

# The Doctor Is Out

Dr. Bill MacEwan is a psychiatrist with a difference—he doesn't wait for his patients to come to him

By Marcie Good // Photographs by Wendell Phillips

**T**WO MEN STAND NEXT TO A DUMPSTER in an alley behind the Carnegie Centre.

"You're back from Sudbury?" says the tall one, who's wearing a long black coat and single earring.

Trevor, black-eyed and stubbled, nods. Two weeks ago he left his room, with its collection of broken furniture piled in front of the window. He tried the meds, he's saying, but they made his tongue feel thick and his body ache.

Their voices disappear under the loud warning beep the garage makes as a van drives out. Further up the lane, a man sitting on the ground empties a loaded needle into his arm. It's a scene loved by television cameras: a tunnel of brick and pavement with no apparent exit. The tall man takes a small rectangular package out of his briefcase.

"I don't mean to be rude or nothin'," Trevor says, shaking his head. In other meetings, Trevor has talked about his childhood: a rambling, almost feral story including an incident in which, at seven years old, he shot a man. The taller man doesn't know if this is true, but he knows that under Trevor's black bomber, buttoned-up jean jacket, and chain with fist-sized links is a scared and skinny little boy.

Trevor resorts to a familiar theme: the homosexual gangs chasing him. He's schizophrenic and suffers from paranoia, but these fears have a kernel of truth. Just before he left for Ontario he was stabbed.

A ball-capped man taps him on the shoulder. "Hey Big Dog, need anything?"

"I'm with my psychiatrist!" Trevor admonishes him. "Y'know what I'm sayin'?"

At the Stanley Hotel. Dr. Bill MacEwan talks with a patient who, like many of the people he sees, is incapable of keeping a hospital appointment



EVERY MONDAY, WEDNESDAY, AND FRIDAY, Dr. Bill MacEwan sees patients like Trevor, often in their rooms at low-rent Downtown Eastside hotels. Usually they're referred to him by hotel staff or by people at social agencies. Some are harder to track down: "wily coyotes," he calls them. Today he was directed to the alley by someone from Vancouver Intensive Support Unit, which follows up on offenders with psychiatric illness.

The anti-psychotic drugs he offers Trevor cause more pain than they're worth, but the 28-year-old has achieved a bit of stability since the first time they met. Then, he put jagged pieces of mirror around his mattress to protect him from spirits. It's one of his coping techniques, perhaps futile but necessary for his survival in this neighbourhood. More recently, those tools included a round chunk of chalk, his "fake dope," that apparently has some street value. All these bits of information are useful to MacEwan, but more important, seeing the young man on his own turf encourages a bond. Trevor, whose darting eyes seldom make contact, seems an unlikely candidate for an ongoing relationship. Yet in the alley, he asks MacEwan if they can go



Addictions can exacerbate mental health issues, and it's sometimes hard to separate the afflictions. MacEwan often explains to patients that their "crazy" thoughts and behaviours are actually brought on by drug-induced psychosis

tions, because they're too difficult.' What we're doing in mental health—and I'm not downplaying what people do, they do a good job—but we're leaving the most severely ill on their own."

That's the professional reason he does this work: it makes more sense to go find people in distress than to wait for them to come to you. But there are lots of reasons he likes it. He is "invigorated" by the enthusiasm of the people who work in the agencies and hotels of this most dysfunctional neighbourhood. There's something endearing about the people who live here, too. On East Hastings, he's often approached by people, like a bearded man carrying ski poles who tells him that someone broke into his room and poisoned his food.

Is there a spiritual side to his work? He laughs when asked if he believes in God. "It's more like, I just don't understand—if you have the opportunity, how can you turn your back?"

LINDA, A SUPPORT WORKER AT THE LIFESKILLS CENTRE, is worried about Frank. He's had a rough patch, she says, and last week he didn't show up for an appointment. "He said he

myself up, but these people, they're knockin' me back down!"

They come up with a plan. Frank will re-start his anti-anxiety and anti-depressant pills, assured they're safe even if he's drinking. MacEwan will get Linda to see him again, and help him get ongoing support from the Strathcona Mental Health team.

"Whoever's doing this, they should be seein' you," says Frank, a smile finally breaking.

"If I ever find them," says MacEwan, "I'd be happy to see them. But let's focus on you."

Frank, says MacEwan, is a good example of a typical DTES psychiatric patient of 20 years ago: middle-aged, male, schizophrenic, drinking. His case is not easy, but at least he's agreeable to treatment and has a will to, as he says, bring himself up. The patients MacEwan often sees here now are different.

Mental health advocates point to the closing of thousands of psychiatric beds at Riverview Hospital since the 1960s as one reason why so many ill people roam these streets. There's truth to that, he says, but another reason is the shocking rise in popularity over the past decade of crack cocaine and worse, metham-

## “At St. Paul’s, one woman caught his attention. Over a two-year period, she racked up almost 100 admissions”

for lunch sometime. Chinese, he suggests. A buffet.

MacEwan also runs the Fraser South Early Psychosis Intervention Program at Peace Arch Hospital in White Rock, one of the largest in Canada, and Ward 9a at St. Paul's. He's also director of the schizophrenia program at UBC. As a specialist, he often sees patients who have already been diagnosed and treated by a family doctor. But this is front-line work, and he seems to thrive on the unpredictability of these afternoons.

Movies and television love the narrative device of the psychiatrist. They usually sit, like *The Sopranos'* Dr. Melfi, in a richly furnished office, walls lined with certificates and books. They are distant and impersonal, say little other than prompts, and once in awhile indulge in a pretentiously worded assessment.

MacEwan is not that kind of shrink. He dresses like one, in his dark suit and long wool coat, but he's at ease in his patients' homes, cell-sized nooks that often mirror their occupants' state of mind. When he explains their conditions, he uses words like "cuckoo" and makes strange behaviour seem, not normal, but human. Why do schizophrenics see people following them? The delusion is a kind of defence mechanism: they feel so much unexplained anxiety that their brain creates a reason for it.

MacEwan listens to the same concerns over and over, as if hearing them for the first time. "You're good at beating around the bush," says one woman, whose son was killed a week earlier, "until there's no bush left."

PSYCHIATRY MIGHT SEEM A NATURAL, almost inevitable line of work for MacEwan, but it wasn't his first choice of specialty. At first he thought he'd do plastic surgery, working to restore burn victims. He grew up in Vancouver and graduated from UBC's Faculty of Medicine in 1982, inspired to choose psychiatry by a teacher, Dr. Mike Myers, whose compassion he admired.

Myers, who specializes in physician health and still teaches at

UBC, recalls a young med student with "psychiatric intuition. He just seemed to have a sense of the big picture. He was not just interested in patients' psycho-pathology; he was interested in them as people, their stories and their families and how something like this could happen to them." MacEwan's treatment approach, says Myers, reflects that understanding. "He's not just about psycho-pharmacology, he's also very interested in their social welfare and all of the community dimensions of things that can make or break a person."

That's exactly why MacEwan started doing these rounds on the DTES almost three years ago: he wanted to know where his patients were coming from. He was constantly seeing the same people at St. Paul's. One woman caught his attention: over a two-year period, she racked up almost 100 admissions. Some of her visits were twice in the same day, and some lasted for months. She had mental illness and substance abuse problems, and the ricochet effects of her desperate behaviour were endless: she was often homeless, traded sex for drugs, got abused, picked up HIV and Hepatitis C. She was brought into hospital for any number of reasons: opportunistic infections like pneumonia or cellulitis, tooth decay, psychotic behaviour. Once she'd been found sleeping in an alley, half-clothed. Often she would flee the hospital.

"At St. Paul's, it's the world's most expensive office," says MacEwan, driving his blue Toyota hatchback from the meeting with Trevor to the LifeSkills Centre by Pigeon Park. Based on a figure of \$1,800 a day—the standard estimate of hospital costs—her care in that period cost taxpayers about half a million dollars. And she wasn't getting the help she needed.

MacEwan is polite and gets a lot done without seeming in a hurry, directing his full attention to whomever he's talking with. But when he talks about the lack of help available for this kind of person, he gets angry. "The analogy I use is, a cardiac team says, 'We're willing to treat anything but myocardial infec-

was on the way," she tells MacEwan in her office. "Well, let's go," he says. "I've heard a lot of people say they're on the way."

Frank's bachelor apartment, a few blocks away, is painstakingly neat, from the pressed shirts hanging on ceiling pipes to the dishcloth draped over a soap bottle to dry. "Sorry for barging in on you like this," says MacEwan, but Frank, thin, balding, with flexed brows and clean white sneakers, is glad to see him.

"What's been happening?"

"Well, this is the truth, okay?" Frank begins, ashing his cigarette. "I've been hearing things in the building here. People have been harrassing me. I'm not imagining things, because the police were here, I phoned them. They were probably mistaking me for someone else, I might have said somethin' wrong, and somebody heard this, whatever I said, and now I'm bein' followed. The police believe I'm hiding evidence."

MacEwan asks questions: why would the police follow him? How is that possible?

"I don't know. It's somebody's idea of a cruel joke."

"I'm going to put this in the middle here," says MacEwan, looking for what he calls "the common symptom" they can agree on. "I think this is psychosis, but I know you experience people following you. How does this affect you—your mood, your appetite, your anxiety?"

"I've been drinking every day! These people are driving me to drink!"

"Well, yes," says MacEwan. "You're a literal example of that phrase."

Frank has stopped taking his pills because the labels warn not to take with alcohol. Other details arise, like his father's death when he was a teenager and his mother's institutionalization for schizophrenia. He doesn't see any connection between his mother's illness and what he's experiencing, but he has a healthy exasperation towards the surveillance: "I'm trying to look for work with Linda here," he says, annoyed. "I'm tryin' to bring

phetamine. Highly addictive, the drugs cause psychosis.

One theory is that schizophrenia has perhaps 20 genes that are pre-disposed to carry the disorder. Someone with 10 of those might never experience symptoms. If they start using crystal meth, however, they could. "It's like, if you've got a genetic bad knee, you might not notice it," MacEwan explains. "But if you start running marathons, the bad knee acts up." A meth user can present exactly like a schizophrenic, but the treatment is more difficult because symptoms may come and go. No one is sure how long the damage will last. Many young people here have histories of abuse and, already, many years on the street.

Liz Evans, executive director of the Portland Hotel Society in the DTES, remembers meeting MacEwan three years ago when he toured the Portland Hotel and Sunrise Dental Clinic with other doctors. He told her he was working with crystal meth addicts. "I said 'wow,'" she recalls. "I've got a whole hotel of people that could benefit from your expertise."

At the time, she had no medical support at the Stanley Hotel, and staff were struggling with the volatile population. After the city gave PHS the Stanley in 2002, it accepted almost 100 of the Woodward's squatters. The intense media coverage of that 10-week sit-in showed how disturbed and vulnerable they were.

"Most of them had never had a home," explains Erin Mathews, the pixie-ish manager of the Stanley, a 150-year-old three-storey building in Blood Alley, between the Downtown Eastside and Gastown. "They didn't know how to....not break things." When Mathews started her job, five years ago, someone had just broken into the building and punched a staff person in the face. Since then, additional security, an extra staff person, and helpful police officers have brought some stability. But getting medical care for the most desperate people has been an ongoing challenge.

MacEwan has been visiting the Stanley several times a week. Liz Evans, who worked as a nurse before founding the PHS in

1993, calls him an “angel.” “It’s continuously frustrating to me that the Bill MacEwans of the world are so few,” she says, “and it’s not really about who he is as an individual so much as an inadequate system response. Our health care system, designed for the general public, simply doesn’t work for this population.”

IT SEEMS SIMPLE to make an appointment and see a doctor. But for most people who use the services of the PHS (which includes five hotels, two mental health supported apartments, a credit union for low-income residents, a café, a dental clinic, a needle exchange, a supervised injection facility, Onsite Detox and Treatment facility, and the LifeSkills Centre), it’s not. Three quarters of them, she estimates, won’t go to a clinic: they’re too ill to leave their room, can’t wait in an office, forget appointments, don’t have a phone. Should people have to earn their health care, she asks, with acceptable behaviour?

The medical supports in the PHS have long been stretched thin: until August, Dr. Gabor Maté worked full-time in the Portland Hotel alone; two nurses moved among the Stanley, Portland, and Washington Hotels. More recently an integrated services team has begun visiting the hotels, starting regular outreach clinics at each PHS site. It’s a difficult job description, almost like palliative care: more about managing people’s pain than curing them.

This summer, however, a new model was implemented in partnership with Vancouver Coastal Health. Three nurses and a social worker now work with MacEwan as a roaming team within the entire PHS system. A nurse or social worker takes residents to appointments with specialists like dentists or HIV doctors that they’d otherwise miss.

The crucial feature of this model, says Evans, is that they get to know the residents, who can be complex and difficult patients. She uses the example of a wafer-thin girl who’d lock herself in her room at the Stanley and wait for days on end. She suffered from a prolapsed rectum but refused to see a doctor. One staff member would check her every day, and after months she finally let him clean her room and do her laundry. Since then she’s agreed to see MacEwan and get surgery for her condition. “That one-on-one care has made a tremendous difference in this woman’s life, although it wouldn’t look so from the outside,” says Evans.

“Those kind of breakthroughs happen all the time in our model, which is to accept



“Bidders,” says photographer Wendell Phillips, “seek anything of value that may have been thrown out. The most dangerous occupational hazard is getting pricked by discarded rigs. Pat is a resourceful bidder who spends his days turning other people’s refuse into money to support his addiction. ‘See?’ he’s saying. ‘What did I tell you?’”

the reality of where a person is and bring the care to them. But it requires tremendous stamina and creativity and flexibility and tolerance. Those aren't things that systems build into their models of care."

DR. RANDALL WHITE, A PSYCHIATRIST at St. Paul's, agrees that B.C. has a long way to go in serving this particular population. De-institutionalization of long-term mental hospitals happened across North America; many jurisdictions responded by putting the money saved into community care. He points to one model, Assertive Community Treatment, that originated in Madison, Wisconsin, in the late 1960s and has been implemented by health authorities across the U.S. and Canada. "Bill is trying valiantly to serve these people, but he's a one-man show," he says. "We need to be doing it systematically."

The ACT model is a bigger version of the PHS's roaming team. It's aimed at the most complex cases: people with chronic mental illness and frequent hospitalization, substance abuse problems, no stable home, and possibly a criminal justice history. An ACT team is made up of 10 to 12 professionals, including typically a nurse, a social worker, a counsellor, an occupational therapist, a psychiatrist, and a psychologist. Each member has a small caseload of up to 10 patients; their job is to go out and find that person as frequently as possible. At least one member of the team is available 24 hours a day, seven days a week, and can respond to a crisis. There's no limit on how long a patient stays in the program.

In the late 1990s, the Ontario ministry of health embraced this model, and there are now 71 such teams across that province. Along with health treatment, the teams offer employment and housing assistance, family support and education, and substance abuse services. The numbers are astonishing: people who used on average 86 hospital-bed-days a year were down to 28 after one year in ACT, 15 days after four years. In 2002-03, the program saved an estimated \$82 million in hospital costs. The clients were also more stable, with 70 percent living in a home of their own after enrollment.

The figures from Ontario don't surprise John Higenbottam, a psychologist and health services manager who was responsible for mental health services provided by the Vancouver Richmond Health Board and teaches psychiatric residents the ACT model at UBC. Higenbottam's on a provincial



"There are those who feel the kind of social documentary work I'm doing is not productive," says photographer Phillips, "and others who think reportage of the human condition has become a fast grab for dramatic images in the guise of social conscience. I've spent 18 months in the DTES because of an insatiable interest in addiction and homelessness, but also because as a journalist I feel the stories here are relevant"



panel looking at the model in different jurisdictions and making recommendations to the ministry of health. One question is where the funding would come from. Some community mental health clinics have outreach teams, but they have limited resources and are not nearly as intensive as the 24/7 ACT model. The people working in the busiest areas, like the Downtown Eastside, might carry large case loads of 80 to 100 patients. “They’d say they need resources just to reduce case loads, that we can’t afford ACT teams. It’s seen as a Cadillac intervention. But the studies show that if we don’t provide that intensity of support, according to the ACT model, it doesn’t work, doesn’t effectively reduce hospitalization.” ACT teams are cost-effective, given their ability to reduce re-hospitalization, Higenbottam says, so it’s not just a matter of money. It’s a matter of vision.

THE MANTRA among Portland Hotel Society staff—“Meet people where they are”—describes MacEwan’s work in a literal sense, but the phrase has a philosophical dimension as well. He accepts people’s bad habits and does what he can to help them. It’s also known as harm reduction.

David, a young man he sees, has a thick dark beard that makes his blue eyes glimmer. He’s child-like, the way he talks and laughs, but can be aggressive. It probably served him well in Junior A hockey, but at 22 he had a bar fight that left him in a coma for months. Years after he woke up, he started having auditory hallucinations. Even a simple task like going to the store can be accompanied by a shouting commentary: “He’s hungry!” He’s also fallen into the “stupid” habit of using drugs.

“Well, don’t put yourself down,” says MacEwan. “The reason you do drugs, it’s not ‘cause you’re stupid, it just happens. Do you feel better when you use crack?”

“No, I get so depressed after.”

“That’s how it is,” MacEwan explains. “At first you feel up and happy, but that stops. You don’t actually get high anymore, you’re just filling this hole, this craving. And David truly regrets things he’s done, he’s a nice guy, he’s got a conscience.”

Along with the memory loss and psychosis, the drugs make him violent. He’s been kicked out of apartments and started scuffles with police.

“David’s a bit of a ...”—he looks at him searchingly—“an interesting gentleman to treat.” David groans. “It’s okay,” MacEwan says, both of them laughing, “It happens!”



“The biner on the facing page isn’t just sleeping, he’s protecting his cans and bottles from human predators on East Hastings. I met Susan (top, this page) in the summer; when I took this photo she was explaining how trapped she feels by her dependancy on drugs, how hopelessly lost. Ashley (middle, this page) is trying to rally friends to demand that the vacant city buildings being guarded by police should be used for social housing. Donald (bottom, this page) and his dog Spaz are inseparable and can often be seen walking the streets together”

The last time David was in hospital, they discussed his ADD and started him on a stimulant. Forty percent of methamphetamine abusers have a history of ADD; the idea of substitution drugs is to use a pharmaceutical stimulant to decrease cravings for methamphetamine and crack, also stimulants. But David fled.

Now that MacEwan has tracked him down, first at The Lookout emergency shelter, and then with the help of Urgent Response and a support worker at the Acquired Brain Injury Program of B.C., they're trying an anti-psychotic injection. It helps him feel calm, David says. MacEwan is under no illusion that he'll stop using street drugs, but the medication might help him stay, for awhile, out of trouble.

THE STANLEY IS KNOWN as the Crystal Palace; it has long narrow brick hallways thick with the smell of shake, the marijuana leaves and stems fished from dumpsters after the buds are gleaned. Across the courtyard, the same orange brick has heritage cachet in hip new bistros and design studios.

A staff person's job here includes buzzing in residents they see on the security screen, keeping the toilets unplugged, handing out medications, collecting information on dangerous people, listening to problems, accompanying people to court appearances, and trying to keep the building acceptable to city inspectors.

Erin Mathews gives MacEwan an update, bounding out of her chair to re-enact events. "The last time I saw Derek, he was like this over the balcony," she says, doubling up. "Then he ripped out all his baseboards." She's also worried about Lindsay, who's been calling 911 and asking the operator, "Am I crazy?"

Today, Lindsay's outside the office waiting for MacEwan. "I need to talk to you," she says, rolling her eyes when he says he first has to take a call.

They go into the yellow-walled room that functions as a clinic. Lindsay, blue-eyed and orange-haired, is wearing a turquoise fitted jacket and skirt, and has the look of a student from the nearby film school except for her bad teeth and habit of rocking back and forth. She launches into a frantic narrative with the same central concern as her 911 calls.

"I speak honest open willing," she begins, "and I don't know if I'm actually sane or I've lost my mind."

"Okay..."

"Someone at the Regency Hotel on the



"Samone allowed me to photograph her amid the self-expression that decorates the walls of her hotel room. I only had a few minutes to make this picture and know little about her. I've returned since, wanting to interview her, but have never found her at home"

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seventh floor that was for sure a serial rapist and was fully able to be a cop or an actor or something I don't know what for sure but I felt really calm throughout the entire meeting and I fought with every inch of my being to live, and I lied about wanting to die to do so. I even pretended to want him. I had myself convinced to the point where I convinced myself. And as soon as he thought I wanted him he wasn't interested."

"Gosh. When was that encounter?"

"Two hours ago. I asked him to be honest open willing, I asked him if he was a rapist I asked him if I was going to die and he answered all my questions with only nods and blinks."

"Geez, so how can..."

"Literally I feel afraid that I'm going to lose pieces or that my only ability to change the cycle, or to live, to have a life, to be able to exist as not nobody as somebody will be gone."

"So, a lot of shit's happening. The first time I saw you, you said things like you're hearing voices, thoughts typed out in your brain, that kind of stuff? How can I help?"

"Well, my main issues are I need to have contact with the public as a self-respecting citizen, I need to have a name that is one of the world, I need to be part of society I need to take care of myself I need to work for a living I can't handle this being nobody and not believing it doesn't work for me at all."

"So tell me what drugs you used last week."

"I don't know how that fits, it just doesn't seem to."

"Well," MacEwan explains, "often people use crack or amphetamine and their thoughts can get really out of control. They hear voices, they get paranoid..."

"They're okay with living by themselves in the world amongst people who are rapists and drug addicts and don't desire to be anyone anywhere?"

"Well, they get psychotic, and I'm worried you're psychotic. How much meth have you used this week?"

"I don't know, a couple bowls."

"How about crack?"

"Every day."

"Any heroin?"

"Yeah."

"Well, the part I'd like to help with is to get you out of this state of mind."

"Can I get some lunch?"

If she takes an anti-psychotic pill, he tells her, he'll buy her lunch today, and give her five dollars to buy her lunch tomorrow if she'll take another pill. The pills won't cure her. All he can hope is that they buy her a bit of time when she might use less meth, eat and sleep better, not use sex for drugs, and be able to think about what she wants.

Her torrents of strangely coherent angst of a character in an absurdist play—the fancy word for this, MacEwan says later, is pathoplasticity, which means that the presentation of your illness is heavily influenced by your personality. Today Lindsay is, by quick turns, smart, funny, vulnerable, and tough, as she is when she's straight.

MacEwan suspects that Lindsay's history includes the horrifying stories he's heard from so many other young women. (Indeed, Lindsay gave Erin a notebook filled with references to an evil stepfather, and memories of how she used to sit on her grandmother's porch and wish that her mother loved her.)

"All I need is my sanity," she tells him, "which I've just given you." She turns the questions back on him, asking about his work. Is there any possibility, she wonders, that he's able to do his job fairly as a, quote, doctor?

"I'm not going to answer any more of your questions," MacEwan teases. "They get me in trouble!"

He follows her across the courtyard of Blood Alley and then Abbott Street, a bus braking as she hurries across without looking. She scurries up and down the aisles of a tiny convenience store, her shoulder sack knocking things over as she turns around. She takes things back and forth before settling on four items totaling \$5.11: a half-carton of eggs, a block of margarine, a samosa, a cellophane-wrapped slice of pie.

MacEwan, turning to head home to White Rock, impresses on me that he's not entirely comfortable buying things for Lindsay, or for any of his patients; he doesn't do it often. But if your treatment philosophy is to meet people where they are, you do what the moment requires. And here—yearning, stubborn, articulate, confused, hardened, helpless, and hungry—is exactly where she is. **vm**