Meeting their Needs?: The Social Supports of Mentally Ill Single Room Occupancy (SRO) Hotel Residents in Vancouver's Downtown Eastside

By

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Abstract

This thesis examines the social supports of low-income mentally ill residents in a Downtown Eastside Vancouver single room occupancy (SRO) hotel. The hotel, known as The Carrall, is operated as a supported living residence for people with a history of mental illness. The hotel employs mental health workers who provide a variety of social supports to the residents. In addition, the residents seek out social support at other area mental health agencies: The Burrard drop-in centre, The Main drop-in centre, and the Downtown Eastside Mental Health Team.

This thesis seeks to understand how residents and mental health workers interpret the benefits of social support. The analysis is performed in the context of the strengths assessment (SA) model, an empowerment oriented model of mental health rehabilitation. Empowerment models encourage the mentally ill to self-determine their service interventions and reduce their reliance on mental health professionals and mental health agencies. The SA model identifies six life domains that require social support interventions: 1) Health; 2) Daily living routines; 2) Friendship supports; 3) Leisure and Recreational Activities; 4) Finances; and 6) Employment and Vocational Training.

The findings of this thesis indicate that the residents' and the mental health workers' interpretations of social support are congruent for some supports and incongruent for others. The degree to which social supports meet or do not meet the needs of residents is a measure of the functioning level of the residents, insufficient agency resources, and a lack of resident involvement in the decisions that affect them. Due to the constraints of the mental health agencies in this study, the empowerment approach to mental health rehabilitation has met with little success.
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Finally, my sincere thanks to the residents and staff of The Carrall, who welcomed me into their lives. It is my hope that this thesis will contribute, in some way, to a better understanding of the social support needs of The Carrall’s residents, and of the low-income mentally ill in Vancouver’s Downtown Eastside.
Chapter 1: Introduction and Overview

Introduction

Vancouver's Downtown Eastside is widely regarded as the poorest neighbourhood in Canada (Baxter 1991; 1997). The popular conceptions which people hold of members of low-income areas, such as the Downtown Eastside, are often negative. This is especially true of one group in particular: The low-income mentally ill.

People with mental illnesses are often characterised as “withdrawn,” “socially isolated,” and “shut-in” (Sokolovsky et al 1978, 5). Many people mistakenly conceive of the mentally ill as living disjointed, criminal lives, and having few attachments to other people. Few people would consider the Downtown Eastside as a neighbourhood where the giving and receiving of social support takes place on a routine basis.

In Canada, scant attention has been paid by academics, politicians and social policy makers to the social supports that exist to help low-income people meet their needs. Poverty, and the difficulties associated with making ends meet, are the major issues that low-income residents of the Downtown Eastside contend with on a daily basis. It is around these issues that a variety of social and volunteer support services have emerged in the Downtown Eastside. Shelters, drop-in centres, health clinics, soup kitchens, court services, de-tox centres and community outreach teams assist Downtown Eastside residents in meeting a variety of needs, such as food, shelter, emotional support, medical care, legal aid, and job training programs. In addition to social and volunteer services, there are examples of informal support between people, such as the borrowing and lending of food, money, and other resources.
For people with a mental illness, the task of meeting their needs is especially daunting. The nature of their illness can hinder their ability to effectively access local services and informal support networks. In many instances, the stigma of being mentally ill results in discrimination by social service providers and abuse by the lay public. This further dissuades mentally ill people from seeking out community supports. As Saraceno and Barbui (1997, 286) note, "mental disorders cannot be managed without directly taking into account the environment of poverty." The fewer the social supports, the more acute one's mental illness. The importance of social support in the lives of the low-income mentally ill lies in the "implication...that persons who are supported instrumentally and emotionally are healthier than those who are not supported" (Lam and Rosenheck 1999, 13).

This thesis examines the social supports of the residents in 'The Carrall,' a single room occupancy (SRO) hotel in the Downtown Eastside. The Carrall is a supported living residence for people with mental illness. It is operated by the Vancouver Mental Association (VMA), a non-profit mental health agency. The VMA was formed by mentally ill people who sought an alternative to the traditional, medical approaches to mental health care. The Carrall came under the administration of the VMA in 1991. In 1993 it began operating as a supported living residence. The Carrall is staffed 21 hours a day by 'hotel co-ordinators,' who are also considered 'mental health workers.' The hotel co-ordinators provide a variety of social supports to the residents, and connect them with outside community supports according to the individual needs of the residents. Two of the hotel's mental health workers have a history of mental illness.
Social support "refers to the functional aspects of a network, including the various types of support that are received or given" (Hall and Nelson 1996, 1743). Social networks are "the structural aspects of the person's support system, such as the number and type of network members" (ibid).

This thesis is oriented towards an analysis of the social supports of the residents of The Carrall. There are two reasons for this orientation. First, the social networks of the residents are small. The bulk of the support that the residents give or receive occurs 'in-house' at The Carrall. This is because of the comprehensive nature of the support provided by The Carrall's staff, which includes food and access to mental health services and medical care. The majority of the residents' close friendships are with fellow residents. Some of the residents have friends at other SRO hotels and drop-in centres in the Downtown Eastside. Other residents have family members living in British Columbia. Some of these residents visit their families over weekends, and others will touch base with them over coffee. Resident visits to family do not normally occur more than once a month. Of the residents interviewed in this study, only one has intermittent contact with his sister, who he meets once every month for coffee. None of the residents interviewed for this thesis have daily or routine social contacts with people or organisations outside of area SRO hotels and the helping services designed for the low-income mentally ill.

Second, the residents and mental health workers express a marked concern for the extent to which the supports that the residents receive adequately meet their needs.

Therefore, the goal of this paper is to evaluate- from the point of view of the residents and mental health workers- the degree to which these social supports effectively
meet the needs of residents. In other words, how supportive are these social supports in the eyes of the providers and recipients of help?

My findings indicate that there are both similarities and differences in how residents and mental health workers interpret needs, the goals of social support provision, and the benefits that they provide. These differences in interpretation occur between groups (i.e. between residents and mental health workers) and within groups (i.e. among the residents themselves). There are also differences in the way that residents and mental health workers: a) identify themselves or define their roles, and the expectations that they impute to these roles; and b) perceive the roles of others, and the expectations that they impute to those roles. Identity and role perceptions vary between these groups, and within these groups.

I refer to these differences of interpretation and perception as 'interpretive dissonance.' Interpretive dissonance represents the differences in how people internalise and express the meaningfulness of actions, symbols, and communication. I use the term 'dissonance' to emphasise that specific needs, roles and labels, such as 'shelter,' 'hotel co-ordinator,' and 'mentally ill,' can mean different things to different people in particular social contexts. In this study, interpretative dissonance is situated largely around issues of the effectiveness of social supports to meet residents' needs and goals. The extent to which social support succeeds or fails to meet these needs is a function of mental health workers and residents' perceptions of 'being mentally ill,' empowerment, rehabilitation, and stigma. To that end, this thesis highlights both the positive and negative aspects of social support provision to The Carrall's residents.
Literature Review

Social Support

There are few studies that examine the social supports of low-income people in Canada. Some examples of formal and informal support in Canada are found in Baxter’s (1991; 1997) collection of case studies on poverty and homelessness in Vancouver’s Downtown Eastside. Baxter’s case studies consist of personal profiles of homeless and low-income residents of the Downtown Eastside, and of community activists. In addition, Ley’s (1994) historical overview of the development of community activism in the Downtown Eastside traces the formation of the Downtown Eastside Resident’s Association (DERA) as a social and political voice for the area’s ‘marginalised’ population.

O’Reilly-Fleming’s (1993) study of homeless Canadians addresses the causes and process of becoming homelessness. He profiles homeless people across Canada and provides personal accounts of their descent into homelessness. Tracey (1993) provides a re-telling of her cross Canada meetings and encounters with people living in poverty. While O’Reilly-Fleming and Tracey provide descriptive accounts of the state of people living in poverty, they do not address how people seek out social support to cope with poverty in their day-to-day lives.

The majority of literature on social support, or 'helping networks,' stems from the United States (Collins and Pancoast 1976; Warren 1981; Maguire 1983; Whittaker and Garbarino 1983; Hoch et al 1985; Venkatesh 1997). These works theorise the general nature of social support, outline some of the differences between formal and informal
helping, and stress the importance of helping as sources of social support and social integration. A concise summary of this body of literature is found in Warren (1981, 8):

Networks operate by: 1) giving emotional support, 2) providing specific information, 3) filling in when a close friend or relative is severed by death, illness, divorce or separation, 4) helping identify arenas of good professional help, and 5) serving in place of professionals when they are not trusted or not available.

Basic to our theory is the idea that bypassing existing helping structures within communities may systematically lower the adaptive capacity of many human populations....

It is an issue of community integration—patterns in which people relate to each other and to the community as a whole, and ways in which resources are co-ordinated and used for the common good—and this can be contrasted with the disintegration of resources and links.

There are surprisingly few studies on the support seeking experiences of the low-income mentally ill (Connor 1999; Forrester-Jones and Grant 1995; D'Augelli 1983; Pilling 1991), and fewer still that give voice to the mentally ill themselves (Forrester-Jones and Grant 1997; Petch 1992).

Connor (1999), D'Augelli (1983) and Pilling (1995) examine the support services available to the mentally ill, such as housing supports, drop-in centres, employment schemes, emergency care, and the extent to which they meet their needs.

The accounts of Forrester-Jones and Grant (1997) and Petch (1992) give voice to the mental health service users and service providers. To 'give voice' is to include the thoughts, feelings, and feedback of the groups and individuals that are studied in social research. Including the thoughts and statements of the mentally ill, and of the mental health workers who help them, is an integral component to achieving a more holistic understanding of their relationships to social supports and their interpretations of the effectiveness of these supports in meeting their needs. As Forrester-Jones and Grant
(1997, 107) note, "the constituents of support are not easily separated from relationships, and in previous studies these have not always been discussed as different dimensions." In other words, the help seeking processes of the mentally ill are informed not simply by the existence of helping services, but in the way that they interpret the benefits of the service to them, and in the relationships that they forge with mental health workers.

Connor (1999) and Petch (1992) found that funding and staffing issues impact on the level of care and service that drop-in centres are able to provide. The result is that some drop-ins, depending on their philosophical and professional orientation towards mental health, focus their resources on psychiatric interventions such as group therapy sessions, rather than the provision of non-psychiatric activities, such as classes and social outings. Pilling (1991) and Petch (1992) found that there were high user 'drop-out' rates from drop-in centres that offered predominantly psychiatric services.

Pilling (1991, 107) notes that:

...the drop-out rate from this setting...was accounted for almost entirely by the group for which the centre was intended, that is, long-term mentally ill people. In this centre, where staff prioritised the verbal therapies, long-term mentally ill people felt over stimulated and so excluded themselves

Giving voice to these issues provides a richer understanding of how mentally ill people decide which services to access. For example, Pilling's (1991) study involved participant observation and interviews with mentally ill people and mental health workers in a variety of British mental health agencies, and yet data from his respondents is not quoted in the study. Petch (1992) performs a similar study in the UK, and incorporates interview data into her work. She provides a more insightful understanding of why people choose not to use mental health services:

The dilemma...arises for the individual of the comparative familiarity and security
of the setting geared towards mental health users as against the desire to be rid of any particular label.

If I could find an interesting activity that would enable me to meet people outwith [sic] the psychiatric services that would be good, and the closest I've come to doing that is going down to the pub. (Petch 1992, 123-124)

**The Social Supports of SRO Hotel Residents**


Several of these studies give voice to the experiences of SRO residents (Glasser 1988; Glasser and Suroviak 1988; Hamburger 1983; Snow and Anderson 1993; Wagner 1993). Glasser (1988) and Glasser and Suroviak (1988) examine how 'community resource' workshops with mentally ill homeless and SRO residents takes place in soup kitchens. Community resource workshops inform groups of soup kitchen users about the helping agencies in their neighbourhoods. Through these workshops, they found that some of the soup kitchen's users began to access a greater number of available services.

Hamburger's two year study of life in an SRO hotel provides a rich, though dark ethnography of the daily lives of the hotel's residents. Unlike Glasser and Suroviak's
(1988) study, the SRO residents in his study expressed little faith in the ability of the helping services to improve their lives:

You think paintin' their rooms and hirin' on more psyches gonna change anything? You're dealin' with trash in here, and they didn't get to be trash overnight. Most of the people, they already had their chance- they had a hundred chances. They been through the prisons, had their alcohol program, their drug program, all kinds of psyches working on them, an' they're worse, they're not better. You gotta look through what you got in these hotels an' forget about all that bullshit about savin' everybody. You throwin' good money after bad. They had their chance. They ain't livin'. Not really. (Hamburger 1983, 319-320)

Other research holds a more optimistic view of the lives of the low-income mentally ill (Hoch and Slayton 1989; Linhorst 1991; Martin and Nayowith 1988), highlighting the advantages of living in SRO housing. SRO housing is one of the least expensive housing options. This is especially significant for persons with mental illnesses who live on fixed incomes (Linhorst 1991). Location is another factor in choosing housing. Most SROs are located in the downtown cores of major cities and offer easy access to public transit, social services, shopping facilities, and employment opportunities (ibid). SROs offer individual privacy and freedom, with the right to privacy being reinforced by “a strict set of house rules” (ibid). A sense of “social community” (Hoch and Slayton 1989, 125) is formed among SRO residents hotels who “[contribute] responsibly to the well-being of others through on-going reciprocal relationships” (ibid., 126). This is echoed by Linhorst, who notes that “SROs allow residents personal freedom and privacy, and they offer a sense of community that is capable of meeting a variety of needs” (ibid., 135).

Martin and Nayowith (1988) examine the role of social work in building natural community networks to assist SRO residents in meeting their socialisation and rehabilitation needs (ibid., 86-87). One support program in New York City started
weekly in-house bingo games and cooking groups at area SROs (ibid). The bingo games
helped to foster informal networks amongst residents, as participating residents would
ask other residents to join them in future games. Eventually, greater numbers of residents
started to play bingo. This provided the opportunity for more residents to socialise, and
to establish friendships with other residents. The cooking group involved teaching
groups of five residents how to prepare a variety of dishes (ibid., 90). The cooking group
served to promote socialisation, and bolster residents' self-esteem by fostering a sense of
self-sufficiency. Furthermore, when the cooking program ended, the residents continued
to come together to make group meals (ibid).

Despite these benefits, the findings of some researchers warn of the propensity to
romanticise SRO hotels as ideal living environments (Rollinson 1990; Linhorst 1991).
Linhorst notes that some SROs are unsanitary and unsafe, and that residents may be
subject to abuse by uncaring landlords (Linhorst 1991, 137). Rollinson found that SRO
residents “were caught in an environment that exacerbated their isolation and withdrawal
from society” (Rollinson 1990, 190). Yet in his case study of Edward, an elderly SRO
tenant, Rollinson concedes that Edward “did feel close to a few elderly friends in the
hotel and contacted them occasionally” (ibid., 197). Edward himself states: “I spend as
many hours as I possibly can outside, because I enjoy being with people, it gives me a
chance to mingle with the millions of people in the area” (ibid., 199).

Linhorst addresses these issues. He notes that “while living conditions in some
SROs are unacceptable, numerous studies have shown that most SROs are not of this
type” (Linhorst 1991, 138). The withdrawal or isolation of residents may be a personal
decision: "residents that were isolated chose that lifestyle, rejecting the opportunities to
socialise that were available in the SRO" (ibid., 137).

The management of SRO hotels is also a key factor in the quality of life of their
residents. Managers "set the tone of the SRO through the fair administration of rules, by
offering various types of assistance, and by actively supporting and encouraging the
 provision of informal aid" (ibid., 139). Clearly, a well managed hotel requires managers
and staff who are concerned with the well-being of their residents.

**Approaches to Social Support: The Medical and Empowerment Models**

The degree to which social supports benefit the low-income mentally ill depends
in part on the approach of mental health workers to the provision of helping services.
There is a virtual absence of literature that examines approaches to social support
Vancouver Mental Health Service Society (GVMHSS), and its efforts to foster more
comprehensive, user friendly supports for the low-income mentally ill. They emphasise
a "community-centred service philosophy" (ibid., 309) to mental health provision,
asserting that "the most effective way to serve the patient and the community is for the
mental health team to be situated in the community" (ibid). The key to providing user
friendly supports lies in the approach to service provision.

There are several U.S. studies that analyse approaches to social support provision
for the low-income mentally ill (Blau 1992; D'Augelli 1983; Dickerson 1998; Ford et al
McLean 1995; Morgan 1996; Rapp 1998). The approach to the provision of mental
health supports is characterised by two models: The medical model and the empowerment model.

The Medical Model

The medical model, also termed "the disease model" (Dickerson 1998, 263) holds that persons with serious mental illness have brain disorders for which medical treatment is primary. In this model, treatment decisions are dominated by the physician and the patient's subjective views may be considered secondary to an objective assessment of illness symptoms. (Ibid)

Medical doctors and mental health workers are trained to identify particular mental illnesses. In this approach, "The professional must take charge and lead the way: They obviously know best" (Rapp 1998, 77).

The spirit of the medical approach is exemplified in Lamb (1990). Lamb advocates for the strengthening of mental health outreach services, to ensure that "Every chronically mentally ill person would be on the caseload of a mental health agency...[to] link patients to needed resources" (ibid., 650). This is important, as the disabling functional deficits of major mental illness...[such as] disorganised thinking and actions, poor problem solving skills, and an inability to mobilise themselves...appear to be important contributing factors to homelessness. (Ibid)

Lamb asserts that "these are crucial deficits that should lead us to intervene, preferably with the patient's consent, but without it if necessary" (ibid [my emphasis]).

Lamb's view of social support is controversial and problematic. It is controversial because it is coercive; it removes control over the mentally ill to make decisions and take action on their own behalf (Morgan 1996; Dickerson 1998). It is problematic because it lends itself to a process of disenchantment. The negative experiences of the mentally ill with mental health services lead many to believe that the "psychiatric system is not
responsive to their particular needs" (Morgan 1996, 91). This leads to a "resistance to the approaches of helping agencies" (ibid.) when help may otherwise be desired.

The Empowerment Model

Progressive approaches to the provision of mental health supports focus on 'consumer empowerment' (McLean 1995). The 'consumer empowerment movement' (ibid.) arose in the 1990s in reaction to the "inadequacies [of] the mental health system and the indignities it engendered" (ibid., 1053). The movement consists of mentally ill people who advocate for alternative mental health programs that are run entirely by and for mental health consumers. The term 'consumer' emerged to imply that mentally ill persons should have the freedom to pick and choose the mental health services that they wish to use.

Empowerment of the mentally ill is defined as "self-determination and control over their entire lives, not only their treatment" (ibid). It is "based on the principle that psychiatric consumers can...reduce their reliance on professionals, and take action on their own behalf" (Dickerson 1998, 255). There are three general attributes to the empowerment model: 1) Sense of personal competence; 2) Self-determination; and 3) Social engagement (ibid., 259).

A sense of personal competence is developed when a person "demonstrates positive self-esteem" (ibid). Self-esteem is "a product of both social feedback and self-appraisal...[it] may be affected by personal experience and therapeutic intervention" (ibid). Self-esteem is at the core of the empowerment model (ibid). The second aspect of personal competence is the acceptance of mental disability:

An awareness and acceptance of these difficulties contributes to a positive self-attitude and facilitates personal recovery. An acceptance of disability represents
the opposite of self-stigma and is a cornerstone of consumer empowerment. (Ibid)

The third aspect of personal competence is an "internal locus of control" (ibid). This refers to "an individual's perception of personal control over events and situations" (ibid). People with an internal locus of control attribute rewards, successes, punishments and failures to their own behaviour (ibid). People with an external locus of control attribute successes and failures to luck, chance, or external forces (ibid).

Persons with an internal locus of control are more likely to accept responsibility for their behaviour, to feel that they can control their own destiny and to take action on their own behalf. Such a view is an important aspect to empowerment. (Ibid)

The second aspect of empowerment, self-determination, concerns the "process by which consumers participate in the decisions that affect their lives" (ibid). It involves "making active choices about their living arrangements, work, and interpersonal relationships" (ibid). It encourages the mentally ill to "exert choices" in their selection of treatment and rehabilitation services, "as well as how and when they participate in these services" (ibid., 260).

The third aspect of empowerment, social engagement, "consists of consumers identifying with and validating each other" (ibid). This involves peer interaction and peer support (ibid). Although peer interaction and support do not always lead to social activism, the empowerment model views peer validation as a necessary step towards advocacy (ibid). It postulates that "consumers may become aware of stigma and other injustices and experience a sense of "righteous anger" that mobilises their participation in advocacy activities" (ibid).
The concept of social engagement is closely related to the discrimination model, which developed in opposition to the medical model and maintains 'empowerment' ideals (ibid., 263). The discrimination model holds that "persons with serious mental illness are impeded largely by external factors, such as stigma, which stand in the way of personal recovery" (ibid). Through active social advocacy, the mentally ill can identify sources of stigma and propose public awareness initiatives that will remove some of the negative stereotypes of the mentally ill, thus affording them greater opportunities for recovery.

Despite the perceived benefits of the empowerment model, both McLean (1995) and Dickerson (1998) note contradictions between its philosophy and practice. In the first instance, there is a problem with the term 'consumer' "to define persons with serious mental illness and the constituency of people receiving psychiatric services" (Dickerson 1998, 262).

Consumer is a market term that implies payment for goods or services that are selected with freedom of choice. In the context of persons with serious mental illness receiving psychiatric care, these market conditions often do not apply. Especially in publicly funded programs, persons with serious mental illness have few choices about the services they receive or about the providers who are available to them. Additionally, such persons often do not pay directly for services, as treatment costs are typically born by a publicly funded insurance plan. (Ibid)

Second, there is little "known about how consumer alternatives operate, how they attempt to empower their users, and how well they succeed in doing so" (McLean 1995, 1054).

Third, mental health users and mental health providers hold "diverse assumptions regarding the definition of ...problem[s], the nature of solution/(s)...[and] who should produce and control production of the solution/(s)" (ibid., 1056). These stem from users' and providers' experiences in the mental health system, as well as their position of power
(ibid) in the mental health hierarchy. While "true empowerment" for the mentally ill may be "nothing less than being able to determine their own choices," it should not be selected from "a restricted menu provided by the mental health system" (ibid., 1056).

McLean draws a distinction between two types of empowerment: "coherent, or client-driven empowerment, and 'co-opted,' or provider driven empowerment" (ibid). According to McLean, there is a "struggle over who determines needs and who controls production of options to satisfy those needs" (ibid). This assertion warrants qualification. My findings indicate that limited funding and access to resources restrict the level of services that mental health agencies are able to provide. Therefore, the degree to which services are coherent and co-opted is in part related to perceptions of how to effectively use limited resources.

A fourth and related contradiction with the empowerment model concerns the promotion of personal competence. Insight of the mentally ill into their illness, "acceptance of their disability... and the capacity to participate effectively with others" (Dickerson 1998, 263), are often compromised by the effects of users' mental illness. For example, persons with schizophrenia typically experience a range of symptoms, such as distorted perceptions, social withdrawal, cognitive deficits, an inability to communicate clearly, and a significant decline in social effectiveness and performance. (Ibid)

The result is that persons with schizophrenia do not always have insight into their illness, and are unable to recognise "psychiatric symptoms, misattributing them to nonillness factors, and underestimating the severity of the problems" (ibid).
Stigma and Mental Illness

The barriers that the low-income mentally ill face in achieving their life goals are not merely the result of cognitive, interpersonal and self-care deficits (Corrigan 1998, 201). The debilitating effects of mental illness are exacerbated by society's negative reaction to mental disorders (ibid., 202). These reactions are born out in stigma, which can be defined as attributes that are "deeply discrediting" (Goffman 1963, 3). Stigma is manifest in some of the negative stereotypes that people hold of the mentally ill: "Mental patients are dangerous." "They can't live on their own." "There is no cure for mental illness." (Corrigan 1998, 202).

Stigma and mental illness have received much treatment in the academic literature. One body of literature examines the media representation of the mentally ill (Philo 1996; Signorielli 1989; Wahl 1995; Wahl & Lefkowitz 1989). Wahl (1995) summarises the portrayal of the mentally ill in the media and its impact on public perception:

The consistent, strong mass media association of mental illness with violence and criminality, which occurs in both entertainment and news media, remains a grossly inaccurate representation of people with mental illnesses. (Wahl 1995, 85-86)

The central tenets of this body of literature assert that the mentally ill are generally portrayed as failures in work and in personal relationships (Signorielli 1989), and that these portrayals have a significant effect on the attitudes of the public. These effects are brought about by "mainstreaming," the way in which "frequent presentations of a similar nature may stamp in [stigmatising] effects" (Wahl and Lekowtiz 1989, 526) and lead the viewing public to accept media representations as accurate.
A second body of literature considers the impact of stigma on the mentally ill (Corrigan 1998; Lyons & Ziviani 1995; Rosenfeld 1997; Scheff 1984). Corrigan (1998, 210) views stigma as learned stereotypes that are "socially given" or "cognitively structured." Socially given stereotypes are the most common form of stigma, and "represent cultural lore about a group handed down by community elders and other authorities" (ibid). Cognitively structured stereotypes are learned by "regular contact with members of a particular group. The public learns stereotypes about mental illness by directly interacting with persons who have a psychiatric disability" (ibid).

These concepts relate to Goffman's (Goffman 1963 in Corrigan 1998) distinction between discredited and discreditable groups. Discredited groups bear "patently manifest stigma" (Corrigan 1998, 210) such as skin colour, or facial disfigurement. Discredited groups are normally identified in the cognitively constructed stereotypes that emerge from face to face interactions. Discreditable groups may not bear manifest signs of stigma, but may bear the stigma of a disease, such as cancer.

The mentally ill constitute both a discreditable and discredited group. We may regularly interact with mentally ill friends and colleagues whose illness remains publicly undisclosed. They do not 'act out' or exhibit 'erratic' behaviour that would illicit a negative reaction from people in face to face interactions. The mentally ill are discredited when we observe manifest behaviours, such as talking to one's self, or screaming at strangers in public.

Corrigan (1998) identifies an overlap in socially given and cognitively structured stereotypes. For example, media images may provide a socially given stereotype of the mentally ill as homeless, poor, and dishevelled. However, not all homeless people are
mentally ill. Socially given stereotypes can lead to misinformation in cognitively structured situations. People who observe or interact with the homeless may draw inaccurate conclusions and misidentify them as mentally ill (ibid., 211).

Lyons and Ziviani (1995), Rosenfeld (1997), and Scheff (1984) examine the effects of labelling on the mentally ill. Labelling theorists such as Scheff view mental illness as a form of deviance (Rosenfeld 1997; Scheff 1984) "The label rather than the behaviour shapes the fate of mentally ill persons, by creating chronic mental illness or by compromising the life chances of those so labelled" (Rosenfeld 1997, 660). Sub categories of labelling have evolved, such as "diagnostic labelling" (Lyons and Ziviani 1995). Diagnostic labelling contribute[s] to a mindset where almost any behaviour of psychiatric patients maybe perceived by hospital staff...as a symptom of psychiatric disorder.... Once people have been labelled mentally ill, perceptions of their actions may be distorted to adhere to the label or to fulfil the prophecy. (Ibid., 1003)

Critics of labelling theory (described in Rosenfeld 1997) argue that the stigma of being labelled is fairly inconsequential, and may in fact bestow benefits upon the mentally ill in the form of needed services (ibid., 660). Rosenfeld examined the importance of perceived stigma versus the receipt of services for the mentally ill (ibid). She found that while the mentally ill benefited from service intervention in the community, most continued to report experiencing a fair degree of stigma (ibid). She concludes that "only interventions that reduce the stigma within communities...can truly improve the life chances of people living with mental illness" (ibid., 670).

To this end, there is a third body of literature that examines the coping strategies employed by the mentally ill to deal with stigma (Holmes and River 1998; Link et al.
Holmes and River (1998) examine strategies to combat self-stigma. Self-stigma occurs when attitudes about severe mental illness become personally salient to an individual following the onset of his or her own illness. Daily interactions with others reinforce the stigmatising thought that individuals with severe mental illness often endorse in themselves, resulting in a loss of self-esteem. (Ibid., 232)

Holmes and River suggest three strategies for coping with self-stigma. The first is psychoeducation. Psychoeducation helps people come to a more realistic understanding of their mental illness, cope with their illness, and reconnect with their communities (ibid., 236). The second strategy is cognitive restructuring. Cognitive restructuring occurs in concert with a therapist who helps people question, test, and collect evidence to challenge the beliefs that people hold about themselves (ibid., 237). The third strategy, exposure, encourages mentally ill people to engage in activities with people whom they would normally avoid. In this way, they come to "experience others as real people who are more than just their stigmatising attitudes and beliefs" (ibid).

Lundin (1998), who has a bi-polar disorder, describes his experiences with stigma. Lundin adopts an exposure strategy to combat stigma. He maintains that "the best way to fight stigma is with truth and disclosure, but the timing for such candour must be careful" (ibid., 229). In order to avoid eliciting negative reactions from acquaintances, trust and confidence must first be established. Once that trust is established, it is easier to disclose the nature of mental illnesses to colleagues and de-bunk the stereotypes they have of the mentally ill.

Mayville and Penn (1998) propose strategies to change society's attitudes towards the mentally ill. Similar to Holmes and River's (1998) notion of exposure, and Lundin's
(1998) notion of disclosure, Mayville and Penn (1998) promote personal contact as a solution to societal change. They note that studies on co-operative tasks involving one on one interaction between the mentally ill and non-mentally ill resulted in decreased stigmatisation and an increased understanding of mental illness.

Mayville and Penn (1998) use "value self-confrontation" (ibid) to account for changes in attitude. The value self-confrontation theory postulates that people hold certain self-perceptions or beliefs about themselves (i.e. I am a tolerant person). When they are encountered with evidence that contradicts their self-perceptions, "a state of dissatisfaction occurs" (ibid., 248).

For example, when one encounters evidence that she is not tolerant of the mentally ill, she will feel troubled that she is not the tolerant person that she thought she was. The value self-confrontation theory thus predicts that she will change her attitude towards the mentally ill, become more accepting, and thereby re-cast her positive self-perception as a tolerant person. While preliminary studies show promise, Mayville and Penn assert that behavioural changes, as opposed to attitude adjustments, are required in order to sufficiently tackle the stigmatisation of the mentally ill. They concede that the majority of evidence to date indicates little change in discriminatory behaviour towards the mentally ill (i.e. refusing employment or housing) and that more research in this area is required (ibid., 250-251).

Link et al. (1991) take issue with the coping and behavioural strategies of eliminating stigma. They warn that stigma reducing strategies such as secrecy, education, and disclosure do more harm than good. First, secrecy does nothing to change people's attitudes towards the mentally ill. A mentally ill person who remains unlabelled
will not anticipate stigma or discrimination, but will also not change the attitudes and
behaviour that others exhibit towards the mentally ill.

Link et al. (1991) find that education and disclosure endeavours are not
successful in alleviating the stigma of the mentally ill. They note that attempts to
overcome labelling effects "fail or even set the labelled person farther apart from others,
making them more deviant in a manner consistent with Lemert's secondary deviance
notion" (ibid., 315). Secondary deviance is a component of Lemert's labelling theory,
which consists of:

1. Primary deviance, the initial act or characteristic.
2. Social reaction, the response of other people to the primary deviance.
3. Secondary deviance, the response of the deviant to the social reaction. (Bowers
1998, 7)

Link et al. note that the mentally ill "fail in their efforts to overcome stigma, reinforcing
for both themselves and others the view that they are flawed and not as competent in
managing their affairs as they should be" (ibid., 316).

This finding is corroborated in Shaw's (1991) seminal study on stigma and the
moral careers of ex-mental patients living in board and care. The term 'moral' is defined
by Goffman (1961, 128) as "the regular sequences of changes that career entails in the
person's self and in his framework of imagery for judging himself and others." The term
'career' refers to "any social strand of any person's course through life" (ibid., 127). In the
context of ex-mental patients, moral career refers to the sequences of change involved in
'being' an 'ex-mental-patient.'

Shaw (1991) found that the process by which residents come to terms with stigma
in the boarding home involved negotiating their place among other residents. This
process closely resembles Holmes and River's (1998) concept of self-stigma. Residents
internalise the stigma of mental illness and apply it to others according to their ability to function as 'normal.' The more functional or normal one behaves, the more respect they gain in the eyes of other ex-mental patients.

To internalise the stigma of mental illness is to accept commonly held cultural beliefs about the mentally ill (Link et al. 1991). Societal change involves a direct aim "at cultural beliefs about how mental patients will be responded to...to alter the nature of contingencies people face upon becoming patients" (ibid., 316). This involves "changing the negative meaning that "becoming a mental patient" has for most people" (ibid).

Link et al. (1991) offer few concrete solutions to affecting societal change. They suggest that the mentally ill must collectively reject culturally discrediting stereotypes in order to develop socially reinforced coping efforts (ibid) to "allow a dramatically different outcome than is possible with individual action only" (ibid).

For Link et al. (1991), the prognosis is not good. "In the absence of concerted, socially focused efforts to overcome labelling and stigma...mental patients will continue to confront an unfortunate state of affairs" (ibid).

Theoretical Framework

Symbolic Interactionism

My general theoretical approach to this study is symbolic interactionist. Symbolic interaction refers to the way in which messages, meanings, values, and opinions are conveyed between people (Gupta 1993, 23). "The fact that human beings interpret or "define" each other's actions instead of merely reacting to them determines the nature of
the response" (ibid). This process of interpretation requires "mental anticipation, reflection, and rehearsal" (ibid., 24). In other words, "prior to... interacting with [person] B, A thinks about that interaction and interprets or rehearses in his mind [the] possible responses of [person] B" (ibid).

In the symbolic interactionist approach, mental illnesses manifest themselves as "the product of interpersonal problems...rooted in poor self-concepts, alienation, frustration, and disenchantment" (ibid).

**Interpretive Dissonance and Role Identity**

Interpretive dissonance concerns the differences in how people internalise and express the meaningfulness of actions, symbols, and communication. In this paper, interpretive dissonance concerns the discrepancies in attitude, perception and understanding *between people* of particular needs, roles and labels.

Of particular salience to this study are the discrepancies in role expectations. That is, discrepancies in the expectations that people have of themselves, and the expectations that others have of them. The concepts of roles and role expectation are briefly outlined below.

McCall and Simmons (1966, 64) note that the "identification of persons and of other things is the key to symbolic interaction." We commonly identify people in terms of broad social categories, like 'military rank' (ibid), 'medical professional,' and 'professor.' These are called *social identities* (ibid). *Personal identities* categorise people in terms that are unique to individuals (ibid), such as 'John Smith of Toronto.'

*Social position* constitutes the status (ibid., 66) we occupy in a particular system, such as captain, psychiatrist, and assistant professor. The expectations that we
have of people in those positions constitute their *social role* (ibid). Our expectations of people in specific roles depend largely on their behaviour, "which is judged more or less appropriate to such a social position" (ibid., 67).

It is important to note that people do not uniformly interpret behaviours in the same way. What is considered appropriate behaviour for a specific social position will vary from person to person.

Social position alone is not sufficient to specify role-behaviour, for the demands of such a position are filtered through one's character or self-conception and are modified to blend with it. (Ibid)

The way in which our character and self-conceptions filter behaviour leads to the concept of *role-identity* (ibid). Role-identity is the:

character and the role that an individual devises for himself as an occupant of a particular social position. More intuitively, such a role-identity is his imaginative view of himself as he likes to think of himself being and acting as an occupant of that position. (Ibid [emphasis in original])

The view of oneself in a position is thus idealised (ibid). It incorporates "standards of conduct and achievement that are unlikely to be consistently attained in the individual's actual day to day performances relevant to that role" (ibid., 68).

These standards do not merely apply to an individual's own role, but to the role of others. People who do not measure up to the idealised expectations that we hold of their social position, fail, in our eyes, to live up to their social role. This is the central assertion of the concept of interpretive dissonance.

Interpretive dissonance bears close resemblance to Hardy and Hardy's (1988) concepts of *role stress* and *role strain*.

When a social structure creates very difficult, conflicting, or impossible demands for occupants of positions within it, the general condition can be identified as one of role stress. ...role stress for one individual also results in
ambiguous or and discordant conditions for occupants of interdependent positions.... the theory deals with the processes through which social structures generate the circumstances in which the ambivalence is embedded.

Role stress is located in the social structure; the source is primarily external to the individual. It may generate role strain (subjective feelings of frustration, tension, or anxiety- a subjective state of emotional arousal in response to the external conditions of social stress) in people in a central role, and in their associated role partners. Not only may high levels of role strain disrupt social interaction, but it may also prevent goal attainment for a role system. (Hardy and Hardy 1988; 159, 165)

Hardy and Hardy (ibid.) are careful to note that "the theory does not address personal difficulties, but rather refers to incompatible normative expectations, attitudes, beliefs, and behaviours assigned to a social position or a set of status."

My concept of interpretive dissonance incorporates the central tenets of role stress and role strain, and applies them to social structures and personal difficulties. The residents of The Carrall share a place with mental health workers in the social structure of the mental health system. It is the goal of the mental health system to help the mentally ill deal with their personal difficulties, since it is mental illness that is the main source of these difficulties. Certainly, the personal difficulties of the mentally ill overlap with the social structural ambivalence of role stress and role strain. That is, the residents of The Carrall attribute their personal difficulties to both external (structural) and internal (personal) forces.

In the context of interpretive dissonance, social structural discrepancies address the extent to which components of the mental health system, such as The Carrall's supported living program, mental health teams, and drop-in centres, meet the needs of the mentally ill. Personal difficulties pertain to personal problems, life skills, and unmet needs that impede the rehabilitation of the mentally ill and their ability to reach their goals. Structural discrepancies and personal difficulties overlap. For example, a few of
The Carrall's residents aspire to become auto mechanics. Structurally, vocational training in auto mechanics may not be offered by the mental health system. Personally, due to the nature of their mental illness, the residents may be unable to concentrate for extended periods of time in a class environment. This would prevent them from enrolling in college run auto mechanic classes. Role stress exists in the mental health system because it cannot provide for the residents' needs. Role strain manifests itself in the residents' criticism and disappointment that the mental health system is not meeting their needs. Furthermore, a vocational auto mechanics course may not be recommended by mental health workers, based on their evaluation of the residents' social skills and aptitude.

In the above example, the interpretive dissonance perspective seeks to contrast the role stress and strain of the residents, to the interpretations of the mental health workers who work with them. The low-income mentally ill have expectations about what mental health workers and mental health programs are supposed to offer them. When they believe that a program is not meeting their needs, or that mental health worker are not fulfilling their duties, they will consider these incidences as structural (in addition to personal) or systemic failures. However, the program administrators and the mental health workers may take a different view, maintaining that they are successfully fulfilling their duties and responsibilities. Therein lies the dilemma of interpretive dissonance as it applies to the provision of social support.

Having outlined the concept of interpretive dissonance, it is important to note that 'dissonance' does not characterise of the totality of interpretations surrounding the support of The Carrall's residents. In some instances the residents and mental health workers will not see eye to eye on the benefit of specific types of social support. In other
instances, appraisals of the value are support are shared. Therefore, 'dissonance' in social support forms only one part of the analysis of this thesis. In addition to the constraints, I will endeavour to highlight the benefits of social support provision as interpreted by the residents and mental health workers in this study.

The following sections define social support and outline the main approaches to the support of the low-income mentally ill.

**Definitions of ‘Social Support’**

Helping or ‘social support’ network theories are modelled according to the composition of the networks. The nature and type of help sought is determined by a number of variables, including age, income, social status, sex, religion, race, or a combination thereof. Young, old, middle-income and lower-income mentally ill persons will have different needs and may each seek out different kinds of help. Social support networks are theorised as:

> a set of interconnected relationships among a group of people that provides enduring patterns of nurturance (in any or all forms) and provides contingent reinforcement for efforts to cope with life on a day-to-day basis (Garbarino 1983, 5).

There is a general lack of agreement among social scientists and social workers as to what constitutes social support (Maguire 1983, 51). Maguire summarises social support as:

> ...a feeling and attitude, as well as an act of concern or compassion. It is what friends, good neighbours, and relatives provide. When these kith and kin link together for the purpose of helping, they form a social support network....

The literature generally distinguishes between personal support systems and community support systems. Personal support systems consist of friends, family, neighbours and colleagues who provide support, help, and a personal care or concern for identifiable individuals. Community support systems consist of the supports or services provided within a community or neighbourhood for helping
residents to meet their own social-emotional needs, as well as general welfare concerns. Community support systems therefore consist of the resources within any given community that can be potentially tapped by individuals in meeting their needs. (Ibid)

Glasser (1988) provides a refined definition of social support. She categorises social support into three types: emotional support, tangible support, and informational support.

*Emotional* support includes intimacy and attachment, reassurance, and being able to confide in and rely on another- all of which contribute to the feeling that one is loved or cared about, or even that one is a member of a group, not a stranger.

*Tangible* support involves direct aid or services and can include loans, gifts of money or goods, and provision of services such as taking care of needy persons or doing a chore for them.

*Informational* support includes giving information and advice which could help a person solve a problem. Tangible and informational support may also serve an emotional support function, as when they signal caring and are not viewed as resulting from obligation. (Ibid., 101-102)

Glasser’s definition of social support offers a simple and practical framework that classifies help into three distinct types of support, allowing for a more precise assessment of a) the needs of SRO residents, and b) the frequency of types of help sought. For example, some people may seek tangible supports more than emotional or informational supports. Glasser’s classification of social support permits the researcher to rank people’s needs in order of importance or significance and then determine what types of help satisfy those needs.

**Support Provision Models: Problems versus Strengths Assessment**

The modern day approach to the provision of social support to mentally ill people follows the 'strengths assessment model.' The strengths assessment (SA) model was conceived by advocates of the consumer empowerment movement. It is touted by the
mentally ill - both former and present mental health users - as an empowered alternative to the medicalised 'problems assessment' (PA) approach to mental health care (Rapp 1998).

The SA model focuses on what people want and aspire to, and seeks to identify their skills and talents (ibid., 79). The PA model places a high value on expert diagnosis. Questions focus on people's problems, deficits, needs, and symptoms (ibid). Table 1 contrasts and compares the central tenets of the SA and PA models.
Table 1: Central Concepts of the Strengths and Problems Assessment Models

<table>
<thead>
<tr>
<th>Strengths Assessment (SA)</th>
<th>Problems Assessment (PA)</th>
</tr>
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<tbody>
<tr>
<td>• What the person wants, desires, aspires to, dreams of. Information gathered about persons talents, skills, and knowledge. A holistic portrait.</td>
<td>• Defines diagnosis as the problem. Questions are pursued related to problems. Needs, deficits, symptoms.</td>
</tr>
<tr>
<td>• Gathers information from the standpoint of the consumer's view of their situation. Ethnographic.</td>
<td>• PA searches for the nature of patient / client's problems from the perspective of a professional. Analytical.</td>
</tr>
<tr>
<td>• Is conversational and purposive.</td>
<td>• Is an interrogative interview.</td>
</tr>
<tr>
<td>• Focus is on the here and now, leading to a discussion of the future/past-asking how they have survived so far.</td>
<td>• Focus is on diagnosis assessment procedures to determine the level of functioning.</td>
</tr>
<tr>
<td>• Persons are viewed as unique human beings who will determine their wants within self and environment.</td>
<td>• Client / patient is viewed as lacking insight regarding behaviour or in denial regarding scope of problem or illness.</td>
</tr>
<tr>
<td>• Is on-going and never complete with the relationship primary to the process. Encouragement, coaching and validation is essential to the process.</td>
<td>• Done at a set time (often at in-take) and largely viewed as completed at that time.</td>
</tr>
<tr>
<td>• SA is specific and detailed, individualises a person.</td>
<td>• PA places the person in a diagnostic or problem category. Often written with generic, homogeneous language.</td>
</tr>
<tr>
<td>• In conducting SA, behaviour is considered a desire to communicate</td>
<td>• In a PA behaviour is seen as symptomatology, attributed to disorder.</td>
</tr>
<tr>
<td>• Consumer authority and ownership.</td>
<td>• Is controlled by the professional.</td>
</tr>
</tbody>
</table>

Source: Rapp 1998, 79

The Principles of the Strengths Assessment Model

There are six principles to the SA model. The first principle is a focus on individual strengths rather than pathology (ibid., 45). Work with the mentally ill should not focus on psychosis, problems or weaknesses (ibid). Work should focus on
what people have achieved so far, the resources available to them, the talents and strengths they possess, and the aspirations and dreams they may hold (ibid). The goal of this principle of SA is to individualise people, rather than viewing them generically (ibid). Case management and the provision of social supports is geared towards the self-identified needs of individual people, as opposed to the professionally identified needs of the mentally ill which "sees all clients as the same" (ibid., 46).

The second principle of the SA model views the community as an oasis of resources (ibid., 47). In addition to focusing on the strengths of the individual, SA also focuses on the strengths of the environment (ibid). The community provides opportunities, "the people to care and support and the resources necessary" (ibid). The focus here is on normal or natural community resources, not mental health services (ibid). This is an important aspect of this principle:

The presence of community based [mental health] services can act as an obstacle to community integration...[they] can guarantee only survival, and can never lead to serious change.... community integration can only occur apart from mental health and segregated services (Ibid., 47-48)

One example of a SA approach to linking the mentally ill to natural community resources is to work with employers to provide job opportunities to mentally ill persons, as opposed to referring them to vocational rehabilitation (ibid).

The third principle of SA asserts that interventions are based on client self-determination (ibid., 50). It is the mentally ill person's right to determine the form, direction and substance of the case management she is to receive. The low-income mentally ill often view their needs as money, access to health care, decent shelter, transportation, opportunities for socialisation, and the availability of help, when required (ibid). Client self-determination thus involves an equal partnership with mental health
workers to assess their strengths and successfully meet their needs: "The professional works on behalf of the client, and the client's goals and aspirations become the centrepiece of the work" (ibid., 51).

The fourth principle of SA stipulates that the case manager-client relationship is essential. Close relationships attenuate stress and prevent the exacerbation of symptoms (ibid., 52). Relationships are co-operative in nature, and build trust and confidence.

As confidence in the relationship replaces scepticism, the client becomes reaffirmed as a person with assets and valid aspirations, goals become more ambitious, communication more honest, and assistance more accessible. (Ibid., 52-3)

A close case manager-client relationship entails engaging in informal types of activities together such as shopping (ibid., 52) or going for coffee together. The time required to engage in greater one-one interaction requires a lower case manager-client ratio. As Rapp notes, "a close collaborative relationship cannot be established with 80 people" (ibid).

The fifth principle of SA advocates aggressive outreach as the preferred mode of intervention (ibid., 53). This principle maintains that social support cannot take place in the mental health worker or professional's office (ibid), it must be carried out in the communities and milieus that the mentally ill inhabit. For example, the way that the mentally ill behave in a mental health program may differ from the way they behave in other settings. People "can cook, clean and socialise in a day treatment program, but will fail to do so in their own apartments and neighbourhoods" (ibid).

A second reason why outreach must be aggressively pursued in the community is that would be mental health service users are unaware of the services available to them in their communities (ibid).
Third, a major part of the mental health worker's job is to model and teach certain
behaviours (ibid). Mental health workers must consistently provide "in vivo instruction"
(ibid., 54) to mental health users. The term 'in vivo' stems from biology and refers to the
processes that take place inside living organisms (Oxford Dictionary). In the context of
behaviour modelling it refers to providing the life skills to cope with the demands of day
to day living.

The sixth principle of SA states that people suffering from major mental illness
can continue to learn, grow and change (ibid). The central belief of the SA model is that
"people are not schizophrenic or chronically ill but that they are people with
schizophrenia. It is only one part of their being" (ibid). This principle fosters the belief
that people have the capacity to change their lives. In the context of mental health
practice, a "can-do" attitude must be adopted in every form of social support (ibid).

*Life Domains*

In following these principles, Rapp (1998) lists six key "life domains," or areas of
need that are identified by the mentally ill as requiring assistance or improvement:

1. *Daily Living Situation*- includes the client's residence and specific features
   like roommates, furnishings, location, condition, access to resources such
   as food store, laundry, etc.

2. *Financial* - focuses on the sources and amount of income, debts, and loans,
   financial and possession assets (e.g. car, home), sources of emergency
   funds.

3. *Vocational / Educational* - pertains to employment and its features, formal and
   informal education activities, specialised training, credentials, etc.

4. *Friendship and Family Supports* - includes family, friends, co-workers,
   neighbours, and the nature of relationships as well as the role of spiritual
   matters of relevance and formal religion.
5. Health- involves the status and resources relevant to physical illness and health promotion (diet, exercise) as well as the mental illness (medications, doctor, side effects, awareness of early warning signs of symptom exacerbation).


The strengths assessment model is described here at length. The SA model is widely supported by the mentally ill as an innovative alternative to traditional mental health care. Moreover, it embodies the philosophy and approach of the Vancouver Mental Association (VMA), the staff of The Carrall, and the other mental health agencies discussed in this study to the provision of social support to the low-income mentally ill.

Methodology and Research Design

Methodology

My methodology adopts a “personal network approach” (Sokolovsky et al 1978). This method involves soliciting members from a given population and “obtaining a list of all other units to which he is linked” (ibid., 6). The advantage of this approach is that it allows “sampling from a large population and the analysis of many variables where it would prove unmanageable to study a whole network” (ibid).

This approach is especially well suited to The Carrall. The Carrall houses approximately 50 residents. Given time and economic constraints, it would have been impossible to include all of The Carrall's residents in the interviews that comprise the major component of this research. As staff members and residents came forward to be interviewed, they recommended other staff, residents, and community workers who might agree to participate in the study. In this respect, the 'personal network approach'
bears similarity to the 'snowball' sampling method, where each of the interviewees suggests others to be interviewed (Bibbie 1992, 292).

**Research Design**

There are two components to this study: interviews and participant observation.

**Interviews**

The analysis of this thesis is based primarily on interview data. I conducted interviews with 16 people over the course of my research. Two of these interviews were preliminary interviews with community activists that were conducted in January and February of 1998. The remaining 14 interviews were conducted between August and October 1999. One of the interviewees, a resident of The Carrall, was interviewed twice, bringing the total number of interviews to 17.

I conducted interviews with six of The Carrall's staff, including the supervisor. I conducted interviews with five of The Carrall's residents. Interviews were conducted with mental health workers at three mental health agencies that serve the residents of The Carrall: The Burrard Drop-in, which is owned by the VMA and caters to people with a history of mental illness; the Downtown Eastside Mental Health Team (DEMHT); and The Main, a Downtown Eastside drop-in for people with a history of mental illness. Residents were paid $15.00 per interview for their participation. This is the standard payment to Downtown Eastside residents who participate in research interviews. Funding for these interviews was provided by a small grant from the VMA. The staff at The Carrall, The Burrard, The Main and the DEMHT were not paid.

The interviews were loosely structured and consisted of open ended questions that sought information on the types of helping and social support received by The Carrall's
residents and the low-income mentally ill of Vancouver's Downtown Eastside. A list of the questions is provided in the appendix.

**Participant Observation**

'Participant observation' refers to the "study of social life involving the participation of the researcher, to varying degrees, in the activities of [a] group..." (Guppy 1998, 533). The purpose of participant observation is to gain an "insider’s understanding of a particular way of life" (ibid); in this case, an understanding of the extent to which social supports meet the needs of The Carrall's residents.

Between August and October of 1999, I spent an average of four hours a week at The Carrall. The bulk of my time at The Carrall was spent on Tuesday nights, one of the nights when the staff prepared a group meal for the residents. I would arrive at the hotel at 3pm and leave at around 7pm. The meals are free, and attract a fair number of residents, thus providing an excellent opportunity for interaction and socialisation. It was at the Tuesday evening meals that I befriended the staff and the residents who took part in this research.

Interviews with staff members of the DEMHT, Burrard Drop-in, and The Main, were conducted on the recommendation of staff and residents of The Carrall. Most of The Carrall's residents are affiliated with the DEMHT. The Burrard Drop-in and The Main are the two most frequently visited drop-in centres by The Carrall's residents. These agencies thus represent important sources of social support for residents of The Carrall.

My approach to the analysis of interview and participant observation data is "anti-reductionist" (Offer 1998) in nature. Anti-reductionism
seeks to explore and account for social life as the end product of people conceived of as language-using, sense-making agents, not the result of 'underlying' or external forces. (Ibid., 8)

In the context of 'giving voice' to the mental health workers and residents who take part in this study, an anti-reductionist approach simply means that the stated views and opinions of people are taken at 'face value,' without an attempt to mould their responses to fit a particular paradigm. In other words, explanations and observations of social action [are not 'effects'] of some structural necessity or of objective interests. Actors formulate interests and reasons for acting, and engage in action. They do so in terms of the means of action, resources, and discourses that are available to them in particular social situations. (Ibid., 11)

An example of a reductionist approach is found in Goffman's (1961) *Asylums*, where he explores the social situation of mental patients in total institutions. A total institution is described as

a place of residence and work where a large number of like-situated individuals, cut-off from the wider society for an appreciable period of time, together lead an enclosed, formally administered life. (Offer 1999,77)

Goffman's thesis is that it is the nature of total institutions (i.e. the regimented, controlled social structure of the mental hospital) and not mental illness, that is the most important factor in forming the identity of the mental patient.

Goffman is criticised by Offer (1999) for taking a 'reductionist' stance. That is, Goffman interprets the actions of staff and patients in the context of the characteristics of total institutions, without giving agency or voice to the staff and patients. The meanings and perspectives of individual staff and patients are not provided. Indeed, there is an absence of interview and participant observation data in *Asylums* which speaks to the individual experiences of the staff and the patients, and their own interpretations of their 'social situation.'
In applying an 'anti-reductionist' approach to this study, I aim to present and analyse interview data in a way that remains true to the self-expressed meanings and interpretations of the mental health workers and residents. To this end, the concept of interpretative dissonance will apply to some aspects of social service provision but not all. The interpretations of the residents and the staff are congruent in some instances and incongruent in others. Where interpretations are congruent, they will be presented as such, with no attempt to impute a "false consciousness" (Offer 1999, 11) to the respondents regarding the validity or reliably of their interpretations. In other words, it is not assumed that all interpretations or meanings are dissonant in nature. For example, if a resident sees benefit in a particular aspect of social support, then it will be presented as such, without a claim that the resident's view is in some way misguided or 'co-opted' by the staff or mental health workers.

Nevertheless, there are some aspects of this thesis that will appear reductionist in nature, such as the organisation of the thesis along the SA model’s life domains, and a discussion of mental illnesses and how they affect the residents and determine their support needs. It is important to keep in mind, however that the organisation and scope of this thesis attempts to mirror (in the context of the methodological limitations described above) the self-expressed concerns of the residents and the mental health workers in regards to mental health care. Put simply, the material presented in this thesis is salient to the concerns of the residents and mental health workers.
**Terminology**

Throughout this paper, I attempt to maintain the voices of the respondents. Despite their wide spread and accepted use in mental health circles, I try to avoid using the politically correct terms 'mental health consumer,' and 'client' unless I am giving voice to the respondents or articulating the organisational language of the agencies that use these terms. My reasons for doing so are twofold. First, as Dickerson (1998) points out, the term consumer implies that people have a choice in the services they use, and that they are paying for these services. All of The Carall's residents receive income assistance. They have few choices in the mental health services they use, and cannot afford to purchase their own mental health care. The majority of services they use are publicly funded or subsidised by the B.C. Ministry of Health or the Ministry of Social Development and Economic Security.

Second, most of the residents I interact with or interview do not refer to themselves as 'consumers' or 'clients,' although several of the residents are familiar with these terms and their meaning. The residents simply identify themselves as 'residents,' 'low-income,' 'poor,' and 'mentally ill.' Out of respect for how the residents self-identify, I use the terms 'low-income mentally ill' or 'resident' wherever possible.

**Ethical Considerations**

Prior to commencing this research, I obtained the permission of the VMA to conduct research at The Carrall. Ethical approval to conduct the research was subsequently obtained from The University of British Columbia by way of a request for ethical review for research involving human subjects.
All interviews required informed consent, and signed consent forms were obtained prior to the interviews. Sixteen of the seventeen interviews were tape recorded and transcribed. Handwritten notes were taken for the remaining interview.

Pseudonyms are used throughout this thesis, and apply to the names of the interviewees as well as to the agencies with staff who are directly involved in the provision of social support to The Carrall's residents. All interview and participant observation data will maintain the anonymity of the interviewees. The identity of the interviewees does not appear in any report or publication pertaining to this research.

Limitations of the Research Design

There are several limitations to this research. First, The Carrall is but one SRO hotel out of many that operate in the Downtown Eastside. An analysis of the social supports of The Carrall's residents cannot be deemed representative of Downtown Eastside SRO residents as a whole.

Second, The Carrall is unique from other Downtown Eastside SROs. The Carrall is owned by the VMA, and is mandated as an empowered self-help living alternative for persons with mental illness. Commercially run hotels do not have such a mandate, and it is likely that the quality of life of residents in privately owned SROs is not as high as that of the residents of The Carrall.

Third, given the scope and time constraints of this study, it was not possible to study other area SROs. Securing access to SROs is a time consuming process which
takes weeks, if not months to obtain. A comparative analysis of two or more SROs could not be completed in the time allotted for the research and writing of this thesis.

Fourth, due to time constraints and ethical considerations, participant observation at The Carrall was primarily limited to Tuesday evening meal times. Since in most cases I visited The Carrall in the late afternoon or early evening, a significant portion of the residents' daily lived experiences remains unobserved.

In the first instance, I would arrive at The Carrall at around 3pm in the afternoon. There were usually only one or two residents in the smoking room, and one or two staff in the back office. At 4pm the staff would start to make dinner, at which point some of the residents trickled into the kitchen to help prepare the meal. On one other occasion I accompanied Peter (Carrall Activity Worker) on a social outing to a coffee shop in Richmond (a Vancouver suburb). Therefore, the degree of activity observed 'in-house' at The Carrall is limited.

Second, the VMA requested that I respect the residents' privacy and avoid being too intrusive into their daily lives. To this end, I did not ask residents if I could accompany them and take part in their daily activities outside of the hotel. Nor, however, was I invited by any of the residents to join them.

As Glasser (1988, 103) notes, participant observation must be "long enough and [intimate] enough to observe interactions that may be perceived as supportive." Indeed, it takes time develop relationships that are familiar enough to allow the researcher into the more intimate and personal aspects of the lives of the people she is observing. This fact is well noted by Glasser (1988), Hamburger (1983), Hoch and Slayton (1989), and Snow.
and Anderson (1993). In these studies, the researchers engaged in daily and routine participant observation over a period of one to two years.

Clearly, the scope of participant observation research in this thesis is limited by an absence of observations of some of the more multidimensional aspects of the residents and mental health workers' lives. The residents' and mental health workers' perspectives of social support thus stem primarily from the data collected in interviews.

Contributions of the Study

This thesis constitutes an exploratory study into the provision of supported living for the mentally ill residents of one SRO hotel, The Carrall. It provides a clearer understanding of the social supports that the residents receive and the extent to which these supports meet their needs. It identifies how the residents, The Carrall's staff, and the staff of mental health agencies perceive the success or failure of social support in meeting the residents' needs.

The philosophy of social support provision at The Carrall is grounded in the empowerment approach to mental health care. It embodies the principles of the SA approach developed and promoted by mentally ill persons ('consumer empowerment groups') who use mental health services. The SA model is a relatively new approach to mental health care. It has only recently been adopted by mental health agencies such as the VMA.

While there are a fair number of studies evaluating approaches to mental health care in the UK (Ross, Campbell and Neeter 1993; Morgan 1993; Morgan 1996; Muijen 1993) and the US (D'Augelli 1983; Dickerson 1988; Ford et al. 1992; Lewis et al. 1998),
there is a dearth of literature that evaluates mental health care provision in Canada (Sladen-Dew et al. 1993).

Given that the SA approach is widely lauded by both the mentally ill and mental health advocacy groups, it will prove useful to evaluate the extent to which the model, in practice, achieves its goals. As previously mentioned, the mental health workers and residents in this study express a marked concern for the quality of the provision of mental health services. Therefore, this thesis will approach the residents' and mental health workers' expectations and interpretations of social support in the context of the SA model. It will outline the similarities, limitations and contradictory views surrounding the provision of supported living to persons with mental illness. As such, this paper will be of use to social policy makers, mental health workers, and other mental health professionals by identifying the benefits and deficiencies of the provision of social support to the low-income mentally-ill.

Following Rapp's (1998) six life domains, chapter two is concerned with the domain of health, particularly the mental health issues of the residents. It provides an overview of the operations of The Carrall, The Burrard, The Main, and The DEMHT. It discusses the mental health workers' interpretations of the needs of the low-income mentally, and their approach to social support. It also outlines the nature of the mental illnesses of The Carrall's residents, the effect that mental illness has on the social and life skills of the residents, and the response of mental health agencies to acute mental crises. The findings of chapter two indicate that the approaches and interpretations of mental health workers are congruent in some instances and incongruent in others.
Chapter three examines the social supports of residents in the remaining five of Rapp's (1998) life domains: 1) Daily living situation and routine; 2) Friendship supports; 3) Leisure and recreation activities; 4) Finances; and 5) Employment and vocational training. The findings indicate that some life domains are better supported than other domains. For example, support in the form of meals and finances provides tangible benefits to the residents. However support in other areas, such as educational and vocational training, have met with limited success.

In addition, this chapter demonstrates that the central tenets of the empowerment approach to mental health practice, which stipulate 'user' self-determination, less reliance on mental health professionals, and increased involvement in decision making processes, have yet to be realised. Much of the social supports of the agencies examined in this thesis do provide benefits to the residents of The Carrall. However, with few exceptions, it is clear that the residents have little meaningful self-determination, input, or control over the services they receive.

Chapter four concludes with a summary of the findings of this thesis, and provides recommendations for improving the participation of the mentally ill in the services they receive.
Chapter Two: Mental Illness, Mental Health and Approaches to Social Support

The aims of this chapter are threefold. First, it will provide an overview of the operations of The Carrall, The Burrard, The Main, and the DEMHT. Second, it will examine the approaches of agency staff to their roles as mental health workers, and to the goals of social support. Third, it will discuss the nature of the residents' mental illnesses, and the impact that these illnesses have on their day to day lives.

This chapter deals largely with health, specifically the mental health needs of the residents. Health constitutes one of the six life domains of Rapp's (1998) SA model.

Few of the residents wished to openly discuss their past, their 'life histories,' or their mental illnesses. Indeed, some of the residents stated that they would not take part in an interview if I asked them about their mental illness. Therefore, I did not solicit the residents about their illnesses or their mental health needs. At times during the interviews, some of the residents freely volunteered information to me about their past. Some of that data is presented in this thesis.

This chapter focuses largely on the orientations of the agencies' staff towards the mental health needs of the residents. Where appropriate, interview and participant observation data from the residents are provided as a comparison to staff observations.

Overview of the Support Agencies

The VMA and The Carrall

The Vancouver Mental Association (VMA) formed in 1971 after the onset of de-institutionalisation, which began in Canada in the mid-1960s. De-institutionalisation saw the downsizing of large psychiatric facilities in British Columbia and across Canada, and a shift in social policy to provide mental health services in local communities (De
Leonardis & Mauri 1992; Goodwin 1997). The VMA, whose members include mentally ill 'ex-service users,' advocated for mental health services that were structured around the self-identified needs of the mentally ill, rather than the traditional 'wisdom' of mental health professionals.

One potential benefit of de-institutionalisation was that services were to be provided 'closer to home' for individuals with mental illness. For the low-income mentally ill however, there was one major impediment: the lack of affordable housing. For people on welfare or a disability pension, housing costs are limited by the shelter portion of their income assistance, which was $325 per month in 1999 (MSDES 1999). The cheapest housing available for them was, and remains, in Downtown Eastside SROs, where rents range from $325 to $375 a month.

According to Doug, a member of the VMA's Board of Directors,

...many of these establishments are very unclean and unsafe. These environments are typified by intravenous drug use, prostitution and crime. Far from precipitating an increase in the quality of life for people with mental illness, the frugal cost cutting of mental health services brought about a sense of hopelessness in downtown Vancouver. ('Doug,' Board of Directors, VMA)

Nevertheless, people with mental illness began to make the Downtown Eastside their home, and a variety of social and volunteer services emerged to meet the needs of this 'disadvantaged' population. At the same time, housing pressures in Vancouver led to encroaching gentrification in the Downtown South and Downtown Eastside (Cameron 1996; City of Vancouver 1995). For example, the stock of SRO housing in downtown Vancouver dropped by 43% between 1970 and 1995 (City of Vancouver 1995, 1).

The VMA recognised that many low-income mentally ill people had made the Downtown Eastside their home, but were at risk of losing their housing. In 1991, the
VMA purchased The Carrall and ran it as a residence for persons with a history of mental illness. In 1993, the VMA secured the funds to run The Carrall as a permanent supported residential program.

The VMA statement of purpose is summarised as

...a unique self-help alternative for psychiatric patients. VMA is a democratic self-help group comprised of former mental patients and promotes the empowerment of its members. All VMA services are provided with the goal of assisting in the rehabilitation and overall well-being of its members (VMA 1999a).

According to Nicola, a VMA housing manager, the VMA works from a philosophy of empowerment. This includes many of the components of what is called psychosocial rehabilitation, or PSR. The guidelines, philosophy, and ethics of PSR are established by the International Association of Psychosocial Rehabilitation Services (IAPSRS). The IAPSRS is not a regulatory body. It encourages mental health workers and mental health agencies to follow its guidelines, but does not mandate them to do so (IAPSRS 1997).

The VMA ascribes to two major tenets of the PSR model. The most basic, according to Nicola, is that "individuals should be facilitated to live in the community of their choice." The second tenet of PSR is empowerment.

VMA has always felt that individuals should have choice in as many aspects of their lives as is possible as this is the only way to be truly empowered. Our main approach at The Carrall is to treat people with dignity and integrity as individuals. The staff's job is to assist each individual to reach their goals. This involves coordination of collateral service provision as well as one on one work in areas of life skills etc. The bottom line is that VMA is a member driven organisation so the members are ultimately the boss. The staff work for the residents. ('Nicola,' VMA Housing Manager)

The residential program at The Carrall is operated as a clean, safe, supported living residence for people with a mental illness (ibid). Mental health, or 'hotel' co-ordinators are on-site seven days a week, 21 hours a day, from 9:00am to 6:00am.
There are three daily staff shifts: 9:00am-4:00pm, 3:30pm-11pm, and 10:30pm-6am. There are three permanent mental health workers, also known as 'hotel coordinators' who rotate weekday shifts. There are three different mental health workers who work the weekend shifts. One is a permanent employee of the VMA, the other two are 'on-call' mental health workers. The supervisor works Monday to Friday from 9am to 5pm. A housekeeper works daily from approximately 9am to 4pm. Over the duration of this study, an activity worker, on a six month contract, worked from 5:30pm to 10:30pm, Monday to Friday.

To the residents, The Carrall's mental health workers are simply known as 'staff,' since they are employed by the VMA, work at The Carrall, and provide services to the residents. The staff consider themselves 'mental health workers,' given their hands-on work with the residents at The Carrall. The supervisor, the three staff members, and the activity worker each monitor eight to nine 'primaries.' Primaries are groups of residents who are assigned to specific staff members. Staff are responsible for touching base with their primaries on a regular basis, in order to assess their 'progress' in social and life skills development, their moods, states, and well-being, and to spot any problems that they may be having with other residents or staff at the hotel. Primaries keep a chart for each resident, noting the progress of the resident, and any problems or concerns that they may have. A progress report of each resident is made in the middle of each month.

The prerequisite for working as a mental health worker is a certificate in mental health counselling, or a university degree combined with at least three years' experience in the mental health field. Mental health counselling certificate programs are normally offered through community colleges, and average about six months in length. All six of
The Carrall's staff members, including the housekeeper and the activity worker, possess mental health certificates and previous experience in the mental health field.

The aim of The Carrall's program is to "encourage self help and respond to residents' individual needs" (ibid). The Carrall provides the following social supports: staff support, help with welfare, food provision, access to recreational activities, laundry facilities, a common kitchen, and a TV room and lounge.

To be eligible to live at The Carrall, prospective tenants must have a history of mental illness, be a member of the VMA (an application is completed when accepted for residency), have no recent history of violence, and be able to live on one's own without disrupting other tenants and neighbours. The cost of living at The Carrall is the Ministry of Social Development and Economic Security (MSDES) income assistance shelter portion of $325 per month.

There are five official rules at the VMA, which apply to all VMA operated facilities, including The Carrall and The Burrard drop-in centre: 1) No violence; 2) No sexual or racial harassment; 3) No drunkenness in common areas; 4) No non-prescription drugs; and 5) No disturbing the quiet enjoyment of others (VMA 1999a).

In addition to VMA mandated rules, The Carrall has its own set of house rules for tenants to follow. Smoking is permitted in the lounge, on the outside balcony, and residents' rooms, but not in the hallways or in the kitchen. Excessive noise is prohibited after 10:30pm in the evening.

Residents are required to clean up after themselves, wash their own dishes, and to keep all common areas clean. For example, a sign in a toilet stall of the men's washroom reads: "We aim to please, we ask that you aim too."
All residents have a set of keys to their room, and to the front and lobby entrances of the hotel. Video cameras monitor a stairwell leading up from the front entrance to the lobby entrance, as well as the hallways of the hotel. There are video display monitors in the staff office, allowing for 24 hour monitoring of the stairwell and hallways. There are security doors at the front entrance, and lobby entrances to the hotel. Both doors are operated by key or by buzzer. The buzzer is controlled by staff from the office. An intercom is located at the front entrance, and all guests must identify themselves before they are buzzed in. Once in the stairwell, staff can monitor visitors, and decide whether or not to let them into the hotel.

Residents are allowed to have visitors, but for security reasons, no visitors are allowed after 11 pm. Residents are allowed to have overnight guests. They are restricted to one guest per night. Guests may stay only three nights in a row, and residents may not have guests more than eight nights a month. According to the staff, restrictions on guests and overnight stays are in place to monitor who is staying at The Carrall and to maintain the safety and well-being of the residents. In the past, some of the guests went knocking on doors in the hotel to sell heroin and cocaine. Other guests included prostitutes who went door to door soliciting residents.

Meals are provided to The Carrall’s residents four nights a week: Tuesday, Thursday, Saturday and Sunday. If there is left over food from any of these nights, a meal may also be prepared the following day. On nights when no meals are provided, the residents are responsible for their own meals. The food for the group meals is donated by a Downtown Eastside food bank. The Carrall’s staff encourage residents to donate $5.00 each per month to the food bank in return for their generosity. It is understood that some
tenants will not donate money to the food bank, either because they are unable or unwilling to do so. In either case, meals are made available to every tenant at every meal. Donating to the food bank is not a prerequisite for receiving food.

All of The Carrall's residents are either on basic income assistance, or disability income assistance, level two, known as 'DB Two.' Basic income assistance pays $500.00 per month. DB Two pays $771 per month (MSDES 1999). DB Two is available to persons with a persistent and recurring mental illness, lasting over two years (ibid). Disability level one pays the same benefits as DB Two, but is temporary assistance for people with short-term disabilities, lasting no longer than six months (ibid).

The majority of The Carrall's residents are on DB Two. Most of the residents who receive basic income assistance suffer from recurring and persistent mental illness, but have never applied for DB Two. It is one of The Carrall’s mandates to help residents on basic income assistance apply for DB Two benefits.

Since all of the residents receive social assistance, they receive free health care and prescription drug benefits through BC’s Medical Services Plan (MSP). Most of the residents take medication for their mental illness. The Carrall assists residents with their medication by having it delivered from a local pharmacy. Daily medication deliveries are made to The Carrall. The staff take written notes of the type and dosage of all delivered medication before passing it on to the residents. This is done in case of a medical emergency, so that staff can advise doctors, nurses, and paramedics of the medication a resident is taking.
It is important to note that The Carrall is not a licensed care facility. The staff cannot administer medication to the residents. The responsibility for taking medication falls on the residents themselves.

The majority of The Carrall's residents are men. At the time of my study, there were approximately 46 people living at The Carrall, of whom only four were women. This number was reduced to three after one of the women 'decompensated,' and left the hotel (this shall be discussed later in the chapter).

The following section provides an overview of two drop-in centres that are frequented by residents of The Carrall: The Burrard, which is owned and operated by the VMA, located in the Kitsilano area of Vancouver; and The Main, a local Downtown Eastside drop-in centre situated two blocks from The Carrall.

**The Burrard and The Main**

The Burrard and The Main are two drop-in centres that cater to people with a history of mental illness. The Burrard is operated and funded by the VMA. The Main is operated by another Vancouver area mental advocacy association. Both agencies are funded by a regional mental health society. The drop-ins are open weekdays from 10am to 10pm, and weekends from 12pm to 7:30pm. The Main is open 365 days a year. The Burrard is closed on statutory holidays, except for Christmas and Boxing Day, when it is open from 10am to 10pm.

There are two other drop-in centres in Vancouver which cater to the mentally ill and are not included in this study. All four drop-ins offer standardised services and programs. Their mandates and philosophies are therefore the same.

The Burrard and The Main share the same mandate. Both drop-in centres
...strive to create a barrier free, safe and accepting environment where consumer-survivors have the opportunity to build human connections and find support, assistance, and encouragement in enhancing their quality of life. Our goals are:

1. To be a resource for accessing the basic needs of food, clothing, and shelter.
2. To offer advocacy, outreach, and crisis intervention.
3. To offer social-recreational and life skills activities.
4. To encourage and support involvement in the community. (VMA 1999b)

Both drop-in centres offer a variety of in-house and outdoor activities. In-house activities include bingo and video nights. Outdoor activities include movies, walks, picnics, museum visits, and trips to Vancouver Island and the United States (ibid).

The Burrard and The Main both offer outreach services. The Burrard employs one full-time outreach worker, The Main employs three. Outreach workers work in the community providing assistance to people with mental health difficulties. The goal of outreach is to connect with mentally ill persons who are not using mental or social services, determine their needs, and then refer them to the appropriate agencies. The goals of outreach are quite broad. Whatever the needs are of people in the community, the outreach staff will try and accommodate them.

The Burrard and The Main both offer food services. Coffee is free and available all day. A hot lunch and dinner is served on weekdays, and a hot dinner is served on the weekends. Each meal is provided at a cost of 25 cents.

The Burrard also provides a 'freebie' store and shower facilities. The freebie store has a wide variety of men's and women's clothing, as well as small household items, all available free of charge. The shower facilities include shower stalls for men and women, and personal hygiene supplies, such as towels, soap, shampoo, and razors.
The Burrard and The Main have the same house rules as The Carrall: 1) No violence; 2) No non-prescription drugs; 3) No alcohol or drunkenness; 4) No sexual or racial harassment; and 5) No disturbing the quiet enjoyment of others.

The Burrard has an additional sixth rule: No disturbing the neighbours. This rule was added because of The Burrard's location in Kitsilano, an upscale Vancouver neighbourhood. The drop-in centres' neighbours include a snow-board store and a Jaguar dealership. The Burrard staff are very conscious of their image in the community.

We are very much concerned with relations with our neighbours. We have a Jaguar dealership over here, we have a Porsche dealership over here. We've got all the skateboard shops and high end stuff. And it wouldn't take too much of a push from some influential Jaguar and Porsche dealers to lobby someone on city council to crack down on us and move us somewhere. (Bernard, Burrard Director)

Therefore, The Burrard has imposed a set of rules that prohibits its clients from using drugs, pan handling, or engaging in improper behaviour within a two block radius of the drop-in.

At either of the drop-in centres, a 'client' who breaks a rule faces a suspension or ban from the use of the drop-in.

**The Downtown Eastside Mental Health Team (DEMHT)**

The DEMHT provides services to the seriously mentally ill of the Downtown Eastside. The majority of their 'clients' have bi-polar illness or schizophrenia. They also provide services to people with a dual diagnosis. Dual diagnosis refers to someone who has both a mental illness and a substance abuse problem.

According to Bill (DEMHT director), the mandate of the DEMHT is:

To provide a service. And to provide as good a service as one can. There isn't an end goal in the sense that mental illness isn't like a physical illness. People often have this illness for the duration of their lives. That is the goal and the goal is to
do the best service one can given the resources available. (Bill, DEMHT Director)

The DEMHT provides a variety of services. The most important services are medication and counselling. The goal of medication is to get people on the right medication with the least side effects. Counselling provides people with a variety of rehabilitation services. Included in this service is housing assistance. The DEMHT helps people find adequate housing if they are homeless or in the shelter system.

90% of the DEMHT's users are self-referrals, or walk-ins. About 70% are men, 30% are women. The DEMHT makes referrals to other agencies on a need by need basis. For example, if people are living in substandard housing, they will refer them to housing associations, such as the VMA. Indeed, the majority of The Carrall's residents are referred to the hotel by the DEMHT.

Referrals are made by case managers. The duty of case managers is to connect their clients to the services that they require. They meet with clients on average once every two weeks to once a month, depending on the severity of their mental illness. At meetings, they determine their client's progress by inquiring about their health, their living situation, and the services they are liaised with. Case managers also watch for changes in behaviour, physical condition, and signs of drug use. There are roughly 20 case managers at the DEMHT, each with a case load of 50 to 60 people.

The DEMHT also provides outreach services. The goals of the DEMHT outreach team differ from those of The Burrard and The Main. In addition to linking people with community services, outreach workers encourage the mentally ill to accept in-house treatment at the DEMHT.
...the job of the out reach team is to engage the individual in the community and provide a service from that aspect. With the goal of getting them to the point where they will accept treatment and will come in at which time the client is transferred to an in-house case manager. (Bill, DEMHT Director)

The DEMHT employs twelve medical doctors; six physicians and six psychiatrists. Each works half-time one to three days a week, providing medical and psychiatric services on-site.

The DEMHT offers a variety of in-house rehabilitation services. 25% of the DEMHT's clients are Chinese, and services are provided in both Cantonese and Mandarin. The DEMHT runs women's and men's groups in Mandarin, Cantonese and English. These groups help people with a variety of living skills, such as cooking. The Chinese groups also receive some English language instruction. A dual diagnosis group is run for people with mental illness and substance abuse issues. Ceramics and wood working classes are offered by volunteers on a weekly basis. One of the more popular services is a computer program, which helps people to develop computer literacy and internet skills. This program is very successful, because it has helped people reconnect with family members living in other areas of Canada and in the United States.

Roles, Goals, and Social Support

The mental health workers in this study each have unique interpretations of their roles, and of the goals of social support for the mentally ill. This section examines how the staff of The Carrall, The Burrard, The Main, and The DEMHT describe their roles and their approach to mental health rehabilitation. In the context of Rapp's (1998) SA model, the orientations of the mental health workers conform largely to the six major principles of SA: 1) A focus on individual strengths, not pathology; 2) The community is
an oasis of resources; 3) Interventions are based on client self-determinations; 4) Strong case-manager client relations are essential; 5) Aggressive outreach is the preferred mode of intervention; and 6) People suffering from major mental illness can continue to learn, grow and change (ibid., 45-54).

Where appropriate, interview material from the residents is drawn on as a comparison to the concepts and opinions provided by the staff.

The Carrall's staff are classified as 'hotel co-ordinators.' Given their experience and training in the mental health field, and the nature of their duties and responsibilities at The Carrall, they prefer to call themselves 'mental health workers.' David, a Carrall staff member, explains why:

Well, we have three different labels. The most difficult one is psycho-social rehabilitation practitioner. Alias mental health worker, alias co-ordinator. We were hired as co-ordinators. I consider myself a mental health worker. The term co-ordinator has different connotations in different places. The term mental health worker doesn't.

The last job I had I was considered an assistant co-ordinator. My actual role was an assistant manager. Its different associations, different groups use interchangeable labels that really don't describe what the - what you are actually doing hands-on day to day.

But a mental health worker seems to have the same meaning throughout the system. A mental health worker is somebody who actually works with what we would call clients- or residents, or consumers, or ex-mental patients, whatever you want to call them. It's a hands-on thing where you are actually working with people. (David, Carrall Staff)

The distinctions that David makes are relatively clear. Co-ordinators may have interchangeable roles, working either in administration or 'hands-on' with the mentally ill. The label 'mental health worker' is less ambiguous, because it refers only to people who work hands-on with the mentally ill.
John makes a further distinction, noting that mental health workers are not 'primary care workers,' such as psychiatric nurses, psychiatrists and other degree accredited health professionals:

I'm- on the official papers my job title is hotel co-ordinator. We think of ourselves and describe ourselves as mental health workers, because of the fact that we are not primary care workers in the usual sense as the term is used in the trade. The focus of attention is to the mental health issues of our residents and how those mental health issues relate to their being able to become integrated into the community and living any kind of a normal happy life with the kind of things that you and I take so much for granted. (John, Carrall Staff)

John's role is to assist the residents with integration into the community. While this is an ambitious undertaking, the implication here is that the social and life skills of the residents must be developed in such a way as to allow them to lead as normal a life as possible. The role of the mental health worker is to mitigate the effects of the residents' mental illnesses on their ability to function on a day to day basis.

Peter, The Carrall's activity worker, views his role as 'all encompassing.' He performs the same duties as the other staff but is primarily responsible for organising social and recreational activities for the residents. Peter attributes a wide degree of latitude to his role, asserting that his job is to do whatever needs to be done for the residents:

I do a lot of the activities and the activity planning at The Carrall, but I also do the general duties that the other weekly employees do. I'm- just like them I do cleaning, and helping to make meals, but on top of that and advocating for people, helping people with problems. Whatever has to be done is a lot of what we do. But on top of that I have the pleasure of organising the activities and doing the activities as well. (Peter, Carrall Activity Worker)

Winston (Carrall Supervisor), sees himself as a team leader who facilitates communication and dialogue between the staff. This is balanced with case management and administrative duties. In keeping with the second principle of Rapp's (1998) SA
model (1998), Winston liases with community agencies to secure resources for the residents:

I'm the supervisor of the program, I answer to the housing manager and to the executive director. And I'm more of a team leader than anything else. I do provide a feedback loop for my colleagues and I feel- I see myself as being the person who makes the decisions if they can't be arrived at through a process of dialogue. You know, it's a balancing act, and, so I perform a lot of the administrative- day to day administrative functions. I also work in case management. I do a lot of net working out into the community to obtain resources and facilitate access to resources on the part of residents along with the hotel coordinator I'm working with on the day shifts. (Winston, Carrall Supervisor)

Lee, the housekeeper, describes his role as follows:

I was hired technically as a housekeeper more or less. But the role in that field changes. I have training in mental health- so I guess that enabled me to get the position. Basically I have a mental health certificate, and that's what I volunteered at the VMA as, for my practicum. And this position came up, so I took it, because I needed work. And I figured I would still keep my foot in the door as a mental health worker, so any kind of training around that would be great. So that's how I got involved with that.

Well basically, my position is housekeeping, but I'm always- I mean I do some work with the clients. Like when I began, clients were helping me clean. We give them odd jobs around there, giving them some work experience. (Lee, Carrall Housekeeper)

Lee qualifies his role as a housekeeper. While he is technically a housekeeper, he emphasises the fact that he engages in mental health work (providing jobs to residents as a form of rehabilitation). Lee views himself as both a housekeeper and a mental health worker. This qualification is made in light of his role status at The Carrall. The other staff provide him with 'mental health' related responsibilities. For example, Winston, the supervisor, asks Lee to 'keep an eye out' for any trouble or difficulties experienced by the other residents. On the other hand, unlike the supervisor, the mental health workers, and the activity worker, Lee does not have a group of primaries for which he is responsible.

Bernard, the director of The Burrard drop-in centre, compares the role of drop-in
staff to those of restaurant workers. He notes that some mental health services view the mentally ill as a 'pain in the neck.' From his perspective, the mentally ill are his agency's source of employment, who are deserving of a service:

I always feel that the staff, myself included, are like staff in a restaurant. Like we're here to serve those people. Sometime in the mental health field, or in other social services, you get the idea that the client, that the receiver of social services, is a pain in the neck. Like why don't you go away? And I say, we should thank them, that we have the opportunity to be of service, otherwise we wouldn't have a job. We'd be doing something else. (Bernard, Burrard Director)

Jane, the director of The Main drop-in centre, views the role of her drop-in staff as one of building trusting relationships. The Main services people who are both high and low functioning, on medication and off medication. Establishing trusting relationships is important to catching the signs of 'decompensation' (when, as a cause of a mental crisis, people's social skills deteriorate, and they lose the ability to cope with the demands of day to day living), and helping people avoid hospitalisation:

We have people who are very low functioning and people who are very high functioning and everything in between. Some of the people who come here don't have to use mental health services, they don't have to be on meds. So we have people who come who are totally psychotic. Part of our role is to befriend and establish a trusting relationship with them, if they start to decompensate to try to catch it before they become hospitalised. (Jane, The Main, Director)

There are similarities and differences in the mental health workers' interpretations of the goals of social support. Winston (Carrall Supervisor) cites safe, supportive housing as the primary goals of social support at The Carrall. He emphasises that support must be based on individual needs, not a regimen of social work:

Our primary mandate is safe and supportive housing. So for some our residents that's simply means I'm a landlord. A representative if you will. And for others I perform other functions. It's very individuated, actually. Because we're not here to social work people. But we are here to respond to needs as they are required, and to provide encouragement and support as people encounter other agencies and
helping professionals. The health and safety of the residents is my primary concern. (Winston, Carrall Supervisor)

James (Carrall Resident) lived in the hotel before it was purchased by the VMA. He describes the benefits of living in a supported environment:

They have a vision for people that, that they can have a life, and it's positive. This has turned from a dumping ground into a friendly, supportive environment where people can actually get better. Like there are all sorts of people in here who are going back to school, that have been on their meds for a while and they're getting their life back. That's good. This place is turning into a really positive place. (James, Carrall Resident)

Winston (Carrall Supervisor) and Peter's (Carrall Activity Worker) orientation to supported living is strongly influenced by Maslow's hierarchy of needs.

I work very strongly on Maslow's hierarchy of need. And in order for us to facilitate the social and ego aspirations if you will of our residents, we have to make sure that we blunt the edge of the poverty, that people with mental health disabilities naturally incur simply by being on welfare. And take some of the sting out of it. And a lot of my focus during the first year of being the supervisor was on that. (Winston, Carrall Supervisor)

Maslow's hierarchy is categorised into five levels of need:

1. **Physiological Needs.** Biological needs such as oxygen, food, water, warmth, coolness, protection from storms and so forth. These needs are the strongest because if deprived, the person would die.

2. **Safety Needs.** Felt by adults during emergencies, periods of disorganisation in the social structure (such as becoming homeless, living in a violent environment).

3. **Love, Affection and Belonging Needs.** The needs to escape loneliness and alienation and give (and receive) love, affection and the sense of belonging.

4. **Esteem Needs.** Need for a stable, firmly based, high level of self-respect, and respect from others in order to feel satisfied, self confident and valuable. If these needs are not met, the person feels inferior, weak, helpless and worthless.

5. **Self-actualization Needs.** Maslow describes self-actualisation as an ongoing process. Self-actualising people are... involved in a cause outside their own skin. They are devoted, work at something, something very precious to them--some calling or vocation. (Norwood 1999 [web site])
Clearly, Winston wishes to see the residents improve on all five levels of Maslow's hierarchy. However, The Carrall is oriented first and foremost to providing for the residents' physiological and safety needs. This is accomplished through the provision of meals, and safe housing. Maslow's theory holds that when people's basic food and shelter needs are taken care of, they will be able to focus their energy and resources on higher order needs. Peter (Carrall Activity Worker) summarises it as follows:

It's like the Maslow thing. If you do take care of the bottom elements, then the person can shift their thoughts to the next level. And The Carrall of course, we are there to make sure that the bottom levels of Maslow's hierarchy are in place, and then also encourage and help people to not only move into that third level but accomplish the goals of that third level. And then fourth level, and then hey, maybe they'll self-actualise. (Peter, Carrall Activity Worker)

The impact of safety and well-being on one's mental health and self-esteem is important. Max, a resident of The Carrall, lived for six years in a notoriously dangerous Downtown Eastside SRO called The Beacon. He compares the living situation at the two SROs:

I guess what it came down to was, there was an element of danger at The Beacon that was a constant... A guy down the hall from me was murdered, and one morning I went into the bathroom about 7am and there was a guy standing there, just covered in blood and the floor was covered with blood. The toilet appeared to be filled with blood. And he was staggering, crashing into the door and getting upright, and then crashing into the door. He had been stabbed probably by his spouse while he was still in bed, and he probably woke up stoned and stabbed, and didn't know where he was or what was happening.

But it's so contrary to that here. The social scene not being hostile- just constantly criminally hostile, which is what it was at The Beacon. It's actually friendly. Recognising human- ordinary human norms. Cleanliness, hanging around and talking and joking and so on. It didn't take long for me to really change my whole attitude towards life. (Max, Carrall Resident)

Max agrees with Winston (Carrall Supervisor) that covering people's basic needs allows them to devote their energies to other endeavours:
They're trying to assure that people are safe, have enough to eat, have a roof over their head and presumably, from that foundation of security and privacy, something naturally develops. Even in those persons who are the least competent or the most stepped on or screwed up or whatever, there is an opportunity to - if you're not constantly anxious about getting a meal together, if you're not running around picking up cigarette butts of the street, if you're not scampering around trying to find some place that's relatively dry so that you can sleep - those things are taken care of. So in that sense I think, yeah, we're getting there. (Max, Carrall Resident)

The issue of safety is reiterated by David (Carrall Staff). Providing a safe and secure environment removes the element of crime, and allows the residents to be themselves without fear of being taken advantage of. David does not think that it is the job of the staff to make people normal. Their goal is to simply provide a stable and tolerant home environment where the residents are allowed to 'be crazy' and live with their illnesses. In keeping with Maslow's theory, David views rehabilitation as a function of living in an accepting environment. If people do rehabilitate, it is because The Carrall has provided them the opportunity to do so on their own terms. This is also consistent with the first and third principles of Rapp's (1998) SA model. By living in a safe environment, the residents can work on developing their natural abilities. In doing so, they set the agenda for the services they wish to use, thereby 'self-determining' their needs:

First of all it's security, at the Hampton security is very important for all the people who live there. Once they walk in that door, hopefully, if we do our jobs properly, they can let down all of their defences, they can relax. They can be with whomever they want to be with. They're not sitting ducks for anyone who wants to make them part of their desperate needs for money and or clothing or this or that. They are more or less free to be who they are. And the staff will - the staff will make sure that their home is stable and that it is quiet and that it is accepting and tolerant and... People can be crazy, and people should be allowed to be crazy, but I don't think it's our job to make people normal. But because people are crazy, they still need a home, they need a place to live, they need stability, they need care. And that's what The Carrall provides. And if by providing those things a
person does, quote unquote rehabilitate, then we have provided the person the opportunity to do that. (David, Carrall Staff)

Max (Carrall Resident) provides an example of how living in a safe and secure environment encourages socialisation and the establishment of sustainable friendships:

In terms of socialising and - from the bottom level of being able to rub shoulders with security, you go to being able to sustain friendships apparently. I have a number persons that I can say I'm friends with, both staff and residents. People that I enjoy talking to, can have a good laugh with, and whom I'm glad to see. I've never been one who needed to express himself very often in my life. I like to talk to somebody. I always enjoy conversation, I like people talking, arguing and joking, things like that. So there's that aspect of it. There's a society in The Carrall. A tenable society in which one can enjoy themselves. And I think that at any time when you're suffering, you go up a few steps when you're in a crowd of people that provide the right atmosphere. (Max, Carrall Resident)

Peter's (Carrall Activity Worker) view of social support differs from David's. Simply providing safe and secure housing is not enough. He asserts that social support must have a therapeutic effect. Therapy in this sense is grounded in the development of people's social skills. As The Carrall's activity worker, Peter's goal is to provide residents with the 'social outlets' that will encourage them to engage in social interaction. He organises outings that expose residents to different social situations, such as pool outings and coffee outings in different parts of town. Low-incomes, coupled with the nature of the residents' mental illness and medication, mean that many residents cannot afford to go on social outings, or are unable to organise them:

There has to be a therapeutic part to it. There's gotta be some sort of growing, right? If they're not being given the chance to develop their social skills, then what we're doing is babysitting, right?

And some people just need a social outlet. They need the change of environment - they need to have some fun, they need to have something to even hope for. They're like this - I live in the Downtown Eastside in a one room apartment, gosh, I've got nothing going for me. And you say, hey you want to go play pool, and they'll say yeah, I do actually! And they don't have the money to do it, right? Or
they do have the money and they can't handle it, or get to the place where they can play pool? Or even organise an outing is sometimes hard for people. It depends on how severe their break is. How delusional they are. Are they suffering from a paranoid effect from their illness? I don't know, but I think it's hard for someone who's paranoid to organise an outing. And I think that the fact that these guys are all on medications, those medications slow you down. (Peter, Carrall Activity Worker)

Peter's views are consistent with principles five and six of Rapp's (1998) SA model. Through 'aggressive outreach,' Peter tries to expose residents to a variety of public settings, providing them with the opportunity to develop their social skills in different milieus. In developing their social skills, the residents learn to 'grow and change' by learning to adapt and cope with a variety of different social situations.

Lee (Carrall Housekeeper) echoes Max's (Carrall Resident) sentiment, that maintaining the upkeep and cleanliness of the hotel creates a positive attitude among the residents. Keeping the physical health standards high has an impact on mental health:

We try to keep a standard. Health is not just mental health, it's health- it shows in every way. If your place is just run down, you know, and you're not doing too well, you know, it all feeds off each other. That's what we believe anyway. So we try to keep that standard up. (Lee, Carrall Housekeeper)

Bernard (Burrard Director) concurs with Winston (Carrall Supervisor) and David (Carrall Staff) that providing a safe environment to the mentally ill is a key element of social support. For Bernard however, the most important aspect of support is treating people with dignity and respect, to help alleviate the stigma and rejection they experience in mainstream society. No matter how stressful the situation becomes, Bernard encourages his staff to, at all times, treat The Burrard's members in a dignified and respectful manner:

My take on it is certainly to provide a safe and comfortable place for people. But also to- I think the most important thing we can give to a person with mental health disability who is stigmatised and rejected everyday of their life by
mainstream society is dignity and respect. And I push my staff constantly to keep those words, those thoughts in their minds. And mind you in the drop-in it's extremely volatile, extremely stressful and every human being tends to react, but I really put that foremost to the staff down there to just always remember to treat people with dignity and respect. It comes back to you. It's kind of hard when somebody's screaming at you, they're psychotic, or they're strung out on drugs and you're trying to - there's 30 other people in here you have to protect. But as much as possible that's kind of been my policy that I've tried to inject into the centre. (Bernard, Burrard Director)

Jane, like Peter (Carrall Activity Worker), is concerned with helping people develop the life skills to become independent and self-reliant.

The whole place runs on the psycho-social rehab model where you do with not for. So it's all about trying to teach people to be independent, and capable as possible while improving their lives, before anything happens. (Jane, The Main, Director)

It is important to note that the majority of The Carrall's residents do not adopt the formal mental health terminology used by mental health workers. In fact, during my research at the Carrall, I never witnessed the staff and residents discussing the topic of mental illness in their everyday conversations. Granted, mental health is a private issue which many residents did not want to discuss openly. It is clear, however, from the interview data presented in this thesis, that the staff approach the well being of the residents from a mental health framework. That is, when the staff talk about social support, it is with an eye to improving the mental well-being of the residents. This is not surprising, given that this is the mandate of the VMA and of The Carrall.

Mental health terminology and 'buzzwords' such as 'functionality' and 'decompensation' are not used by the residents. This is in part due to the fact that the staff do not use these terms in everyday conversation with the residents. Moreover, it is also related to the residents' approach to social support. The residents, with few exceptions, are not so concerned about their mental health per se as they are with improving their
general living condition. This approach is manifested in how they view The Carrall's staff.

To the residents, the 'mental health workers' are simply 'staff;' and Winston is their 'supervisor.' The way the residents interact with the staff is determined by their day to day observations of what individual staff members do and how they conduct themselves.

A large part of Winston's time is devoted to handling administrative details. He therefore spends the better part of his day in the back office. The other staff members, namely John, David, and George have more routine contact with the residents and are better acquainted with the day to day problems and issues that they encounter. The residents appear to be more comfortable approaching them then they do Winston, for the simple fact that he spends less time with them. Different residents feel more comfortable around particular staff members with whom they have a rapport. Some residents will actively seek out one particular staff member when they need help or advice, and all together ignore or avoid other staff members with whom they are less familiar.

Peter, the activity worker, is familiar with a group of about seven residents who routinely accompany him on outings. These residents are noticeably more at ease with Peter, because of the positive association they have of his role as a social co-ordinator. To the residents, his role is to engage them in activities that they find enjoyable.

In the eyes of the residents, Lee is 'the janitor.' The implication of 'janitor' is that the residents see him as someone who is there to clean and maintain the building, not as a 'staff member' or a mental health worker. In this respect, some of the residents feel more
comfortable talking to him, because he is not directly involved in the mental health
'management' of residents:

One way that I'm always in contact with clients. They see me. Let's see. Say if I
had a quote unquote status quo as a mental health worker- they don't see me that
way. So they will come and tell me things. (Lee, Carrall Housekeeper)

Other residents have different expectations of him. They see him as a janitor and
therefore expect to perform the duties of a janitor. One evening I overheard Lee talking
to Winston about an incident that occurred between himself and another resident. The
resident complained bitterly to Lee that he did not like his room, because the faucet did
not work and there was paint peeling off the walls. He expected Lee to fix the faucet and
paint the walls on the spot. Apparently he told Lee, "I'm not paying $325.00 to live in a
dump. I thought this place was supposed to be nice. And that's your job right? So why
don't you do your job!"

The positive side to being a housekeeper, or janitor, is that some residents will
open up to Lee about issues that they are not comfortable discussing with other staff.
Nevertheless, Lee is the janitor and many residents view him as someone who is there to
provide them with a service- as any other apartment or hotel janitor might do.

There is a certain amount of dissonance associated with Lee's position. In his
interview, Lee spoke about his position in the context of fostering of mental wellness
among the residents. However, to the residents, he is first and foremost a janitor, whose
primary duties are to maintain the hotel.

Stated simply, the residents express less concern with mental health issues and
more concern with meeting with their daily needs. To this end, the residents view the
staff as people who assist them in their daily living, rather than as mental health counsellors.

The above distinctions between the staff and the residents' approach to social support are important in the context of the 'raison d'être' of mental health programs. All mental health programs, no matter what their orientation—be it 'medical' or 'empowerment'—exist to help people cope with mental illness and alleviate the social, economic, and psychological effects which it has on their lives. As Peter (Activity Worker) aptly states, if there is no therapeutic component to the work they do, then the staff are simply babysitting.

This illustrates the tension that exists between the theory of mental health models and their application in the practice of mental health programs. In theory, the SA model, conceived by mental health users, seeks to empower the mentally ill by allowing them to self-identify their needs and build on their own strengths according to their own ability to do so. The model is based on the six life domains commonly identified by the mentally ill as requiring the most support. However, when the mentally ill identify areas of their lives that need assistance, they may not always do so with their mental health in mind. In other words, 'being mentally ill' and the need to 'get better' do not form the basis of all of their decisions.

David (Carrall Staff) comments on this tension in mental health programs. For him, the problem lies in the 'evolutionary' process of helping for the mentally ill:

It's like an evolution, where people start off with nothing, and they evolve into this sort of middle class existence, almost against their will. Where once they had nothing and no one cared whether they lived or died, and now they're cared for in this what I refer to as Club "Med" - it's like you're almost lost in the care. There's so much care around, they're not seeing anymore. (David, Carrall Staff)
David relates the notion of being 'lost in care' to government regulations surrounding the funding of mental health programs. Accountability procedures, especially in 'licensed care facilities' (facilities that are licensed to dispense medication and that have psychiatrists and registered nurses on staff) determine the way in which mental health programs are administered:

You seek out funding from the government, it's inevitable that that will happen. Ok, they will say, here you have 5 million bucks. Ok, you want to put up a big, beautiful facility to house forty people, but, we want to know every move you guys make, every minute of the day. In fact, we're going to put people in place who are going to make sure we know what's happening every minute of every day. And we are going to come in whenever we feel like it and we're going to audit you. And if you didn't give out a pill at two o'clock when you were supposed to, you're going be dragged into some room, you know, the resident is going to be interviewed. We are going to do all of these things to make sure that you follow the rules, the letter of the law, every rule. (David, Carrall Staff)

David compares the approach of licensed care facilities to the approach of The Carrall:

We are concerned with the state of people's mental health at The Carrall, but it's not the be and end all of the people living there. That's why we're there, but it's hopefully done subtly. You know, this is your home where you live. We will- we care about your mental health, but we want to know you, we want you to know us as people, as friends, as people who are there, who care for you. We care for you- we care for all of you sort of thing- we're not constantly writing charts, or dissecting a person's... perhaps I sound a little bitter. But it didn't have to happen that way. That's what does happen when a place becomes a licensed facility. It's almost inevitable. (David, Carrall Staff)

David interprets The Carrall's approach to mental health care as 'subtle,' yet the hotel's mental health program is partially funded by the Government of British Columbia, and therefore subject to accountability procedures. Recall that The Carrall's staff each have primaries for whom they responsible. A monthly progress report is produced for each resident. Incidents and complaints are written down in a log. The number of residents entering and leaving the hotel is also monitored. The purpose of the these
procedures is to justify the existence of the program to the provincial government and, ostensibly, to demonstrate that it is succeeding in its objectives.

I did not have access to residents' files, primary reports' or other administrative data. Furthermore, government rules, regulations, and expectations surrounding The Carrall's supported living program were not addressed in detail by the staff in their interviews. Therefore, an analysis of the impact of government regulations on mental health programs, as well as moral and philosophical debates on the raison d'être of mental health care, are beyond the scope of this thesis.

The point here is to demonstrate that all publicly funded mental health programs are expected to maintain a mental health focus that is oriented towards improving the mental wellness of the people who use their services. Indeed, a program runs the risk of losing its funding if it is found to be simply 'babysitting' the mentally ill instead of providing them with some type of 'therapeutic' benefit. Furthermore, the funding that mental health programs do receive is generally less than what programs require. If funding is limited and resources are strained, then the scope of the services that a mental health program can offer will be limited.

In the context of the SA approach to mental health care, the staff will interpret their roles and approach social support in a way that may be at odds with the interpretations and approaches of the residents. Certain types of support will not be available to the residents, and the quality of some of the supports that the residents receive may not meet their expectations.

Accountability requirements, coupled with service limitations, hinder a program's ability to achieve all of the goals that it aspires to achieve. To this end, the administration
of the program requires that certain procedures and regulations are followed in order to satisfy funding requirements and account for service shortfalls.

One component of these procedures and regulations concerns the rules that govern the residents' behaviour. In order for the program to be of benefit to all residents, 'house rules' are established in order to ensure the 'success' of the program. The enforcement of these rules lies with the staff. The degree to which these rules are enforced varies according to the interpretations of individual staff members.

In light of service limitations, rules and regulations, and differences among the residents and the staff in their approach to mental health care, an evaluation of the SA approach to The Carrall's supported living program is required. In theory, the VMA and The Carrall seek to empower the residents by allowing them to self-identify their needs and take ownership in the services they receive. It will be demonstrated that while the residents benefit from the support provided by The Carrall, they do not have ownership over the services they receive and have little meaningful input into how the hotel is operated.

Chapter three addresses these issues, and also examines the degree to which social support meets the needs of the residents. In order to better understand the support needs of the residents, it is first necessary to understand the types of mental illness that affect them. It is also necessary to examine the staff's approach to mental illness.

The following section of this chapter considers the nature of the residents' mental illnesses, and the degree to which these illnesses affect their day to day lives. It also examines the approach of the staff at The Carrall, The Main, The Burrard, and the DEMHT to mental health issues. In the context of the SA approach to mental health
care, the staff at these agencies express a marked concern for how mental illness affects the 'life skills' of the residents.

**Mental Illness and Life Skills**

The majority of The Carrall's residents have either mood disorders, such as bi-polar disorder and depression, or schizophrenia. Gupta (1993), in the *Sociology of Mental Health*, provides a succinct explanation of the effects mood disorders and schizophrenia.

**Mood Disorders**

People with bi-polar disorder, also known as manic depression, experience conditions of extreme highs and lows (Gupta 1993, 117). They veer from states of superactivity and euphoria, to states of despondency and immobility (ibid). Their thoughts are dominated by frustration, negativity, hostility, and pessimism (ibid).

Depression is described as an emotional state of sadness or unhappiness (ibid). Depression may be latent, but outwardly people will appear normal. Feelings of sadness and despondency may be short lived, or last for extended periods of time (ibid., 118). Extended or frequently recurring depression in known as *dysthymia* (ibid., 119). Symptoms of depression include a loss of interest in usual activities, a loss or gain in weight, insomnia and other sleep disorders, psychomotor retardation or agitation, decrease in sexual drive, loss of energy, fatigue, feelings of worthlessness, self-reproach or inappropriate guilt, difficulty in thinking and concentrating, persistent restlessness, and suicidal thinking or attempts (ibid., 118-119).
Schizophrenia

Schizophrenia is a group of psychotic disorders marked by withdrawal, seclusiveness, lack of interest in the surrounding world, daydreaming, diminished emotional responsiveness, inappropriate response, mild hallucinations, and disjointed thought processes (ibid., 132). The term schizophrenia, which means 'split mind,' was introduced by Swiss psychiatrist Eugen Blauer in 1924 (ibid). According to Carson and Holloway (1996, 160), schizophrenia remains one of the most perplexing mental disorders: "Its cause is poorly understood, its course variable and highly unpredictable, and its management exceedingly difficult."

There are seven significant characteristics of schizophrenia. The first is the presence of psychotic symptoms. These include delusions, hallucinations, agitation, fragmented thought and communication processes, loosening of associations, grossly inappropriate affect, and catatonic behaviour (Gupta 1993, 133).

The second characteristic is a noticeable impairment in daily functioning. This happens when people "observe that the person is not the same anymore" (ibid). This concept will be explored further in the next section.

The third characteristic is that the symptoms were present in childhood and adolescence. Children and adolescents may exhibit early signs of schizophrenia, but they are ignored or are attributed to disciplinary problems (ibid).

Fourth, the 'self' and relationships with the external world are problematic. People experience problems with their identity, particularly gender identity. Grandiose presentations of self are made, often related to cosmic feelings of attachment to a god or a deity (ibid).
Fifth, there is an absence of affect (emotion) and volition. The ability to experience joy, pleasure, pain and sorrow maybe low or absent. In a process called "blunting," emotional shallowness will not allow a person to react to situations in an appropriate manner- for example, laughing at the funeral of a loved one (ibid).

The sixth characteristic is the disturbance and fragmented use of language and communication. These symptoms are manifest in the "cognitive slippage," "derailment," and "loosening" of associations. Schizophrenics often switch over from one incomplete statement to another, or match objects and situations that do make sense. In the context of this definition, the following statement from Allan (Carrall Resident), could be construed as a characteristic of schizophrenia. Allan speaks of the types of jobs he is interested in:

As you can see I have stuff here that I'm [points to a list he has written on the front of his fridge] - I'm going to develop a web page. Just thinking of stuff that I do. That I'd like to do. Like fixing services, doing home repairs. Painting the house, or anything to do with home repairs, and escort Japanese tours. Take Japanese people around as a tour guide and fishing and wilderness tours. Deep wilderness tours back to Vancouver Island where I am from. And I do auto-mechanics. I'm trying to develop a web page so that I can get odd jobs here and there to make enough money where I can develop my expertise more. ('Allan,' Carrall resident)

People may often think about trying new things, or even switching careers. The issue is that when they do, they 'normally' have a clear sense of how they will go about acquiring the skills that they wish to develop. This is not to say that Allan is incapable of learning how to do these jobs. Rather, a 'cognitive slippage' exists in his ability to conceptualise how he will pursue these goals. For example, he states that he is developing a web page, but during my three months of participant observation at The Carrall, I found no evidence
to suggest that Allan was developing a web page, or was seeking ways to develop the skills to create one.

The seventh characteristic of schizophrenia concerns motor behaviour and peculiarities. Schizophrenics may exhibit agitation, excitement, and perform unusual ritualistic acts, such as twisting hair or pulling on ears. They may also exhibit peculiar movements, such as grimacing, rigid posturing, and muteness (Gupta 1993, 134).

The sociological, medical, and psychological models of mental health differ in their aetiologies (science of the causes of disease) of schizophrenia. The sociological model views schizophrenia as the product of conflicting social messages which have their genesis in the family or in social class. Familial theories focus on problems with parental socialisation. Problems occur when parents act irresponsibly and confuse their children instead of teaching them norms and values that will help them in the future (ibid., 142). As they grow older, they experience frustration in social encounters, and this leads to mental problems (ibid). The difficulty with this perspective is that there are very few empirical studies that validate its claims.

The social class perspective cites a high correlation between low-income and incidences of mental illness. Mental illness is caused by the social stresses experienced by low-income people: poverty, the inability to make ends meet, anxiety about money and meeting expenses, social stigma, and discrimination against the poor. Indeed some sociologists, such as Thomas Szasz, speak of the 'myth of mental illness.' Szasz claims that a) mental illnesses are socially constructed categories, and b) the medical profession cannot prove the physiological existence of mental illness, because if they could, they would identify objective and determinate symptoms (Bowers 1998, 19). Rather, mental
'sicknesses' are merely metaphors for life difficulties, such as poverty. Szasz has been largely rebuffed on the basis that some medical research has shown correlations between brain activity and schizophrenia. The social class perspective has been largely discredited because lower income people tend to seek out medical support at publicly funded mental facilities, which collect mental health statistics (Gupta 1993, 145). Members of the upper classes may experience similar mental health problems, and use private mental health services whose statistics are not reported to public agencies.

The medical model looks to hereditary, neurochemical, neurophysiological, neuroanatomical, and neuropsychological factors as the cause of mental illness (ibid., 137). For example, recent medical advances in brain electric activity mapping (BEAM) have shown low metabolic activity in the frontal lobes of schizophrenics (ibid., 139). However, it is not known how this activity relates to the symptoms of schizophrenics (ibid).

In the psychological perspective, Schizophrenia is viewed as a product of a person's inability to live with dysfunctional relationships, to escape from a cruel and unbearable social world and seemingly unsolvable conflicts by altering the inner representations of reality. (Ibid., 139-140)

The psychological perspective is largely criticised by people like Szasz, who argue that the nature of 'dysfunctional relationships,' 'unsolvable conflicts,' 'inner representations of reality' are constantly open to redefinition and negotiation. As Gupta (1993) notes

Currently, we know something about the factors associated with schizophrenia, but clues to its causes point in several directions. Therefore, many myths and controversies have prevailed ....the aetiology of this class of disorders is still unclear. (Ibid., 137)
Decompensation, Functionality, and 'Timing Out'

The term 'decompensation' is widely used in mental health circles. Gupta (1993, 141) describes decompensation as a "person's inability to focus, select, and appropriately react to situations." Decompensation occurs when people with mental illness misinterpret communications and experience difficulties fitting information into stable categories (ibid).

At The Carrall, decompensation is commonly attributed to residents 'going off their meds.' When people stop taking their medication, distinct behavioural changes occur. Peter describes decompensation as follows:

Generally their social skills deteriorate - it depends on the person. Sometimes very rapidly. Sometimes not so rapidly. They're off their meds for a while. And we are very tolerant of that. We'll ask people all the time- Allan, Victoria, you know, are you taking your meds? And- what business is it of yours? It means, no, I'm not. Well, you know I've noticed a change in how you're acting, and you can't continue to act that way while you're here, so you need to start taking your medication again. (Peter, Activity Worker, The Carrall)

Decompensation is related to another behavioural concept, functionality. Functionality is defined as one's ability to adequately cope with everyday living, such as grooming, shopping, budgeting, cooking meals, using public transportation, making and keeping appointments, et cetera (Gupta 1993, 141). It also relates to one's ability to interact with others and handle social situations appropriately (i.e. disagreements with others).

The degree to which a resident is lower or higher functioning depends on the 'insight' they have into their mental illness. Insight is determined by the level of understanding one has into the effects of mental illness on his or her behaviour. It means that one is aware of the steps one must take to maintain 'normal' or socially appropriate
behaviour. At The Carrall, this means that residents are aware of the need to comply with hotel rules and to take their medications on a regular basis.

John views behaviour as a benchmark of the severity of one's mental illness, and of their ability to function properly at The Carrall. Functionality is assessed when prospective tenants apply to live at The Carrall. If it is determined that an applicant will not be able to function at The Carrall, her application will be rejected:

The last thing that we want is someone who is apparently quite ill and has very little of any insight. That would normally mean that they won't be taking their medications, and if they're not taking their medications then they are probably not going to fit in here well in terms of their ability to live in community...it is one of Winston's [Carrall supervisor] very definite bottom lines that can this person live in community or can they with some degree of ease come to learn to live in community? And if they can't then we won't accept their application. (John, Carall Staff).

Determining residents' functionality at the time of their application is no guarantee that residents' behaviour will not change. For example some residents, after moving in, go off their medication and decompensate. People generally go off their medication because of its strong side effects. Most of these medications are psychotropic in nature. "They're hypnotic...They cause people's metabolisms to be slowed down. They have less energy to do things" (Peter, Carrall Activity Worker). Residents will go off their medication in order to feel more alert, and to regain their energy. The trade off is that the symptoms of their mental illness become more acute, causing a variety of behavioural problems.

The psychological and emotional effects of decompensation on the individual and on others should not be underestimated. When I first began my research at The Carrall, in August of 1999, I befriended a woman named Victoria. Victoria, originally from Mexico, was pleasant to talk to and considerate of others. She would go out of her way
to say hello and engage people in conversation. On Tuesday meal nights she would come in to the kitchen at 5pm to watch The Young and the Restless (a soap opera) on TV. I would sometimes sit and watch it with her, discussing the characters and the story line.

By the beginning of September, Victoria stopped saying hello to me. If I made an effort to talk to her, she ignored me. It was as if I was not even there. She became irritable and upset. By mid-September she stopped watching the Young and the Restless. When she came in to the kitchen she would start yelling, for no apparent reason, at myself, at the staff, and at other residents.

The following week, Victoria was yelling in her room on a regular basis. On one meal night, sausages were made. The staff had made enough to give each resident three sausages. As residents lined up for sausages, Victoria barged through the line and took six of them with her fork. Peter reprimanded her, and Victoria began yelling. She marched out of the kitchen and went to her room. Peter later informed me that Victoria had gone off her medication.

The changes in Victoria’s behaviour were disheartening to everybody. For the residents, the staff, and myself, it was emotionally draining to have someone who we considered a friend turn angry and hostile. She adversely affected the mood of the residents and staff. Residents were on edge in her presence, and her behaviour taxed the ability of staff to devote their time to other residents and to other duties at The Carrall.

Eventually, Victoria was ‘timed out.’ Residents are timed out when they decompensate to the point where they cannot control their behaviour, and it interferes with the well-being of other residents. When this happens, the staff call ‘Car 87.’ Car 87 is a mobile unit consisting of a psychiatric nurse and a police officer. ‘87’ is the
designated police code of the mobile unit. There is only one Car 87 unit in the City of Vancouver. Car 87 is a partnership between the Vancouver Police Department and the Greater Vancouver Mental Health Service Society (GVMHSS) (Sladen-Dew et al. 1993).

The purpose of Car 87 is to evaluate people in mental crisis. If a person is in crisis and unable to control her behaviour, Car 87 will take her to a licensed care facility.

When people in crisis are placed in a licensed care facility, they remain there until they are ‘stabilised.’ I asked Peter how long timed out residents remain in licensed care, and how long it takes them to return to The Carrall:

They'll take the person away, and they'll take them to Journey [a licensed care facility]. Often the person is off their meds. If the person is off their meds, it could take a week or two for the meds to really get back to where they need to be, to get the therapeutic part of that medication in their blood system? So you've got to expect that if a person goes to Journey, they're going to be gone for a couple of weeks at least. If they even take their meds. And if they're not going to take their meds, they're gone for indefinitely. You may never get that person back. (Peter, Carrall Activity Worker)

Indeed, after Victoria was timed out, I never saw her again.

Timing out poses a dilemma to The Carrall's staff. On the one hand, empowerment oriented approaches hold that the mentally ill should have the freedom and ability to make their own decisions. On the other hand, there are limits to the behaviour that staff can tolerate, without it becoming disruptive to other tenants and to the goals of the supported living program:

....it's kind of like, yeah, you know, to what extent is a person functional versus being affected by the illness. It's not always clear, you know, initially where a person's needs are in terms of medication. I mean, as a rule of thumb it's better to take your meds. We have to make some tough calls about the behaviour that we can manage, the safety and health of our residents. There are several residents right now who were working with on that basis, who have limited insight into
their own illness. They have very interesting explanations for their behaviour and to discount what they say entirely I think is a great mistake. And to discount what they're saying isn't necessarily the way to encourage insight.

And I think sometimes with the medical model, there's a tendency to think, well, let's just get them in there and get 'em on those drugs, and then they'll be fine. But I think, if a person who is psychotic or suffering from more severe elements of their illness isn't supported in the right way, you're not necessarily going to help them build enough insight to go through the scariness of encountering their illness and the need for change in behaviours and self-care routines in the use of medication. (Winston, Carrall Supervisor)

Winston notes that a balance needs to be struck in what is expected from a supported living program. Drugs alone do not augment functionality. The right 'self-care' routines must be promoted to help residents avert the need to stop taking their medication.

For example, many people stop taking their medication because of its negative side effects. Nevertheless, there are new drugs on the market that have fewer side effects. Some residents may use medication that is not right for them, or that has adverse side effects. This goes largely undetected because of their reticence to see doctors, or to communicate to doctors the effects that their medication is having on them:

So I have this elder fellow who came down to me and expressed his problem at that time, which was he was administered Prozac, which is a highly therapeutic medication. But on some individuals the side effects are more pronounced than the therapeutic effect. And this fellow came up to me and told me that whenever he takes that such and such colour of a pill, it makes him have bad dreams, and when he wakes up there seems to be voice that tells him go hurt somebody. So I read his file- turned out he was on Prozac, from how he described that. So I phoned his nurse and we discussed the side effects that he was experiencing. And on that same day he was cut off from Prozac. So needs like those we communicate with the team. That's not difficult. (George, Carrall Staff)

An improved self-care routine that promotes communication may help residents get on alternative medication that has fewer side effects. This, in turn, will result in lower incidences of residents going off their medication and decompensating. This is one example of the type of self-care strategies that The Carrall is trying to promote.
Bill, the director of the DEMHT, has a different interpretation of timing out, noting that it is at times a grey area in crisis intervention. The Carrall staff may be unable to handle the behaviour of a resident, and time her out. However, the DEMHT psychiatrist who interviews her may find that she does not require hospitalisation:

Sometimes the individuals we see can be problematic but not problematic enough to require hospitalisation. And that becomes more frustrating, particularly if you are working at The Carrall and are troubled by that. But it's sort of a grey area there where you have people who are in trouble but not so troubled that they require hospitalisation. And they're saying look, leave me alone, I don't want to see a mental health worker. (Bill, DEMHT Director)

When this happens, the resident is forced to leave The Carrall, but is not ill enough to be hospitalised. The Carrall or DEMHT staff then attempt to find temporary housing for the resident at area shelters. However, if the resident is not taking medication and not receiving psychiatric care, it becomes unclear whether or not she will remain functional enough to remain at the shelter. According to Jane (The Main, Director), the resident will move from shelter to shelter, before ending up at an unsafe and unclean SRO hotel. The worst case scenario is that the resident drops out of the shelter system and becomes homeless.

Jane criticises SROs such as The Carrall for having too many restrictions on behaviour:

Even if there is the SRO type of housing available, I don't think that would meet the needs of our client population. For some of them it does and they live there by choice and that's fine. But if they could get into clean supported housing, it would be like dying and going to heaven for them.

But the flip side of that is that a lot of the supportive housing have a lot of kind of restrictive stuff. Right? And some expectations around the behaviour. And our folks, some of them who have more behavioural problems, sort of go from place to place to place to place to the Graceland. Which you know? That's the dead end. And once people are in the Graceland, it takes some doing for them to move out. You know, they're kind of there. I would love to see more tolerant
supported housing, less restrictive supported housing. (Jane, Director, The Main)

Clearly, a measure of the success of The Carrall's program is a resident's ability to function in the hotel. To a certain extent, timing out is viewed as a failure of the program to adequately meet the needs of residents. Jane interprets the problem as one of rule making, rule breaking, and a low tolerance for deviant behaviour.

The Carrall staff view timing out in the context of balancing the needs of the individual to the needs of the other residents. From an empowerment perspective, they place responsibility on the tenants to take their medication and conform to the behavioural guidelines of the hotel. At the same, the staff recognise that they are partially responsible for not catching the signs of decompensation, nor effectively communicating with an individual to identify the supports that would promote the appropriate self-care strategies. As Peter (Carrall Activity Worker) notes, this is partially due to the fact that staff may not be fully aware of a residents mental history:

I mean at The Carrall, we don't have the signs of decompensation. Whereas in a licensed care facility you do. You know for each person what their individual signs for decompensation are. A person might start complaining about dirt. And that might be the first sign of them decompensating. But you don't know that unless it's written down somewhere, or you've seen that person decompensate before. (Peter, Carrall Activity Worker)

The practice of timing out can be assessed from an interpretive dissonance perspective. Winston, Peter, Bill, and Jane are all concerned with the same issue: maintaining the mentally ill in supported housing. Residents are timed out of The Carrall when they go off their medication, experience psychotic episodes, and disrupt the well-being of other residents. Bill (DEMHT, Director) is concerned with how The Carall and the DEMHT staff define 'mental crisis,' the criteria for hospitalisation and the implications these decisions have on the housing situation of the residents. Jane (The
Main, Director) views the staff's intolerance of rule breaking as the source of the dilemma. Winston (Carrall Supervisor) states that timing out is not merely an issue of staff's personal tolerance of deviant behaviour. Rather, disruptive behaviour impacts on the ability of staff to maintain the well-being of other residents and the goals of the program. He concedes that the staff's ability to foster appropriate self-care routines also mediates the extent to which residents will decompensate. As Peter (Carrall Activity Worker) notes, this relates in part to incomplete medical files and the inability of staff to adequately spot individual signs of decompensation.

Winston (Carrall Supervisor) and Peter (Carrall Staff) perceive timing out as a structural problem that is caused by 'social stress' in The Carrall's program. The program is not designed to tolerate decompensation and extreme mental crises. This is exacerbated by the staff's inability to identify the early signs of decompensation and take preventative action. In their view, the residents cannot handle the social stress of the program, which leads to role stress and role strain. That is, the structure of the program cannot provide the supports required to help those residents who are lower functioning to maintain a stable level of mental health. The residents decompensate, their behaviour becomes intolerable, and they are evicted from The Carrall.

Bill (DEMHT Director) and Jane (The Main, Director) also view timing out as a structural problem. Bill cites role differences and social stress as the problematic aspects of timing out residents. The interpretations of Carrall staff and the interpretations of DEMHT psychiatric nurses and psychiatrists sometimes differ. This is complicated by the fact that hospitals will not accept people who are not in 'genuine' mental crisis. Implied in Bill's assertion is that the DEMHT is more qualified to determine whether or
not the residents are in fact in mental crisis, since psychiatric nurses and psychiatrists have more in-depth medical knowledge of mental illness, and are better acquainted with hospital in-take policies.

Jane (The Main, Director) believes that The Carrall's rules are too restrictive, and argues for more tolerant supported housing. Tolerant housing requires tolerant mental health workers. In the context of role identity, Jane has an idealised concept of the role of 'SRO mental health worker,' in that the standards of conduct she envisions from supported living programs do not reflect the reality of day to day practice.

**Social Skills and Behaviour Modelling**

Mental illness, functionality and the concept of self-care are closely related to the residents' abilities to cope with the demands of day to day life. This is especially true for schizophrenics. Carson and Holloway (1996, 165) note that:

> On average, people with schizophrenia...show significant deficits in the basic skills of social interaction (for example, responding to others and engaging other in conversation).

John (Carrall Staff) and Peter (Carrall Activity Worker) provide insight into the effects of schizophrenia:

> Like schizophrenia typically affects people first- their first psychotic experience when they are sixteen, eighteen, twenty years old- at a time when young men are typically learning a whole lot of skills. And you are afraid to turn on the TV because the guy on the TV may be talking to you personally and threatening you, then you really don't have your mind on those kinds of skills. And they're psychotic as hell at that stage. (John, Carrall Staff)

> You know, like I said, depending on what age your mental illness began. Some people stop developing socially for a long time when they have mental illness. So the social skills that they had when they were fifteen or maybe twenty years, they're not going to develop those skills. The social skills are actually going to erode a bit for a while until they get their life back on track, and then they can start doing that. But what happened is they probably had a mental illness and their - they haven't acted properly around people, and people have not wanted to
be around them, so all of a sudden they’re getting low self-esteem, they don’t understand what’s happening, and their social skills are going backwards at this point in time. Then they get medications and all of a sudden they’re able to relate to people again, but they’re relating to people on the level of a seventeen year old. (Peter, Activity Worker, The Carrall)

Mental illness stunts the development of social skills. When a mentally ill person behaves inappropriately around others, he is stigmatised, eliciting a negative reaction which reinforces the fact that he does not belong, and is not a contributing member of society. This has disastrous effects on his self-esteem.

One evening, on my way to The Carrall, I noticed Chris, a resident, sitting on the street corner pan handling for money. Most passers-by simply ignored him. Others told him to 'fuck off,' and 'get a job.' Being poor is an added stigma to that of mental illness. Abusive comments like these transfer feelings of low self-worth. Low self-esteem is therefore a major issue for the residents:

Not in any particular order but as things come to my mind, self-esteem basically is a big issue. People's self-esteem on a scale of one to ten varies around here from minus five to three, four, five, six on a good day. (John, Carrall Staff)

In countless conversations with residents, issues of self-esteem were raised. Comments such as: "I'm nothing, I'm a bum, I could never find a job, I couldn't work" were common place, and indicate that many residents have internalised the negative labels that others have projected on them. Recall that Holmes and Rivers (1998) refer to this process as self-stigma, which occurs when people come to accept the traits that others impute to them.

One way that the staff address self-esteem, self-stigma and social skills, is through behaviour modelling. Staff set examples for the residents to follow, and give advice to
residents who have questions about how to solve specific problems or approach particular situations that they are not familiar with:

It again goes back to my perception of my job here. One of my jobs for better or for worse- real low key- is to model behaviour. They may never get up when a woman comes into the room. They may never help a woman on with their coat. I'm just picking a couple of old-fashioned things that I do, because that's the way I was brought up. But they will at least see that, and they may realise that there's - all the movement notwithstanding - that there are big differences- and that one of the functions of men is to relate a certain way with women. And that may not always be in their experience. I don't say that they- it's not that they couldn't do that- if they weren't really sick. (John, Carrall Staff)

In fact, behaviour modelling, or showing by example, is one of the primary goals of an empowered approach to mental health rehabilitation, and exemplifies the fifth principle of Rapp's (1998) SA approach, 'aggressive outreach as the preferred mode of intervention.' It is interesting to note that the staff of The Carrall approach behaviour modelling in the context of their roles and responsibilities.

Winston (Carrall Supervisor) views behaviour modelling in the 'holistic' sense of mental rehabilitation. His conception of modelling is one that motivates people from within. His role is to reassure residents that they 'have it within themselves' to deal with their problems. Positive staff direction provides residents with an increased personal capacity to handle their mental health issues:

Facilitating ability too. Sometimes a person's social skills are right on the edge of being developed, and I tend to look at shit happens, it's grist for the mill. It provides you with an opportunity to cultivate increased capacity and ability. When people experiencing difficulties, are simply in need of a little reassurance, of a little positive direction, and then they can encompass new skills. And gain self esteem by knowing that they are capable of responding to their own positive feelings in a way that's creative and productive. (Winston, Carrall Supervisor)

But you know those skills are there in a lot our members already. Some of them are very highly developed and others they're sort of waiting on the edge to do this. And unfortunately one of the things that people with mental health concerns often get from society at large is you don't have that ability and you never will have that
ability and that's bullshit. Unless a person's very very ill, there's a distinct possibility that they can encompass new behaviour and gain self-esteem in the process. I'm capable of coping with that person who annoys me. I don't let it bother me the way I used to, or I respond in an assertive way. And those are the kind of things that we all need to do in order to feel better about ourselves So for me there's a lot applied communication skills involved in the work we do. Modelling them and encouraging our resident to believe that they encompass them as needed, and more often than not, they do in fact bear out our faith in their abilities. (Winston, Carrall Supervisor)

Consistent with his role as a mental health worker, David (Carrall Staff) views behaviour modelling as a means of promoting conflict resolution and social interaction skills. He provides an excellent example of how one resident's negative behaviour influenced others:

We had one guy who came in, and something happened- he was rather upset and angry, and he walked into this group of people and he started to complain. And every second word that came out of his mouth was 'fuck.' But when it was all over, we got together and had a de-briefing and we got that person and we brought him in and explained to him that the next time he is upset and out of sorts, it's quite all right for him to come and complain. But it's be better in the future if he came and speak to us in private, or to leave the word 'fuck' out of his language because it makes people feel intimidated, uncomfortable, nervous, tense. It creates tension, especially when it's said in anger. It creates tension among people. And all the people who were in that room really didn't need to hear you say that.

And the funny about it is the very next day this woman came to me, she was upset, and she started to use the word. I said, "Why are you saying that?" She said, "I want my rights." And I said, "You don't have to use that word to get your rights." She was taking her cue from this guy the day before. She figured, if I don't say 'fuck,' no one will listen to me.

Yeah, it's role modelling. And as I said, hopefully that will provide a positive one. It's how we treat one another. How we treat the person who's next to you, not how you're going to treat another person, or how you treated another person sometime in the past. Or how you would like to treat another person. It's how you treat the other person that's right next to you. It could be on the bus, it could be in the park, it's the person right next to you. (David, Carrall Staff).

To David, the residents' behaviour feeds off of each other. If one resident is bitter and angry, it will affect the other residents by making them feel uncomfortable. Furthermore,
other residents may view anger and swearing as an acceptable way of getting attention and 'asserting their rights.' David's solution is to emulate behaviour that encourages the residents to treat other people with respect.

As The Carrall's activity worker, Peter models acceptable public behaviour to residents when he takes them on outings. He encourages them to be themselves, but emphasises that certain behaviour is unacceptable:

I also kind of let them know that it's ok not be just like everybody else around you. But at the same time, you don't, you don't do things that are- you don't act out, you don't yell at people.

I used to take them to Hooters. It sounds like a wild bar. But it's not. But one of the guys, Allan, couldn't handle that environment. He started hitting on the waitresses and then he got irritated, he got a little bit annoyed- noticeably annoyed- that they weren't, they wouldn't keep on responding to him. They did at first, because they were being waitresses and you know and they're playing up to the person just a little bit? But when he couldn't get further and further and further, he started getting irritated and annoyed by it. And it became a thing where I knew he couldn't handle that environment? So if I think they really can't handle an environment, I will tend to not let them go on those types of things very often.

Certain things like that just are not acceptable. And I've had to draw lines with people sometimes, and say, you know what, you can't continue to do this. I won't be able to take you anywhere if this continues. You have to stop doing what you're doing right now. And usually that doesn't work. Saying that to people it doesn't help, because they are not able to. If they were able to they wouldn't be doing it. If they had insight into the fact their behaviour was way off- sometimes it works, sometimes it bombs.

But modelling myself, modelling behaviour. I don't model behaviour where you have to be rigid, I model behaviour of a relaxed, social interaction. Have fun, laugh, you know? Enjoy yourself. You don't have to be exactly like everybody else around you but at the same time there are still certain limits to how you can act. (Peter, Carrall Activity Worker)

Peter tries to model behaviour that promotes sociable interaction. Residents should be allowed to be themselves, to be comfortable with their mental illness. At the same time, they have to aware that there are limits to how they can act. Peter again raises the notion
of 'insight' into mental illness. Behaviour, in the context of insight, is determined by whether a resident is high functioning or low functioning. High functioning residents have better insight into their mental illness, and therefore have greater control over their behaviour- their 'insight' is grounded in an understanding of how different environments affect their behaviour, and of the social norms that prevail in particular situations.

Peter (Carrall Activity Worker) applies the concept of insight to Allan (Carrall Resident). It is not appropriate to persistently solicit a waitress. Allan repeatedly comes on to this waitress, and she ignores his advances. It is acceptable, according to Peter, to flirt, have the waitress 'play up to you,' and then politely stop. In Allan's case he persisted, becoming irritable and upset when she failed to respond to him. Being unable to 'handle the environment' means that he was unaware of the social norms and boundaries that govern 'normal' public social interaction.

I witnessed a similar episode with Allan during my last week of participant observation at The Carrall. Craig, a weekend staff worker, had become seriously ill and was hospitalised. Craig was having financial difficulties, and the staff at the VMA and The Carrall planned some fundraising activities on his behalf.

In the meantime, Allan had become obsessed with buying a car, despite the fact that he did not possess a driver's licence, and had no idea how he would maintain the car and pay for insurance. Allan, having heard about the fundraising efforts for Craig, approached Winston (Carrall Supervisor) about fundraising money for him to buy a car. Winston explained to Allan several times that fundraising to help a friend who is ill differs significantly from fundraising to help someone to buy a car. Winston made it
clear to Allan that he was being selfish. Allan became irate, and persisted in his request. Eventually Winston began to ignore him.

Allan is a friendly, compassionate person and was clearly sympathetic to the fact that Craig required help. It appeared, however, that he had trouble interpreting the charitable and humanitarian meaning of fundraising, inaccurately placing his needs for a car on par with Craig's need for humanitarian financial assistance.

The level of functioning of the residents varies widely at The Carrall. Some residents are very high functioning, while others are quite low functioning. For some residents, even the most basic of personal care skills are not adequately developed.

Some people are- I don't know if I'm allowed- if it's a breach or anything. There's a downside of things too- you know like I'm cleaning right, so I see things that happen. Not so much anymore, but every now and then we had toilet accidents. We had people with problems manipulating the toilet seats. They would spread poo all over the toilet seats. Things like this. But that doesn't go on now. Usually it's an accident now if it happens. But I haven't seen anything like that that much. (Lee, Carrall Janitor)

Lee was uncomfortable giving me this information, and none of the other staff approached this subject with me.

Bryan (Carrall Resident) notes that this is not an isolated incident, but rather a recurring problem:

...this guy, we all know that he makes a mess in the washroom. One day we were in the TV room, and everybody says, every time he goes to the washroom, he always makes one bigger mess. I got the impression it was him too because he always wears jeans, but probably you couldn't tell. But once I saw him wearing sweat pants- a light coloured grey. I saw in the back a big long stretch of faeces. You could tell. Then one day I saw him sitting on the table near the food. He's just sitting right on there. I think staff should- staff is very friendly toward him.

But sometimes I complain, they will tell me- if I see other tenants doing things, I will tell other tenants don't do this, don't do that. Instead of saying, oh, you did the right thing. Staff will come to me and say, don't try to be the police in The
Carrall, you have no right to do that. You're just another tenant. (Bryan, Carrall Resident).

Bryan is a 'high functioning' resident who is critical of the residents' behaviour and of the staff's performance. As previously noted, most of the residents do not use mental health terminology such as 'decompensation,' and 'functionality.' For Bryan, the issue is simply one of discipline. The tenant who makes a mess in the bathroom continues to do so because the staff are lenient. When Bryan chastises other tenants, he is reprimanded by the staff for over stepping his boundaries, because he is simply a resident like everybody else.

Bryan is clearly at odds with the staff over how to deal with problem tenants. The staff approach to social support is to provide empowered and flexible guidance to tenants based on their individual abilities. In their view, Bryan is wrong to berate other residents, because he too is 'just another resident,' and is therefore not in a position to tell others what to do. Bryan, however, maintains that there is one set of behavioural standards that should apply to all tenants: "I mean there are rules and regulations. And in the house everybody follows it. If they don't like it, they can move out." The staff are remiss if they do not enforce the same standards for all residents.

Paradoxically, both Bryan and the staff are concerned about the same issue: improving the level of functioning of the residents. The difference lies in their perceptions. Bryan's understanding of the goals of supported living is predicated on residents' strict adherence to rules and regulations. The staff's understanding of supported living is predicated on a mental health oriented interpretation of the individual needs, skills, and abilities of the residents.
Staff and resident interpretations are at times conflicting. The staff recognise that different residents have different needs. Therefore, different residents receive different levels of support. With respect to house rules and self-care expectations, 'lower functioning' residents are treated with greater leniency when they break rules and violate behavioural norms. This is problematic, because some higher 'functioning residents,' such as Bryan, interpret this leniency as preferential treatment. In other instances, it is viewed as the failure of staff to fulfil their duties and responsibilities.

The following chapter will examine the life domains of the residents, and the social support that the residents receive from friends, neighbours, and mental health agencies. It will further address the differences in how residents and staff interpret and approach the concept and provision of social support.
Chapter Three: Life Domains and Resident Supports

This chapter discusses the types of social support that the residents of The Carrall give and receive in their day to day lives, and the degree to which these supports meet their needs. The social supports of the residents are examined in the context of the following five 'life domains': 1) Daily living situation; 2) Friendships supports; 3) Leisure and recreational activities; 4) Finances; and 5) Vocational and educational training (Rapp 1998).

Following Glasser (1988) and Warren (1981), the residents of The Carrall seek out a variety of tangible, emotional and informational supports to meet their needs. The majority of their supports are concentrated in-house at The Carrall. Some of the residents in this study also seek out assistance at The Main and The Burrard drop-in centres.

The residents of The Carrall use the Downtown Eastside Mental Health Team (DEMHT) primarily for professional mental health services. This is normally in the form of monthly or bi-monthly meetings with case managers or psychiatrists. The purpose of the meetings are to assess the residents' overall health and mental health, monitor their medication and dosage, and to liase them with other social services (such as health clinics or courses) as needed. For all residents, mental health assessments are required in order to receive and maintain their income assistance. Therefore, the residents tend to view visits to the DEMHT as administrative necessities to obtaining social services.

The residents normally take advantage of services that meet their immediate day to day needs. Bernard (The Burrard, Director) asserts that The Burrard drop-in centre 'covers the basics of [Maslow's] the triangle.' They provide food services, help with 'DB Two' income assistance applications, and opportunities for social interaction. Winston
(Carrall Supervisor) asserts that The Carrall's primary goal is to provide resources that supplement the residents' incomes:

...to make sure that the income they do receive is supplemented so that in effect, they have some resources to divert towards recreational purposes, social purposes, goals, as such. Being able to afford to do the things they like. Making sure that we're being methodical. Right now we are working on residents to bring their disability level up to maximum. (Winston, Carrall Supervisor)

Clearly, the mental health agencies in this study are making a strong effort to meet the basic needs of the low-income mentally ill. However, in the context of Maslow's hierarchy, many of the residents' 'higher order' emotional, belonging and self-actualisation needs are not adequately met. In the context of interpretive dissonance, the residents express low self-valorisation and a diminished sense of social identity. Their perceptions are the result of role stress and strain in the mental health system, and of the social stigma associated with mental illness. For one resident, this is manifest in his conflicts with residents and Carrall staff over resident behaviour and staff performance. For the others, it is manifest in inadequate work-related opportunities, which lower their self-esteem and hinder their ability to realise their goals and aspirations.

**Daily Living Situation and Routine**

According to Rapp (1998), the 'daily living situation' encompasses aspects such as the physical condition of the residence, roommates, and access to resources. The focus here is on the residents' routines- where they go, who they see, and how they interact with others to receive and give social support.
The Residents’ Daily Routine

James (Carrall Resident) notes that most residents do not keep track of time.

Instead, the residents identify days of the week according to staff shifts and meal nights:

For one thing, time doesn't mean much here. You know whether it's day or night or whatever time of the week it is, just- you can usually tell what day it is by what they feed you. If you get hotdogs it's Thursday. If there's another meal it must be Tuesday. Staff change. If Larry's in [a weekend staff member] you know it's the weekend. Things like that. (James, Carrall Resident)

James' days are characterised by running small errands, and talking with staff and residents. A couple of times a week James visits The Main drop-in centre. The Main offers him a respite from the hotel environment. James, who has an interest in computers, 'self-studies' computer programming and operating systems on his own time. The Main provides him a space to study. In addition, The Main has a non-smoking section. James is a non-smoker. The majority of The Carrall's residents smoke. The Main offers him an indoor space where he can get away from the smoke:

...drink coffee, have a snack, hangout with - my social life is going into the office and talking with staff. I think I spend more time talking with staff then I do with the other people here. You know, go to the store to buy some coffee creamer, some chips. A couple of times a week I will go into the drop-in centre, The Main up the street. I'll just go up there. They have nice big tables there and you can spread your books out, study. It's place to go when you have cabin fever from here.

The basic attraction for me I suppose is it's somewhere out of the hotel. And they have nice big tables there. I can study there, if the radio's not too loud. They have a no-smoking section which is important. I'm becoming very intolerant of the smoke. On a physical level it just bothers me. It gets into my eyes.

James regularly spends late evenings after 11pm on the internet. None of the residents, including James, can afford their own phone line. Instead, The Carrall offers residents a common phone. The phone is in frequent use during the day. James is therefore unable to access the internet until the 'down time' of 11pm.
James normally makes a computer purchase on 'cheque day,' the third Wednesday of each month when the residents receive their welfare cheques. James' interest in computers is a focal point of socialisation. He often meets with a fellow resident to discuss computer related issues:

And the main thing that I suppose marks my time is when I can get on the internet, which is after 11 o'clock. So I have tendency to sleep in the day time, and stay up and play on the internet at night. And outside of that that's the only schedule I keep.

And usually sometime around cheque day, when I have more money, I will go out and make a major computer purchase.

I'll drag it in here, and spend the next two weeks trying to configure it- if it works properly. Have little discussions. I'll go down to Rick's room. He has this computer. He's showing me things. That's about it really. Spend a lot of time in other people's rooms. (James, Carrall Resident)

Jack's (Carrall Resident) day is spent somewhat differently. Before he moved into The Carrall, he was homeless, and relied on Vancouver's shelter system for temporary housing. Much of his days were spent pan handling and binning for cans. He often used The Burrard drop-in centre, because of their pool table, video nights, and food services. On cheque day he would take in a movie.

Now that he is living in The Carrall, Jack does not go to The Burrard as often. This is because The Carrall provides for most of his needs in-house:

These days I don't go often to The Burrard, which I did before, because I was homeless. I will go every now and then to say hi, have a coffee, meal, and use their computers. If go on the right day I might go on an outing. I like to be at home at The Carrall. We have food, a TV, I do crosswords, and there's a computer to play video games. (Jack, Carrall Resident)

Bryan (Carrall Resident), has lived at The Carrall for about one and a half years. He has depression, and feels that he was more active when he first came to The Carrall. His days are now spent at home at The Carrall. He attributes his reduced activity to a
loss of energy, brought about by the living conditions at The Carrall. Bryan's criticisms of the hotel's living conditions will be discussed in later sections of this chapter:

Well right now I really don't have a routine, because last year I kind of had a routine but this year day by day I don't really have a routine. Right now I shouldn't go back to bed so late. I wake-up late, and kind of wander around, take my herbal supplement, watch a bit of TV, sometimes wander around and the whole day is gone. One of the reasons I find I have low energy. It's not the same as last year, because last year when I first moved in I had lots of energy. But this year it's totally different and I don't know why. I think it probably has to do with living conditions at The Carrall. (Bryan, Carrall Resident)

According to Winston (Carrall Supervisor), the degree to which residents get out in the community depends in part on their level of functioning (acuteness of mental illness), and energy. He also notes that stigma is a barrier to mobility. Half of the residents are 'Downtown Eastside bound' because they experience less stigma, and are more accepted in the local community. The other half get out 'according to their means.' The higher functioning the person, the less stigma they will experience outside of the Downtown Eastside. Ultimately, Winston feels that money is the greatest obstacle to the residents' mobility:

I think that varies, you know, according to ability to get around, function, energy level. And sometimes in ways that one would find surprising given the level of disability that somebody may be dealing with. I guess a lot depends on access to money. My sense is that people could stand to get out of this neighbourhood a little more often than they do for the most part. I would say it's about fifty fifty you know. Some of our residents are pretty Downtown Eastside bound. This is their community, this is what they know. They get greater levels of acceptance here. They run into less stigma. They stand out by the nature of their clothing, things like that. It's surprising. The other fifty percent I think does get out a fair bit, according to their means. I see some of the residents out where I live sometimes, trucking along Commercial Drive. I think the major obstacle is money, plain and simple. Again it comes down to once people's basic needs are met, people's inclination for adventure increases. (Winston, Carrall Supervisor)

A Welsh study on the social supports of ex-mental patients notes that "Relative poverty was raised as a constraint upon engagement in community based activities"
David (Carrall Staff) articulates this assertion in his observation that the right to engage in many community based activities is contingent upon the purchase and consumption of goods. For example, you cannot sit in a coffee shop with friends if you are not buying something to drink. If you are a poorly dressed, low functioning, mentally ill SRO resident, then chances are you will attract undue attention to yourself and be asked, or forced, to leave the establishment. Drop-ins are popular with many of The Carrall’s residents because they are not obliged to consume anything, and the staff will accept them for who they are:

There are any number of places where you can go and eat. In fact we have a list posted [a list of soup kitchens and drop-ins]. They’re all over the city actually. I think if I were mentally ill, I would find a drop-in- it’s the most useful. That’s your place where you can go during the day. You don’t have to have money. You don’t have to be dressed smartly. You just get out of bed, brush your teeth, take a shower, and go over there. I myself sometimes find it difficult to find a place. I find there are not enough benches in this city. You either have to be in a coffee shop, or a restaurant, or you have to be consuming something with money in order just be outside of your own place. Of course you can go to the beach and the park and stuff, but it’s nice just to able to sit anywhere without having to pay for it. So I think drop-in centres are really good places for these people. And they’re accepted too. They walk in the door and they are accepted right away. They don’t have to prove themselves. And if they’re having a bad day, they are not going to be told to move on, or asked for their ID, or harassed. (David, Carrall Staff)

**Food**

In low-income neighbourhoods, food provision is the most heavily used service of any benevolent organisation (Wagner 1993). In the context of relative poverty and mental illness, the extent to which The Carrall’s residents use its in-house food services varies. Food services are least used on cheque day, when residents will eat out at fast food restaurants or local area 'greasy spoons.' According to the staff, they are most used in the two weeks prior to cheque day, when many residents run out of money.
High functioning residents use food services the least, because they possess the skills to cook for themselves. Bryan (Carrall Resident), who is on basic income assistance ($500), receives only $175.00 a month on top of his shelter portion of $325.00. He never eats out and shops for himself on a regular basis:

I couldn't afford to go out. Not with the money I make. 500 minus 325, I only get about $175.00 for the whole month. I can't really go out- even McDonald's probably costs two or three dollars per hamburger. I shop in Chinatown. Because they've got really good price on food. (Bryan, Carrall Resident)

On the other hand, low functioning residents, including those on DB Two ($771.00 per month), use The Carrall's food services regularly, because they are unable to cook for themselves.

James (Carrall Resident) notes that it is difficult for people to go without food in the Downtown Eastside:

...they provide so much free stuff now it's almost a waste of money to go buy food. You get four meals minimum. You get a breakfast on Sunday which is five. You get the food bank which is another meal. It's six days- you know there's no shortage of food in this neighbourhood. I can go up to the drop-in centre and they have meal somewhere in the afternoon. If you're really hungry you can go to various organisations here that have meals everyday. You could probably get good meals everyday. If you put that on top of what you get here and at the drop-ins it's enough to survive easily.

Winston (Carrall Supervisor) disagrees. The existence of food services is not, in and of itself, sufficient to meet people's needs. The extent to which the low-income mentally ill can access food is directly related to their level of functioning:

I never take it for granted that we are gonna have enough to eat. There's this thing that you can't go without in the Downtown Eastside. Well, if you're disorganised and your mental health is poor and you're depressed and you're motivation is down, well then yeah, you can go without. (Winston, Carrall Supervisor)
Motivation is one reason why some low functioning people do not seek out food at soup kitchens. The other is that people who are visibly mentally ill are common targets of abuse in the Downtown Eastside:

The mentally are victims of violence. A guy rattles down the street talking to his voices and somebody doesn’t like it, he just decks him. They’re easy victims. (Andrew, Community Activist)

Jane (The Main, Director), provides an example of how low functioning mentally ill people are commonly victimised at area soup kitchens:

There’s tons and tons of food in this area but part of my concern for my population- and we are talking about the mentally ill, is that until recently- until last November, we didn't have a daily food program in this centre. And our members were standing in the line-ups at the sisters, or the Tabernacle, or whatever to get their meals, but they were getting beaten up, they were getting victimised. The way I see our folks is that they are at the bottom of the food chain, the most victimised, the most defenceless in many ways. But it's just kind of how it is. The more low functioning you are the more you are victimised. (Jane, The Main, Director)

Clearly, providing food services in-house is a safer alternative to having residents fend for themselves at hostile soup kitchens. Another benefit of in-house food services is that residents avoid the tiring 'soup kitchen circuit':

My very dear friend, who works in the Downtown Eastside, has gone around and put herself in food lines for a day- and she describes how she felt at the end of the day. She was exhausted. Just worn out- from standing in line and getting enough to eat. She has a blood sugar problem and by the end of the day she had literally passed out in the Tabernacle Church in one of the pews from the effects of chasing food in food lines. It’s exhausting. Being poor is hard, hard work. And that’s something that a lot of people don’t appreciate either. Every service that you need you have to line-up for and you have to wait for. You can’t just walk in somewhere and get what you need. Unless you have money of course. That’s one of the great attractions of cheque day- when people have money. They are Kings for a day. Suddenly they have some power. They have some control. They can go in and buy a sandwich, and it takes them 5 minutes. So most of the day can be spent just getting enough to live on- just getting enough to eat. (Andrew, Community Activist)
As part of my preliminary research, I took part in the soup kitchen circuit with Brenda, a community activist. It is indeed an exhausting and belittling experience. It is exhausting because of the energy involved in running from soup kitchen to soup kitchen to get food. Most of the time is spent travelling from place to place, standing in line, with only a few minutes to sit down and eat before the 'kitchen' is cleared and cleaned for the next meal.

The experience is belittling because of the religious nature of many of the organisations. People are forced to endure ten to fifteen minutes of proselytising before being allowed to eat. It is for this reason that Jack (Carrall Resident) did his best to avoid soup kitchens when he was homeless:

I don't like soup kitchens because you have to sing for your supper. You should pay us for making us go to church. If they can't give it freely then don't give it at all! (Jack, Carrall Resident)

Despite the benefits associated with in-house food provision, several criticisms can be made of the nature and quality of food provision at The Carrall. In the first instance, the food offered at The Carrall is not always the most nutritious. The Carrall does not have a budget for food. It receives all of its food from food banks. Therefore, the type of food received is dependent on what is donated from the food banks. The Carrall receives many high sugar snack foods such as chocolate bars, potato chips, and cream filled pastries. Fruit such as apples and oranges is often provided, but it is not always fresh and in some cases turns bad by the time it reaches The Carrall.

The food for meal nights is comprised wholly of pre-made meals such as lasagne, hotdogs, hamburgers, sausages, and even pre-made salad in a bag. The only foods that are occasionally 'made from scratch' are mashed potatoes and boiled carrots and onions.
Max and Allan (Carrall Residents) both comment on the quality of the food at The Carrall.

There aren't enough fresh vegetables with the meals. No wonder everybody is low on energy. They aren't eating right. (Allan, Carrall Resident)

The meals are mostly pre-made stuff with lots of additives and preservatives. It's not healthy. I only eat them if I'm really short on cash or my own food. I'm on level two disability so I'm usually ok. It's more nutritious that way. (Max, Carrall Resident)

While Allan and Max were the only residents to comment on the quality of the food provided, it is conceivable that dissatisfaction with the food is one reason why those residents who are able to do so, choose to buy their own food and cook their own meals.

The second criticism of food provision pertains to the preparation of group meals. The Carrall's kitchen has only one medium sized stove, a microwave oven and a small sink. Cooking implements, such as knives, pots, and pans are few in number. While Winston (Carrall Supervisor) wants to buy new cooking supplies and a second stove, there is not enough money in the VMA's budget to do so.

Making meals for 40 to 50 people thus poses a challenge. Meal preparation starts at 3pm and ends at around 5:30pm. Food is made in 'shifts'. For example, if there are five lasagnes to be made, only two can be made at a time, since the stove cannot accommodate more than two baking pans. This prolongs the amount of time it takes to prepare a meal. If the staff are delayed, meal preparation may not start until 4pm or later.

On one Tuesday afternoon, meal preparation began at 4:30pm. About 150 sausages were being made for about 50 people, including the residents, the staff on duty, and myself. The sausages were frozen solid and had not had time to de-thaw. It was clear that the meal would not be ready until at least 6:30pm. At 5:30pm, a few residents
strolled into the kitchen to ask "When's dinner gonna be ready?" And, "What's taking so long?"

The staff, feeling the pressure to have dinner ready sooner rather than later, turned up the temperature on the oven in order to have the sausages cook faster. The sausages were made in 20 minute shifts in two baking pans until the last batch was removed by 6pm. The sausages from the first batch were reheated briefly in the microwave.

After the residents had been served, I took two sausages for myself. The sausages were practically raw. Since they did not have time to de-thaw, they did not cook properly. When no one was looking, I dumped my sausages in the trash can. I noticed that other people had done the same.

Clearly, the benefits of food provision at The Carrall warrant scrutiny. The quality of the food provided at The Carrall is compromised. Due to budget restrictions, the hotel is wholly dependent on food banks. The Carrall staff have little control over the type of food they receive. This is exacerbated by a lack of cooking facilities, such as a second stove, poor quality cooking implements, and the problems associated with cooking for 40 to 50 people.

Perhaps the most salient aspect of this finding pertains to the degree to which residents are dependent on food at The Carrall. Residents who are on DB Two and who are able to cook for themselves will not take advantage of the food provided by The Carrall. Residents who are not on DB Two or are not able to cook for themselves must rely on the hotel's food. The exact number of residents who buy their own food versus those who use The Carrall's food program is not known, and a closer examination of the dietary choices of the residents is beyond the scope of this thesis. However, it can be
inferred from Max (Carrall Resident) that residents on DB Two have the resources to purchase food that is of higher quality and nutritional value than the food provided at The Carrall.

**Cigarettes and Smoking**

Cigarette smoking is a large part of the residents' daily routine at The Carrall. According to James (Carrall Resident), "most of the people here smoke, there are probably only three or four non-smokers." Smoking is a central focus of social interaction at The Carrall. Recall that 'on the books,' smoking is prohibited in all common areas (kitchen, hallways, and bathroom), except the TV lounge and the outside patio.

The bulk of my participant observation research took place over August and September. The warm weather made the outside patio an ideal location for smoking, and a site of constant social interaction. When I first began my research at The Carrall, Winston (Carrall Supervisor) told me that "If you want to make friends quick, give them cigarettes, it's a sure fire way to meet people." I brought a pack of cigarettes with me each time I visited The Carrall. Upon arriving I would head out to the patio, offer cigarettes to the residents, and strike up a conversation. Indeed, it was on the patio where I befriended the majority of the residents who took part in this study.

Several studies have examined the routines and 'culture' of smoking in shelters, soup kitchens and drop-in centres (Desjarlais 1997; Forrester-Jones & Grant 1997; Glasser 1988). According to Forrester-Jones and Grant (1997, 99), "cigarettes [are] the main...source of conversation in their lives." Furthermore, "smoking serves to an add an element of organisation to their lives" (ibid., 98). At The Carrall, dinner is served between 5:30pm and 6pm on Tuesday evenings. Smoking and socialisation is at its
highest during the 'pre-dinner' hour, between 4:30pm and 5:30pm. For residents who have trouble keeping track of time, the flurry of staff cooking and activity in the evening signals that dinner is being prepared. Residents wander into the kitchen, talk to staff, ask what is for dinner, and meet with other residents. A few of them step outside onto the patio, or go into the TV lounge to smoke and chat about the day's events.

Residents are always borrowing and lending cigarettes. There were only a few instances where people felt that other residents were taking advantage of them by 'bumming' cigarettes and never giving them. More often than not these exchanges were reciprocal. For example, on numerous occasions, residents would seek out other residents to give them cigarettes, saying, "Want to have a smoke? You lent me a smoke yesterday and I just bought a pack."

The ritual and routine of smoking is thus a source of emotional support for the residents. It offers residents an opportunity for social interaction, and a sense of attachment to a group. The borrowing and lending of cigarettes also fosters trusting reciprocal relationships between the residents, since they know that they can depend on each other for cigarettes in times of need.

In addition to the exchange of cigarettes among the residents, the staff at The Carrall sell single cigarettes to residents at a cost of $0.25 each or five for a dollar. This is also a common practice at some drop-in centres in the Downtown Eastside, including The Main and The Burrard. It is illegal to sell single cigarettes, much less sell them under the table, yet some agencies do, in order to provide cigarettes to people who would not otherwise be able to afford a whole pack.
The staff at The Carrall recognise the social benefits that smoking has for the residents. As a form of informal help, staff will give away free cigarettes, especially on the evening before cheque day, and on occasional meal nights:

Some may come to me for cigarettes, specially on the night just before cheque issue day. I hand out cigarettes to them once in a while. Whenever we make big meals we hand out cigarettes as more of a token...there are instances when I personally believe that handing out a cigarette is healthier for them in some sort of mental wellness. I think that. (George, Carrall Staff)

Despite the social benefits of smoking, some helping agencies in the Downtown Eastside are reticent to provide free cigarettes, or allow smoking indoors. As Glasser (1988, 96) notes, the rationale is that cigarettes are unhealthy, and that "if [people] are poor, they should not be spending their money on cigarettes." Nevertheless, smoking is a lifestyle enjoyed by many low-income people in the Downtown Eastside. Andrew (Community Activist) is critical of helping agencies that take the 'moral high ground' and choose not to provide cigarettes to their members. The result is that finding cigarettes becomes a labour intensive process:

And one of the big jobs of the day would be to find some cigarettes. If they can afford to buy them or have tobacco, then great. Otherwise they're out literally scrounging for butts or bumming. They start off the day looking for cigarettes. Which is a major issue in their lives, but one that nobody addresses is that people smoke and its really important to them. It's being denied access to tobacco through higher prices and everything else- it really hurts these people. The amount of damage to their health caused by smoking is nothing compared to the damage caused trying to chase around and find money for cigarettes. On a corner of a street panhandling. Or picking up butts off the street. Doing what they have to do to find cigarettes is really hard. So in a morally self-righteous way no program ever offers free cigarettes. (Andrew, Community Activist)

While the staff are supportive of the residents' choice of lifestyle, there are, as previously mentioned, rules that prohibit smoking in the common areas of The Carrall. The degree to which smokers follow these rules is of particular significance to the hotel's
non-smokers. James (Carrall Resident), a non-smoker, describes the living situation when smoking was allowed throughout the hotel:

Yeah. They've actually clamped down quite a bit on the smokers here. It used to be that you could smoke anywhere. All these people walking around, making their own rollies and smoking all over. It was horrible. There were times when-the room opposite this, where the TV room is? It used to be just this size- they knocked down walls over there. You could go in there and you couldn't see the other wall practically. Because there's three guys in there just chain smoking. I'd go in there to watch TV and my eyes would start watering. (James, Carrall Resident)

James is pleased with the fact that the staff have 'clamped down' on smoking in The Carrall. However, other non-smokers would disagree.

Bryan (Carrall Resident), notes that residents regularly disobey the smoking rules, namely smoking in the common areas. Bryan cites a number of other rules that are frequently broken, and criticises the staff for failing to enforce them. In general, he feels that the staff are not adequately performing their duties.

The central focus of the next section is on the conflicts and problems that arise between residents, and between residents and staff in day to day social encounters at The Carrall. Bryan (Carrall Resident) is the only resident in this study to articulate the nature of rule breaking activities at The Carrall. Therefore, the following section pays particular attention to his interpretations of resident behaviour and staff responses.

 Residents, Staff, Conflict and Empowerment

Recall that The Carrall has five official rules which govern the residents' behaviour: 1) No violence, 2) No sexual or racial harassment, 3) No drunkenness in common areas, 4) No non-prescription drugs, and 5) No disturbing the quiet enjoyment of others (VMA 1999a). Studies on the behaviour of mentally ill 'service users' is sparse.
According to Foster (1998), placing behavioural limits on service users is necessary to ensure the safe and secure functioning of mental health programs:

agencies put limits on individual freedom in order to protect the safety of the setting. The provision of a safe setting, and our willingness to ensure that it remains safe, provides the basis for our therapeutic work. Without this, our efforts will be in vain. (Ibid., 87-88)

Winston (Carrall Supervisor), provides his interpretation of The Carrall's rules:

The basis for eviction is physical violence of any kind. Abusive behaviour that I guess you could say is extended in duration. That can't be resolved, where people aren't taking ownership. Somebody refuses to take ownership of their negative behaviour towards another, and is particularly abusive. For example, taking resources, money- things that don't belong to them. Sustained verbal abuse. Not just people getting angry at each other, you know, saying fuck off today and they're friends tomorrow, but any kind of persistent harassment on the basis of sexual, racial orientation. You know, behaviour that demeans another individual. (Winston, Carrall supervisor)

In addition to running a safe and secure environment, Winston interprets the rules in a way that gives residents 'ownership' over their behaviour. Ownership in this context means that residents are aware of the consequences of their behaviour, and are willing to acknowledge when their behaviour is abusive or adversely effecting others. To this end, the staff use a system of warnings to bring to the residents attention the fact that their behaviour is inappropriate. The warning system is loosely structured on a 'three strikes and you're out' model: verbal warning, written warning and timing out or eviction. In most cases, behavioural problems can be resolved through verbal interventions:

In many cases we can resolve those matter through verbal interventions and warning around those behaviours- sometimes we have to move towards timing out. And on rare occasions when the action is warranted we simply have to evict. Basically, physical violence of any kind is just not a go. I mean a very clear demarcation line. You can be pissed out of your mind and vent your anger but you know, the minute you go at it physically with somebody you can't be a member of our community, it's very simple. (Winston, Carrall Supervisor)
While violence is a clear grounds for eviction, other behaviour is treated with greater leniency, with the understanding that the functioning level of people with mental illness varies widely. Therefore, when approaching conflicts and problems, Winston models respect in his interactions, encouraging and providing the residents an opportunity to correct their own behaviour without taking punitive measures. Dealing with problem behaviour is a balancing act that necessitates 'being honest without being overly directive':

The skills required to do this- to keep things in hand, I think as workers we need to be assertive and proactive. We need to model respect in an on-going way all the time. You need to find a way to do your own venting in such a way that it doesn't spill into the lives of our residents. I mean you have to find a way to work with people that communicates honestly without being overly directive. Our residents as individuals fluctuate between periods of time when they are very capable of exercising their autonomy and other times when they are more dependent. And being able to work with people as they fluctuate from place to place, maintaining an honest relationship that doesn't intrude unnecessarily is balancing act, but it's one worth making. (Winston, Carrall Supervisor)

Winston's approach to inappropriate behaviour follows an empowerment oriented perspective whereby residents are accountable for their own behaviour. Accountability varies according to the acuteness of a person's mental illness. The degree to which a resident is reprimanded for inappropriate behaviour is gauged according to their level of functioning and a desire to avoid the medicalised approach where the mental health worker knows best:

It's a style of working with people that is supportive, that is empowering. We don't try to take away people's natural consequences. We don't follow the old model where we try and teach them a lesson. What being accountable means can vary, according to the person's state of mind. But I think most of the residents appreciate the fact that we do hold them accountable, as any other person is-ourselves included. And if we do that correctly our authority is legitimate in the context of those situations, and it's very important to me that we communicate respectfully with people around those issues, and in a direct and honest way, without over extending the nature of what we do. For example, if we do have to
deal with conflict situations between residents where somebody's behaviour is inappropriate, we need to gauge our response. We do need to intervene but we do need to gauge our response so that we maintain a relationship of adult to adult. (Winston, Carrall Supervisor)

Peter (Carrall Activity Worker), provides a simple interpretation of The Carrall's rules:

Yeah, you're going to have to really push the rules because we're not there to facilitate people acting like jerks. We're there giving a person a second chance. And I mean this is the Downtown Eastside. This is the place for second chances, am I right? (Peter, Carrall Activity Worker)

For Peter, The Carrall is a place for second chances, to give the residents an opportunity to rebuild social relationships with people. Part of this means that people will make mistakes, but deserve the chance to learn from them on their own.

The staff view The Carrall not only as a supported living program, but first and foremost the residents' home. The rules provide the basic code of conduct, but the residents should be allowed to live their lives with as much freedom and choice as possible, with minimal staff intervention:

The Carrall is just a hotel that was bought by the Vancouver Mental Association to provide accommodation for people who are mentally ill. But it's just a hotel. I think it should stay that way. The supports are there, but they're subtle. Things are done subtly. In other words, it's not pointed out to you, from the time you open your eyes in the morning to the time you go to bed at night, you are reminded that you are mentally ill, constantly. (David, Carrall Staff)

The goal of support is to assist, not to subjugate. In the context of conflicts and rule breaking behaviour, residents must take responsibility for their actions and make an effort to resolve conflicts independently. Excessive staff intervention in dispute resolution is disempowering. It undermines the ability of residents to deal with their own problems and assumes, by virtue of being mentally ill, that they are unable to do so.
In theory, the staff's approach to modelling 'respect' and 'empowered' conflict resolution leads to the amicable settling of behavioural problems and disputes. In practice, this is not always the case. Many high functioning residents, such as Bryan, do not effectively communicate with other residents and rely heavily on staff to settle their disputes and act on their complaints.

On the basis of interview and participant observation data, Bryan's reliance on staff to settle disputes is a function of both his interpretation of the rules and the way in which he interacts with other residents. In my interview, Bryan was most vocal about the residents who broke the rules by smoking in the common areas:

Well, the bad things- you know there's no smoking in the hallway. They can only smoke outside or in their room. They just do what they want with their cigarette. They walk in the hallway with their cigarette and those kind of things. And I tell the staff. Sometimes they do, they just tell the tenant, but they'll come back and do it right away. (Bryan, Carrall Resident)

Bryan is upset that the residents consistently break the rules. He complains to the staff that residents are smoking in the hallway, the staff talk to the residents, and then moments later the residents are back smoking in the hallway.

Bryan, who emigrated from Taiwan to Canada 20 years ago, has been subject to racial harassment by four different residents at The Carrall:

And I've been called racial slur by four different tenants in the building. And I think this does reflected on the management. I'm not saying that management should hold 100% responsibility for the type of behaviour. However, when things are brought to their attention, they should deal with it immediately -with this kind of stuff. (Bryan, Carrall Resident)

Management is synonymous with staff. He views the staff as managers, who should take action and enforce the rules and regulations of the hotel, when problems such as racial harassment arise.
With respect to racial harassment, it is necessary to assess the context in which it occurs. In Bryan's case, 'racial harassment' is directly related to conflicts with other residents concerning rule breaking, particularly Jack:

For example, Jack, the junkie. The first time he calls me racial slur, I didn't do anything, because he's just smoking in the non-smoking area. He called me racial slur. The next time I brought it to Winston's attention. He said, I heard you call him junkie. Therefore he refuse to believe me, because I was the bad guy, who started calling him junkie. And in my opinion- like there's a law against calling racial slur, it's against the law. And they could be prosecuted. A junkie- there's thousands of junkies on skid row. It's not as bad, calling someone a junkie.
(Bryan, Carrall Resident)

The use of racial epithets is a response by Jack to Bryan's complaints about his smoking in common areas. Jack is only outwardly racist when he has conflicts with Bryan.

However, in my conversations with residents at The Carrall, I found that many of them used racial epithets in the course of common conversation. For example, one evening before cheque day, Jack mentioned to me that "I'll probably head over to the chink restaurant down the street for lunch tomorrow." I noticed, however, that he was careful to monitor his speech in the presence of staff and other visible minorities.

There is scant literature on racism among 'service users' in supported mental health residences. The majority of literature focuses on mental health worker's racial bias in the provision of mental health care (Lewis et al. 1998; Morgan 1993; Morgan 1996; Murphy 1991).

It is important here to draw a distinction between a 'bigot' and a 'racist.' Jack is clearly bigoted, as evidenced by his regular use of racial epithets. However, he is not 'racist' in the sense that he believes in racial superiority and open discrimination against Asians or other visible minorities. On the contrary, he regularly associates with minority residents at The Carrall, which includes people of Asian and Caribbean backgrounds.
Jack's overt 'racism' towards Bryan is best conceived as a retaliatory measure against Bryan's complaints of his smoking in common areas.

An empowered approach to conflict resolution has its basis in resident conciliation. For example, when residents approach Peter (Carrall Activity Worker) about conflicts, he encourages them to 'stand-up' for themselves and deal with others in a pro-active manner:

"Advocating for themselves, standing up for themselves, disputes, solving disputes between one another. I've had things where one person comes to me and says can you tell the guy in the next room to turn down his radio, and I say have you asked him yet? No, that's your job. And I go, well, if you haven't asked him, why are you coming to me and asking me? Just ask him yourself. Oh no, that's not my job, I don't want to do that, you have to. And then they'll go back to their room and suffer through a person not turning down their radio rather than knocking on their door and saying excuse, can you turn down your radio?. (Peter, Carrall Activity Worker)

One day while on the patio, one of the 'lower functioning' residents of The Carrall came out from the kitchen and asked someone for a light. After lighting his cigarette, he peeked inside to make sure there were no staff members in the kitchen (a no-smoking common area). He proceeded to make his way across the kitchen to the TV lounge, which is about twenty feet from the patio entrance. As he walked into the kitchen, Bryan came in from the hallway. He began to yell at the resident viciously, "Put that out stop it! Stop it!" The resident ran through the doors into the TV lounge. From that episode, it appears that Bryan does not possess the social skills to deal with conflicts in a conciliatory manner. Given his treatment of this resident, it is no wonder that he gets the better of Jack. His adversarial approach to conflict resolution serves to escalate disputes and increase his dependence on staff to solve his problems. When the staff reproach him for
taking an adversarial approach to problem solving, he accuses of them of being one-sided.

Bryan is incensed that the staff accuse him of wrong doing by calling Jack a 'junkie.' In his opinion, the use of racial epithets is worse than calling Jack a junkie, because 'junkie' is a commonly accepted term to describe chronic drug users (Jack is a recovering heroin user, presently in a methadone treatment program).

The staff, according to Bryan, engage in preferential treatment. Jack consistently breaks the rules by smoking in common areas. Jack calls Bryan racial epithets when Bryan tells him not to smoke in the common areas. Jack is in violation of two of The Carrall's primary rules, but the staff let him go unpunished:

This is my complaint about the staff. I'm not saying if you break the rule once. I can understand we're all human beings, we all make mistakes. But when you keep doing and doing it over and over it seems like you have one thousand, two thousand, three thousand chances. While other people have no chances. I see a lot of unfair treatment in the building. Like staff think you have category one, category two, category three. Each category is treat differently. Some can get away with anything, they're still in the building, they didn't get kicked out. Others, they get a warning right away. So I see this unfair treatment by the staff. The staff are to be unbiased, regardless of class, or gender, or racial things. (Bryan, Carrall Resident)

To Bryan, The Carrall's rules are 'set in stone' and apply equally to all residents. In contrast, the staff gauge their response in light of the severity a residents' mental illness and their consequent level of functioning. Bryan's interpretation of rule enforcement is akin to the medical model. The staff are ultimately responsible for monitoring and correcting the residents' behaviour:

And that's why I felt very mad. I think probably because when I first moved in I thought this was great. I have no place to stay, now I have a place to stay, and we'll have the staff there, and if other tenants break the rules, they'll deal with it. The thing is, do job to make tenants behave better, I see you perform your job. Like with smoking. People don't obey rules, there's a sign in the washroom that
says no smoking. I see them numerous times walking into the washroom smoking. You're breaking rules here. But with this going on, it's just making my depression worse. Make my anger build up. That's why I felt like doing nothing, because of staff preferential treatment to other tenant. (Bryan, Carrall Resident)

When Bryan moved into The Carrall, he expected that the residents would follow the rules and that the staff would enforce them. Some residents break the rules, and this has led to interpersonal conflicts, both with staff and with Jack. If staff do not correct the behaviour of residents, then they fail to perform their job.

Bryan makes an interesting observation. The staff treat some residents leniently, excusing their behaviour by virtue of being 'sick,' or low functioning. In his opinion, a 'different law' applies to the mentally ill. They are 'above' others, because they get away with things that normal people are not able to. For example, one Carrall resident repeatedly breaks windows at The Burrard, is taken to court, represented as a mental patient, and then let go:

I was a mental patient at that time too. And I did talk to some nurses, doctors, and psychiatrists. And what they say is they know they're mental patients and they know a different law applies to mental patients. And so they think they can bend the rules and break the law. They to go to court, and lawyer represents this particular person and say he's a mental patient. In court he's in his best form and he gets away with it. With a mental illness, I'm above certain people. So if with major things, then with minor things, of course they can get away with it. Like I know one guy, he breaks windows numerous times at The Burrard. He broke this numerous times! He goes to court and the judge says don't do it next time. And he does it again, it's expensive- to replace it costs a lot of money! And he gets away with it. So of course if he can get away with this, then breaking The Carrall rules is nothing. I'm just breaking The Carrall rules- no big deal. (Bryan, Carrall Resident)

Bryan's example is an excellent illustration of the sick role, first developed by Talcott Parsons. The sick role is defined in terms of "rights and obligations" (Meleis 1988, 366). Sick people are not responsible for becoming sick, and "society is expected to accept the sick role as long as [people continue] to accept four conditions" (ibid). Sick people are:
1. Obligated to seek help and co-operate with the help given.
2. Obligated to want to get well and admit sickness is undesirable.
3. Exempt from usual tasks and from moral responsibility for becoming sick (provided they accept patient status).
4. Entitled to competent technical help. (Ibid)

Bryan accepts tenets one to four of the sick role, but not tenet three. He does not exempt his fellow residents from being responsible for their own actions by virtue of being mentally ill.

Meleis (ibid) applies an interactionist perspective to the sick role. He notes that people's interpretations of the sick role "evolve from the interactions of a person with the social system of which he or she is a part..." (ibid., 367). This leads to "congruency or incongruency between self and others' expectations and meaning" (ibid., 368).

The interactionist process is also influenced by cultural factors. In regards to stress and conflict, Lewis et al (1998, 52), state that

a person's interpretation of stressful situations is often culturally determined. Thus, a particular cultural, ethnic, or racial group may find certain events as stressful, but others may not interpret them as such.

This point is emphasised by Bryan:

I think it's probably my background. I wasn't brought up in white western culture. I was brought up in oriental culture so I see things quite differently than the caucasian world. Because I see that's how the western world education brought up their own kids. Kind of do your own thing, be yourself. So they have this problem they can go out and do their own things. I see caucasians as self-centred because they see everything considering them self. Whereas oriental they think you've got to sacrifice yourself to better society. It's two different philosophies. The staff approach is too laid back. (Bryan, Carrall Resident)

Bryan's expectations are in part influenced by his cultural background. The notion of 'sacrificing yourself' to society is evident in Bryan's criticism that the staff are not committed to changing the residents' behaviour:
That's why staff should be working on them. You'll never change them over night. I don't expect that. It's just a little bit everyday. There's the saying, Rome wasn't built in a day. I don't expect them to change overnight. Just like you do in university. You don't learn all your knowledge in one day. It takes time to learn how. I discuss this with staff, and his response always is, we cannot change the world. I do not ask him to change the world. I ask him to correct one person's behaviour. And they sat there. This is what I said earlier. They should be doing their job. (Bryan, Carrall Resident)

From an interpretive dissonance perspective, Bryan's interpretation of rule adherence and conflict resolution is fundamentally at odds with that of the staff. The staff adopt a controlled 'laissez-faire' approach, consistent with empowerment ideals, that models appropriate behaviour and proactive conciliation, but places the onus of rule adherence and conflict resolution on the residents. The staff will only intervene in extreme situations, such as an escalated argument, acute decompensation, and incidents of violence.

Bryan adopts an authoritarian, 'medical' oriented approach that places the responsibility for controlling the residents' behaviour and resolving conflicts squarely with the staff. He interprets the laissez-faire approach of the staff as one of neglect, not empowerment.

The conflicts between Bryan, the other residents, and the staff are indicative of a lack of communication between the staff and the residents concerning the goals and objectives of The Carrall's supported living program. The staff and the residents do not have frank and open discussions with each other about their philosophies and approaches to the rules, mental health rehabilitation, and social support. Furthermore, the residents do not have sufficient input into how the hotel is run.
In chapter one, Nicola, the VMA housing manager, asserted that: "The bottom line is that the VMA is a member driven organisation so the members are ultimately the boss. The staff work for the residents." This implies that the residents have some authority and control over the day to day operations of The Carrall. This contention is inaccurate, if not misleading.

The residents are not effectively involved in the decision making processes at The Carrall. Of course, the staff do make an effort to solicit the input of the residents. For example, Sunday morning breakfasts are occasionally held to give the residents an opportunity to talk about what they like and do not like about The Carrall, and to provide their feedback and suggestions for improvement. However, few of the residents attend these meetings. As Jack (Carrall Resident) notes:

Winston puts up notices and arranges meetings, but few people come. People never read notices, and mentally, a lot of them are not capable of thinking that far ahead. (Jack, Carrall Resident)

Some of the residents who attend these sessions note that they amount to little more than "bitch sessions." They tell staff their problems, and give them their suggestions, but ultimately, the staff make the final decisions about what gets done and how things are run.

In addition to weak consultation, the actions of some staff actually dissuade constructive dialogue with residents and their involvement in The Carrall’s affairs. For example, several residents have had problems with staff ‘abusing their power.’ The most frequently cited problem pertains to the staff use of the TV room. Bryan provides an example:

Sometimes I go into the TV room and see three or four staff standing around doing nothing. In my opinion, the TV room is for the tenant enjoyment, right?
There's two of them who want to watch hockey. They are like hockey nuts. They watch a lot of hockey in the hockey season. So we have this conflict about that. But in my opinion staff is not hired to watch TV, the tenants have the first choice. But because they're staff they have a whole power over the tenants. Twice these staff have turned out the TV on me- they just turn it right out, and I cannot turn it on. Twice they turned it out and there other tenants in the room watching TV- watching the show I was watching. But because they want to watch hockey they have power over me, they just turn it right off. And the second time he turns the TV off I couldn't watch it, so I just left the room. And he slammed the door behind me! So I go to my room. About ten minutes later I need to use the sink I come down to use the sink, the TV's on, hockey game! So this is something I complained. Don't you think is for the tenants to enjoy? They shouldn't be doing this to other tenants. I had one tell me, once he turned the TV off, the other tenant told me, he says, the staff had no right to do that. He says first of all, the staff doesn't live here, secondly, they're abusing their power.

The above incident does not support the assertion that the 'members are ultimately the boss.' The TV room is designed for the leisure of the residents, not the staff. Forcefully turning off the TV, and slamming the door behind one's back creates an intimidating and inhospitable environment for the residents. This is clearly contradictory to the tenets of user empowerment, which gives the residents authority and ownership over their living arrangements (Rapp 1998).

There are three avenues that the staff can pursue to foster greater resident empowerment and involvement in the day to day operations of the hotel. The first is to have a clear understanding of their duties and responsibilities as mental health workers, and of the goals of social support. The second is to establish open lines of communication with the residents, so that both parties have a better understanding of their needs, expectations, and limitations in a supported living arrangement. As Morgan (1993, 196) notes, this is one way to avoid misunderstandings:

...[a] major pitfall to guard against when considering the process of user empowerment is the possibility, conscious or otherwise, of producing only token gestures in practice. There may exist a general appeal for workers and managers to talk about consulting the user- useful statements to include in planning.
documents and operational policies. There may even be real discussions held where users are asked their opinions. But if we find that behind the bold statements of intent there are clearly stated actions for carrying the results into practice, it is likely to amount to negative results in anger and frustration.

Third, the staff must devise a strategy whereby the residents share in the authority and ownership of The Carrall on a more equal footing with the staff. This is not easy, since "the most significant barrier to implementing the ideas engendered in user empowerment is the workers' fear that they will lose some of their existing power" (ibid., 195).

The task, however, is not impossible. For example, the staff of The Burrard encourage the direct involvement of their members in the operational policies of the drop-in:

And that’s another thing, staff don't make the rules. The members do. The staff get an idea of the rules, they bring it to the membership and the members vote to enact then rule. So we try and minimise the top-down concept. We're not shoveing things down their throat. And if there's a problem then always me and my staff will lay it out to them. If there's a problem, one solution might be, one solution might be... invariably they'll look to us to guide them, and they'll make the right decision. And if they don't the next meeting they realise they've screwed up and they change it. Meetings are every sixth Tuesday. (Bernard, Burrard Director)

Bernard goes on to mention that behavioural problems are generally quite low, because the members feel that they have a say in the operations. Indeed, Bryan and Jack (Carrall Residents) enjoy going to the drop-in because of its calm, congenial atmosphere.

The barriers to establishing 'user-led' supported living programs is an emerging theme in the literature (Morgan 1993; 1996). In the first instance, 'user-led' programs are often synonymous with 'partnerships' between the mentally ill and mental health workers, rather than the mentally ill as mental health workers (when mentally ill 'service users' are trained and employed as mental health workers). Second, few studies have
examined the attitudes of the mentally ill and mental health workers towards the establishment of user-led support programs. This area of research warrants further investigation.

**Friendship Supports**

In spite of the conflicts that sometimes arise, there exist many mutually supportive friendships among The Carall's residents. The friendships and helping networks of the low-income mentally ill are well documented in ethnographic studies of street people (Snow and Anderson 1993; Wagner 1993), soup kitchens (Glasser 1988; Glasser and Suroviak 1988), shelters (Desjarlais 1997), SROs (Hoch and Slayton 1989), and in community mental health studies (Ross et al. 1993; Murphy 1991).

The residents give and receive informal emotional, tangible, and informational help to each other in a variety of ways. Max (Carrall Resident) provides an example of the emotional support he provides to residents dealing with mental health issues:

> I spontaneously respond to the environment that generally is at home with people here. Not all of the people react like that, but for the most part, if somebody's crazy, there's a lot of sympathy. You try to talk sense to them and not speak in their language of delusion, and at the same time not speak in a harsh contradictory fashion. (Max, Carrall Resident)

Part of the emotional support Max gives is based on having sympathy for the illnesses that people have. He avoids mirroring 'their language of delusion,' but interacts with people in a respectful manner that accepts them for who they are.

Max also receives emotional support from the residents when he is feeling down. He notes that the group camaraderie of the hotel is a factor that strengthens individual survival skills to help people cope with their mental illness:
The same is true with me. I can walk out there being capable of reading and doing all the things I'm capable of doing, and still feel lousy. And I get a response from people that's - joking around and friendly. And that's - there's a camaraderie element in any human group that seems to reinforce the survival ability, the survival strength of an individual. That's something that I think you make an effort to accomplish, to help out the other person who's feeling nervous or psycho or whatever. To try and put things right. And when there's no crisis, just have as much fun as possible and have a good laugh. (Max, Carrall Resident)

Two of The Carrall's residents likened the nature of friendships to an extended family:

It's kind of like an extended family. Pretty good people. It's kind of amazing that you get all- you know my vision of skid row way back when was drug addicts, drunks, the lowest of the low. And you see all these guys like Doug and Sam and they're doing their own thing. Despite the drugs and the mental illness, they end up down here and they're good people. A lot better than some of the people out there in the real world, you know? (James, Carrall Resident)

...the way we live, it's like an adopted family atmosphere. (Jack, Carrall Resident)

As previously discussed, the residents engage in tangible mutual support through the exchange of cigarettes. Residents also engage in other types of exchanges, such as small monetary loans:

Well most of the relationships here are friendly. People support each other emotionally, bum cigarettes back and forth, small loans and all that, but that's all. That's the basic good thing about The Carrall, is the support of- the community aspect. You feel secure, you can start rebuilding your life and building up. (James, Carrall Resident)

The community aspect of The Carrall is evident in the trusting relationships and sense of good will between the residents. Reciprocal relationships are set by precedent and example. The residents know that in order to receive, they also have to give, and that taking advantage of others will jeopardise the opportunity to borrow from others in times of need:

Some people lend each other money. And people will then actually look for the guy all day long to pay him back. And you're thinking, Downtown Eastside
right? Who'd pay who back? No one trusts each other. But there, because they live with each other all the time, and they know, if I want to get that again, I'll have to pay him back. So that's the community sense that I really respect there. And they develop that on their own, just by living with each other. (Lee, Carrall Housekeeper)

The provision of tangible support is not only measured in the borrowing and lending of money, cigarettes, and food. As Winston (Carrall Supervisor) notes, tangible support is also provided in the form of assisting people with errands and tasks. For example, when one of The Carrall's residents recently fell ill, some of the residents in neighbouring rooms began helping him with day to day tasks:

What I'm noticing is neighbours are doing things like doing errands for him, helping him with tidying his room on occasion, socialising with, just to maintain his spirit if you will. It can be as simple as going out shopping and getting food, so that he's not totally dependent on staff, so he can maintain some level of independence as he's going through this. And there's a lot of good heartedness in our residents. (Winston, Carrall Supervisor)

Another source of informal support is information. As Brenda (Community Activist) notes, in any given SRO there are 'message carriers,' people who are extroverted, sociable, and adept at transmitting information to others. Brenda is a housing activist, and is constantly liaising with Downtown Eastside social organisations and residents to apprise them of social housing initiatives, welfare services, and SRO closures. She uses 'message carriers' at SROs as a means of relaying important information to hotel residents:

More and more it was noticing who are the message carriers in the building and who lived there. And people who are usually extroverted, have got strong social skills- are somewhat dominant in their environment or are elderly and quite respected such that people go to them for information. And we would take these people out for coffee and go over in detail the information that we wanted to provide until we knew that they had it accurately. And then we could trust that they would provide the information within the building. (Brenda, Community Activist)
Winston (Carrall Supervisor) notes that information about welfare services and community resources is commonly exchanged between The Carrall's residents. Much of their knowledge is gained from everyday experiences with community agencies:

Information too. Because some of them are quite adept at getting through what's available through the welfare system. I mean they don't always get their information from professionals like ourselves. Some of them have got it down in terms of knowing where things are and what resources are and they help each other out in that respect by sharing information about resources in the community. (Winston, Carrall Supervisor)

The Burrard drop-in centre is also a site of helping and information exchange. Bernard (Burrard Director) provides an example of how people exchange beneficial information with each other:

Well, somebody finds out that there's $25 vouchers available from the Salvation Army on Kingsway, and comes down, they walk in the door, they're yelling "$25 vouchers!" (Bernard, Burrard Director)

Clearly, the friendships at The Carrall and The Burrard constitute informational, tangible and emotional sources of informal mutual aid. Nevertheless, there are two aspects to their relationships that remain unexamined. The first is the nature of their personal intimate relationships, if any. The second is the absence of relationships outside of the mental health services in the community at large.

There is little written on the intimate relationships of the mentally ill. One reason may be the stereotypical assumptions of researchers, conscious or unconscious, that the long-term mentally ill are unable to build and sustain intimate relationships. Another reason may be that intimate relationships are a private matter, and are not to be openly discussed.

Most of the residents I interviewed were reluctant to talk about present or past intimate relationships. During participant observation at The Carrall, I did notice a fair
degree of bravado among the men. Conversations on the patio regularly focused on the cars they used to drive (or wanted to drive), and the women they had slept with. Serious discussions of relationships were not the norm. Perhaps this was out of pride, or perhaps their past relationships were too painful to discuss.

The majority of The Carrall's residents are single. Indeed, most SRO residents are single men (City of Vancouver 1995), and women constitute only about 20% of the population of the Downtown Eastside (Baxter 1997), which is perhaps one factor in the low number of heterosexual relationships. I did note one couple at The Carrall- a man and a woman, who were intimately involved. However, due to their reclusiveness, and their aversion to interaction with others, I was unable to establish a relationship with them.

One of the residents I interviewed, Allan, was forthcoming about his desire to meet a woman. Finding a girlfriend was high on his agenda:

Like I said, I'm trying to get a girlfriend right now, so - yeah, I'm trying to find girls to date. Wherever I can start up a conversation. But I find this city. This is a real point of interest. This city is getting colder and socially colder every single day that I'm out there. I find it harder and harder just to have a conversation- just to have somewhat of a conversation with a female. I'm not too sure why. I'm finding it harder and harder to socialise. So I'm trying the chat line and stuff. Yeah, I'm buying into the chat lines and stuff. People who want to talk are on there. I just started actually. Yeah I've had some luck. I met a girl from Delta. And she's gonna give a me a call next week so I'm off to the races. (Allan, Carrall Resident)

Recall Allan's experience with a waitress from chapter two. Allan has trouble gauging people's personal boundaries, and becomes easily frustrated when his advances are not acknowledged. The fact that he has trouble socialising with women is most likely the result of a lack of social skills. One resident at The Carrall, Alice, recounted a time when Allan 'came on to her':

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I was in the TV lounge, and Allan came in and asked me to fuck him. I was so pissed off. I was really angry. I told him to fuck off. He's not a bad guy. I like him, we're friends, but he shouldn't have done that. (Alice, Carrall Resident)

Another reason why he has bad luck with women is social stigma. In the first instance, striking up a conversation with complete strangers is inappropriate, depending on the situation, especially for the purpose of 'coming on' to them. Second, clothing, appearance, and the manifestation of signs of mental illness (such as acting out, or erratic speech) will 'tip people off' and motivate them to ignore mentally ill people and to keep their distance.

This leads to the second aspect of the residents' relationships, a lack of friendships or social networks in the community at large:

Well, I think my closest friend lives here. It wasn't like that before. It wasn't like that before in the beginning when I first here. My friends were on the outside world. As things progressed, things change, people change- I figure all my friends live here basically. The people that I'm closed to are like the staff and James and Fred next door he's my good friend. (Allan, Carrall Resident)

Allan used to have friends on the 'outside world' before he became ill and 'people changed.' Other residents spoke of the fact that after becoming mentally ill they lost contact with family and friends. Re-establishing connections to the outside world is not easy.

Morgan (1993), Murphy (1991), and Ross et al. (1993) note that social stigma is the single largest barrier to 'community integration' and the establishment of social ties to the community at large. The mentally ill find a greater sense of acceptance among themselves. It is no wonder that strong ties exist between residents of The Carrall:

They reach out to each other, providing each other with friendships and social support that they might not get in the outside community and in fact more often than not they won't. It's a tremendous stigma that people with mental health concerns bear. (Winston, Carrall Supervisor)
It seems to me like everything's coming down to the crunch in the outside world so I'm trying to keep my inside world as stable as possible. (Allan, Carrall Resident)

The following sections on leisure and recreational activities, and educational and vocational training, explore the concepts of social stigma and community integration, by assessing the extent to which the activities and training provided to the mentally ill assist them with expanding their social ties into the community.

**Leisure and Recreational Activities**

The residents of The Carrall take part in a variety of individual and group activities. Group activities are either planned by Peter (Carrall Activity Worker), or by drop-in centre staff, such as at The Main and The Burrard.

The first section of this chapter describes some of the activities that residents take part in individually as part of their daily routine. This section shall focus primarily on group activities.

As discussed in chapter two, the residents do not normally plan group outings on their own. Functionality, the effects of psychotropic medication and the economic constraints of a low-income limit their ability to plan and engage in many activities. The goal of group outings, according to Peter (Carrall Activity Worker), is to provide the residents with a social outlet, a change in environment, an opportunity to have fun, and 'something to hope for.'

Some outings, such as pool and coffee outings take place in the Downtown Eastside. The Carrall has the use of a six passenger van, The Burrard has the use of a
four passenger van. More often than not, residents and members are taken on outings outside of the Downtown Eastside area:

Driving to different places. They like to get out of the Downtown Eastside- a lot of them. And just go anywhere but the Downtown Eastside. So, I mean- it's great that we have- there are things we could do in the area. But they're not interested in doing anything in the area. They just want to go far. I'm planning a canoeing trip this week, and PNE trip this week, a movie outing, and also going to Granville Island for coffee this week. And they usually have music there. Some times there's an outdoor band? So, that's just this week for us. (Peter, Carrall Activity Worker)

We have an activities program. Where I would say on an average of four days a week we have bus- a four passenger bus that goes somewhere and does something. They go trips to Victoria, they go to Bellingham, they go to the mall, they got kayaking, they got to Whistler, they go horse back riding, go car racing. And it's a wide variety of things. Some of them are more sedentary people, some of them more active, some of them more functional. (Bernard, Burrard Director)

In addition to out of town trips, The Burrard has a variety of indoor activities that it offers to its members:

We also have inside activities. We have pool tournaments, bingo, crib tournaments, we have a men's group. We have a bike- a bicycle group. They are all in addition to the van trip. We have - it's all kind of one on one, but not quite. Staff will take two or three- staff will leave here with a couple of people and go for a walk with them and go down to a coffee shop. It gives them a chance to talk. (Bernard, Burrard Director)

Generally, given the space limitations of the van, only four to five residents can go on an outing at any given time. There is a sign-up procedure for some outings, depending on the popularity of the activity. For other activities, participation is on an ad hoc basis:

Sometimes there's a sign up list. Sometimes there is isn't. It all depends. If it's something that a ton of people are going to want to do, and it's special- like going canoeing, I might have a sign-up list. But in general I ask people who I see. I've asked everybody in the hotel a couple of times over, and there's some people who just do not want to go on any outings. And there are some people who only want to go on certain types of outings. And there are certain people who I'm always asking because they're really looking for something to do? And I'll tend towards people who I feel socially need that? Or people who are in a place at that point in time. Like you look at their needs. (Peter, Carrall Activity Worker)
Allan (Carrall Resident) describes why he enjoys outings:

It's kind of like a bunch of friends going out and seeing what's on the outside world, different parts and areas of town. See the city, see how it's going. Pick little things out of it. Maybe I can do that or maybe I can get a job like that guy who works at the car dealership, or I can live in a house like the guy down the street in a white picket fence house. You just see different things and it keeps your mind going. It's food for thought. It keeps your mind going. It gets the creative energies going, which is important. (Allan, Carrall Resident)

Allan enjoys outings because they provide him with a glimpse of the 'outside world,' and take him to areas of town where he would not usually go. Peter's notion of giving the residents something to hope for is illustrated in Allan's comment about 'picking little things' out of what he sees and wondering if he would be able to do those things himself.

One evening I accompanied Peter and some of the residents, including Allan, on an outing. We went to a coffee shop in Richmond. On the drive down, Allan looked wistfully out the window of the van, occasionally calling out the names of businesses as we passed them by, and pondering aloud whether or not he could work for them.

Allan: "Auto mechanics shop, I'm wondering if I could get a job there. Hey Peter! Do you know how I could get a job there?"

Peter: "I don't know, but I think you need a mechanic's certificate, or some courses or something like that."

Allan: [Muttering under his breath]"Oh, Christ."

Another goal of the outings is to encourage the residents to talk to each other and socialise. On the drive down, Allan wanted to turn on the radio. Peter told him "No, the point is for us to have a little social interaction here." Upon arriving at the coffee shop, we went in and ordered our drinks, and then went to sit out on the patio. I sat with Peter and a group of three residents. Allan sat behind me at another table with one other resident. Peter and I engaged the residents at our table in general conversation.
Behind me I could overhear Allan talking about an apartment building across the street from the coffee shop. He was wondering how much the rent was, as he eventually wanted to find his own place. He turned to the people at the table next to him and said, "Hey guys, do you know how much those apartments are?" At this point, Peter snapped his head up and looked intently at the interaction between Allan and the people next him.

Allan caught Peter's attention because he violated a residual, or 'unofficial' (Bowers 1998) social norm that discourages people from talking to strangers and interrupting private conversations. It was clear that Peter was monitoring Allan to ensure that the interaction went smoothly. The people next to Allan stated that they did not know how much the apartments cost and the conversation stopped.

The incident described above indicates that group outings are controlled environments. Peter, the activity worker, has full control of the situation and monitors the residents' behaviour to make certain that they remain out of trouble.

Holloway and Carson (1996, 87) note that supervised outings and drop-in centres provide artificial social networks, and do little to foster the development of new social networks. By building on social skills, the mentally ill should be encouraged to use community resources such as pubs, cafes, libraries, and community centres (ibid) independently on their own. The relationships forged in supervised environments and drop-in centres are "at their best contrived relationships that are indistinguishable from natural friendships" (ibid).

Ross et al (1993) note that for the mentally ill, the use of pubs, cafes, and community centres is a two way street. That is, the owners, patrons, and members of these establishments must also "learn some social skills...to accept troubling distress and
difference. The first step towards that objective is to break down the barriers...of ignorance, stereotypes and fear...." (ibid).

Indeed, the stigma of mental illness so great that it is one of the reasons why some of the residents, often the higher functioning ones, refuse to go on group outings or be seen with other mentally ill residents in public:

I think I have far too much awareness that this is a crowd of lunatics that I'm going to be going out in public with. And I can't go out and enjoy myself with that stigma. That's my being stuck-up, I'll admit that. Yeah, it's that sort of absurdity, because I think I would in this crowd stick out like a sore thumb as one of the members of this vile, non-class of lepers, mental lepers, and so it's almost out of the question from that standpoint. (Max, Carrall Resident)

In the context of discredited and discreditable groups (Goffman 1961), Max engages in a form of selective social withdrawal (ibid). He avoids public fraternisation with the mentally ill in order to maintain his discreditable status. Although he has been diagnosed with a mental illness, he is very high functioning, and can 'hide' the fact that he is mentally ill. However, to be seen in the company of the mentally is to reveal his 'true identity'- that he is in fact, 'one of them.' Put simply, it is guilt by association.

Max describes his experiences with the severely mentally ill in community settings, and the public's reaction to them:

A number of times I've been sitting in restaurants and lunatics have walked in and I've thought well, here I am reacting probably just like everybody else. He walks in, talking and saying things while everybody's sitting there trying to eat. That's my symbol of the lunatic in crisis in society. Everybody wishes so sincerely that this person gets the hell out, that they would feel satisfaction if somebody grabs him, puts his arms behind his back, and shoves him out the door. And there's no objection if he's dragged off and shoved around. It's something like the pack senses that there's something diseased in its' midst. And it senses that the disease has to be driven out, in order for a feeling of balance to return, and also- here's a place where all our hate can be funnelled for while. (Max, Carrall Resident)
Max provides a well articulated interpretation of how people react in their thoughts— if not in their actions— to the presence of the mentally ill in public settings. For mentally ill people such as Max, the expectation that they will encounter social stigma is high.

This warrants a re-examination of Holloway and Carson’s (1996) assertion that the mentally ill should be encouraged to use public community resources, rather than the artificial social networks designed by mental health services for the mentally ill. In the first instance, Holloway and Carson (1996) do not adequately address the impact of stigma on mentally ill people who use, or attempt to use public community resources. As Mayville and Penn (1998) note, 'stigma-reducing interventions' such as contact with the mentally ill, and 'value-self confrontation' have had negligible impact on societal attitudes towards the mentally ill. Some studies have shown that contact does in fact reduce social stigma and result in more positive attitudes towards the mentally ill. However other studies show that contact confirms people's stereotypes of the mentally ill and reinforces negative social stigma. The efficacy of value-self confrontation remains relatively unknown, due to a lack of substantive empirical evidence (ibid).

Second, there is a tendency to group the mentally ill together as a whole, without taking into account individual income levels and functionality. As previously discussed, it is more difficult for the low-income mentally ill to use community resources, since they may not have the money to pay for them. The degree to which one is functional also determines one's ability to independently seek out community resources. Clearly, higher functioning people are capable of using community resources, but their encouragement to do so must be accompanied by concomitant efforts to raise their income levels and, as best as possible, confront stigma in the community.
Third, to assume that drop-in centres are artificial and contrived environments is erroneous. Some drop-in users do in fact develop friendships that continue outside of the drop-in centre:

You know sometimes members will—somebody who gets their money every Wednesday, will have a dinner at their house. Something like that, because a bunch of people don't have any money. Or they'll do stuff. They visit each other in their places. They go and have card nights at their own homes and things like that. (Jane, Main Director)

Drop-in centres, as noted earlier in this chapter, offer the low-income mentally a place where they are accepted for who they are (David, Carrall Staff). Drop-ins are a respite from the stigma that the low-income mentally ill experience in mainstream society, and offer the benefit of establishing real friendships and a natural social network.

In light of this contradictory evidence, Holloway and Carson's (1996) harsh criticism of the drop-in environment is unwarranted, especially given that efforts at reducing the social stigma of mental illness in the community have met with limited success.

**Finances**

One mental health initiative that has met with a fair degree of success is the provision of help with income assistance and personal finances. The Carrall, The Burrard, The Main and the DEMHT provide money management services and teach budgeting skills, so as to help people spread their money over the month until the next cheque day. They also help their members to qualify for disability assistance, level two (DB Two).
Budgeting

Many residents have poor budgeting skills, and run out of money anywhere from one week to three weeks from the date they receive their monthly cheque. The primary problem is keeping track of where their money goes. John (Carrall Staff), regularly provides informal' budget counselling' to the residents:

now it gets back to the budget thing. Some people must run out more quickly than others. It works out badly for some individuals. And with a recurrent thing as predictable as death and taxes, ten days before the next cheque day- the next cheque day will be due a week from yesterday- and people will be on and on that they don't have any money. I'll be saying on seven o'clock on the night before cheque day, anybody that wants to can come by here and I can talk to you about budgeting- just the simple ways of it. It's what young people call the KISS approach- you keep it simple stupid.

The pie is so big, there are so many slices. This, this and the other. You can make that slice bigger only at the expense of spending less on one of the other slices. e. And if you have to divide your money up literally- and put in envelopes labelled week 1, week 2, week 3, week 4- that might not be a bad way to... I've had people who sit down and say- I feel silly doing this John! And I say, you would feel as silly doing this as you would running out of money two weeks before cheque day. And people ask, will you keep these for me? I don't really think so, because you need to have your hand in this. You need to be the one that learns to live with the fact that you don't have enough money to get by. (John, Carrall Staff)

The benefits of budgeting are described by Jack (Carrall Resident). Jack is one of the few residents who gets his money administered on a weekly basis by the staff of The Carrall. Recall that Jack is a recovering heroin user, now in a methadone program. The reason why he has the staff administer his money is not because he is tempted to cash his income assistance cheque and spend all the money on heroin. Rather, it is to learn how to spend his money more wisely so that his cheque lasts throughout the month:

I asked Winston to break up my cheque and give me the money on a weekly basis. I know how much I have for the week and I'm learning to live on that amount to the end of the week. After I really get the hang of it I will start to take care of my own money. (Jack, Carrall Resident).
While John prefers that residents take care of their own money, Jack demonstrates that staff administered money management has its advantages. Short-term staff money management is beneficial in his case, since it is helping him to acquire skills that he did not have before. Once Jack learns how to get by on a set amount of money on a week to week basis, he will be in a better position to take responsibility for his own money and manage it independently.

'DB Two'

Few residents of The Carrall would deny the importance of staff support with obtaining DB Two assistance. Bryan (Carrall Resident), despite his numerous conflicts with residents and staff at The Carrall, sees the advantage of remaining at the hotel in order to secure DB Two benefits:

I don't want to move, because I want to get up to DB Two, and I think there's an advantage right now to live at The Carrall, to get on DB Two. Once I got DB Two- another reason, I don't want to move out is that for social housing, I have to be on DB Two to get in. I don't have DB Two, so if I move out I will probably have to move to another downtown skid row building around here. And probably it would be worse. When I get my DB Two, then I will put my name on the list for the social housing. And by that time- it's hard to say- maybe I will move out. Maybe I will get social housing. But the thing is I will be here until I get my DB Two. So I want to get something better, not something worse if I move to another dump. (Bryan, Carrall Resident)

For Bryan, getting on DB Two is a stepping stone to improved social housing. Since Bryan is only on basic income assistance of $500 a month, to leave The Carrall prematurely would no doubt relegate him to a substandard living environment, sever his connections to the helping network at The Carrall, and decrease his chances of securing DB Two.

Most residents at The Carrall are entitled to DB Two benefits, by virtue of a persistent mental disability that has lasted more than two years (MSDES 1999).
However, many residents were unaware that they qualified for DB Two, and so never applied. It is only recently that The Carrall has engaged in assisting residents with DB Two applications, and making them aware of their welfare entitlements:

Right now we are working residents to bring their disability level up to maximum. And we weren't doing that type of stuff as a program prior to this because our manpower was a little bit lower and there was a little less method involved. It was, to a certain extent, a scattered approach and quite frankly some the residents were being ill-in terms of what we were capable of doing. And because of lack of effort but simply lack of manpower and method.

Yeah, it's a process. It involves a lot of hoop jumping and a lot of our clients can get discouraged by having to find their way through the bureaucracies, going through appeals that, to a large extent are engineered by the system to contain cost, regardless of whether somebody is entitled or not.

In that sense we do practical advocacy work. Practical one to one work. That can be as simple as accompanying people to welfare appointments. Making sure that welfare workers involved are apprised of submissions and applications that we are putting through for clothing vouchers, crisis grants, where you can obtain higher disability levels, access to funds which are available for vacations and things like that- recreational purposes. (Winston, Carrall Supervisor)

Indeed, the mentally ill normally find income assistance applications a daunting and intimidating task to undertake alone. As Morgan (1993, 125) notes:

...living on social security benefits...means having to deal with a large and confusing government department; and it can mean many hours spent queuing and waiting in quite degrading and sometimes intimidating, social security offices.

The DB Two application has three sections. In the first section, the applicant must complete information about his or her disability, or have someone chosen by the applicant to provide this information. The second section must be completed by an "assessor who has a professional relationship with the applicant," and who is familiar with her condition, such as a social worker or a nurse. The third section must be completed by a medical doctor, and should provide a medical diagnosis of the applicant's
disability (MSDES 1999). Given the complex nature of the application process, it is no wonder that some mentally ill persons experience difficulty completing the application on their own.

Mental health workers at The Carrall, The Burrard, The Main, and the DEMHT assist applicants with sections one and two. The third section is sent on to a physician. In order to ensure a successful application, mental health workers 'coach' the physicians on the wording they should use when they complete their section of the application. Bill (DEMHT Director) provides an example of how the DEMHT handles a DB Two application:

Well they need to clearly have a serious mental illness. The form has to be signed by a physician, either a medical doctor or it can be a psychiatrist. The case manager will do a fair amount of the groundwork, but the physician will have to sign it off. Staff do the applications and take them over to doctors. And they coach the doctors on what to write and on what not to write. There are certain words they should use and not use— all those kinds of things, right? You're saying the same thing but in a different way? Because they don't know the right terminology to use. We don't tell them what to say, we don't tell to say that a person has a seizure disorder when they don't have one, or something like that, but there is terminology which will be more likely to succeed than others. And so that kind of coaching happens. (Bill, DEMHT Director)

Bernard (Burrard, Director), notes that almost all people who apply for DB Two on their own are turned down. It can take anywhere from six to twelve weeks to process DB Two applications. If people are turned down, an appeal can be made, but this can take a further three to six months. Winston (Carrall Supervisor) noted that the application and appeal procedure is part of the MSDES cost containment strategy. The longer the process involved in securing the benefits, the less money the ministry has to pay. And as Bernard (Burrard Director) notes, people who apply and are turned down will be discouraged to
re-apply. He feels that it is almost official MSDES policy to turn people down the first time, so as to prolong the appeals of some people and prevent others from re-applying:

If you've got an appeal for an application for disability without the help of a pretty slick professional, they'll turn you down. I mean it's a given, you will be turned down. Which if nothing else, delays it three to six, so they don't have to pay them money for three to six months. I almost think that it's their policy from the get-go to just turn everybody down the first time and if they appeal it well then maybe you're going to win, and maybe you're going to lose. And a lot of people get discouraged. They get turned down that first time and they never apply again. (Bernard, Burrard Director)

The irony of the application procedure is clear. In theory the income assistance program exists to provide people the benefits they are entitled to, yet in practice it adopts procedures which prevent people from receiving them. Nevertheless, Bernard maintains that most mental health workers in the Downtown Eastside have a better understanding of the application procedure than ministry staff, and that his staff have a high success rate with their DB Two applications:

...we have a 90% plus something success rate when we take the ministry on, because we know the legislation better than they do. (Bernard, Burrard Director).

For the residents of The Carrall, securing DB Two benefits has a major impact on their self-esteem. As Winston (Carrall Supervisor) notes, income has a direct impact on the residents' quality of life. It increases their disposable income, allowing them to spend money on items they might otherwise not be able to afford:

That means every resident on disability benefit has anywhere- depending on how they spend their money- has an additional $50 to $150 a month in their pocket to defer to other purposes. And I know some people may that's being soft, well I don't think it is. It's the anxiety level that goes with poverty. I think it's very hard for people who get three meals a day all their life to imagine what it must be like to sometimes go without, and the impact it has on people's moods and on their sense of self and on their self-esteem. And I think that if you've done anything on that level over the past year, I'm very happy about that. I think we have taken a lot of the sting out of the poverty that our residents have had to deal with living
down here. People aren't running out of tobacco as much and the little luxuries that they allow themselves, and that's important. (Winston, Carrall Supervisor)

In an individualistic society that places a high value on independence and the ability to support oneself, sanctioning the use of income assistance to provide for a greater disposable income constitutes, for some, a travesty of the welfare system. At best it is 'counterintuitive' to the goals of getting people back into the workforce.

This line of thinking assumes that the mentally ill have the desire and the ability to re-enter the workforce. This may or may not be the case. What is clear, however, is that higher incomes allow people to restructure their resources and devote their energies to activities that they were hitherto unable to pursue. In many cases, these activities contribute to an improved sense of self-worth and self-esteem. James (Carrall Resident) became proficient at computers after he was approved for DB Two. With a greater disposable income, he was able to buy old computer parts, computer books, and peripherals, and taught himself how to repair and program computers:

You know I wasn't getting much money back then. I was basically on welfare for people with physical problems or something? It's $50 more a month but it meant that I could go out and spend $50 on books or computer parts or whatever. And this opened- that was a big thing for me. That's been my big project in the last, almost decade now. (James, Carrall Resident)

In addition to improving his self-esteem, the other residents of The Carrall benefit from his expertise. Another resident who had collected a large number of old and broken computers, decided that he wanted to give them away to the residents, and asked James to help him fix them. According to Lee (Carrall housekeeper), it is because of James' expertise that many residents now have their own computers.

Jack (Carrall Resident) recently had his application approved for DB Two benefits. Recall that much of Jack's day was spent pan handling for money. Now that he
is on DB Two, he no longer has to pan handle. The increase in income allows him to provide for his own cigarettes, and for more of his own food. In addition, Jack has taken on a part-time job selling a popular homeless newspaper around town:

Now that I have more money I can buy more of my own things. I don't have to pan handle and bin anymore. The Carrall has food so that's taken care of. I've started selling a homeless paper around Vancouver. I just hang out on street corners and sell papers. It's not the best job. I get a bit of what I sell, the rest goes to the paper, which gives back to a lot to homeless organisations down here. It's nice to be doing something to help others. (Jack, Carrall Resident)

While selling a homeless newspaper on street corners is not the best job, it does provide Jack with a sense that he is contributing something back to society.

Jack does, however, have greater ambitions. He aspires to open a non-profit bike store where he can repair bikes and sell them at low cost to people in the Downtown Eastside community. Indeed, during my time at The Carrall, I often heard the residents talk about the jobs they would like to have in the 'real' world. Clearly, some of the residents have a strong desire to work, but expressed frustration that they did not have enough options and could not find a job to their liking. The following section on employment and vocational training explores some of these issues.
Employment and Training

Employment and training for the mentally ill is a controversial issue in mental health circles. On the one hand, the empowerment movement advocates that the mentally ill be given the choice to work, and greater employment opportunities should be made available to them (Morgan 1993). Ideally, mental health agencies will forge links with employers in the community in order to foster the 'community integration' of the mentally ill. Other work options may include government employment programs that target the mentally ill.

On the other hand, the reality is that many mentally ill people are not capable of holding down full time jobs, and lack the necessary skills and qualifications to perform certain types of work (ibid). The low-income mentally ill do not possess the economic resources to pursue work-related training or higher education. In many instances, the nature of their mental illness prevents them from keeping a regular schedule and thus inhibits their ability to 'keep up with the work.' In addition, mental health services are constrained by limited funding and do not have the resources to provide classes and training courses.

Ross et al. (1993) offer an interesting perspective on the issue of employment. The authors of this article are themselves mentally ill service users. They assert that the notion that the mentally ill will eventually enter or re-enter the world of employment is unrealistic. For most mentally ill people, "employment...will be quite unlikely if not completely impossible (ibid., 326). However, Ross et al (1993) and Hall (1996) recognise that employment has many positive benefits, such as autonomy in purchasing goods and services, and a recognisable social identity (Hall 1996, 282).
Those who desire to work must receive consistent and skilled personal support (Ross et al. 1993, 327). This support should be located in the areas that people frequent, such as drop-in centres, or in the case of Carrall residents, in the hotel itself. Small support groups should be established, so that residents who want to work will have a mutual support base to which they can turn to, to discuss difficulties and exchange ideas on how to deal with work and employment related issues. Ross et al. (1993) maintain that small scale, ground-level initiatives must be made in order to ensure that the individual needs of residents are met (ibid). Otherwise, employment and vocational efforts will not be successful.

The vocational needs of residents are determined by the jobs they wish to perform, and their level of functioning:

Our employment needs are extremely varied. In this sense, as in so many others it is unhelpful to think of us as a single group- the so-called mentally ill. Not only are there differences in the desire for... employment but also- and most crucially, for full and part time employment. At present, those who want part-time or flexible employment...often find themselves falling into a 'benefits' trap which destroys all incentive to make permanent employment a goal. (Ross et al., 1993, 327-328)

This raises another issue, the threat of losing DB Two benefits if residents apply for work. At present, people on DB Two can only work 20 hours a month (MSDES 1999). However Bill (DEMHT Director) notes that money is not the major issue, it is the social benefit of working, of improving your self-esteem, and of having the feeling that you are contributing something to back to society. In this context, working 20 hours a month can be enough to improve someone's self worth. Furthermore, due to the nature of their illness, many people may not be able handle more than 20 hours of work per month:
20 hours a month. It can be enough. It can make a difference. They're doing something. And not only that, it's something that they can handle as opposed to-a lot of - it may sound patronising but there are a number of clients who would want to take on more but wouldn't be able to handle it. If nothing else, it's a straight economic benefit. And I think there's a social benefit for many of them too. (Bill, DEMHT Director)

The one benefit of the DB Two system is that if people do find employment and subsequently- for whatever reason- leave their job, they are immediately entitled to get back on to DB Two assistance and receive benefits (MSDED 1999).

In an affirmation of Ross et al's (1993) observations, the residents of The Carrall note that the desire to seek out work is often inaccurately interpreted as the desire for full time work. If a full-time interpretation of 'work' is adopted by mental health workers and mental health agencies, then it will lead to practical difficulties in meeting the residents' needs. This is because the mental health worker may be thinking: "How do I link my clients to full-time work, when I know that they may be incapable of holding down a full time job, and knowing that I would have difficulty finding someone to hire them?"

In fact, the opposite is true. Most residents want part-time, occasional employment that provides them an opportunity to work when they are able, and offers them a feeling of self-fulfilment. In this case, the role of the mental health worker is to seek out employers who are willing to hire people on a sporadic basis. This is no easy task, given the societal norms that govern employment and work hours. Most part-time positions demand a seventeen to 20 hour work week. DB Two recipients are limited to 20 hours of work per month. This reduces the likelihood that mental health workers and mental health agencies will find employers in the community who are willing to provide work to the mentally ill.

Max (Carrall Resident) speaks to these issues, and offers a utopian solution:
They’re insisting on having housing for the lunatic. So I think that this is a compassionate approach. It’s good. But they can’t figure the more complex matter of how to make a person fulfilled and productive and at least having this part of the community and relatively free and sort of self-sufficient, is far better.

If they had a series of choices. And then they could come to this housing operation or that housing operation by getting on some kind of a transport, that would leave regularly from part of the organisation to the other, then there would be those moments of opportunity where a person might say, I want to get up everyday at 10 o’clock and at one o’clock I’m going to go to work- maybe in a shop, fixing furniture, small engines, whatever. Some kind of a shop where you have a lot of people who know what they are doing and willing to teach a new guy every half hour. But that obviously is a utopian image. That would be extremely expensive and would generate outrage in the rest of society. (Max, Carrall Resident)

For Max, the ideal solution to the problem of work is to have one umbrella organisation that offers work opportunities to the mentally ill, and that allows them to work at the job that they want, when they want. A utopian solution to be sure, but it emphasises the problem of finding flexible and meaningful work for the mentally ill. Lee (Carrall Housekeeper) notes that not enough has been done to meet the employment needs of the residents:

But I think if we could help them get educated a bit more, and help them jobs it’d be great. One day a week, two hour job, you know? Just to give them some independence, you know? I know that there are some services, but there’s not enough. Because I always hear residents asking about it. And there’s not a lot to get people in involved that much to help them. I’ve met a few people who have started their grade twelve and everything, and they need some help. (Lee, Carrall Housekeeper)

James (Carrall Resident), notes that in terms of vocational training, he would not be able to handle a classroom environment. The ideal solution would be to create a fund for hobbies and offer in-house courses, to enable people to build on their skills:

But a little fund for projects. There are a few people in here with mechanical skills, so possibly they could use it. Everybody here pretty much wants to get into electronics, and includes me. But there’s just no money for projects like that.
I was thinking more in-house, yeah. It would be nice to take courses. But the idea that most people have of courses is that they get 40 students and slap them into a room and then lecture them or something. It's sort of a general social phobia I would think. I just don't like hanging around with strangers especially. (James, Carrall Resident)

Jack (Carrall Resident) echoes this sentiment, but notes that many residents would not be motivated to engage in classes and hobbies. Rather, the staff should make a concerted effort to have residents take part in extra curricular activities, such as volunteer work. In Jack's view, volunteering will help people deal with their mental illness, improving their sense of self-worth and self-esteem:

They should have hobbies- a hobby night. There are just not enough interested people. It's lethargy- people are just sitting like vegetables and never going out. They should strive to get some of these people out, even for just a walk, or a picnic. All this helps to build their self-esteem. Some of us are capable of volunteer work- we can work with older people, and help them out. Learning and helping, that would improve our self-esteem. Mental agencies need volunteers. There are people in wheelchairs who need help. Getting out for them is a breath of fresh air, it makes them smile. Getting out makes a world of difference- both for us and the people we could help. Someone with depression should be able to do something good for their self-worth and self-esteem. (Jack, Carrall Resident)

Allan (Carrall Resident) wants to improve his quality of life, but feels that there are not enough avenues open to him. He believes that the residents are underrated in their abilities, and do not have the opportunity to pursue their own interests. He states that each resident should have a 'profession,' based on their ability to work at what they are good at. Residents should be given the choice to do what they want to do, and should not be confined by the limits of mental health agency conceived employment programs:

I'm trying to improve the quality of life but it seems like I'm just not accomplishing. I'm barely accomplishing it. Like I have no avenues. I figure that we should each have a profession. This is the first time in my life basically that I've had a chance to really get back to the things that I want to do. If it's just somebody else's persona projection on you, that you're buying into I mean you're not going to be happy with what you're doing. We're all terribly underrated. (Allan, Carrall Resident).
It is useful here to differentiate 'choice' from 'aspiration.' I use the case of Max (Carrall Resident) to illustrate this point. When Max fell ill, he was pursuing a university degree. He was brought up in an environment that encouraged the pursuit of higher education. Given the nature of his mental illness, and the fact that he is on income assistance, he is unable to pursue university studies. The issue of 'choice' needs to be qualified. At one point Max aspired to pursue higher university education. Now, his education and employment expectations are lower. The range of vocations available to him is determined by his mental illness and his socio-economic status. Therefore, the vocational aspirations of residents are not reflected in the employment and training opportunities that choices that are in fact available to them:

I'm looking into the Cambie Trade School. They have a list of course offerings. Some of them are kind of light, and are just an activity. And some of them are actual training.

When I was first really sick, when I was about 20, or 21, I was in university, studying a Bachelor of Music Education. Because that's the way I was brought up. I was brought up to get a BA, an MA and a PhD. I was brought up to live in a certain kind of society. I was brought up to believe in a certain kind of social interaction which is primarily intellectual, based on a grasp of the idiom of discussion of our modern society, and all the books that are published and the magazines and the general thought and concepts of the universities and so on. And it's absolutely impossible to enter that. I could not possibly aspire to be a member of that society. So it's- for me it's the attempt to get in on the lowest level of functioning in society. (Max, Carrall Resident)

The extent to which residents of The Carrall have access to employment is a function of their illness, income assistance restrictions, and mental health agency resource constraints. Depending on the nature of their illness, some residents may not want to work, or only work for several hours a week. If they wish to remain on DB Two, then the amount they can work is restricted to 20 hours per week.
The number of residents who wish to find work determines the number of jobs that The Carrall's staff have to find. While it is conceivable that the residents will look for work independently, in practice this is highly unlikely. Unpleasant job seeking experiences and the desire to avoid public stigma dissuade many residents from actively seeking work. Wagner (1993, 69) notes that most people who are poor, suffering from psychological distress, and are dressed inappropriately, "will be hastily shown the door, if not a paddy wagon" when they show-up looking for work.

The task of finding employment opportunities falls on the staff. Budget limitations prevent The Carrall from providing 'in-house' vocational experiences. It is conceivable that The Carrall's expertise at outsourcing for food could also be applied to networking for job opportunities. However, the benevolence of businesses to offer food and their willingness to hire an ex-mental patient are two different matters. It may be a 'hard sell' to overcome people's stereotypes and convince them to give a mentally ill person a chance. Indeed, the time required for 'employment outsourcing' may be too much of a burden on The Carrall's staffing resources. As previously noted, The Carrall was short of staff, and only recently offered assistance with DB Two applications. There are clear limits to what the staff are able to accomplish:

It's important that they [residents] understand that there are limits to the resources we have, and that we are fair minded in our division of those resources, and that we in addition to saying yes, we can say no. (Winston, Carrall Supervisor)

The ideology of empowered 'consumer' employment and the reality are indeed two different things. As Morgan notes (1993), bold policy statements may look good on paper, but practice, not rhetoric, is required to meet the needs of the mentally ill.
As McLean (1995, 1065) notes, structural conditions impede "the establishment of the idealised conditions of empowerment" (McLean 1995, 1065).

In the case of The Carrall, a lack of resources represents the biggest obstacle to resident employment. In addition, the rhetoric of consumer employment has yet to be empirically validated. There are few examples in the literature of successful workplace initiatives for low-income mentally ill SRO residents. Clearly, devising an employment strategy that accommodates the needs of The Carrall's residents will prove a difficult, yet potentially valuable task.
Chapter Four: Conclusion

This thesis has offered an account of the nature of the social supports of mentally ill residents at The Carrall, a Downtown Eastside Vancouver SRO hotel. Its goal has been to assess, from the perspective of the residents of The Carrall and the mental health workers who work with them, the extent to which these social supports meet their needs.

The Carrall's approach to mental health care is modelled after the strengths assessment (SA) model, an empowerment oriented approach to mental health care. This thesis identifies inconsistencies between the theory and reality of empowered care for the mentally ill. I approach the inconsistencies and contradictions in mental health care from the perspective of 'interpretive dissonance.' Interpretive dissonance addresses the differences in the mental health workers' and residents' understanding and perception of the needs of the low-income mentally ill and the goals of social support.

The empowerment model of mental health care, developed and promoted by mentally ill 'consumers', is premised on the principle that the mentally ill can reduce their reliance on health care professionals and take action on their own behalf. The empowerment approach is adopted by the mental health agencies in this study, and is manifest in Rapp's (1998) strengths assessment (SA) model of mental health practice. The six principles of SA include: 1) A focus on individual strengths, not pathology; 2) The community is an oasis of resources; 3) Interventions are based on client-self determination; 4) A close case manager-client relationships is essential; 5) Aggressive outreach is the preferred mode of intervention; and 6) People suffering from mental illness can continue to grow and change.
The above principles of SA are applied to six life domains: 1) Health; 2) Daily living situation; 3) Friendship supports; 4) Finances; 5) Leisure and recreational activities; and 6) Vocational and educational training (Rapp 1998). The extent to which the social supports of The Carrall meet the needs of the residents can be assessed in the context of these six life domains.

The domain of health focuses on issues of mental health, specifically issues of 'functionality' and 'decompensation.' There are differences in interpretation among The Carrall, The Main, and the DEMHT staff in regards to tolerance for decompensation and the criteria for the timing out of residents. The staff of The Carrall perceive timing out in the context of the hotel's supported living program. Residents are removed from the program when their behaviour adversely affects the other residents and the staff's ability to support their needs. In some instances, the staff at the DEMHT attribute less severity to the mental crises of timed-out residents than do the staff at The Carrall. The interview data suggests that the impact of timing out is detrimental to the residents.

If The Carrall staff's assessment of decompensation is not equivalent to DEMHT and hospital criteria, residents who are timed out enter a 'nether region' of mental health care, where they may drop out of the 'system' and lose their access to social support.

Few people who are timed out of The Carrall return to the hotel. As Jane (The Main, Director) notes, people will move from the shelter system to poorly run SROs, or possibly become homeless. This further jeopardises the health of the mentally ill, and leads to a paradox in mental health care. The mental health system is designed to help people in crisis. Yet when agencies disagree on the severity of one's mental illness, the mentally ill run the risk of being ejected from the system.
In the context of the empowerment oriented ideals of self-determination and user-led involvement, there is little evidence to indicate that the mentally ill have any meaningful input or control over what happens to them when they decompensate and suffer an acute mental crisis.

The domain of daily living is assisted with the provision of food. Residents spend less of their disposable income on food because meals are provided at The Carrall four nights a week and on Sunday mornings. This allows residents to divert their funds to the purchase of other items. Because the meals are offered in-house, the residents do not rely on soup kitchens for their food. This adds an element of safety to their lives, since the mentally ill are common targets of violence at Downtown Eastside soup kitchens.

Nevertheless, there are negative aspects to food provision at The Carrall. The Carrall is wholly dependent on food banks for its food program. Therefore, neither the staff nor the residents have any input into the type of food that is supplied. The hotel receives a fair amount of junk food, and the main meals consist largely of processed and pre-made foods. Some of the residents interviewed expressed concerns about the nutritional value of the food provided to them. The quality of the main meals is further exacerbated by resource constraints at the hotel. The lack of proper cooking facilities and implements limits the ability of the staff (and the residents who help them) to properly prepare meals for a group of 40 to 50 people.

Problems in daily living stem largely from the violation and enforcement of The Carrall's house rules. The rules are enforced differently according to a resident's level of functioning. Lower functioning residents are treated with greater leniency than higher functioning residents. Given the mix of high and low functioning residents at The Carrall,
some residents, such as Bryan, interpret the enforcement of rules as preferential treatment. This results in conflicts between the residents and the staff. These conflicts stem from a lack of communication between the staff and the residents concerning the staff's approach to supported living and their attitude towards rule enforcement. The staff approach to rule enforcement is premised on an empowerment approach that encourages the residents to resolve their own conflicts. This approach is not clearly articulated to the residents, and in many cases, they are not able to effectively mediate disputes. This is exacerbated by the fact that the residents are not involved in the rule making process, and do not have a stake in rule adherence. If residents were more involved in the rule making decisions of The Carrall, a greater degree of dialogue and understanding between residents and between staff as to the goals of the rules and rule adherence could be established.

Friendship supports are a source of informal tangible, emotional, and informational help. Residents form trusting bonds among each other through the reciprocal borrowing and lending of cigarettes, money, and other resources. Emotional support is given between residents in the form of mutually supportive friendships that mirror a 'family-like' environment. When people are feeling down, they can count on others for help. Informational support is provided in the exchange of information about welfare and community resources that help the residents to seek out agencies that provide services that will meet their needs.

Financial support has a direct impact on the residents' level of income. Mental health workers have an intricate knowledge of the income assistance program and the DB Two application procedure. They coach physicians on what terminology to use for DB
Two applications and achieve a high degree of success with the applications they submit on behalf of the low-income mentally ill. The MSDES has a cost containment practice of denying applications made directly by an applicant. Therefore, 'professional' assistance with the application procedure is essential to securing DB Two benefits approval.

Leisure and recreational activities, such as outings, offer the residents an opportunity to get out of the Downtown Eastside and to socialise with each other in different social milieus. However, little contact is made with the general public. Outings are supervised by activity workers and the residents interact only among themselves. Drop-in centres such as The Main and The Burrard cater specifically to the mentally ill, and offer a variety of 'in-house' activities. Drop-in centres and supervised outings are criticised by some who adhere to the empowerment model. The empowerment model encourages the mentally ill to use public community resources independently. Drop-in centres foster a dependence on artificial social networks and discourage residents from using establishing 'real' social networks in the community.

However, critics note that the empowerment model fails to take into account that many mental ill people avoid public settings because of the stigma and discrimination they experience in the community at large. Encouraging the mentally ill to use public settings maybe necessary, but not sufficient to encourage community integration. Stigma reducing interventions that seek to challenge public perceptions of the mentally ill have met with limited success. Furthermore, the assertion that drop-in centres foster artificial social networks is inaccurate. Mentally ill people do foster friendships in drop-in centres that exist outside of the drop-in environment and in the community. In any case, the
mentally ill should not be criticised for establishing friendships in trusting and accepting environments. Given the persistent stigma of mental illness by the public at large, empowerment adherents who place the onus of community integration on the mentally ill engage in little more than 'blaming the victim'.

Evidence from this thesis indicates that employment has a positive effect on the self-esteem of the low-income mentally ill. The empowerment approach to employment and training initiatives is geared towards the community integration of the mentally ill and the fostering of greater economic independence. In theory, mental health workers will liaise with community employers and seek out jobs that will meet the needs and abilities of the mentally ill. In reality, many mentally ill people cannot hold down conventional full or part-time jobs and lack the qualifications to compete with the public in the open job market. This limits the types of jobs that they are qualified to work for. Furthermore, MSDES income assistance restrictions limit the amount they can work to 20 hours per month.

In order to maintain their income assistance benefits, most residents will seek occasional employment of four to five hours per week. Previously unsuccessful attempts at finding work, coupled with social stigma, discourage the mentally ill from actively seeking work. The responsibility of liaising with potential employers thus falls on mental health workers. The staffing resources of some agencies, such as The Carrall, are limited. This places an added stress on mental health workers who may experience difficulty liaising with employers who are willing to hire a mentally ill person for only a few hours per week.
It is clear that the goals of the empowerment model of mental health practice have yet to be achieved. Indeed, we must assess the extent to which the goals of the empowerment model are even feasible or realistic. First, the concepts of 'user' self-determination and user led programs require major qualifications. This thesis provides little evidence to suggest that the residents of The Carrall are actively involved in the operation and decision making processes of the hotel. The empowerment model does not provide a framework for creating bona fide user led mental health programs that have users in positions of power and authority.

In other words, many mental health agencies hire people with a history of mental illness, but few programs employ the users of these programs or provide them with positions of authority.

The closest example of user self-determination is offered at The Burrard drop-in centre. The rules of The Burrard are devised by the mentally ill who use the drop-in. This provides them with a sense of ownership in the centre. However, their decisions must be approved by the staff. Even in this case, it can be argued that the real decision making power rests with the staff.

Second, resource constraints limit the amount of services that mental health agencies can provide to the mentally ill. There is a utopian undertone to the empowerment model which assumes that its postulates can be effortlessly acted upon by mental health agencies. This is clearly not the case.

Third, the effectiveness of the empowerment approach is heavily dependent on the level of functioning of the individual. High functioning people are likely to meet and exceed the goal of reducing their reliance on mental health professionals. On the other
hand, low functioning people will remain dependent on mental health professionals and mental health agencies to adequately meet their needs.

In this respect, the needs of individual residents are over-looked by the uniformity of social support services. Some residents are satisfied with the level of support provision at The Carrall, while others are not. Staffing and resource constraints at The Carrall make it difficult to cater to individual residents' needs. Claims that the empowerment approach is in fact empowering bear closer scrutiny.

The application of the SA model in mental health settings has met with limited success. A lack of user self-determination, resource strains, and the varying functioning levels of the mentally ill complicate the ability of mental health workers to meet the needs of the residents. When the results do not reflect the ideals, a condition of interpretive dissonance is created, where the service expectations of the mentally ill exceed the ability of mental health workers to meet them.

This thesis offers only an exploratory analysis of the social supports of mentally ill SRO residents. Much work remains to be done. The concepts of empowerment and ownership in mental health and other helping services have not received adequate treatment in academic literature. The concept of the mentally ill taking ownership over the services they use is vague. It works well as a rhetorical device to promote the empowerment model, but there is little clear evidence of 'ownership' in mental health practice.

In the first instance, does ownership mean that mentally ill people should be trained to administrate mental health services? Or does it mean that they are given a say, such as in the case of The Burrard Drop-in Centre, on how programs are run? Academics
tend to equate empowerment and ownership with 'choices,' service satisfaction, and overall life improvement. For example, in Glasser's (1988) ethnography of a soup kitchen, she claims that the low-income poor who use the soup kitchen have 'power' because the soup kitchen offers not just food, but an opportunity to socialise, feel accepted, and develop meaningful friendships. While these facets of the soup kitchen have positive social outcomes for people, there is little evidence in Glasser's (1988) study to suggest that they exercise any power in the soup kitchen or over the other helping services that they use.

From the perspective of the low-income mentally ill, 'ownership' and 'empowerment' pertain to choice and consultation rather than active control or involvement in the helping services that they use (illustrated in Ross et al., 1993). Indeed, the residents at The Carrall expressed little desire to take an active role in the administration of the hotel and expressed more concern with the extent to which the services they received met their needs.

In the context of dissonance, there is a discrepancy between the theory and practice of the staff's approach to mental health care at The Carrall. The notion that the residents are the 'boss' and that the staff work for the residents implies that the residents exercise control over the administration of the hotel's supported living program. This is clearly not the case. The staff determine the parameters of the support provided, set the rules and enforce them.

In my interviews, the staff promote some aspects of The Carrall's supported living program (i.e. food provision) in a rhetorical nature. They assume that by virtue of the fact that services exist to help the low-income mentally ill, the residents will find these
services beneficial and useful. For example, all of the staff speak of the benefits of food provision, but resident interviews and participant observation data speak to the low quality of the food and the difficulties associated with meal preparations. This highlights a discrepancy in service provision that is attributable to a lack of communication between the staff and the residents about the goals of the hotel's supported living program. In addition, this shows the impact that resource limitations and constraints have on the quality of support that a supported living program is able to provide. Closer communication between the staff and the residents concerning these limitations may help to foster mutual understanding and alleviate the amount of dissonance between the two groups.

Future research on the social supports of the low-income mentally ill must seek to compare and contrast different approaches to supported living programs, and the social supports of SRO residents who live in both supported and non-supported environments.

Are there supported living programs for the low-income mentally ill that are better attuned to the needs of residents? Are there supported living programs that give the mentally ill ownership and control over the services they use? What are their similarities and differences to other programs? What makes them work? There are few ethnographies of supported living programs and even fewer that compare the social situations of the low-income mentally ill in supported and non-supported living situations.

What are the needs of SRO residents in non-supported housing? How do they access social support and how do they interpret the quality of the supports they receive? Do these supports adequately meet their needs?
The social support needs of the low-income mentally ill vary according to their social and residential living environments, as well as the acuteness of their mental illness. The findings of this thesis demonstrate that different residents have different needs. Resource constraints limit the ability of helping programs to adequately meet the needs of individuals. As governments cut funding to mental health programs, they will have to seek more assistance from the community at large. In order for community outreach to be successful, stigma reducing strategies aimed at changing negative public attitudes towards the mentally ill must be devised. The evidence to date suggests that these strategies have met with little success. Creating social support programs to meet a diversity of mental health needs will thus prove a challenging endeavour.
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Interviews

Community Activist Interviews

'Andrew' - February 26, 1998
'Brenda' - March 26, 1998

Carrall Staff Interviews

'John' - Carrall Staff - August 12, 1999
'David' - Carrall Staff - August 18, 1999
'George' - Carrall Staff - August 20, 1999
'Peter' - Carrall Activity Worker - August 23, 1999
'Winston' - Carrall Supervisor - August 25, 1999
'Lee' - Carrall Housekeeper - September 2, 1999

Carrall Resident Interviews

'Max' - September 8, 1999
'Bryan' (Interview 1) - September 10, 1999
'Bryan' (Interview 2) - October 22, 1999
'James' - September 21, 1999
'Allan' - September 28, 1999
'Jack' - October 19, 1999

Community Mental Health Agency Staff

'Bill' - DEMHT - September 22, 1999
'Jane' - The Main - October 12, 1999
'Bernard' - The Burrard - October 20, 1999
Appendix I: Sample Interview Questions

Appendix Ia: Sample Interview Questions, Carrall Residents

1. How long have you lived in the Downtown Eastside?

2. How long have you lived in The Carrall?

3. Where did you live before coming to The Carrall?

4. How did you hear about The Carrall? Why did you apply?

5. What are your sources of income? How much do you receive per month?

6. How much do you spend on food/utilities?

8. Describe your apartment - and living conditions. Are you satisfied with your living conditions - why or why not?

9. What is your daily routine? Describe your average day - where you go, who you see, what you do.

10. Describe your relationships with other tenants at The Carrall. How often do you see or speak with your neighbours?

11. Describe some of the problems you have had to deal with in the past, or that you are presently dealing with (health problems, money problems etc).

12. How do you cope with these problems? Who do you go to for help? Do you receive help from neighbours and staff at The Carrall? Do you receive help from other people and places in the Downtown Eastside?

13. What kinds of help do you receive? Does this help meet your needs and assist you in dealing with problems that you may experience?

14. Do you help other residents with their problems? In what ways do you provide help? Do you help other people in the Downtown Eastside? How?

15. Comment on any improvements to services you would like to see at The Carrall or in the Downtown Eastside.
Appendix Ib: Sample Interview Questions, Carrall Staff

1. What is your position at The Carrall?

2. What types of services do you provide to the tenants?

3. Describe the mandate / philosophy of The Carrall.

4. What are the needs of residents?

5. What types of problems do residents commonly experience (i.e. mental health, social, economic)?

6. What role do Carrall staff play in helping residents meet their needs and cope with problems?

7. Do residents help each other with problems? How? How often do residents interact with each other?

8. Do you feel that residents have an attachment to The Carrall and to the Downtown Eastside? Why or why not? If so, describe the nature of these attachments.
Appendix Ic: Sample Interview Questions to Community Mental Health Workers and Activists

1. How long have you worked in the Downtown Eastside?

2. What type of work do you do in the Downtown Eastside?

3. What is the official mandate, purpose, or goal of your organisation?

4. What types of services does your organisation offer to Downtown Eastside residents?

5. What types of problems are people coming to you for help? How do your services help them with these problems?

6. When providing services and/or assistance, do you or your organisation act outside of your mandate or purpose? If so, how?

7. How would you describe the Downtown Eastside? Do people have attachments to each other? Why or why not? If so, describe these attachments.
Appendix II: Contact Letters

Appendix IIa: Carrall Resident Contact Letter

I am a graduate student in the Department of Anthropology and Sociology at the University of British Columbia. I am working with the approval of The Carrall on a project which is looking at how Carrall residents give and receive help in the hotel and in the Downtown Eastside neighbourhood.

I would like to interview you about the types of help you give or receive in The Carrall hotel and in the Downtown Eastside.

The interview will last about one hour.

I do not need your real name or any other information which could publicly identify you. I will not tape record the interview without your permission. You may refuse to do the interview, or end the interview at any point.

If you have any questions, please contact my supervisor, Dr. Gillian Creese, Department of Anthropology and Sociology, University of British Columbia, 822-2541.

I will contact you in approximately one week to discuss your potential participation in this research. Thank-you.

Kareem Sadiq
Appendix IIb: Carrall Staff Contact Letter

I am a graduate student in the Department of Anthropology and Sociology at the University of British Columbia. I am working with the approval of The Carrall on a project which is looking at how Carrall residents give and receive help in the hotel and in the Downtown Eastside neighbourhood.

As a staff member of The Carrall, I would like to interview you about the types of support you provide to The Carrall's residents.

The interview will last about one hour.

I do not need your real name or any other information which could publicly identify you. I will not tape record the interview without your permission. You may refuse to do the interview, or end the interview at any point.

If you have any questions, please contact my supervisor, Dr. Gillian Creese, Department of Anthropology and Sociology, University of British Columbia, 822-2541.

I will contact you in approximately one week to discuss your potential participation in this research. Thank-you.

Kareem Sadiq
Appendix IIc: Mental Health Worker / Community Activist Contact Letter

I am a graduate student in the Department of Anthropology and Sociology at the University of British Columbia. I am working with the approval of The Carrall on a project which is looking at how Carrall residents give and receive help in the hotel and in the Downtown Eastside neighbourhood.

As a member of a community/social service organisation in the Downtown Eastside, I would like to interview you about the types of help you provide to Downtown Eastside residents.

The interview will last about one hour.

I do not need your real name or any other information which could publicly identify you. I will not tape record the interview without your permission. You may refuse to do the interview, or end the interview at any point.

If you have any questions, please contact my supervisor, Dr. Gillian Creese, Department of Anthropology and Sociology, University of British Columbia, 822-2541.

I will contact you in approximately one week to discuss your potential participation in this research. Thank-you.

Kareem Sadiq
Appendix III: Consent Forms

Appendix IIIa: Carrall Resident Consent Form

Helping in the Community

I am a graduate student in the Department of Anthropology and Sociology at the University of British Columbia. I am working with the approval of The Carrall hotel on a project that is looking at how Carrall residents give and receive help in the hotel and in the Downtown Eastside neighbourhood.

As a resident of The Carrall hotel, I would like to interview you about the types of help you give or receive in The Carrall hotel and in the Downtown Eastside.

The interview will last about one hour.

I do not need your real name or any other information that could publicly identify you. I will not tape record the interview without your permission. You may refuse to do this interview, or end the interview at any point. Your name will not appear in any publication or report that is a part of this research.

You will receive $15.00 for your participation in the interview.

I am available to answer any questions you may have concerning this research. If you have any concerns about your rights or treatment as a research subject, you may contact Dr. R. D. Spratley, Director, Office of Research Services, 822-8595. You may also contact my supervisor, Dr. Gillian Creese, Department of Anthropology and Sociology, University of British Columbia, 822-2541.

If you agree to be interviewed, please sign below. Thank-you.

Kareem Sadiq

I agree to be interviewed, and acknowledge receiving and reading the consent form.

Name  Witness  Date
Appendix IIIb: Carrall Staff, Community Worker Consent Form

Helping Networks of Carrall Residents

I am a graduate student in the Department of Anthropology and Sociology at the University of British Columbia. I am working with the approval of The Carrall hotel on a project which is looking at the helping networks of single resident occupancy (SRO) hotel residents.

As a staff member of The Carrall / community worker in the Downtown Eastside, I would like to interview you about your work and experiences with Downtown Eastside residents in SRO housing.

The interview will last approximately one hour.

I do not require your real name or any other information which could publicly identify you. I will not tape record the interview without your permission. You may refuse to do this interview, or end the interview at any point. Your name will not appear in any publication or report that is a part of this research.

I am available to answer any questions you may have concerning this research. If you have any concerns about your rights or treatment as a research subject, you may contact Dr. R. D. Spratley, Director, Office of Research Services, 822-8595. You may also contact my supervisor, Dr. Gillian Creese, Department of Anthropology and Sociology, University of British Columbia, 822-2541.

If you agree to be interviewed, please sign below. Thank-you.

Kareem Sadiq

I agree to be interviewed, and acknowledge receiving and reading the consent form.

Name ____________ Witness ____________ Date ____________