Riverview Village

An innovative, ground-breaking community for the Riverview Lands

Discussion paper by Herschel Hardin, July 2, 2014

We welcome your comments. Please address them to herschel@riverviewvillage.ca..

Herschel Hardin

Herschel Hardin is an author, playwright, and former broadcaster, newspaper columnist, economic historian, lecturer, community organizer, public policy and strategic-planning consultant, and corporate director, among other things in a long life. He has a son with schizophrenia, who had several long stays at Riverview Hospital. His son lived for a time, as well, in one of the Riverview cottages. Herschel, consequently, has a strong personal connection to the Riverview Lands.

For the better part of 25 years he has been active in the North Shore Schizophrenia Society (NSSS), in a variety of areas, including support, education, and advocacy, and has also been involved in issues affecting the mentally ill in other capacities. Working closely with his wife, NSSS's long-time support coordinator Marguerite Hardin – and through their son and other personal connections – he is intimately familiar with the severely mentally ill and with the struggles of their families in trying to help them get back on their feet.

He has, similarly, direct experience with general hospital psychiatric acute care wards (Vancouver General, UBC, St. Paul's, Lions Gate, Royal Columbian), mental health emergency services, community mental health teams, and police officers (in connection with the mentally ill).

He is the author of a bellwether commentary on involuntary admission, "Uncivil Liberties," first published in the Vancouver Sun in 1993. ("Uncivil Liberties" is accessible at www.northshoreschizophrenia.org/Uncivil_Liberties.htm.) The article makes the case for the use of involuntary admission where appropriate. It has been widely circulated both in Canada and the United States, and continues to be cited and reproduced more than 20 years after first publication.

He has made innumerable presentations on issues involving the mentally ill and on NSSS programs, to a variety of audiences -- mental health service providers, police forces, community agency workers, service clubs, other community groups, Family-to-Family (education course) classes, conference participants, and others.

A major and continuing role has been advocacy, including editorship of the *NSSS Advocacy Bulletin*. The *Bulletin*, with circulation across Canada and, in a few cases, in the U.S. and the U.K., discusses current issues, details system failures, and puts forward solutions. Back issues are accessible at www.northshoreschizophrenia.org/bulletin.htm.

From 2010 to 2013 he was NSSS president, and continues on the society's board. He is currently vice-president, advocacy coordinator, leader of NSSS's Support Team training, and co-chair of the Fundraising Team.

Riverview, the neighbourhood

The Riverview Lands offer an extraordinary opportunity for social innovation of great help to the seriously mentally ill and hence to all of us. The ground-breaking possibilities are compelling. It's an opportunity that should not be wasted.

We accordingly propose, for the Riverview Lands,a multi-use neighbourhood or village, with both mentally ill and non-mentally ill residents, whose leading objective is interaction between the two in a real community – a neighbourhood for the seriously mentally ill, but not exclusively of the mentally ill. It will also be designed to provide optimum opportunities for engaging its mentally ill residents in creative work and projects and in other ways that will enrich their lives. The neighbourhood, to be no larger in population than a village, will be pioneering a model for helping a cohort of the seriously ill in a new way, stemming from the interaction with others – a cohort for which other arrangements, from supported housing to Assertive Community Treatment teams, not to mention community mental health teams, don't manage adequately on their own.

The development of this unique model can be expected in turn to provide insights and experience to inform other possibilities elsewhere and generate spin-off ideas, both within the model and for others.

Wikipedia describes a village as "a clustered human settlement or community, larger than a hamlet but smaller than a town, with a population ranging from a few hundred to a few thousand." One of the benchmarks to establish, as we proceed with discussion of this idea, is the smallest population necessary to make the model successful, although without being limited to that number. Let's posit, for the moment, something in the range of 600 to 1,200 all told as a minimum, and take it from there.

We are going to describe, below, the starting point behind the concept – the problems and dilemmas the seriously mentally ill face – and then go on to discuss the model in outline, with their mental illness as the backdrop. Also covered will be the special kind of community planning required and the dynamics of the interaction and linkages envisaged. Please be patient with us, as it's important this background be explored and understood.

Having gone into the rationale of the concept and its dynamics, we then move on to the particulars of the proposed Riverview neighbourhood itself.

We'll close with a section on feasibility.

Note that in all this we take as a given that the needs of the most seriously mentally ill have priority for the Lands. Deinstitutionalization, with the gradual closing down of Riverview Hospital, has been disastrous for this cohort. We owe it to them to give them first dibs on the Lands and meet their needs.

Note, as well, this cohort, for which the proposed village is primarily meant, doesn't include those who are relatively high functioning and who interact well in the larger urban landscape,

although it will be open to some of them, too. The reference is to those particularly affected by residual (negative) symptoms and those with other chronic difficulties.

Starting point

The Riverview neighbourhood, or village, we want to see created begins with problems the seriously mentally ill face. These include, among other things, avolition (lack of motivation), limited interaction with those who aren't mentally ill, difficulties many of them have with substance abuse, dependence on the health system (community mental health teams, ACT teams, and so on) for most of their support, limitations of support by even the most committed of family members, and the narrowing of a sense of challenge and accomplishment because the residual symptoms of their illness may hold them back.

The interactive neighbourhood community we are proposing is aimed at changing those parameters and providing social animation to engage and integrate this cohort of the mentally ill and broaden their horizons.

A new model

Schematically, we can say there are currently two basic models for living situations for the seriously mentally ill. The first is the one embodied in the old Riverview Hospital and other provincial mental hospitals before anti-psychotics and acute-care psychiatric wards in general hospitals existed. The provincial mental hospital was all "in-house," with services, such as a barber and dentist, and activities, such as working at Colony Farm or doing crafts, all within the hospital structure.

A rural community for the mentally ill based, say, on the Camphill example – gardening, art, music, crafts, theatre, exercise, household chores, comradeship and play in a quasi-utopian setting, would schematically fit in this category, because it, too, would be self-contained.

The second is the so-called "deinstitutionalization" model, where the seriously ill in an acute phase are treated in acute-care wards and then discharged back into the "community," with support where available and needed. If they are particularly hard-hit and slow to respond to treatment, then they're moved to a tertiary treatment facility or refractory (now called "B.C. Psychosis"), but the aim is always to discharge them once they're stabilized. "Integration into the community" is the motto. The assumption is that everyone can get there – that even with very limited expectations and limited routines, they'll recover and self-actualize in their own way.

Long-term tertiary care, in this model, still isn't considered permanent or long-term in any definitive way. Program activities and utilization of services – say art classes or clubhouse visits, or small bits of work responsibility – are largely elsewhere and are seen as gradualized steps towards integration in the urban landscape. Anything else would be seen as turning one's back on the "recovery model," where integration out and beyond is the sought-after outcome. Similarly, having an appreciable number of mentally ill living in a single area, as different from locating them in living quarters spread out in the Lower Mainland at large, is condemned as

segregation unless, that is, the concentration is unplanned, when it isn't segregation but just one of those things, and technically still qualifies as "integration into the community").

"Integration into the community" was the same rationale for the setting of a six-month limit for stays at the Burnaby Mental Health and Addiction Centre for concurrent disorders, this limit then extended to a year, and may have a bit of flexibility added to it even then. The expectation remains that patients there will be reintegrated – must not even be seen as patients but as "consumers."

This so-called integration model, then, covers a diverse spectrum – from those who do well on their own or supported by a community mental health team; those who live in a group home, in a dedicated apartment building for the mentally ill, in a shared house, on their own in "semi-independent living", in a care home for seniors although not old enough to otherwise qualify, or in more cases than is imagined, with their parents; through to clients of assertive community treatment (ACT) teams, sometimes described as a "hospital without walls," where care is available around the clock although the client, really the "patient," doesn't live in a hospital at all.

Sometimes, however, this model doesn't work. Many ill people end up in the streets. Substance abuse (concurrent disorder, dual diagnosis) of the mentally ill is widespread, affecting as many as half of those with serious mental illness. The leading question we have to ask ourselves, however, when assessing the "integration into the community" model, is quite different: Patients discharged from acute care or from a tertiary facilities are taken as being integrated in the "community" simply because they are no longer in a treatment facility, but how integrated are they really, other than physically living elsewhere than in the facility? The question is especially relevant for those with schizophrenia. How much do they participate in the community with others who aren't mentally ill? How many non-mentally-ill friends do they have? Are they working, even part time, or participating in volunteer activities? Do they, instead, spend most of their time sitting around, drinking coffee, smoking, and watching television, or in a corner with a computer, hooked to the Internet, which isn't integration into the community at all, but more abandonment of them or warehousing them? Next to this, a decent psychiatric residential hospital with a regular structure and a diverse range of programs would be a relatively stimulating environment. Is living in a group home and going every weekday from there to a clubhouse specifically designed for the mentally ill, where they can be comfortable and not have to compete socially, any the less segregation than living in a community of the mentally ill?

There is, of course, as already mentioned, a clinical cause for the limitations of this model when it comes to the seriously ill, especially those with schizophrenia, namely the illnesses themselves. In the case of schizophrenia, for the most seriously affected, there are the residual long-term "negative" symptoms – lethargy, lack of motivation, inability to plan and follow through systematically, metabolic syndrome (physical consequences of the illness) - and perhaps, added to this, the sedative effect of their medication. As yet, there is no medication for these "negative" symptoms – no equivalent to anti-psychotics for psychosis (the so-called "positive" symptoms) – and other treatment programs for these symptoms, like cognitive remediation, while useful, have limited scope and may not be readily available. Anxiety and chronic depression are also severe limiters. Gaps in social development, especially with schizophrenia which, in males, often hits in the teens, also can limit interaction with others.

What we are proposing here, for the Riverview Lands, is a third model, the creation of a mixed neighbourhood specifically designed to encourage the interaction of the seriously mentally ill with others, which means in practice a neighbourhood planned with the mentally ill foremost in mind. This model incorporates the idea of a larger population of the mentally ill on the Lands than currently exists, the number being determined by how the model develops. Like all new models, it is an experimental model, deriving from a formative concept, but open to change in its details.

It is inspired by two other examples. The first is the Camphill movement for the developmentally disabled, whose premise is that given a community of their own with programs that respect and engage them, they can flourish and blossom. The second is Geel, Belgium, where interaction of the mentally ill from an infirmary (asylum) with others in the larger community goes back to the 13th century: Patients went out into the town during the day and returned to the asylum at night. Subsequently, as the number of patients rose, Geel established a foster system, where ill people were fostered in the homes of Geel citizens, sometimes for their whole lives.

Our Riverview neighbourhood model, however, while inspired by those two examples, is different in kind – a new model.

Creating a liveable neighbourhood

Without creating a liveable neighbourhood or village in connection with the severely mentally ill who may reside at Riverview, we run the risk of duplicating the downside of institutionalization without the advantages of major institutionalization represented by the old Riverview Hospital. The Riverview model has been dismissed as old-fashioned institutionalization removed from community. Even with the advent of anti-psychotics, this underestimated the value of Riverview as a dedicated place for the most seriously ill. It also underestimated how much of a community Riverview was in its original conception and with its growth through to the 1950s when it reached its maximum population of 4,630 patients. You can't have that many people, plus hospital and other staff, without constituting a "community" or village, really a small city, for better or for worse.

A community has workplaces, social meeting places, services, and mixed housing. Riverview Hospital, which was much more than a hospital, did have some of that – a farm, workshop/ occupational therapy, recreation hall, nurses residences, employee cottages, soccer and baseball fields, a tuck shop, and a credit union. Some of the patients' workshop products, incidentally, were of very high quality.

Take away all those activities and meeting places and you're left with something vulnerable to warehousing, although mitigated by recreational programs organized by residence staff. This was apparent in the latter years of Riverview Hospital. The range of activities available to patients in those years, with patient population just a fraction of what it had been, was narrower than in the original Riverview model.

Work and play

Integral to life in a village, and to lives lived anywhere, are work and play. The seriously ill, especially those who are refractory, have limited functioning. How limited, though, does it have to be, if residents are given a hospitable and creative environment? The question is both clinical and environmental. In creating a "village" for mentally ill residents, the planning process would keep their possibilities for participation foremost in mind, with a view to helping their lives develop to the fullest. This includes the possibility of paid work.

Let us give you an example, an anecdotal story that family members (those with an ill relative) who have heard it will not likely have forgotten. Some time ago, Vancouver psychiatrist Phil Long took a group of his more serious long-term patients to Hawaii on a holiday, to broaden their horizons and give them a good time. Instead of exuberantly exploring the holiday location, however, they spent an inordinate amount of time hanging out in their hotel rooms. Part of the reason was their residual, long-term "negative" symptoms, outlined above, combined with anxiety in the face of unfamiliar surroundings. Another part of the reason, though, would be the environment – a tourist locale catering to tourists but not to this cohort who were tourists of a different kind.

This wouldn't have come as altogether a surprise for many of those with a severely ill relative, even when the ill person no longer has psychotic symptoms.

Here is the challenge for us in developing a new Riverview neighbourhood – to create it in such a way that it will address those residual symptoms as well as addressing the primary symptoms of those whose psychosis hasn't altogether cleared up. What would optimize their participation and creativity while still keeping them safe? What would facilitate their making connections outside the ones in their residence or in other units where they are living? What would make it easier for them to deal with clinical obstacles, say anxiety, for example, so as to facilitate and encourage connecting with others and participating in new work and leisure activities?

In summary, the Riverview Lands surrounding long-term residences for the mentally ill should be developed with the mentally ill specifically in mind, in such a way that residents are able to tap into a wide range of work and leisure activities and develop capacity. This would include linkages to the Riverview "neighbourhood" or "village" around them that would help overcome the effects of their chronic residual symptoms.

A secondary premise of this model is that program activities of dedicated residences, such as the current Connolly Lodge and Cottonwood Lodge, while useful, cannot in themselves offer what might be described as "larger community" – the development of natural, spontaneous, and evolving relationships with non-mentally-ill people and the larger environment. A larger community, but developed always with the mentally ill in mind, will ideally provide the kind of dynamic where mentally ill residents' participation and development will have an optimal chance to grow and take more individual paths. Existing programs (e.g. visits to a clubhouse, art session in town) and the neighbourhood envisaged here will complement each other.

Population make-up and acculturation

The three Fraser Health lodges currently on the Lands are tertiary facilities with a treatment framework, where residents are expected eventually to move “into the community.” The housing for the mentally ill in this proposal, by contrast, will be “permanent” homes in the same way that a placement in supported housing in the Tri-Cities and elsewhere would be considered home. The Riverview Lands will be their neighbourhood and community.

As envisaged, there will be at least some housing for those mentally ill who are higher functioning and who choose to live in the area, although the main cohort will be those who are more seriously affected. In both cases, they will have the same health-authority and housing-society support they would get living anywhere else, from community mental health teams through to assertive community treatment and 24-hour housing supervision, on a spectrum, depending on their needs.

Their housing will also be intermixed with other housing in the neighbourhood in a variety of different ways – units in mixed housing (equivalent to “semi-independent living” elsewhere), small constellations within the neighbourhood at large, and dedicated larger constellations (equivalent to dedicated apartment buildings elsewhere) – again reflecting needs.

All of these cohorts will be plugged into their neighbourhood just as much as they would be if they were living in, say, Vancouver – indeed will be plugged in more because the neighbourhood will have been created to accommodate and engage them, which is the point. It will optimize interaction in the same way that someone living in a small town may know many more people and be involved in a lot more activities than if they were living in a large city, where even those without an illness may feel isolated.

Unlike a random neighbourhood in Coquitlam, Port Coquitlam or elsewhere, however, those living or working in the neighbourhood who are not mentally ill will have a commitment to the project and to the mentally ill, beginning with openness, interest, and respect through to close working and social relationships. The commitment may arise from having a family member or close friend who is ill, from having worked with the mentally ill in other circumstances, or from sheer interest, idealism, or spirit of creativity.

In all cases, though, with minor exceptions, the non-mentally-ill will be given a grounding in mental illness, its symptomology and course, treatment and how it works, the signs of relapse and their seriousness, dangers of street drugs for the mentally ill, the trauma of falling mentally ill, empathy, how to communicate with someone who lacks insight or who is agitated, an understanding of the mentally ill’s sometimes constant struggle, and what are realistic expectations.

This training, and the interaction with those who are ill, will bring another advantage – their being able to help by noticing troubling symptoms or when they have other concerns, by contacting mental health service providers in much the same way as involved family members would do, or by getting together to help someone when appropriate. The neighbourhood would bring the strength of community to helping the seriously ill do well.

A given in this proposal is that community activities, from a chess club to soccer games to governance, and also work possibilities, shall be as inclusive as possible and be managed assertively for that end.

We can call the process of how this relationship with mentally ill residents will evolve the "acculturation of the neighbourhood" The community that is created thereby we can describe as a "community that fits." This acculturation is the final, and essential, component of a community that fits the mentally ill, as different from the deinstitutionalized mentally ill living elsewhere and having to fit into a random community at large.

Reciprocal understanding

A model like this only works if there is a structure to enable it to work and an understanding on everyone's part of what can be expected. Accordingly, there are some aspects of the social infrastructure for the village that should at least be mentioned at this stage.

There has to be some assurance, inasmuch as assurance in human affairs is possible, that the non-mentally-ill residents are genuinely committed to making the model work. A screening process and a contract have been mentioned as possible Instrumentalities.

Residents also need to be assured of safety. A safety plan has been mentioned as a prerequisite. Keep in mind that those with a mental illness, when following treatment, are no more prone to violence – probably less prone – than the public at large. Plans should also include protocols by which the community will help keep the mentally ill free of drug-dealing predators. Predation is a problem for the vulnerable mentally ill everywhere. A premise of this model is that the power of an engaged, interactive community offers the best first line of defence for dealing with the problem.

Also part of this model is that, over and above the physical and financial management of the village, there will be core village staff involved in the neighbourhood's central social dynamic. Functions would include helping the mentally ill to participate in everything the village has to offer, animating their participation to begin with, overseeing and facilitating debriefing after crises and, perhaps most important, helping residents in the neighbourhood in their building of relationships.

This is at the heart of the model. The more that everyone works intentionally on building relationships, the stronger and more rewarding the community will be.

Components of the "village"

Having established the concept, we can now, and only now, go on to discuss the components of the neighbourhood, looking to the best ways of facilitating and supporting the concept.

Keep in mind that the development of a true neighbourhood is a dynamic process, evolving and adjusting as the development takes place, and where some things start small and take time.

- The village should, of course, in addition to housing, have shops and services, a coffee house or two, playing fields, a community centre and other meeting places, community gardens, transportation, and other amenities consistent with the anticipated population density. A community centre, for example, could be quite modest, even part of another building. A village in itself can't have everything – we don't envisage a school on the Lands, for example - but inventiveness and a cooperative social structure can go a long way.

- The current arboretum (collection of trees) is a given. An extended possibility is visitor-destination arborist or horticultural centre (and perhaps even an attached café/tea house). Such a centre, as its way of contributing to the community, should " belong" in some sense to the residents in terms of allowing them participation to whatever extent they can manage, including guiding tours if any.

- An absolutely key component, to be taken on with enthusiasm and determination, and towards which allocation of resources and every effort should be made, is the interior renovation, including design alterations, of the heritage buildings, specifically Centre Lawn and East Lawn. These are landmark buildings and, perhaps because of their porticos, not without a kind of elegance. More important, they have profound historical value. The allowing of West Lawn to deteriorate is shameful.

- Still more important are the future possibilities inherent in the the two buildings as hubs of cultural and artisanal work, offices, and interior retail and leisure spaces. Think of the two buildings the way that a few bold minds thought of a forlorn former industrial area in False Creek, once also home to a disreputable shanty town, and full of empty lots, and turned it into Granville Island.

  The use of the buildings for artisanal workshops, art studios, craft studios, music studios, and outlier activity like computer animation or clothing design, is particularly attractive because of the possible linkages to the seriously mentally ill living in the neighbourhood. One of the most valuable activities for the mentally ill, in the old asylum days before the introduction of antipsychotics, was artisanal and craft work, such as weaving, leatherwork, and woodwork. The rewards of work like that, for the seriously ill, in creativity and achievement, and in engagement, have been overlooked or understated in the rush to desintitutionalization.

  The building of an artisanal "cluster," or any other cluster of activity, accordingly, would take into account what the mentally ill residents might be able to relate to and participate in.

  Let's envision a scenario. Someone participates in an art session currently scheduled by the residences at a location elsewhere in Coquitlam. Someone in the group develops an interest in a particular technique or material. They might, consequently, drop by an art studio that has sprung up in, say, the Centre Lawn building and show their work to the artist or sculptor on location. A relationship develops in which the Centre Lawn artist acts as a mentor and might even sell some of the work of the resident, or the resident might help the artist with something. It might be a matter of the resident dropping by for a few unscheduled minutes now and then, with the relationship being open and unorganized, and following its own path. Or it could be something more regular and structured, like a group teaching session, out of which, however, friendship and community might grow.

Centre Lawn's and East Lawn's considerable size present an additional opportunity – for creating multi-purpose milieux. Think of these buildings with not just studios and some retail space but also apartments, common rooms, a studio theatre and/or other performance space, even certain kinds of manufacturing like custom fashion. We would be creating "Vancouverism" all within a couple of buildings.

- There has been talk over the years of creating, on the Lands, a research centre dealing with mental illness, which would be a welcome addition if it doesn't simply duplicate research happening elsewhere in B.C. and the country. We propose, as the core element of such a centre, the study of the interaction of the mentally ill with the larger community and of engagement helping to overcome the residual (negative) symptoms of schizophrenia and other mental disorders, for which the Riverview Neighbourhood would be a living laboratory. This would give to any research centre on the Lands a distinctive and innovative role, with the research both assisting, and being informed by, the evolution of the community.

  Therapeutic programs related to overcoming the residual impact of illness, such as cognitive remediation therapy, which improves neurocognitive abilities and leads to improved social functioning, would also fall within the ambit of this research.

- Another possibility for inclusion in one of the two heritage buildings, or in another building grandfathered from the existing collection of structures, is a Museum of Mental Illness and associated historical library, drawing on the history of Riverview Hospital but not limited to it. This was foreshadowed by the announcement of the City of Coquitlam, on acquiring the Riverview Hospital collection in 2012, of its intention to eventually showcase the collection. Such a museum, in our view, should have a much larger scope than just this collection, going back in time to the early records of madness and covering the uneven progress over the centuries of efforts to understand mental illness and help those affected.

- On the housing side, housing for the non-mentally ill should include some low-cost housing as part of the overall mix.

- Film industry use of Crease Clinic will continue and other possible commercial activity for the building will be explored, as long as they make business sense for the village (through income), and are appropriate to the village. The commercial rental of Crease and any other buildings along Lougheed Highway, notwithstanding these buildings are somewhat off to the side, should also take into account the villages's larger objectives. We've already described the use of the more central heritage buildings as an artisanal hub, with linkages to the mentally ill residents in the neighbourhood. We should keep in mind, and try to develop, other possible linkages of work and social activity in the use of these other buildings, even if the linkages in the end turn out to be limited. It's important because many, and possibly most, of the non-mentally ill residents will be at work elsewhere during weekdays, so any daytime activity allowing for possibilities for the mentally ill residents has extra value.

Riverview would, thereby, have the same degree of neighbourhood integrity as Kitsilano, say, or the Drive, or Ambleside, or the West End, while being a quite unique neighbourhood in its own right.

Feasibility

We'll look at the different aspects of feasibility, in increasing order of importance.

An artisanal and/or artistic cluster. The objection has been raised that artisans and artists won't want to work (or both work and live) at Riverview or display their work there, being removed from their usual haunts and, for sales, from dense street traffic or central locations. There is, however, no existing artistic colony in the Lower Mainland encompassing everyone in the arts and in craft work. Artists and craftspeople live and work everywhere. Available space, relatively low rents, teaching/workshop contracts, and the challenge and joy of working with the seriously mentally ill in some of their time, would be attractions. Nor are Riverview and Coquitlam any longer geographically remote. As for sales, having some work on display at Riverview doesn't preclude selling one's work elsewhere as well.

All that would be needed for a start, moreover, would be just a few pioneers.

It's not beyond imagination that in the symbiosis of non-mentally ill and mentally ill artists and craftspeople working together or side by side, or just knowing each other, a Riverview Artists' Cooperative, say, might spring up, or some other coming together of creativity and distinction with market returns.

Non-mentally ill residents locating in the Riverview Neighbourhood. Living in Riverview won't be just living near many mentally ill, or next to many mentally ill, but living integrated with them and interacting with them in the same neighbourhood. We've been told that given the stigma surrounding mental illness, nobody is then going to move in unless prices, for purchase or rent, are going to be steeply discounted.

We say to this argument based on the prevalence of stigma, "Bring it on." Explaining our proposal, and promoting the settling and development of the neighbourhood, would be a great destigmatizing opportunity. Besides, many people in different places in the Lower Mainland already live close to groups of the mentally ill, without having pulled up stakes and heading elsewhere. What they don't do is interact with them and enjoy knowing them and doing things with them, which is the difference.

We're reminded, again, of Geel, Belgium where, for centuries, profoundly ill people, their illness unabated by anti-psychotics, interacted with the community. The foster system, incidentally, still continues. It's true that, in Geel's case, the openness and generosity of the population had religious leadership behind it, but British Columbians have their own sources of inspiration.

Nor are we looking at hundreds of thousands of residents, just a few hundred to a thousand. There are 2.5 million people in the Lower Mainland, of which more than enough will be interested.

Administratively, for housing, a leasing structure similar to the one in Granville Island and some projects in Vancouver could be used, with, in this case, B.C. Housing leasing the land, and new housing being built by, say, housing societies, under long-term leases and mortgage arrangements.

Financial feasibility. Much has been made of B.C. Housing's declaration that the redevelopment of Riverview must pay for itself. What exactly, though, does this mean and, even more relevant, what should it mean? And does it take into account that any such redevelopment with a public purpose should have a long horizon, for which new sources of capital can, over the longer term, become available or where current capital investment can be amortized?

The financial planning for Riverview should also be done with discipline, where (a) services and facilities are underwritten by the appropriate bodies rather than compromise the vision, and (b) external savings are fully tabulated and entered into the account.

We therefore propose the following working principles for the planning process:

1. The cost of homes and associated services for the mentally ill be underwritten in the same way they would be if they were located elsewhere – by provincial and municipal allocations to housing societies or to whoever else is responsible for such housing, just as they are now elsewhere, and in the same way that Fraser Health underwrote the construction of their three lodges on the Lands. Additional housing for the mentally ill is needed and were it to go next door, in Coquitlam or Port Coquitlam, say, dedicated funding for that purpose is exactly how it would be financed.

2. The savings externalities be estimated and fully accounted for as a capital equivalent in the decision-making. Remember what we're proposing here: neighbourhood involvement which does not exist elsewhere, playing an interactive role in the continuing recovery and ongoing engagement and stabilization of the seriously ill, with fewer relapses and associated hospital and medical costs than otherwise and fewer police and justice system costs than otherwise. This unique neighbourhood, in other words, will provide substantial added value to the public purse. These continuous savings externalities should be capitalized for purposes of the Riverview redevelopment's capital savings/cost calculation.

3. The calculation of the capital cost of the rehabilitation of Centre Lawn and East Lawn be defrayed in part or in whole by the net present value of the rental income from studios, offices, retail space, and apartments provided for in the plan.

4. The capital cost of the proposed Museum of Mental Illness and associated historical library be undertaken by the City of Coquitlam on its own, in conjunction with the Royal B.C. Museum, and/or in conjunction with other municipalities in the province. There may also be other sources of funding for the premises and development of the museum. Think laterally.

5. This leaves us with the other resources stemming from the Riverview Lands themselves: the income from the leasing of land for homes for the non-mentally ill, the rental revenue from existing buildings with commercial potential such as Crease Clinic, and other leasing/rental income. If the value generated by such revenue flows is such that it allows for assuming greater responsibilities than outlined here, all the better, but only if the planning objectives of the redevelopment project, like the renovation of Centre Lawn and East Lawn, are met, and only if the integrity of the neighbourhood (horticultural, social and design integrity) is not adversely affected. For example, we ourselves don't favour high-rise development on the Lands as a way of generating capital or providing lower-cost housing. Such development would, in our view, be

out of keeping with both the landscape character of the Lands and the design character and modest density we envisage, notwithstanding we might sympathize with what the proponents of the idea are trying to get at.

We collectively, in planning for Riverview, should, instead, focus on what kind of neighbourhood we want to create, with particular attention to the interactive model we are proposing for the seriously mentally ill, and then, with discipline and imagination, work towards the appropriate financing of its diverse components.

It takes a village

If, as in some communal cultures, it takes a village to raise a child, we can also say it takes a village to fully allow for the optimal realization of potential and enjoyment of life of those seriously mentally ill who might have difficulty coping in other milieux. We have already mentioned some other models that overlap slightly the model we are exploring here. The Riverview "neighbourhood model" proposed here, however, is quite different, deriving from the very circumstances of the severely mentally ill in B.C. following the dramatic deinstitution-alization of the last 50 years, and deriving also from the unique opportunity provided by the Riverview Lands and the best of its remaining major buildings.