COMMUNITY-BASED MENTAL HEALTH SERVICES IN BC

CHANGES TO INCOME, EMPLOYMENT, AND HOUSING SUPPORTS

Marina Morrow

with Silke Frischmuth and Alicia Johnson

AUGUST 2006

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CANADIAN CENTRE for POLICY ALTERNATIVES
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Summary

BC has been seen as one of the leading provinces in Canada in mental health care reform and in the development of active recovery models of treatment for people with mental illness. Active recovery models recognize the importance of providing a range of hospital and community-based services and the critical links between income, employment, housing and mental health.

In 1998 British Columbia released a new mental health plan that proclaimed BC's commitment to enhancing mental health care throughout the province. Since that time, the government has organized mental health care in different ways, but has always returned to the commitments in the 1998 plan. The plan pledged increases of annualized funding for mental health services including supported independent living beds, residential care resources, and increases to staffing and training for community-based services.

A key goal of the plan was to work towards comprehensive, integrated mental health services. One promising development in this regard was the establishment of a Mental Health Advocate, the first position of its kind in Canada, to help monitor systemic problems with the mental health care system.

However, an evaluation of the plan in 2001 by the Minister of Health's Advisory Council on Mental Health[i] (prepared for the new provincial government) found that the province was already behind in its commitments, especially with respect to providing adequate community resources and in meeting service targets for housing, clinical care, rehabilitation and crisis services. Three years later, the Minister's Advisory Council reported that the government had still not fulfilled many of its commitments, including the completion of performance measures and accountability structures in mental health and the development of comprehensive discharge planning for individuals leaving hospitals.

When the current government came to power in 2001, one of its first actions was to eliminate the position of the Mental Health Advocate and the protected envelope for mental health services that previously ensured that money allocated to mental health would not be used for non-mental health related services. The government reduced staff in the Adult Mental Health Division of the Ministry by 70 per cent, thus radically altering its policy and leadership capacity. During this time the government also instituted deep cuts to social welfare services and legal aid. To date, little attention has been paid to the combined impact of cuts and policy changes to social services and mental health care.

This study is concerned with documenting the changes and examining the current impact on housing, employment and income-related supports for people with mental illness, with a particular focus on one BC health region, Vancouver Coastal Health (VCH), which includes service areas in Vancouver, the North Shore, Coastal Garibaldi, and Richmond.

The study finds that some positive steps have been made under the current government. For example, income assistance rates for those designated as Persons With Disabilities (PWD) were increased by $70 (merely bringing the after-inflation rate back to where it was in 2000), earnings exemptions for people with disabilities and persistent barriers to employment were increased to $500 per month, supportive housing units for people with mental illness were added, the Premier's Task Force on Homelessness, Mental Illness and Addiction was established, and mental health and addiction services were integrated.

Nevertheless, this study finds that the negative impacts of the government's recent cuts and policy changes outweigh the aforementioned positive developments. For example:

- In BC we do not have comprehensive, accurate data of the numbers of people with mental illness who are homeless and/or under-housed and therefore do not know the full extent of poverty amongst people with mental illness.
- Changes to eligibility criteria and the complexity of the application process for both basic income supports and disability benefits have made it virtually impossible for people to successfully apply for benefits without the help of an advocate.
- Advocacy mechanisms for the meaningful participation of consumers in treatment decision-making and policy development have been badly eroded.
- Community-based mental health services continue to be under-funded and active recovery models are under valued in the overall system of mental health care.
- Housing for people with mental illness that conforms to federal best practices standards is extremely inadequate and wait lists are unacceptably high.
- Housing, especially in Vancouver, is often provided in unsafe locations and outside of a therapeutic environment.
- Employment supports in the province are geared primarily toward people without mental illness. Further, support for innovative models that actively promote consumer empowerment through meaningful activity is lacking.

The provincial government has ignored its responsibility to develop a comprehensive mental health strategy for the province that establishes the provision of income, employment and housing supports to people with mental illness as part of comprehensive mental health care provided by the Ministry of Health.

Overall, this study finds that, despite some positive initiatives, the province has acted without an overall framework for mental health that recognizes the importance of income, employment, and housing security for people with mental illness. This study's analysis suggests that the province has lost sight of active recovery models and is letting a preoccupation with cost containment guide decision-making, rather than the values reflected in 'best practices'[ii] for the care and support of people with mental illness.

Notes

[i] The Ministry's Advisory Council on Mental Health established in 2001 was comprised of 15 people from various parts of the province representing in equal membership consumer, family, and caregiver perspectives. Appointments were made through nomination to the Council by the Minister of Health. The role of the Council was to advise the Minister of State for Mental Health about provincial mental health service delivery and reform. The Minister of State for Mental Health and the Advisory Council have both subsequently been eliminated.

[ii] In 1997 the Health Systems Research Unit of the Clarke Institute of Psychiatry, under the auspices of the Canadian Federal/Provincial/Territorial Advisory Network on Mental Health, released the report, *Review of Best Practices Mental Health Reform*. Subsequently, BC formed working groups to undertake consultations and a review of the literature in order to establish best practices for BC's mental health system. The result was seven reports, entitled *BC's Mental Health Reform Best Practices*, published in February 2002 (see http://www.health.gov.bc.ca/mhd/bpelementsbc.html. Accessed, June 2005).

OVERVIEW

Key Changes to Supports for People With Mental Illness Since 2001

Mental Health Care

- 56 health authorities rapidly amalgamated into six, and Greater Vancouver Mental Health Services absorbed into the newly-formed Vancouver Coastal Health Authority (VCH).
- Staff in the Adult Mental Health Division of the Ministry of Health reduced by 70 per cent, and further staff positions lost as new management structure implemented.
- The model of mental health service delivery shifted to a corporate, cost-containment orientation.
- The position of the Mental Health Advocate eliminated and provincial structures that supported the input of consumers and families de-emphasized.
- Cuts in community-based mental health programs.
- Loss of the protected envelope for mental health monies within the Ministry of Health. The mental health budget is now subsumed under the general health budget, making it vulnerable to being used for resources outside of mental health.
- Cuts to mental health teams and to psychosocial rehabilitation programs, resulting in unacceptably high caseloads for mental health workers.
- The position of Minister of State for Mental Health and Addictions and the Minister's Advisory Council on Mental Health created, but then subsequently eliminated.
- The amalgamation of mental health and addictions under the Ministry of Health.
- Riverview Psychiatric Hospital redevelopment that resulted in $138 million investment in tertiary care facilities being developed in regions throughout the province.
- Development of initial mental health performance indicators.

Changes to Disability Benefits

- Repeal of *The Disability Benefits Program Act* and its replacement with the *Employment and Assistance for Persons with Disabilities Act.*
- The government review of all people receiving disability benefits (due to public outcry, this review was eventually cancelled for people with mental illness).
- The addition in the new Act of mental illness or a cyclical or episodic illness as a possible criterion for receiving benefits.
- Replacement of Disability I and Disability II with two new designations: Persons With Disabilities (PWD) and Persons with Persistent and Multiple Barriers to Employment (PPMB), and the introduction of a new application process.
- The loss of a permanent disability designation, which means that a person's status can be reviewed periodically to confirm their eligibility for assistance.
- In response to a court challenge, the introduction of policy changes by the Ministry of Employment and Income Assistance that promote greater fairness when the ministry alleges overpayments against recipients of income assistance and disability benefits.
- The determination that addictions, when they are the person's primary problem, do not count as a medical condition sufficient to warrant eligibility for disability benefits.

- The introduction by the ministry in 2003 of an "employability screen" for people designated as PPMB that assesses employability (not disability) to determine whether the person is eligible to continue to receive supplementary benefits.
- The increase by the ministry in 2005 of support benefits by $70 per month and the increase in the allowance for additional income from $200 to $500 for those designated PWD. Earnings exemptions for those designated PPMB also increased to $500.
- Staff cutbacks and wage rollbacks for organizations that provide advocacy for people with mental illness to access disability assistance.
- The ministry reorganization of its Employment and Income Assistance workers, such that clients no longer have consistent caseworkers who know their personal circumstances. Instead, a "pod" system means clients never know who they will be dealing with. This move has caused distress for clients who are often required to repeat their histories for new workers.

Changes to Employment and Rehabilitation Supports

- A move to individualized, cross-disability supported employment and education that fails to address the specific needs of people with mental illness.
- The establishment of the Employment Strategy for Persons with Disabilities (EPPD) program in 2004. These services are available to BC Employment and Assistance (BCEA) clients with a PWD or PPMB designation and to non-BCEA clients who have been accepted for planning and employment services.
- The expansion of BC Society of Training for Health and Employment Opportunities (THEO) services across the province.
- Cuts to some VCH employment programs, particularly outside of the City of Vancouver.
- Increased funding for employment programs through the Ministry of Employment and Income Assistance, while funding through the Ministry of Health Services remained the same.
- Introduction of performance-based funding, which created a disincentive for program providers to offer extra services and an incentive to "cream" clients most likely to find employment.

Changes to Housing

- The centralization of the application system and access to mental health housing in 2002.
- In the VCH region, an increase in the number of supported mental health housing units by 153, emergency shelter beds by 38, and low barrier housing units by 595, though the formal waitlist for people with mental illness in VCH is still 750, and the informal estimate is much higher.
- The establishment of the Premier's Task Force on Homelessness, Mental Illness and Addiction.
- Changes to welfare policy to allow for only two outstanding damage deposits (except in circumstances where a woman is leaving an abusive relationship or a residence is being abolished or condemned, in which case the limit is extended to three).

In addition to the above summarized changes, changes to regular income assistance also had an impact on people with mental illness, as did changes to legal aid.[1]

Introduction

In May 2006 the long-awaited report on mental health by Senator Michael Kirby, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada,* was released and lauded by most mental health advocates[2] for its straightforward presentation of the appalling state of mental health care services in Canada.[3] Kirby's two key recommendations—the establishment of a Mental Health Care Commission and a Mental Health Transition Fund[4]—are designed to address the historical marginalization of mental health relative to the rest of the Canadian health care system.[5]

The marginalization of mental health care has been apparent in the scarce allocation of funding and resources. Indeed, since the deinstitutionalization movement of the 1950s and 1960s, advocates have consistently pointed to the lack of supports for people with mental illness at the community level and highlighted the links between mental illness, poverty, and social disenfranchisement.[6]

Although there have been some progressive reforms in mental health care over the last three decades (such as the introduction of recovery and empowerment models, mechanisms to involve consumers[7] and families in care decisions, etc.), the mental health care system continues to be bio-medically and clinically focused with an emphasis on symptom management and psychopharmacology with much less attention on addressing the social determinants of mental health.

Furthermore, few studies have focused their attention on how recent shifts in disability and social welfare policies might be perpetuating the problems identified in the mental health care system. This study looks at these links in one health region in British Columbia (Vancouver Coastal Health) with a focus on how changes and cuts are affecting housing, employment, and income related supports for people with mental illness. Although since 2001 the government has instituted some changes that

positively impact people with mental illness (such as a modest increase in supportive housing units), the cuts and negative policy changes appear to outweigh these benefits. This study's analysis suggests that the province has lost sight of active recovery models and is letting a preoccupation with cost containment guide decision making, rather than the values reflected in 'best practices' for the care and support of people with mental illness.

Many advocates have called for a paradigm shift in mental health[8] that would put people with mental illness at the centre of determining their care and their lives. In this paradigm the provision of mental health services is seen as just one aspect of a continuum of care that includes social supports and access to the "elements of citizenship"—housing, education, income, and work.[9] This study finds that the political decisions made since 2001 and ensuing policies and cutbacks are currently undermining the possibility this progressive paradigm offers.

Mental health care encompasses a range of hospital and community-based treatment and support options for people with mental illness, including acute care, inpatient/outpatient care, consumer and family initiatives, housing, income supports, and assertive case management.[10] Hospital and acute care resources are critical for stabilizing people and providing psychiatric assessments and drug treatment. Community-based services are the supports that sustain people once they have left the hospital—and when good services are in place, keep people from re-hospitalization. The term "community-based services" is used to describe both where services are located (i.e., in community settings) and alternatively to describe a philosophy of care (i.e., care that is based on consumer empowerment and recovery principles). However, not all services provided in the community enact community-based principles in their delivery of care.

Since the deinstitutionalization movement of the 1950s and 1960s, advocates have consistently pointed to the lack of supports for people with mental illness at the community level and highlighted the links between mental illness, poverty and social disenfranchisement.

In the Vancouver Coastal Health region, community mental health services are delivered by interdisciplinary mental health teams (nurses, occupational therapists, physicians, psychiatrists, psychologists, social workers and support staff) that provide specialized services to adults, youth, children and older adults. The VCH funds non-profit and private organizations to provide a range of housing options for people with mental illness. Vancouver General Hospital and the University of British Columbia Hospital provide acute services that include inpatient programs, ambulatory clinics, and consultation/liaison services. VCH also works closely with Providence Health Care, which provides emergency, inpatient, ambulatory, and specialized tertiary care services at several Vancouver hospitals and care centres.

The population that is provided with mental health care services includes individuals who have serious and persistent mental illness with or without concurrent addictions (representing about 3 per cent of the population) and others who have less serious and more episodic mental illness (representing about 17 per cent of the population).[11] Access to care is typically determined by severity of illness and the degree to which illness limits a person's ability to function. The emphasis is on medically managing high acuity cases, with less recognition of the need for stable housing and income supports. Additionally, there are individuals with mental illness who are undiagnosed and unable to access mental health care services and are therefore reliant on general community-based and social welfare supports. Recent analysis of the Canadian Health and Social Survey found that 5.4 per cent of all British Columbians have unmet mental health care needs. Of these, the barriers identified included accessibility (18.2 per cent), availability (16.3 per cent), and acceptability of services (76.3 per cent).[12]

The links between mental illness and poverty are clear, with the literature showing that poverty both exacerbates mental illness and can lead to poor mental health.[13] Although poverty numbers in Canada

are not disaggregated to accurately reflect poverty rates amongst people with mental illness, studies in the VCH region suggest that people with mental illness and addictions are disproportionately poorer than other citizens and often inadequately housed.[14] Statistics drawn from information about people who receive disability assistance in BC (of which mentally ill people are a part) show that 29.8 per cent of people with disabilities live in poverty, compared with 18.4 per cent of people without disabilities.[15]

The average annual welfare income for someone with a Person With Disability designation (PWD) in BC in 2005 was $10,656[16] or 51 per cent of the poverty line. For those people on welfare with a mental health problem who do not have a disability designation but who are recognized as having significant employment barriers (i.e., those with a PPMB designation) the benefit rates are even lower, and lower still for those on regular income assistance.[17] For example, individuals who live on income assistance in BC survive at a level far below an adequate standard of living and far below all measures of the poverty line.[18] Goldberg and Wolanski (2005) estimate that income assistance benefits in BC meet only 44 to 60 per cent of minimum living costs. Numbers compiled by Human Resources Development Canada (2003) estimate that 20 per cent of individuals in BC live below a decent standard of living.[19]

In Canada and the US, research shows that people with mental illness have extraordinary rates of unemployment.[20] Further, evidence suggests that those who become ill while in the workplace are poorly supported and are sometimes actively stigmatized and discriminated against.[21] In BC people with disabilities are more than twice as likely as individuals without disabilities to be unemployed.[22]

The links between mental illness and poverty are clear, with the literature showing that poverty both exacerbates mental illness and can lead to poor mental health.

The health implications of homelessness have been well documented.[23] Canadian and US rates suggest that the number of people with a diagnosed mental illness who are homeless is high.[24] The City of Vancouver 2005 Homeless Action Plan estimates that one third of the homeless people on Vancouver streets have symptoms of mental illness. In Vancouver, the number of people without shelter on any one night (depending on the season) approximately doubled between 2001 and 2005, from 300 to 600 per night to 500 to 1,200.[25] A report on homelessness in Vancouver indicated that a substantive proportion (50 per cent) of people living on the street who are unable to work have no income because they have difficulty accessing the new welfare system.[26]

Emergency workers in shelters that specialize in mental health and addiction related problems indicate that they routinely turn people away due to lack of space. One shelter in Vancouver's downtown eastside reported a 300 per cent increase in people being turned away in the last three years and reported, for example, that 7,000 people were turned away from their services in 2003.[27]

Some factors that contribute to housing instability for people with mental illness include their generally low income and the weakness of their social support networks (many lose contact with their families of origin). The cyclical nature of some illnesses also contributes to instability as people may lose their housing as a result of hospitalization. Stigma and discrimination play a role in whether people with mental illness and especially those with concurrent addictions will find housing.[28] The symptoms of illness can make people more vulnerable to exploitation by others. Women with mental illness are particularly vulnerable to abuse and violence while living in unsafe housing conditions.

The Research

The material in this report is based on a year long research project guided by the following questions:

- What services in the Vancouver Coastal Health region currently provide housing, employment, and income-related supports to people with mental illness in BC?
- What recent funding and policy changes have affected housing, employment, and income related supports for people with mental illness?
- How are policy and service delivery changes in other areas (e.g., legal aid and income assistance) affecting income security and housing for people with mental illness?

The research project benefited at the outset from the guidance of an advisory committee that included representatives from VCH, the Canadian Mental Health Association (CMHA), and community-based service providers working with people with mental illness (see Appendix A). An environmental scan was undertaken to determine the type of programs available to people with mental illness. This involved gathering relevant policy documents and reports as well as assessing the data available on the number of people served and the number of people living in mental health housing in the VCH region.[29]

Twenty interviews were conducted with representatives of VCH in managerial or policy-related positions and with a range of individuals providing community-based mental health services, advocacy, and legal supports to people with mental illness. This included mental health workers staffing housing programs and drop-in centres, running employment-related services, and working as advocates, occupational therapists, outreach workers, and drug and alcohol counsellors. Interviews were conducted in various locations in the VCH region, including Vancouver, Richmond, the North Shore, and Coast Garibaldi (Sechelt, Bella Coola, and Powell River). Information was also obtained from employment and income assistance workers and a community legal aid worker specializing in disability law. Three focus groups (two in Vancouver and one in Richmond) with housing and income support workers were also conducted. In the interviews and focus groups respondents were asked to describe their services and their clientele and to discuss how individuals access their services as well as barriers to access. Further, respondents were asked to reflect on policy and program changes in mental health since 2001. Quotes from these interviews and focus groups are included throughout this report.

The findings of this report are divided into three sections: income supports, employment and rehabilitation supports, and housing supports. Each section provides an overview of the current delivery system followed by a discussion of the implications of policy and other system changes. The findings are followed by conclusions and recommendations.

Income Supports

People with mental illness who are unable to do paid work generally receive income support from one or more of the following sources: savings or families, the Canada Pension Plan, workplace disability plans, or provincial income assistance, either with or without additional disability benefits (of these, provincial income assistance alone cannot be combined with other income sources). The housing and food costs of people in institutional settings are paid by the province. Some inpatients may also receive a 'comforts allowance' from the provincial income assistance system for clothing and other personal items.

This report focuses on income assistance and disability benefits provided through the provincial Ministry of Income and Employment Assistance (MEIA), which administers income assistance programs for the province. These programs are governed by the *Employment and Assistance Act (EA Act)* and the *Employment and Assistance for Persons with Disabilities Act (EAPD Act)*. Each act has extensive regulations and a policy manual that sets out the ministry's interpretation of the acts, which guide ministry staff.[30]

People with mental illness are spread across all categories of income assistance. Most individuals with a serious and persistent mental illness who are connected with mental health services are on income support with disability benefits; however, some people are misplaced in the "expected to work" category of basic income assistance and are unable to sufficiently navigate the system to qualify for additional disability benefits. Two kinds of disability benefits are currently available in BC: Persons with Disabilities (PWD) and Persons with Persistent and Multiple Barriers to Employment (PPMB) (see Appendix B for eligibility requirements). The benefit rates for assistance vary according to category of assistance.

Accurately assessing how many people with mental illness are on disability assistance in BC is difficult because the numbers are not disaggregated from the general number of people on disability benefits. Further, physical and mental health issues often co-occur, making any such breakdown problematic. What we do know is that in the past eight years the number of people receiving income assistance in BC overall has fallen dramatically, while the number receiving disability benefits has steadily risen. Analysts suggest that the reduction in the welfare rolls is primarily due to fewer people accessing income assistance and not, for example, a reduction in poverty.[31]

Implications of Changes

Impact of the Re-application Process

In 2002, the BC government initiated a large-scale disability benefits eligibility reassessment, during which the province initially contacted 19,000 people on DB II (the precursor to PWD) to have them reassessed. Reports of suicides and the general fear and stress expressed by people with mental illness, however, resulted in pressure on the government from advocates to exempt people with mental illness. The government eventually capitulated and exempted 5,000 people from this review.

A subsequent Auditor General's review of the government's actions concluded that the Ministry of Human Resources moved too hastily: "The ministry embarked on a fast-track review of all former disability benefit recipients before assessing whether the risk of paying benefits to ineligible recipients was high, and before fully examining other options for confirming eligibility."[32] Further, the Auditor General noted that the review cost the government over $5 million to find that just 40 of the ministry's 62,000 disabled clients were ineligible for continued assistance and concluded that the review did not result in substantial cost savings and caused increased anxiety for many disabled clients.[33]

> Some people are misplaced in the "expected to work" category of basic income assistance and are unable to sufficiently navigate the system to qualify for additional disability benefits.

Providers we spoke with in the VCH region indicated that the re-application process caused undo stress to clients. They reported that clients' psychiatric stability was threatened, likely leading to increases in hospitalization, medication and new anxieties. One occupational therapist in Vancouver commented, "probably some suicides [were] directly connected to that [the changes to disability benefits]." A housing worker in Vancouver said, "Certainly that whole review that they undertook caused an enormous amount of grief to clients….I mean, they were devastated by it and many people were worried sick about it." Indeed, during this period, the BC Coalition of People with Disabilities reported an increase in psychological stress amongst people with disabilities, and in suicides that were thought to be related to the stress arising from the re-application process.

Under the *Employment and Assistance for Persons with Disabilities Act* disability status is no longer a permanent designation and therefore people are potentially still subject to reassessment. The rules around this appear to be vague and some respondents in our study indicated that their clients still experienced stress related to fears about re-assessment.

The Application Process

Respondents noted several challenges with the new application process, which requires applicants, their doctors, and advocates to complete a 23-page, three-part functional assessment form. In the transition period there was a great deal of confusion about the new forms and some doctors and other professionals initially refused to fill them out until it was confirmed that they would be paid to do so.

Workers described the process as "arduous" and indicated that it posed a significant barrier to already-marginalized individuals. An occupational therapist in Vancouver said, "If you don't have the support to get it done, you won't get it done. I don't know how someone gets on it [PWD] without a university degree." A staff lawyer at a community legal clinic said with respect to applying for disability benefits: "for people with mental disorders…or addictions, the complexity makes it very difficult for them to comply and a lot of them just give up." People with mental illness are at a disadvantage because they may be less likely to have a regular doctor or the supports available to apply for disability. Additionally, the symptoms of mental illness mean that the person may also experience confused states, which make the complexities of the application process even more daunting.

Advocates reported that assessors (e.g., physicians) also had difficulties with the forms, especially in the early stages of the changes. Current concerns are about the amount of time it takes to fill out the forms (up to 2.5 hours). There was also the feeling that some of the same questions on the form are reiterated but reworded, creating a greater margin for applicant error. Advocates indicated that the assessors were not always aware of how to frame responses on the forms. In the case of applying for temporary disability status, many physicians may be uninformed about the degree to which an applicants' temporary disability affects their daily living and must rely on limited knowledge to guide them. Because an addiction on its own or addiction as a person's primary concern will not qualify them for disability benefits, if people with multiple issues state their problems in the wrong sequential order (i.e., addictions first) they are at risk of being denied benefits.

Qualifying for Benefits

Most of the discussion from our respondents regarding qualifying for disability benefits focused on the requirements for the Persistent and Multiple Barriers to Employment designation (PPMB). It was noted that people must be on income assistance for 12 of the past 15 months to qualify for PPMB and that the employment plans associated with income assistance in the interim could be enormously stressful. In some instances, individuals who are unable to comply with employment plans because of their physical or mental health have their benefits terminated before they even get the opportunity to apply for PPMB status. The employability "screen" changes in 2004 affecting PPMB, which increased the minimum qualifying score to 15, was also noted as a barrier (see Appendix B).

Applicants must submit a significant amount of documentation to be considered for PPMB status and they generally need extensive assistance from an advocate and a good Employment and Assistance Worker (EAW). Reports from front-line workers suggest that applicants for PPMB are frequently denied assistance because they have not provided the necessary evidence for their case, and must then go through multiple levels of appeal, after which many people still do not receive benefits. Indeed, this is one of the claims made in a recent report to the Ombudsman[34] that sets out the administrative unfairness of the process, including the lack of legal representation and advocacy for people with disabilities.[35] Although it is difficult to accurately track how many eligible individuals are turned down, there is evidence from our research that this is occurring. For example, an EAW worker in Vancouver reported that "Out of 100 applicants [for disability benefits] we are seeing only maybe 20 approved." Other studies have likewise

found the application process for basic income assistance itself (the precursor to gaining disability benefits) to be too complicated for many people with mental illnesses to navigate on their own.[36] Overall, the process of accessing basic and disability assistance has been made harder, and those with mental illness are particularly prone to find the application process difficult. And, even when successful in applying for basic income assistance, many people with mental illnesses remain misplaced in the "expected to work" category.

Addictions on their own are not considered a disability or barrier to employment. This creates problems for people with concurrent diagnoses of mental illness and addiction, some of whom may be unable to qualify for PPMB and are thus subject to employment plans and lower rates. Our respondents expressed concern about the stress this might place on the individual and how this stress affects their mental illness and their ability to deal with substance use problems.

Documentation Requirements

Many of our respondents indicated that their clients with mental illness struggled with the amount of medical documentation needed to support their applications, especially if this documentation required repeated visits to physicians (e.g., in cases where people may be eligible for a monthly diet allowance this has to be renewed every 12 months) or where multiple documents were needed for the same condition (e.g., one to get a diet allowance and one to get transportation assistance). For people with mental illness whose symptoms often prevent them from being able to make and keep appointments these kind of requirements can amount to a serious barrier to accessing benefits.

For people with mental illness whose symptoms often prevent them from being able to make and keep appointments these kind of requirements can amount to a serious barrier to accessing benefits.

Although doctors have been given an increased role under the new legislation in terms of determining who qualifies for benefits, the ministry ultimately determines who is eligible. There was some concern by our respondents that allowing the ministry to overrule a doctor's opinion about a person's employability is problematic and might result in some individuals with mental illness not qualifying for benefits.

Three-Week Waiting Period

In our study, mental health workers reported that the three-week waiting period for people receiving income assistance has put pressures on emergency services. Some emergency shelters reported that their average stay has increased since 2001. Evidence that the burden of care has now shifted was apparent in discussions about hospital services and the availability of psychiatric emergency care beds. Bed closures and shorter stays prevent admission to emergency services, while at the same time, need in the community has increased reliance on emergency services. A number of workers related stories about emergency hospitalization. For example, a Vancouver housing worker said:

> *I have a friend that works at [a large urban hospital] in the psychiatric ward and its common practice for them to say 'Okay, we need three beds, you need to go out and assess the people here …and who are the three best people who are going to do the best on the outside whether or not they are ready to go.'*

Another housing worker told us:

> *I had somebody walk into Emergency at [a large urban hospital] … with a pretty horrible history, lots of self-harm…they wouldn't take her… she had very severe symptoms, they suggested she might want to try going to [another hospital], it was in the winter time…and they just told her to walk at three in the morning…they didn't even send her in a cab.*

Less Personal Connection to Front-Line Staff

A number of administrative changes at the ministry are affecting access to disability benefits. For example, a new "pod" system has replaced the previous practice of having a consistent case worker familiar with a client's history. Evidence from our research suggests that these changes hinder workers from having a contextual understanding of their client's lives and may mean that people are not getting referrals to apply for disability benefits. This was particularly a concern for individuals living outside of Vancouver. In some communities ministry offices have been closed down and in others, even if there is a remaining office, individuals are now reliant on a 1-800 number for services. In one such community, advocates reported that the inability to speak directly to workers has caused a lot of confusion for people with mental illness. In another small community the ministry office is now closed and individuals requiring assistance speak to workers by phone in a nearby town. Advocates we spoke to in this small community indicated that this has resulted in clients feeling disconnected from local sources of potential support.

Changes to the ministry and the role of employment and assistance workers has altered the nature of financial aid work. A court outreach worker in Vancouver said:

> *I think it [the shift to regional offices] was a deliberate thing…to make it more impersonal, because I remember a time when you could call the welfare worker and know them and they would know the person and you would tell them the story and they would have discretionary amounts that they could allot… But now it's like 'hello worker 101'… and there is nowhere to go because they have made it impersonal, I think on purpose.*

In some communities ministry offices have been closed down and in others, even if there is a remaining office, individuals are now reliant on a 1-800 number for services.

A housing worker in Vancouver said:

> *So these people [EAWs] who were already working hard to deal with the number of clients they had now have double the caseloads so getting a hold of them is actually impossible, sometimes you get their voicemail and that's all you deal with.*

Calling the impact of downsizing "pretty substantial, " an employment assistance worker in Vancouver noted "There are fewer staff to do the job, more stresses, and more people away sick… People [staff] are dropping like flies and are more alienated, frustrated and depressed."

Lack of Legal Representation

Access to fair processes for British Columbians with mental illness has been gravely endangered by the massive cuts and changes that have occurred to legal aid. On August 30, 2002 all Legal Services Society direct service delivery positions for poverty law were eliminated and replaced by a telephone service (Law Line). There is now virtually no legal support for people who have issues related to poverty, including concerns about income assistance. Cuts to legal aid have had serious consequences for poor people, as

well as women leaving violent relationships. These issues have been compounded by changes to administrative tribunals and concurrent cuts and service reductions in other areas, including to advocacy resources and women's centres.[37]

In our research, respondents expressed concern that people with mental illness are not always well-informed about their right to appeal and that the process itself is a barrier to many individuals. A housing worker in Vancouver said:

> *Everyone who applied for disability was refused initially, virtually, and then the appeals were being won at a very high rate…and so the government… did an analysis and they discovered all these appeals were happening so they immediately changed the appeal process and made it narrower.*

The reduction in legal advocacy across the province means that people with mental illness are often unaware of or unable to access their legal rights, not only with respect to income assistance but also with respect to the practice of forcibly subjecting people to psychiatric treatments against their will. Involuntary treatment laws are one of the foremost concerns of people involved with the mental health system, and potentially affect any British Columbian who finds themselves in a psychiatric crisis. Lack of awareness of legal rights was reported especially by advocates outside of Vancouver who indicated that many of their clients did not have consistent access to legal advocacy regarding involuntary treatment.

Rehabilitation and Employment Supports

Rehabilitation services provided through Vancouver Coastal Health are designed to help people with mental illness and those with other disabilities participate as fully as possible in their communities. They are focused widely on helping people with mental illness in a range of domains including personal life, leisure, education, and volunteer opportunities.

The underlying philosophy from which programs are run vary from traditional rehabilitation models (where the emphasis is more on personal care and home management) to those using peer support and consumer empowerment and leadership as key components. In the VCH region, rehabilitation programs are generally designed more specifically for people with mental illness, whereas employment programs are less specialized and may be available across disability.

Programs in the VCH region are most highly concentrated in the Lower Mainland. They include:

- The Vancouver Community Mental Health Team Rehabilitation Adult Services;
- Access Community through English (ACE), which provides English language and life skills programs to people in Vancouver and Richmond;
- Art Studios, which is cooperatively run by consumers;
- Community Link Program, established in 1994 as a result of Riverview Hospital downsizing;

- Gastown Vocational Services, which helps people meet employment and education goals;
- BC Training for Health and Employment Opportunities (THEO BC), established 29 years ago, which offers employment preparation services;
- Canadian Mental Health Association (CMHA), which has a BC Employment Inventory to support people with mental illnesses in securing competitive mainstream employment;
- Coast Foundation Society, which provides several kinds of supports for employment, including the Transitional Employment Program and Coast PACT Employment Services;
- Volunteers in Partnership Program;
- Supported Volunteers Program;
- Consumer-Run Business Project;
- VCH Peer Support Program, which trains consumers to work as support for other people with mental illness;
- Vancouver Agreement Projects, including the ministry-funded outreach to street homeless people and the ministry's focused employment strategy targeted to the homeless population;
- BC Centre for Ability Foundation, a cross-disciplinary program targeted at children and youth; and
- Employment Program for Persons with Disabilities (EPPD), a recent three-phase program that is cross-disability and operates in areas of the province outside Vancouver.

The mandates of these programs are, for the most part, to serve people with the most serious and chronic forms of mental illness (e.g., people with Axis I diagnoses[38]), but this depends in part on the program. THEO BC, for example, has two program streams: an employment stream funded by VCH, and a vocational rehabilitation stream, the Employment Program for Persons with Disabilities (EEPD), funded by the ministry. The criteria for accessing the VCH-funded program is that the person must have a mental illness; however, it is not based strictly on diagnosis and the person can be self-referred. In contrast, the ministry-funded program requires that participants have a formal diagnosis. Participants in the ministry-funded program who have both mental health and substance use problems must be in active treatment, while the VCH-funded program simply asks that individuals with substance use problems do not attend while under the influence of drugs. In the employment stream individuals must speak English, but in the vocational rehabilitation stream services are provided service in other languages, including Punjabi and Hindi.

Respondents in our study who work in rehabilitation and employment supports reported that they saw equal numbers of men and women, that 90 to 95 per cent of their clients have a mental illness (and PWD status), and many have concurrent addictions. They indicated that the number of immigrant and Aboriginal clients was limited, as was the general diversity of visible ethnic groups. Very few of their clients were reported as homeless, suggesting that homelessness often precludes access to programs.

Implications of Changes

Changes to Service Mandates/Shifts in Funding

Concerns were raised when most employment services were transferred to the Ministry of Employment and Income Assistance that the specialized needs of people with mental illness would not be met. Mental health workers argue that a range of options are needed for people with mental illness. According to one EAW worker in Vancouver, employment plans work for only about 30 per cent of her clients and other options, such as education, are more suitable to the others. This implies a continued need for more specialized programs for people with mental illness on disability assistance.

Service mandates present a barrier to access for some people—especially restrictions regarding substance use. Additionally, immigrants and refugees have limited access to services. As an occupational therapist on Vancouver's North Shore noted, "Those people [immigrants] who fall into both categories [mental health and immigration status] are probably underserved." It was noted generally that there is a lack of outreach to Chinese and Indo-Canadian communities, as well as the employment of staff from these populations. An employment worker in Vancouver said, "More inroads need to be made to these communities."

Performance-Based Funding (Fee for Service)

The change to service mandates and a shift of funding from the Ministry of Health to the Ministry of Employment and Income Assistance has resulted in the introduction of performance-based funding. Prior to 2001 employment service providers received "blanket" funding; the method is now "fee for service." An occupational therapist in North Vancouver said the practice of funding agencies by case or by milestone is challenging. "I feel that pressure when my billings are low," she said, noting that some types of pre-employment services are non-billable. There was speculation that this was affecting staff behaviour because they no longer have an incentive to provide extra support to clients. There were reports of the fee for service structure leading to "creaming" applicants (i.e., selecting those most likely to become employed).

Cuts to Services

Study participants noted that funding for VCH vocational rehabilitation services have remained stable in Vancouver due to a well-established service delivery structure. However, other areas of the province have seen reductions and programs have been cut. For example:

- In 2001, Sechelt lost 1.5 mental health outreach workers. While one of these positions was subsequently restored, the losses were compounded by cuts to other programs in this community (e.g., drop-in services and legal advocacy).
- In Richmond, THEO BC has taken over all employment services for people with mental illness. All other local agencies were closed.

Overall, there are concerns that resources for employment supports in VCH are primarily designed for people without mental illness, and that the employability focus of these programs is not always appropriate for people with mental illness.

Housing Supports

Housing for people with mental illness ranges from acute care (hospital/treatment centre) to independent living in the community. The types of housing between these two options can be categorized as follows:

- Residential/family care: Licensed care facilities that provide 24 hour care and supervision by professional staff, with supervised medication intake. Typically 6 to 10 beds. This category of housing also includes family care beds where a person lives with a family in the community.
- Supported housing: A range of housing options where landlords receive a direct rent subsidy for the individual living there.[39] The individual has access to support workers. Supported housing includes:
    - Group homes: Tenants share a home and the services of on-site support workers (Monday to Friday).
    - Purpose-built apartment buildings: All tenants have a mental illness. They live in self-contained suites, and receive daytime support.
    - Supported independent living: Tenants live in scattered market rentals, and have access to outreach workers by appointment. This category includes SIL and Super SIL, described below.

Two other types of housing are also available to people with mental illness, although these options house other groups of people as well:

- Emergency shelters: Short-term accommodation and support with connecting to services for homeless people with mental illness.
- Low-barrier housing: Housing that is not contingent on a person receiving treatment services or, in the case of drug or alcohol abuse, not contingent on the person ending substance use. Typically, people enter low-barrier housing from shelters or directly from the street. Low-barrier housing includes hotels where tenants live in single rooms and have access to supportive on-site staff.

In 2006, VCH also began to provide housing spaces for people whose primary concern is substance use. As of April 2006 there were 170 of these housing spaces available.

Supported housing is recognized as furthering most clients' recovery from mental illness far better than residential care. It is also much more cost-effective.[40]

Supported housing programs administered by non-profit organizations vary. The most common include:

- Supported independent living (SIL) programs: Tenants live mostly in market rentals (apartments, for instance), and have access to outreach workers by appointment. The goal is to build daily living skills. Some SIL programs are run in buildings that exclusively house tenants with mental illness and have on-site staff for five or seven days a week.
- Super SIL: The ratio of outreach workers to clients is higher than in SIL programs, resulting in more intense support work.
- Enhanced SIL: This program, offered only by The Portland Hotel Society and The Kettle Friendship Society, includes one hot meal a day and 24-hour staffing in a facility used exclusively by tenants with mental illness. Tenants live in self-contained suites governed by the *Residential Tenancy Act,* but have access to intensive support services. This model is considered to be one of the best practices in mental health housing because it combines autonomy for the client with access to community support and protection against victimization.

Mental health housing is generally provided by non-profit organizations that sign agreements with VCH, and VCH funds part or all of the operating costs. In the case of purpose-built facilities, non-profit mental health construction companies such as the Katherine Sanford Society build and administer the facilities.[41] Non-profit service organizations such as the Motivation, Power and Achievement Society and the Coast Foundation staff the facilities with support workers.

Applicants for mental health housing administered through VCH must have a serious mental illness, be connected with a mental health team or psychiatrist, and comply with a medication regime. An access team meets regularly with housing providers, gathers information about vacancies, and assesses and approves applicants. Mental health teams submit their clients' applications through a VCH liaison worker. Some service providers, such as the Triage Emergency Services and Care Society, administer their own mental health housing. Triage recently signed an agreement with VCH reserving 15 beds in the Princess Rooms[42]and five beds at the Vivian[43]for clients channelled through the access team.

A comparison of available housing units from 2001 to 2006 provided by the manager of mental health and addictions at VCH (Table 1), illustrates that residential/family care beds have decreased slightly, but that supported mental health housing units have increased (by 153), as have emergency shelter beds (by 38) and low barrier housing units (by 595). While increases in supported housing are welcome, they are not sufficient to meet the backlog of demand from previous years. The formal waitlist for people with mental illness for supported housing in VCH is 750[44]; however, it is estimated that the actual housing requirement (e.g., those that are homeless and/or otherwise under-housed and not on waiting lists) is much higher.

Respondents in Vancouver reported both an increase in the number of people needing services, and a substantive change in clientele. Organizations running drop-ins (e.g., COAST and MPA) reported that those using their services have increasingly complex mental health and substance use problems that are often compounded by other health related issues (e.g., tuberculosis, infections, physical disabilities). Workers reported a rise in violent behaviour and indicated that long-term clients are now intimidated from using some of their services. As a Vancouver SIL worker described, "So they [drop-in centre] are getting a lot more street-oriented people, it used to be more like a clubhouse for mentally ill people and now there is …more hard drug users and it's had a big impact on the program."

Respondents in Vancouver reported both an increase in the number of people needing services, and a substantive change in clientele. Organizations running drop-ins reported that those using their services have increasingly complex mental health and substance use problems that are often compounded by other health related issues.

BC now has the highest priced housing market in Canada. Rental costs for houses and apartments in Vancouver are particularly high. Gentrification is also increasing in some rural areas of BC, particularly in towns preparing for the Olympic Games in 2010, causing rents to increase disproportionately over the last two years. As a housing worker in Vancouver noted, "There is this big push to get people away from the downtown eastside, but everybody is just drifting back because there is no affordable housing." The worker added: "We are housing people in things that to my mind, you know it's a slum, we have people in places that are repulsive… and dangerous." There were also concerns raised by interviewees that, as Riverview Hospital completes its downsizing, current housing units will not be sufficient.

Table 1: Mental Health Housing – 2001 and 2006

TYPE OF HOUSING	UNITS 2001	UNITS 2006
Residential (Licensed Care and Family Care Homes)	383	380
Supported (includes unlicensed group homes, staffed apartment buildings, enhanced apartment buildings, SIL and super-SIL units)	773	926
Emergency shelter beds	70	108
Low-barrier housing	181	776
TOTAL	1,407	2,190

Note: Data as of April 2006.

Implications of Changes

Centralized Access

Respondents in our study indicated that the centralized referral system through the access team works with mixed results. While some workers reported that it meant access to housing services was more streamlined, others indicated that under the old system workers had more personal and direct contact with people needing housing, allowing them to more closely assess their needs. With the centralized system this personal touch was lost, resulting in some referrals being less appropriate. It was noted, however, that from the perspective of clients, having one access point was better and that it is also now easier to track people through the system.

New Commitments to Supported Housing

The introduction of new housing units, especially supported housing units, is a welcome advancement. However, more people are in need of housing, especially in Vancouver, where housing prices have increased substantially since 2001. Increased homelessness is putting pressure on the entire social service system, and mental health housing workers indicated that waiting lists for housing are still unacceptably long (in some instances up to seven years). There is also evidence to suggest that more housing has not always alleviated need, especially if staffing levels have been cut. As one worker said, "So we (SIL) are getting a higher amount of clients, but less quality of care, because you can only see them so often…" An emergency shelter worker concurred: "They [the government] build these 'hard-to-house' projects, typically they are very poorly staffed, and people move into them and really it is a dead-end ghetto. … They [the clients] are just parked there."

The introduction of new housing units is a welcome advancement. However, more people are in need of housing, especially in Vancouver, where housing prices have increased substantially since 2001.

Clients stable enough to move from SIL programs are unable to easily qualify for rent subsidies (i.e., they must enter the regular application process for social housing, which can take years). These individuals are blocking current SIL spaces for people in need of regular outreach support. Some organizations estimated that 20 to 25 per cent of their clients need only a rent subsidy (i.e., no additional support services), but have no suitable housing to move on to.

Service Cuts

Despite government commitments to maintain mental health funding, some housing related services have suffered cutbacks. The Kettle Friendship Society, for example, which provides mental health advocacy and drop-in services, lost one full-time advocacy position, while other organizations sustained temporary cuts (e.g., Triage). In Powell River there was concern that no extra monies have been allocated to mental health services: respondents in this area indicated that the number of clients had gone up, but funding and staffing levels have remained the same.

The cuts have had other implications, such as service providers having to more narrowly define their mandates. A court outreach worker in Vancouver reported that "The cuts have really affected the gaps between the services, because services have had to more narrowly define their client base….so there are more people who don't fit into 'boxes.'"

Concurrent Drug Addiction

Most mental health housing options exclude active drug users, and mental health teams generally do not work with people with drug-induced psychosis. Restrictive mandates and criteria (medication compliance) means that people often fall through the gaps in the system, with the result that difficult clients are shunted away from the mental health care system. As an SIL worker in Vancouver said:

> *… the teams are over-packed with people…and if they are not cooperating with the programs that are set up for them, they won't continue services for them… Very often what happens is people go off their medications quite frequently and then you have a person wandering around the streets, not medicated and a harm to themselves and the teams wash their hands of them…*

Legal Changes

While cuts to the Residential Tenancy Office have made it difficult for all British Columbians to enforce housing rights, the barriers are greater still for people with mental health concerns. Respondents indicated that their clientele have great difficulties in accessing support through the branch and that some landlords take advantage of this and exploit their tenants.

Legal changes that now allow for only two outstanding damage deposits can be another barrier for people with mental illness in securing housing. Damage deposits are deducted beginning after the second assistance cheque is received (formerly this money was not deducted until move out day or at the time the person terminated assistance). In addition, the minimum damage deposit repayment that is deducted has increased from $10 to $20 per month. As documented by the Tenants Rights Action Coalition, tenants are responsible for recovering their damage deposits, which can be difficult if landlords are uncooperative. A mental health worker in a small town responded that in her experience people with mental illness often do not get their deposits back because they leave to go into hospital and are not able to clean or keep their housing adequately cared for, and that "housing deteriorates because their mental health deteriorates."

Conclusion

In the forward-thinking template for mental health policy, *A Framework for Support*[46], authors Trainor, Pomeroy and Pape introduce what they call a "community process paradigm":

> *It fully recognizes the importance of mental health services, but goes further to include the role of families and friends, generic services and supports and consumers working together on their own behalf. It also acknowledges the fundamental elements of community to which every citizen should have access: housing, education, income and work. Taken together, the components of CRB [community resource base] comprise the various elements that individuals with serious mental health problems need in order to live a full life in the community and to maximize their potential for recovery."*

The evidence contained in our report suggests that BC still has a way to go before this forward-thinking paradigm is in place. Although since 2001 the government has instituted some changes that positively impact people with mental illness, the cuts and negative policy changes appear to outweigh these benefits. The ability to take the "elements of citizenship" (regular work, housing, education and income[47]) seriously in mental health begins with a recognition that mental health care cannot be limited to assessment, diagnosis and emergency care, but must include access to a wide range of mental health and other community-based supports.

People with mental illness are found across all levels of social assistance. First, some people with mental illness are inappropriately placed in the income assistance category of "employable" because without an advocate they are unable to navigate the bureaucratic process to access disability benefits, which would allow them higher levels of support and exempt them from job searches. Second, it has been argued that the repeal of *The Disability Benefits Program Act* reflects a shift in philosophy away from a system based on need, to a system that evaluates people based on how long they have been receiving assistance and whether they are employable.[48] This shift has implications for people with mental illness who often require ongoing forms of support throughout their lives.

Employment supports in BC are geared primarily toward people without mental illness. The introduction of more cross-disability employment programs and the shift of resources from the Ministry of Health to the Ministry of Employment and Income Assistance has further entrenched the focus on employability. In Vancouver, mental health teams typically refer people to THEO and other employment support services, with very little connection between the mental health care team and the rehabilitation team. Progressive employment and community development models for people with mental illness that have shown success in other jurisdictions (e.g., Ontario) have not been well-integrated or supported in BC's current system.

Housing supports for people with mental illness are not governed by an overarching framework that would reflect best practices in housing. Instead, housing is largely a function of what is available for people at any given time. Wait times for what is recognized as the best form of housing for people with mental illness (SIL) are unacceptably high and the result is that many people are living in dangerous or precarious situations.

The amalgamation of mental health and addictions services under one ministry is an important step toward streamlining services and recognizing that mental illness and addictions often co-occur. Despite this, pressures on the system still result in some individuals being screened out of care, particularly if addictions are their primary problem.

Dramatic cutbacks to legal aid have made it virtually impossible for people with mental illness to access legal advocacy related to housing, income, treatment options, or human rights. The loss of the BC Mental Health Advocate and of structures for consumer participation has further eroded the rights of people with mental illness. Critics have suggested that the mental health system is moving away from the progressive empowerment models introduced in the 1980s and 1990s toward "professionally controlled community treatment models" that emphasize the bio-medical causes of mental illness over contributing social and structural factors.[49] The loss of legal rights gives credence to this assertion and threatens to further marginalize people with mental illness.

The current provincial government continues to focus mental health care funding on acute care and hospital-based care rather than much-needed services based in communities. Indeed, community-based organizations have suffered cutbacks and are increasingly overwhelmed with new requests for service. This in turn has tightened the mandates of mental health teams such that only those people with the most serious forms of mental illness are able to access support systems. In this regard the government has ignored its responsibility to develop a mental health strategy for the province that offers income and housing supports as part of comprehensive mental health care.

Recommendations

Overarching

To improve the lives of British Columbians living with mental illness, the provincial government should:

- Increase income and housing security for people with mental illness.
- Balance the mental health system to better support community-based mental health services. Specifically, community-based mental health services must not be seen simply as an extension of the medical model, but valued as a distinct service delivery model.
- Adopt "elements of citizenship" (regular work, housing, education and income) as integral to mental health care, as outlined by the community process paradigm in the forward-thinking template for mental health policy, *A Framework for Support*.[50]

Disability Benefits/Income Support

Recommendations from advocates regarding disability benefits and income support in BC are well summarized in a 2005 complaint to the BC Ombudsman.[51] A number of those recommendations that are supported by our findings are presented here, marked with an asterisk. We also include further recommendations arising from our research.

Establish a new provincial disability benefits act*

- A new provincial disability benefits act should be established, including a preamble that reinstitutes the principles from the older act—specifically, that makes the values of fairness and dignity clear.

Increase disability benefits*

- Increase disability benefit rates to better reflect BC's cost of living and, like CPP, have the benefit rate linked to a formula for annual cost-of-living-increases.
- Increase comforts allowance for people living in group homes or other health facilities to $200 per month.

Make PWD a permanent designation*

- Enact disability benefit status as a permanent designation so that people can suspend benefits during periods of wellness and be able to resume them when needed.
- Ensure that PWD recipients can retain supplementary medical coverage if they become ineligible for provincial disability benefits.

Improve the application process

- Provide more advocates to assist with the current complicated application process.
- Work with mental health advocates to streamline the application and documentation process so that people with mental illness can more easily meet requirements.

Shift the employability focus

- Monitor the shift of funds/responsibilities from the Ministry of Health to the Ministry of Employment and Income Assistance to ensure that people with mental illness are still able to access employment programs specialized for their needs.
- De-emphasize the employability focus in ministry programs for mental health clients (as appropriate to individual client need).

Employment Supports

Expand consumer initiatives and employment programs

- Expand and support individualized placement models.
- Enhance vocational resources, such as temporary placements, job coaching and skills training.
- Support and fund consumer-led initiatives and community economic development models that allow consumer-run businesses to thrive using models developed locally and in Ontario and Nova Scotia.[52]
- Provide full-time paid jobs for mental health consumers as peer advocates as part of mental health teams or in the context of occupational therapy.

Housing Support

Expand supported housing

- Act on the City of Vancouver's call under the Homeless Action Plan (2005) for 3,200 new housing units, which includes 750 units for people with mental illness, and 750 units for people with drug addictions.
- Expand the Enhanced SIL programs currently offered only by The Portland Hotel and The Kettle Friendship Society.
- Staff supported housing adequately in order to give clients a genuine opportunity to learn living skills and become independent.

Expand affordable housing

- Adjust the shelter allowance to reflect market rents.
- Increase the supply of affordable housing (e.g. by allowing secondary suite renting in all zones and requiring property developers to build a certain number of affordable housing units).

Improve rent subsidies

- Change ministry policy so that individuals who are stabilized in SIL housing and ready for independent living can easily access rent subsidies or public housing.

Fund emergency shelters

- Provide block funding to emergency shelters specialized in clients with mental health problems.

Advocacy and Legal Aid

- Provide adequate funding for advocacy services and legal aid to meet the needs of mental health clients who cannot navigate income or housing programs on their own.
- Provide access to publicly-funded legal representation for poverty law matters.
- Ensure independent legal representation when people are involuntarily committed.

Advocacy and Consumer Involvement

- Restore the office of the BC Mental Health Advocate and/or develop a range of independent systemic advocacy centres.
- Enhance and develop consumer participation decision-making mechanisms.
- Expand the VCHA Peer Support Program into hospitals to support hospitalized clients and help them to connect to services immediately after discharge.

Mental Health and Addictions

- Work to ensure that people with co-occurring mental illness and addictions have more specialized services and are not routinely screened out of programs because of their addiction.

APPENDIX A

Advisory Committee Members

BC Coalition of People with Disabilities
Sue Baker, Motivation, Power and Achievement Society
Heather Edgar, COAST Foundation
Dominick Flanagan, Vancouver Coastal Health Authority
Catharine Hume, Canadian Mental Health Association
Judy Shirley, Motivation, Power and Achievement Society

APPENDIX B

Eligibility Requirements for Disability Benefits[53]

Persons with a Disability (PWD)

To be eligible for PWD status a person's disability must be a severe mental and/or physical impairment and be expected to last for at least two years, and it must directly and significantly restrict their ability to perform daily living activities such that they require help from an assistive device, another person or an assistance animal. Persons with a PWD designation are eligible for monthly support and shelter allowance, medical coverage (including MSP, pharmacare and some dental and optical), a $500 earnings exemption per family per month, a bus pass and a vehicle fuel tax rebate. PWD is not a permanent designation and people can be re-assessed anywhere from 1–5 years after getting PWD status. The rates for PWD vary according to whether individuals are single or have a family but range from about $531–$949 per month. $949 represents a family unit of 7 and $35 is added for each dependent above that.

Persons with Persistent and Multiple Barriers to Employment (PPMB)

To receive a PPMB designation a person must have been on income assistance for 12 out of the 15 months immediately before they apply for PPMB and their doctor must provide details about how their medical condition prevents them from seeking, accepting or continuing employment. Individuals with this designation are assessed according to an "employability screen" and must receive a score of 15 or greater and have taken all reasonable steps to overcome barriers to work, and they must have a medical condition that has lasted for one year and is likely to continue to reoccur frequently for at least two years. If a person's score on the "employability screen" is lower than 15 and they can still demonstrate that they have had a medical condition that precludes them from searching for, accepting, or continuing in employment, they may also be considered for PPMB. People with a PPMB designation have support rates that are significantly lower than PWD rates and range from $282.92-452.06 per month. PPMB designates are able to keep up to $500 a month in earned income and are eligible for extended medical benefits. PPMB designates may be eligible for other things including: a higher support rate, medical coverage that includes general health supplements, dental supplements and exemption from the 2 out of 5 year welfare time limit (see Policy Manual section 7.14).

Temporary Assistance

People can also apply for short-term temporary assistance on the basis of minimal documentation by a doctor. The rate for this assistance is on par with general welfare rates.

Addictions, when they are the person's primary problem, do not count as a medical condition sufficient to warrant granting of disability benefits.

Notes

1 For a full description of changes to income assistance see Bruce Wallace, Seth Klein and Marge Reitsma-Street (2006), *Denied Assistance: Closing the front door on welfare in BC*, Vancouver: Canadian Centre for Policy Alternatives and Vancouver Island Public Interest Research Group. For a description of the cuts to legal aid see Alison Brewin and Lindsay Stephens (2004), *Legal Aid Denied: Women and the Cuts to Legal Services in BC*, Vancouver: Canadian Centre for Policy Alternatives and West Coast LEAF.

2 A notable exception are advocates working on women's mental health as detailed in a report released in anticipation of Kirby's research (Ad Hoc Working Group on Women, 2006) and in a subsequent press release by the Canadian Women's Health Network (see http://www.cwhn.ca/resources/cwhn/mentalHealth.html). For a consumer/survivor advocate's perspective on Kirby's lack of discussion regarding involuntary treatment, see Rob Wipond's piece at http://www.rabble.ca

3 Kirby, 2006.

4 The Mental Health Commission is meant to allow for better collaboration and cooperation between the provinces and territories and would act as a body for information exchange. The Mental Health Transition Fund is meant to allow the Federal government to make money available (over a 10 year period) to fund community-based services and housing for people with mental illness.

5 Roy Romanow (2002:178) notes that "Mental health has often been described as one of the 'orphan children' of medicare."

6 Capponi, 1992; Church, 1997; Everett, 2000; Goering, Wasylenki, Lancee, & Freeman, 1984; Lesage, Morisette, Fortier, Reinharz, & Contandriopoulos, 2000; Nelson, Lord, & Ochocka, 2001.

7 Individuals who receive mental health services are described using various terms (e.g., psychiatric survivor, consumer, consumer/survivor, ex-patient, mental health care recipient, client). The authors intend the use of the term "consumer" throughout this report to be inclusive of these differences.

8 Everett, 2000; Nelson, Lord, & Ochocka, 2001; Trainor, Shepherd, Boydell, Leff, & Crawford, 1997.

9 Trainor, Pomeroy, & Pape, 2004.

10 Assertive case management involves interdisciplinary mental health teams which provide individualized and intensive care on an outreach basis often with extended hours.

11 Kirby, 2006.

12 Mental Health Evaluation & Community Consultation Unit (Mheccu), 2005.

13 Culhane, Metraux, & Hadley, 2001; Wilton, 2004.

14 Goldner, Snider, & Mozel, 2000.

15 Ross, Scott, & Smith, 2000.

16 National Council on Welfare, 2006.

[17] Ibid.

[18] Ibid.

[19] "Decent" in this context is based on the 'market basket' measure of poverty.

[20] Ettner, 2000; Marcotte et al., 1999; Marcotte et al., 2000.

[21] Dewan, 1999; Lesage et al., 2004; Stuart, 2004. In Canada there have been recent moves to increase the support to those individuals that are already employed, especially with respect to raising the awareness of employers. A key example of this would be the Business and Economic Roundtable on Addiction and Mental Health, which was founded in 2002 by Bill Wilkerson. The senior chairman is businessman, former federal finance minister and current US ambassador Michael Wilson. The Roundtable has been active in educating businesses and in developing guidelines on how to handle employees with mental health problems (Lesage, Dewa, Savoie, Quirion, & Frank, 2004).

[22] BC Minister of Employment and Income Assistance, 2005.

[23] Acorn, 1993; Hwang, 2001; Wood, 1992.

[24] Canadian Mental Health Association, 1998; Fischer & Breakey, 1991.

[25] City of Vancouver, 2005.

[26] Graves, 2004. In response to this a Homeless Outreach Project is currently being piloted by the Ministry of Employment and Income Assistance, the Ministry of Housing, and the City of Vancouver.

[27] Interview, emergency housing worker, Vancouver, 2005.

[28] BC Ministry of Health's Advisory Council on Mental Health, 2002; Kirby, 2006.

[29] Each organization providing supports to people with mental illness keeps statistics on their client base. There is, however, no centralized mechanisms for keeping statistics in the VCH region as a whole. As a result, the information we provide about clients is primarily descriptive and drawn from interviews with providers.

[30] BC Ministry of Employment and Income Assistance, 2005.

[31] Goldberg & Wolanski, 2005; Wallace, Klein, & Reitsma-Street, 2006.

[32] Auditor General, 2004:2.

[33] Auditor General, 2004.

[34] A complaint on behalf of 15 community-based organizations in BC including the BCCPD has been lodged with the Ombudsman (February 2005) against the Ministry of Employment and Income Assistance for unfair treatment of people on income assistance including those on disability benefits. The main thrust of the complaint is that legislative and policy changes have drastically eroded the rights of people on income assistance and their access to needed supports, including people with disabilities (BC Public Interest Advocacy Centre, 2005). The Ombudsman has responded to some of these complaints and subsequently the ministry has made some changes regarding the three-week work search, home visits, and reconsideration and appeal rights. The Ombudsman has not yet released his report on the issues related to disability applications (see www.bcpiac.com/pub/currInterest/FactSheetMay2006.pdf. Accessed June, 2006).

[35] BC Public Interest Advocacy Centre, 2005.

[36] Wallace, Klein, & Reitsma-Street, 2006.

[37] Long & Beveridge, 2004.

[38] *The Diagnostic and Statistical Manual of Mental Disorders*, used by most mental health care professionals in North America, classifies mental illnesses along two axes: Axis I disorders (e.g., schizophrenia and severe affective disorders) are considered more severe than Axis II disorders (e.g., some affective disorders, personality disorders).

[39] Rent subsidies are based on the current CMHC average rent for a one bedroom apartment in that geographic region. The supplement is the difference between the average market rent and the disability shelter allowance. The consumer of mental health services never directly receives the money.

[40] Trainor, Pomeroy, & Pape, 2004.

[41] Capital funding is secured in partnership with BC Housing, federal housing programs, the City of Vancouver, VCH, and other agencies. Land is leased from the City of Vancouver or the province.

[42] Transitional housing for people with complex needs (mental illness, drug addiction) and challenging behaviour; 45 units.

[43] Transitional housing for women with mental illness, substance use issues, and histories of experiencing violence; 24 units.

[44] City of Vancouver, 2005.

[45] Ibid.

[46] Trainor, Pomeroy & Pape (2004:11). The Framework Policy Project was first initiated with the support of the Canadian Mental Health Association in the 1980s. Its main focus was on involving consumers and families in mental health care treatment and policy development. The subsequent document *A Framework for Support* has became widely used as a forward-thinking template for mental health policy development.

[47] Trainor, Pomeroy, & Pape, 2004:2.

[48] BC Coalition of People with Disabilities, 2005.

[49] Nelson, Lord, & Ochocka, 2001; Wilton, 2004.

[50] Trainor, Pomeroy, & Pape, 2004.

[51] BC Public Interest Advocacy Centre, 2005.

[52] For example, the Consumer Development Initiatives Fund in Ontario and the Self-Employment Project from the National Network for Mental Health in Nova Scotia.

[53] This information is taken from fact sheets prepared by the BC Coalition of People with Disabilities. These fact sheets were accessed at http://www.bccpd.bc.ca/ September 2005. The fact sheets were updated March 2005.

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