These beds, however, are often few and far between as most shelters operate on a 'first come, first served' basis.

winter because they have been banned from all of the homeless shelters because they are too violent, unpredictable or are generally noncompliant with rules. And for many of the mentally ill, this is certainly not the case. However, the fact that the majority of the mentally ill population is receiving adequate community care only serves to draw attention away from those individuals who are not experiencing these same outcomes. It is these severe and persistently ill individuals who are of most concern for the frontline workers who participated in this research, and until there are systemic changes made to the mental health system to eliminate barriers, allocate funds, and assess what these clients actually need in the community, these frontline workers will continue to face challenges in trying to connect the current mental health policy to community practice.

Because of the diversity of the needs of clients in the community, both for the severely ill and those whose acuity is lower, frontline workers are responsible for understanding and applying the policies of the larger mental health system and then putting those policies into practice through their various roles. Yet the expectation to do so appears to be oversimplified based not only on the volume of research dedicated to highlighting the shortcomings of the current community-care model and the policies that underpin it, but also based on the information provided by front-line workers for this study. As discussed earlier in the literature review and the 'balancing of services' model, there is little dispute that deinstitutionalization was a step in the right direction for the progression of mental health care. Instead, much of the concern identified by this and other research focuses on the lack of planning and poor implementation of this shift. As Goodwin (1997) asserts: "Deinstitutionalization and the development of community care have been generally seen by policy makers as complementary developments; as one declines, the other takes over. This model, where it is assumed that new services provide an adequate substitution for old, is, however, increasingly being questioned" (p.149). Most of the research used to benchmark the success of the substitution of care and guide policy has been statistical in nature[27]. This research project was therefore developed in an effort to understand if it is the structure of the larger system, the complex needs of the severely

[27] A Google search for Canadian mental health research returned results from Statistics Canada, The Canadian Mental Health Association, Centre for Addiction and Mental Health and the Mental Health Commission of Canada, all of which yielded studies that utilized quantitative methods to look at systemic challenges, indicate client outcomes, and predict future needs.

mentally ill population, or both, that affects the ability for frontline workers to care for the mentally ill in the community.

This research project was also intended to give a voice to the frontline mental health workers who are otherwise silenced by a hierarchical structure where they find themselves at the bottom. Their experiences should not only be used to guide policy, but should also be part of the dialogue when determining the needs of clients. Because frontline workers have both the burden and benefit of operating on middle ground by putting policy into practice, their opinions of how those connections are or are not made seem arguably more constructive than from those who may never have had contact with a mentally ill individual. Expectedly, not all frontline workers are going to hold the same views and have the same experiences that will allow for a consensus on the needs of all clients, however, it may be beneficial to hear from frontline workers across all levels and departments of mental health in order to get an accurate interpretation of the system in its entirety. To allow for the frontline workers who treat the most severely and persistently ill to have a say in how that treatment is delivered would allow them to feel that they are valued and that their knowledge of the system of the clients is taken into account. This, in turn, may result in better care for the clients. However, until policy makers show any regard for the knowledge, experience and opinions of frontline mental health workers, the entire mental health system and the clients it serves remains vulnerable.

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APPENDIX A: SURVEY & INTERVIEW QUESTIONS

PART I – Background and Experience

1. How long have you worked in the mental health field?
2. What is your current job position?
3. Can you tell me about the typical job duties you perform on a daily basis?

PART II – Current Mental Health Policy

1. How familiar are you with Canada's Mental Health Strategy?
    1.a. If not familiar, move to question 4.

2. How do you feel this new policy framework will affect how frontline workers like yourself deal with mental health crises?

3. Is there anything that you were expecting to see in this framework that was omitted?

4. In your opinion, does current mental health policy offer frontline workers like yourself the opportunity to offer appropriate services for the chronically mentally ill?

5. Are there any initiatives or services that you feel have been consistently lacking or missing from mental health policy?

6. Do you feel that as a frontline worker you have the ability to influence policy?

PART III – Attitudes Towards Current Practices

1. In your opinion, what are the challenges of putting mental health policy into practice?

2. In your opinion, how well connected are mental health policy and practices for frontline workers like yourself?

3. Do you ever feel that there are limited resources for you to utilize while dealing with a mental health crisis?

4. Are there any policy constraints that have hindered your ability to effectively deal with a mental health crisis?

5. Can you tell me about some of the frustrations you have felt while dealing with mental health crises?

6. With respect to outcomes for clients, how well are current practices in your field working?

PART IV – Institutionalization

1. What are your feelings about the deinstitutionalization of the mentally ill?

2. What are your feelings about the availability of appropriate community services for the chronically mentally ill?

3. What are your feelings about revisiting institutionalization as a potential solution to the 'revolving door' problem that occurs in emergency mental health services?

4. What do you think would be problematic if institutionalization was revisited?

5. What do you think would be successful if institutionalization was revisited?

PART V – The Future of Mental Health

1. In your opinion, what is the future direction of emergency mental health services in terms of your job?

2. In your opinion, are government efforts to continue treating the chronically mentally ill in the community positive or negative? Why?

3. Do you have any solutions about how to offer long-term treatment to clients who are seriously and persistently mentally ill?