



PARKLAND ALBERTA WRITERS SERIES

LIVING IN HOPE

A response to 2009-2010 Bed Closure
Process at the Alberta Hospital

By Curtis Gillespie



“In depression . . . faith in deliverance, in ultimate restoration, is absent. The pain is unrelenting, and what makes the condition intolerable is the foreknowledge that no remedy will come -- not in a day, an hour, a month, or a minute. . . . It is hopelessness even more than pain that crushes the soul.”

William Styron, “Darkness Visible”

“Everything that can be counted does not necessarily count; everything that counts cannot necessarily be counted.”

Albert Einstein

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ALBERTA HOSPITAL EDMONTON

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- conduct research on economic, social, cultural, and political issues facing Albertans and Canadians;
- publish research and provide informed comment on current policy issues to the media and the public;
- sponsor conferences and public forums on issues facing Albertans; and
- bring together academic and non-academic communities.

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ABOUT THE ALBERTA WRITERS SERIES

"Living In Hope" is the inaugural publication in Parkland's new *Alberta Writers Series*. The series will include research, opinions and personal reflections on policy relevant issues in Alberta by a variety of Alberta writers.

EXECUTIVE SUMMARY

This essay is a response to the Stelmach government's proposed closure of 246 beds at Alberta Hospital Edmonton (AHE), a plan made public August 14, 2009 (called Plan 246 for the purposes of this essay). In early 2010, the government announced that only the geriatric beds would be moved from AHE. The fate of the hospital remains uncertain and the facility is in need of significant investment in maintenance and upgrading. This essay considers key aspects of the issue: how are mental health policy decisions being made in Alberta? Is there an adequate number of high-quality acute care mental health beds in Alberta? And, in conjunction, are the levels of services in the community adequate?

The closed door decision to remove these beds from AHE and redistribute them without a detailed plan provides an important window into how the Alberta government views mental health, and is a critical backdrop to the current debate. The Stelmach government encountered heavy criticism for both the Plan's philosophical underpinnings and the seemingly scattershot method of its implementation (or, at best, its scattershot consultation and communications strategy). The decision indicated that mental illness is not treated with the same level of service and care, and dignity, afforded other serious illnesses. The statistical reality of mental illness in Alberta (much of which has been compiled by the government) shows that this attitude only increases the instability of already-at-risk Albertans.

- Mental illness, including suicide, accounts for fully 15% of the burden of disease in established market economies. This is more than that caused by all cancers.
- 20% of all Albertans will suffer from a mental illness during their lifetime.
- In 2002-03, over half a million Albertans were treated for a mental health issue. Over that same span, those half a million Albertans made an average of five physician visits each in which mental health was the primary purpose for the visit.
- In 2001-02, some 34,000 Albertans visited, or were taken to, a hospital emergency room for a mental health crisis.

MENTAL HEALTH REFORM IN ALBERTA

Alberta ranks low in the number of acute psychiatric beds per capita when considered against various jurisdictions. The province has just 45 beds per 100,000 population, compared to the EU average of 100 beds per 100,000. Prior Mental Health reviews have raised this issue for the Alberta government and recommended against bed closures. The 2007 McDermott Report, commissioned by and submitted to the Alberta Mental Health Board, stated that, "reductions in bed numbers would also not be appropriate at this time," especially given the low bed numbers.

The McDermott Report advocated for the adoption of Balanced Care Mental Health, a sensible and patient-focused mix of Primary Care, Mainstream Mental Health, and Specialized/Differentiated Services. This included increased spending on community mental health. The report noted that whether beds were moved from AHE or not was irrelevant at best, and harmful at worst, if there wasn't proper funding for community options.

AUSTRALIA CASE STUDY: TOO FAR TOO FAST

Australia has been embroiled in controversial mental health policy, which has seen a reduction in mental health beds in public hospitals by 80% in the last forty years (1965-2005), from 300 beds per 100,000 population, to 30 beds per 100,000 population. According to numerous studies, as well as reports from psychiatrists and even government officials, Australia's deinstitutionalization policy failed to ensure those needing mental health care got the right support when they needed it, support that would have been linked to better mental health outcomes. Accordingly, this policy failure has resulted in the chronic blocking of acute hospital beds by patients who cannot find proper treatment and care in the community, a drop in the quality of therapy in those acute wards, a poor quality of life for patients with severe disabilities from their mental illness (whether in hospital or not), and a demoralization and skill depletion in staff who work in the remaining long stay care environment.

Australia's aggressive deinstitutionalization policy has been termed a "policy failure" by many of the country's psychiatrists, since it has failed to properly provide for patients severely and chronically disabled by mental illness. Some Australian psychiatrists have even called the policy a "blight that will come back to bite patients and their families for many years to come."

It appears that in Australia the pendulum has swung too far, past eradicating the Victorian era asylum, to an "equally destructive approach which minimizes admissions and prioritizes rapid discharge."

The Australian case study provides a number of critical lessons for Alberta's mental health strategy. The most notable is that acute psychiatric care is an ongoing part of the care continuum. According to Australian psychiatrist Dr. David Copolov, "most people with psychiatric illnesses can, should and wish to be treated in the community...But neuro-biological diseases such as schizophrenia are often enduring, relapsing and serious, and are sometimes life-threatening. For a significant minority, care in the community will, at times, be unable to provide an adequate standard of care. Under such circumstances, admission to hospital should not be considered a sign of failure, any more than admission to hospital after a myocardial infarction should be considered a sign of failure."

The experience of the Australian mental health system is a cautionary tale for Alberta, particularly in light of the lack of foresight shown by Plan 246. As Australia has learned, moving beds from dedicated psychiatric hospitals into the community is therapeutically unwise in certain contexts, but it is also philosophically and logistically complex enough to warrant years of consideration and planning, not weeks.

LESSONS FROM VANCOUVER

Closer to home, the city of Vancouver underwent a significant deinstitutionalization beginning in the 1970s and reaching its apex in the 1990's when the office of the Mental Health Advocate in BC was shut down, significant cuts were made to mental health staff, and the dedicated psychiatric hospital Riverview was closed (its patients and services distributed--supposedly--throughout the province). It was seen as progressive at the time, but more recently seen as a failure by most, including Premier Gordon Campbell.

In January 2008, the Vancouver Police released a report stating that from a policing perspective there has been a clear connection between the mentally ill homeless/criminal population and the drain on public resources such as policing. The key finding of this research is that there is a profound lack of capacity in mental health resources in Vancouver. The result has been "alarmingly high number of calls for police service to incidents that involve mentally ill people in crisis."

ALBERTA NEEDS TO LEARN FROM THESE MISTAKES

The human wreckage created by the Australian and Vancouver mistakes can be avoided. However, there are crucial lessons to learn. First, there is a minimum number of acute care psychiatric beds required. Second, complementary services such as therapy, dual diagnosis, rehabilitation and others such as those offered by Alberta Hospital Edmonton guarantee the best mental health outcomes. Last, and most significant, the closure of hospital beds without ensuring adequate community service and community beds is inviting human disaster.

ARE ACUTE PSYCHIATRIC BEDS COUNTS TOO LOW IN ALBERTA?

Alberta's acute care psychiatric bed counts are low by international standards and when compared to recommended levels. Recent academic research confirms that Alberta's bed levels may already be too low, even prior to further thoughts of deinstitutionalization. This conclusion follows from findings that for certain patient groups the stays may already be too short. According to

data uncovered by University of Alberta Nursing Professor, Donna Wilson, younger persons are the highest users of hospital services, and are consistently given a primary diagnosis of mental illness. Readmissions are common, raising the concern that general hospital stays for these younger mental health patients are not long enough to stabilize their illness. General hospitals, in short, are already under pressure from younger high users suffering from acute mental illnesses. Reducing the number of available acute care beds at specialized psychiatric hospitals such as AHE will only increase the already-significant pressure on Alberta's general hospital beds.

DOES ALBERTA HAVE ADEQUATE COMMUNITY SERVICE AND BED LEVELS

According to Alberta's 2008 Auditor General's report, the community service levels are very dissatisfactory from the perspective of the physicians. In surveying physicians, the Auditor General's report found that more than 60% were dissatisfied with the local support/specialist mental health services in their RHA. The survey also found that well over 50% of physicians felt that:

- access to specialists is not timely;
- case management and community follow-up are not adequate;
- appropriate mental health community treatment programs are not available; and
- appropriate housing options are not available.

Academic research reinforces this. Donna Wilson's research found an inability of readmitted patients to care for themselves in the community, or for the community to care for them. She concluded that few community options were in place and that patients felt the hospital emergency department was the only resource available to them for a mental health crisis.

Dr. Wilson notes that "community-based options may not be as advanced, effective, or accessible as needed by acutely or severely mentally-ill persons... (and) closing psychiatric hospital beds, beds that are used by persons who are at considerable risk of being high users of inpatient and ambulatory hospital care services, would likely have an impact on general public access to all acute care hospital services; including inpatient beds, ERs, outpatient clinics, and day surgery clinics."

CONCLUSIONS AND RECOMMENDATIONS

A society's intrinsic humanity is most accurately measured by the dignity it affords its least fortunate citizens. The deinstitutionalization experiences of other jurisdictions, the current pressure on Alberta's existing hospital resources, and the overall lack of community capacity all indicate that Alberta would be wise to revisit any plans for deinstitutionalization.

There is likely never going to be a definitive answer as to whether treating mental illness biologically or existentially, institutionally or in the community, ought to take predominance as a treatment mode, but what is clear is that when the biological treatment of severe mental illness is recommended it is often best pursued in a specialized setting such as AHE. Should a dedicated specialist psychiatric hospital be part of the spectrum of mental health services? Is the community a central part of the spectrum of mental health services? The answer to both, the evidence seems to show, is Yes.

Without presuming to speak for those who suffer from a severe mental illness or for those professionals who work every day trying to improve the lives of the afflicted, there are a handful of actions that would simultaneously send a powerful signal of genuine collaboration and act as the first steps in creating a solid foundation from which to build open and sensible mental health policy development channels. Actions the Alberta government could take or at least initiate today, are:

1 | REDRAFT PLANS TO REFURBISH AHE.

AHE should be recognized as a well-supported spoke in the wheel of mental health services, with community supports (for every level and type of mental illness) as the hub.

2 | EXAMINE THE REALITY OF DEINSTITUTIONALIZATION FOR ALBERTA.

All plans for de-hospitalization should be reconsidered and a transparent and representative advisory committee should thoroughly review the implications.

3 | INCREASE THE PURVIEW AND VISIBILITY OF THE MENTAL HEALTH PATIENT ADVOCATE.

4 | ADJUST THE STRUCTURE OF STEPHEN DUCKETT'S COMPENSATION.

Stephen Duckett's compensation should be restructured to maximize his salary through improved mental health outcomes instead of cost reductions, a structure based on his own academic recommendations for valuing health care performance.

5 | CREATE AN ACCESSIBLE MENTAL HEALTH PATIENT'S BILL OF RIGHTS.

6 | *INCREASE MENTAL HEALTH SERVICES.*

Alberta should increase overall health spending allocated to mental health, both community and acute care. The level of community services and the number of psychiatric beds must not be seen as counter-weights, in which adding to one subtracts from the other. Both are vital and require immediate investment.

Even a governmental change in attitude such as the above, by no means a given, will not immediately improve the quality of the policy parameters that dedicated mental health sector staff will be asked to operate within. But it is the only place to authentically re-start.

Taken together as a new starting point, these and other such real and symbolic actions would signal to persons suffering from a severe mental illness that we have begun to match rhetoric with action.

INTRODUCTION

This essay is a response to the Stelmach government's proposed closure of 246 beds at Alberta Hospital Edmonton (AHE), a plan made public August 14, 2009, and which was much discussed through the fall of 2009 and the winter of 2010 (for brevity, I will hereafter refer to the government's approach as Plan 246). The form and extent of the services a society affords its mentally ill citizens has, of course, been a subject of debate for centuries. There always has been and always will be any number of irresolvable points in the discussion: What, precisely, constitutes a mental illness? What is the optimal mix of therapy and psychopharmacology? Are mental health patients better off being treated in the community, in general hospitals, or at dedicated psychiatric facilities? There are many more questions, and definitive answers are hard to come by. There is, however, one generally accepted point in the field that through persistent, if not willful, misapprehension continues to stain the public policy of mental health services in Alberta and elsewhere. This fact is that severe and/or chronic mental illnesses such as major clinical depression, schizophrenia, dual diagnosis, and psychosis, among others, are just that: illnesses.

Debate along the biological/existential divide certainly continues around mood disorders such as minor depression or anxiety, among others (Is it an illness, a condition, or an emotion?), but there is little such debate about severe mental illness. A severe mental illness is not a phase, a funk, a choice, an over-reaction, a weakness, a punishment, or a cop-out. It is an illness, not a personal failing or an emotional collapse. A person does not give in to clinical depression. Impulsivity does not invite bipolar illness. Someone suffering from acute schizophrenia has not brought it upon him or herself. A young teenager who has shot himself to end the intolerable anguish of his every waking minute has not taken the easy way out.

This is germane to the controversy surrounding Plan 246 because understanding and accepting that severe mental illness is an illness is necessary to a compassionate evolution of mental health services. In the absence of such consideration those who suffer from a mental illness will invariably be judged, usually for the worse. Stigmatization and discrimination are generally not significant factors for a person dealing with cancer or heart disease, but they are for a person with a severe mental illness. And when negative moral judgments are delivered, whether consciously or not, the quality, consistency and transparency of mental health policy will fall short of levels created for illnesses far less damaging to society (but which happen to evoke less stigma and more empathy). Unless mental health is seen as equivalent to other serious illnesses, the policies will, simply and inevitably, fail the people they are meant to help. The issue of mental health bed distribution, and, by extension, the extent and quality of all mental health services in Alberta, is directly related to our policy makers' acceptance and empathy toward the plight of the mentally ill and to

viscerally grasping the reality of how mental illness affects individuals and our society.

MENTAL HEALTH IS A SERIOUS ISSUE IN ALBERTA

Mental illness is a deeply serious matter, a seriousness not reflected, to date, by the mediocre content and sloppy execution of mental health policy delivered by the Stelmach government. The problem will deepen if inconsistent and poorly thought-out policy remains the norm. The statistics on mental illness show that it comprises a significant portion of all illness and of acute care services and that the Alberta government needs to treat it with much more seriousness.

The McDermott Consulting Group delivered a report entitled “Beyond Beds... to Balanced Care Mental Health” to the Alberta Mental Health Board (AMHB) in 2007, and in this report they referenced a study called the Global Burden of Disease, conducted by the World Health Organization, the World Bank, and Harvard University. This report stated that mental illness, including suicide, accounts for fully 15 per cent of the burden of disease in established market economies.¹ This is higher than the percentage for all cancers.

The numbers pile on top of one another. In 2005, the Capital Health Region released its *Roadmap for the Future* which pointed out that, “studies show that almost 34 per cent of Edmonton adults meet the criteria for mental illness. Over 20 per cent have substance abuse disorders, including alcohol and drug problems. Other problems include schizophrenia, manic depression, depression, anxiety disorders, anorexia, antisocial personality and cognitive impairment.”² Furthermore, 20 per cent of all Albertans will suffer from a mental illness during their lifetime. Alberta’s suicide rate is consistently the second highest in Canada (behind Quebec),³ and in 2002-03 over half a million Albertans were treated for a mental health issue. Over that same span, those half a million Albertans made an average of five physician visits each in which mental health was the primary purpose for the visit. That’s 2.5 million physician visits for mental health purposes, and in that same period close to 40 per cent of physician’s billings were in some way related to mental health issues. In 2001-02, some 34,000 Albertans visited, or were taken to, a hospital emergency room for a mental health crisis.⁴

In other words, in a province of 3.5 million people, mental illness must be treated with the same level of service and care, and dignity, afforded other serious illnesses. This would go without saying, except for the fact that it seems to need saying over and over again. The “same level” of service means proper funding, of course, but before funding it means context. It means treating an

illness with enough gravity, and affording it enough dignity, so that an idea to close 246 beds at a dedicated psychiatric facility is investigated through significant consultation and with enough advance planning to provide services at the same or higher level in the community (but only if that were to have been the advice of the gathered experts and other stakeholders upon such consultation).

TRIAL BALLOONS SUBSTITUTE FOR REAL PLANNING

The Alberta government seems to have been using a strategy of floating a trial balloon with people's lives to see if it will fly. When the Plan 246 balloon began to leak, the government initiated backtracking movements, (such as Stephen Duckett's statement, after the announcement, in early October 2009, when he said, "Our plans aren't firm yet."⁵). It then reversed the decision when the balloon popped. This is not merely bad governance and bad policy, it is a direct insult to those suffering from severe mental illness, and to mask it under the guise of "listening to feedback" is to further demean those already afflicted. Tellingly, there are even some who initially advocated for Plan 246 who have now reversed their stance. Dr. Patrick White, head of mental health services for AHS at the time of the Plan 246 announcements, voiced his concerns to the press in October 2009, warning that the government was moving too quickly and that the result could be a "disaster" for patients. Rather than taking years to gradually move patients out of AHE, White said there was pressure to get the beds closed in the next six to 12 months. White added that he was "getting the feeling this is a cost-cutting exercise. I firmly believe the move away from Alberta Hospital is too fast and not clearly thought out. I am really worried this whole plan will go off the rails, and we're going to make the same mistakes that were made in other countries like Italy, Ireland and in Vancouver. I know we've had assurances there will be no reduction in capacity, but I don't see evidence to date that this is patient-focused."⁶

Sadly, there is precedent in Alberta for the trial balloon technique of policy and legislation development. The Klein government attempted a similar action in March 1998, when, in violation of the Charter of Rights and Freedoms, it put forward Bill 26, which sought to limit the court's ability to award compensation to forced sterilization victims (2,800 people in Alberta institutions were sterilized without their consent under Alberta's eugenics program between 1928 and 1972). The outrage over Bill 26 was immediate and the government retracted it one day later. Plan 246, despite the backtracking that ensued, signaled an uncomfortable drift towards the same policy tendency – namely, circulate hazy and arbitrary cost-cutting measures purely to gauge the level of resistance rather than develop appropriate and detailed policy in the first place. And although the Alberta Tories aren't the first government (nor will

they be the last) to cut where the voice of resistance is weakest, most splintered, and least politically active (the mentally ill, persons with developmental disabilities), it is heartening to consider that with both Bill 26 and Plan 246 it was stakeholder outrage and public opinion that caused the reversals.

Through the fall of 2009, it became clear that the entire extent of the Plan 246 community-service redistribution strategy amounted to, “Trust us.” The Stelmach government encountered heavy criticism for both the Plan’s philosophical underpinnings and the seemingly scattershot method of its implementation (or, at best, its scattershot consultation and communications strategy). Backtracking in the form of reassessments and purported alterations to the plan ensued, a backtracking all the more dizzying given that in less than a year the government had gone from full-on plans for the redevelopment of AHE, to closing a majority of its beds, to leaving most of them open and shifting just one patient population. Plan 246, as we know, was altered in mid-January so that one hundred geriatric beds were reallocated to a still-under construction facility, Villa Caritas, with the remaining 146 mental health beds to remain open at AHE.⁷ This decision was announced literally within hours of a major cabinet shuffle that resulted in the replacement of embattled Health Minister Ron Liepert with the more conciliatory Gene Zwosdesky, all of which signaled that the government recognized the error of its ways while failing to arrive at a more appropriate solution.

Yet to this writer’s eye it seems that it’s principally the foundation of developing good policy that has been lost in the shuffle(s). For it is only by bearing in mind, vividly and with empathy, the despair of depression, the mind-rending confusion of schizophrenia, the torment of a person pushed so far he or she is willing to do the only thing that will bring an end to the pain – to kill him or herself – it is only through the prism of deep empathy that we can have a discussion around mental health bed allocations which respects the plight of the mentally ill. To do otherwise is to acknowledge that these citizens are less worthy of service and strong policy than an Albertan afflicted with lung cancer or awaiting bypass surgery. We don’t effectively toss cancer victims or coronary disease victims out on the street during phases in their care and recovery when they still desperately require acute hospital care. Why do we do it to those stricken with a severe mental illness?

This essay will explore some of the details surrounding Plan 246, and it will attempt to deconstruct the patterns of this and other deinstitutionalization approaches. It will not be comprehensive, due to space and time limitations, and it will not be overly prescriptive, since that task must lie in thorough and open consultation with both the people providing services to persons suffering from mental illnesses and, of course, with those they serve. It’s also important to point out that this essay does not consider deinstitutionalization, or “dehospitalization” as some in Australia call it,⁸ inherently negative

or positive. Deinstitutionalization as a philosophical stance is value-neutral for the purposes of this essay.⁹

The Alberta government conveys the impression of being fixed in a decades-long recurring, and therefore stultifying, cycle of policy mis-development around the configuration and distribution of mental health beds.¹⁰ There have been no fewer than 12 major mental health reviews and studies in Alberta since the 1967 Blair Report,¹¹ and yet it would be fair to say that there has been more bureaucratic change than attitudinal change in this province. No one doubts that civil servants and frontline care givers are individually committed to finding the best therapeutic results for persons suffering from severe and debilitating mental illness, but a variety of factors invariably seem to stand in the way of comprehensive systemic solutions: broad political partisanship; an absence of political accountability; inefficiency; fluctuating budget allocations; opposing philosophical stances; lack of communication and coordination between related health services; and many others.

A compassionate and efficient delivery of acute mental health services, and therefore of the beds within those services, is a challenge under the best of circumstances. But what this essay will demonstrate is that the Alberta government has put the health of Albertans with severe mental illnesses at risk by designing policy that ignores common sense approaches the now-disbanded Alberta Mental Health Board endorsed, that it has chosen not to take into consideration readily available evidence from other jurisdictions about the perils of overzealous deinstitutionalization, and that it has failed to perform due diligence in ensuring that community capacity exists to accommodate the redistribution of beds and services from specialized psychiatric hospitals into other areas of the broader health system. Transparent policy and treatment discussions in which people suffering from a severe mental illness do not find their dignity or human rights compromised would be a good platform from which to begin designing a new mental health services delivery model. As this essay hopes to illustrate, Plan 246 did not display a commitment even to this basic principle.

MENTAL HEALTH POLICY RESEARCH IN ALBERTA

Trying to understand the milieu in which Plan 246 was developed and its execution attempted, it's helpful to consider Alberta's past research into mental health sector reform since it might offer some insight into what to expect in the near and intermediate future. The 2007 McDermott Report was a major study submitted to, and accepted by, the Alberta Mental Health Board. It called for a move to

a Balanced Care Mental Health Model, which was embraced by the mental health sector but largely suppressed by the government.

The most recent major study undertaken, referenced earlier, was the 2007 McDermott Report, a detailed and comprehensive report of the Provincial Mental Health Bed Review, commissioned by and submitted to the Alberta Mental Health Board (then operating under Alberta Health and Wellness). A professional and largely dispassionate report, it would also be fair to say that it was written with a predisposition towards deinstitutionalization, although it did recommend retaining one specialized psychiatric hospital, the Centennial Centre in Ponoka.

The humanistic and broadly sensible approach that is everywhere apparent in the McDermott Report only increases the mystery around why the government attempted to suppress it, and why it became the subject of controversy and Freedom of Information requests.¹² True, some of the report's conclusions were challenging to the government; it pointed out that Alberta had a quarter of the mental health beds as the national average (45 per 100,000 as opposed to the Canadian provincial average of 190 per 100,000; this number has since shrunk as low as 26 per 100,000, according to some estimates¹³), and it openly called for the government to address this shortfall (albeit with dedicated mental health beds to be placed in the community).¹⁴ But the government threw author Irene McDermott, or at least her report, under the bus despite her extensive track record and experience. As far back as 1994 she wrote "The Mental Health Action Plan for the Edmonton Area," a report prepared for the Edmonton Regional Mental Health Planning Committee. In this report, she highlighted the need to move towards a new consumer-focused system with a blend of community and institutional services, a form of deinstitutionalization-lite (which may, in itself, ultimately prove forward-thinking).

The attempted suppression of the McDermott Report is perplexing for two reasons: first, as alluded to above, the shortfalls it highlighted were important but not nearly sensational enough to bring down a government (and the report was accepted by the AMHB, after all). The second puzzling element of the furor around the report was that it advocated for a broad course of action the government has since declared it wants to pursue, namely deinstitutionalization. It can only be guessed that attempts were made to bury or ignore the report because although it recommended deinstitutionalization, it recommended not cost-cutting but increased spending funneled into community services. Presumably, the government wished to suppress it because accepting it would have placed it in the position of having to consent to a wide spectrum of humanistic and comprehensive principles. These principles were fine as they stood on their own, but the report married them to spending increases and not so much a system overhaul as a system reinvention (the Balanced Care model). Certainly, anecdotal and narrative evidence suggests the mental health system was enthused with the Balanced Care model, to the degree it

was allowed to experience it, but the report and its model have still never been “officially” released to the public.¹⁵

In any event, the McDermott Report illuminated Alberta’s long history of mental health policy ambiguity married to a long history of commissions and studies examining this ambiguity. Past reports in Alberta included the 1967 Blair Report, the 1980 McKinsey Report, two reports on child mental health in 1986, and a major 1992 government paper. Another significant discussion paper was released by the Alberta Alliance on Mental Illness and Mental Health in 2000. As alluded to earlier, there have been a dozen major studies of Alberta’s mental health sector since the Blair Report. There is yet another study currently under way examining how to best construct a new shelving unit to hold the studies banished to storage.

As the latest in this long line of reports, the McDermott Report advocated for the adoption of Balanced Care Mental Health, a sensible and patient-focused mix of Primary Care, Mainstream Mental Health, and Specialized/Differentiated Services. And although, as mentioned, it makes no effort to hide its bias, the report does speak to the danger of pursuing deinstitutionalization overzealously.¹⁶

Beds are seen as critical for the mental health system, are defined broadly, and are recognized as an interdependent element of the system all of which is consistent with balanced care principles. The bottom-line for beds is that the current availability, access and use of mental health beds is dependent on the corresponding availability, access and use of the full array of community care, support and treatment services required by individuals coming to the mental health system. This is where the balance is played out. Having the full array of services available allows for the delicate balance between the use of beds and community services. One without the other does not allow the system to function as it can. They must both exist and they must both function as a whole, not as separate factions.”¹⁷

Of course, complications arise at every corner when trying to count and define beds and bed usages. For instance, bed utilization tends to be higher where there are more beds available. More community options tend to reduce the length of stay in a mental health bed. And, naturally, the more alternative services there are, such as primary care, crisis intervention, emergency services, home treatment, and so on, the more the bed usage numbers will be impacted. The point is that it’s hard to define precisely what is the “correct” number of beds, although the McDermott Report states very clearly that, “reductions in bed numbers would also not be appropriate at this time,” especially given the low bed numbers alluded to earlier (45 beds per 100,000 population, compared to the EU average of 100 beds per 100,000). An Australian model of stepped care recommends an average of 70 mental health beds per 100,000, based on a complex formula of acute beds, rehab beds, 24-hour staffed community beds,

and part-time staffed community beds.¹⁸

Overall, the McDermott Report was rooted in moving the government and our province's mental health policy toward a greater sense of respect and dignity for those who suffer with a mental illness. Yes, it does present deinstitutionalization as inherently superior to care delivered in a specialized psychiatric hospital (a conclusion that is far from certain, as we will see), but nevertheless the report pointedly summarizes the dangers of poor planning and, in some ways, predicted the problems the Stelmach government would face in the absence of thoughtful process around Plan 246. In writing about the need to look at the system comprehensively and to take the time to fully understand the interdependence of its very complicated parts, McDermott wrote,

Lack of attention to the coherence of the model will result in the issues that the province continues to struggle with today. The lack of fully developed community services, lack of attention to housing and basic living needs of individuals with mental illness, taking one system away (e.g. reducing beds) before another is firmly in place (e.g., increasing community options) and so on, all impact the functioning of the system. As was not the case in the previous "deinstitutionalization" efforts, it is critical to attend to an evolution of the system to one of balanced care. This evolution process requires the development of additional services before decisions can be made about others.

In this case the question of whether the current overall complement of traditional mental health beds (acute care and rehabilitation) is increased must be held until the endorsement of the model is followed with development of services that directly impact the need for and use of beds. These include crisis services including short stay beds either in or out of hospital, community in-home treatment teams, mental health presence in emergency departments, knowledge awareness of mental health and mental illness in primary care, a full array of supported living options for individuals with mental illness and a comprehensive set of community services.¹⁹

Whether one feels as predisposed towards deinstitutionalization as does the McDermott Report (recognizing that the report actually calls for mental health bed increases, just in the community), the fact remains that there is an inescapable truth in its pages. A person suffering from an acute mental illness is in an exceedingly fragile moment in their lives, and to attempt adjustments to the mental health service delivery landscape requires compassion, caution and sensitivity. Plan 246 did not display these characteristics. Instead of compassion and caution, AHE patients were informed in December of 2009 that they would no longer be supplied with toiletries.²⁰

Towards the end of her report, McDermott wrote as if prefiguring what might become of both her report and of the mental health bed discussion. Under her actions, she notes that many of her recommendations are dependent upon a

shift in thinking from the government, towards her favoured Balanced Care model, but that whether beds are moved from AHE or not will be irrelevant at best, and harmful at worst, if there isn't proper funding for community options. "Without this endorsement and additional support," she writes. "it is likely that inpatient beds will need to be increased within the region."²¹

McDermott's justified frustration at seeing her extensive work shunted to the side like so many other reports was expressed in a recent article for *Alberta Views* magazine. "We expect the mental health system to be organized according to people's needs and designed to promote mental health and support people with mental illness. Instead we find a system organized according to the 'artificial' structure of government departments and designed to suit needs of providers, not users."²²

Of course, we know that this additional support did not materialize in Plan 246. As Tom Shand, executive director of the Alberta division of the Canadian Mental Health Association, said when Plan 246 was announced, "It's almost like putting up a building at the same time you're bringing in tenants. The broader planning has not been done."²³

"Broader planning" is at a premium in Alberta. The province's history of oppositional, binary thinking (right vs. left, rich vs. poor, urban vs. rural, west vs. east) has led to an either/or mentality with deinstitutionalization, a pattern unearthed in the McDermott report, and which was reinforced by Plan 246. But this is not an either/or situation. It calls for subtlety, nuance, new and fresh ways of thinking that have as their goal one thing and one thing alone: the process that will best serve a person with a mental illness. Whether that process ought to involve full-steam-ahead deinstitutionalization is far from conclusive, as jurisdictions outside of Alberta have found.

RECENT MENTAL HEALTH POLICY IN AUSTRALIA

Australia has undergone an extensive deinstitutionalization over the last four decades, but the results have been decidedly mixed. A large number of mental health professionals in Australia are now decrying what they call the "dehospitalization" of mental health beds, and are calling for the government to return to a system of dedicated mental health beds in specialized psychiatric settings combined with a more comprehensive commitment to community services. Australia, many there are saying, has gone too far and the lives of persons with severe mental illnesses are now worse than before because the health system has lost the ability to provide adequate services

for this population.

One aspect of the psychiatric bed issue plainly of value is in seeing and understanding the experiences of other jurisdictions, and to examine whether there are parallels worth observing and interpreting. Albertans can consider those experiences when deciding how best to respond to the still-live issue of Plan 246 and the possibility of the redistribution of large numbers of beds into the community and various general hospitals. One jurisdiction worth studying is Australia; a pointed example, given that President and CEO of Alberta Health Stephen Duckett is an Australian hired for his touted wealth of experience in overseeing health sector transformation. Widely trumpeted as a change agent capable of making and implementing tough decisions, Duckett hails from a country that has been embroiled in controversial mental health policy evolutions, revolutions and, some would say, devolutions for the last 20 years or more.

Over the last four decades, but particularly in the last two, Australian policy-makers carried out a deinstitutionalization and acute bed redistribution. The number of available long-stay beds was reduced dramatically, Australia has reduced its public sector mental health beds, meaning beds in public hospitals, by 80 per cent (from 30,000 to 6,000) in the last 40 years (1965-2005), a period in which its population doubled. The simple statistical reality is bracing. Australia's population in 1965 was roughly 10 million, and approximately 20 million in 2005, which means that in 1965 Australia had 300 beds per 100,000 population, a number that had fallen to 30 beds per 100,000 population by 2005.²⁴

The reforms in Australia included a shift of emphasis onto community services and beds. According to Ruth Vine, the former head of mental health at the Department of Human Services, as of 2005 65 per cent of available mental health beds were in the community. That was double the percentage of community beds in the 1980s.²⁵ There has been heavy criticism of the Australian reforms from advocates and service providers.

Dr. Simon Byrne is a psychiatrist with decades of experience in Western Australia, and in 2005 he wrote to the Senate Select Committee on Mental Health, in response to its Terms of Reference, around the extent to which, "the National Mental Health Strategy... (has) achieved its objectives, and the barriers to progress." Dr. Byrne's primary concern was what he termed the "policy failure" of the national strategy for not properly providing for patients

severely and chronically disabled by mental illness.²⁶

Dr. Byrne noted for the Senate Committee that although deinstitutionalization began in the 1950s and had met with varying levels of success with different populations along the way (in that it has proven beneficial to persons with developmental disabilities), there was nevertheless increasing research to show that “long stay” mental health patients (usually a year or longer) still required and used hospital stays. This patient group has typically been comprised of patients who are elderly, behaviourally disordered, schizophrenic and assaultative, brain-damaged and assaultative, and psychotic, among others. These are, Dr. Byrne points out, patients who are “extraordinarily difficult to find placement for in the community.” They are also likely to be re-admitted after initial discharge.²⁷

Since Australia launched its National Mental Health Strategy in 1992, successive Mental Health Plans have not, insists Dr. Byrne, properly considered the needs of long-stay patients, as evidenced by the low number of available long-stay beds.

Dr. David Copolov, a Professor of Psychiatry and for 20 years the head of the Mental Health Research Institute of Victoria, does not use the word deinstitutionalization, but *dehospitalization*, and in a 2010 interview for this paper called the policy a flawed social experiment, “a blight that will come back to bite patients and their families for many years to come.”²⁸ This policy failure, he has written elsewhere, has resulted in the chronic blocking of acute hospital beds by patients who cannot find proper treatment and care in the community, a drop in the quality of therapy in those acute wards, a poor quality of life for patients with severe disabilities from their mental illness (whether in hospital or not), and a demoralization and skill depletion in staff who work in the remaining long stay care environment.²⁹ Dr. Byrne, in concert with Dr. Copolov, says that the policy priority ought to be creating long-stay wards with a rehabilitative focus.

It is therefore rather misguided to close long-stay beds and simply hope that general hospital acute beds can accommodate the need. If long-stay beds are to be transitioned away from stand-alone psychiatric hospitals, the number of overall beds must not change, nor must the resource allocation. They must be dedicated long-stay beds, with a rehabilitation focus. The reality remains, however, says Dr. Byrne, that although such patients should be seen as moving towards community life in the future, “the work necessary to achieve this may take very long periods of time and may not always be successful.”³⁰

The difficulty of community treatment of mental health patients severely disabled by their illness was addressed by Dr. Copolov in an essay in the *Sydney Morning Herald* in late 2005. In this article, he commented upon what he saw as flawed policy from the Australian government. He criticized the “absence

of capacity” in the community. It is clear, he went on, that “most people with psychiatric illnesses can, should and wish to be treated in the community...But neuro-biological diseases such as schizophrenia are often enduring, relapsing and serious, and are sometimes life-threatening. For a significant minority, care in the community will, at times, be unable to provide an adequate standard of care. Under such circumstances, admission to hospital should not be considered a sign of failure, any more than admission to hospital after a myocardial infarction should be considered a sign of failure.”³¹

The point being, Dr. Copolov argued, that mental health policy architects in Australia have ignored the reality that there is an “absence of the capacity to adequately deal with the consequences of taking people out of hospitals.”³²

In other words, deinstitutionalization, or *dehospitalization*, was enacted without due consideration for how to replace the same level of care and expertise in the community, the result being pain and suffering for those whose illnesses could not be properly treated in the community. Dr. Copolov did support many findings of the Australian Mental Health Council’s 2005 report, *Not for Service*, but felt compelled to criticize it for not having a single specific recommendation for providing “more and a higher standard of acute and long-term psychiatric hospital beds. This is a notable omission given that the report includes a constellation of powerful personal stories of profound hardship and sometimes tragedy, many of which could have averted by the ready availability of high-quality specialist psychiatric hospital facilities.”³³

It’s worth noting that Australia utilizes a two-tier health system; a variety of private hospitals offer mental health beds, and in fact there are many stand-alone specialist psychiatric hospitals in Australia.

In general, it would seem that a critical misread of the daily reality of the mental health patient severely disabled by his or her illness took place in Australia as a result of its perhaps overzealous deinstitutionalization process between 1965 and 2005. Repercussions continue to be significant. The journalist Peter Ellingsen, writing in *The Age* newspaper in 2005, said that the Australian Health Service was failing people with psychiatric illnesses, and that the Department of Human Services was urgently requesting more beds from the Victoria state government. Public hospital emergency wards were being “swamped” by psychiatric patients, and the state president of the Australian Medical Association, Sam Lees, had labeled mental illness as the state’s most important overall health problem.³⁴

Dr. Lees told Ellingsen that the state of Victoria had a fraction of the beds available in other jurisdictions around the world, at 21 per 100,000 population (with Australia as a whole at 30 beds per 100,000, Canada at 193 beds per 100,000³⁵ and Alberta at 45 per 100,000.³⁶) This lack of bed space was directly responsible for conditions of overcrowding in public hospital emergency and

psychiatric wards, a direct compromise to the dignity and human rights of the patients seeking help, both for mental health issues and other physical issues. This has all happened despite the fact that Victoria has attempted to move most of its acute beds into community settings. Dr. Lees noted that patients with severe mental illnesses simply need more – more access to psychiatrists, more acute hospital beds, and more time spent on assessment and consultation.³⁷

These concerns were echoed in a joint 2008 article entitled “The Number One Priority for Mental Health Services: Caring for the most seriously affected patients.” In this article, seven of Australia’s most eminent mental health clinicians reiterated for policy-makers that managing the most serious mental disorders is extremely difficult and sensitive work, and that “unless adequately managed these disorders place a severe burden on the patient, their relatives, and the wider community.”³⁸

Their assessment is that upon first admission a patient with a serious mental illness will typically require four to eight weeks’ stay in a dedicated psychiatric facility (as opposed to Melbourne’s current average stay of 11 days). A stay of four to eight weeks allows for thorough assessment and the establishment of treatment modules, whereas a stay of 11 days all but guarantees readmission. The shortened stays are directly linked to the drop in beds available in Australian public facilities alluded to earlier, from approximately 300 per 100,000 population in 1965 to 30 per 100,000 population in 2005.³⁹

Again, it’s important to reiterate that deinstitutionalization and the placement of mental health beds in the community and in general hospitals is not an inherently negative action; theoretically, and frequently in reality, it can increase the quality of life of a person with a mental illness, especially if medication compliance is not an issue. However, using admirable restraint, the esteemed psychiatric panel wrote that, “there is ample evidence that there has been a very substantial overshoot in the reduction of inpatient facilities so that currently patients with severe psychiatric illnesses are often deprived of appropriate periods of hospitalization.” They go on to write that a good deal of evidence now exists to show that the consequences of such deprivation include a high rate of mental illness among homeless populations and amongst the imprisoned.⁴⁰

Furthermore, recent research has also shown that a clear relationship exists between a low bed number per capita and high suicide rates. Canada and Australia have similar national suicide rates,⁴¹ but Alberta’s suicide rate is consistently the second highest in Canada (behind Quebec),⁴² signaling that, at the very least, caution is warranted with regards to the Alberta government’s worryingly ill-defined reassurances that community services will be properly funded.

A fundamental conclusion, write the Australian panel, is that “the culture among mental health administrators that most admissions are bad and that the more days they last the worse it is must be stamped out.” It’s obvious that if deinstitutionalization and the transition of beds to the community and general hospitals results in an improved quality of life for the severely mentally ill, this can only be a good thing. Banishing the “asylum” is a good thing. However, it appears that in Australia at least, and in the opinion of these eminent psychiatrists, the pendulum has swung too far in the opposite direction, past eradicating the Victorian era asylum, to an “equally destructive approach which minimizes admissions and prioritises rapid discharge,” so that the decision now is not the quality of care in the round, but simply “whether the patient is able to be managed without suicide or assault in the community.”⁴³

The approach and perspective on policy must change, they assert, “to a much more therapeutic, patient-centred” outlook.⁴⁴

The panel recommended an expansion of bed-based services and increasing the stock of mental health beds in a variety of settings; the creation of a comprehensive database; and the reformation of inpatient policy to take into account the need for longer stays for patients with severe symptoms and other risk factors. Lastly, while discussing early intervention strategies, the panel noted, simply, that “outcomes for patients – in terms of function and rates of readmission for seriously mentally ill people of any age – are greatly improved by the provision of good services involving adequate periods of inpatient care in a therapeutic environment; family and carer involvement; ongoing support and rehabilitation; substance abuse treatment; and the provision of stable accommodation in low crime neighbourhoods.”⁴⁵

More recently, in 2008, the Hon. Nicola Roxon, Australia’s Minister of Health and Ageing, stated that some of Australia’s mental health funding in years past was “directed into poorly targeted or designed programs, and these programs have struggled to achieve targets.” The overarching failure of the Australian mental health policy, she said, was its inability to “ensure that people are receiving the right support where they need it and that this support results in better mental health outcomes.”⁴⁶ This assessment was echoed by John Mendoza in 2009 at the Sydney conference of the MHCC-NADA, in a paper entitled *Where to for Mental Health Reform in Australia?* Mendoza, Chair of the National Advisory Council on Mental Health, reiterated that national funding and effective governance structures are vital for properly supporting persons with complex and severe needs, but that instead Australia needed to be wary of what he termed a “10-year cycle of failure” that was a historical trend in mental health policy.⁴⁷

Over the last four decades, but particularly in the last two, Australian policy-makers carried out a deinstitutionalization and acute bed redistribution that was, if not radical, then at least comprehensive and single-minded. It also

seems clear that this process was enacted without ensuring proper supports were in place at various community levels. In fact, there was and remains considerable resistance in the therapeutic community to the redistribution of these beds. Aside from the policy resistance, a consistent criticism is that appropriate financial and administrative support did not follow beds, or patients, relocated to the community and to general hospitals. There has also been an absence of support in the implementation of various strategies, not to mention a lack of recognition that community living is not the right answer for every person suffering from a mental illness, particularly those with severe and enduring illnesses.

The Australian mental health system's experience is a cautionary tale for Alberta, particularly in light of the patent lack of foresight shown by Plan 246. As Australia has learned, moving beds from dedicated psychiatric hospitals into the community is therapeutically unwise in certain contexts, but it is also philosophically and logistically complex enough to warrant years of consideration and planning, not weeks.

THE VANCOUVER RIVERVIEW EXPERIENCE

In closing its Riverview psychiatric hospital, the city of Vancouver experienced what some would call radical deinstitutionalization beginning in the 1970s and peaking in the 1990s. Seen as progressive at the time, the results are now best seen as mixed at best and many, such as the Vancouver Police Service, are saying it has turned out to be a negative influence on the city. Even Premier Gordon Campbell labeled the Riverview deinstitutionalization a "failure."

Closer to home, the city of Vancouver underwent a significant deinstitutionalization beginning in the 1970s and reaching its apex in the 1990s when its dedicated psychiatric hospital Riverview was closed, and its patients and (supposedly) services distributed throughout the province.⁴⁸ It was widely trumpeted as progressive at the time,⁴⁹ but the lens of history has revealed a gap between the high expectation of theory and hard truths of implementation. Reporters on the subject have written that it is "obvious to anyone with eyes to see that the policies around caring for the mentally ill have been such a tragic failure. Just look around. Hundreds of vulnerable people are clawing out a pitiable existence on our streets, in dumpsters, in filthy and dangerous skid-row hotels or in jails -- largely because of the misguided efforts of civil libertarians and "social-justice advocates" to keep them out of mental institutions. But the mentally ill people who haunt our streets and cause us to turn away in embarrassment should actually serve as eye-opening proof of the failure of deinstitutionalization. The decision to drastically downsize institutions like Riverview Hospital and eliminate hundreds of psychiatric care beds was meant

to free mentally ill people from stigmatizing confines of padded rooms, white-jacketed wardens and forced drug therapy. In the name of human dignity, the mentally ill were turned into the streets. Then they were forgotten and left to fend for themselves. What's so "dignified" about that?"⁵⁰

It was British Columbia Premier Gordon Campbell who eradicated the office of the Mental Health Advocate in BC and who made significant cuts to mental health staff in his province, but it was also Gordon Campbell who, in a speech to the Union of British Columbia Municipalities on October 27, 2006, admitted that deinstitutionalization had been a "failure."⁵¹

There have been other sources coming out to offer their experiences with Vancouver's deinstitutionalization. In January 2008, Detective Fiona Wilson-Bates of the Special Investigation Section of the Vancouver Police, released "Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Resources." The essential message of the report is that from a policing perspective there has been a clear connection between the mentally ill homeless/criminal population and the drain on public resources such as policing, and that this gap is the result of poor community resource follow-on in a post-deinstitutionalization landscape. She pointed out that with the numbers she was about to provide, it was probably the case that there was an "underestimation of calls for service that involve a mentally ill person as opposed to an overestimation." She continued:

A conservative economic analysis suggests that police time spent dealing with incidents where a person's mental illness was a contributing factor in police attendance is equivalent to 90 full-time police officers, at an annual cost of \$9 million. This would not include indirect policing costs, or the costs to other agencies such as the ambulance service, hospitals, or the court system.

There are several possible contributing factors to the excessive police interactions with mentally ill individuals. These include a mental health system that has not kept up with the loss of resources in the wake of deinstitutionalization; a profound absence of information sharing between mental health resources in the Lower Mainland; and an unwillingness on the part of service providers to fully utilize the provisions of the *Mental Health Act* due to a lack of available resources and/or personal ideology. These services are particularly sparse for people who are mentally ill and also addicted to illicit drugs or alcohol. Although patrol officers have become front line mental health responders, investigating over 1,744 incidents where an individual was arrested under the provisions of the *Mental Health Act* in 2007 alone, the options available to them when interacting with a person who is mentally ill are limited to institutions (jail, court, hospital) that are struggling to accommodate people for whom they lack capacity and/or were not designed to manage.

In particular, the Downtown Eastside is a predictable example of what happens when people who need various levels of community support are left to fend for themselves. Drawn by cheap accommodation and access to services, they are often the victims of predatory drug dealers, abusive pimps and unsavoury landlords who take advantage of their vulnerabilities. These people are consequently coming into frequent contact with VPD members who in turn rely on the provisions in the *Criminal Code* in the absence of an acceptable response from hospitals to admit mentally ill patients.

The key finding of this research is that there is a profound lack of capacity in mental health resources in Vancouver. The result is an alarmingly high number of calls for police service to incidents that involve mentally ill people in crisis. VPD officers, along with the citizens with whom they come in contact, are bearing the burden of a mental health system that lacks resources and efficient information-sharing practices, often with tragic consequences. In an effort to address the current situation, several recommendations are made that centre on the need to better serve people who are mentally ill in Vancouver.⁵²

Among the recommendations that Detective Wilson-Bates's report makes are to construct a new mental health care facility in Vancouver with capacity for up to 500 patients. It also calls for an "Urgent Response Centre" where individuals can be assessed and triaged. Dual diagnosis service increases are also recommended, as is a considerable increase in supportive housing in Vancouver. Wilson-Bates reports that an estimated 70 per cent of Vancouver's inner city population (who are either homeless or living in flophouses) have mental health issues and that 23 per cent have a diagnosed mental illness. Lastly, she calls for enhanced admission processes at general hospitals, better data gathering and collation, and an accessible database.⁵³

The Federal Government has also sounded recent notes of warning and alarm around the criminalizing effects of deinstitutionalization without community support follow-through. In the 2008-2009 Annual Report of the Office of the Correctional Investigator, former federal Public Safety Minister Peter Van Loan stated "that over the past three decades, we have progressively moved toward a community and outpatient system of 'deinstitutionalizing' the mentally ill from provincial facilities, only to discover that we are 're-institutionalizing' them as prisoners." Van Loan bluntly characterized the problem as one of "criminalizing the mentally ill."⁵⁴

Further, the Correctional Service of Canada has pointed out that "since 1997 there has been an 85 per cent increase in the number of offenders identified with a mental health disorder at intake" and that their improved intake screening test for mental illness "suggests one in four offenders has some

degree of mental illness at admission.”⁵⁵

Based on the evidence presented in Vancouver, if Alberta, and in particular Edmonton, wish to develop a “Downtown Eastside” with a significant population of the homeless and criminalized mentally ill, we need only to follow the Riverview example: pursue zealous deinstitutionalization, claim there are community resource plans, fail to follow through for many years, ignore the advice of experts on the street, and then have a future premier – given that Premier Stelmach and Stephen Duckett will have long since retired – announce that the deinstitutionalization measures of the 2010 era were a failure. By then, we will have thrown away the lives of hundreds if not thousands of Albertans. Hospital capacity will have disappeared. The political appetite for reconstructing the system will have evaporated. The public’s level of empathy will have been sorely tested. All of which will no doubt have further increased the stigmatization of the severely mentally ill. This possibility, supported by the evidence from other jurisdictions gathered herein, is clearly at odds with Stephen Duckett’s remarks that the “worldwide literature” fully endorses deinstitutionalization?⁵⁶

Undoubtedly, and not without logic, Mr. Duckett and the Alberta government will protest that the issue with the Riverview deinstitutionalization was not the move itself but the ensuing lack of community capacity. Such a statement would be reasonably open to debate, but even if we were to allow it as fully valid, the response is obvious: Do not, then, proceed with any level of deinstitutionalization until and unless community and general hospital capacity is at least the equal of the service currently offered in specialized psychiatric facilities. Not “planned for.” Not “we are committed to providing.” Already in place, waiting, staffed, ready. *There*. Otherwise, Edmonton’s own Downtown Eastside will allow us to feel as if we are visiting Vancouver, though this is perhaps not the west coast experience most Albertans will wish to replicate.

COMMUNITY CAPACITY

Evidence from academic studies by Donna Wilson at the University of Alberta and the Auditor General of Alberta indicate that the community capacity is currently not adequate, and was inadequate prior to the announcement of Plan 246.

Research conducted by Dr. Donna Wilson of the University of Alberta has indicated that hospitals in Alberta are under pressure from younger high users suffering from acute mental illnesses. To close beds at AHE under these circumstances would significantly increase the pressure on the system and on this patient group. Wilson’s study also included a survey of factors contributing to the significant need for and use of inpatient hospital beds by younger readmitted mentally ill patients as well as older long-stay patients, many of

who were also suffering from some form of mental illness. Wilson found her investigation evolving around three distinct themes: (a) serious illnesses and high care needs, (b) hospitals are an accessible and often sole place to get needed care, and (c) factors external to these people engender long hospital stays or readmissions.⁵⁷

Some of the details of the qualitative research are worth examining in greater depth. In the first theme category, “Serious Illnesses and High Care Needs,” she points out that readmitted patients – those younger adults with a severe mental illness – reported a variety of factors for returning to the hospital, but their inability to care for themselves in the community, or for the community to care for them, was a common thread.⁵⁸ Most were unable to care for themselves, and were at increased risk if they lived alone. Some of the patients she spoke with lived in unsupportive family arrangements, and a social worker she spoke with said that in cases of patients without social support, they tend to be hard to support, “which exacerbates their isolation and loneliness issues. The acutely ill also don’t tend to have self-insight.”⁵⁹

In the second theme that emerged during Dr. Wilson’s qualitative research – hospitals are an accessible and often the sole place to get needed care – she found that two categories predominated: (a) few community-based care options were available, and (b) emergency departments are often the only place one can go.⁶⁰ The records and accounts she accessed showed that patients were all admitted through the emergency department in a state of advanced illness and/or “crisis,” and that many thought of the hospital as the “only” option. Furthermore, many of these patients were not aware of any publicly funded or free resources/supports available to them in their community, other than their family doctor. One nurse reported that mentally ill patients are often unaware of the few existing resources in the community, as demonstrated by her comment, “The thing is, clients have to know about it too. They may be out there, but the people don’t know about it.”

The “reality” of everyday living for those without a mental illness is a radically different thing than for those suffering from a severe mental illness. What we know as real is not the same thing as what a suicidal or psychotic person knows. Whether a service or option is “real” or not is, of course, irrelevant if a person can’t find it, can’t access it, or isn’t allowed to use it. Dr. Wilson found that even mentally ill patients familiar with services or programs in the community often reported these as “few and far between” and “ineffective,” and that none appeared to be well-suited to their needs..⁶¹

Under her third theme –concerning long stay or readmission elements external to the person – Wilson noted that there were both in-hospital and post-hospital factors involved. Among them were “unmet needs” in the hospital, such as “being lonely and needing assistance with suicidal and other negative thoughts,” which Wilson noted were commonly reported among the mentally

ill patients she gathered data from and on. And in each case, she added, “they did not feel and the charts did not reflect that these needs were recognized, particularly when they were admitted to a unit that was not designed and staffed for the mentally ill.”⁶²

Post-hospital the situation did not dramatically improve and in some cases there was a clear deterioration in quality of life. First off, there was typically a longer than needed wait for discharge due the lack of appropriate housing for mentally ill patients. As one nurse told Dr. Wilson, “Our clientele don’t really fit in anywhere. They fit between the cracks.” Another interviewee, a physician, told Wilson that safe and affordable housing is hard to come by for persons suffering from a mental illness because, in his words, they “face discrimination” when seeking a community living situation, given that private facilities “can choose who they want (and) do not choose people who might be difficult.” This has been a common feature of the transition to community living for the mentally ill across many jurisdictions since the inception of deinstitutionalization.⁶³

Many people suffering from a mental illness have had issues with addictions and violent behaviour, which has also often precluded them from accessing many transitional and residential facilities. One nurse also told Dr. Wilson that many such people were discharged from post-hospital facilities for “rule infractions,” meaning that they were forced onto the street or into living situations detrimental to recovery.⁶⁴ This nurse was concerned that people with mental illness are highly vulnerable to being taken advantage of, especially if they live on the street, saying “mentally ill people are often readmitted to hospital as the community is not safe for them.”

Post-hospital financial difficulties were also a problem. All mentally ill participants interviewed were currently unable to work. When not in hospital, they relied on charity, disability allowances, or social assistance funds that one said would “barely pay the way.”⁶⁵

Wilson concluded this section of her report by noting that “hospitals were an accessible and in many cases the only place” where long-stay and readmission mentally ill patients felt they could find the care they needed. As we have already noted, for a person with a mental illness a return to community living is the goal, but although sometimes a long-term goal and sometimes a short-term goal, it is never a realistic goal if the community does not possess the capacity to care for such a person. The evidence would certainly appear to indicate that Alberta has not yet reached the threshold of community capacity required to support significant dehospitalization, to use David Copolov’s term, or even the “mainstreaming” suggested by Stephen Duckett (a word he uses to describe transferring mental health beds to general hospital settings).⁶⁶

Wilson’s exhaustive study also examined many other aspects of the hospital

usage landscape, and one of these was psychiatric hospital use. She found that at AHE nearly five out of six patients admitted were in the younger category, and that younger people with mental illnesses tended to be admitted multiple times, whereas older patients typically had longer stays, even if it was often due to waiting for an appropriate community bed, as alluded to earlier. Wilson noted that at the two full-use hospitals she studied, it was still nevertheless mental illness that was the most common diagnosis among the younger high-users. These findings, she said, were “remarkable, as mental illness affecting younger persons has not been recognized as a risk factor in the high use of hospitals. Nor has mental illness care been considered as a factor for the long waits for hospital-based diagnostic tests and treatments of physical ailments.”⁶⁷ “Mental illness,” Wilson continues, “was also found to be a significant factor for the use of acute care hospital services. This use of hospital resources for acute mental illness care has not been widely recognized, although the 2008 CIHI report on mental illness care in Canada outlined that a considerable proportion of acute psychiatric care is now provided in general hospitals.”⁶⁸

Meaning that, colloquially speaking, general hospitals are already struggling with an official mental health caseload. The situation, Wilson’s data shows, is not trending in the direction AHS has been willing it to go. In the evident absence of a concerted and transparent shift of resources to the community, how, one wonders, does AHS imagine that a radical closure of designated mental health beds will actually better the situation in Alberta’s general hospital emergency rooms, or, even more significantly, better the lives of Albertans suffering with a mental illness?

In the middle of her concluding statement, buried in the middle of a paragraph, Wilson puts a finger square on the problem. “The findings from the two-hospital study, the qualitative study, and the psychiatric hospital study suggest that community-based options may not be as advanced, effective, or accessible as needed by acutely or severely mentally ill persons.” And further on she adds that “this case study indicates that closing psychiatric hospital beds, beds that are used by persons who are at considerable risk of being high users of inpatient and ambulatory hospital care services, would likely have an impact on general public access to all acute care hospital services; including inpatient beds, ERs, outpatient clinics, and daysurgery clinics.”⁶⁹ Even in the decision to move the 100 geriatric beds from AHE to Villa Caritas we could see palpable effects on the broader hospital system. “Closing 100 psychiatric hospital beds,” she writes, “is likely to put pressure on the 154 mental health beds in the nearby city, as well as the other 1,867 acute care hospital beds. Other issues could occur with the backlog of patients needing acute psychiatric care in acute care hospital and nursing home beds around the province, such as patient and staff safety issues. Still other issues could occur if community-based care options are not expanded, as more persons would need a higher level of community-based care with the acute psychiatric hospital bed closures.”⁷⁰

Even the Villa Caritas aspect of Plan 246, then, appears both therapeutically and financially suspect when placed under a clearer light. The Government has acknowledged that the bed closures are a cost-cutting move. Viewed narrowly, it is cheaper to keep a patient in a nursing home (in the case of Villa Caritas) than in an acute-care bed (approximately \$57,000 a year as opposed to between \$150,000 and \$200,000 a year to keep one in an acute-care bed, according to Stephen Duckett.)⁷¹ However, the concentration of expertise and mental health professionals at Alberta Hospital creates economies of scale. The treatment at Alberta Hospital is second to none. Indeed, Alberta Health Services has noted that AHE is “well recognized for several treatment programs” and is a “national and international leader in the field of research.”⁷² A review by Capital Health once said that AHE’s services “are among the best available anywhere.”⁷³ It is far from clear that the level of care in a separate community facility would be as high quality or as cost-effective. Nor is it clear that the government has considered the fiscal and social costs of potentially worse patient outcomes if the standard of treatment is lower, a possibility researchers examined in the journal, *Clinical Practice and Epidemiology in Mental Health*.

Residential alternatives to long-stay hospital wards may prove less expensive and reduce the alienation of the severely mentally from community resources and opportunities. But unless they are associated with an improvement in the quality of treatment that is provided, many will remain mere asylums in the community that may lead to increased stigma for such disabled people and calls to re-open the large institutions.⁷⁴

Alberta’s Auditor General, in the Report of the Auditor General of Alberta released in October 2008, noted significant shortfalls in Alberta’s ability to care for its mentally ill citizens in the community. He began by saying bluntly, “There are no adult mental health standards in Alberta.”⁷⁵ Going on to note that the then Regional Health Authorities had a “shortage of safe, affordable housing for people with a mental illness,” he delved further into the reality and the perception of mental health capacity in the community.

More than 60 per cent of (physician) respondents disagree or disagree strongly with the statement, “I am satisfied with the local support/ specialist mental health services in my RHA.” The psychiatric specialists and emergency physicians are more likely to agree or strongly agree with that statement but still indicate disagreement at rates above 50 per cent.

On a series of questions about particular mental health issues, physicians indicated their concern. We list the issues relevant to our audit findings, followed in parentheses by the percent of those agreeing (agree or strongly agree) and disagreeing (disagree or strongly disagree) that the issue is adequately handled.

- Access to specialists is timely (14 per cent agree; 72 per cent disagree);
- Case management and community follow-up are adequate (eight per cent agree; 70 per cent disagree);
- Appropriate mental health community treatment programs are available (14 per cent agree; 60 per cent disagree);
- Appropriate housing options are available (three per cent agree; 74 per cent disagree);
- Mental health service delivery in Alberta has improved in the last three years (17 per cent agree; 45 per cent disagree).

Too often a person with a mental illness does not seek help until he has a crisis and ends up in the hospital emergency room. When stabilized and leaving hospital, he has no services to help him return to the community. Because mental illness is chronic, the cycle starts again.⁷⁶

Summarizing work of this detail we have seen in this section is difficult, but one obvious conclusion is that there was, and is, an absence of the sort of community capacity AHS needed to enact Plan 246. Dr. Wilson's work in particular illustrates that the capacity simply isn't there. To have fully implemented Plan 246 would have been to invite an experience like Vancouver's or Australia's, replicating the homelessness, incarceration and deepening stigmatization of the mentally ill we have seen in those and other jurisdictions.⁷⁷

WHAT NEXT?

A society's intrinsic humanity is most accurately measured not by how much it pledges to Haiti earthquake relief or African AIDS research, worthy though these causes are, but by the dignity it affords its least fortunate citizens. In Alberta, that simple standard would judge us well at the front-line service level, but poorly at the policy level. As the William Styron quote that opens this essay alludes to, a person suffering from a mental illness is afflicted in as traumatic and often in as mortal a way as a person diagnosed with terminal cancer or heart disease. Substituting mental illness with any other similarly societally devastating illness is an instructive exercise; imagine that the Stelmach government had announced on August 14th, 2009, that it was closing the Cross Cancer Institute, or the Mazankowski Heart Institute, so as to distribute the services across the health spectrum without providing ample detail or offering proof that the rest of the system was financially prepared and stocked with expertise.

It wouldn't happen.

Common sense tells us that most people are more comfortable in their own homes and communities than in a centralized and/or antiseptic institutional

setting, but that same common sense also tells us that this is true only to the degree that the setting is the one that best facilitates their recovery and continuing health. A bed (whether it's in the community or an institution) not only has no inherent value, it has a negative value if the person occupying it deteriorates when they might have improved somewhere else. And as we have seen, there have been warnings from both home and abroad about the perils of deinstitutionalization when community services are not fully provided. Further to that, in the Foreword for the 2005 report "Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia," Ian Hickie, a Professor of Psychiatry and the Executive Director of the Brain & Mind Research Institute at the University of Sydney, wrote,

In the early 1990s, as a result of a decade of clinical innovations in community-based mental health care, Australia occupied a unique position internationally...It can be argued that a great deal was achieved between 1993 and 1998...Since the late 1990s, however, there have been persistent and disturbing reports of fundamental service failures. These reflect disorganised and dislocated health and welfare systems and a lack of commitment to the provision of quality mental health care, particularly in the public sector. Community-based care depends not only on organised health services but coordination of welfare, housing, police, justice and emergency care services. Multiple state-based inquiries have been conducted by health departments, coroners, auditor-generals, parliamentary committees and non-government organisations...Tragically, the themes from all these investigations converge. When any of us seeks mental health care we run the serious risk that our basic needs will be ignored, trivialised or neglected.⁷⁸

This should not be the case here or anywhere. It's worth noting that the AHS at least knows the language of promoting the value of good relations with its patients. On its website, under the Mission Statement, the first of their four "key enablers" is "patients as partners." This enabler, they say, is "built upon the principles of respect, information sharing, participation and collaboration."⁷⁹

Bearing this in mind, perhaps it's worth revisiting an earlier statement that this essay would not be prescriptive. Without presuming to speak for those who suffer from a severe mental illness or for those professionals who work every day trying to improve the lives of the afflicted, there are a handful of actions that would simultaneously send a powerful signal of genuine collaboration and act as the first steps in creating a solid foundation from which to build open and sensible mental health policy development channels. Actions the Alberta government could take or at least initiate today are:

1 | REDRAFT PLANS TO REFURBISH AHE.

Immediately begin to redraft plans to redevelop AHE so as to maintain and increase its widely-acknowledged advantage in research and in the treatment of severe mental illness. This redevelopment must take place regardless of future deinstitutionalization trends, to whatever degree they occur, given that every party in the debate acknowledges, at the very least, AHE's valuable role in forensic psychiatry. Even recent government documents and plans indicate the accumulated value and expertise that AHE represents.⁸⁰

2 | EXAMINE THE REALITY OF DEINSTITUTIONALIZATION FOR ALBERTA.

Retain the transition team (at least the model, if not the actual individuals) set up to ease the concerns around Plan 246, and have this team (stocked with additional members from key stakeholder groups) examine the global experience around deinstitutionalization and its effects. The current membership of this transition team contains considerable expertise,⁸¹ but although many in AHS, Stephen Duckett among them, refer frequently to the "worldwide literature" strongly coming down in favour of deinstitutionalization,⁸² even the limited scope of this essay was able to uncover considerable evidence to the contrary, particularly in practice as opposed to theory. And it hasn't gone without notice that the government initially chose not to consult with the psychiatrists working at AHE.⁸³ Even Stephen Duckett admitted the AHS consultation process had been found wanting ("Our level of consultations hasn't been sufficiently specific or probably at high enough a level," he said in early October 2009⁸⁴).

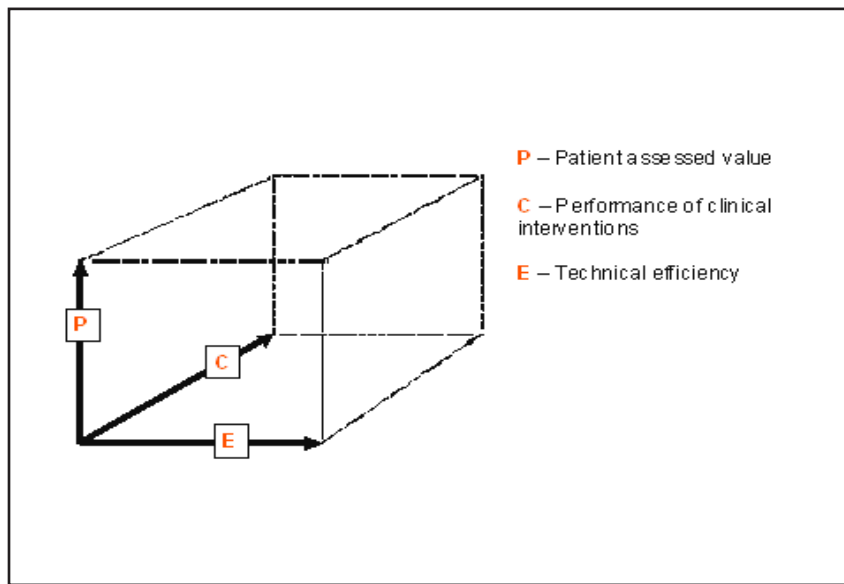
Commissioning such an Advisory Council (which would report not to the Minister of Health, but to the same all-party committee overseeing the expanded Mental Health Patient Advocate office), to examine the theory, the implementation and, most importantly, the on-the-ground reality of the impact of deinstitutionalization would go some way towards demystifying what is today a very muddled picture. Once clear evidence has been returned as to the deinstitutionalization experience of those suffering from a severe mental illness, we can then begin to plan openly and in collaboration for the next phase of mental health care in Alberta. If this transition team is already in the process of doing the above, a much greater level of transparency and communication around their activities needs to begin immediately.

3 | INCREASE THE PURVIEW AND VISIBILITY OF THE MENTAL HEALTH PATIENT ADVOCATE.

Expand the office of the Mental Health Patient Advocate (MHPA) to adequately deal with the daily demands of the office, as well as with broader research and representation in the public and in the media. Anecdotal evidence indicates many mental health patients feel lost, without information, and without representation.⁸⁵ A significantly expanded Communications portfolio in the office of the MHPA would help ameliorate that. Provide the office of the MHPA with a dedicated Communications position, so as to immediately work towards reducing the amount of confusion and lack of access that so many mentally ill people and their families experience daily. The MHPA currently reports directly to the Minister of Health, and this reporting structure could be altered so that the Advocate reports to an all-party committee of the Legislature.

4 | ADJUST THE STRUCTURE OF STEPHEN DUCKETT'S COMPENSATION.

Adopting this recommendation will signify that the mental health of living, breathing Albertans (a *qualitative performance measure*, to use the bureaucratic parlance) is more important than simple cost reduction (a quantitative measure). The Alberta government should immediately remove the bonus clause from the contract of Stephen Duckett, which calls for up to a 25 per cent bonus if a variety of hard number targets are met (which is, in any case, a somewhat retrograde compensation structure in a non-profit, health sector).⁸⁶ Instead, pay him the flat salary his talent and experience warrants, up to another 25 per cent on top of his current salary if that's what he's worth, but then judge his performance publicly and according to targets that include a broad spectrum of criteria, including widely gathered patient satisfaction information. This compensation model would, somewhat ironically, be consonant with Duckett's own area of research and expertise from his academic career in Australia. A paper he co-published with Michael Ward in 2008 on how to analyze the return on investment in health care spending proposed the adoption of a "value cube," as illustrated below, in which "patient assessed value" was given a position of prominence.⁸⁷



As he and his co-author wrote:

We suggest that the ‘value cube’ framework (can) graphically represent the global return on investment of health care funding in a scalable form. In essence this approach can concisely define and demonstrate value in healthcare by showing whether clinical intervention(s) produce the desired patient outcome(s) efficiently and effectively. This need for this type of analysis will assume increasing importance with the increasing implementation of ‘pay for performance’ funding models.⁸⁸

Applying Duckett’s “value cube” to his own salary, with the revisions appropriate to Alberta and to executive as opposed to clinical performance, would be justified and would be a powerful signal to those suffering from mental illness that their health and recovery is the single most important aspect of an exceedingly complex system. It’s also important to point out that ‘pay for performance’ is not the same thing as a bonus. Meeting performance criteria along a “scalable” matrix that is a subtle mix of narrative and quantitative measures so as to maximize your compensation is a different thing than hitting a blunt target number that automatically triggers a single payment.

5 | CREATE AN ACCESSIBLE MENTAL HEALTH PATIENT’S BILL OF RIGHTS.

The foundation upon which this essay rests is that the Alberta government has displayed a lack of respect for those stricken with a severe mental illness. One step towards rectifying this lack of respect would be to

convene a broad-based symposium on mental health patient's rights, the goal of which would be to emerge with a Mental Health Patient's Bill of Rights. This Bill would be adopted into the AHS Mandate, so that instead of having as a key "enabler" the phrase "patients as partners" it is simply stated that AHS, in its Addictions and Mental Health sector, will adhere first and foremost to the Mental Health Patient's Bill of Rights. This would be a separate and more colloquial document than the rights outlined for mental health patients under the Mental Health Act (which could act as a starting point).⁸⁹ Clearly, there are complexities involved with mental health rights that must be accommodated (given the realities of possible harm to self and others that severe mental illness can sometimes engender), but developing a document of rights specifically for patients and their families would be an authentic step forward.

6 | INCREASE MENTAL HEALTH SERVICES.

The research indicates that the path towards best serving Albertans with severe mental illnesses is one that provides more and better services in the community *and* in dedicated psychiatric settings. There is no doubt that community capacity must be increased before any further discussion of bed redistribution, but even so, experts from around the world are highlighting that the chronic and cyclical nature of many severe mental illnesses make specialized psychiatric hospital beds a necessity. The level of community services and the number of psychiatric beds must not be seen as counter-weights, in which adding to one subtracts from the other. Both are vital and require immediate investment.

Taken together as a new starting point, these and other such real and symbolic actions would signal to persons suffering from a severe mental illness that we have begun to match rhetoric with action. Our policy-makers begin anew with first principles, the most fundamental of these being to honour the struggle of those afflicted with mental illness by pursuing thoughtful and compassionate policy options. Plan 246, the bluntest of tools, symbolized instead the Stelmach government's apparent belief that people suffering from a mental illness were an easy target for cuts.⁹⁰ As alluded to earlier, many times in the past and often in Alberta's direct past governments have targeted the voiceless, particularly the mentally ill and the developmentally disabled. And in some ways, the struggle for dignity faced by the severely mentally ill is even more profound than that of the developmentally disabled for one primary reason: a person with a developmental disability is impacted from birth, which means their families consistently remain by them from birth. Their challenge is known to their support network from Day One and that support network tends, often heroically and through great struggle, to stay by their side. This, sadly, is too infrequently the situation of a person with a mental illness, an illness with later onset and which features side effects and behav-

itorial changes capable of alienating even the closest of loved ones. Mental illness can be a deep dark place, and the goal of good policy is to help shine a light on the way out.

Not that it isn't staggeringly complex. As *The New Yorker* writer Louis Menand recently wrote in an essay on how depression has been defined and treated in the psychotropic era, "Mental disorders sit at the intersection of three distinct fields. They are biological conditions, since they correspond to changes in the body. They are also psychological conditions, since they are experienced cognitively and emotionally – they are part of our conscious life. And they have moral significance, since they involve us in matters such as personal agency and responsibility, social norms, and character, and these all vary as cultures vary."⁹¹

There is never going to be a definitive answer as to whether treating mental illness biologically, institutionally, existentially, or in the community – or in combination – ought to take predominance as a treatment mode, but what is clear is that when the biological treatment of severe mental illness is recommended it is often best pursued in a specialized setting such as AHE. Is a dedicated specialist psychiatric hospital part of the spectrum of mental health services? Is the community a significant part of the spectrum of mental health services? The answer to both, the evidence seems to show, is Yes. As Alison Read wrote in a recent issue of the *UBC Medical Journal*, "Some mentally ill people cannot function optimally in the community"⁹² and require more structure and support than others. In particular, suicidal patients may benefit from the control and long-term treatment offered by institutions. In the shift from paternalism to individualism, many psychiatric patients have been granted autonomy, but lack resources to maintain well-being. There needs to be a balance between independence and support; it is apparent from the current mental health situation that this balance has not been achieved."⁹³

In the end, the temptation is to label Plan 246 a failure, but this would be a hazardous conclusion. Not because it wasn't misguided and poorly executed (which it was), but because labeling it a failure would be to imply that the thinking behind the plan has altered or concluded. We have no evidence that this is the case, which is why Albertans are well-advised to continue to press AHS and the Stelmach government for greater transparency in any future discussions about mental health services. After all, Plan 246 betrayed a "book-smart, people-wrong" misread of the history and implications of deinstitutionalization, as well as a striking lack of empathy for the plight of the mentally ill. It all led to poor policy, botched communications, and costly retractions, none of which contributed in the least to improving the lives of persons suffering with a severe mental illness.

We have seen that, although deinstitutionalization must never be written off as a viable component on the palate of mental health service options when

pursued with attendant community support, it has yet to prove its worth as a centerpiece of any mental health sector overhaul. There is growing evidence that it is either too great a leap for some amongst the severely mentally ill or too politically tempting to not fund the community follow-up, or both. We have also learned from the recent work of Dr. Donna Wilson that there is simply an absence of community capacity right now in Alberta, and that closing psychiatric beds at specialized hospitals might place an intolerable pressure on the general health system.

And so we come full circle, back to the persistent inability amongst our policy-makers to understand that a severe mental illness is an illness, that a person with a severe mental illness is not to blame, and that mental illness must be treated with the same gravity and compassion as cancer or heart disease or pediatric complications or any number of other major societal health issues. Even a governmental change in attitude such as this, which is by no means a given, will not immediately improve the quality of the policy parameters within which dedicated mental health sector staff will be asked to operate. But it is the only place to authentically re-start.

Politicians and policy-makers may respond to this and like charges with indignation, asserting that of course they regard the mentally ill with full respect. The reply is simple and timeless: Don't say it, prove it. On August 25th, 2009, after the initial outcry over Plan 246 and the ensuing widespread request for details about the plan, Stephen Duckett wrote on his blog that he was unable to provide the details about his plans for more community care until he could consult with professionals and other stakeholders. "We can't be more definitive about what the next steps might be," he wrote. "I recognize that there are concerns about whether or not the community spaces will be created. To that I say: Watch us."⁹⁴

Many Albertans did precisely as Mr. Duckett suggested, and continue to do so; perhaps with more attention than he and his political masters expected or wanted.

ENDNOTES

1. Irene McDermott, "Beyond Beds...to Balanced Mental Health Care. The report of the Provincial Mental Health Bed Review," July 2007, p 8.
2. "Roadmap for the Future, 2005-2008," Capital Health Authority, 2005, page 19.
3. "Suicide in Canada," Powerpoint presentation, Centre for Suicide Prevention, 2004, p 24.
4. McDermott, p 11.
5. As reported by Jodie Sinnema, Edmonton Journal, 7 October 2009
6. Sheila Pratt, Edmonton Journal, 2 October 2009
7. A decision that was highly controversial in its own right. The Villa Caritas beds had been earmarked for patients currently in beds at Edmonton General Hospital. These patients were involved in the fundraising and planning for their new facility, and the cancellation of their transfer was devastating. See J. Sinnema and S. Pratt, "More Bed Closures Pending," Edmonton Journal, Sept 16, 2009
8. David Copolov, "Dehospitalising the Mental Health Sector: Drivers and Consequences," a presentation, 10 August 2006
9. This stance is derived from the author's direct experiences working both with persons with developmental disabilities, for whom deinstitutionalization has, by and large, been successful, and with persons with severe mental illnesses, for whom deinstitutionalization has been of mixed success to date.
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11. Irene McDermott, "Not Another Review!", Alberta Views, January/February 2010, pp 42-43
12. "Leak exposes mental health failures," Alberta NDP website, April 20, 2009
13. Dr. George Santana, quoted by Jodie Sinnema, Edmonton Journal, 7 October 2009
14. McDermott, pp 42-43.
15. Author interview with Irene McDermott, March 10, 2010.
16. McDermott, p. 28. "Although this process (of Alberta's move towards deinstitutionalization) acknowledged the need for community services, these services were not fully understood or developed."
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18. Ibid., pp 42, 43
19. Ibid., p 46
20. Archie Maclean, "Cost-cutting pulled back at Alberta hospital," Edmonton Journal, December 19, 2009.
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22. Irene McDermott, "Not Another Review!", Alberta Views, January/February 2010, pp 42-43
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24. "Priorities for Australia's Public Mental Health Service," a submission to the Minister for Health, the Hon Nicola Roxon, in response to A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission, June 2009, seven authors.
25. Peter Ellingsen, "The Forgotten People," The Age, 9 Jan 2005
26. Dr. Simon Byrne, Letter to the Senate Select Committee, 1 April 2005
27. Dr. Simon Byrne, Letter to the Senate Select Committee, 1 April 2005

28. Email exchange, David Copolov and Curtis Gillespie, February 1, 2010
29. Dr. David Copolov, Sydney Morning Herald, 30 November 2005
30. Ibid.
31. Dr. David Copolov, Sydney Morning Herald, 30 November 2005
32. Ibid.
33. Ibid.
34. Peter Ellingsen, "The Forgotten People," *The Age*, 9 Jan 2005
35. Ibid.
36. his number is derived using statistics from 2004, provided by Alberta Health and Wellness as reported in *Beyond Beds*. The provincial population was 3,164,810 and the total number of psychiatric beds was 1437, resulting in 45.4 beds per 100,000 population.
37. Peter Ellingsen, "The Forgotten People," *The Age*, 9 Jan 2005
38. "Priorities for Australia's Public Mental Health Service," a submission to the Minister for Health, the Hon Nicola Roxon, in response to *A Healthier Future For All Australians – Final Report of the National Health and Hospitals Reform Commission*, June 2009, seven authors.
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40. Ibid.
41. Stephanie Langlois and Peter Morrison, "Suicide Deaths and Attempts," *Canadian Social Trends*, Autumn 2002, p 23.
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44. Ibid.
45. Ibid.
46. Nicola Roxon, Address to the Grace Groom Memorial Lecture, National Press Club, Canberra, 12 June 2008.
47. John Mendoza, "Where to for Mental Health Reform in Australia?," a presentation to the Network of Alcohol and other Drugs Agencies, and Mental Health Coordinating Council conference, May 2009
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50. Ibid.
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54. *Alberta Hospital Edmonton: It's Time for Redevelopment*. A publication of the AUPE.
55. Ibid.
56. Duckett, iblogs.albertahealthservices.ca/ceo/, 15 October 2009.

57. Ibid.
58. Wilson, p. 27.
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62. Ibid., p 30.
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68. Ibid., p 35.
69. Ibid., p 36.
70. Ibid., p 36
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74. A. Mastroeni¹, C. Bellotti¹, E. Pellegrini, F. Galletti, E. Lai and I. RH Falloon, "Clinical and social outcomes five years after closing a mental hospital: a trial of cognitive behavioural interventions" (Clinical Practice and Epidemiology in Mental Health 2005, 1:25 <http://www.cpemental-health.com/content/1/1/25>)
75. Report of the Auditor General of Alberta, October 2008, p. 163
76. Report of the Auditor General of Alberta, October 2008, p 197, p. 172.
77. David Copolov, in his presentation, "Dehospitalising the Mental Health Sector: Drivers and Consequences," from 10 August 2006, noted that while 18 per cent of the general Australian population have a psychiatric disorder, fully 47 per cent of the homeless population have a significant psychiatric disorder. Regarding Vancouver, a recent Vancouver Police Department study, *Lost in Transition: How a Lack of Capacity in the Mental Health System is Failing Vancouver's Mentally Ill and Draining Police Reserves* (2008), noted that the closure of 200 beds at the Riverview Psychiatric Hospital was followed by a surge in the number of hours police officers spent dealing with calls related to people suffering from mental illness. The report found that 31 per cent of all calls to the Vancouver Police Department were related to mental illness and estimated the annual demand on resources to be the equivalent of 90 full-time police officer positions.
78. Ian Hickie, "Not For Service: Experiences of Injustice and Despair in Mental Health Care in Australia", A report of the consultations by the Mental Health Council of Australia and the Brain and Mind Research Institute in association with the Human Rights and Equal Opportunity Commission, 2005, p V.
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