Disability White Paper Consultation 2014—
Ensuring mental health and addictions are part of the conversation

A submission on behalf of the Canadian Mental Health Association (CMHA) BC Division and CMHA Vancouver-Burnaby

Canadian Mental
Health Association
British Columbia
Mental health for all

Acknowledgments

We would like to thank the following people for helping make this consultation event possible:

- Lyle Richardson, Volunteer, CMHA BC
- Kendra Milne, Lawyer, Community Legal Assistance Society
- Dana Wilson, Public Policy Researcher/Analyst, CMHA BC
- Krista Carlson, Public Policy Researcher/Analyst, CMHA BC
- Sarah Joosse, Social Learning & Knowledge Exchange Coordinator, CMHA BC
- Tricia Subido, Resource Clearinghouse & Customer Service Coordinator, CMHA BC
- Kevin Love, Lawyer, Community Legal Assistance Society

And thank you to each of the community members who attended to share their experiences and ideas for change.

Background

On February 24th, 2014, the Canadian Mental Health Association (CMHA) BC Division and the CMHA Vancouver-Burnaby hosted a community consultation focused on mental health and addictions, in response to the British Columbia Government's Disability White Paper Consultation process.

The objective of this consultation was to ensure that the experiences, ideas, perspectives, and opinions of individuals living with mental health problems and/or addictions, their caregivers, and their supporters informed the BC Government's provincial consultation activities on disability.

In the end, almost forty individuals participated in this community-organized consultation, along with a number of community organizations. In just under three hours, and in response to a series of consultation questions, a vast amount of feedback and responses were recorded. This submission is a tabulation of the community feedback, organized against the tables at which the dialogue took place, linked to each question. You can find a list of each of the questions in Table 1.

Table 1

Barriers	Opportunities
1. What are the current barriers to accessing provincial disability supports?	What can BC do to reduce the barriers to accessing provincial disability supports?
2. What are the current barriers to accessing care?	What can BC do to reduce the barriers to accessing care?
3. What are the current barriers to finding secure, long-term employment?	What needs to be in place to find secure, long-term employment?
4. What current barriers exist to finding safe and secure housing?	What can BC do to make it easier to find and keep safe and secure housing?
5. What current obstacles exist to engaging with and being supported by their communities?	What can BC do to make it easier for people to engage with and be supported by their communities?
6. What are the current barriers to income or financial security?	What can BC do to reduce these barriers to income or financial security?

In keeping with CMHA's values and its Framework for Support, we decided to start our consultation by inviting Lyle Richardson, a long-standing volunteer at CMHA BC Division, to share his experiences and ideas. Lyle generously agreed to participate in a live interview, providing a rich account of his hard won knowledge and recommendations for systems change. This interview provided an important departure point for our consultation and set the stage for the remainder of our consultation process.

We used a "World Café" process during our consultation. This process involved a series of conversation rounds, prefaced with the questions in Table 1. These questions were attached to particular tables at our consultation venue. Participants were asked to select their first table, and then after 20 minutes of conversation, they were asked to move to a different table. We had time to complete three rounds of conversation for the questions in the "barriers" column and two rounds of conversation for the questions in the "opportunities" column.

For the purposes of this submission, we have decided not to represent the consolidated data in a summarized or thematic form. Rather, we want to preserve the diversity of responses, and they are represented below as recorded by each of our table hosts/recorders.[1] Of course, there are limitations linked to how each of the table hosts/recorders interpreted the responses shared at their table, and we have made some minor edits to the data for the purposes of spelling, grammar, and completeness of sentences.

During the final stage of our world café process, we asked each of the table hosts/recorders to provide a synopsis of the dialogue that had taken place at their table. We harvested these summaries into a series of high-level themes. We then invited participants to vote for the themes they identified as being of highest priority for making BC the most progressive jurisdiction for people living with disabilities, including mental health and addictions. The top priorities identified were:

1. **Improve initial access points (access to care and service);**
2. **Increase the numbers of advocates, supports, and mentors in community (community support);**
3. **Address key determinants of health (e.g. housing, income) AND the inadequacy of rates (e.g. disability benefit, income assistance)**

Of note, the role of the police as an access point to the system was also identified as a priority issue, given that the police are often an initial interface for individuals living with mental health and/or addiction problems.

We appreciate the opportunity to make this submission to the BC Government, and we look forward to the findings of this consultation process.

Respectfully submitted:

Jonathan Morris, Director, Public Policy, Research, and Provincial Programs (CMHA BC)

1 Please note the responses included in this submission do not necessarily align with or represent the policy positions and opinions of the Canadian Mental Health Association. This submission is designed to represent the diversity of voices in relation to mental health, addictions, and the BC Government's " 2014 White Paper Consultation Process.

Community Responses

✷ Table 1

For people with mental health and addictions disabilities, what are the current barriers to accessing provincial disability supports?

Accessibility of Ministry of Social Development and Social Innovation (MSDSI) services in general

- Clients are lined up out the door at the offices.
- Accessibility is a huge issue—service delivery is increasingly pushing clients out the door. Clients have no access to worker, no designated workers system, and can only access the Ministry through the toll free phone line, offices are being closed, clients are given a numbered id, and front line workers are being replaces with call centre employees.
- Clients with mental health issues can lead chaotic, disorganized lives, lose housing, lose ID, or have no access to a phone. The current system is hard for them to navigate. For example, if eligibility interview over the phone, clients don't get calls back and may have no fixed address.
- These kinds of situations exacerbate mental health conditions and clients give up and disappear. Advocates don't know what happens to them and it's heartbreaking.
- The loss of case worker model means that clients are forced to re-hash their story every time. It's inefficient and frustrating. The division of labour between staff all causes the same problems (a client gets passed on to a worker assigned to different issues, who can't deal with more than one issue at the same time, so the client has to access multiple workers to have issues resolved, leading to repeated administrative costs). This makes the system incredibly inaccessible for clients.
- While staff specialization can be effective, it can also just create barriers for people.
- It's the people with no other supports who are in the most need that end up not being able to access the system.
- The system, from the design to the conduct of frontline workers, actively terrorizes clients because its hostile and that is debilitating for clients. Offices are set up like probation offices, on the assumption that clients are dangerous. Clients are dehumanized in the offices through overcrowding, long waits, surveillance by security, a lack of access to basic things like bathrooms, being forced to queue up in street over lunch closures, and no sense of how long they might need to wait. Clients are not treated like people and staff can be actively hostile because they don't know the answers to the clients' questions. Being made to wait is hostile; being shunted to a phone system as you wait is hostile. It's all dehumanizing and rude.
- People are placed in these incredibly complex application structures that they may not understand to get what they need.
- There are major impacts on clients with mental health issues: it causes anxiety, it's intimidating and debilitating. People give up and go away. It's destabilizing, it makes people feel like shit, and they're already dealing with stigma. They're often in fragile emotional states and it makes them feel worse.
- Doctors try to get clients in to MSDSI and they just can't access the services (they lose housing, etc. by the time they can access the system).
- The system is intimidating to engage with.
- Advocates walk into Ministry offices and you see how clients are treated by staff: not overtly hostile, but not friendly. Then you see the tone totally change when an advocate comes up in line and the workers suddenly treat us well.
- Staff are incredibly overworked and it's sad; they are short tempered and impatient.
- Separate people on Persons With Disabilities Benefit (PWD) from those on regular income assistance because people find it too hard to go to the regular offices.
- In terms of accommodation of clients with mental health disabilities, there is nothing in the Online Resource that I can remember. There is nothing in day-to-day procedure that suggests that it might be necessary.

- The system prevents Employment and Assistant Workers (EAW) from helping individual clients.
- There is a danger of blaming Ministry workers, but it's a challenging system to work in; I feel sorry for the workers.
- There is an assumption of literacy. Clients are expected to be able to read things and figure out things to make their way through the system. Even using "Your Welfare Rights", people can find info and cannot act on it on their own.
- The reduction in funding for advocates is even more problematic when they are necessary to access the system.
- People are getting screwed by the MSDSI not paying retroactively.
- With the cuts in the mental health system, it's less accessible than it used to be. People on PWD are not getting the support they needs, like councillors and access to those kinds of services. We need to get away from a physical disability lens.
- Barrier-ridden services seem to rule people out because they don't use the right phrases, etc.
- If you're turned down for something, it's a daunting appeal system (after the often daunting applications system).
- The person who needs it is the least likely to get through the current administrative system.
- It seems like staff get rewarded for closing files or denying people.

Online self-serve assessment and toll free phone access

- The online application for income assistance is difficult to navigate even for someone who is literate and comfortable with technology.
- If people try to apply in-person, they are told to go home and do it online.
- There is no assistance available in many MSDSI offices.
- People give up or go to other orgs and use up important resources that are already stretched; this is an offloading of services to non-profit organizations.
- The phone system creates huge barriers.
- People without home phones cannot access MSDSI phone serves and offices tell people to go home and call.

PWD assessment and adjudication

- PWD adjudication is inconsistent. There are waves in adjudication style; currently lots of PWD applications are being initially denied and then approved on reconsideration.
- Most applications denied are approved on reconsideration; it's a waste of everyone's time and money.
- A lot of people give up and don't go to reconsideration → savings for the Ministry.
- Doctors don't want to increase the client's feelings of hopelessness so he/she focuses on promoting what the client can do instead of what they can't, but the PWD criteria forces clients to fit themselves into negative boxes about what they cannot do.
- There is no support for doctors about how to full out the PWD application form.
- If someone knows to go and get help, they are much better off because the advocate will coach the doctor. This is inequitable.
- It also creates needless workload and makes it very hard to help people because it seems like it's not in MSDSIs interest to encourage doctors to fill out form properly.
- Historically, there have been periods when PWD applications are more frequently denied; other benefits like Monthly Nutritional Supplements and Person with Persistent Multiple Barriers seem to follow similar patterns.
- Adjudication was pretty good for a while, but tide is turning now and people are getting denied that previously would have been approved. The denials are unreasonable. It seems to totally depend on who adjudicated the application.
- There are also people who cannot even get PWD application submitted. They have no GP and cannot get into an advocate's office.
- The increasing wait for initial adjudication is also really problematic for people.

- People apply for PWD because they need the money and then they get saddled with labelled with "disability" and they end up on longer than they would have been otherwise. Framing periodic conditions in the worst light possible to get PWD status becomes self-fulfilling all because the client is trying to get the increased rate.
- Clients need exact words to get PWD status or to get a disability-related benefit. Advocates end up getting the doctor to say the exact words.
- The Ministry's rules are not accessible and transparent. The rules are also more and more specific and they're changed a lot so it's hard to keep up.
- The current system doesn't recognize the episodic nature of illness.
- Remand system: clients with addiction issues cycle through, people never get Persons with Persistent Multiple Barriers (PPMB) or PWD (they're they are told not eligible).

Persons with Persistent Multiple Barriers

- Addictions are expressly excluded; this is a huge barrier for those people and it's punitive and judgmental.
- The exclusion of addictions from PPMB is a human rights case.

Other benefits provided through MSDSI

- Healthcare benefits are difficult to get even with the assistance of an advocate. It is difficult to determine eligibility and hard to get the same information from doctors for different reasons.
- Getting a health benefit is incredibly labour intensive; it can take 3–4 notes from the client's doctor. The doctor feels disempowered and it hurts the client's relationship with their doctor.
- It's hard to get the necessary information from doctors because they don't get paid for it.
- Even to get a crisis grants, you need to use the exact wording or it won't be granted despite the client's need.
- I suspect a lot of people don't get things because they don't know the exact phrases to use.
- Many benefits that used to exist don't exist anymore (for example, I had a client who had a tracheotomy and needed an electronic voice box, but it wasn't covered anymore so we had to be put under wound care).
- Access to health supplements is erratic.
- Sometimes clients cannot pay for their medications and they're under special authority so they can't get them (sometimes Plan G will cover it, but sometimes it won't).
- Bus passes are a nightmare. You cannot get in and try to get an application. It's very stringent and if clients have barriers it very hard to coordinate to get to it.

PWD rates

- The current rates also don't allow people to live.
- It doesn't make sense to draw the distinction between disability and welfare. The rates are inadequate no matter what the client is one and disability-related costs can be made up through supplements.
- Page 3 of disability white paper powerpoint hand out: the tone is that the government is spending a lot of money and don't want to be. Disability supports need to be raised. Where will it come from if the budget is likely to be cut?
- I'm tired of hearing the Premier say that tax payers don't want that or want to pay for it. I would really like to know where they get that from (do they only care about tax payers?)

For people with mental health and addictions disabilities, what can BC do to reduce the barriers to accessing provincial disability supports?

- Fast track for high needs clients.
- Designated workers for people with mental health disabilities. Now, you can ask for one, but it's not transparent and no one knows about it. Make it proactive and not based on having to ask.
- Train EAWs on accessibility issues.
- Provide flexibility to come on and off the system—this would promote more holistic recovery for people.
- Better training for the doctors about what the different benefits are about (types and levels of disabilities, especially with respect the mental health issues).

- Training for staff and doctors (like police training on how to assist people with mental health conditions).
- Develop a tiered system so that the doctor can just review the form. Fund peer support for clients to complete the majority of the form themselves.
- Create some kind of referral service to help high risk or marginalized clients find doctors to help them with PWD applications or to even take them on as patients. Currently, clients with addictions issues may have a hard time even finding a doctor to take them on.
- Develop a literacy level assessment for the client so the system has an idea of what you're dealing with (see California).
- Use a client centred, full spectrum model instead of assuming everyone is at the same level.
- Acknowledge and embrace the legitimacy of peer-driven organizations for what it means to have that condition/diagnosis, etc. (look at other kinds of service models).
- Acknowledge that improvement should not be a barrier to accessing future services. The current system stops you where you are and doesn't acknowledge your strength.
- Ensure fluidity and flexibility in supports.
- MSDSI needs to be keep track of people who are on Medical Services Only (MSO). Staff are booting people off this system in error. Making sure that people who are eligible stay on it.
- Provide education to decrease the stigma around mental health diagnoses so that clients get the services they need.
- Fund English and a second language/cultural services for people so that they can access the services they need.
- Acknowledge that it's most effective to deal with people in a way that avoids crisis instead of causing it. It saves cost in the long run and needs to be part of the balanced budget/cost effectiveness discussion.
- Train workers to be nicer, and support them because they're burned out.
- Open up a human rights commission.
- People who work at MSDSI should have legal responsibility to tell people everything they're entitled to and they should not have to rely on an advocate.
- Those that get status are the less needy because they have better supports. We need to shift to ensuring that those with the most need get the services.
- Go back to the old model that included a mandate of proactively looking for those that are in need.
- Make system more flexible to accommodate people that don't fit into computer boxes (systemic barriers currently bar people from accessing that).
- Right now, if you get PWD status, you get no life. They should offer accredited treatment; if you finish it, you get into recovery homes as long as school/working. After that, depending on nature of disabilities, your supports would vary. (Be part of society again again)
- More qualified treatment programs.
- We need to reassess the whole economics of mental health and look at what passes as evidence-based treatment at the moment. In fact, even in mainstream psychiatry, research shows that meds do not work and produce great harm. Harm ends up adding to the medical bill because of diabetes, etc. as an example. Right now the money goes to drug companies. Unless you bring that into the picture, you can't get a real picture. Assertive community treatment is about enforcing compliance with meds; it's about money going to drug companies (for treatments that don't work).
- We need a poverty reduction initiative. There are only two provinces that don't have one in Canada and it has a huge cost not to have one.
- We can reduce health costs if we go back to determinants of health model—housing, income, etc. as a first priority and fund actual need.
- Re-jig the third party administration system. Right now, people end up getting caught between the third party and MSDSI (people don't get what they need).
- We need individualized funding; it will lead to increased autonomy and cost savings.

Table 1 Facilitator's summary of three key points:

- Centralizing service delivery and overtaxed staff create major barriers for people with mental health issues to access Ministry services.
- Those that have the highest needs are the most likely not to be able to navigate the system.
- We need a client-centered approach to service delivery focused on determinants of health (housing, adequate income, etc.) and actual need.

✷Table 2

For people with mental health and addictions disabilities, what are the current barriers to accessing care?

Unwelcoming system

- A general lack of respect in the system for patients experiencing mental illness makes it feel "unfriendly" and can result in making consumers feel frightened of the police, court systems, medical systems, etc., that are in place to help them.
- Comparison made between the empathy that patients find when getting care for cancer vs. mental illness.
- Disrespect/lack of understanding comes from police, doctors, etc.
- Especially if first point of contact with the mental health system is through the police, you are often treated poorly. This can be a traumatic experience and erode trust in the system. First encounters are unfortunately often memorable and troubling.
- Hospital environments are not conducive to mental health and recovery. Physical environments themselves are often not therapeutic. It is difficult to communicate, staff not always pleasant or approachable.
- There is secrecy within the system. It's difficult to find information about your own care and the services available to you.
- It does not feel like care is individualized to the needs of the person. Patients are interacted with as a "diagnosis" not as a person.
- Police are ill equipped to deal with mental illness concerns.

Available treatment options

- The mental health system does not address non-traditional views or approaches to mental health.
- Services are focused on medications but not on other forms of therapies (such as talk).
- Coverage for non-medical treatments (especially complimentary therapies) not covered by Medical Services Plan (MSP).
- People are unable to access wanted services (such as counselling) due to availability and cost.
- The mental health system feels difficult to access and acute care focused. You must access system through Emergency Room (ER) dept.
- There is less availability for services that are preventative.

Fragmented services

- The system is divided/segregated/fractured and communication between parts of the system is not always smooth. It can be difficult and overwhelming to navigate.
- Currently you have to "shop" for different aspects of care at different places/with different people. For example, money is from the ministry (PWD, Income Assistance, etc.); medication is from a psychiatrist; housing is from a housing coordinator, therapy is from a therapist or group (and not always covered by MSP).
- Further, one Cognitive Behavioural Therapy (CBT) group may be full and another may be accepting patients; these groups don't necessarily know about one another or know that there is space in the second group.
- Confusing to find services.
- It can be hard to find the services that you need online.
- Often the websites themselves (eg. Health authority or ministry websites) are confusing to navigate.

Stigma (from community and system)

- Stigma can prevent people from wanting to access help for mental illness before it becomes worse.
- Embarrassment created when involved with police or mental health services.

For people with mental health and addictions disabilities, what can BC do to reduce the barriers to accessing care?

- Lack of respect: Police and first responder education or have mental health workers present for all mental health related police calls. Stronger differentiation between arrest and apprehension (health vs. criminal issue).
- A smoother/more streamlined system for accessing care would be helpful. Barriers to a streamlined system should be identified and addressed.
- A central place to access mental health services (online or in person) may be helpful. This could feature peer support workers who understand both the system and the experience of accessing it well.
- The differences between mental and physical disabilities should be recognized and these differences should be accounted for and built into the system.
- Need to provide better ways to find services. For example, a centralized place to find services and complimentary therapies.
- Gatekeepers needed: people who are approachable at the gate rather than doctors only (potentially peer-support workers or people with lived experience).
- More opportunities for people with lived experience in mental health roles, specifically well paid positions that encourage lived experience to apply. This would create a system that encourages people on disability to work.
- Car 87 is always busy, may need more of these available.
- Decreasing waitlists for needed services and groups. Acknowledge the demand for services and improve communication between existing services (ie. there are multiple groups that offerCognitive Behavioural Therapy (CBT) but not all are well known to the public or each other). Offer better follow-up/consistency.
- Fragmented services: we need better entryway points to service; better communication between bodies; decrease costs and access for non-traditional therapies and talk therapies; increase preventative services; and provide better communications between different transitions points in service (Community → hospital → etc.).
- Respond to mental health concerns in a less obvious manner (non-identified cars, without sirens blaring to decrease embarrassment/stigma for the people they are picking up).
- Need to identify barriers and backup points in the system and streamline them so that patient doesn't have to "shop" at different places for different types of service (PWD, Employment, housing, medication, therapy, etc.).

Table 2 Facilitator's summary of three key points:

- There are problems with initial access points to the mental health system.
- The system is crisis-driven and lacking in preventative/lower acuity services.
- The system is very difficult to navigate.

✷Table 3

For people with mental health and addictions disabilities, what are the current barriers to finding secure, long-term employment?

- Resources. Phone, internet all needed for a job.
- Need transportation, which costs money too.
- If you have to have particular clothes for the job, have to but those, but no money.
- Time. Takes a lot of time to care for other needs before you can even start looking.
- For example, taking care of medication can often be number one challenge, but need to care for that before person can consider working. Takes time and money. Many people don't know about government program to cover meds.
- With income limits and deductions from welfare, you don't really get anywhere.
- Tough to know what to do with resume gaps. Hard to explain to employers.
- Prejudice from employers if they find out about mental illness. Duty to accommodate, some employers are good but others not so much.
- Volunteering has value for people with disabilities, but Ministry has messed around with volunteer supplement.

- Need flexibility in the workplace is needed. Good days and bad days. Volunteering is great for this because it provides structure and lets person be productive without rigidity of job.
- The application process can be very stressful, especially when it stretches on for multiple interviews. This can adversely affect mental health.
- Bit of a mystery how employment centres work now. All integrated now, multiple government programs, but just doesn't seem to be as accessible.
- All services need to be more integrated and accessible to make it easier for people to access help.
- Concern about what's turning up on police record checks re: mental health.
- People with addictions face unique challenges. Not everyone who is using is unemployable. Problems in the past with Methodone, but people can work on a Methadone program.

For people with mental health and addictions disabilities, what needs to be in place to find secure, long-term employment?

- Apprenticeship and mentoring programs are key.
- Incentive programs for employers to encourage them to hire.
- Change how earnings are deducted from benefits to create more incentive for people to work.
- Rates need to be raised so people are not destitute.
- Services need to be more integrated and accessible so people understand what is out there to help.
- Create more help for people looking for work, help with resume's etc.
- Need peer support.
- Question whether people should be forced to work or volunteer as part of recovery and reintegration?
- Create more flexible workplaces.
- Encourage people to volunteer.

Table 3 Facilitator's summary of three key points:

- Improve employer accommodation training and availability.
- Increased resources to apply for work needed.
- Develop Incentives increased for hiring and increased accommodation assets.

✷Table 4

For people with mental health and addictions disabilities, what current barriers exist to finding safe and secure housing?

Adequacy and affordability

- There simply isn't enough safe and secure housing.
- Stock/availability of housing units. Tenants generally face the issue of sacrificing tenure vs. safety.
- We need to take a look at the parameters of the program; balancing the budget—overarching issues is affordable housing.
- The government refuses to acknowledge that not building housing is more expensive than building housing.
- Elected government as a barrier; the problem is that voters are not aware (lack of public knowledge). Make housing affordable—look at interventions in the market in a much broader range of income levels. Opening that up would mitigate problem.
- Health regions—reallocate dollars and resources per health region.
- Affordability—welfare rates for children have gone up. Housing rates are insane. Usually the only option to survive. People use 80% of their benefits on housing and that makes them more vulnerable.
- The BC Housing model has problems. For people who are living in BC housing buildings with mental health issues, behaviors associated with mental health and addictions will put their tenancy in jeopardy.
- Low income—people cannot keep up with healthy diets. They need better food intake, etc.
- Rental subsidies—tenants cannot make more than a particular amount of $.

Legal protections

- BC Housing residents have no rights whatsoever and their tenancy is dependent on the decision of service providers.
- Residential Tenancy Agreement (RTA): There is a lack of legislative protection for shared accommodations and transitional housing. This lack of coverage impacts those with mental health issues.
- Recovery houses—individual landlords will rent, sign tenancy agreements, but say it's not under RTA.
- No flexibility about whose conduct is contrary to expectations to the RTA. Legislation doesn't accommodate flexibility in terms of mental health.
- Mental health education should be part of licenses and tenancy.

Public and private housing options

- Subsidized housing dispute resolutions are generally handled by non-profits, which are not properly equipped deal with them. They also lack an effective oversight in dispute resolutions and in other aspects of non-profit subsidized housing. Non-profits are an excellent examples for not providing housing—providing housing vs services.
- There is a lack of accessible outreach – private landlord market—tenancy system doesn't support system for making accommodations for disabilities.
- We need a legal housing model where there is support provided and it is effective, but tenants are protected. We need to recognize that one program does not work for everyone and that there are different stages of housing (e.g. sober housing, women's only, etc.). We need a spectrum of housing options and the RTA needs to apply so people have recourse when things go awry.
- Lack of housing—supportive housing.
- Mental health disabilities are viewed differently than physical disabilities. They are not recognized in communities. Landlords do not generally recognize mental health symptoms and concerns as disability-related. STIGMA.
- Difficult to apply for subsidized housing and people can drop out of program/wait list or get knocked off without being informed.
- Home care required otherwise living standards may be difficult and dangerous.
- Mixed buildings (sunset towers on west-end)—expectation that everyone abides by the same rules. It's very difficult.
- In low-income buildings, most residents are drug addicts.
- It's difficult to find accommodation because landlords know where payments are coming from (MSDSI). Privacy is not there.
- Difficult to keep housing especially if it's for-profit housing.
- If you are a responsible tenant, you should not be forced to disclose particular illness.
- Public housing—serious shortage of homes. Someone needs to take a look at BC Housing. When people can get out of that "desperation" period. 3 cars per one unit—they can pay rent. BC Housing employees receiving grants event though they receive lots of grants.

For people with mental health and addictions disabilities, what can BC do to make it easier to find and keep safe and secure housing?

- We need more housing.
- Skills development programs.
- Have rights be protected.
- Navigation system.
- 5000 units of housing should be built immediately.
- Rent freeze should have happened. Stop the wealthy exploit the poor.
- High property taxes.
- Long way to go before people would be comfortable renting out to someone to someone with disability or welfare.
- Skill building—networks of friends. Can cause problems because of parties.
- Workable, natural, life experiences.
- Want to house communally—having cheques and payments coming in.
- You can find responsible people to live with.
- Problem: massive amounts of housing that is left empty.

- Safe and secure housing: Vancouver Coastal Health region; who gets to define what is safe and secure. Vancouver Coastal Health (VCH) currently expanding their teams and defining "safe and secure housing"—definition tied with programs that enforce medication regiments. We need to define for ourselves what is safe and secure housing.
- Disabilities in general: provision of housing for people with particular disabilities. What about other people with multiple disabilities—and how that effects their medication.
- Make the language easier—navigation services. Make it easier for people to understand what is available to them. Each complex is suitable for A, B, C.
- Independent living to suit different needs: full assistance, or just to administer medication. How many resources they should be allocating.
- Stage housing—provision of stage housing.
- Skills building is very necessary.
- You do not understand why you are being micro-managed, but sometimes homes need that structure. You want to maintain independence. Need a balance.
- Rent freezes.
- How do you get on that particular list for a particular home? System navigation.

Table 4 Facilitator's summary of three key points:

Challenges:

- Affordability of rent—individuals experiencing mental health issues, unemployment
- Availability of housing units (private and public)—lack of stock
- Accessibility to housing programs and services by people with multiple disabilities—requirements for individuals to access housing programs and services

Opportunities:

- Rent Freezes
- Skills development
- Improvement in systems navigation

✸Table 5

For people with mental health and addictions disabilities, what current obstacles exist to engaging with and being supported by their communities?

Stigma

- Medication, gaining weight, etc. Is the physical part of living with a mental disability (need more support to reach their physical challenges).
- Mental health and addictions (addictions is stigmatized- you are a criminal and not worth anyone's time).
- Communities are concerned they will steal something, worried they will break something.
- Peer support model for addictions is seen as a drug sharing.
- Not able to be acknowledged as a disability often.
- Can't find an addict stable enough to go through a court case to move forward.
- Very nature of addictions make it more marginalized.
- People only want to be around the palatable addicts/ palatable mentally ill.
- Unfortunately those prejudices exist among mental health consumers and survivors too.
- Distancing saying drug users are different than mental health patients—not a dichotomy.
- In Vancouver, huge segregation in community (extreme wealth and extreme poverty; two sides never meet); why labeled as mental health community?! When I lost my job, couldn't find a job and then grouped into homeless slot.

Service delivery

- Issue with community agencies talking to each other and sharing knowledge of who does what (need to research to find out what others do and know what is accessible).
- If it's hard for an advocate to figure it out, it must be hard to someone who isn't connected to the system to figure it out too.
- No means to communicate with workers at this point.
- Positions are being eliminated which eliminates possibilities to do things in a systematic way. Huge loss to plan, see gaps and look to future.

- Don't know what community to help us (doctors need to help).
- Some people just take medicine but don't have support—doctors need to help direct patients.
- It is easy to say go here for food, but what about what exactly should I eat? One mental health dietician at my organization; not enough to go around; not enough support.
- Not in a good place to take that first step so need someone to help you (advocate).
- Many patients are cut off at the start because of the way they are going at it (addictions patients).
- We are not equipped to understand patients who have trauma.
- If you don't want into a disabilities office with the exact demeanor they want, then you are done and no service provided (doesn't work for all patients).
- Face to face contact has been taken away; huge additional barrier.
- Changing a community can make it more difficult to access services (push of social mix to fix low income, not high end communities and you're not welcome in any community).
- Community with mental health services and addictions (ex. Downtown east side, want to live because access to community and peer support, and a park- and others don't want to stay there cause it can be triggering).

Other

- Historically we have looked at a disability model from a person centered approach without thinking about the community and the community's responsibility.
- We're trying to change the person without changing the environment.
- Engage community in how they can help and what role can they play?
- Financial: community itself can either provide a financial discount or break on something; like a community centre (access passes); what more can they do to help with that financial barrier?
- People are shocked to learn about what others do.
- Need to connect with others but not sure who is out there.
- Need open interdisciplinary dialogue to discuss who is available and what they do.
- Problem with motivation.
- Depends on needs at the time (who do they hear? Depends on who is around making noise!).
- Gap between how people experience their need and how they can participate in their own community.
- Hard to know the first step; once first step is taken, much easier.
- First step in services and then first step in mobilizing community.
- Motivational dialogue for interviewing would be a big eye opener for all employees to take.
- Motivation is important.
- Many people feel like they are stuck between a rock and a hard place—lack of community itself.
- People are saying that it's our community that must change, not helpful.
- Major depression sufferer, but the system is causing it (crippling system).

For people with mental health and addictions disabilities, what can BC do to make it easier for people to engage with and be supported by their communities?

- We need the education piece: reducing stigma and changing environment.
- We need to ask community what is your responsibility? And how can you support them?
- Very brief engagement today; engagement process like today should be ongoing and supported.
- Need to be listening to disability communities on an ongoing basis (democratic short fall).
- Need peer support worker; need friends/supports to help motivate people to plan.
- Need class to teach what food, medicines to take (help to read instructions), class to help edit a video to upload to Youtube.
- Open door is doing a photo study so ask them about a video editing course.
- Early 70s brief following—people trying to reclaim what mental health could be for themselves; seen as old fashioned now; we have lots of advocacy groups but also integrated into system.

- People who are suffering with problems should be notified (the poor).
- Democratic control of community agencies.
- People need to know how much the organizations are receiving, how much the employees are making.
- We need to say that police will not pick up mentally ill and take them to the hospital; not helping the problem.
- More than 1/2 people diagnosed with mental health problem have their first experience in a psychiatric ward and then are diagnosed; not a good way to deal with it.
- Police have no role in mental health and addictions.
- Trauma informed therapy—they are not supposed to upset you (no guns and not hand cuffing patients).
- People who don't want to connect with community if they are marginalized.
- Don't want it connected to police, it goes on your record.
- A lot of people are experts in their own mental illness and are sick of being told how to behave (so it needs to be client driven).
- University of BC (UBC) project: treatment of heroine so they can get their lives back; success stories out of program in Europe; critical for people who are addicted to get stable supplies to integrate back into society.
- Patients could be self-medicating for a more serious mental illness.
- Peer support workers could be gatekeepers to community in general.
- In Vancouver, a big community, difficult to feel connected.
- Need a mentor to help navigate the system.
- Stigma is a large issue (more mental health events, social media, more big screen movies related to mental illness)
- Need to have things at schools where it starts in elementary and secondary where they are taught about mental illness.
- Need to make it so it's not a foreign you/us thing.
- So much fear, so need a way to tell the story in a way that there is an integration (some way to break down the fear and personalize it—need to do this in a way that is not just focused on the mental health community stepping up).
- More Technology, Entertainment, Design (TED) talks on mental health.
- Initiatives at the Royal Canadian Mounted Police (RCMP) level to make police officers better trained to support mental health patients (training happening in BC, mandatory for new recruits).
- Need a lot more of it (training).
- Police and physicians should not be the front line mental health workers because they don't have the training to receive it; refers to psychiatrics, etc. instead of providing resources.
- Have a community where everyone know where to go for their specific service.
- Crisis line can play a large role (people can get help and call to get resources as a preventative measure—get steered into the right direction).
- Change name of crisis line (mental health information line?).
- Marketing it better (bus stops, crisis line name); shift name.
- Every community has a clubhouse; so people who have issues can go there and spend some time.
- Some agencies will help get employers on to help support you.
- Who is the gatekeeper? The police are.
- Catch 22 with smaller communities (you know where things are but it is limited).
- Don't want a sea of information to know where to go. 211 redbook (can get a copy).
- Funding may make it difficult for organizations to communicate (muddled vision).
- Need to know you have a mental health issue first (getting education to recognize the warning signs to reach out for help).
- Heretohelp.bc.ca
- Separate crisis line and separate resource line.
- Interactions between people with police and people with addictions is negative (get people together in a symposium with more.

- First point of contact with community is often police which stigmatizes you as criminal, etc.
- Police have stigma too (they are for safety and help for everybody).
- Communication between community and police is paramount.
- Police headquarters are in stable neighborhoods not troubling neighborhoods.
- Police are in schools as part of community.
- "to serve and protect" is police slogan (but it is more to repress and protect).
- Specialized mental health officers would be helpful.
- Only one person responsible for this (car 87) that has a nurse or someone in civil clothes, sends a different message (need more of these).
- Within mental health system itself, blank stare for services (unwilling to share information); information needs to be open and easy to access.
- Need a centralized portal to share information.
- These people need more services/support than general population (get benefits, services that you need, based on conversations and relationship).
- More social workers connected to those positions where the gateways are and peer advocates so we know where to go; what to do.
- Partnership within organizations but still gap between us and governments.
- Great if information is all available online; not helpful if you call a number and the secretary is new and has no idea; no one available to help.
- Community centers could help; have community courses to support.
- Problem with support programs is that it is based on funding, no stability there.
- If support services don't have stability and support, how can we support those in the community?
- Reduced budgets from government but expected to do same work.
- Involuntary discharges because of funding cuts (one year program regardless of where you are).
- Diagnostics were not meant to include/ exclude people; wasn't supposed to hamper system (diagnosis has a bad name because of exclusion criteria instead of being used as a treatment and theory).

Table 5 Facilitator's summary of three key points:

- Increase advocates/ peer supports/ mentors.
- Increased communication between organizations and between police and community.
- Reduce stigma (more communication, increased education, better marketing).

✷Table 6

For people with mental health and addictions disabilities, what are the current barriers to income or financial security?

MSDSI issues

- Abolish the five week months—would increase overall income.
- Disabled benefits—the more screwed up you are the harder it is—lower barriers for people with disability.
- PPMB—person persistent multiple barriers excluded addictions. So, if your primary issue is addiction, then you can only get lowest level of benefits.
- People who could get on PPMB—have to have been on welfare for the last 12 of 15 months—this is a barrier.
- Bus pass—has already been paid for—issues with selling—paying for picture.
- Lack of ability to find out what is available—fear of going to the welfare office—have security guards in the office—pressure on people trying to access it
- Workers should be able to tell you what you are entitled to.
- Trying to access disability—can be held up by therapists who don't support the patient.
- Incredibly difficult to find out what you can do—need exact wording.
- On disability they are supposed to give you all the pamphlets—should be some local place

- Orientation to the process is hard for those advocating.
- Less info they give you the less money they have to spend.
- Alberta got $500 raise in disability—why is ours so low?
- We have too many people on disability.
- Rates—when did they last go up? Rent vs welfare—should have a regional indicator of inflation.
- In Alberta, they don't have the same policies. You can keep what you earn—less administration.
- Like being under a microscope—being on a battlefield—welfare office.
- Toll free number—frustration in calling in.
- Deductions are a problem—can't get trusts, bonds, insurance, those go against your cheque—everything is deducted.
- Can make 9000 a year—then deducted dollar for dollar.
- They have access to your bank account—you can only have 5000 savings.

Other issues

- Surrey have 20 tickets for skytrain to go to new west for medical and legal—lack of access transportation.
- Take a fee for methadone from your disability.
- Job training.
- Inter-generational problems—poverty links
- Housing co-op trying to push disabled people out.
- Lack of flexibility in policies.
- Lack of mental health awareness.
- Government's assumption of literacy is a problem.
- Job training—should be a program that give incentives to employers with positive messages—how disabled people can contribute to society.
- Accommodations lead to stigma—difference between physical and mental disabilities.
- Need to show employers how it will benefit them to hire people with disabilities.
- Registered Disability Savings Plan (RDSP)—save up until 49 then collect at 59.
- Complete lack of financial security.
- Emotional aspect.
- Putting walls between consumers—not serving the people who need it the most.

For people with mental health and addictions disabilities, what can BC do to reduce these barriers to income or financial security?

- Guaranteed annual income—people wouldn't be stigmatized.
- Raise the rates!! To a living disability wage—similar to private ones
- Needs to be transition planning—from whatever you've been on to financial security.
- Like ageing out of foster care—financial plan.
- Start providing office service again—re-open the offices they've closed, provide continuity.
- See social workers in administrative positions.
- Mental illness often starts quite young—hard to do when you've dropped out—need to develop programs.
- Wage subsidies and training.
- RESP—hard to get people to want them—need to have a caregiver to set up RESP. Also RESP is not provincially protected.
- Address the problems with having to get certified or designated as disabled.
- Criminal records—tied in to problems with health.
- Importance of family help.
- Collaboration between gov't social worker and caregiver.
- Diversity rather than disability.
- Develop and ID number for PWD—recognized across institutions and gov't.
- Move away from looking for fraud—like shelter benefits and focus on supporting people.
- Increase accessibility.
- Increase the rates.
- Change PPMB—make it so people can get on quickly and to access to addictions services.

- Asset management and development—Judith Cook prof.—matching funds from orgs in special savings.
- RDSP—only geared towards those who are young. Widen it.
- There is a disability trust but we need another category to help people to save money.
- Stop with child support claw backs—no benefit from extra money.
- Child Tax—also clawed back is lump sum paid.
- Make sure that you are developing a population that is literate—life skills and literacy.
- Plain language doesn't make the whole thing better or easy to navigate.

Table 6 Facilitator's summary of three key points:

- MSDSI benefit rate are inadequate.
- We need to increase accessibility of the welfare and disability assistance system.
- Asset development is important.

About the Canadian Mental Health Association, BC Division (CMHA)

CMHA BC is part of one of Canada's most established national mental health charities. Our vision is mentally healthy people in a healthy society.

As the nation-wide leader and champion for mental health, CMHA facilitates access to the resources people require to maintain and improve mental health and community integration, build resilience, and support recovery from mental illness or addiction. We do this by building capacity, influencing policy, providing services and developing resources.

Each year, CMHA BC together with a network of 18 BC branches provides services and supports to over 82,000 British Columbians, promoting mental health for all and supporting the resilience and recovery of people experiencing mental illness or addiction.

To learn more visit www.cmha.bc.ca

Contact us

1200-1111 Melville Street,

Vancouver, BC

V6E 3V6 Canada

Phone 604-688-3234

Toll-free phone (BC only) 1-800-555-8222

Fax 604-688-3236

Email info@cmha.bc.ca