No. 13, Fall/Winter 2001

CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE

# BC's Mental Health Journal Visions

# Employment

BC's Mental Health Journal

Visions

is a quarterly publication produced by the Canadian Mental Health Association, BC Division. It is based on and reflects the guiding philosophy of the CMHA: the "Framework for Support." This philosophy holds that a mental health consumer (someone who has used mental health services) is at the centre of any supportive mental health system. It also advocates and values the involvement and perspectives of friends, family members, service providers, and community. In this journal, we hope to create a place where the many perspectives on mental health issues can be heard.

The Canadian Mental Health Association invites readers' comments and concerns regarding the articles and opinions expressed in this journal. Please e-mail us at **office@cmha-bc.org** or send your letter with your contact information to:

**Eric Macnaughton**
**Visions Editor**
**CMHA BC Division**
**1200-1111 Melville Street**
**Vancouver, BC V6E 3V6**

Subscriptions are $25 a year for four issues. To subscribe, purchase back issues, or inquire about advertising in Visions, call us at **(604) 688-3234** or if you are calling from outside the Lower Mainland, call toll-free: **1-800-555-8222**.



A main focus of this issue of Visions is how to help people with serious mental illness choose, get and keep employment that is meaningful to them. In the field, this is known as "supported employment" or "supported *competitive* employment," the extra word in recognition of the fact that our expectations for people's abilities have historically been too low and that, with the right kind of support, we can significantly raise the bar.

Helping people attain their employment aspirations has not traditionally been thought of as part and parcel of mental health services. The evidence is clear, though, that work of whatever definition — whether paid, competitive, or more recreational or volunteer — is integral to an individual's well-being, whether they have a serious mental illness or not.

In this issue, we'll look at some of the key issues relating to the employment needs of people with serious mental illness and at some of the latest, most innovative thinking about how to design supports that are genuinely effective. We'll also consider some issues that cut across the population of people with mental illness, whether serious or not. Specifically, we'll look at some of the general issues relating to work and well-being, looking more closely at the mental health risks associated with certain occupations and work settings. Another overarching issue we'll examine is discrimination in the workplace relating generally to employment practices, and specifically to things such as health and disability-related employee benefits.

One key issue in this regard is disclosure (i.e., telling employers about one's mental illness) so that one can be eligible for relevant benefits and supports. Another related issue that we'll focus on is accommodation which hinges on disclosure and entails restructuring the job or work environment in ways that enable people with mental illness to optimize both their workplace contribution and their health. The dilemma for people with mental illness is that disclosure enables accommodation but also makes the individual more vulnerable to discrimination.

For this edition, we are especially fortunate on two fronts. One is the opportunity for our readers to learn from the thoughts of guest editors Marianne Farkas and Judi Chamberlin — true pioneers in the field. The other is to hear a message from the Honourable Gulzar Cheema, our Minister of State for Mental Health in this province, and his commitment to the vocational aspirations of people with mental illness.

**Eric Macnaughton**

- This issue of Visions is dedicated to the memory of Garry Long. Many of us here at CMHA BC worked with him while he was an employee of our organization, before he went on to become the Executive Director of Action Research and Advocacy, based in the downtown eastside of Vancouver. We will well remember his intelligence, his love of language, and perhaps above all, his determination. It was this quality that enabled him to overcome the obstacles in his own life, and that made him such an effective advocate for people with a mental illness.



- The Canadian Mental Health Association is grateful to the BC Ministry of Health Services which has assisted in underwriting the production of this journal.

## CONTENTS

# Supported Employment:

## An Idea Whose Time Has Come

*Marianne Farkas and Judi Chamberlin*

Marianne Farkas, *Director of the World Health Organization Collaborating Center, Boston University, Center for Psychiatric Rehabilitation*

Judi Chamberlin, *Consultant and Consumer-Survivor Advocate*

In North America, work is an integral part of one's identity. Historically, the mental health system has viewed work as a form of therapy or treatment rather than viewing it as a meaningful outcome of service. Predicting who is likely to benefit from vocational services or who is likely to achieve vocational outcomes among individuals with severe psychiatric disability has proven to be somewhat of an illusive exercise[2,7] as evidenced by the ongoing low rates of employment among people with serious psychiatric disabilities. Nearly 70% of those with long-term psychiatric experiences in the United States are almost entirely dependent upon Social Security programs for financial and medical support and few ever leave the Social Security roles to move into competitive employment.[9] Nearly 50% of those who do obtain jobs through rehabilitation programs lose them within a one-year period.[5] No more than 30% of those who do work have been able to move beyond entry-level positions that keep people with serious psychiatric disabilities near the poverty level.[6]

People with serious psychiatric disabilities, however, who are within the age group of those who typically work in our society, for the most part, *do want* to work.[8] Most also find serious obstacles to obtaining and keeping competitive employment at levels commensurate with their skills, education, experience and interests.

Baron and Salzer describe a "culture of unemployment" among consumers, policy-makers and providers that is both pervasive and persistent.[4] In this culture, mental health professionals are used to believing that work may be so stressful that it is thought to threaten the consumer's possibilities for progress. Many mental health professionals and vocational rehabilitation counselors view consumer's personal work goals as "unrealistic." Baron points out that the national system of supports, such as Social Security Disability Insurance, health care and housing subsidies create strong disincentives for anyone who wants to return to work. Similar disincentives exist in Canada.[3]

Returning to work, usually in a low-paying, entry-level position, can threaten a person with the loss of good medical coverage for medications and therapy, and the loss of housing subsidies which make decent housing a possibility. Many rehabilitation programs are not adequately funded to provide the array of vocational rehabilitation services needed to even obtain an entry-level position. With such obstacles facing an individual's desire to regain the valued role of a worker in our society, it is simplistic to perceive an individual's readiness for work as simply a function of the individual's capacity to perform work adjustment skills and control his or her symptoms. In fact, there is some evidence to suggest that many of the predictors that have traditionally been thought of as predictors of unsuccessful vocational rehabilitation — poor employment history; poor work adjustment skills; more hospitalizations; receiving benefits; being black, unmarried or unskilled — are *not* related to outcome if a person seeks and is engaged in a vocational program.[1]

Supported employment is designed to help those individuals who have the desire to work gain and keep competitive employment. Supported employment assists people, who may not have strong support systems of their own, take advantage of a very natural human tendency to seek help and approval from others. Good supported employment models begin from the premise that work that is commensurate with an individual's talents, skills, education and interest level is a prime contributor to a sense of well-being and purposefulness in life, as well as being one path to regaining respect from others in the society. Supported employment can help individuals maintain their motivation for work because the approach helps individuals first gain competitive work and then learn what they need to learn "on the job," rather than being in long training programs that may or may not result in gaining real work.

Supported employment is neither about placing people in "work slots," nor about creating "busy work" to break up a boring routine. The model is a method for assisting individuals to quickly obtain the kinds of work that they want and have the ability to perform, through a system of individualized, flexible, ongoing supports. While many workers, disabled or not, may have problems with an insensitive supervisor, too

heavy a workload or unfriendly colleagues, these difficulties may appear overwhelming when a person is returning to work after a period of unemployment and/or is unsure of his or her own abilities. In such circumstances, a support person can mean the difference between long-term success or immediate failure. The "job coach," who is available by phone or in person to deal with the workplace difficulties and pressures, can negotiate with supervisors where appropriate and can assist the individual to persevere in the job. The job coach can be a professional (e.g., nurse, teacher, occupational therapist) or may be a paraprofessional (e.g., entrepreneur, consumer-survivor). A good job coach is able to listen, negotiate and problem solve and do so in as unobtrusive a way as possible in order to reduce workplace stigma.

Supported employment is most successful when it is used to assist people who have had some fairly recent past work experience that they would like to regain. While the concept of supported employment can be used to support people in managerial or professional positions, it has been most often used for those who are looking for entry-level positions. Supported employment serves the needs of people best when there is an array of other vocational resources available. Some individuals may need or want to try volunteer jobs, internships or a variety of job shadowing opportunities before they are ready to choose a career path.

While supported employment may be a part of the career exploration plan, it usually serves people who are ready to take a position in the immediate future. Temporary Employment programs, for example, may help individuals to make a career choice that can then be followed up by a Supported Employment program to maximize the possibility that the individual can gain meaningful employment. If there is only one vocational model available within a service system, service system pressures tend to force individuals into the one available program, whether or not they want to work, know their interests and talents, or are even ready. Supported employment is a powerful and indispensable tool in the struggle to transition from being a client of a mental health system to being an employee and all that being a tax-paying member of a community implies. ■

References


1 Anthony, W. A. (1994). Characteristics of people with psychiatric disabilities that are predictive of entry into the rehabilitation process and successful employment. *Psychosocial Rehabilitation Journal, 17*(3), 3-13.

2 Anthony, W. A., Rogers, E. S., Cohen, M., & Davies, R. R. (1995). Relationships between psychiatric symptomatology, work skills and future vocational performance. *Psychiatric Services, 46*(4), 353-358.

3 Baron, R. (1997). *Hearings before the subcommittee on social security of the committee on ways and means / House of Representatives.* Washington, DC: US Government Accounting Office.

4 Baron, R. C. & Salzer, M. S. (2000). The career patterns of persons with serious mental illness: Generating a new vision of lifetime careers for those in recovery. *Psychiatric Rehabilitation Skills, 4*(1), 136-156.

5 Cook, J. & Rosenberg, H. (1994). Predicting community employment among persons with psychiatric disabilities: A logistic regression analysis. *Journal of Rehabilitation Administration, 18*, 6.

6 Kirszner, M., Baron, R., & Rutman, I. (1992). *Employer participation in supported and transitional employment for persons with long-term mental illness.* Final Report to the National Institute on Disability and Rehabilitation Research. Philadelphia: Matrix Research Institute.

7 Rogers, E. S., Anthony, W. A., Cohen, M., & Davies, R. R. (1997). Prediction of vocational outcome based on clinical and demographic indicators among vocationally ready clients. *Community Mental Health Journal, 33*(2), 99-112.

8 Rogers, E. S., Walsh, D., Danley, K. S., & Smith. (1991). *Massachusetts client preference assessment: Final report.* Boston, MA: Center for Psychiatric Rehabilitation, Boston University.

9 United States General Accounting Office. (April 1996). *SSA disability: Program redesign necessary to encourage return to work.* Report to the Chairman, Special Committee on Aging and the US Senate. Washington DC: General Accounting Office (GAO/HEHS 96-62).

# Ministerial Thoughts on Employment

*Hon. Gulzar Cheema, MD*

As many readers will know, I have recently been appointed by Premier Gordon Campbell to the newly-created portfolio of Minister of State for Mental Health for BC. It is a portfolio that I feel was needed in our health care system — one that will place greater attention on mental health services, mental health care and mental health planning. As minister, my goal is to ensure that mental health is granted equal status in health care services in British Columbia, so that mental health care becomes part of the mainstream of health services. Giving equal status to mental health care will help remove the myths and misunderstandings that surround mental illnesses. Communities will become knowledgeable and more accepting of mental illness, allowing sufferers to seek and receive assistance without fear of judgement. It is time to take mental illness out of the dark and into the light — time to let mental illness be accepted by the public with compassion and understanding so that people with mental illnesses can become full participants in their communities.

While I will work hard to support all aspects of mental health, an area of particular interest for me is helping people with mental illnesses participate in the workforce within their communities. Employment is a key to well-being for all of us, providing financial gains, a source of personal identity and the opportunity to make meaningful contributions to community life.

It wasn't that long ago that society generally accepted that people with mental health issues were unemployable. And that wasn't just the opinion of the public; it was a view shared by service consumers, family members, provider agencies, advocacy organizations and legislators. But times are changing, as are the roles of mental health clients in the workplace. I want to support that change to improve employment opportunities for people with mental illness. The rates of unemployment for people with a diagnosis of schizophrenia, bipolar disorder or clinical depression are far too high. A diagnosis of serious mental illness should not be used to determine whether or not someone is capable of being employed. It may mean that employment of a mental health client might require accommodation in the workplace, but it does not preclude employment. A recent publication of the Matrix Research Institute and the University of Pennsylvania reports that people with a mental illness who are employed generally have a stronger sense of self-esteem, more independent functioning skills and less need for emergency hospitalization. Those who take part in employment programs, with the appropriate support, make less use of the most expensive mental health services. A study in this review also reports that 70% of employers expressed willingness to continue working with rehabilitation programs that place and support people with a serious mental illness.

Traditionally, the approach to employment for people with long-term mental illness has been to create separate, isolated environments that provide repetitive work, low expectations for career development, low job satisfaction, few employment choices, less than minimum wage and segregation from the mainstream population. Relatively new findings are challenging this approach and evidence indicates that given the appropriate services and support, people with long-term mental illnesses can succeed in the workplace.

People with mental illness want to work and can work, and rehabilitation programs play a key role. The challenge is to utilize our current knowledge to move toward a future in which people who want jobs have the opportunity to get them. This may require support at a variety of employment stages — interviews, job offers, learning new skills — in order to benefit from the positive experiences employment can provide.

Our role is to continue working with the government of Canada, the Canadian Mental Health Association and British Columbia health authorities which have many innovative employment programs to promote consumer-centred models identified in the Best Practices report on vocational and educational support. We also need to work together developing and implementing a wide range of new initiatives that provide the sustainability needed by people with mental illnesses.

As Minister of State for Mental Health, I will be working with the Adult Mental Health Policy Division of the Ministry of Health Services and will liaise with all other areas of government that can support services for all British Columbians with a mental illness. I will focus on the full range of services provided to the mental health consumer. Are services available when and where they are needed? What services in the province are working? Which ones are not working? Are there new, innovative initiatives that show promise and, if so, what are they and what kind of timelines are we considering in taking these new programs to the consumer?

I am reviewing existing information and will seek further input from policy-makers, health care providers and institutions, mental health consumers and their families in the coming months. It is imperative that people who are seeking mental health services have a say in how those services are delivered and which services are delivered. They, more than anyone, know what has to be done to meet individual needs so that forgotten mental health consumers within the system receive the care and respect they deserve. ■

*Dr. Cheema is the newly-appointed Minister of State for Mental Health. He is also a family physician. To read his full biography, go to www.gov.bc.ca/prem/popt/exec/cheemag.htm*

BRITISH COLUMBIA
Ministry of Health

# Just Doing It:

## Helping People with Mental Illness Get Good Jobs

*Joe Marrone*

*Adapted from Marrone, J., Gandolfo, C., Gold, M., & Hoff, D. (1998). Just doing it: Helping people with mental illness get good jobs.* Journal of Applied Rehabilitation Counseling, 29(1), *37-48.*

*For reprints, contact Joe Marrone, Institute for Community Inclusion 4517 NE 39th Avenue Portland, OR 97211 Tel: (503) 331-0687 E-mail: JM61947@AOL.COM*

In the past, placement efforts for individuals with disabilities, including mental illness, have often been based on appeals to altruism. No real business needs of the employer have been met and such efforts continue to reinforce stereotypes of individuals' needing charity, not opportunity. Employment efforts continue to be viewed in terms of convincing the employer to hire that person, a strategy based on the concept of finding what job openings exist in the job market and finding individuals to fit those openings.

Such strategies make the assumption that the job market is one arena, with limited flexibility, under the employer's total power and authority. The reality is that employers' needs are flexible; they are growing increasingly accustomed to meeting the demands of a diverse workforce. Employers may have only incomplete information about their labour market, and job development involves brokering an exchange process, providing usable information to both job seekers and employers. In order to increase the chances for long-term employment success, a strategy focusing on the following elements is needed:

- **Needs:** A need can be characterized as an issue, situation or problem which requires a solution.
- **Features:** A feature is what a product or deliverable consists of.
- **Benefits:** A benefit is what is gained as a result of that feature.

To identify how agency features translate into benefits for the employer, it is vital that staff gain a well-rounded picture of the consumer. The agency staff should work with individuals on identifying their interests, skills, positive personality traits, career goals, likes, dislikes and the kind of environments in which they are most comfortable. Furthermore, in representing the individual to the employer, the features and benefits of the agency's services should be clearly understood.

The individual and the agency should communicate with the employer in a way that creates a positive impression. Prior to discussing a job with an employer, potential objections (and how to address them) should be discussed with the person. Employers should be provided the opportunity to raise objections, in order that they can be countered. Employers may have a fear of asking the wrong question, and so may be hesitant to voice them. It is up to the individual and the agency to create an atmosphere of openness and honesty so that concerns can be discussed comfortably. Objections posed by an employer can be dealt with from two perspectives: the individual and the agency. Therefore, when an employer raises an objection, it can be addressed by calling attention to the strengths of the individual or by calling attention to the services available from the agency that provide solutions to the objection.

Disclosure is an issue in developing relationships with employers, particularly in responding to objections. There should be a clear idea of what a job entails, in order to assess whether it's necessary to disclose the disability. Prior to disclosing any information concerning disability, this issue should be discussed with and approved of by the consumer (see follow-up article on p. 40). Any disclosure should be accompanied by an explanation of the implications of the information being disclosed. Depending on individual needs, disclosure of such information may include emphasis on the availability of assistance from the rehabilitation provider. Maintaining confidentiality on sensitive issues is of paramount importance, but questions and fears should not be created in the employer's mind that are left unanswered.

### "Readiness" Concepts

Frequently, individuals with mental illness are labeled "not job ready" but:

- One cannot reliably predict who will be successful in employment
- Community settings can accommodate a wide range of skills and behaviour
- People do not always generalize skills and behaviour, i.e., they may not be able to perform in one job, but be able to perform well in another context
- Problem behaviours and skill deficits cannot be improved in segregated settings
- Real situations can only be simulated to a limited extent, so it is important that people be exposed to "real world" integrated job settings.

Waiting to get all disability related issues under control may mean that the consumer is never perceived as "ready." Having a parallel focus of employment, support and work on disability issues is reasonable. All individuals must find jobs that they can do and work cultures in which they can fit. "Job readiness" can be summarized as creating a match among the skills, interests, values and needs of a person with the demands of a specific job and the values and needs of a particular employer. As such, to create a good job fit, staff must:

**Understand the consumer's** abilities, values and needs
**Understand the employer's** needs and values
**Understand the job —** What skills are required? What is the work culture?

## Consumer Involvement in the Placement Process

An essential element of helping people with mental illness in the job hunt is the job seeker's direction of the job search and involvement in all aspects of the process. Successful employment, like any other aspect of personal change, requires that the consumer take an active role which, in turn, helps to ensure satisfaction with the outcome and investment by the worker in staying employed.

Figuring out job/career goals is perplexing for most people and made more challenging when dealing with a mental illness. Fears make many job seekers with mental illness reluctant to seek employment and prone to give up early in the job seeking process. Past failures, lack of skills and/or experience, and manifestations of the disability itself can put job seekers with mental illness at great disadvantage when competing with other job seekers. The prevalence of discrimination and the required skill and persistence needed to advocate successfully can be an overwhelming challenge for the person.

Five guidelines are offered in thinking about designing services that actively promote involvement by individuals with mental illness:

1. Involve the job seeker as an important member of the team
2. The level of involvement and support in the job hunt needs to be matched to the abilities and preferences of the job seeker
3. Involvement is not all or nothing; the important thing is the ability to re-adjust supports as needed to promote it
4. The issue of disclosure of a disability is a decision that is made by the individual, based on a particular situation
5. Understand that formal professional supports, as opposed to informal supports, have both potential benefits and drawbacks.

## Disability Disclosure

An often difficult and emotionally charged issue for many job seekers with mental illness is how much to tell a prospective employer. Drawing attention to the mental illness may lessen chances of getting the job. Below is a template that can be used to assist the job seeker to decide what to tell an employer regarding mental illness:

- Personal ethics of the job seeker related to non-disclosure
- Is the truth better?
- Is the truth relevant?
- Can the facts be checked?
- What are the effects on the job seeker and the employer of non-disclosure?

If the job seeker does choose to present information on disability, it is preferable to present that information in person so that the individual can gauge how the information is perceived and address any concerns immediately. Whenever disability related information is shared, it should be presented in a way that focuses on what the job seeker has to offer and how past problems have been resolved.

## Follow Up

Obtaining a job interview is not the final step in the process. Job seekers should be encouraged to take an active role in following up on interviews through letters, phone calls and checking with references. Professional support should include reviewing with the job seeker what occurred during the interview and follow-up strategies. The job seeker must be able to accept critical feedback while maintaining a polite manner with the employer to keep future opportunities alive. Due to negative stereotypes of people with mental illness as being dangerous or out of control, it is important for such job seekers to handle the negotiation process in a manner that dispels such stereotypes.

## Conclusion

General components of effective job marketing strategies are relevant for anyone regardless of the presence or nature of a disability. The specifics of the approach can be adapted in the case of a mental health impairment, especially insofar as societal fears and stereotyping are more intense than for people with most other disabilities. Skill and comfort in working with people facing these problems will determine effectiveness in easing employer anxieties. If better employment outcomes are to become a reality for people with psychiatric disabilities, then structures and frameworks built must reflect a shift from vocational programming to helping people find and maintain employment and careers. ■

# Mental Illness + Workplace Violence

*Dr. Nancy Hall*

*Nancy wrote this piece when she was the provincial Mental Health Advocate of BC. The office was closed November 2001*

Mental Health Advocate *of* BC

This spring, BC residents were greeted with concerning news of people with mental illness in the school system. In one local case, a BC teacher was remanded for psychiatric assessment at the Forensic Psychiatric Institute for setting fires in her school. The teacher had a history of mental illness and had worked in other school districts where people had noticed her symptoms and, it seemed, encouraged her to move on to another job. It appeared she went to another job without substantial assistance to address her health concerns. In the other case, a former school janitor in Ikeda, Japan had a breakdown and allegedly took the lives of eight children in a bizarre killing spree. The man has a history of mental illness and had been arrested previously for allegedly putting tranquilizers in the tea that he gave to teachers at a school where he was employed.

What's to be done? Some suggest the way to avoid these unfortunate circumstances would be to ban people with mental illness from the workplace. Indeed, a recent Supreme Court decision overturned the BC Human Rights Tribunal where a man with bipolar illness was banned from working as a fishing guide. The Court felt the employer had a bona fide concern for the safety of the clients of the fishing lodge — even though the man is now in treatment with his symptoms in remission. Another solution proposed in a recent *National Post* editorial was to force all people with schizophrenia to take their medication. Unfortunately, that wouldn't solve the problem because people with schizophrenia do not create all societal violence. A recent study reported in *Psychiatric Services* by Drs. Stuart and Alborleda-Florez of the University of Calgary found that only 3% of criminals arrested for violent crime have a mental disorder. In other words, 97% of admissions to prison were so-called "normal" people.

**FACT**

80% of homicides at work are the direct result of a robber or felon.

— Kraus, J. F., Blander, B., & McArther, D. L. (1995). Incidence, risk factors and prevention strategies for work-related assault injuries. *Annual Review of Public Health, 16,* 355-79.

Another more proactive approach would be to understand that mental illness and addiction are extremely common. For a variety of reasons — workplace productivity, workplace safety and employee satisfaction — it makes sense not to wait until a problem arises. We need to be able to recognize when someone is mentally ill or showing signs of chemical dependency. Workers and managers alike need to know how to support people in getting help. It shouldn't take people from three to ten years to just get a label. Nor should people get discriminatory labels with no help.

It is in all of our best interests to think about mental illness differently. We need to enlarge our understanding and compassion. Those who are charged with the responsibility need to get on with creating a treatment system that works. Workplaces, particularly those which employ "professionals," need to be much more proactive in their approach to mental illness. We should expect employee mental illness to be the rule rather than the exception. People with mental illness can and do work in supportive environments. Yet I am not aware of many large or small employers in British Columbia that have taken a proactive approach towards mental illness. In most cases, people report that owning a label of a mental illness is used to disqualify people rather than support them. Indeed, I attended an inquest recently of the death of man whose symptoms of depression were seen as reason for management to discipline him rather than support him into treatment.

Consider what the Department of Psychiatry at the University of British Columbia does to address the situation of a doctor with a mental illness. Each year, the Hospital Department Head conducts an annual performance appraisal of doctors. Where previously, doctors were asked if they had a mental illness, now doctors are asked if during the past year, they have "any emotional problems that might interfere with them doing their job." If someone says yes — and some do — the manager and the employee plan a support program for the person that might include regular letters from the person's doctor indicating how the person is doing and compliance with treatment. In turn, the College of Physicians and Surgeons requires every doctor who treats a doctor with a mental disorder to report that individual to the College. The College has a variety of employee assistance programs to support the individual who is then required to attend treatment as a condition of employment. The thing about this approach is that it is positive and supportive and is done with the assumption that many of us will have emotional problems during the year and that help is available.

The reason many people with a mental disorder don't report it to their employers is that studies show that eight out of ten people experience discrimination once their diagnosis becomes known. People assume violence and then increase their distance from consumers. Help and support evaporate as the troubled person's friends and co-workers vanish. The person's health deteriorates and symptoms emerge that are no doubt objectionable. In my opinion, the current situation in BC is that people are more likely to be disciplined for the symptoms of their illness, than they are likely to be assisted.

If one in five of us will experience a mental disorder in the next year, it behooves us to get on with addressing our prejudices against people with mental illness, getting that much-promised treatment system in place and among other things, developing supportive workplace policies for employees with mental health concerns. It makes more sense to get used to the possibility of mental illness in our friends and co-workers and work with it than to continue with the present approach of keeping our head in the sand.

# Navigating Workplace Minefields

*Tanya*

My first experience with mental illness was at twenty-three years old. At the time, it seemed a marauder had entered my mind and overturned everything reliable; reality itself was in flux. It was a brutal experience, one that took me about two-and-a-half years to recover from. Once my feet were planted on the earth again, I sought employment. I had received no financial assistance since my breakdown, so I was anxious and nearly bankrupt.

I got a job in a "big bank" as a cash clerk. The work was a bit mundane, but I found the routine reassuring. I had not informed anyone that I had a mental illness, not only because I wanted to protect my privacy, but also because I was in denial. I believed that my experience was an isolated one and was one that would not occur again. This denial led to my next relapse. I eventually stopped taking medication, believing that it was unnecessary. I ended up in the hospital and was on paid leave for about two months, recovering.

After my leave, I returned to work. Obviously, my supervisors now knew of my mental illness, but my fellow employees were another matter. It seemed to me, disoriented as I was, that everyone was treating me differently. To this day, I am not sure if they did or did not know, or if there was perhaps not some rumour of mental instability. The experience was isolating, and became part of the cycle of my next relapse. I started on another manic cycle that eventually deteriorated approximately eight months later into another relapse and institutionalization. This time, my supervisors undoubtedly contributed, as they had become hostile and provocative. Whether they were aware or not of the nature of my mental illness is something I still do not know.

My doctor filed the paperwork to the group insurance carrier stating that I required three months leave. After only three weeks, I got a call from the insurance company telling me that I had to show up for work the next day. So I did.

In retrospect, I realize that the nature of mental illness is very isolating and can be dispiriting. Where before the onset of mental illness I was quick to anger at any injustice or evidence of prejudice, I had eventually become submissive. I had run the gamut from anger to resentment, from resentment to bitterness, and from bitterness to resignation. I came to expect disrespect and adopted an apologetic manner.

Later, after my early return to work, my supervisors seized any opportunity to pressure me to resign. They began to manufacture pretexts for complaining about my work. I was disoriented and feeling like an outcast, so when they asked me to leave, I complied. I now had no income and a car and an apartment to maintain. I tried to claim Employment Insurance without revealing I had a mental illness. My case was refused and I filed an appeal. The tribunal convened in response to my appeal was held without me because I was only notified of it after it had actually occurred! During this period, I was hospitalized yet again. I also lost my apartment and my car due to the financial pressure, as I was not qualified to collect social assistance with a pending EI claim. I would have been destitute had it not been for family support.

Perplexed, I changed my EI appeal from a basis of wrongful dismissal to one of a medical pretext, i.e., my mental illness. I was again in a stalemate. The authenticity of my medical claim was questioned and considered to be a gambit of last resort. Apparently my illness had not been mentioned by my former employer at the tribunal, as they were probably instructed not to do so. I was very resentful, so when I finally received a letter from the EI office personally signed by a case worker there, I called her. When I asked her what the obstacle was in my claim and explained all the financial chaos I had suffered as a result of my appeal, she was unmoved. Hardened, I asked her if she had been handling my case from the beginning and she asserted, with the bravado of someone believing herself to be morally righteous, that indeed she had. Very confrontational now, she claimed that she did not believe that I could substantiate my claim of a medical reason behind my resignation. I asked for her address and forwarded her a copy of my entire medical file and received a settlement within a month.

It is difficult to gain any empowering insights from my experiences and I can only hope that one day I will have attained some sort of better balance in my outlook on the world. At some point, I would like to say that my experience has been personally valuable in that it has allowed me somehow to help others overcome *their* obstacles, internal or external. Perhaps writing this is a step in the right direction. ■

## Feeling discriminated against by insurers?

Do you feel that you have been the victim of discrimination by an insurance company due to a mental health disability claim? If so, tell us your story! Contact the Canadian Mental Health Association BC Division and become part of the **Workplace Insurance Project.**

**Lower Mainland:**
604-688-3234

**Toll-free across BC:**
1-800-555-8222

**Email:** cmccormick@cmha-bc.org

# Getting Behind and Beyond Counters


*Catherine Bryson*

Counters have acquired a symbolic significance for me over the years — symbolic of the world between those who have jobs and those who don't. I have stood behind many counters in my day: mental health centres, community agencies, health clinics. And I would presume that, after a while, the person behind the counter would get to know my face. Would they classify me as belonging to a group or class (recipient of services, poor woman, welfare bum, etc.) or would they resist that temptation and see beyond such rigid lines and see the real person? I wonder. For sometimes, our roles are deeply entrenched. And certainly I had a lot of practice playing my role, which mainly consisted of waiting. Oh the hours I spent in waiting rooms; if I added them all up, I could have written novels.

I currently spend less time waiting — about half as much as I work part-time. How difficult was the climb, just to get where I am now (though my pay cheque remains small). There were tears in my eyes at my college graduation, stunned tears. How often the effort had seemed like running up the down escalator, a childhood game but now a rather serious reality. For I have read that once you enter the poverty trap, it is very difficult to get out — hence the escalator feeling. And of course, if you add the somnolent effect of the medications, you have to work twice as hard.

Still, it's worth it in the long run: to earn one's bread, (or part of it). Truth to say, nothing could have been sweeter than the first pay cheque since I became ill, back in 1994. I struggle against fatigue and somnolence — but I really treasure my place behind the counter. I treasure it all the more now, having stood in front of it for so many years. I suppose it's nice to have both perspectives now — but actually I think I'd like to get beyond counters altogether. Eventually I'd like to see less "behind" and "in front of" and more "side by side": less role-playing and more just being. That day may come, and I hope to be a part of it. In the meantime, I continue my flight up the down escalator. At the very least, it keeps me in shape. ■

# My Struggle Toward Film School

*Patricia Duncan, BSpEd*

*Patricia is a consumer-survivor advocate and recipient of a Lorne Fraser Educational Fund bursary from CMHA*

It has been a permanent challenge in my life to have been born a creative artist with an active imagination into a family which valued practicality and judged my creativity as something I could only express as a hobby. This conflict led to years of justifying traits that I inherited.

I first saw the film *The Wizard of Oz* when I was nine years old. My family and I were living in Northern Ireland, and I was determined to somehow get to the place that could make such a fantastic film. Finally, at age 54 after many trials and tribulations, I am able to plan to attend Vancouver Film School in Fall 2001. The delay in achieving my artistic ambition can be directly associated with what I see as interference by staff of the Vocational Rehabilitation Services (VRS) of what used to be called the Ministry of Social Development and Economic Security. The name of this Ministry has changed several times over the nine years that I have been entangled in the red tape of VRS bureaucracy and what I feel to be their discrimination.

Although I wanted to go to art school on the recommendation of my art teacher when I graduated from high school, my parents insisted that I take a Clerk/Typist course at Vocational Training School "to have something *practical* to fall back on." I found office jobs very boring and I had a spirit for adventure. I decided to get a job that would give me money to travel.

It is important to note that I always tried hard to be very good at whatever profession for which I got training. When I graduated as a Licensed Practical Nurse at age 21, I received the award for Best Bedside Nurse. In those days, it was significant, because practical nurses were responsible for all bedside care of hospital patients. Many years later, after my son was born, I transferred from Langara College to the University of British Columbia to study for a teaching degree in Special Education. One of my professors nominated me for the AJ Dauphinee Award, which was a bursary given to "an outstanding female student in the field of teaching children with learning disabilities."

The birth of my son inspired a career switch from nursing to teaching, because I recognized that it would be difficult to get child care while doing shift work as a nurse. For a few months, I had actually attempted training to become a Registered Nurse, but gave up.

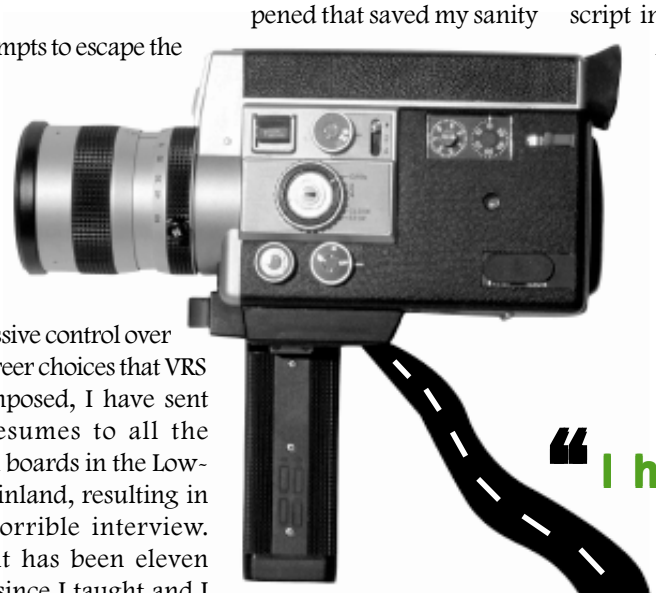
I became a consumer of mental health services in

1987. It was not until I had been unemployed for a year in Nanaimo in 1992, that I found out about VRS. I had a growing child with medical, dental, nutritional, and clothing needs to support; thus, parenthood became the driving force behind my determination to recover and regain socioeconomic security. In my opinion, the chronic poverty that my son and I have been forced to endure — and which continues to this day — is a direct consequence of the lackluster performance of all my VRS contacts whose behaviour sabotaged my recovery many times.

Looking back, I can now say with certainty that there is distinct discrimination against people with mental illness by consultants who work in VRS. For example, even though my psychiatrist in Nanaimo wrote a letter stating that there was no medical reason why I could not work full-time, my VRS consultant withheld funding because he decided that I did not handle stress well! That initial note on my VRS file has haunted me all the way down the line through every consultant who has handled my case.

During the nine years that I have been involved with VRS, I have been referred to other agencies for related support services including Gastown Vocational Services, PACT Employment Services of Coast Foundation, and THEO BC (when it was formerly known as Arbutus Vocational Society). I did gain better computer skills as a result. However, I have been exposed to constant references to my age and gender as being "barriers" to my becoming a film maker: one time it happened while I was actually holding a book on female job opportunities in BC which included openings in the BC Film Industry.

In attempts to escape the oppressive control over my career choices that VRS has imposed, I have sent out resumes to all the school boards in the Lower Mainland, resulting in one horrible interview. Now it has been eleven years since I taught and I would have to go back to university for refresher courses or a Masters Degree to get rehired; VRS doesn't fund either.



Over the years, I have been asked to provide numerous letters from my doctors concerning my competence to work. The heroine of my VRS meetings is my case manager, Diane Krane. After a delay of two years to give me financial assistance to study motion picture production at Capilano College, Diane bluntly told VRS that she had observed that they always seemed to "have an agenda hidden under your agenda," that I had just as much chance of succeeding as anyone, and that it was time for me to get help to go to film school.

VRS had insisted on me being assessed by an occupational therapist who said in her report: I can do it! As long ago as Spring 1996, Gastown Vocational Services' tests indicated that I should be working in the field of visual and performing arts.

Something marvelous happened that saved my sanity and helped me realize that one way or another, I will be taking film study courses in Fall 2001. I received a letter from the BC Division of Canadian Mental Health Association that informed me that I had been awarded $500 from the Lorne Fraser Educational Fund, which would go to the registrar of the school that I will be attending. I have been accepted by Vancouver Film School and have applied for a student loan.

Ultimately, Student Services awarded me a Student Loan that fell $9,000 short of the $23,000+ tuition of Vancouver Film School. I seriously had to review my plans! VRS had insisted I complete part-time courses to "prove" my aptitude for film. In the end, my family encouraged me to use their help in combination with the CMHA bursary I had already been awarded. This means a compromise in which I'll be able to complete part-time courses in producing and production planning at Vancouver Film School as of September 2001. I have already begun to do research for my first script in — what else? — MENTAL HEALTH!

**"I had just as much chance of succeeding as anyone, and it was time for me to get help to go to film school."**

# On the Road Again

*Victoria Maxwell*

*Victoria speaks on 'Wilderness Tips for Bipolar Illness,' 'Depression in the Workplace' and 'The Power of Humour and Healing'. She is currently writing a creative non-fiction book and play. To reach her, contact her at healthyliving2@hotmail.com*


Most of my life, I've taken work for granted, along with the cynicism, apathy and boredom — took it for granted until I couldn't work at all. Four years after a diagnosis of rapid-cycling bipolar disorder, I was unable to volunteer, let alone work.

In 1992, my former vital — albeit chaotic — life as a working actor came to a startling halt. After a brief psychotic reaction following a period of intense meditation, I was diagnosed with bipolar illness. At this point, I split my time between cashiering at Safeway, decked out in their signature polyester uniform, and acting on local film sets, lured by the dream of fame and infinite access to good shoes. After the first psychosis, I had an all-inclusive stay at 'Club Medication,' also known as A2: Lion's Gate psych ward. Then, after several manic episodes, four psychotic breaks, innumerable bouts of depression and three hospital stays, I sat in my psychiatrist's office.

It was now 1996. My illness still hadn't stabilized and I was unable to return to work. I stood at a painful crossroads. What was my next step going to be? It had to be a realistic one. And the ones I'd made so far obviously weren't working. Dr. Dillon, my psychiatrist, didn't encourage or even suggest I leave acting. I did. I needed to. For the sake of my sanity and dignity, I needed to walk away. Acting is a punishing career regardless of your resilience. At best, it's unpredictable; at worst, it's down right dangerous. I didn't need stardom; I needed stability.

In the four years after the initial psychosis, I had accumulated a hefty debt, and was getting very little work as an actor. Both my financial and artistic reserves had been tapped dry. I could continue living in denial and quickly spiral into further debt and illness or accept the disorder and begin to eke out a living and a smarter lifestyle. It was my choice, of course. I chose the latter. My decision though was not motivated by virtue. No. My decision was propelled in no small way by fear: basic, unadulterated fear; and by the loving encouragement of wise parents and a good doctor.

I moved back in with my folks — God bless their willing souls. Next I quit my Safeway job (this part wasn't so hard. Leaving polyester behind was one of the few things I could actually look forward to). I went on social assistance and applied for disability benefits. And I left the world of acting to others who had a higher tolerance for rejection.

I now faced a new frontier: what the hell to do with the rest of my life? Dr. Dillon, my 'meat and potatoes' mentor, had the uncanny ability to make the practical sound seductive. He came from the school of psychiatry that was simple, strong and unequivocally caring. His suggested goal? Learn to support myself and stay that way. Find a career, get a job, and move out on my own.

The first of many fears that surfaced was that I'd discover that the one and only talent I had was that of acting. Not a readily marketable skill. During the following time of career exploration, I had the assistance of countless people behind me, cheering me on toward my coveted target. The label 'mental illness' can, all by itself, dismantle the strongest sense of self. Support is not a luxury in recovery, it is a necessity — at least it was for me.

I started with the Vocational Rehabilitation Services (VRS) and underwent testing at Youngs-Ferris Vocational Agency. The very act of taking this almost overwhelming battery of aptitude and interest exams helped me recapture some of my former chutzpa. After several weeks, the tests were complete. Yes, I had a knack for acting, but I also had strengths in areas I hadn't even considered: marketing, media, and interior design. I narrowed it down to marketing.

I hadn't worked in over four years. I was unsure if I could even work a full eight-hour shift. At the downtown Mood Disorders Association office I happened upon a brochure: GVS — Gastown Vocational Services, a pre-employment program for those with a mental disorder. I decided to investigate. A wait list. A long one. But lo' and behold…a

loophole. I lived on the North Shore. I wouldn't have to wait as long; something about regional quotas. GVS was the most pivotal factor in getting me on my employment feet. It was a three-month program, six hours per day, three days per week. Its purpose: to help people return to work — whatever kind of employment that may be.

The format of the program forced me to be punctual, reliable and committed. It gave me a routine to schedule my other activities around as my illness stabilized. Bipolar disorder, especially the depression, has an insidious way of making structure seem pointless, and goals unfathomable. When I had fellow students and instructors expecting to see me, I became more likely to show up, even if it was only not to disappoint myself.

The work placements available through GVS were invaluable, not to say the least bit nerve-racking. My job coach, Peter, was a godsend, my touchstone. When anxieties reached their typical zenith and I wanted to walk, he was my bridge to reality. He would calmly listen to my panicked cries of 'I can't do this'…or 'what the *#%! do I do now?'. He would gently ask me to take a breath and slow down. We'd then tackle the problem at hand — if there was a problem at all. Usually it was a case of insecurities running amok.

During one of my work placements at a small marketing company, the owners offered me a full-time position. I didn't know whether to jump for joy or run screaming in the other direction. With calm reassurance from my parents, Dr. Dillon, and Peter, I accepted the job. This was a test. This was definitely a test. I built my challenges slowly: working first three days per week, then shifting to five.

The couple I worked for was remarkably patient. They helped me travel the terrain from what I only thought I could do to actually doing it. When I began, I wasn't what you would call computer competent, so VRS sponsored me to take a basic course. I am proud to say I am now only moderately computer illiterate.

As my time on the clock accrued, so did my confidence. I belonged. I was making a contribution — however small I felt it to be — and getting paid for it. I discontinued welfare and settled my debt. My dream of self-reliance was imminent. In 1998, I moved into a house with two other women. About a year later, I bought a used car. Then in October of last year, I moved into my own apartment. I had wheels, a pad and I was single. *Sex In The City:* look out.

As I reassessed my goals, I decided to return to writing and acting. I vowed it would be different. I pledged to maintain the healthy quality of life and financial stability I'd fashioned. It was essential to my sanity — literally.

Last May, I co-wrote a play, began a novel and started giving speaking presentations on the very illness that put me in this position. These events marked my initiation back into the world of theatre and film. I make the majority of my money working part-time as a mental health worker and as a 'background performer' on local film sets. It doesn't always feel secure or even smart, but the self-esteem I've recouped by returning to the work I love makes it all worthwhile.

I appreciate being able to be bitter about working on a sunny day. I'm happy just to be able to go to work. Period. ■

# Consumer Education and Employment

*Darren Campbell*

*Darren is a consumer living in Vancouver*

I used to take education and employment for granted. If I worked hard and applied myself, I knew that my education and training would lead to a good job and a great life. That was back in 1995, when mental illness did not dominate my life. Since then, learning and working have become much more complicated. A diploma or a degree is no longer a given, and a high-paying, stable job is just a dream. Despite the obstacles that my illness has placed between me and my career goals, I try to stay motivated and hopeful. Unfortunately, I have struggled to translate my academic success into satisfying employment.

My education as a consumer took place at the BC Society of Training for Health and Employment Opportunities (THEO BC). While at THEO BC, I graduated from a Building Service Worker program and an Introduction to Computers course. I felt comfortable at the school because it has created a consumer-friendly environment. Tuition was free, class sizes were small, and the workload was manageable. I found the staff to be professional, understanding and knowledgeable about the barriers that consumers face. The structure, support and flexibility of the school helped me to succeed even during my darkest days.

While attending school, I learned about many of the personal and institutional problems that face me and many other consumers. Education, training, workplace practicums and employment counsellors are great, but until issues such as funding, old student loan debts, and money management are straightened out, consumers will continue to find their educational opportunities limited. Lately, the transit strike and labour action have forced consumers to delay their education and lose their jobs. This upsets me tremendously because the chronic nature of my illness means that I need to learn and work when my mental health is peaking. If ▶

**Visions** Our next issue of Visions (due out in early spring) is on **Anxiety Disorders in Children and Youth.** If you have a story idea you want to share, contact our editor Eric Macnaughton at (604) 688-3234, toll-free at 1-800-555-8222 or via e-mail at emacnaug@cmha-bc.org

I miss my window of relatively good health I may not be healthy enough to attend school or work for months, and an opportunity is lost.

When it comes to my attempts at employment I've had to learn to judge my success according to the effort invested rather than the results obtained. I've only been able to hold on to a part-time job for nine months. Eventually, my mental health becomes so poor that I have to leave. Unlike many consumers, I worked for an employer that created a consumer-friendly work environment. I didn't have to worry about disclosing my illness to my employer because they already knew about my health problems. There was no stigma and I always felt supported and respected.

It felt great to contribute to society by earning some money of my own. I made some excellent connections with my co-workers and I enjoyed the structure, responsibility, and extra income that my job provided. I know that I was lucky to find a good job with a great company; many consumers aren't so fortunate.

Consumers' employment opportunities are limited by personal mental health, stigma, the Employment Standards Act, unions, disability rules and regulations, geographic isolation, a lack of transit, and so on and so on. There are so many barriers to employment for consumers that I sometimes wonder what the point is of getting educated and trained if there are no suitable jobs after graduation.

All of society's stakeholders need to create a consumer-friendly job market. This is the major challenge, but if employers and consumers are willing to be creative and flexible, I am sure that great strides can be made. ■

# From Devastation to Dedication

*Kathy Smith*

*Kathy is the founder of Smith Secretarial & Design Services in Victoria*

I am a mental health consumer who runs her own home-based secretarial/communications business. I am also a freelance writer, specializing in mental health issues. Three years ago, at the age of 37, I found myself out of work due to a mental health issue from which I continue to suffer. It was a completely unexpected turn of events in my life as I have always had the ability to work, starting from the age of 16. To suddenly find myself ill and unemployed was devastating.

Having a strong desire to keep working despite my circumstances kept me going. No matter how awful I felt or what was going on around me, I vowed that I would keep working somehow. After much deliberation, I decided the best thing to do was to work from home. That way I could have more control over my health and still do the kind of work I loved. In 1997, I applied to a local employment agency's grant program and was awarded a small amount of money to help with start-up costs for my secretarial business. I settled in, waiting for the onslaught of new clientele, but clients were few and far between. Was this due to my 'disability' — the inability to leave home? In part, yes, but I have since learned that that doesn't have to be a barrier — and that maybe it was my attitude toward my situation — my own stigmatization — that was holding me back.



I have always been a very resourceful person, and this skill is what has helped me get as far as I am today. I have an excellent ability for networking with others and being able to research solutions for myself. Recently, I was successful in obtaining a business loan through the ABLED (Advice and Business Loans for Entrepreneurs with Disabilities) Program. This loan is much larger than the grant I had previously applied for and has enabled me to fully furnish my home office with up-to-date computer equipment and supplies, etc.

Going through the application process was a great learning experience. It really made me pinpoint exactly what I wanted to do. I also had to explain how I was going to manage my disability while working. This was also a very good thing for me — to get clear about how I would work when not feeling my best.

For me, having someone else with a similar skill set and office experience that could support me was the ticket. And luckily for me, my sister Vikki fits that bill. Vikki works in my office twice a week, and while she's here, I make most of my appointments. When Vikki is unavailable I also have another work colleague and my husband upon whom I can rely to be on hand.

What is also good about Vikki's help is that if I am having a particularly bad day, she can look after anything urgent, so the work gets done and I get some rest or whatever it is I ▶

# Employment for Consumer-Survivors:

## What I Can See From Here

*Jill Stainsby*

Many of the presentations at the recent World Assembly for Mental Health conference in Vancouver had to do with employment possibilities for consumer/survivors: peer support programs throughout BC, Gallery Gachet artists' cooperative, the Ontario Coalition of Alternative Businesses, a self-harm workshop and training program for service providers, a play about recovering from mental illness, and many booths staffed by consumer/survivor employees of several of the local mental health organizations.

I believe we are "coming into our own" in terms of employment in mental health. This is an exciting, energizing time for consumer/survivors in many ways, both with reference to our ability to influence policy and regarding our access to employment possibilities within mental health, if we wish to pursue them. This does not appear to be limited to BC or Canada.

Consumer/survivor employment in the mental health system or community is on the increase. Mental health support workers who themselves have diagnoses are commonplace now at many housing facilities and service agencies. There are several local self-help organizations, which by definition require that their employees have a diagnosis. Advocacy programs are staffed as far as possible with consumer/survivors.

There are also significant numbers of consumer/survivors who regularly work on contract doing research and building community consensus around different mental health initiatives. Some of us write policy. Some of us are professionally employed at all levels within health and mental health. Some of us manage programs that employ other consumer/survivors. Some of us manage organizations and projects that go from grant to grant.

For example, peer support programs have proliferated throughout BC over the last few years, and they are often staffed by consumer/survivor administrators as well as peer support workers. This "stepping stone approach" to employment — typically twenty hours a month, on a six-month contract — has been steadily growing. A provincial Peer Support Resource Manual is currently being distributed (see p. 30), which will assist local communities in designing their own programs.

Peer supporters find their work challenging and fulfilling. They are providing support and/or assisting other consumer/survivors to accomplish specific goals. They often talk about "my clients" or "my ladies." Often, the most difficult thing for a peer supporter is to maintain a bit of distance from their client and not give him or her their own home phone number or see him or her outside the peer support role.

"Supported employment" initiatives like peer support are not costly, to say the least. They work well as top-up programs for consumer/survivors who may be on Disability Benefits, but they do not replace full-time or even half-time employment. Transition from peer support work into other employment is still difficult. Hopefully, several current initiatives in the province, including the supported competitive employment initiative and a consumer-run business planning project, may help address this gap.

When I started work in mental health in 1994, I felt

▶ cont'd bottom of next page

*Jill is a Consumer Support Worker for Vancouver Community Mental Health Services, of the Vancouver/Richmond Health Board*

need. In the best of all worlds, I'd like to be able to hire my sister on a more permanent basis and also have home support services available for days when she's not here, but it will be some time before I can afford it all.

Even so, I am coping without all the services I need. Just getting this loan has been a huge boost to my self-confidence. Now that my business is finally official and taking on several new clients, I know I've made the right choice. I do what I do for several reasons: first, I have to work for my own mental wellness; second, it's extremely important to me to give back to society by helping others; and third, I love doing what I do.

I have been a freelance writer for the past eight years, specializing in mental health issues. I write about people and organizations in a sensitive, unbiased manner. Being sensitive and diplomatic are qualities I learned from working in the mental health field for over five years with a variety of consumers, families and professionals.

I know I will be successful. And I'm learning not to self-stigmatize! Just because I work from home and have this disability, it doesn't mean I don't have what it takes to make it. I have a wealth of work experience. I have self-determination. I have passion. And I know working in mental health is what I was born to do. With support from my family, friends and co-workers, I can't go wrong. ■

*To learn more about the ABLED loan program Kathy used, see page 29*

# Getting Back to Work

*Allyson Muir*

*Allyson is an occupational therapist*

*Reprinted from* OT Line, *June 2001*

It's a good day in vocational rehab when one of your clients calls to tell you he or she got a job. This is what the team works toward — occupational therapists, job coaches, psychologists, and most of all, our clients. But a lot precedes this moment. For people with mental illness, the road to work can be long.

Clients coping with chronic mental illness face many difficulties in entering or re-entering the work force. The vocational rehabilitation process is not a linear one. We have had clients "drop out" of the program, only to come back a year or two later and tell us they are ready for the next step. And they are. People who have been out of the workforce can be surprised by the new work environment. Dress codes, social proprieties, interview styles and resume formats are constantly changing. Time needs to be spent helping people adjust to the new work realities. Many clients identify an exciting career goal, but find they do not have the training or education to pursue it and need to access training opportunities.

Over the years, most of our clients have provided feedback as to what they have found helpful in returning to work. Learning to catch the early warning signs of illness and having as much control as possible over their symptoms and reactions to stress helps people to remain stable and positive, helps them to get and keep a job. Time management, goal setting, learning to set personal boundaries, and accepting and giving constructive feedback have all been identified as important skills.

Preparing for this article, I asked two clients two questions: "How is looking for work different for you now, having experienced a mental illness, than it was before you were diagnosed?" and "What are the issues that a person with a mental illness faces in looking for work that a person without a mental illness doesn't face?" Their responses were similar. Both mentioned that they now had to take into consideration personal limitations that they had not before: "I have to look more realistically at what my limitations are — what I'm realistically able to do versus what others think I should do." One client, formerly self-employed, noted that she now had to be more conscious of the stability and structure offered in a job: "Being aware of having to slow down, to be in an environment that supports my health. I wouldn't have considered this before."

Both had concerns about disclosing their illness to prospective employers or co-workers. As one put it, "You feel alienated by the so-called normal people." The other said, "You don't know whether it's noticeable or not. The amount of energy you spend on trying to look 'normal' is exhausting." Clients' self-confidence has often been eroded, and self-doubt is common. One client said, "It's hard enough having a mental illness when you're not employed, but all the symptoms are magnified when you have to perform at work. Now you have to show up and be responsible to someone other than yourself." These are challenging issues, but they can be met with perseverance, support and encouragement. The results are well worth the effort. ■

**What I Can See From Here** — cont'd from previous page

like a fish in a glass bowl. As far as I knew then, I was one of few consumer/survivor employees within the system. It had not been something I had planned to do after I completed my education. However, opportunity knocked in the form of an ad in the Careers section of the local newspaper, and I was one of the successful applicants for a position at Riverview Hospital. Now some years later, I believe I belong in mental health, given that I was already both a family member and a consumer/survivor in my own right.

My analysis, from having now come in to two or three organizations as an employee with an acknowledged mental health diagnosis, is one that I have shared with other service providers at workshops and casually.

When I begin work in a new mental health organization, the service providers with whom I come into contact do what they are trained to do with their clients: they look for any social/mental/emotional deficit. Once they become accustomed to the fact that I have no more or less of a deficit in the workplace than they do — this takes between one and two years, routinely — they relax and then some of them disclose their own mental health history to me. Typically for this group, they have not disclosed this to their employer.

I find this mostly sad. It seems that even — or perhaps especially — in mental health, employees who are providing support and assistance to clients often do not feel that they can request this kind of assistance for themselves or even admit to any frailty, without consequences.

The stigma that we all know so well can play a negative role in anyone's life. I think that perhaps for service providers within mental health, the stigma of self-disclosure of a mental illness might be worse than for an employee in any other industry. To me, this is the opposite of a healthy workplace. I can only hope that, as more of us with diagnoses become employed in mental health, we will be able to shift this perspective. ■

# Simon Fraser Health Region

The Simon Fraser Health Region is an evolving and progressive health care region serving the communities of Burnaby, New Westminster, the Tri-Cities, Maple Ridge and Pitt Meadows. The Region is renowned for the high quality of its Mental Health Services which provide intensive, specialized treatment for patients with severe and persistent mental disorders. We are currently seeking experienced nursing professionals with current RNABC or CRPNBC practicing membership, and registered Social Workers for the following roles:

## Burnaby Mental Health Services - RPNs/RNs

### Supervisor, Adult Day Program – Level II (Regular Full-time)

You will coordinate and supervise a multi-disciplinary team of a psychiatric day program for the treatment and rehabilitation of adults with serious mental health difficulties. You have 3 years' related experience, including one year in a supervisory role, and a current CPR certificate.

### Community Mental Health Nurse, Adult Day Program – Level I (Relief Full-time)

You will work as part of a multi-disciplinary team to provide assessment, planning, implementation and evaluation of treatment for adults with serious mental disorders in a specialized day treatment program. Two years' recent psychiatric nursing experience with adults with serious and persistent mental illness, along with a valid BC Driver's Licence is required.

### Community Mental Health Nurse, Inpatient Unit (Relief Full-time)

In this role, you will provide and coordinate nursing care to assigned patients consistent with current standards of professional practice and the nursing philosophy of Burnaby Mental Health Services. You possess one year of recent inpatient psychiatric nursing experience and a current CPR certificate.

## New Westminster Mental Health Services - RPNs/RNs/Social Workers

### Community Mental Health Nurse, Adult Community Support Services (Regular Full-time, Relief Part-time/Full-time)

As a member of an interdisciplinary community mental health team, you will provide direct care to clients with mental illness. You will conduct assessments, develop relevant care plans and help evaluate process and outcomes to ensure the continuing quality of service. Three years' recent experience in acute psychiatry, in either a community or hospital setting, working with adults with serious and persistent mental illness is required. You also must have a valid BC Driver's Licence and access to a vehicle.

### Coordinator, Adult Community Support Services (Regular Full-time)

You will oversee the daily operations of the program, including supervising staff, performing administrative duties and providing direct clinical care to adults with serious and persistent mental illnesses. Your Bachelor's degree in Social Work is complemented by management and/or supervisory courses and 5 years' related experience including 3 years as a supervisor in a psychiatric and/or community mental health setting. Candidates who possess a Master's degree, management and/or supervisory courses and 4 years' similar experience will also be considered.

### Social Worker, Adult Short Term Assessment & Treatment (Regular Full-time)

Delivering programs and services to adult clients with various mental disorders will be your primary responsibility. Your duties will include providing group therapy and education, consultations, case reviews and quality of service evaluation. You have a Bachelor's degree in Social Work plus 3 years' experience in a psychiatric and/or community mental health setting. Candidates with a Master's degree and 2 years' similar experience will also be considered.

## Tri-Cities Mental Health Centre

### Mental Health Therapist, Adult Short Term Assessment & Treatment (Regular Full-time)

As a member of an interdisciplinary team, you will provide short term assessment and treatment services to adults with various mental disorders. Your duties will include intake functions and brief therapy in a primary therapist capacity, assessments, treatment, consultations, case reviews and evaluation of process and outcomes to ensure the continuing quality of the service. You have a Bachelor's degree in Social Work (Master's preferred), along with 2 years' related mental health service experience.

## Continuing Care, Maple Ridge/Tri-Cities/New Westminster

### Clinical Social Worker (Relief Full-Time)

Providing assessment and treatment services for Continuing Care clients who experience a variety of medical diagnoses will be your primary responsibility. You will also participate in educational services, planning, program development and policy recommendations, as well as provide consultation, support and the social work perspective to the multi-disciplinary team to develop and enhance services. You must possess either a Bachelor's degree in Social Work and 2 years' related experience or a Master's degree and one year of experience. A valid BC Driver's Licence is also required.

For immediate consideration, please send your resume, indicating the desired position, in confidence to: **Human Resource Services, Simon Fraser Health Region, 33 Blackberry Drive, New Westminster, British Columbia V3L 5S9. Fax (604) 517-8652 or email: gayle_gardner@sfhr.hnet.bc.ca**

We thank all applicants; however, only those selected for an interview will be contacted.

**www.sfhr.com**

SIMON FRASER HEALTH region

# Keys to Success:

## Get the Job you Want!

*Cathy Johnson*

*Cathy is the Employment Programs Coordinator at PACT Employment Services of Vancouver-based Coast Foundation Society*

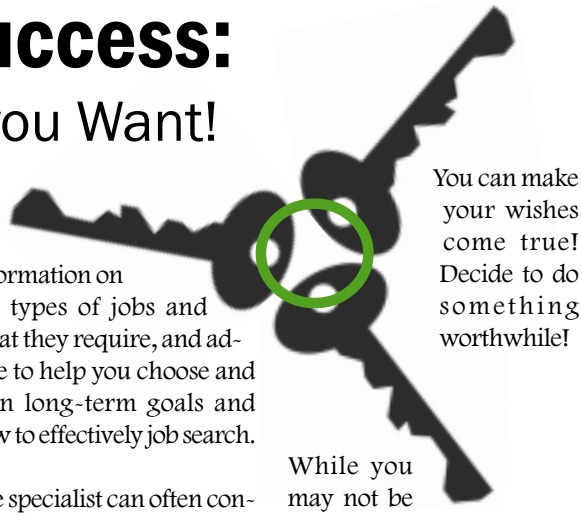
*For more information about supported employment, please contact Cathy Johnson at (604) 877-0033 or cathyj@coastfoundation.com*

When I was asked to write a few words on employment and the keys to success from the professional perspective, I had to ask myself what would be the most important steps to get the job you really want. How to discover your best skills, explore career alternatives, get the job fast and how to do well in the new job — all of these things came to mind. Information for job search can be found everywhere: in the library, on the internet and at employment offices and community agencies.

There are a number of questions that individuals and families might want to ask themselves. What natural supports are available? What are the positive and negative influences of the medication I am taking? What do I know about my illness and the symptoms that might present during work? What is my need for income and how will my benefits be affected by employment? Am I happy where I am currently living and can I look for a job while living there? These seemingly simple questions can be discussed with a skilled employment specialist. Having decided to take the road to employment, here are a few tips for job seekers and those families supporting family members in their employment goals.

Approaching work can be daunting for most individuals. Where do you start and what the dickens do employers want? What does work mean to you? Work can be just a way to earn a living or extra money, or something you have to do to eat and have a place to live. Or work can be what you enjoy doing and/or a way to help you do something you feel is important. However you feel about work now, your feelings are likely to change during your lifetime.

To do well in a competitive and rapidly-changing job market, you need a new set of survival skills. The best approach is to sit with a trained employment specialist to develop a plan that suits your individual needs. The specialist will guide you through a number of steps on getting to know yourself, your interests, hobbies and past training and skills. They will have information on the types of jobs and what they require, and advice to help you choose and plan long-term goals and how to effectively job search.



The specialist can often contact employers on your behalf and develop a position to suit your needs. And the employment specialist will be most helpful to support you once you are working.

To succeed as a job seeker and a worker, you need to understand an employer's point of view. Many people feel that an employer thinks differently than the rest of us, but employers are just like you and me. Try to think like an employer. Consider what you'd want your employees to do and you can figure out what is expected of you as a worker. And knowing what employers want will help you present yourself successfully when you are looking for a job.

No one can know you better than you. There is more to life than work. While it is often an important part of your life, your work is only one part of how you spend your time. The ideal job is one that is satisfying. It will help you enjoy what you want in life. You need to consider what is important to you and how much time you want to work. Having the natural supports around you to encourage you is an important aspect of the job search.

You can make your wishes come true! Decide to do something worthwhile!

While you may not be able to do everything that you want, good planning can help you get closer. What can you do now to start making your dreams come true tomorrow? Take action! Be clear about your goals and set up something you can do to meet them. Get a coach to help you or find a peer that is working and knows what it is like to look for work. Join others who are job seeking. There are job programs and community organizations that will offer you a self-paced introduction to work.

You have hundreds of skills. Most people do, yet very few are able to explain their skills to others. You may take for granted many things you do well that others would find hard or even impossible to do. One study of employers found that three out of four people interviewed for a job did not present the skills they had to do the job. Most people don't have the language to present the skills they have. Knowing what you can do well is important because it can help you decide what kind of work is right for you and find work where you ultimately can be more successful. It is also important to do things you enjoy doing because if you enjoy what you do and are

good at it, your job and your life will be more satisfying. Explore your skills with an employment specialist or try to use your skills as a volunteer to see what you like. And when you do get a job, put your energy into it and do it as well as you are able.

Surviving on the job takes skill. When starting a new job you will probably feel a bit of fear. You often don't know what to expect and how you will fit in. Not getting along with other people who work there is the number one reason people leave jobs. Not getting along could affect your productivity on the job. Asking for a good orientation and training on your new job and talking to your support people during this adjustment period will help with this stressful time.

Enjoy life. It's sort of the same as having fun, but lasts longer and means more. Most people don't find the job search to be a fun experience. Don't get discouraged by the rejection involved. To avoid failure, some find lots of ways to avoid looking for work; of course, delaying your job search just leaves you unemployed longer than you want. Don't get discouraged! The best way to shorten your job search is to structure your time, have good supportive people around you and approach your time as if your job search is your job. Practice the communication skills you will need for when you start your job. Looking for a job is hard work, so take time for breaks. And take time to take care of yourself. Someone out there needs you — and will be happy to have you as an employee. ■

# Job Coaching 101

*Karla Barnes*

*Karla is a job coach at Laurel Enterprises, Capital Mental Health Association, Victoria*

It is hard work keeping a job. Managing a mental illness can add to the demands of a successful and satisfying career. Studies have shown that "ongoing contact with a support person is one of the best predictors of job retention for workers with a serious mental illness." [1]

The job coach model is a component of supported employment for persons with severe mental illness. The Capital Mental Health Association Job Coach Program focuses on supporting people once they have obtained employment. Job coach support can take place on the job or away from the work site. On-the-job support usually takes place when an employee is starting a new job or returning to work after a leave of absence. When meeting an employee away from the job, getting an accurate impression of the climate and demands of the job can be difficult. Three strategies to deal with this challenge are meeting the client on breaks during the work day, being available by phone for support, and providing a work journal to the client in which they can note issues as they occur. They can then bring those to the next meeting with the job coach.

When providing employment support, it is important to be aware of the following:

1. A job is often a person's identity and livelihood and should not be treated lightly; sensitivity and an empowering approach are essential.
2. Providing support during the job loss process is a crucial role of the job coach.
3. A holistic approach as a job coach is important, since personal problems can affect an employee's work performance and their mental health. Talking about the problem can provide some relief and help the employee focus on work. Other times, a referral can be made to the appropriate service.

During the four years I have held the job coach position, I have worked with a number of people employed in a wide variety of occupations. Repeatedly, I have witnessed a great deal of courage and tenacity by many of these individuals who have struggled with the symptoms of mental illness and still managed to remain committed employees. ■

## Managing work and mental illness

- have a support person you can talk to about work
- find a mentor at work
- look for comfortable socializing opportunities at work
- plan interesting things to do on your work breaks
- do not work through your breaks
- learn to identify early warning signs of stress piling up
- learn as much as you can about your illness
- practice stress management techniques such as meditation, visualization and exercise
- have a life outside of work
- make sure you get enough sleep and eat healthy foods
- communicate clearly with your supervisor

## Job coach services

**On-the-job support can involve:**

- meeting with the employer and client to address mental health and performance issues
- problem solving with the client around work issues
- working with an employee during the orientation phase of the job

**Support away from work can address issues such as:**

- problem solving work-related issues
- requesting workplace accommodations
- time management
- disclosing the employee's mental illness to the employer
- coping with the symptoms of a mental illness and the side-effects of medication at work
- improving work skills
- preparing for a new job
- stress management
- developing healthy work habits

Related Resources

1 Steinberg, W. (2000). *Making it work! A resource guide to supporting consumer participation in the workforce.* Toronto: CMHA National Office.

2 Furlong, M., Jonikas, J. A., Cook, J. A., Hathaway, L. & Goode, S. L. (1994). *Providing vocational services: Job coaching and ongoing support for persons with a mental illness.* Chicago, Illinois: Thresholds National Research and Training Center.

# My Work as a Consumer/Provider

*Ingrid Olson Mercer*

*Ingrid is a recreation coordinator at Laurel House, Victoria*

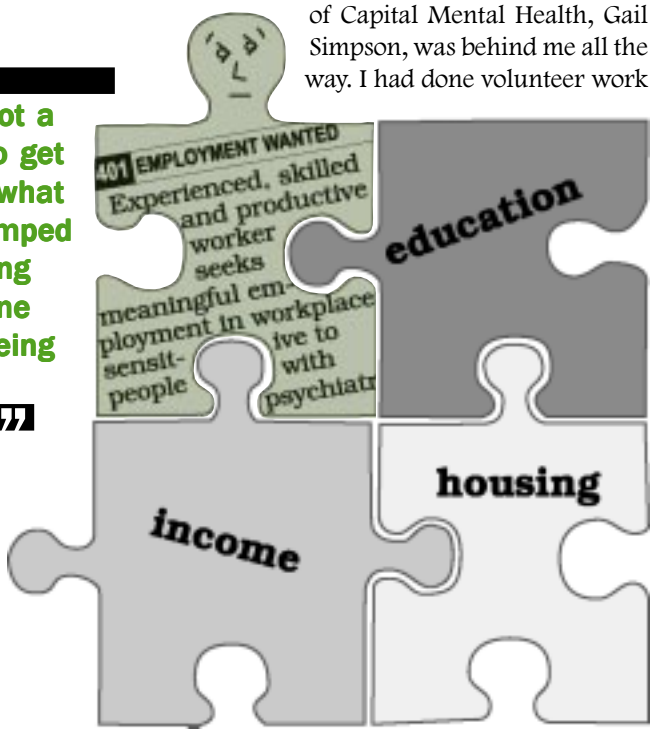
I am an ex-mental patient. I always will be. It's as much a part of my identity as being Icelandic. I now work in the same clubhouse, Laurel House, (a program of Capital Mental Health Association) where I was once a member. One member said to me: "Gee, when I get better, maybe I can get a job here too." I said, "I certainly hope so." I believe I offer a model of hope to others that they can get a job here (or somewhere) too.

One of my more radical friends feels that I have sold out, calling me a "mental health prostitute." I used to work at a completely consumer-run activity centre, but it was all volunteer work. It was valuable work, both to me personally and to the community, but it was unpaid. I did a lot of unpaid volunteer work and it was all worthwhile, but when I got a chance to get paid for what I do, I jumped at it. Being paid is one way of being valued. I started work at Laurel House in February 1995.

I started slow, working one-and-a-half days a week, so that I wouldn't become overwhelmed. I sure didn't want to fail again. After one psychotic episode where I wound up in psychiatric intensive care, my employer at the time sent me a letter firing me while I was still in the hospital. I hadn't done anything wrong on the job, but they didn't want me back.

I was very lucky this time because the Executive Director of Capital Mental Health, Gail Simpson, was behind me all the way. I had done volunteer work at CMHA and served on their board and Gail knew me quite well. She believed in me when I wasn't sure I believed in myself. Having a mentor or job coach or some support person is a real blessing to someone struggling to return to the workforce after suffering bouts of mental illness. A person's self-confidence has usually been blasted all to pieces, and fear of recurring illness is always at the back of my mind. I went to an IAPSRS (International Association of Psychosocial Rehabilitation Services) conference in Detroit where I presented the consumer's point of view about CARF (Commission on Accreditation of Rehabilitation Facilities). It was a big leap forward. I was very nervous and apprehensive, but I'm so glad I pushed myself to do it. Once again, my mentor Gail gave me the encouragement I needed.

> **"When I got a chance to get paid for what I do, I jumped at it. Being paid is one way of being valued."**




We consumer/survivor/ex-patients have the lived experience of mental illness which provides us with knowledge and wisdom that is valued by many receptive people in the mental health field. When I presented at another IAPSRS conference in Minneapolis, Gail introduced me to Donald Naranjo, the president of IAPSRS, leading me to apply to serve on the Board of Trustees of CARF (I was elected in December 1999). Donald has been a valued mentor as well. Gail also encouraged me to pursue an APRP (Associate Psychiatric Rehabilitation Practitioner) designation, which I was granted in June 2000.

My job is Recreation Coordinator at Laurel House. I take people swimming, bowling, golfing, camping, on nature walks, out to coffee houses and libraries. I teach basic computer skills and public speaking. I assist in Qi Gong and Tai Chi. The beneficial effects of all these activities aid me in my own ongoing recovery as well as my clients. While learning to understand their illnesses, I learn about my own. They generously share their wisdom with me. I'm not entirely free of symptoms, but I've learned to live with a certain level of discomfort and to never let my stress level get too high.

I am very fortunate to work in and help to create a healing, restorative environment. I am part of a five member team with a very supportive supervisor, Terry Miller, who has the great talent of bringing out the best in people. I would strongly encourage consumers with an interest in psychiatric rehabilitation to pursue a career in this field. There's an excellent book: *Consumers as Providers in Psychiatric Rehabilitation.* (1998). Eds. Mowbray, Moxley, Jasper & Howell and published by the International Association of Psychosocial Rehabilitation Services. I was fortunate to attend a one-day presentation by some of the editors and authors of this book. It is an invaluable resource for consumers. ■

# Rehabilitation Resources in BC:

## Preliminary Findings

*David Wells*

*David is the Director of the BC Supported Competitive Employment Initiative, administered by CMHA BC Division*

The BC Supported Competitive Employment Initiative has three thrusts: the first seeks to change policies that create disincentives to employment for people with mental illness; the second seeks to disseminate information about "what works" with respect to creating effective programming; the third seeks to enhance the capacity to provide rehabilitation-related services throughout the province. Because of these three elements — policy, education, and capacity —the project is known as the PEC initiative.

The first step to enhancing capacity is to achieve a greater understanding of the vocational rehabilitation resources that we already have in the province. So as part of the PEC initiative, an environmental scan is being done in order to start to create a provincial inventory of resources. At this point, we can provide some preliminary insights into the state of employment/rehabilitation services throughout the province, in relation to the state of resources in large, medium, and small-sized communities in BC.

### Trends

Each size of community currently faces various structural and systemic challenges in the delivery of employment and rehabilitation programming. Thus far, two general themes have emerged from the research. First, employment and rehabilitation services that would be appropriate to the specific needs of the mental health community are often incompatible with the limited resources and expertise of most communities in BC. Second, as community size and resources increase, so too does an environment of protectionism in which service providers isolate their clients from other service providers in the community, creating a silo effect in which clients and programs may not be ideally matched.

### Small communities

In smaller communities (<30,000), the following challenges have been noted:

- **Few or no mental health specific employment/rehabilitation resources** at all, beyond the clinical services offered by the local health centre — little or no mental health expertise or training with regards to rehabilitation and employment
- **Single employment resource**, responsible for serving the entire population — little knowledge or expertise in working with people with any disabilities, let alone psychiatric ones
- **Narrow focus** — services available in those communities fortunate enough to have mental health-specific resources serve only a narrow part of the mental health population.

### Mid-sized Communities

In medium-size communities (30,000-200,000), the following challenges have been noted:

- **Disability employment services lack the resources and expertise** to support people living with mental health disabilities — services often lack the more direct linkages with community health services. There is not a lot of cooperation or communication across the disability communities or the employment services communities
- **Political environment around resources and service delivery** — funding from federal, provincial and regional health sources is often not coordinated, resulting in a situation of unnecessary administrative duplication, or conversely, resources are not activated as they are singly inadequate to support employment programming
- **Lack of program evolution and competitive change** — employment programs often develop 'favoured child' status that precludes competitive ideas or options from entering the community. The relation between service and funder often becomes too closely entwined, preventing objective performance evaluation.

### Large Communities

In larger communities (>200,000), the following challenges have been noted:

- **Lack of knowledge, cooperation, and interplay** between various employment and rehabilitation services and funding agencies — ongoing funding and viability is tied to caseloads and utilization statistics rather than outcome measures, resulting in a protectionist mentality where individual agencies operate in a silo protecting their caseloads from encroachment by other service providers. This is not conducive to the creation of a full range of employment and rehabilitation services that reach all aspects of the mental health community. The lack of cooperation and communication also means resources and services do not go where they are most effective. An individual-based service model is compromised by a system where the interests of the service agency are paramount
- **Missed opportunities through lack of cross-sectoral communication** — greater insights may be gained from understanding what has been successful with other disability groups and other employment services. Resources could be further maximized if some of the existing capacity could be leveraged for cross-sectoral service development and delivery. ■

# The Individualized Placement and Support (IPS) Model:

## A Pilot Project of CMHA Vancouver/Burnaby

*Elizabeth A. Mackie, RRP and Jonathan Oldman*

*Elizabeth is a Vocational Rehabilitation Counselor at the CMHA Vancouver/ Burnaby branch. Jonathan is the Executive Director of the branch*

A strong societal work ethic currently influences Canadians. The media warns us of the high cost of social programs and the resulting government debt. We might look to any number of examples in our entertainment and reading materials that urge us to make money and be successful. Sadly, however, Canadians with barriers to work resulting from mental illness have seen little change in their employment status. In order to change this, we at CMHA Vancouver/Burnaby branch have adopted the Individual Placement and Support Services Model — which follows from the model first developed by Becker and Drake in New Hampshire — and are currently piloting that with mental teams in Vancouver and Burnaby.

There are a number of differences between the new model and the original which, as of October 1996, was known as Supported Employment Services. This original program utilized specific intake and assessment staff, facilitated pre-employment skills training groups and employed job developers. One drawback of this model was that consumers were required to meet and influence many staff members prior to entering a job search process: first, the intake and assessment staff member; second, a pre-employment group facilitator; third, a vocational counsellor; and finally the job developer. A more significant barrier was that job developers were expected to "sell" the consumers to employers without the benefit of personal experience with a client's skills, presentation, prior work experience and most importantly what job accommodations would be required. Other differences include the older model's lack of coordination with clinical services and its emphasis on extended pre-employment process. Research conducted during the development of the Individualized Placement and Support model showed that consumers involved in pre-employment training experienced no greater success in gaining employment than those not attending training. In fact, those directly accessing employment services acquired work faster than those attending training prior to a search for work .

With these factors in mind, CMHA Vancouver/Burnaby branch (CMHA-VB) began seeking a service method to better meet the employment needs of people with mental illness. Having researched varying service models, the branch entered into a partnership with Vancouver Community Mental Health Services and the Simon Fraser Health Board to offer the Individualized Placement and Support (IPS) Model of supported employment. In January 2001, a trainer/practitioner (Jennifer Marchand) from the original IPS program was brought in from Manchester, New Hampshire. She provided training and information to the general public, specific stakeholders, and CMHA-VB's Vocational Rehabilitation Counsellors (VRCs) around the key principles of practice, which are:

- **Non-existent entrance criteria** — the only requirement for service is a stated desire by the consumer for paid competitive work
- **The service forgoes pre-employment training** — job search is rapid (a time period for job placement of six months is considered good)
- **Assessment is continuous** — assessment begins with the vocational counsellor's initial contact and continues on throughout employment
- **Placement is based on a individual's work preferences** — prior findings support that most consumers stated work preferences accurately reflect their work potential and that most consumers keep their jobs longer when they work in fields they have chosen
- **The degree of assistance supplied to get and keep work is based on each consumer's skill level** (VRCs don't perform tasks that consumers are able to do for themselves)
- **Support is without time limit** — consumers remain involved with the employment service long-term while employed
- **The employment process is considered integral** to a consumer's medical treatment
- **Employment services are integrated with clinical sites**, both being a part of the rehabilitative and recovery process.

### Benefits to Date:

#### Impressions from consumers, families and staff

Integrating employment services with mental health teams has resulted in a variety of reported benefits by consumers and family, IPS practitioners and clinical staff including physicians and case managers. Consumers participating in this service provide encouraging comments:

- "The resources, support and encouragement are highly beneficial."
- "I couldn't have got it together to do it on my own."
- "I need the support and encouragement to get out and look for work."

A comment by a parent noted that the Vocational Counsellor is "always there for him, whenever he needs her. He is doing great, I am so proud of him." "He is working now, he is a man," said another parent who related that as the oldest employed male in his home, his son's status has in-

creased dramatically.

Both physicians and case managers at a mental health team made the following supporting comments of IPS:

- "Barriers to service have been reduced in a variety of ways."
- "Team clients no longer have to navigate new bus routes; the clients are familiar with attending the mental health team and they can meet with the VRC when they visit other team staff."

Clinical staff also spoke about the benefits of integration with the employment staff, for instance, about the ease of communication with the IPS worker, since informal conversations can happen in hallways and offices without the need to spend time for phone calls, faxes, and returning voicemail messages. VRC can now easily attend case reviews or supply observations about the effects of clinical treatment changes on the individual's performance at work, or about the individual's readiness to start the rehabilitation process. Said one case manager, "In the past, when I would refer a client to the old employment services they often were considered not ready." A physician stated that "those clients who require more intense initial support could not have made the transition without the employment service at the team." The report of one VRC stated, "there is increased ease in accessing pertinent medical information." It was also stated that "the vision is streamlined" and that "our role and task are clear." A second spoke to ease of the vocational rehabilitation process: "all areas of service, from receipt of the referral to job support, are supplied by one staff person" where information is not lost during communication between staff members. The person commented also about the benefits of maintaining a coordinated approach once a client has started work, adding, "It's very exciting. I have observed the process, wherein employment and the resulting conflicts and issues become a treatment focus — involving the case manager, the VRC and the client."

Clearly the IPS service has merits, but it has not come into place without difficulties. Change is never easy regardless of how often we experience it or the benefits we can foresee, and the challenges of transitioning services were varied. We can all imagine the challenge of being separated from work friends and developing relationships with new colleagues, none of them having the same employer as you. In addition, a challenge is created in that medical treatment practices differ in philosophy and approach from rehabilitation services. Further, clarifying and negotiating the VCR's role has been an issue, given the clear limits and guidelines of the IPS model, which can seem to contrast that of a possibly-overworked case manager. Some consumers and service providers have expressed views that the definitions of the IPS model can limit options for service, although this issue may be less pressing once the program moves beyond the pilot stage.

Staffing the IPS service has also presented challenges such as the varied areas of individual expertise among practitioners, the necessary high degree of commitment to the service vision, and the necessary faith in consumers as a whole to grow and recover.

The term "pilot" may possibly imply a limited future and may leave referrers, consumers and VRCs with a sense of uncertainty or lack of confidence in the service. Of final importance is the need to get beyond a few common misunderstandings some participants had regarding supported employment such as the belief that there is a formal job pool for a consumer to choose from. Another issue relates to a lack of understanding about the competitive nature of employment experience where, with support, people with mental illness are expected by their employer to produce results in the same way as would a person without such a disability.

All said, keep in mind that CMHA-VB's supported employment service has and is continuing to assist people to get and keep jobs. When we started, there were some people with mental illness who were unsure they would get a job, those unsure of their ability to work, and service providers disbelieving these same people could keep jobs. Those consumers are working now!

Perhaps the most important reason for our success to date is the philosophy behind the program:

- **Work is a structured, purposeful activity that is central to our lives**
- **Obtaining work is part of recovery from mental illness**
- **Everyone has the right to work**
- **One who is motivated to work has the right to be supported in their pursuit**
- **Everybody is valuable and we all have the right to make our own choices.** ■

# Gastown Vocational Services:
## Program Evaluation

*Mariella Bozzer*

*Mariella is the Program Coordinator of Gastown Vocational Services*

### Background

Gastown Vocational Services (GVS), based in Vancouver, was designed to provide a step-by-step vocational approach — including assessment, work readiness training, work experience and job search assistance — to helping individuals with mental health disabilities return to work.

During an earlier phase of its existence, GVS staff conducted an evaluation of program effectiveness and published the results in the 1999 *Canadian Journal of Community Mental Health*. This article is a brief summary of that earlier paper. The results presented here focus on the twelve-week work readiness program, which offers modules in illness management, assertiveness, self-esteem and confidence building, as well as management of stress and anger/frustration.

### Study Questions

The purpose of the research was to help answer the following questions:

① Does the vocational program help participants to be more assertive and improve their work-related skills and behaviours?
② Do the program participants improve in their level of depression, anxiety and quality of life?
③ Does the program help people to get jobs?
④ How did the people on the wait list compare to the program participants with respect to the above three questions?

With the help of the psychologist on staff, we decided upon the tools and measures we could use to help us to objectively answer these questions and, over a two-year period, we collected data on 60 participants who completed the entire program.

### Results

Results showed that participants did improve in their assertiveness, while individuals on the wait list (which functioned as the control group) showed no significant change in their assertiveness.

With regard to participants' level of depression, a similar pattern was evident. The participants showed a decrease in their symptoms of depression, with no change in the control/wait list group.

Anxiety levels showed no change either in the wait list or the participant group. It was interesting to note that the anxiety levels of the latter group did not worsen while undergoing active vocational rehabilitation. There are certainly stressors, both positive and negative, involved in attending a program and in entering new environments such as work experience placements. The fact that the participants' anxiety levels stayed the same despite the stressors may indicate that they were utilizing coping strategies taught within the program.

Participants were also evaluated by employer/supervisors before and after the program on five key areas of work behaviour: task competence, social relationships, confidence/initiative, authority/supervision and work enthusiasm. Results indicated significant improvement in the participants' work behaviour following the program, as evaluated by the employer/supervisor. These results were maintained at six-month follow-up. The wait list showed no significant change, despite showing better work behaviour scores at baseline assessment than the participants.

In terms of employment, 22% of participants were employed at six-month follow-up in a variety of jobs including computer programming, advocacy, public relations, auto mechanics, bookkeeping, and peer support. Also, 56% were in work experience placements, and 6% in volunteer jobs. Perhaps if participants were followed longer, greater employment rates would have been shown since many people were still in the work experience phase.

In summary, this program evaluation demonstrated positive results for the participants in terms of improving assertiveness, decreasing depression, improving work behaviour, and, for some, obtaining jobs. The results demonstrate that a step-by-step approach to vocational rehabilitation can have positive results, despite the rapid "place and train" approach advocated by such researchers as Dr. Gary Bond.

It is apparent to this writer that a variety of vocational/supportive employment approaches can be effective. Ensuring individuals have choice, adequate access and information about programs, and the ability to decide on which program best suits his or her needs is of utmost importance. ■

# Job Readiness and Outcomes Achievements:

## The Laurel Enterprises Model

*Gail Simpson, Harvey Teal, and participants, Laurel Enterprises*

*Gail is Executive Director of the Capital Mental Health Association in Victoria*

*Harvey is the Work Experience Coordinator, Laurel Enterprises*

### Background

There has been considerable debate over the past decade or more about service models in the vocational rehabilitation field. Themes have been "Choose-Get-Keep," "Natural Supports," "Transitional Employment," "ISP" (Individualized Service Plan), and "Place and Train." Supported employment remains a major opportunity for people with a mental illness who want to strengthen their community connections, and there are many methods of helping people do so. In my opinion, a lot of time has been wasted debating the models. The fact is that probably all are needed, and more as well, to achieve the goals of work for those who want that opportunity.

In 1978, Capital Mental Health Association, unaware of any of these controversies, developed a proposal to the Federal/Provincial Work Abilities Program, in response to numerous requests from members of our modified clubhouse, Laurel House, who wanted to become involved in the world of work. (The members suggested the name Laurel Enterprises to link the new program with its club roots.) Our proposal was approved and became the first psychiatric rehabilitation program of three in BC to be approved for funding under the Federal initiative; Laurel Enterprises was launched in 1980.

This article describes the core Laurel Enterprises (LE) program, as well as the program component focusing on job search. Laurel Enterprises' job retention services, through the job and education coaches, are described in a separate article on page 19.

### Program Description

From the start, we were guided in program development by what the participants wanted and what their goals were. Today, as in the beginning, we have a continuous intake, and a weekly drop-in orientation where anyone who wants to know more about the services can come by.

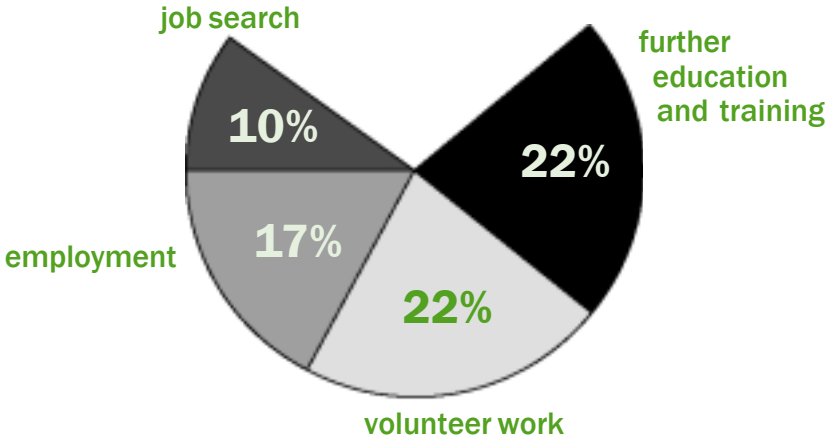
One aspect of the program consists of small-group life skills classes focusing on work-related topics. Each individual then designs a rehabilitation plan, with staff support, based on each person's goals. We also use simulated on-site work experiences and community work experience in the area of interest of the participant (e.g., a retail store, a restaurant, computer repair). Length of program participation is very individual, and may range from a couple of months to a year, with the average length of attendance for ongoing participants being six months.

Once participants go through the program, there is a bi-monthly 'graduates' group (initiated under a grant from the BC Division of Canadian Mental Health Association) which offers ongoing peer and team support through a dinner social meeting. A graduate may attend for as long as he or she wishes to be involved; some come back after a period of time just to check in.

About twenty people attend the LE program at a time. There are 4 ½ core staff and for the past five years we have been fortunate to retain the services of half-time job and education coaches. The staff in these positions work mostly with people outside the program, but are also available to consult with participants.

### Outcomes

Our contract with Capital Health Region's Mental Health Services lists program objectives as job readiness, return to educational opportunities and volunteer work. Those who completed the initial-month assessment period successfully and graduated in the last year achieved the following outcomes:




### Job Search

If you ask a person who is recovering from mental illness what he or she would change about their life, often the first response is "a job." By that, people may mean they wish to make a contribution to their community and to be recognized for that. Helping people find employment is the focus of individualized job search function at Laurel Enterprises.

Prior to initiating a search, there are practical barriers to ▶

overcome, such as the fact that a person receiving BC Disability Benefits has to earn more than minimum wage to make an equivalent amount; in cities such as ours, however, the economy is over-weighted with hospitality industry jobs which typically pay minimum wage to start. So there are some challenges for the participants who are job-ready and want to work. Several graduates over the years have been able to enter provincial government jobs through access programs which are very effective.

For eleven years, we had a Federal Government (HRDC) contract to assist individuals with job search. Under this program, many people attained excellent jobs which matched their skills and interests. When that program devolved to the provincial level, a choice was made to address generic needs, rather than the needs of individuals of specific disability groups in the program mandate. Since then, the Laurel Enterprises' work experience coordinator has offered individualized job search to people with psychiatric disabilities from the general community as well as Laurel Enterprises.

Some participants merely need a person to talk with who understands the barriers that psychiatric disabilities pose to the job seeker. Others need and want more aid. This might involve help with assessing an individual's strengths, interests and skills. It could include help with preparing a resume, practicing a job interview or locating employers. All want ongoing support while they are looking for work. What is most important is that each individual chooses how much help and support they need.

## Job Retention

Once a person has started a job, the question arises of accommodations or other supports to make retention more likely. The role of the job coach is to provide ongoing supports that help people develop and maintain their effectiveness at work, and to develop strategies to manage their illness on the job.

Finally, we would like to take this opportunity to invite you to visit our programs "in action" if you are coming to the Victoria area. Just call (250) 389-1211 to make arrangements. Or you can check out our web site at www.mentalillnessrecovery.com ■



## Some Comments from Laurel Enterprises' Participants

**What does the program mean to you?**

*"The Work Abilities Program is most beneficial and helpful to persons with mental illness and/or for persons who have been out of the workforce for a long time due to a setback of some type. I am a person who had a "setback" in a time of my life when loss of self-esteem and depression did not help me in continuing my job search after completing a diploma program. The program — and especially the facilitators — enable group participants to independently fulfill their career goals, while being available for support and encouragement. The structure of the program enables participants to experience what it would be like to work a day. I really appreciate having educational resources available and to be a part of a wide variety of skills-enabling tasks such as clerical, woodshop, life skills, and a special-activities outing day."*

*"I have found the program to be extremely supportive in many ways. After being diagnosed, I found making a career change a great challenge. I was trying to reconcile a new career path, illness and fear of social stigma. I am able to rediscover myself and my options. Laurel Enterprises enabled me to spread my wings knowing I have a soft place to land should I need it."*
— **G.A.**

*"It gives me a chance to work and get together with others that have the same problem as me. It gives me a chance to show what I can do and learn things that I don't know. Pat is a fantastic instructor who should be here to give her time and energies until she is ready to retire; I have really enjoyed and learned lots from her in class and out. I learn about looking after the front desk and dealing with the people upstairs and going through my own fears and seeing what I can do which I thought I couldn't."*
— **Ken Williams**

*"As a participant of the Laurel Enterprises Program, I have found that it has enabled me to clarify what I want to do concerning schooling and work. I have also found the program useful in maintaining a schedule, meeting new people and it gives me an idea as to whether or not I could participate in a full-time job. What I have come to realize while attending the program is that I would prefer to work part-time rather than full-time. I believe that I would be more productive on the job if I had a short work week."* — **A.M.T**

*"The program instills confidence and builds up my self-esteem at handling job-related issues that come up daily. It should help me attain goals over the next few years. I feel it's helped me cope better with depression; therefore, I feel better about myself."* — **Jeff D.**

*"Laurel Enterprises is a place where I can explore my skills and strengths and where I need improvement. It helps me to increase self knowledge that enhances my life personally and in a career-related way. I couldn't do this alone without the support from staff. I really appreciate the support."*
— **Dawne E.**

# The Self-Employ Project:

## Work-Creation Innovations

*Jane Loop*

*Jane is the coordinator of the Self-Employ Project*

The National Network for Mental Health (NNMH), founded in 1992, is a consumer-run, non-profit society delivering a variety of programs in Canada. In 1997, this self-employment project originated in Nova Scotia. Through success and some Human Resources Development Canada funding, seven sites are now active across Canada. Recently, the NNMH expanded its operations to Vancouver, opening the Self-Employ Project in January 2001.

Some of our bold new ideas are refreshing and unique. We believe that not only employment, but also the creation of employment itself, can be fun and rewarding. The strong emphasis is on developing a wellness plan to deal with the challenges that creating self-employment may bring.

Creating a wellness plan and finding employment can impact other areas of participants' lives, bringing about many positive changes including higher self-esteem, enhanced problem-solving abilities and a renewed enthusiasm for life.

The program is entirely client driven, supporting people to identify and achieve their employment goals — in whatever vehicle they choose to create — through a coaching and mentoring support service.

Key to the service is coaching participants to build success upon success. Individuals are encouraged to become very clear on what needs they want to meet in order to feel happy and productive.

The guiding philosophy of our program is: "we feel that all individuals, no matter where they are on the come-back trail, have deep reserves of strength and perseverance that can be tapped into and applied in all areas of one's life."

Whether you are looking for full-time employment or a few hours a week, the program will help develop an action plan that suits your needs, because no one knows what you need better than you do.

So feel free to check out this warm, friendly service. The program is located at #201-532 East Broadway in Vancouver, open Monday to Friday, 9:00 to 4:30 pm. For more information, call (604) 707-9005. ■

# Three Perspectives on Rehabilitation Needs

Several years ago, Kim Calsiferri, then of Greater Vancouver Mental Health Services, led a review of the rehabilitation services of the Vancouver mental health teams. Central to the study was a comparison of the perspectives that three groups — consumers, family members, and professionals — held about the rehabilitation needs of people with mental illness. In the intervening years, the results of the study, which showed that in most instances far greater needs for services were expressed by consumers and significant others than by case managers, have provided the impetus for significant reform. Kim talked to Visions about the study and its impact.

*Kim is currently Director of Rehabilitation Services for Vancouver Community Mental Health Services, of the Vancouver/ Richmond Health Board*

**Visions: What was the initial motivation for the study?**

KC: "At the time, there was very little rehab. We were also doing a review of services and there was an opportunity to hire staff at two of the mental health teams so it was a good opportunity to do the study. We realized, too, that to deliver services you have to look at what consumers say are high priorities."

**Visions: What were the main findings of the study?**

KC: "With the initial study and with follow-ups that we did, the amount of perceived need was quite different, since perhaps the case managers felt that some of the needs were being taken care of elsewhere. In terms of the area of need, the same results came up again and again: dealing with stress, living a healthy lifestyle, understanding one's illness, getting back to work and going back to school."

**Visions: What was the reaction to the findings?**

KC: "There were a range of reactions: some were not surprised, some were surprised or there was a kind of denial associated with an old belief system that getting a diagnosis, meds, support and a residential facility is all we can do. Most people, though, were very interested in trying to do something. The research was important because if there is going to be any change, it's important to have mechanisms for people to discuss what their beliefs and ideas are and the research was a systematic way of doing this; all the programs we got off the ground were based on what had been identified by these studies."

**Visions: Tell us a bit about the changes in employment programming that came about as a result of the study?**

KC: "THEO BC has refocused all its programs to have more flexibility with regards to training and supported education. Gastown Vocational Services has also become more flexible and has added placement and on-the-job supports. ▶

The Individual Placement and Support model [see article on p. 22] is being implemented at three of the mental health teams in partnership with CMHA Vancouver/Burnaby branch. With consumer initiative funds, we implemented peer support and now have a number of consumers hired on as staff within the teams. Related to this, we developed a project on consumer involvement in the workplace which looked at how to do a better job of employing consumers in the workplace."

**Visions: What other changes would you like to see happen in the future?**

KC: "I'd like to see more consumers hired in the mental health system, in both the hospital and community systems — if that's what people choose. Because some people don't want that, we need to have the kinds of programs to enable them to go back to school or to work in other areas. We also need our workplaces to be safe and supportive enough so that people with mental illnesses who currently work within the system are able to be open up about that. This needs addressing in our system as well as the rest of society. We need a huge public education campaign to address this.

Another area consumers should be playing more of a role in — and we're moving in the right direction here — is the area of policy, implementation and evaluation of the service system at large. The system also really needs to empower people around their own care and rehabilitation in the services that are in place so that services can be a guide or a coach towards recovery. Sometimes people want be taken care of, but for the most part we have to be able to step back from that." ■

# The Self-Employment Option

*Nan Dickie*

*Nan is a freelance writer living in North Vancouver*

*Nan has recently authored a highly-acclaimed book called* A Map for the Journey: Living Meaningfully with Recurring Depression *(AmericaHouse). Find a review of it on our web site at www.cmha-bc.org or purchase it at amazon.com*

Employment is a necessity for most people. We all need money to survive, to put food on the table. Paid work makes us self-sufficient, that is, not reliant on government financial support whereby we feel we become a 'drain' on society. Furthermore, paid work improves our quality of life immensely by increasing our self-esteem.

Fortunately today, paid work can be done in many ways, from a career-driven full-time permanent job, to part-time permanent work, to various forms of self-employment.

Working full-time as a permanent employee means the worker is regularly paid, gets conventional benefits (including medical, and perhaps dental, insurance), and has access to a pension plan. Furthermore, full-time employees are often assured sick leave, short- and long-term disability benefits, and Employment Insurance (EI). They do not have to market their skills for each project they undertake, and for some, the workplace comes with a ready-made social circle.

People with mental illnesses cannot always choose full-time employment for a variety of reasons. If our illness is episodic, there will be times when we have diminished intellectual and/or motor capabilities. We cannot always take for granted our constant availability for, or ability to, work.

Hence, many of us turn to self-employment. Self-employed individuals are those who work temporarily for one employer, or periodically for different employers, or "work for themselves" offering contracting or consulting services, or a product of some sort (as those with home-based businesses do). Self-employed people are paid directly by an employer or purchaser for a specific service or product, not by a salary for a range of services. The self-employed person may sell services or goods independently or through an agency.

Self-employment may be full-time contract work, seasonal (for instance, fishing or fruit-picking), or another type of intermittent work. Generally, it is either time-limited, or completely dependent on the marketplace. Whether one is in good health or has a mental illness, there is not, for most people, much security in self-employment.

Self-employed individuals must pay their own income tax (requiring time-consuming and often complex accounting procedures). They must frequently market their services or promote their product. They are responsible for their own financial safety net (for possible sick time), health insurance (medical and dental) and RRSPs. They generally do not have access to employment insurance (even if they would choose to pay premiums for it as full-time people do), short-term or long-term disability, or company pension plans.

For some of us with mental illnesses who aren't eligible for nor choose to use government-funded employment services, self-employment becomes a way to accommodate our illness while meeting the need to financially support our families and ourselves. For us, there are distinct advantages to self-employment. We can often work our own hours (and take the break or nap we may require, for instance), and work at least part of the time at home (and so hide tremours or other physical vulnerabilities). We can choose to work or to look for work when we are well, and refuse work or remove ourselves from the workforce when our illness

manifests. Self-employed people are able to bid on contracts that are of interest to them. Furthermore, they can sometimes bid on the entire job itself, and not be paid on a per-hour basis. The advantage of this for those of us with mental illness is that we can be guiltless about taking the extra time we may need to do the job if we are recovering from an episode or feeling vulnerable to our illness.

There are special responsibilities for those of us who are in the workforce with mental illness. We must try to understand the pattern of our illness as much as possible and monitor each cycle of mental health (if our illness is intermittent). We must be realistic about our capabilities at all times; we may sometimes have to ask ourselves: is it time to quit this contract because of a decline in mental health?; am I well enough to return to work when in the recovery phase of an episode?; and, not least of all, we must ensure that our own frailties and vulnerabilities to episodes do not put other people at any risk.

The negatives of self-employment for people with mental illness are basically those areas that one relinquishes when one does not work full-time. Most poignantly, the disadvantages of self-employment may be:

- Not being able to count on a guaranteed income stream. This, of course, has implications for any financial dreams we may have. For instance, purchasing a home may be impossible because we can't meet the continuous monthly payments.
- Facing the possibility of being dismissed from a contract at any time or finding that we are not able to market our product properly.
- Being continuously responsible for employment and health insurance, planning for unpaid holidays, saving for our retirement, etc.
- Having to market our services or products over and over again. This can be very stressful at the best of times, let alone during recovery or when we are feeling shaky.

As well, we face other special risks by choosing self-employment:

- If our illness is an intermittent or episodic one, we don't know when the next episode may strike.
- We may have to quit a contract or stop selling when we are ill because we are not able to meet commitments of the job.
- It's difficult to tell when we're well enough to return to work after an episode. We may try to return to work when we are not yet mentally fit, or wait much longer than necessary to market our skills or product again.

Clearly, there are many responsibilities, disadvantages, and risks that people with mental illness face in choosing self-employment. However, when we are able to work, we are contributing, productive members of society.

# ABLED:

## Advice and Business Loans for Entrepreneurs with Disabilities

Forty guests representing the ABLED Advisory Council, the disability community and service agencies gathered March 22 for a community launch of VanCity's Advice and Business Loans for Entrepreneurs with Disabilities (ABLED), a new source of capital and small business development for people with disabilities. According to Reva Dexter, vice-chair of the VanCity Board of Directors, ABLED was developed with the involvement of community and stakeholder groups with one end in mind: "to make it easier for entrepreneurs with disabilities to pursue their business goals and contribute to the economic growth of the community."

"This loans initiative is a tool which the individual can use for the start-up or expansion of their business," says Marilyn Neudorf, VanCity's Enterprise Development Specialist who oversees the program. "The focus of ABLED is entrepreneurship. It is not a training program or social support — ABLED is a self-employment option, a way to access capital. Strong referrals from the community are a critical factor toward the success of ABLED." ABLED offers a valuable tool towards supporting people with disabilities achieve self-employment and self-sufficiency.

ABLED provides repayable loans for business start-up or expansion to entrepreneurs who are self declared as having a disability. The loan assessment criteria stresses the strength of the individual's character, the strength and viability of their business plan, and a reasonable credit history. Personal investment may be as low as 10% with substantiation. The Enterprise Development Specialist provides business counseling and support, along with assistance with development of business plans. To date, VanCity has assisted four new businesses through ABLED. Sylvia Anne and Marilyn Grace of "Chariots aLive," two entrepreneurs with disabilities, and guest speakers at the launch, both agreed that ABLED's focus on reducing barriers and encouraging 'ability' will be a boost to entrepreneurs in achieving independence and business success.

A public/private sector partnership with VanCity, Western Economic Diversification and Capital Coast Savings, ABLED provides entrepreneurs with disabilities who are unable to obtain financing from traditional lenders, access to business loans up to $75,000. Loans can be used to start or expand a business, purchase and apply new technology, upgrade facilities and equipment, develop marketing and promotional materials, or establish working capital.

**FACT**

About 300,000 working-age British Columbians have a significant disability. Two-thirds of these people consider themselves able and willing to work. Far too many people with disabilities encounter obstacles that make it difficult for them to achieve this goal.

— Ministry of Social Development and Economic Security. (2001). *Enhancing Employment Opportunities for People with Disabilities*.

*For more information on this and other Micro-Credit products call 1-888-VANCITY or contact Marilyn Neudorf directly at (604) 709-6934. Telephone service for the deaf call 871-5408 (TTY) Information about ABLED is available in alternate formats including Braille, large print, electronic diskette and audio tape*

# Peer Support Providing Employment Opportunities for Consumers

*Marquise Beaudin*

*Marquise works in the Adult Mental Health Policy Division, Ministry of Health Services*

Across Canada, increasingly, the importance of self-help is emerging as a theme in progressive mental health reform planning. Funding paid peer support workers within the mental health system is an integral aspect of this theme.

In recognition of the importance and potential of this issue, the International Association of Psychosocial Rehabilitation Services (IAPSRS) conference on peer support in Richmond, November 1999, and the provincial Mental Health Advocate both identified the need for a provincial inventory and resource guide on peer support and the development of peer support standards.

In January 2000, the Minister of Health announced $150,000 in annualized funding for mental health peer support. In order to make optimal use of this funding, advocacy organizations, health authority staff and existing peer support workers recommended to the Ministry that it create and disseminate to health authorities a provincial inventory of existing peer support options, which contained a description of features of effective peer support programs.

A provincial steering committee was struck and guided the development of the "peer support manual" project. The research and writing was contracted to two consumer-based organizations.

There were a number of steps taken in the creation of the manual. First, health authorities were sent a survey, requesting information about existing peer support programs and copies of their peer support training manuals.

Then, the researchers, under the guidance of the Peer Support Steering Committee, reviewed these materials and information from other jurisdictions to:

- identify the values and principles which underpin peer support
- collect and categorize the different kinds of mental health peer support programs in BC
- identify the key elements necessary for success in each category of peer support
- document some of the important considerations in implementing mental health peer support programs
- document existing programs, key features and contacts.

The draft Peer Support Resource Manual was shared with the Ministry of Labour to ensure the language and spirit of the initiative was consistent with the *Employment Standards Act*.

On March 15, 2001 a "funding letter" to Regional Health Boards and Community Health Services Societies identified $5,000 in one-time funding for mental health peer support "infrastructure" which would precede the annualized funding.

The annualized $150,000 for peer support programs will be made available through the health authorities, now that the Peer Support Resource Manual is approved for distribution.

It is the expectation of the Ministry that the Peer Support Resource Manual and associated funding will help to promote the quality and quantity of mental health peer support programs throughout the province. ■

# Hiring Ex-Patients as Staff

They are a nurse, a social worker and a doctor — all professional mental health caregivers at Eastern Middlesex Human Services in Wakefield, Massachusetts. Their common bond lies in their personal experiences as mental health patients.

Amy, Dan, Deborah, and Linda meet together at least once every three weeks to share support around issues which arise from their ongoing struggle to not only deal with their own job-related issues, but to join in creating a model of treatment "where a patient is accepted as a person rather than a diagnosis." Eastern Middlesex is one of a small but growing number of agencies which actively hire ex-patients.

For most of the members of the support group, this was the first job application where they felt safe in honestly answering the question, "Do you have a history of mental illness?" "I used to deal with it by not letting it out — not completing it on the application. I'd work three or four years and then quietly let it out, once they'd gotten to know me without a label," said one.

For mixed reasons, group members were hesitant to let coworkers know that they had been patients. One says, "I'm not willing to set myself up as an ex-patient, with such a strong label that if I ever have a problem again, I wouldn't feel that was okay. For me, it is not something that happened 15 years ago, it's an ongoing vulnerability." ▶

Eastern Middlesex hired Dan in an upper management position in 1987. They encouraged his being open about his experience as an ex-patient. "There's a positive in referring to my experiences as a patient, which breaks down the role that people see me in as a psychiatrist. I kind of use it as an antidote, or balancing factor.

Linda was extensively involved in the ex-patient movement and worked for a time in the first state-funded peer support program in Massachusetts. "I was so angry at the way I was being treated in the system. I was getting what they had to offer, not what I needed — support not judgment; acceptance as the person I was, not seen as 'defective,' but as needing normal information." She spent several years as a "conference circuit" speaker before seeking a position where she wouldn't have to hide her background "not only in the interview but on the job."

Amy works as a psychiatric nurse. "I speak to having been on both sides. There's no stigma in having a broken leg or cancerous tumour; a physical breakdown is acceptable. I think now that we've started coming out as professionals in the system, we keep it more alive and present."

Deborah struggled with the conflict in being both a consumer and a social worker. "I read an article on a psychiatric rehabilitation program at Boston University that was supporting individuals to become part of the work world once again. I called them and said I wanted to talk with them, and that's how I found out about my present job. Before that, I would go back to work and have relapses in part because I felt that I was not being accepted for who I was; I was being labeled because of my diagnosis."

After disclosing that they have been patients, group members say that it is not unusual for staff to comment, "Well, you couldn't have been really sick," or for consumers to say, "You were never as sick as I am" or "You won't be strong enough to help me."

Dan, in concert with a former member, started the support group. "We decided that if we were going to be an agency who hired ex-patients, we had to provide more support. This is our dividend." The group meets regularly and maintains regular contact by phone calls. They have no set agenda or formal topic from meeting to meeting, believing that the topics that come up will spring from issues they are dealing with.

"Many ex-patients' groups are political. Anger comes up and they are bound together by their anger. I didn't want the anger of my past to be the only thing that motivated me to work as an ex-patient. I didn't want to be stuck in my anger. I am angry about things from the past, but I need to feel more positive."

People in key managerial positions at Eastern Middlesex are open and supportive. Members of the group say these leaders readily acknowledge that life experience is as crucial as academic training. "They never tell us to be careful in what we say. They want us to do retraining with clinical staff. They understand that we are an important resource to the agency."

But group members feel they need to be especially wary of being seen as experts. "The greatest challenge to re-entering the field is in sitting back and not offering to fix everything. I have to constantly check myself."

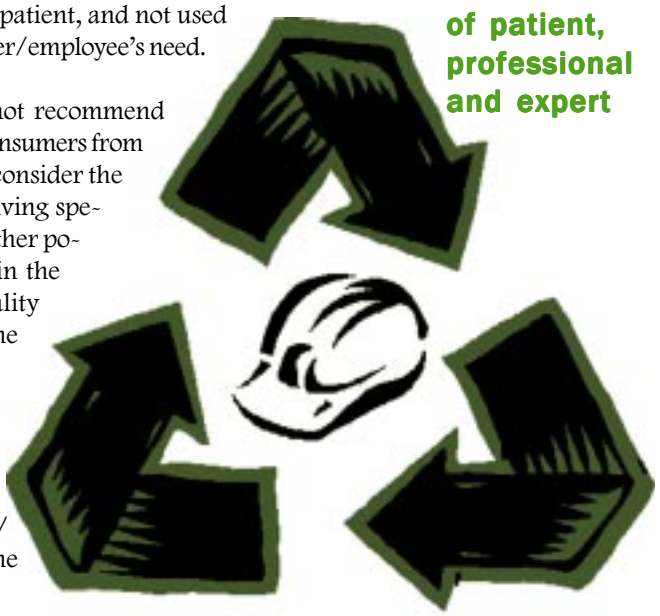
*Meg Simon*

They have been accused of being "too much on the side of patient rights." Does being an ex-patient blur the roles? "The difference between client and staff is not that we don't have the same issues, but that I have boundaries and commitment not to act out or burden them with my confusion. With our consumers, we tell them that their input to each other is equally as valuable as ours." This has been a positive experience for all four members of the group, although they have been told that some patients have felt pressure: "if I had 'made it,' they would have to."

*Reprinted from Resources, a publication of the Human Resource Association of the Northeast, Holyoke, MA, USA*

They feel that former patients have a great need to use self-disclosure in their work because the experience of being a patient receiving services in the system is in most cases a demeaning one which increases learned helplessness. This disclosure should be used only when needed by the patient, and not used based on the consumer/employee's need.

**blurring the traditional boundaries of patient, professional and expert**



Some members do not recommend that an agency hire consumers from within. Clients may consider the person hired as receiving special treatment, and other potential conflicts are in the areas of confidentiality and peer support, the group says.

What should agency managers know to work towards an effective consumer/employee model? The group suggests:

- **Be prepared!** Recognize that more preparation is needed for the person coming in: you can't just say, "He's an ex-patient." An ongoing support group is essential.
- **Written materials:** articles, studies, stories about how staff at other agencies (both ex-patient and non-) have experienced their work. A serious effort to cull experience, ideas and information on this issue is needed.
- **Individual orientation:** "Former patients will feel stigmatized on the job in a subtle way unless they accept the idea that life experience is as good as education. They may have anger at the way they were treated as ▶

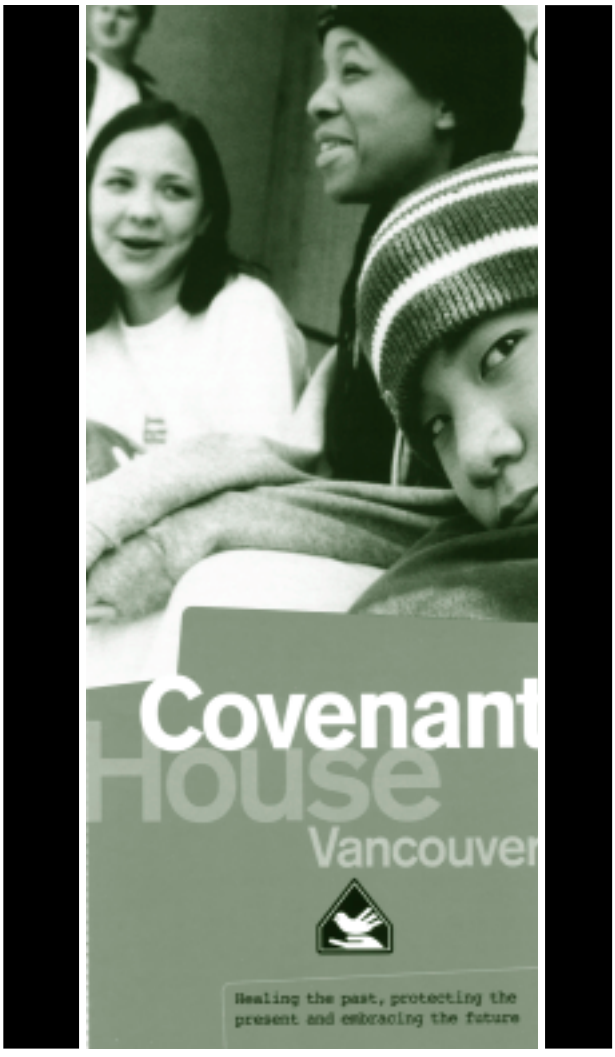
patients, which may come out as trying to help people by working for their 'best interests' rather than 'expressed wishes.'"

- **Mentor systems** help. Especially important during the first period of work is the presence of someone — not necessarily another ex-patient — the new employee can go to within the agency to discuss things. "None of us really got to know well enough what was going on, the ins and outs. There's a need to talk to someone else for debriefing if any of their issues get triggered as they work."
- **Staff training** sessions on empowerment and recovery are needed on an ongoing, formalized basis. These include two-way formats where ex-patients can offer points of view, although outsiders hired for the purposes may be better able to deliver those views. "[Presentations on] what it felt like to have mental illness and to receive services from the viewpoint of the consumer/employee, and why providers felt that they provided the services they did, will be invaluable."
- **Exposure:** the more dialogue and discussion with consumer/employees that occurs among staff, the greater the acceptance for all concerned. "Sometimes it's hard to speak out. I fear that if I disagree, I'll be invalidated." The more people speak from experience, the less anxiety and fear exists for staff ex-patients.
- **Knowledge:** the group recommends that agency managers stay abreast of what's happening in the larger world of ex-patients who have gone back to work within the system. Increasing the network, sharing updates and workshops with other agencies which employ ex-patients can increase their success. Several members of the group hold outreach meetings in the community where they educate others about returning to a working life. ■

# At-Risk Youth Seek Employment

*Jenny Simpson*

*Jenny is a former staff member at CMHA BC Division*




Covenant House International began in New York City in 1972 and now has over twenty locations across North America serving street youth, including two Canadian locations in Toronto and Vancouver. The Toronto location opened its doors in 1982 and Vancouver's Drake street residence opened thirteen years later in 1995. The Covenant House International message is best put by its President, Sister Mary Rose McGeady: "We try to give (the youth) back what the streets take away: dignity, health, safety and hope."

Covenant House Vancouver operates as a Resident Crisis Shelter that houses 22 youth per night and offers a Community Support Services Centre (CSS). The Centre provides recreational and vocational support by supplying meals, offering drop-in hours, as well as a clothing room, street outreach, computer access, and counselling. The CSS' objective is to provide transitional services that give youth the best possible outcome whether they are seeking affordable housing, employment, referrals to other services, or whether they wish to begin a new path. There are 52 full-time staff, 7 part-time staff, 20 relief workers and over 76 volunteers that work at Covenant House.

Each youth that stays within the Residential Crisis Shelter is contacted daily by two youth workers and helped to develop a plan for their future. Often this is where Employment Services step in.

There are two ways Employment Services aid the youth who access their services: through daily drop-in services which help by referring youth to potential employers, assisting with resume work, job search skills, lending clothing, and

providing message services; and through employment training/internship programs which last six to twelve months.

Funded by Human Resources Development Canada's (HRDC) Homeless Initiative, the program placed over 20 youth in entry-level jobs from manual labour to food service in 2000. Hired for twelve months, youth gained new skills, on-the-job experience, and, in many cases, ongoing employment.

*Youth Build,* the intern project for 2001, is also funded by HRDC and involves 15 youth who are gaining construction and carpentry skills through their work with the non-profit organization Habitat for Humanity. The program consisted not only of work experience, but life skills classes and high school education at Convenant Houses' Gathering Place where many of the youth are completing grade twelve.

Many young people that enter Covenant House are emotionally vulnerable either due to their previous living conditions — either in their homes or in transient living conditions — and due to poor health. A number of them have addictions problems, fetal alcohol syndrome, attention deficit disorder, depression, and other mental illnesses. Poor mental health is often one of several barriers impacting the search for employment as well as safe and affordable housing. Covenant House staff often act as counselors for youth and also may provide referrals to other local mental health workers. Despite the available support in the downtown area, there is a *great* need for more, especially for transient youth and adults.

Many of the youth depend on programs such as the Homeless Initiative to give them the support and inspiration they need to seek employment since many suffer not only the stigma of being "street youth" but also having a mental illness. The employment counselors and youth workers often have to work with these youth very closely to ensure that they are able to make the transition from street life to stable employment and housing despite their obstacles.

Although Covenant House and the given employers are aware and willing to accommodate the youth involved, illnesses such as depression can hinder the youth's success at maintaining employment. Many find it hard to accept the success they find and are also without access to services that could help them through this period such as support workers, mental health counselors, or peer support workers who deal with mental illness.

Despite these needs, there have also been many successes when it comes to youth with mental illness or emotional disorders. One example is a young man with bipolar disorder who came to the CSS in search of employment. He was then connected with an employer who needed a shop helper on a part-time basis. This position not only gave him the satisfaction of making money and gaining independence but also gave him the confidence he once lost on the streets. He was able to provide himself stability: something which medications and psychotherapy cannot offer alone. Employment and a sense of purpose are highly necessary steps on the road to recovery for those with mental illness: especially youth at risk. Through access to services, youth workers and necessities, these youth are able to not only see a future, but are also given the tools they need to access the future they once envisioned for themselves through the CSS at Covenant House.

If you would like to contact Covenant House for more information, or donate your time or funds to their initiatives, please call them at (604) 688-7457. ■

# What Ever Happened to Bob?:

## A Challenge to Employers and Union Leaders

*Rafe Mair*

*Rafe Mair is an author and radio broadcaster with his own show on CKNW. He is an Honourary Patron of CMHA BC Division*

Slowly but surely depression, in all its manifestations, is coming out of the closet — though we've a long way to go; and one of the places we have to go is the workplace.

Is there any among us who hasn't wondered about good old Bob?: the "can't miss" guy when he first came into the office, always a superior producer and clearly marked to run the whole show, someday. But then it was booze — Bob was an alcoholic. Or perhaps he suddenly became moody and argumentative and didn't join in the social activities any more. Or he was absent, it seemed, a day every week. Whatever — suddenly Bob was on the carpet and one day he was gone. It could have been Jane you watched fall apart. And maybe you were one of the folks that tried to find out what was bothering Jane or Bob. Was it trouble at home? Was it a money problem? Health? You got nowhere. When you think about Bob or Jane, there is, of course, the personal tragedy involved, but there is also a very significant loss to the company which trained them and did so much of their planning around them.

More and more companies are realizing that there may be an obvious answer — depression — and that the obvious solution wasn't found for two reasons: Bob and Jane couldn't talk about their problems and there was no one available for them to talk with anyway. The stigma is still there even though the "cure" — and often a 100% recovery — is so often available. Some companies deal with this through a human resources department and that's fine. But there is a better answer. Many larger companies use what's called ▶

the Employee Assistance Program (EAP), a confidential outside service that guarantees that Bob and Jane need have no worry that their cases are being discussed by the brass over coffee. Why not extend this idea to smaller companies through their trade or professional organization, so that the cost is borne among many? Such an idea would be perfect for professional organizations whose members are often small units — such as doctors, lawyers, accountants and the like — and it also should work for trade organizations, business groups and trade unions for that matter.

The biggest single barrier to treatment for depression is the stigma attached to mental illness. If, when I was diagnosed back in 1989, I'd had to go to a company employee, I doubt that I would have found the help I did. I was lucky to have a family doctor who had read up on the subject. The world of commerce is getting much better at dealing with depression once diagnosed. The problem remains that it is not dealt with soon enough. Help *is* available. Since I was diagnosed, I have maintained a highly stressful daily radio show, several weekly columns and have written three books. Without help, God only knows where I would have been.

So listen up, employers, professionals and union leaders — that big disappointment down the hall may just need a confidential opening to get the sort of help he needs to make your dreams for him come true. Why not create that opening? ■

# Workplace Stress:
## A Modern Epidemic

*Chris Allnutt*

*Chris is the Secretary-Business Manager of the 46,000-member Hospital Employees' Union, the BC Health Services Division of the Canadian Union of Public Employees*

*The* Workplace Anti-Stress Guide *recently received an award for excellence from the Canadian Association of Labour Media. Copies can be accessed on the union's web site at www.heu.org under "Publications," or by contacting the Hospital Employees' Union at 2006 W. 10th Avenue, Vancouver, BC V6J 4P5 or by phone at (604) 734-3431*

Chronic stress: it's one of the most serious problems facing workers today.

It seems that everywhere we look, on-the-job stress is out of control. It's certainly true in health care, where front-line workers are paying the price in injuries, anxiety and conflict.

Canada's health care system is feeling the strain of budget cuts and increased patient demands. Downsizing and restructuring are commonplace. Patients and their families are frustrated by delays and diminishing services. Employees are under enormous pressures to do more with less. Care providers are working short-staffed and may be dragging themselves into work even though they are already sick or injured. Changes from the top of the organization seem to be never-ending. There's just too much stress, with no apparent end in sight.

The Hospital Employees' Union, in response to members' concerns about the ever-increasing pressures in the workplace, launched an anti-stress initiative last year. The foundation of the initiative is a booklet, the *Workplace Anti-Stress Guide*, that not only explores causes and effects of work-related stress, but offers tangible solutions to this growing problem.

### Stress Effects

Normal stress is a fact of life, but ongoing stress at work is not normal; it's dangerous. Studies prove that chronic or "toxic" stress wears down the immune system and causes physical and psychological problems. Everyone's cheated by work stress.

People often think their jobs are stressful because they have too much work, or they're fighting with their co-workers, or their manager is unreasonable, or some individual has poor coping skills. Job stress is not caused by individuals or by personal qualities. It is rooted in the organization of the workplace: structural issues such as the job design, physical environment, organizational culture (e.g., "top-down" reporting structures), violence and discrimination. Workplace stress is an organizational problem that requires an organizational solution. The only way to stop the damage is to change the workplace.

### Workplace Democracy

A 1990-92 study of Ontario work sites looked at the relationship between lower Workers' Compensation Board claims and organizational culture. It found a correlation between lower claims and management practices that encouraged workers to use their own initiative and participate in decision-making. Lower WCB claims were also associated with lower grievance rates, high-functioning Joint Occupational Health and Safety committees and better labour relations. Moreover, these healthier work sites had low staff turnover and more experienced workers with considerable seniority.

The research suggests that good labour relations and participatory management practices can cultivate a stable, experienced and motivated work team — and these workers will be relatively free of toxic stress, a prime cause of lost time.

Workplace stress is preventable and fixable. There is plenty we can do together with co-workers, unions, employers, government and other organizations to create safer, healthier and more respectful ways of working.

### Who Benefits?

Everyone benefits. It isn't just workers who thrive when a workplace is committed to healthy job design and democratic principles. The benefits are wide-reaching and extremely significant. In a ▶

nutshell, workers have fewer injuries, illnesses and disabilities; job satisfaction increases; quality of work and productivity go up. In the case of health care, patient care improves; employers and governments save money due to reduced injuries, sicktime, rehabilitation costs, turnover, etc.; and the economy and society as a whole are strengthened. ■

### What makes a job less stressful?

Stress is high when a workplace lacks a respectful environment. The opposite is also true. Workplaces with good labour relations have fewer injuries, less absenteeism and lower turnover. In a healthy work environment, you would have:

- decision-making powers and the right to use your initiative
- a reasonable workload
- support from supervisors and co-workers
- maximum use of your skills, plus opportunities for training and growth
- an effective health and safety committee
- formal ways to work with management on problems including timelines for action
- job-sharing, flextime and other options to help with family obligations

When you have some control over your job, heavy demands are less stressful.


# Depression in the School System

*Crawford Kilian*

Depression is widespread among Canadians, particularly in groups and age ranges typical of teachers and older students. A 1995 Statistics Canada survey revealed that among adults aged 25 to 44, 3.5% of men and 8.6% of women had experienced a "major depressive episode" in the previous twelve months. BC teachers with up to twenty years experience would fall in that age range. Assuming BC teachers are typical of the general Canadian population, then, almost two hundred male teachers and almost a thousand female teachers experienced major depression that year. Told these percentages, the former president of the BC Teachers' Federation didn't hesitate: "I'd say three to four times that number," Kit Krieger replied. But he admits his union hasn't broken down its statistics on why teachers go on extended leave for illness reasons.

Depression at other levels of education may be more widespread than we realize though, again, few institutions seem to have formally studied the problem. Simon Fraser University lost a president to depression a few years ago. Most college and university faculty can think of colleagues on leave for mental health reasons. Others have stayed on the job while seeking private counselling, now provided as a benefit by most post-secondary employers.

Based on the Statistics Canada survey of the depression rate in Canada, we can assume that hundreds of BC's full-time college and university teachers also deal with depression; but post-secondary faculty tend to be in their fifties, and the women's depression rate falls off after age 45 to 6.3%, while men stay at 3.5%. So the problem may not be quite as serious as in the K-12 system.

What about students? Statistics Canada estimates that 41,050 Canadian male teenagers experienced a major depressive episode in 1995, and more than twice that number of girls — 93,423 or 8.6% of all Canadian girls between 12 and 17. That means that about one teenage girl in twelve is struggling to cope with school despite her problems.

One Surrey high school counsellor who requested anonymity says she often deals with depressed students. "Boys are more likely to be in self-destruct mode," she says. "They may drink and do drugs and drive too fast. Girls may drink and do drugs too, but they may also just slump or develop eating disorders. Boys are more likely to act out their depression, girls more likely to be introverted, to shrivel."

If we apply the 1995 depression rates to BC post-secondary students, we can estimate that in a given class of fifteen men and fifteen women, one male and two females have experienced major depression in the past year. This number arises partly from the 10.8% depression rate among females of traditional college age, 18-24. In addition, many part-time students are women. Their median age is 25-29 and their depression rate (if they are typical of Canadian women in that age range) is 8.6%. By comparison, only 6.6% of males aged 18-24 experience depression, a rate that drops to 3.5% after age 25 (See Figure 1 for a summary of all the above school system statistics).

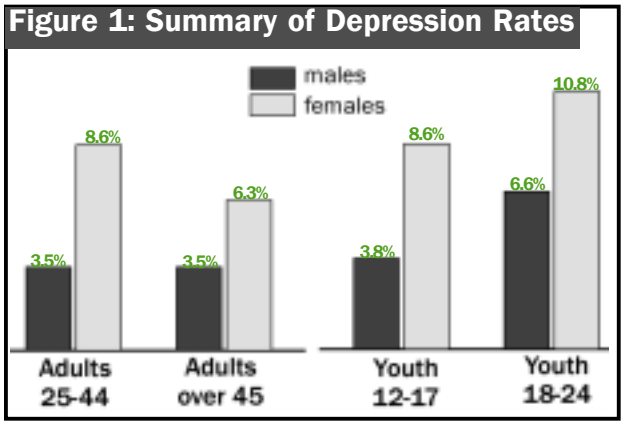



**Figure 1: Summary of Depression Rates**

Chances are that very few depressed students seek on-campus counselling or notify their teachers. Many may not realize what's happening to them. Some may see their physicians or seek psychiatric help, but most literally suffer in silence. They will find it painfully hard to study and to complete assignments. Good grades mean little to them, and their own low self-regard will make them dismiss their teachers' encouragement.

cont'd bottom of next page

*Crawford is a writer and instructor at Capilano College in North Vancouver*

*Portions of this article appeared originally in the Georgia Straight. They are reprinted with permission of the author*

# Mental Illness in the Workplace:

## A Nurse's Story

*Anonymous*

My friend 'Jane' has been a nurse for over thirty years. She was diagnosed with depression several years ago and continued to work as a critical care nurse, while trying desperately to find some happiness and stability in her personal life. Jane is a generous, kind and caring person.

About a year ago, the medications weren't working and Jane's depression was overwhelming her. She continued to work, but was increasingly stressed out at work, and her colleagues began to complain about Jane's negative "attitude." I worked with Jane as well. Sometimes, it was pretty frustrating because she *was* negative and difficult to communicate with.

I think what shocked me the most about all of this, though, was seeing colleagues who care so much about their own patients turn on one of their own. It was quite obvious to a small group of us that Jane was not okay, but to the larger group she was now an inconvenience, a focus for complaints. The entire morale of a unit was blamed on Jane.

People might assume that health care workers would be more enlightened about mental illness, but when the ill person is a fellow nurse, we're not always responsive. In fact, at the same time Jane was ill, another nurse suffering from a physical illness was showered with support and kindness.

Jane was pretty open about her problems to her colleagues. People knew she'd sought psychiatric help and that currently her medications for depression were altered because they weren't working. Still, none of us really knew what we could do to help. We saw her deteriorating in front of our eyes, while some of our colleagues continued to complain about her behaviour.

Eventually, of course, management was watching. I was hoping they would help her. Instead, Jane realized that she was being watched and felt even more under pressure. She felt everything was being documented as evidence against her, unless she could try to put on a happy face. Many of us can fake a happy face when we're having a bad day, but I've come to realize that when you have depression, it's impossible to do that. It started to become obvious to her friends that Jane might be fired. I was terrified about what she might do if her job and her financial resources were lost.

One day a Labour Relations Officer (LRO) from the British Columbia Nurses' Union contacted me. The LRO told me that she had knowledge that Jane was, in fact, in imminent danger of being fired. I was called because I had just recently become a steward in the union, but also because I was Jane's friend and could help support her through whatever was to happen. We had a meeting with Jane, and the LRO suggested that she immediately go on sick leave, as she needed to take care of her own health needs, and also needed to be away from a workplace where every day could put her in more jeopardy of being fired. The union then began negotiating with our employer to allow Jane to get the help she needed without losing financially.

As a result, Jane has been allowed to retire early, but has been ensured financial stability, and I can't believe the difference in my friend now. She is involved in her community, enjoys her life and has many friends who care deeply about her. She feels gratitude towards the people who stepped in to help her. Jane still has depression, but with support and less stress in her life, is able to cope with it.

Looking back, I don't think anyone in our work area was intentionally mean, but just had little understanding of what it is like to have a mental illness. Whether you believe in unionism or not, I believe my friend would have been fired and penniless by now, if the union hadn't stepped in to help. Although simply 'having an attitude' at work isn't very strong grounds for dismissal, Jane was simply too fragile to fight for herself. After thirty years of nursing, I do believe she was about to be discarded, and that she really would have just given up rather than fight. ▶

---

**Depression in Schools** — cont'd from previous page

Failure, however, will confirm their low opinion of themselves.

Depression exacts a cost — not only on depressives and their families, but on society and the economy. We still think of depression as a failure of character rather than as a disease, which is, doubtless, why it carries such a stigma. We rarely think of it as a direct cause of academic failure, alcohol and drug abuse, and suicide within the schools.

Education is not the only institution contending with both depression and its denial; but depressed workers from all walks of life were all once part of the education system, and that system clearly failed to recognize their problem. If even the most educated among us don't want to confront this disease, then the prospects of those who suffer from it are surely that much harsher. When educators do face the problem and take steps to remedy it — not just pep talks and Prozac, but tackling the social and physical causes of depression — then they and their students will be only the first to benefit. All of society will benefit as well. ■

# Reducing Work Stress and Improving the Work Life of Staff in Long-Term Care Facilities

*Gail Butt, RN, MHSc, Dr. Susan Kennedy, Dr. Aleck Ostry, Vita Kolodny, RN, MSc(A), Dr. Reva Adler*

## Introduction

Stress in the workplace has been identified as a major cause of workplace injury and staff turnover. Because of intense downsizing and restructuring of the health care system over the past decade, stress among nurses and long-term care aides has increased.

This article describes a two-year intervention, funded by the Occupational Health and Safety Agency for Health in BC, and designed with representatives from the Care Directors Group of the Lower Mainland, the Health Employees' Union of BC, the BC Nurses' Union, the Registered Nurses Association of BC, and the Vancouver/Richmond Health Board.

The intention of the research phase of the project is to identify the sources of stress felt by nursing staff working in long-term care facilities. During the second twelve-month phase, the research findings will be used to develop an education and problem intervention — involving both staff and management — for use in three Lower Mainland facilities.

## Background

There is an increasing demand for provision of long-term care services, as the over-85 age group is the fastest growing segment of the population. This growth is producing pressure for more long-term care facilities. Residents in long-term care facilities may be physically frail and/or mentally frail. The most frequent reasons for placement are changes in brain functioning resulting in forgetfulness and difficulty managing the basic activities of daily living.

Residents in long-term care facilities require help with things such as meal preparation, bathing, dressing, grooming, toileting, walking and socialization. They must rely on staff and family to do the things they can no longer do themselves. This dependency can be stressful for the elderly person, their families and the staff.

Occupational stress in long-term care facilities has historically been a significant problem for nursing staff, as a number of studies demonstrate. Occupational stress in long-term care facilities has been linked to high rates of injuries, high rates of absenteeism, staff burnout and staff turnover.[1, 2,3] It has a negative effect on staff as well as the organization, and more importantly, on the quality of care to residents and their families.[4,5,6]

While we know a fair amount about the impacts of occupational stress, we know very little about what makes the work stressful, and thus little knowledge upon which to develop programs to address this issue. Such programs, once developed, have the potential to improve services and to reduce the costs associated with staff illness, injury and turnover.

## Study Objectives

The main objectives of the study are to:

1) **Conduct a survey** that will identify the most significant stressors for front-line nursing staff (registered nurses, registered psychiatric nurses, licensed practical nurses and care aides) in a group of long-term care facilities in the Lower Mainland.
2) **Develop and test a program**, in three facilities, that will use education and problem solving to prevent or modify the most significant stressors identified by the front-line nursing staff in those facilities.
3) **Design the project** to serve as a feasibility test for future randomized controlled trials to be conducted in other long-term care facilities.

## Method

A survey instrument measuring stress levels experienced by front-line nursing staff in four domains was recently conducted using a self-administered questionnaire. The four main areas under investigation are hypothesized to be important in generating stress: stress in general, working with residents, working with families, and working with staff/ ▶

Jane had a small group of people in the unit who wanted to help her, but we really didn't know what to do. Something has changed though. Many people at work have thought about how we reacted to Jane's predicament. I think we all grew and examined our own behaviour. I really do believe that if there is a next time, we would all react very differently. There is so much more we could have done to support Jane. As co-workers, there is much we could do to support others who may find themselves in the same situation. For anyone else in a similar plight, though, I would recommend enlisting the support of the union, just to be sure. ■

management. The questionnaire was distributed to staff in 35 facilities in the Lower Mainland.

The results are presently being analyzed. During the analysis, the research team will identify major stressors for staff and their frequency of occurrence. The results will be tabulated for individual facilities, as well as for the entire group. Once results are available, work will begin with the three selected facilities to develop a program that will eliminate or modify the stressors identified in the survey.

Initially, the three participating facilities will be given a report of the overall results of the survey and the specific results from their facility. The research study coordinator and a skilled facilitator will work with the staff and management to discuss the issues, and to develop and carry out an action plan. They will plan and facilitate monthly meetings at each facility, act as a resource for obtaining information, assist in problem solving and developing education/training programs if required. They will also develop a package of resources to assist the facilities in meeting their specific needs. ■

*Inquiries about the project should be sent to: Gail Butt, Administrator, Prevention and Care Management, BC Hepatitis Services, 655 West 12th Avenue, Vancouver, BC, V5Z 4R4*

References

1 Boyd, N. (1998). *Gently into the night: Aggression in long-term care.* Workers' Compensation Board of British Columbia.

2 Cohen, M. J. (1989). Sources of satisfaction and stress in nursing home caregivers: Primary results. *Journal of Advanced Nursing, 14,* 383-388.

3 Holtz, G. A. (1982). Nurses' aides in nursing homes: Why are they satisfied? *Journal of Gerontological Nursing, 8*(5), 265-271.

4 Hay, D. (1972). The Psychological stresses of intensive care unit nursing. *Psychosomatic Medicine, 34,* 109.

5 Norbeck, J. S. (1985). Perceived job stress, job satisfaction, and psychological symptoms in critical care nursing. *Research in Nursing and Health, 8,* 253-259.

6 Waxman, H. M., Klein, M. & Carner, E. A. (1985). Drug misuse in nursing homes: An institutional addiction? *Hospital Community Psychiatry, 36,* 886-887.



# Canada Pension Plan Policy Changes

*Karen Hobbs*

*Karen is a Rights Advocate for the Mental Health Empowerment Advocates' Program, a program of the Vancouver Mental Patients' Association*

People with disabilities, physical or mental, should always be given the opportunity to improve their self-esteem. One way is by making contributions to society through paid or volunteer work. There will always be people with mental health-related disabilities on Canada Pension Plan (CPP) Disability Benefits who are capable of some form of contribution. The problem has been that many find CPP rules on paid work confusing and fear losing their benefits.

A Bulletin from CPP (May 2001) announced a plan to make it easier for everyone. This new policy is called the Allowable Earnings Initiative. Basically, if you are receiving CPP Disability Benefits, you will be allowed to earn $3800 in 2001 before you are required to report it to CPP. That is, if between January 1, 2001 and December 31, 2001 (and thereafter) you earn money from paid employment, you do not have to inform CPP until you make $3800. At that point, you must call your local Human Resources Development Canada (HRDC) office. A case will be opened and a case manager will want to talk to you about what kind of work you are doing, how long you think it will last, and whether an assessment needs to be done about your capacity for regular work. There are other programs within CPP, such as the three-month work trial period, which may be discussed with you, but none of this starts until after you report to the HRDC office. The policy is unclear at this point but as far as we know, you will probably keep your benefits until you start to earn more than $775 per month. CPP feels that this new policy will prove to be more objective in assessing people's capacity for work. They hope that it will encourage more people on Disability Benefits to try out some paid employment. The Bulletin specifically notes that CPP recognizes that some people will only ever be able to work a little bit, while some are interested in testing the waters to see if they will be able to return to the workforce. Not having to worry about the first $3800 should help out.

For more information, you can call your local HRDC office to ask about ISP Policy Guideline Allowable Earnings Bulletin No. 07/2001-CPP-01. If for any reason your file is being reviewed, or if you are only applying for CPP Disability Benefits, or you are at the appeal stage and need some help, you may want to call our office at (604) 738-5770 and talk to an advocate. We attempt to stay current on many of the barriers to applications, especially new policy interpretations of the legislation. ■

# Avoiding Executive Burnout

*Michael MacDougall*

*Michael is the Director of PricewaterhouseCooper's Centre for Career Management in Vancouver. He can be reached at (604) 806-7074 or via e-mail at mike.macdougall@ca.pwcglobal.com*

*Portions of this article appeared in* The Vancouver Sun. *They are reprinted with permission from the author*

Today's corporation is no longer a stable or secure place. It is an uncertain, turbulent environment where executives often find their compassion and humanity in conflict with the pressures of competition and ambition. With a thrust towards mergers and consolidations to better achieve global positioning, corporations are involved in a continual change process that creates heightened anxiety for all concerned.

The prevalent attitude sustained by Boards of Directors, shareholders and stakeholders alike is that executives are seen as units of investment who must enhance their return on investment on a quarter by quarter basis. The focus is on velocity to generate revenue, reduce costs, improve efficiency and enhance both employee and customer satisfaction. The question is whether executives are role models exemplifying excellent coping skills, effective growth and health management, and a proper balance of work and personal life.

Most executives would prefer to be seen as "agents of change" as they go about their work, restructuring their companies to compete in a changing environment. However, many are branded as corporate assassins with ice water in their veins and a pocket calculator for a heart. In addition, management feels pressured as sales and production quotas continue to climb, but operating budgets, salaries, travel allowances, expense accounts and opportunities for promotion dwindle.

Executives feel that they are at the end of an electronic leash, compelled to carry a beeper and cellular phone, and to check their voice mail and e-mail messages on a continual basis to remain in constant "touch." As a result, they have raised expectations about what the whole purpose of "vacation time" should be for both themselves and those individuals that report directly to them. Furthermore, they are expected to stress teamwork accountability, open communication, respect for diversity, and coaching over managing. With all these added pressures to perform, the workplace no longer energizes; it drains.

It is becoming more apparent that corporations do not have as firm an understanding of the human aspects of restructuring as they do on finance and technology. The end result is becoming well known as survival sickness, or burnout. This is generally caused by prolonged or cumulative long-term stress. Recognition of it is not easy since the condition is slow to develop. By the time it is noticed, permanent damage to an executive's health and happiness may have been sustained. A major reason for this is that many executives prefer to remain in a state of denial for fear of being perceived as "damaged goods" — a strong survival instinct, but at what personal cost?

Research has identified four phases of stress reactions that can lead to burnout:

## Warning Phase

The warning signs are predominantly emotional in nature: feelings of vague anxiety, constant fatigue, depression, boredom with one's job, and apathy.

## Mild Symptom Phase

If an executive chooses to neglect or ignore the early warning signals, they will become fixed and begin to intensify. In this phase, some physical signs are added to the emotional ones:

- reduced emotional control
- increasing anxiety
- sleep disturbances
- headaches
- diffuse back and muscle aches
- loss of energy
- hyperactivity
- excessive fatigue
- moderate social withdrawal
- nausea

## Entrenched Phase

An executive who has allowed a prolonged stress reaction to become entrenched will suffer through some of the most painful conditions he or she has ever encountered. Career, family life and personal happiness are all on the line, and immediate help is essential. Signs include:

- skin rashes
- generalized physical weakness
- strong feelings of depression
- increased alcohol intake
- high blood pressure
- migraine headaches
- loss of appetite
- loss of sexual desire
- ulcers
- severe withdrawal
- excessive irritability
- emotional outbursts
- development of irrational fears
- inflexibility in thought

## Debilitating Phase

If an executive somehow manages to survive this destructive final phase, he or she is rarely able to continue working in the same field. Careers end prematurely as do lives. Sufferers are usually quite sick, both emotionally and physically. Symptoms include:

- asthma
- coronary artery disease
- diabetes
- cancer
- heart attacks
- severe depression
- lowered self-esteem
- inability to function in the job or in personal affairs
- severe withdrawal
- uncontrolled crying spells
- suicidal thoughts
- muscle tremours
- severe fatigue
- over-reaction to emotional stimuli
- agitation
- constant tension
- carelessness
- feelings of hostility
- development of moderate to severe thought disorders

Such burnout is almost totally preventable if corporations are prepared to create an environment in which executives are encouraged to take sufficient care of themselves, and if individuals know and heed the danger signs, and are prepared to keep their work and home lives in balance. ■

# Dealing with Disclosure of Disability:

## Some More Considerations

*Joe Marrone*

*Joe is with the Institute for Community Inclusion, in Portland, Oregon*

An often-difficult and emotionally-charged issue for many job seekers with mental illness is how much to tell a prospective employer about their disability. An employer may ask all applicants for a busy sales position how they would handle stress and customer complaints. Although this question may seem pretty straightforward, for the job applicant with mental illness who is trying to account for periods of unemployment, or who will need certain supports or accommodations to be successful on the job, what to say about the disability may be less clear. This becomes even more difficult because by drawing attention to the mental illness, the job seeker may lessen his or her chances of getting the job.

Below are some questions that can be used as considerations to assist the job seeker in deciding what to tell an employer regarding his or her disability:

- **Personal Ethics?:** Does the job seeker view non-disclosure as lying or simply omitting non-essential information?
- **Is the Truth Better?:** Can periods of unemployment be better explained by stating the job seeker had a problem and received help to overcome the problem, or by other explanations such as staying home to take care of family or being involved in a family business?
- **Is the Truth Relevant?:** If the job seeker can do the job and doesn't need extensive accommodations or support at the workplace, it is probably not necessary to inform the employer about the disability.
- **Can the Facts Be Checked?:** Past employment history and school records can be checked by employers, but other personal history (such as self-employment and medical leaves) are less likely to be scrutinized.
- **Effect on Job Seeker?:** Will telling (or not) cause more or less apprehension for the job seeker?
- **Consequences?:** What will increase or decrease the chances of getting and successfully maintaining employment?

If the job seeker chooses not to disclose a disability, their references need to avoid inadvertently doing so, for example by mentioning the name of the disability agency that helped the individual find the job (e.g., Centre for Mental Health). If the job seeker does choose to present information on disability, it is usually preferable to present that information in person so that the individual can gauge the reaction and address any questions or concerns immediately.

If there isn't any need for special accommodations and the individual can receive adequate support outside of work, but still feels it is important to let the employer know about the disability, then the individual might want to consider not disclosing the psychiatric disability until they are beyond the probationary period. Whenever disability-related information is shared, it should be presented in a way understandable to the employer by focusing on what the job seeker has to offer and how past problems have been resolved. ■

# To Disclose or Not to Disclose?


As an agency providing vocational services for people who have a mental illness, we are frequently asked questions by individuals preparing to enter the workforce on the issue of disclosing their illness to prospective employers.

There are many aspects to this dilemma and the decision needs to be approached according to the particular situation and needs of the individual. However, there are some ground rules that bear consideration before arriving at your decision.

A key consideration affecting your decision to disclose, and your decision about the timing of your job search, is the degree to which your symptoms are under control. This depends on you having a fundamental understanding of your illness, including an awareness of the environmental factors that may contribute to an increase in those symptoms, such as undue stress. It also depends on whether you are ▶

receiving the right kinds of support, as these will play a pivotal role in maintaining good health. A supportive mental health worker can act as a sounding board as you consider these issues relating to your degree of wellness, and can offer constructive feedback as to the timing of your decision to embark on the arduous task of the job search.

When you are feeling confident and secure enough about your career objective and the prospects for entering the workforce, then you are ready to embark upon the next critical step of the process. This involves the compilation of a detailed resume, an ability to market your skills, and an ability to provide convincing responses to questions about gaps in your employment history. You are now ready to enter into the interview stage, which is when that critical issue of disclosure needs to be thought through carefully.

Some of the factors that you may wish to consider are:

1. Do you have the required skills for the position?
2. Do you have the work tolerance and physical endurance for the hours required?
3. Do you have the interpersonal skills that would enable you to feel comfortable with your co-workers and fit into the team?
4. Can you account for any significant breaks in your employment history due to illness with convincing responses such as a career change, travel, educational or skill upgrading, or even "for personal reasons"?

After strategically weighing up these factors you are now ready to make a decision. Do I need to disclose because I am feeling insecure about a certain area? Or do I not disclose and "attack" the job search game with the same degree of confidence as a candidate who does not have mental health issues with which to contend.

This choice of disclosure may come down to a specific moment in the interview process when the interviewer asks a question such as, "Do you have any health issues that could affect your ability to do the job?" This is that decisive moment that could cost you the prospects of being hired! Your response should be weighed accordingly. If you believe that you have the skills and abilities to do the job, that your symptoms are under control, and that you can satisfactorily answer the considerations listed above, then you can honestly answer "No." If, however, you have some doubts about your level of functioning due to your illness, then it would be unwise to lie and answer "Yes" with the risk of termination should you become sick once employed. If you are not asked the "health question" during the interview, you may choose to disclose and negotiate accommodations after you have been offered and accepted the job.

Should you choose to disclose and you feel confident enough about your core skills, you may wish to enter into negotiations around what possible accommodations you may require to help alleviate a possible increase in your symptoms. These may be around such issues as flexible time-off for critical appointments, taking several "mini-breaks" instead of a long lunchtime break, or starting later in the day. There are a number of accommodations that most employers would consider for a physical disability and as such should be prepared to consider relating to mental health disability. The degree of understanding may vary from company to company, depending upon the personal experience of key people and their knowledge and attitude towards mental illness (e.g., the company may be more supportive if the owner of the company has a son with schizophrenia and attends BC Schizophrenia Society support meetings).

Accommodations should not be thought of or presented as requests for favours, but rather as necessary adjustments to a person's work environment that enable the employee to carry out his or her duties more effectively. In certain cases, this can be seen as a right, but may need to be handled sensitively around co-workers so that is it not seen as the new employee receiving preferential treatment.

It is also advisable that the issues around mental illness be approached with caution when talking to co-workers as well as employers until some level of trust and understanding has been established. At the organizational level, there is still not a uniform level of acceptance towards mental health issues; therefore, a supportive environment and openness for disclosure depends greatly on the awareness and attitudes of individual co-workers.

There are two specific situations where disclosure can be a benefit, even for those individuals who may tend towards "non-disclosure" of their illness. The first is in cases where a history of mental illness is considered an asset to the position, such as in the mental health field, where knowledge of mental health services and resources and the ability to empathize with others are explicitly valued in the job posting.

The other occasion when disclosure may be advantageous is when applying for a position with a government agency or company adhering to the principle of employment equity. In this situation, there may be an opportunity to apply for a designated position as a candidate from a "visible minority." Often this category includes aboriginal people and people with physical and mental health disabilities as key groups given preference for such a posting, though some research may be required to assess how many positions have been allocated and filled for various minority groups. For these positions, identifying that you have a disability can be made on the employment application, without giving specific details regarding the disability.

So in conclusion, the issue of disclosure of a mental illness in today's workplace remains an issue of personal choice which requires careful consideration and planning. Thinking through some of the suggestions and guidelines discussed above will enable you to make a strategic plan of action, which will hopefully lead to successful and ongoing employment. ■

*Peter Phillips*

*Peter is a Vocational Rehabilitation Worker at Gastown Vocational Services in Vancouver*

*Gastown Vocational Services can be reached at (604) 683-6047*

# Making Disability Accommodations

*June Soroskie*

*June works for the Vancouver Mental Patients' Association as an advocate*

My name is June and I am a mental health advocate at the Vancouver Mental Patients' Association. You might be asking: what's so different about that? Well, I have been a consumer of the mental health system. I've been treated for depression and through that I've learned the tools to keep me focused and understand the needs of others. My depression can be considered an invisible disability and is something that many people suffer from, but I'm different because I also have a physical disability, which is quite visible.

I have had a physical disability since birth, a defect that restricts the movement of all joints due to a lack of complete muscle development before birth. I am unable to reach above my waist or bend my knees, so going up and down stairs can be impossible. There are times when I get depressed because I'm unable to do the things that a physically normal person is able to do.

I'm fortunate that I have an employer who has made my work environment accessible physically and psychologically. Stairs are almost impossible for me to navigate, so an office was set up on the main floor in the drop-in centre for me. At first this was difficult for me to adjust to, as I was being separated from a team I had worked with for many years. This feeling of separation soon lessened when it was suggested that the team meet downstairs every morning where I work to touch base and keep the communication lines open. There is a handicapped-accessible washroom, and the door handles on the office were changed to a lever and positioned at a height that I am able to use. As well, a headset was provided to make my workdays easier because I'm unable to use the phone without some difficulty. The staff who work in the drop-in are very accommodating and always willing to help if I'm in need of assistance. Also, the daily members of the drop-in stop by my office frequently to see if they can do anything for me or to just say "hi" and sit and talk awhile. If I have a fax that needs sending, there is always someone willing to run it upstairs for me.

If I have a medical appointment I need to take, there isn't a problem. There might be a day that I'm feeling a little stressed, so I'm able to take a mental health day. We are also encouraged to take educational training courses that also help us do our advocacy work better, for example, workshops on the myths surrounding a mental health disability, on management of a difficult client with a mental illness, on identification of the different mental disabilities and their characteristics, or on disability rights and law. It's also important to understand that a person with a physical disability can have a mental health disability.

The criteria for being employed in this organization as a mental health advocate is having personal experience with a mental illness and being able to establish empathy with someone who has a mental illness who is going through the system. We also have to be able to "self-identify" (i.e., disclose our illness to others), as we deal with persons who have a mental illness and also, possibly, a physical disability.

The personal pain and discomfort I have experienced have not stopped me from assisting others wherever I can. I feel that I can understand and assist others because of my own life experiences. I feel that everyone needs and deserves to have people who listen and understand. The support I get at work allows me to make my experience available every day to help the people who need it, whether they have a mental disability or a physical disability as well. ■

# Disability Insurance Barriers

There have been numerous stories in the news lately identifying stress and other mental health problems as a leading cause of disability in the workplace. An article in the Victoria *Times Colonist* stated that "mental and nervous conditions — from depression to post-traumatic stress disorder and psychotic conditions such as schizophrenia — now make up about 30% of the reasons for long-term disability." Another news story reported that 47% of Canadian workers are thought to suffer from stress. In 1993, a Saskatchewan court ruling reinforced the need for strengthening the position of persons with mental disabilities by ruling that insurance companies could not discriminate against people who filed claims for mental problems, as opposed to physical ones.

Given the increasing media attention to workplace stress in the media as well as this court ruling, one would think that equitability of disability insurance covering short or longer-term loss of work due to mental disorder might be uppermost in insurers' or in employers' minds. Four situations I've discovered would lead me to believe otherwise.

## Donald Mayer

One of the most drastic scenarios, where a denial of disability insurance ended tragically, is the case involving Donald Mayer, a Langley truck driver whose psychiatric history began with mild

depression and ended with his death.

The story unfolds in July of 1999 when Mr. Mayer attended his doctor's office complaining of anxiety and insomnia, explaining that his Workers' Compensation Board (WCB) claim for work-related stress had been denied. At that point, his doctor recommended that he take six weeks off work and proceeded with the application process for short-term disability benefits.

Mr. Mayer waited for a decision on this claim, and then on a decision on an appeal when his initial claim was denied. While he waited, his depression worsened; by August he was expressing suicidal intentions. In December, he was referred to a psychiatrist who offered a secondary medical opinion supporting the disability claim, but there was a delay in getting that doctor's report to the insurance company. Despite the assistance of the mental health professionals involved in Donald Mayer's case, no progress was being made, contributing to his further deteriorating mental health.

On December 17,1999, Mr. Mayer was admitted to Emergency where he told the staff he "wanted to kill someone." When Mr. Mayer failed to get the help he was looking for, the situation escalated and he became increasingly agitated and upset. Finally, the police were called, and Mr. Mayer died of a gunshot wound in the resulting confrontation.

A key question raised by the Coroner's jury at the inquest into this death was this: if the insurance claim had been settled, or at least if some progress had been made, could this death have been prevented? The jury supported more thorough investigation into stress-related disability claims, recommending that "adjudicators of apparent work stress claims should investigate the claims to rule out the possibility of a larger problem such as clinical depression and/or anxiety which has simply been triggered by a work stress related event."

## Richard Voight

Another incident, quite different but equally serious, involves a paramedic, Richard Voight, who was denied WCB benefits after being diagnosed with post-traumatic stress disorder (PTSD). *The Vancouver Sun* published part of a letter from WCB to the paramedic stating, "symptoms relating to stress or anxiety are not generally considered … to constitute personal injury. There must be evidence that an injury … arose out of and in the course of work."

A further barrier is that for post-traumatic stress disorder to be considered by WCB the result of workplace stress, there must be just one clear incident that caused the disorder. As Mr. Voight argues, research shows that PTSD can be cumulative, that is, result from a number of incidents that happen over time.

After his claim was refused, Mr. Voight tried to return to work and lasted only six days: a situation he says was not helped by the refusal of his claim. The irony of this situation is that he appears as a sufferer of the disorder in a WCB-produced training video educating BC paramedics about this condition.

## "Samantha"

"Samantha" is a nurse who works with Alzheimer's patients in Creston. She wrote to CMHA BC Division about her experience taking time off from work due to clinical depression. Because short-term disability was not available to her, she had to use all her sick days and then 21 days of unpaid leave. She then had to go on Employment Insurance, which paid only 50% of her wages. Also, she had to pay back some of her benefits as she had gone over the number allowed.

Samantha compared her situation to that of a pregnant woman who is allowed to take time off from work with pay and benefits, feeling that the same treatment should have been afforded her. She could not get disability to cover her time off work of one-and-a-half months; the only coverage available was for long-term disability of six months or longer.

Efforts have been made by Samantha to rectify her plight by writing her MLA, CMHA BC Division and the Nurses' Union.

## Anna

Anna, also from the East Kootenays, had been receiving a disability pension for two years but was unable to see her psychiatrist when it came time to ask for an extension on the claim. Her general practitioner wrote that she was severely depressed and unable to join the workforce, but because he was "only a GP," it was considered that his opinion didn't count.

Anna was given 90 days in which to get a psychiatrist's report, but could not get to see one before the end of that time, so was unable to get her disability cheques re-instated.

She has since returned to work, but in a lesser-paid position than her previous one. It is difficult for her to predict when she is going to go into a down time again, but she feels that her GP should be allowed to treat her and that his diagnosis should be validated.

## Conclusion

The commonality all the above cases share is that obtaining disability insurance for reasons of a mental health problem seems to be much more difficult than for a physical ailment. This situation speaks to the broader problems of stigma and misunderstanding. When someone has a bodily injury, it is visible, we can see it; when an individual is wounded emotionally, the symptoms are not often as apparent.

The impact of the denial of disability insurance claims was devastating to the lives of the four people featured here: in one case, death appeared to be a related consequence; in the others, symptoms of mental illness worsened. The record of providing adequate disability insurance benefits for psychiatric disorders has not been good. How many more have to suffer and die before we see change? ■

*Barb Bawlf*

*Barb is Coordinator of Consumer Issues and Peer Support at CMHA BC Division*

# Mental Illness and Human Rights

*Harinder Mahil*

*Harinder is Acting Chief Commissioner of the British Columbia Human Rights Commission*

Discrimination because of mental illness, or a history of mental illness, is a widespread social problem. While polite society recognizes that you do not refer to racial groups by racist names, or that jokes about a person's physical disability are considered in poor taste, derogatory references about people with mental illness are constant. Our language itself uses derogatory stereotypes of people with mental illness as generalized insults: "you're crazy," "he's nuts," and "weirdo" are insults we hear everyday. While this article focuses on discrimination against people with mental illness in employment, discrimination occurs equally in the provision of services and housing. Clearly, we are at a very early stage of changing society's attitudes towards people who experience mental disability.

## Box 1: Frequently Asked Questions

### What is Discrimination?

Discrimination is when a person is treated unfairly, harassed or denied something because of the group they belong to, or because they have a certain characteristic. Under the *BC Human Rights Code,* it is against the law to discriminate against someone because of any one or more of the following characteristics (these characteristics are called protected grounds):

- race (including colour, ancestry or place of origin)
- political or religious beliefs
- marital or family status (including being married or single, being a parent, or simply who you're related to)
- physical or mental disability
- sex (being female, male or transgendered; pregnancy; breastfeeding in public)
- sexual orientation (being lesbian, gay, heterosexual or bisexual)
- age (where a person is between 19 and 65 years of age)
- a criminal record unrelated to their employment

### When am I protected from discrimination and harassment?

You are protected from discrimination and harassment when you are:

- at work
- applying for a job
- attending school or some other educational institution
- looking for a place to live
- renting or buying property
- wanting to access a service or buy a product that is available to the public

Under the *Code,* the Commission investigates complaints, creates public education programs and advocates for human rights. The BC Human Rights Tribunal, a separate agency, is responsible for the adjudication of complaints.

The *BC Human Rights Code* is intended to foster a society where everyone enjoys full and free participation in the economic, social, political and cultural life of British Columbia. As important, the *Code* promotes a climate of understanding and mutual respect where all are equal in dignity and rights. Under the *Code,* discrimination is prohibited under a number of grounds, including physical and mental disability, where mental disability is meant to include a person with a mental illness. (See Box 1, above).

Before someone can use a human rights protection system, they must know a system exists and that it is there to help them address the discrimination they struggle against. Unfortunately, most people with mental illness are so used to discrimination that they often don't recognize it as discrimination when it happens. They do not necessarily know that there is a system that can help. As a result, the number of complaints brought to human rights commissions from people with mental illness represents just the tip of the iceberg.

The Commission has experienced an increase in complaints filed on the basis of mental disability in the past year. Still, it is difficult to generalize about the types of employment-based complaints brought by people with mental illness. As with all forms of discrimination, each complaint is unique, as is each potential remedy. When thinking about types of discrimination, what is most important to remember is that all individuals have rights to fair treatment in the workplace. Under the *Code*, workers have the right to work free of harassment, including freedom from harassment based on a mental illness. A person with a mental illness cannot be denied employment unless the employer can demonstrate that a job has certain specific requirements the person cannot meet. Once hired, they cannot be denied opportunities and/or promotions unless, again, it can be demonstrated that they cannot do the job because of their mental illness. (For examples of recent complaints brought forward by people with mental illness, see Box 2 on the opposite page).

In addition, an employer has a duty to reasonably accommodate a person with a disability, including a mental illness, up to the point of "undue hardship" to the employer. To determine undue hardship, a number of factors may be considered including the accommodations' cost, the size of the company's workforce and safety considerations. Accommodating a person with a mental illness can mean different things in different situations. It may mean an employer must provide additional training, adjust work schedules or even re-structure a job. While the Commission is there to address discrimination, there is no question that the human rights enforcement system is difficult to navigate. As a result, many victims of discrimination, whether because of race, or sex, or a disability such as a mental illness, do not exercise their right to file a complaint (To learn about the process if you do file a complaint, see Box 3 on the opposite page).

To begin with, the human rights complaint process is complainant driven. This means that victims of discrimination, or the people who can act for them, must approach the Commission to tell us their experience. This requires a level of functioning that a person with a mental illness may not have at the particular time they experience discrimination. Another barrier is that the system is quite formal, generally requiring a high level of written and oral communication skills. Mental illness often interferes with these skills and, ▶

although every reasonable effort to assist people is made, the system can be frustrating.

Before a complaint can be accepted, a complainant must be willing to talk to Commission staff about their mental illness. Naturally, many people are not comfortable talking about their illness to strangers. They have an understandable reticence about discussing personal experiences with strangers and a reasonable fear about the stigma attached to people with mental illness. Added difficulties are created when investigation requirements may make it necessary to seek independent medical information about the complainant. Often, the other parties involved in the complaint must be provided with this information.

## Box 3: The Complaint Process

**Inquiry**
A complaint must be filed within one year of the last alleged contravention of the *Code*. When someone contacts the Commission with a complaint, an initial assessment of the complaint is undertaken to determine whether it falls under the *Code*. If the complaint appears to fall under the *Code*, a complaint form seeking more detailed information is provided to the person making the complaint.

**Intake**
The completed complaint form is reviewed to determine if the complaint does, in fact, fall under the *Code*. If the Commission can assist, the complaint is referred to a Human Rights Officer for investigation. If the complaint falls outside the *Code*, the complaint is dismissed.

**Mediation**
The Commission will offer to assist the parties (the complainant and the respondent) to settle the complaint through mediation. As long as the parties are willing to mediate, mediation can take place anytime during the intake and/or investigation process. If a complaint is settled through mediation, the complaint file is closed and no further action is taken. If a complaint is not settled, it is referred to investigation.

**Investigation**
During an investigation, the Human Rights Officer gathers evidence from the parties and from any other witnesses who may be available. A written report summarizes the evidence and recommends whether the complaint should go forward to the BC Human Rights Tribunal for a hearing or be dismissed. Both parties have the right to review the investigator's report to provide comments and any additional information they might deem relevant prior to the report going forward. Once a decision is made, both parties are informed in writing. If a party disagrees with the decision, they can ask that the decision be 'reconsidered' or reviewed.

**Hearing**
Hearings are conducted by an independent agency called the BC Human Rights Tribunal. If a complaint is referred to the Tribunal for a hearing, the Tribunal informs the parties of the required next steps. Depending on whether they meet eligibility requirements, legal aid services may be available to the parties.

**Remedies**
The following are some common remedies in settlements or when the Tribunal finds that discrimination occurred: a letter of apology; money for lost wages, expenses and hurt feelings; job reinstatement, promotion or whatever was denied due to discrimination; and/or implementation of an employment equity plan or human rights training by the employer.

## Box 2: Recent Canadian Human Rights Cases

- **In Mager v. Louisiana-Pacific Canada Ltd.**, the complainant was a victim of sexual assault. She became morose on the job and experienced a long period of clinical depression. She told her employer and union about the symptoms but did not say she had a disability or a medically-defined condition. The employer took little notice and offered a settlement known as a "technological change permanent lay off" which happened to be available at the time. The Tribunal found that the employer ought to reasonably have known there was a serious problem and provided greater assistance to the complainant within the context of its existing benefit system. With minimal effort, the employer could have provided options to assist the complainant. Failure to do so was discrimination.
- **In Zaryski v. Loftsguard and Percival Mercury Sales,** a complaint at the Saskatchewan Human Rights Commission, the complainant had a work history of expressing her unhappiness, lack of concentration, and personal problems. One day, after acting in an inappropriate manner with another in *Gibbs v. Battlefords and District Co-operative Ltd.*, the complainant developed a mental illness and had to take time off. She was covered by a long-term disability plan. However, the plan provided for two years coverage for employees unable to work due to a physical disability but only one year for people unable to work because of a mental disability. Eventually the case worked its way to the Supreme Court of Canada. There, the Court said the underlying rationale for the insurance plan was to provide income replacement for those unable to work because of disability. The distinction between people with physical and mental disabilities was discrimination. The Court noted that the limit on benefits appeared to be grounded on stereotypical assumptions concerning the behaviour of mentally disabled persons.
- **In Thériault v. Outaouais-Hull School Board,** a decision of the Quebec Human Rights Tribunal, the complainant was a teacher. His doctor advised him to take some sick leave because he was suffering depression. After an extended leave, he wanted to return to work. The School Board and his doctor disagreed on the condition of his mental health. To resolve this, the parties agreed that an independent expert would examine him. That doctor reported his opinion that the complainant had a paranoid personality and his condition should be considered permanent. The School Board terminated his employment. The Tribunal found that the medical evidence was credible and was such that he was unfit for employment as a teacher. The Tribunal found that teachers are in a position of influence and trust in relation to their students. They are also inextricably linked to the integrity of the education system. The Tribunal determined that there was no way to reasonably accommodate the complainant's medical condition. The complaint was dismissed.

Given the barriers that a person with a mental disability faces when struggling against discrimination, it is vital that parents, guardians and advocates who support people with mental illness inform themselves about human rights. Supporters can help the person identify discriminatory actions, do the things needed to file a complaint, and assist the person to navigate the human rights process. They can provide the moral support victims of discrimination often need to press forward with their discrimination complaints.

It's important to remember that the human rights process is one avenue for a person whose rights have been denied; other avenues do exist. Often the most effective outcome occurs when the human rights process is combined with support from other organizations and individuals. The Commission urges people to bring forward their discrimination concerns. If communities work together, people with mental illnesses will gain much needed and long-overdue improvements in human rights protection. ■

*For further information, or if you believe you may have a discrimination complaint, call (604) 660-6811 or toll free 1-800-663-0876 or visit the Commission's web page at www.bchumanrights.org*

# Risks and Protections for Employees with Mental Illness:

## Catch-22s of Getting and Staying Employed

*Dulcie McCallum*

*Dulcie is a lawyer and the former Ombudsman of British Columbia. She is also an Honourary Patron of CMHA BC Division*

Under current legislation and case law, employers have a duty to care for their employees who become ill while they are employed. Employers provide short and long-term benefits to their employees in the event of illness. These benefits are provided under employer-funded insurance plans often referred to as STIIP for short-term disability (less than six months) and LTD for long-term disability (more than six months). If the illness or injury, however, occurs as a direct result of the work, the benefits are provided under Workers' Compensation, a compulsory compensation scheme established by legislation for workers injured on the job.

Human rights legislation protects employees against discrimination in the workplace. This means that people are protected against being refused the opportunity to work or denied equal treatment in the course of their employment on the basis of mental disability. Mental disability includes any diagnosis that can be characterized as a mental illness. In fact, employers are under a duty to accommodate an employee's disability in their employment so long as that accommodation does not place the employer under an "undue hardship" (see the previous article for a definition).

That means that individuals who have had a mental illness and apply for a position and people who become mentally ill while working should not be refused work or fired after they are employed simply on the basis of having an illness such as depression, bipolar disorder, anxiety, or schizophrenia. There are three possible scenarios to consider where a person with mental illness tries to gain or maintain access to employment; in each of these are risks for the (prospective) employee and legal protections may need to come into play.

### SCENARIO ONE:
### A person with a prior history of mental illness being denied work

The first possibility is that a person with a history of mental illness may be denied entry into the workplace. People who have a disability may be invited to declare the nature of their disability at the time of application for work. By law, however, this information is not to be considered by the employer in the course of considering the individual's application. In more progressive places of work, such information is documented separately from the hiring process and is not considered until the person has been short-listed and the employer is in a position to determine the cost of making disability-related accommodations to the workplace or job task.

### SCENARIO TWO:
### A person who develops a mental illness as a direct result of working conditions

The second possibility is that a person suffers from stress, anxiety or depression as a direct result of work conditions. This person may also require leave from work and could try to make a Workers' Compensation claim. The risk of taking this course of action is to appear to be criticizing the employer's workplace as an environment that causes emotional and psychological harm to its employees. This may have serious consequences for the employee and his or her relationship with the employer.

### SCENARIO THREE:
### A person who experiences mental illness after they start employment

The final possibility is that a person experiences mental illness while in a job, where the illness is not considered to be a direct result of the working conditions. In this case, the risk for the employee is that in making an application for disability benefits, the individual is forced to divulge information on the insurer's required medical documentation that comes into the hands of the employer (or to future employers). Insurance companies who fund benefit schemes are becoming increasingly demanding of employers to provide detailed documentation to justify the claim being paid. With this information, the employer might then try to fire the person while on short or long-term disability on the basis that the mental well-being of the employee is required in order to fulfill their obligations as an employee or supposedly to protect co-workers. Case law helps us understand how these issues may play out in the courts in "real life."

The *King v. CDI Career Development Institutes Ltd.* tribunal decision out of Saskatchewan found that Ms. King was terminated, at least in part, because she had a mental disorder (panic/anxiety attacks). The employer was forced to pay $2,000 in compensation for mental anguish and $2,000 for injured feelings resulting from the termination. There was no order to reinstate her in her job; the reasons given do not make it clear why.

*Watt v. Foster* is an interesting case in BC this year, where an employee with a mental health issue was terminated because of the employer's claim that mental well-being was a "bona fide occupational requirement" (i.e., that mental well-being was necessary to do the job). The ruling supports a claim for compensation for the harm resulting from the termination itself. The ruling also ▶

indicates that an order for production of medical records can be given, if those records relate to the employee's claim of a history of mental illness, where this is at issue. An interesting counter-claim by the person claiming discrimination was to apply for employer records regarding the employee's supervisor's mental health to gain insight on the legitimacy of the employer's claim, in an attempt to flush out a possible corporate double standard.

## CONCLUSION:
### The 'catch-22' of disclosing mental illness

Unfortunately, life for a person with a mental illness doesn't always unfold fairly as it would for a person who has a physical ailment. The reality is that our communities continue to stigmatize people labelled mentally ill, and as a result, many people who have a mental illness deny any attachment to that label and do not ask for accommodations in the workplace. On the other hand, others may be upfront about the nature of their problem and declare it as a situation they must live with and trust that employers will honour their responsibilities to hire or make accommodations for them in the same way they would for a person with a physical disability or disease.

One is quickly struck by the seemingly impossible situation or catch-22 a person with mental illness finds her or himself: declare and demand accommodation and take the risk of being denied even the opportunity to work; remain silent at the outset or have the onset of the illness on the job and in laying claim to short or long-term disability, take the risk of being fired; or the worst of all, remain silent in order to try to keep the job, thereby denying yourself sick-leave benefits or on-the-job accommodation. If these choices are not already overwhelming for all of us to consider, imagine having to try to decide when you already suffer from all-consuming anxiety or depression.

The stark reality is that many cases of discriminatory practices against people with a mental illness go unchallenged and unnoticed. This is often because the people involved are very ill and not in a position to protest, they fear retaliation or they are too embarrassed. A comprehensive program of education is required by such organizations as CMHA to ensure employers understand their obligations and gain a full appreciation for the true nature of mental illness. Only then will employees rest in the knowledge that their mental health will be protected and their rights respected. ■



## Resource List

### Supported Employment

**Best Practices for BC's Mental Health Reform: Psychosocial Rehabilitation and Recovery**. Report and factsheets available from CMHA BC Division.

**CMHA National's "Routes to Work" Project.** The links section features sites on job-search strategies, job postings, skills development, educational upgrading, volunteering and accommodations: www.cmha.ca/english/routes/home.htm

**International Association for Psychosocial Rehabilitation Services:** www.iapsrs.org

**Center for Psychiatric Rehabilitation, Boston University:** www.bu.edu/cpr/

**The Matrix Institute:** www.matrixresearch.org/jsindex.html

**Planning Processes for Providing Supported Accommodation for People with Mental Illness.** New Zealand Mental Health Commission: www.mhc.govt.nz/mhc_Pubs.htm#2000

**Mental Health, Employment and Training: A Report from The UK Mental Health Foundation:** www.mentalhealth.org.uk/html/content/employtrain.cfm

**The Employment Intervention Demonstration Program Coordinating Center:** www.psych.uic.edu/eidp/

**National Mental Health Association (US), Fast Track to Employment: Model Program:** www.nmha.org/pbedu/schizophrenia/model/fasttrac.cfm

**THEO BC:** www.theobc.org

**Coast Foundation:** www.coastfoundation.com

**Mental Health Works.** CMHA Ontario Division: www.ontario.cmha.ca/mhic/MHWorks/mhworks.html

**'Making It Work' Policy Framework for Employment Supports for People with Serious Mental Illness.** Government of Ontario: gov.on.ca/health/english/pub/mental/pfes_e.pdf

**Employment and Mental Health: Issues and Opportunities.** New Zealand Mental Health Commission: www.mhc.govt.nz/Publications/Publications/Employment.pdf

## Job Search and Educational Upgrading

**Top 100 Internet Sites for Learning and Employment:** HRDC: www.jobboom.com/conseils/top-100.html

**YouthOptions BC.** Provincial Government: www.youth.gov.bc.ca

**Opening Doors.** A BC post-secondary guide: openingdoorsbc.com

**Seeking Employment**. MIND (UK): www.mind.org.uk/information/factsheets/E/Employment/Employment.asp

**Diversity World: Enriching Workplaces and Employment Barriers:** www.diversityworld.com/disability.htm

**RecruitABILITY!** For job seekers with disabilities: www.disabledperson.com/recruitability.asp

**WorkInk.** Canadian Council on Rehabilitation and Work's virtual employment resource centre: www.workink.com

**Canada's Network for Entrepreneurs with Disabilities:** www.entrepreneurdisability.org

**www.worksupport.com:** offering resources connecting employers with qualified individuals who have disabilities. A similar service offered at **worktechsolutions.com**

**Beneficial Realities of Volunteer Employment**. National Alliance for the Mentally Ill: www.nami.org/about/volunteer.html

## Mental Health in the Workplace

**Best Advice on Stress Risk Management in the Workplace.** Health Canada: www.hc-sc.gc.ca/hppb/ahi/workplace/pdf/stress_risk_management_2.pdf (part of a workplace health series at www.hc-sc.gc.ca/hppb/ahi/workplace/resources.htm)

**Mental Health in the Workplace.** UK Mental Health Foundation: www.mentalhealth.org.uk/html/content/bkworkplace.cfm

**Employment Advice for Employers or Employees Experiencing Difficulties or People Wanting to Work.** MIND (UK): www.mind.org.uk/information/single.asp?topic=Employment

**Mental Health in the Workplace Policy Papers.** MH Foundation of New Zealand: www.mentalhealth.org.nz/policy.asp

**The Economic Burden of Mental Health Problems in Canada.** Stephens & Joubert, Health Canada: www.hc-sc.gc.ca/hpb/lcdc/publicat/cdic/cdic221/cd221d_e.html

**Mental Health and Work.** Employment kit based on World Mental Health Day 2001 theme: wfmh.org/wmhday/toc.html

**Labor Day 2001 Report.** National MH Association (US): www.nmha.org/pdfdocs/laborday2001.pdf

**Mental Health and Work Report.** International Labour Association: www.ilo.org/public/english/employment/skills/targets/disability/index.htm

**Mental Health in the Workplace** factsheets. MH Association of Ireland: mhai.healthyirish.com/mentalworkplace.html

**Depression in the Workplace** factsheets. NIMH (US): www.nimh.nih.gov/publicat/workplacemenu.cfm

**Employer Checklist.** New Zealand Mental Health Commission: www.mhc.govt.nz/Publications/Publications/Employment_Checklist.pdf

**Canadian Business and Economic Roundtable on Mental Health.** Reports: www.mentalhealthroundtable.ca

## Recruitment and Accommodations

**Employer Tips on Recruiting People with Disabilities:** www.disabledperson.com/RecruitABILITY/emptips.htm

**Tapping the Talents of People with Disabilities:** www.conferenceboard.ca/pdfs/disability.pdf

**The Duty to Accommodate in the Canadian Workplace:** 216.13.114.21/workink/national/Lynk/lynk.htm

**Accommodation Ideas for Persons with Psychiatric Disabilities:** www.jan.wvu.edu/media/Psychiatric.html

**Personal Assistance Services for People with Psychiatric Disabilities:** www.worksupport.com/Main/proed10.asp

**Directory for Accessibility.** Ontario March of Dimes: 209.227.217.26/dbsearch/public/searchpage.cfm

**Reasonable Accommodations for Mental Illness:** www.bu.edu/cpr/jobschool/whatareRAs.html

**Paths to Equal Opportunity.** Government of Ontario: www.equalopportunity.on.ca

Resource List



CANADIAN MENTAL HEALTH ASSOCIATION
L'ASSOCIATION CANADIENNE POUR LA SANTÉ MENTALE
BC Division
1200 - 1111 Melville St.
Vancouver BC, V6E 3V6