BUILDING AN EQUITABLE FOUNDATION:

Removing barriers to access for people with
mental health and substance use-related disabilities

FINAL REPORT

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Building an Equitable Foundation: Removing barriers to access for people with mental health and substance-use related disabilities

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Written by: Kendra Milne and Amelia Hamfelt

Legal research support by: Raji Mangat and Kate Feeney

Designed by: Justyna Krol

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Canadian Mental Health Association
Mental health for all

100 years of community

905 – 1130 West Pender Street,
Vancouver BC, V6E 4A4
Tel: 1-800-555-8222
www.cmha.bc.ca

The CMHA BC office is located on the traditional, unceded lands of the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish) and sə̓lilwətaʔɬ (Tsleil-Waututh) Nations

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EXECUTIVE SUMMARY

We know that mental health begins where people work, live and play, but all too often conversations about mental health focus on hospitals and healthcare for people who are experiencing a crisis. What would it take for each and every person to have an equal chance at being mentally well? How do we move from illness to wellness? People need more than access to healthcare to achieve positive mental health.

International human rights and health research tells us that we need a solid foundation of basic necessities such as income, housing, food and meaningful employment to enjoy mental wellness.

Without this foundation, people experience higher rates of mental health and substance use-related illness, requiring access to more intensive health and social services.

Unfortunately, the systems in place to support those impacted by mental illness and problematic substance use can exclude the people they are supposed to help. The skills needed to access services are the same skills that are often impacted by mental illness.

International human rights agreements acknowledge that our right to basic necessities and our right to health are related to and dependent on each other—you cannot enjoy one right without the other. This foundation of mental well-being is recognized all over the world in international human rights law as key to our overall health.

Research on what determines health outcomes for people with mental health and substance use-related conditions similarly lays out the relationship between having basic needs met and experiencing good health.

Multiple factors from housing to income to employment influence the ways a person can experience either the health promoting effects of social inclusion or the harmful effects of exclusion.

If a person has friends and healthy relationships, feels they are a part of a community and can meet their basic needs, they are less likely to experience anxiety, depression or problematic substance use. Conversely, people in recovery who are living with mental illness or problematic substance use are deeply impacted by barriers they face getting and keeping the resources and relationships they need to feel included. In other words, social inclusion and the factors that either promote it or deny it are important to having an equal chance at mental wellness.

People already experiencing some form of exclusion or marginalization, including people who experience discrimination on the basis of indigeneity, gender, race or disability, face additional barriers to inclusion that overlap to worsen and add to unequal conditions. This is especially true for Indigenous people in BC, who have experienced dislocation from land, culture, family and community as a result of historic and ongoing colonization. Such dislocation shows up as insecure income, housing and employment. Dislocation excludes and isolates them from their communities and society at large, and contributes to inequitable health outcomes.

Unfortunately, the very systems in place to support those impacted by mental illness and problematic substance use—like income, housing and employment supports—can exclude the people they are supposed to help. The communication and organization skills needed to access services are the same skills that are often impacted by mental illness and problematic substance use.

Confusing application procedures and overly strict eligibility criteria can exclude people from BC public services because of their mental illness or substance

use-related symptoms and other aspects of their disability. People who are unable to apply because of their health-related limitations never get a chance to access such services unless they have someone else to help them. People who do access services such as affordable housing or income supports may not be able to maintain them because of their symptoms of illness and the ways services are designed.

People living with a mental illness or substance use-related disability require access to fair and equal services that respond to their disability-related needs. They need assistance to overcome any barriers they face. BC public service providers, including the provincial government, are required to provide services that are accessible to people with disability-related needs, unless there is a justifiable reason they cannot. To fail to give equal and fair access to services or meet the needs of people with disabilities without an adequate reason is discrimination.

That's why CMHA BC is committed to improving access to our public services and promoting social inclusion. In this report, we focus on subsidized and supported housing, disability assistance and WorkBC employment supports because of how important they are for building a foundation for wellness.

This focus is supported by our community research with BC residents, who have lived and living experience of a mental health or substance use-related health issue. We asked them whether they had access to public services and, if they did not, how it impacted their mental health, well-being and use of substances. Many people very clearly told us that barriers to accessing services impacted their ability to build a solid foundation for improving their health, or relationship with substances.

They reported that while some service providers went above and beyond to meet their disability-related needs, the majority did not because the system does not create conditions for providers to respectfully respond to and help the people who access their services. Many felt that being unable to access these services created health set backs, not only curbing their desire for and ability to achieve independence, but also keeping them tied to a system that causes them shame and further worsens their already poor health.

CMHA BC used what we learned from the expertise of people with lived and living experience, combined with research, to develop practical recommendations to better support the foundation of mental wellness for people with mental health and substance use-related disabilities in our province. The 12 recommendations that follow outline necessary steps for BC to continue its recent progress and achieve accessible pubic services for those in need:

HUMAN RIGHTS

1. **The BC Human Rights Commission should audit the laws and policies governing the provision of social services** to identify and eliminate accessibility barriers that prevent or dissuade people with mental health and substance use-related disabilities from obtaining the supports and services they are eligible for.

2. **Alternatively, the Ministry of Mental Health and Addictions should establish an independent Mental Health Advocate to monitor the performance of public services** that impact people with mental health and substance use-related health issues, receive and act on systemic disability-related complaints and protect the human rights of people living with illness who access services.

3. **The Ministry of Social Development and Poverty Reduction should ensure that its commitment to develop and pass comprehensive accessibility** legislation will go beyond physical notions of accessibility and ensure that people with invisible disabilities, in particular people with mental health or substance use-related disabilities, can fully participate in their communities.

HOUSING

4. **Relevant public bodies should continue to build additional affordable housing that offers a flexible and progressive range of supports** specifically designed for people with mental health or substance use-related disabilities. For example, a person should have the option to move from a group home with on-site staff to an apartment managed by a local mental health non-profit as their health improves and if they chose to do so.

5. **The Ministry of Municipal Affairs and Housing should develop a neutral, easy-to-use process for tenants to identify and voice their tenancy and assistance needs**, with a focus on clients that might experience disability-related barriers doing so on their own (for example, clients in supportive housing arrangements). The service should be contracted out to be delivered by a low-barrier community-based

organization where people with disabilities already access services.

6 **The Attorney General should create a legal means to consider tenancy and anti-discrimination rights** under the BC Human Rights Code when they are raised before the Residential Tenancy Branch. This could include a process for the BC Human Rights Tribunal to issue interim orders once a human rights complaint has been filed, and amendments to the Residential Tenancy Act that allow for an interim delay in a residential tenancy dispute when such an interim order has been issued.

DISABILITY ASSISTANCE

The Ministry of Social Development and Poverty Reduction should implement changes to BC's social assistance programs and access centres, and increase funding to non-governmental agencies to provide or considerably enhance advocacy and support services that assist people with mental health or substance use-related disabilities in completing applications, including:

7 **Continue steps to simplify and improve the income and disability application processes** with the Ministry's own disability-related "daily living activities" (e.g., decision-making or communicating effectively with others, etc.) in mind. In particular, the application should only collect information that is necessary and relevant; avoid asking for the same information twice; and not focus solely on deficits, but allow applicants to identify positive qualities, abilities or activities such as volunteering without impacting eligibility.

8 **Train frontline Ministry workers in trauma-informed service provision to ensure people who access services are treated with compassion, patience and understanding.** The training may include education on mental health-related barriers and stigma reduction provided by people with lived or living experience of illness and of accessing assistance.

9 **Provide funding for case managers and peer navigation staff in community organizations that serve people with mental health and substance use-related disabilities** and complex issues such as homelessness to help them gain access to the system. Trained people with lived or living experience should fill these roles wherever possible to ensure low barrier, empathetic and responsive services.

WORKBC EMPLOYMENT SERVICES

10 **The Ministry of Social Development and Poverty Reduction should align the provision of WorkBC's customized employment (CE) program with the Individual Placement and Support (IPS) model** that prioritizes strengths-based, rapid job search and placement, and reduce barriers to entering the program for people living with mental health or substance use-related disabilities, such as repeat information gathering and skills assessments.

11 **The Ministry of Health in partnership with health authorities and the Ministry of Social Development and Poverty Reduction should integrate the modified CE program within primary care networks** and specialist mental health teams to ensure clients receive wrap-around supports that meet their needs.

12 **The Ministry of Social Development and Poverty Reduction should include mental health and substance use-related accommodations in accessibility guidelines** given to WorkBC service providers such as varying levels of privacy and openness in waiting or self-serve areas, flexibility in pace and frequency of programs, and mental health literacy training for all staff.

INTRODUCTION

How can we all have an equal chance to achieve our best mental health? Too often mental health and substance use is seen as synonymous with the individual. Initially, and for a considerable amount of time thereafter, pervasive stigma meant that mental illness or an unhealthy reliance on substances was viewed through a moral lens and understood to be a character flaw or a defect of the person. We have progressed since then to view mental health and substance use-related problems as health issues, but illness still tends to supersede the person and we look towards medical care as the primary or sole response. Yet all people have mental health and use substances, and only some develop problems that lead to chronic, at times disabling, conditions.

We all need a foundation to cultivate and maintain our best mental health. Health equity refers to the recognition and elimination of systemic disparities or differences in the health of different groups of people.[1] All people should have equal opportunity to access what they need to be healthy, which requires acknowledging and dismantling barriers that deny or restrict some groups from attaining health. A core concept of health equity is recognizing that systems themselves often create health disparities and can have far more influence on health outcomes then individual biology or decision-making.[2] Equity also recognizes that people who experience systemic barriers or marginalization need to be treated differently to attain a meaningful, equal opportunity for their best health simply because they face different obstacles than those who do not experience the same marginalization.[3]

In the context of mental health and substance use, equity means that we remove systemic barriers and provide tailored supports when necessary so that every person has a meaningful opportunity to achieve their best mental health and to have a healthy relationship with substances. While removing barriers related to accessing health and medical services is important, a vast body of interdisciplinary health research confirms that people also need a number of other material and social conditions to be well and recover from illness.[4] These conditions are commonly referred to as the social determinants of health.

Public services such as subsidized housing, income assistance and benefits, and employment supports address key determinants for health and have the potential to lessen health disparities for those who are marginalized.

International human rights agreements formulate the underlying principles of public services, recognizing that we all have an equal right to our best physical and mental health, and that right can only be fulfilled if we have an equal right to an adequate standard of living, housing, healthy occupational and environmental conditions, and all other social determinants. In other words, our human rights, what each and every one of us is entitled to have based on our shared humanity, parallels the material and social conditions that, in part, determine our mental health and use of substances. With this understanding, governments that enter into human rights agreements have an obligation to provide public services that span both social and health care to address systematic disparities and prevent rights violations.

If we look around at the people of our province, however, we will find examples of health inequities and violations of human rights. We will see many people living with mental illness and problematic substance use; in particular, those who experience other forms of exclusion and discrimination on the basis of personal characteristics such as race, indigeneity, gender or migration status. Still more people live in poverty without sufficient income, housing or employment, and at high risk of developing a mental health or substance use-related condition. BC's public services can and should do more to uphold the rights and improve the health outcomes of its population.

There has been progress. The BC government has taken concrete steps to address inequities and provide more accessible public services to those in need. The Poverty Reduction Strategy, TogetherBC, released in 2019, identified the importance of improving both the social and material conditions of people living in poverty and outlined a series of policy actions that range from increasing affordable, stable housing, with a particular focus on people experiencing homelessness, to amending employment supports to better meet the

1 Braveman, P & Gruskin, S. (2003). *Defining equity in health*. Journal of Epidemiology and Community Health, 57:254–258.

2 Braveman supra note 1.

3 Note the terminology related to equity and equality can be confusing. The public health system refers to "equality" to describe applying the same system or approach to everyone regardless of their needs, while "equity" refers to creating systems or approaches that recognize specific needs and barriers of traditionally marginalized groups and respond to those needs with potentially differing treatment in order to create meaningful, equal opportunity. The human rights system uses the term "equality" to cover both concepts, but distinguishes between formal equality (treating everyone the same regardless of differing needs or barriers) and substantive equality (recognizing that systems may need to treat people differently based on their different needs or barriers in order to level the playing field). In this project, we will use the term "equity" to refer to the latter concept.

4 CMHA BC. (2019). The Social Determinants of Mental Health and Substance Use: A Literature Review. Retrieved from: www.cmha.bc.ca

complex vocational needs of people with disabilities, to re-establishing the Human Rights Commission and introducing new accessibility legislation. Such actions are needed and necessary for equitable public services, but are only the beginning. More remains to be done.

What are truly equitable public services? How can we achieve them here in BC? This report endeavours to explore these questions. While neither conclusive, nor definitive, the content that follows offers some possible ways forward by both reframing how we think about the causes and treatments of mental illness and problematic substance use, and recommending how our public services can be more inclusive, equitable and accessible to those in need. We are greatly indebted to the many people living with illness who shared their stories and illuminated the stark lived realities hidden within more theoretical policy, legal and public health research. Our central takeaway is that supporting people to live with dignity and fostering meaningful social inclusion through policy interventions and public services is the single most effective means to support people to achieve their best mental health, uphold their human rights and strengthen the foundation that prevents the erosion of both.

THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

Human rights provide a useful framework for understanding health equity. Internationally, many countries have entered into formal agreements to solidify their commitment to protect the human right to health. These international agreements create binding legal obligations for state parties, with international enforcement mechanisms. They also express important normative commitments about what people need to live with dignity. Since their origin in the aftermath of World War II, international human rights agreements have recognized an equal right to health, or health equity, as a core foundation of living with human dignity.

As early as 1947, international discussions concerning the creation of the World Health Organization recognized the necessity of an equal right to health and early discussions expressly contemplated the need to ensure equity with respect to both physical and mental health.[5] The commitment to the human right to the highest attainable standard of health, and mental health in particular, was most distinctly set out in the International Covenant of Economic, Social and Cultural Rights ("ICESCR").[6] That Covenant, which Canada ratified in 1976, sets out the following in Article 12:

> 1. The States Parties to the present Covenant [like Canada] recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Previously, the Universal Declaration of Human Rights,[7] proclaimed by the United Nations General Assembly in Paris on 10 December 1948, established a common standard of achievements for all peoples and all nations, and laid the foundation for state ratified agreements such as the ICESCR. It set out, for the first time, fundamental human rights to be universally protected. Specifically, Article 25 states:

> 1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Since then, variations on the right to the highest attainable standard of health have been protected in a number of other international human rights agreements in addition to the ICESCR, including the International Convention on the Elimination of All Forms of Racial Discrimination (Article 5(e)(iv));[8] the Convention on the Elimination of All Forms of Discrimination against Women (Articles 12 and 10(f));[9] the Convention on the Rights of the Child (Article 24);[10] and the Convention on the Rights of Persons with Disabilities (Article 25).[11]

The Declaration on the Rights of Indigenous Peoples ("UNDRIP") also sets out equity-based principles that promote the fulfilment of health-related rights, referencing the legacies of colonization and dispossession that have resulted in vast health disparities between Indigenous and non-Indigenous persons within the same state. Specifically, Article 24 states:

> 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals

5 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. Canada was one of the original signatories on 22 July 1946 and indicated its acceptance on 29 August 1946; also see annex 23, at p. 70.

6 International Covenant on Economic, Social and Cultural Rights, 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976). Canada acceded to the ICESCR on 19 May 1976 and it took effect on 19 August 1976. The ICESCR has been ratified by 169 countries and signed (but not yet ratified) by a further 71.

7 *The Universal Declaration of Human Rights*, 10 December 1948.

8 *International Convention on the Elimination of All Forms of Racial Discrimination*, 07 March 1966, 660 UNTS 1 (entered into force on 4 January 1969). Canada signed CERD on 24 August 1966 and ratified it on 14 October 1970.

9 *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, 1249 UNTS 1 (entered into force on 3 September 1981). Canada signed CEDAW on 17 July 1980 and ratified it on 10 December 1981.

10 *Convention on the Rights of the Child*, 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990). Canada signed the CRC on 28 May 1990 and ratified it on 13 December 1991

11 *Convention on the Rights of Persons with Disabilities*, 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008). Canada signed the CRPD on 30 March 2007 and ratified it on 11 March 2010

and minerals. Indigenous individuals also have the right to access, without any discrimination, all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.[12]

The inclusion of a health-related right in UNDRIP that is connected to and interdependent with cultural, social and economic rights recognizes how colonialization has disrupted the practice of Indigenous traditions in ways that detrimentally impact health and social well-being. It also requires states parties to uphold the rights of Indigenous peoples through the provision of social and health services that protect and prioritize self-determined health and healing practices. The latter call to action is situated within the broader context of UNDRIP that foregrounds Indigenous peoples' rights to self-determination and land sovereignty.

All the international human rights agreements that include a health-related right recognize that health inequities exist between certain groups of people within and across countries, and that states have an obligation to both acknowledge and take steps towards addressing them by providing equitable public services.

MENTAL HEALTH REQUIRES MORE THAN HEALTH OR MEDICAL SERVICES

What does the right to the highest attainable standard of mental health mean in practice? The right to the highest attainable standard of health is not a stand-alone "right to be *healthy*,"[13] which may be influenced by both systemic conditions and individual biological and lifestyle factors. Instead, the right relates to material and social conditions that are crucial to realizing positive mental health – it is essentially the right to the best health possible for each individual. The right encompasses both the right to enjoy appropriate health care, including the right to control one's own health and body,[14] and the right to access what one needs to live a healthy life, which extends well beyond access to health services and includes other social determinants of health.[15]

A key foundation of human rights law is that all rights are interdependent, indivisible and interrelated[16], meaning that they cannot be fully enjoyed individually, rather each right is necessary to the full enjoyment of all rights. The Committee on Economic, Social and Cultural Rights ("CESCR") has developed a guiding document called General Comment No. 14 to outline a framework for understanding the right to the highest attainable standard of health.[17] It states in part:

> The right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, assembly and movement. These and other rights and freedoms address integral components of the right to health. [18]

The right to health is not limited to access to medical care; instead, it encompasses the underlying determinants of health, or the material and social conditions necessary to have an opportunity to maximize health and wellness. These underlying determinants often include access to safe and potable water, adequate sanitation, adequate food, housing, healthy occupational and environmental conditions, and access to education and information.[19]

12 UN General Assembly, United Nations Declaration on the Rights of Indigenous Peoples, 13 September 2007, UN Doc. A/RES/61/295 (adopted by majority of 144 states in favour, 4 against and 11 abstentions).

13 General Comment No. 14 at para. 8

14 Article 12 grants rights-holders the freedom to control their own health and body and freedom from interference with their bodily integrity in the forms of torture, non-consensual medical treatment and experimentation. General Comment No. 14 at para. 8.

15 By way of illustration, General Comment No. 14 interprets Article 12 of the ICESCR as guaranteeing a "right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health." General Comment No. 14 at para. 8.

16 Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights, held in Vienna, 14-25 June 1993, UN Doc. A/CONF.157/23.

17 CESCR, General Comment No. 14 on the right to the highest attainable standard of health. UN Doc. E/C.12.2000/4 (11 August 2000) ("General Comment No. 14).

18 General Comment No. 14 at para. 3.

19 General Comment No. 14 at para. 11.

The UN Special Rapporteur on the right to health has also highlighted the significance of socio-economic determinants of health in interpreting the scope of the right, stressing that states parties' obligations go much further than the provision of medical care. States are equally required to address the conditions that lead people to require medical care in the first place.[20] The Special Rapporteur has stated that "[e]quating the right to health with a right to medical care is a misinterpretation of international human rights law."[21] The Special Rapporteur has also critiqued the tendency of governments and international organizations to focus their attention and resources on medical care "at the expense of the underlying determinants of health."[22]

Beyond recognizing the close relationship between socio-economic conditions and the right to the highest attainable standard of health, the right also includes the right to services and supports that are available, accessible and of adequate and acceptable quality.[23] The CESCR has set out the core obligations of the right to the highest attainable standard of mental and physical health that states parties are obligated to ensure, which includes healthcare and many other services:[24]

a. To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

b. To ensure access to the minimum essential food that is nutritionally adequate and safe to ensure freedom from hunger for everyone;

c. To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;

d. To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;

e. To ensure equitable distribution of all health facilities, goods and services;

f. To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; that shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.

International human rights frameworks that set out our most fundamental rights demonstrate that having an equitable chance to maximize mental wellness requires much more than access to medical and health services. Mental wellness and positive relationships with substances require a solid foundation that includes adequate income, housing, employment and social inclusion. In order for BC to comply with Canada's obligation to ensure that everyone has an equitable right to their best mental health, the province must ensure that the services that support the conditions for wellness are in place and accessible to those who need them.

20 UN General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UN Doc. A/62/214 (8 August 2007) at para. 45. For a more comprehensive look at the social determinants of health and health equity, see CSDH (2008), *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*, Geneva, WHO.

21 Report of the Special Rapporteur at para. 46.

22 Report of the Special Rapporteur at para. 48.

23 General Comment No. 14 at para 12.

24 General Comment No. 14 at para 43.

A note about the human rights of people who use drugs

The right to the highest attainable standard of mental health of people who use illicit drugs is frequently violated by or runs into conflict with the international drug control regime, which has historically obligated states to criminalize people who use and possess drugs.[25] Over the past decade or so, however, a shift has begun at the international level. Drug control measures are increasingly being considered through a health and human rights framework that centers the dignity and well-being of persons who use drugs. Overly punitive approaches to drug control are increasingly being recognized as causing more health-related harms than they prevent. International agencies are realizing that persons who use drugs are entitled to the same rights guaranteed to all other people.[26]

The Special Rapporteur on the right to the highest attainable standard of health has been particularly vocal on the need for human rights to be integrated into the international response to drug control, including making harm-reduction measures and drug-dependence treatment services available to people who use drugs. The disproportionate focus on criminalization and law enforcement that has come with the "war on drugs" has and continues to create discriminatory barriers for people who use drugs in accessing a wide range of services that would benefit their health. Stigma associated with drug use and fear that personal information about drug use will be shared with law enforcement or the criminal justice system reinforce these barriers.[27] Discrimination and stigma can also have a negative impact on individuals' mental health and their relationship with substances.

A major obstacle to the accessibility of services for drug users is the criminalization of personal use and possession of drugs. CESCR,[28] the United Nations High Commissioner for Human Rights,[29] and the Special Rapporteur on the right to the enjoyment of the highest attainable standard of health[30] have all recommended that serious consideration be given to removing these obstacles to the enjoyment of this right, including by decriminalizing the personal use and possession of drugs.

25 Three treaties form the core legal framework of the United Nations international drug control regime: (a) the Single Convention on Narcotic Drugs (1961) as amended by the 1972 Protocol; (b) the Convention on Psychotropic Substances (1971); and (c) the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (1988).

26 UN GA, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (6 August 2010), UN Doc. A/65/255 at para. 8.

27 UN GA, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (6 August 2010), UN Doc. A/65/255 at paras. 22-24.

28 See, e.g., CESCR, Concluding observations on the combined fifth and sixth periodic reports of the Philippines, (26 October 2016), UN Doc. E/C.12/PHL/CO/5-6.

29 See, e.g., UN HRC, Study on the impact of the world drug problem on the enjoyment of human rights: Report of the United Nations High Commissioner for Human Rights (4 September 2015), UN Doc. A/HRC/30/65.

30 See, e.g., UN GA, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (6 August 2010), UN Doc. A/65/255.

HUMAN RIGHTS APPROACH ALIGNS WITH PUBLIC HEALTH RESEARCH

The approach taken in international human rights law to recognizing the right to the highest attainable standard of health, particularly as it pertains to the social determinants of mental wellness, aligns with public health and other interdisciplinary research.

Recent and growing evidence shows that mental health and many common mental disorders are shaped to a great extent by social, economic and physical environments across the life span.[31] Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality, the higher the inequality in risk. A review of global evidence by Vikram Patel and colleagues for the WHO Commission on Social Determinants of Health reports that low socioeconomic position is systematically associated with increased rates of depression and anxiety disorders.[32] This correlates to socioeconomic status such that middle-income citizens are at a greater risk than high-income citizens and low-income citizens are at the greatest risk of all. The implication is that relative poverty and not absolute poverty is a key determinant of mental health.[33]

THE IMPACT OF INCOME INEQUALITY ON MENTAL HEALTH AND SUBSTANCE USE

Richard Wilkinson and Kate Pickett take the correlation between income and mental health a step further. Their epidemiological study of health and social problems, *The Spirit Level*, makes the case that income inequality is a causative factor for increased rates of depression and anxiety when situated within our shifting paradigm of social relations. Referencing population-level data published by the World Health Organization,[34] Wilkinson and Pickett explain the dramatic increase in mental health problems in high income countries by correlating "insecure narcissism" to widespread experiences of chronic stress. More and more people report a false sense of self-esteem that manifests as an all-consuming preoccupation with one's own identity and how others perceive them in response to iterative "social evaluative threats" or incidences where they feel their worth and value is being judged by others.[35]

The psychological impact of near constant evaluation is validated by Sally Dickerson and Margaret Kemeny, who after collecting findings from over 208 published reports, documenting people's cortisol levels in response to environmental stressors, found that "threats to self-esteem or social status, in which others could negatively judge performance, particularly when the outcome of the performance was uncontrollable, provoked larger and more reliable cortisol changes than stressors without these particular threats."[36] This psychosocial correlation corroborates a similar biomedical body of research that demonstrates a causative relationship between indicators of chronic stress and increased rates of chronic illness that includes mental health and substance use problems.[37]

But not everyone is equally affected. Wilkinson and Pickett demonstrate that our vulnerability is directly correlated to our position in the social hierarchy. People of higher status carry connotations of being better, more successful and more able, and can comfortably rely on displays of wealth to reaffirm their own identity and others' perceptions of their value. People who are economically disadvantaged are more regularly called upon to demonstrate their worth and win other's esteem. The consequence is that greater income inequality between rich and poor, whereby fewer people can claim the status conferred by wealth, equates to a higher percentage of the population who are vulnerable to social evaluation anxieties and depression.[38]

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31 World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*; Allen, J., Balfour, R., Bell, R. & Marmot, M. (2014). *Social determinants of mental health*. International Review of Psychiatry, 26(4): 392-407

32 Patel V, Lund C, Hatheril S, Plagerson S, Corrigall J, Funk M, et al. (2010). *Mental disorders: equity and social determinants.* World Health Organization: 115-34.

33 Compton, M.T. & Shim, S.S. (2015). The Social Determinants of Mental Health. *Focus*, 13(4): 419-425; Fisher, M. & Baum, F. (2010). The social determinants of mental health: implications for research and health promotion. *Australian and New Zealand Journal of Psychiatry.*

34 Kessler, R.C. et al. (2004). Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. *Journal of American Medical Association*, 291(21): 2581-2590.

35 Wilkinson, R. & Pickett, K. (2010). How inequality gets under the skin. *The Spirit Level: Why Equality is Better for Everyone* (pp. 31-45). London, England: Penguin Books.

36 Dickerson, S.S. & Kemeny M.E. (2004). Acute stressors and cortisol responses: a theoretical integration and synthesis of laboratory research. *Psychological Bulletin*, 130(3): 355-91.

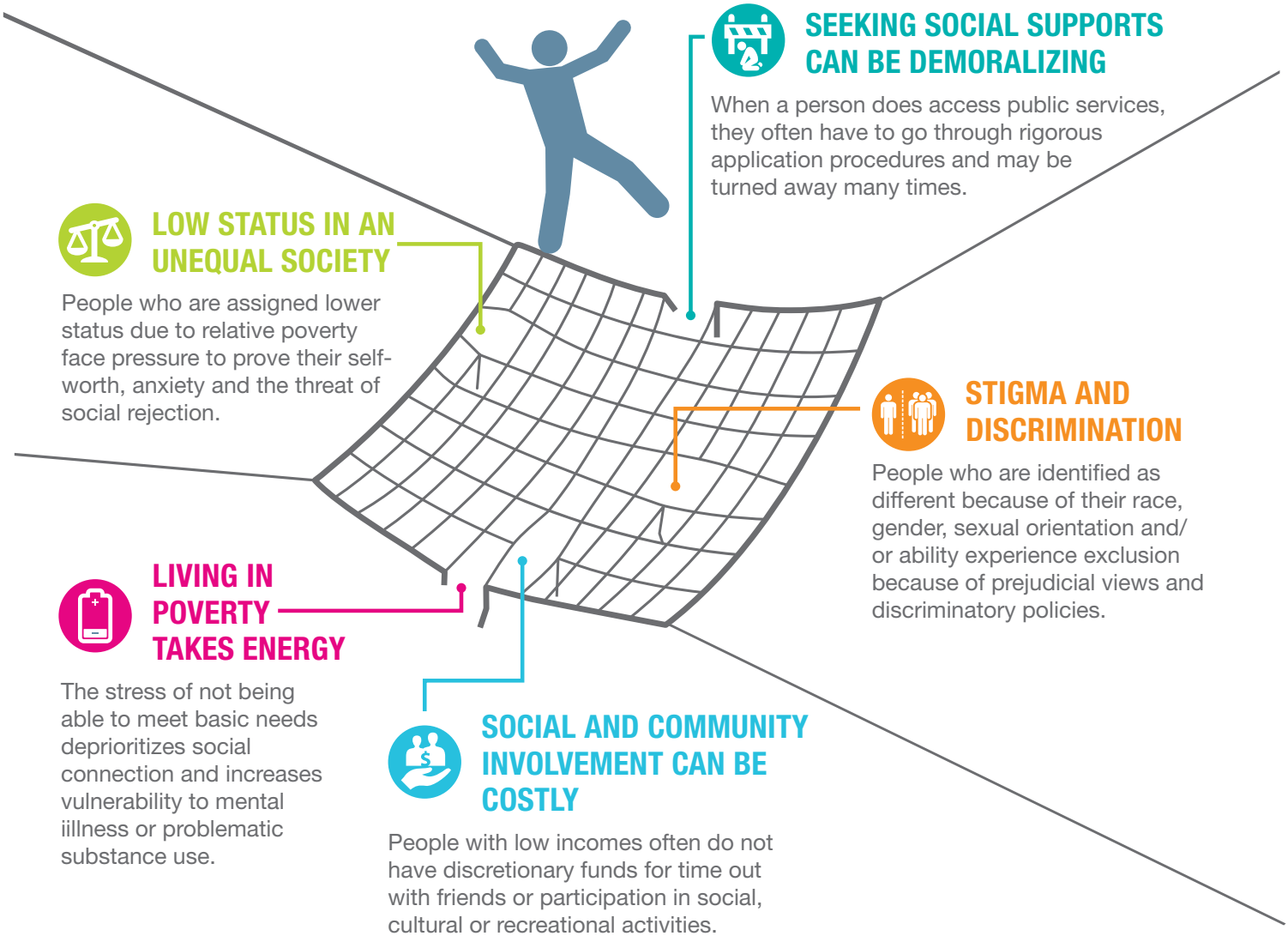
37 Taylor, S. E. (2010). *Mechanisms linking early life stress to adult health outcomes*. Proceedings of the National Academy of Science of the United States, 107(19):8507-12.

38 Wilkinson, R. & Pickett, K. (2010). Mental Health and Drug Use. *The Spirit Level: Why Equality is Better for Everyone* (pp. 63-72). London,

SOCIAL INCLUSION: THE KEY DETERMINANT OF MENTAL WELLNESS

The literature on the social determinants of health reveals a single, consistent theme in connection to mental health and substance use: social inclusion.

Whether or not a person can meet their basic needs, cultivate friendships, secure a sense of place within a community and maintain a stable position in the social hierarchy determine their vulnerability to anxiety, depression and problem substance use. The recovery potential of people living with mental illness or addiction is deeply impacted by the barriers they face obtaining and maintaining the resources and relationships necessary for social inclusion.



SEEKING SOCIAL SUPPORTS CAN BE DEMORALIZING

When a person does access public services, they often have to go through rigorous application procedures and may be turned away many times.

LOW STATUS IN AN UNEQUAL SOCIETY

People who are assigned lower status due to relative poverty face pressure to prove their self-worth, anxiety and the threat of social rejection.

STIGMA AND DISCRIMINATION

People who are identified as different because of their race, gender, sexual orientation and/or ability experience exclusion because of prejudicial views and discriminatory policies.

LIVING IN POVERTY TAKES ENERGY

The stress of not being able to meet basic needs deprioritizes social connection and increases vulnerability to mental iillness or problematic substance use.

SOCIAL AND COMMUNITY INVOLVEMENT CAN BE COSTLY

People with low incomes often do not have discretionary funds for time out with friends or participation in social, cultural or recreational activities.

INCOME

1 in 5 BC children live in poverty

Income shapes living conditions and affects mental health.

Income is more important when social services and benefits are not accessible.

Low income imposes isolation.

High levels of physiological and psychological stress arise from conditions of low income.

HOUSING

People who are unstably housed report poor mental health and/or problem substance use.

Those who spend a large part of their income on housing are more likely to feel socially excluded.

FOOD SECURITY

A single person who receives basic welfare has an annual income that reaches less then 40% of the poverty line

People who experience food insecurity are often excluded from the social practice of food sharing.

Adults who are food insecure are are more likely to experience depression and social isolation.

The failures of BC's social safety net worsen food insecurity, e.g., having to provide multiple documents to access food banks.

UN/EMPLOYMENT

While employment provides income, purpose, social contacts and status, un- or under-employment leads to material and social deprivation.

People living with mental illness benefit from employment if it aligns with their recovery goals. Work can be a means for participating in community.

Percentage of people with mental health issues who experience stigma, almost 3X the rate of people with other health conditions

PREVALENCE OF MENTAL HEALTH AND SUBSTANCE USE-RELATED CONDITIONS IN UNEQUAL COUNTRIES

Unsurprisingly, a much higher percentage of the population suffer from mental illness in more unequal countries. The proportion of mental illness in Canada is 1 in 5 people each year and stands in close comparison to other unequal countries such as United States where more than 1 in 4 people are affected. Data from WHO surveys indicates that sub-types of mental illness such as anxiety disorders, impulse-control disorders and severe illness have the strongest links to inequality. Similarly the use of illegal drugs such as cocaine and heroin is more common in more unequal societies.[39]

The distribution of prevalence rates in Canada aligns with the correlations drawn out in the research. Income inequality is contained within larger urban centers, where over 80% of the population resides. Montreal, Toronto, Calgary and Vancouver include almost all of the country's very rich and very poor citizens[40] and the vast majority of people receiving services for mental health or substance use problems. BC's rate of service usage is 167 per 1000 population, with a range from 39 per 1000 population in rural districts to over 200 per 1000 population in densely populated urban areas such as Vancouver's Downtown Eastside. The highest concentrations of people living with poor mental health are found in BC's lowest income neighborhoods. Overall 800,000 people or 17% percent of the population are affected, with the vast majority reporting anxiety (30%) and depression (50%) and many possessing multiple diagnoses that include personality, psychotic and bipolar disorders, as well as trauma, substance use and self-harm-related conditions.[41]

THE REINFORCING CYCLE OF SOCIOECONOMIC DEPRIVATION AND POOR MENTAL HEALTH

While income inequality is a strong predictor of prevalence rates of mental illness and illicit substance use, modern life in a low-income bracket is characterized by more than a constant fear and experience of social judgement and censure. The realities of living without social esteem and financial resources contribute to experiences of chronic stress due to the sheer difficulty of maintaining an adequate standard of living. Poverty, homelessness, unemployment and food insecurity keep people at the margins of society through the denial of social goods and economic exclusion. Many people report how poverty is self-reinforcing. The loss of employment results in loss of income and housing.[42] Homelessness—oftentimes reduced to the administrative detail of not having an address—can mean people are turned away at food banks,[43] unable to fill out applications for government assistance or attend job interviews and denied participation in civic activities.[44] The actual experience of homelessness is worse still. People who have unstable or insecure housing or no housing struggle to keep warm, find food, access health services, attain employment and maintain connection to others, oftentimes losing all sense of place and community. The paradox of needing stable housing to find a job or apply for income assistance and a regular income to obtain housing often keeps people from breaking out of the cycle of social deprivation and exclusion, which increases the risk of developing mental health and substance use-related health problems.[45]

STIGMA AND DISCRIMINATION CREATE ADDITIONAL BARRIERS TO WELLNESS

The onset of illness is followed by additional barriers of stigma and discrimination. A review of the literature

England: Penguin Books.

39 WHO International Consortium in Psychiatric Epidemiology. (2000). *Cross-national comparisons of the prevalences and correlates of mental disorders*. Bulletin of the World Health Organization 78(4): 413-26.

40 Fong, F. (2017). Income Inequality in Canada: The Urban Gap. *Chartered Professional Accountants Canada*; Please note that census data does not include Indigenous people who live on-reserve. The statistics stated here do not account for this particular population.

41 BC Ministry of Health. (2016). Establishing a System of Care for People Experiencing Mental Health and Substance Use Issues. *Unpublished draft*.

42 Government of British Columbia (2018). What We Heard About Poverty in B.C. Retrieved from: https://engage.gov.bc.ca/app/uploads/sites/242/2018/07/WWH_Report-PovertyReductionStrategy_FINAL.pdf

43 Pivot Legal Society. (2019). Project Inclusion: Confronting anti-homeless and anti-substance user stigma in British Columbia. Retrieved from: http://www.pivotlegal.org/project_inclusion_service_gaps_and_barriers

44 Carnegie Community Action Project. (2018). *No Pill for this Ill: Our Community Vision for Mental Health*.

45 Dunn, J. et. al. (2006). Housing as a Socio-economic Determinant of Health: Findings of a National Needs, Gaps and Opportunities Assessment. *Canadian Journal of Public Health*, 97(3): 11-15.

on mental illness-related structural stigma by James D. Livingston reveals that people with mental health disabilities often contend with arbitrary restrictions on their rights and opportunities. Inequities and injustices are manifest in policies and practices of most institutional systems and evident in everyday interactions between people who possess status or power over people who do not.

As subjects of stigma, people living with mental illness have their identities engulfed, their relationships transformed and the directions of their lives shifted because they are marked with a stereotyped attribute that has been deemed socially unacceptable or deserving of condemnation. In practice this includes systematic exclusion, rejection, shaming and devaluation that produces a decline in an individual's social status and a worsening of both their physical and mental health. Such conditions of deprivation, isolation and social exclusion reinforce both illness and poverty regardless of whether a mental illness or substance use disorder led to poverty or poverty and its association with chronic stress and low social status led to poor mental health and harmful coping behaviours.

Stigmatized characteristics and statuses do not act in isolation. Multiple attributes cohere to determine a person's identity, subjective experiences, social relationships and life chances. Since people who experience any form of discrimination are at a higher risk of mental health and substance use problems,[46] the intersections between gender, sexual orientation, race, indigeneity and ability are important for understanding how discrimination is experienced.

A NOTE ABOUT THE SOCIAL DETERMINANTS OF INDIGENOUS MENTAL HEALTH

Indigenous people in Canada experience both systemic and interpersonal discrimination that creates health inequities and stems from and continues on the basis of colonialism. In their discussion of Indigenous health, Charlotte Reading and Fred Wien contend that racism and social exclusion have been a reality for Indigenous people since colonial contact. The usurpation of land, destruction of communities and imposition of western systems of governance created "social stratification along racial lines, with a consequent hierarchal distribution of resources, power, freedom and control, all of which detrimentally affected Aboriginal health." This discriminatory positioning of Indigenous people at the bottom of the social hierarchy is evident in social policies that restrict, limit or neglect to enforce equitable access to education, income, economic opportunities and healthcare.[47]

The social exclusion experienced by Indigenous people operates on multiple levels. Poverty and discrimination created and reinforced by colonialist policies keep Indigenous people at the margins of Canadian society. Inequitable distribution of and access to income, employment, housing and food, in combination with both systematic and interpersonal discrimination, and disconnection from land, culture and community, create the conditions for anxiety, insecurity, low self-esteem and feelings of hopelessness that are linked to increased prevalence of depression, violence, addiction and suicide.[48] This patterns holds true for many marginalized populations, but has particular salience for Indigenous peoples who have experienced generations of systematic interference and who are often called upon to navigate between two differing socio-cultural spheres that of Canadian society and that of their Indigenous community.

The importance of cultural identity and cohesion for mental wellness of Indigenous populations has been well documented. A series of epidemiological studies by Chandler and Lalonde have revealed that among First Nations people in British Columbia rates of suicide vary dramatically and are associated with the level of social and cultural cohesion within the community. This factor was termed 'cultural continuity' and identified as traditional intergenerational connectedness, maintained by intact familial relationships and autonomous self-governance. The communities with low suicide rates possessed land title, control of education, delivery of social policies and programs, and cultural resources.[49]

The First Nations Health Authority's policy on mental health and wellness specifies five core principles that reflect what research has elucidated: focus on the conditions

46 Guidry-Grimes, L. & Victor, E. (2012). Vulnerabilities compounded by social institutions. *International Journal of Feminist Approaches to Bioethics*, 5(2): 126-146.

47 Reading, C. & Wien, F. (2009). Health Inequalities and Social Determinants of Aboriginal Peoples' Health. *National Collaborating Centre for Aboriginal Health*.

48 Reading, J.L, Kmetic, A. & Gideon, V. (2007). First Nations Wholistic Policy and Planning Model: Discussion Paper for the World Health Organization Commission on Social Determinants of Health. *Assembly of First Nations*.

49 Chandler, M.J. & Lalonde, C.E. (2008). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In Kirmayer, L. & Valaskakis, G. (Eds.). *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp 221-248). University of British Columbia Press.

for mental health and address root causes; foreground culture and traditional approaches to healing; provide equitable, culturally-safe, trauma-informed and person-centred programs and services; integrate system design and delivery; and prioritize First Nations self-determination. This paradigm shift for transforming the mental health system for Indigenous populations recognizes that "facilitating supportive environments for individuals, families and communities to enjoy positive mental health and wellness… requires working not just with health system partners but also with partners spanning social and environmental sectors and beyond."[50]

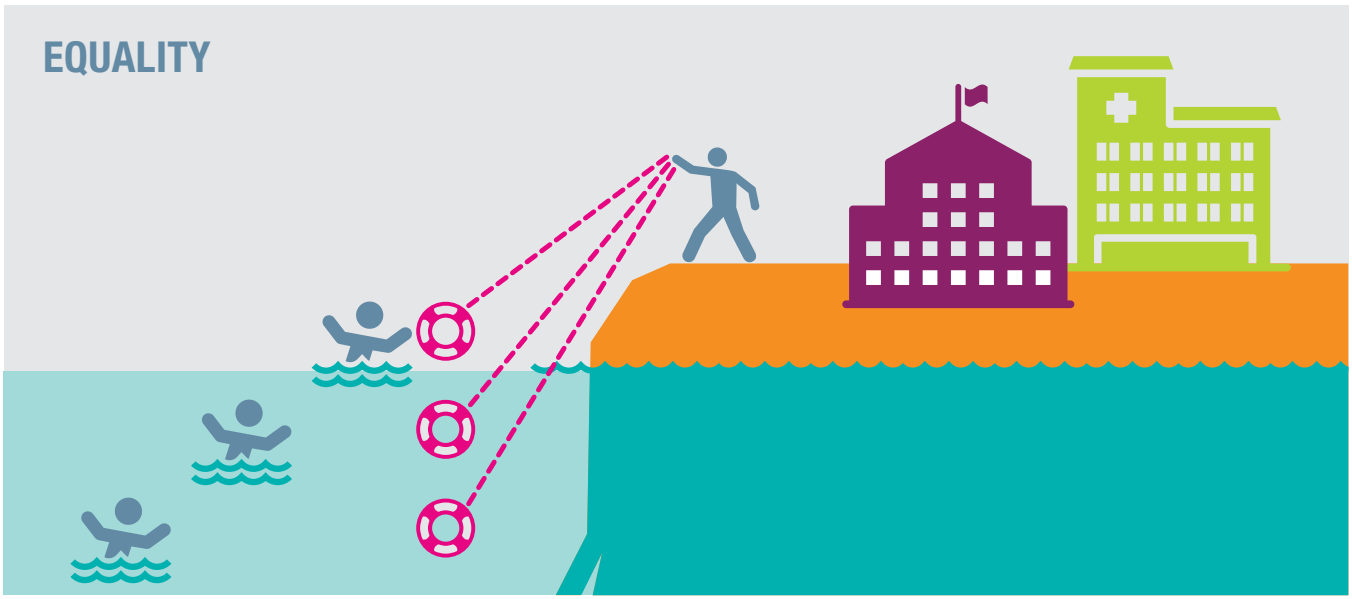
Mental wellness depends on community and connection to others. All the social determinants of mental health from socioeconomic status to housing to employment to discrimination operate in relation to multiple layers of social inclusion. Whether or not a person can meet their basic needs, cultivate relationships, secure a sense of place within a community and culture, and maintain a correspondingly stable position in the social hierarchy determines their vulnerability to anxiety, depression and problematic substance use; while the recovery of people living with illness is deeply impacted by the barriers they face obtaining and maintaining the resources and relationships necessary to feel included.

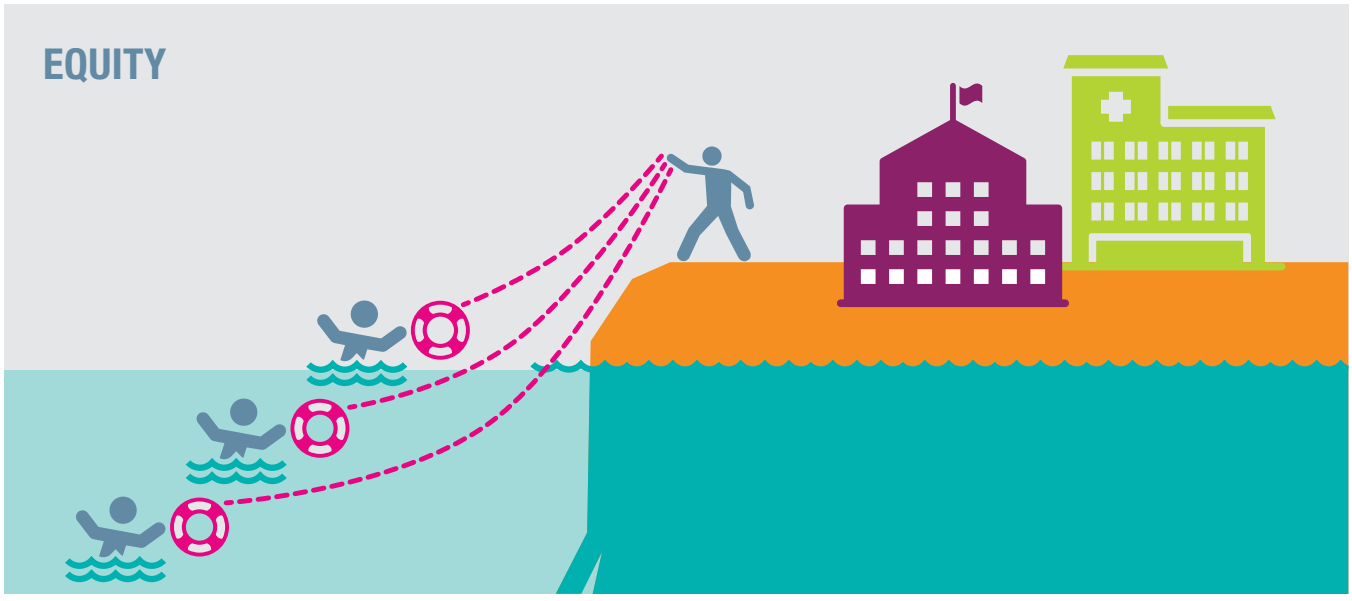
50 First Nations Health Authority. (2019). FNHA's Policy on Mental Health and Wellness. Retrieved from: http://www.fnha.ca/wellnessContent/Wellness/FNHA-Policy-on-Mental-Health-and-Wellness.pdf

CREATING ACCESSIBLE SERVICES TO SUPPORT MENTAL WELLNESS

International human rights and public health research confirm that in order to have an equitable chance of achieving their best mental health, people must have a solid foundation that meets their social and economic needs, including access to an adequate income, housing and employment. Such a foundation is crucial to supporting positive mental health and relationships with substances.

There are a number of public services in Canada and in BC that are intended to build this foundation for people experiencing mental health or substance use-related disabilities—from supportive and subsidized housing, to income and benefit programs, to supportive employment programs. Many public discussions have taken place about whether enough funding is dedicated to these services and whether they are extensive enough, but what is rarely touched upon is whether the services fulfill their potential of reducing health inequities by supporting everyone regardless of the barriers they may face. There is little to no attention paid to the adequacy of these kinds of services using the lens of human rights and equity or with a focus on the consequences for social inclusion and





mental health when barriers to services prevent people from having the support they need to be well.

BC's Human Rights Code[51] places obligations on employers, rental housing providers and service providers (including, but not limited to, the provincial government) not to discriminate on the basis of specific aspects of individual identity, including mental or physical disability.[52] The *Code* differs from international human rights agreements in that it primarily provides legal redress once discrimination has already been experienced. In Canada, courts have found that domestic human rights instruments like the *Code* and the *Canadian Charter of Rights and Freedoms* do not provide a legal tool to enforce Canada's obligation to protect positive rights to the highest attainable standard of mental health, an adequate standard of living, housing, essential food, etc.[53] as required under international agreements. Instead, the *Code* provides redress for discrimination and requires that one or more aspects of a person's identity be at least part of the reason for exclusion or the barriers they face in accessing service. For example, it is not currently illegal in BC to deny someone fulfillment of their right to housing because their income is not high enough, but it is illegal for a landlord to refuse to rent to someone because of their disability. Even if someone is denied a basic right because of a personal characteristic, the legal process to address such discrimination is complex and lengthy. The international human rights that Canada is obligated to protect for everyone are typically not considered.

In the event that human rights protections are enforceable through the *Code*, they do not typically require that service providers ensure access to services that do not already exist;[54] however, if the government or any other public service provider is offering supports or services, they must do so in a way that does not discriminate and must take reasonable steps to ensure everyone has equitable and meaningful access.[55] Such an approach sometimes requires providing tailored or specialized supports for some people in order to meet their disability-related needs. In other words, in order to meaningfully level the playing field, some people actually need to be treated differently to remedy systemic and structural barriers they face.[56] It is not enough to create inaccessible systems or services and expect that people with disabilities just adapt. Barriers must be removed or addressed during service or system design whenever possible.[57] **This approach is required to achieve equity.**

Tailored services or supports may be necessary to help people with mental health or substance use-related disabilities overcome any barriers they face as a result of their health-related symptoms or differing needs. For example, someone who lives with an anxiety disorder and experiences worsening symptoms in crowded spaces may need to communicate with social assistance staff via mail to prevent them from having to wait in lengthy lines at Access Centres. To comply with BC's *Human Rights Code*, service providers must provide their services in an equitable and non-discriminatory way. They must take steps to ensure their services are accessible to people with disabilities, which includes mental illness and substance use-related disabilities. This is key to fulfilling the right to the highest attainable standard of mental health within the public and legal systems we currently have in place.

HOW INCLUSIVE DO SERVICES THAT SUPPORT THE SOCIAL DETERMINANTS OF MENTAL HEALTH HAVE TO BE?

If a person experiences a barrier to accessing rental housing or a public service in BC, there is a simple three-step test to determine if that barrier is a violation of the *Human Rights Code*:[58]

1. The person has or was perceived to have a mental or physical disability.

2. The person experienced negative treatment or a negative impact, such as being denied services or being unable to access services provided by the service provider.

51 RSBC 1996, c 210.

52 Human Rights Code, RSBC 1996, c 210 at ss. 8 and 10.

53 *Gosselin v. Quebec (Attorney General)*, 2002 SCC 84.

54 *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, at para. 71; *University of British Columbia v. Berg*, [1993] 2 S.C.R. 353, at pp. 381-82.

55 *Moore v British Columbia (Education)*, 2012 SCC 61 at para 26.

56 *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, [1999] 3 SCR 3 at para 41; *Oger v. Whatcott* (No. 7), 2019 BCHRT 58 at para 125.

57 *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, [1999] 3 SCR 3 at para 41.

58 *Moore v. British Columbia (Education)*, 2012 SCC 61 at para. 33.

3. The person's disability was a factor in the barrier to access or the denial.

Most human rights claims do not raise issues around the definition of disability because they involve conditions that are well recognized as disabilities under the Code. With respect to mental health and substance use, recognized disabilities include diagnosed or undiagnosed mental health disorders (e.g. depression)[59] and substance use disorders (e.g. alcoholism).[60] Commonly experienced emotions, such as stress[61] and anxiety,[62] are not in and of themselves disabilities, though they may be symptoms of a disability. Similarly, substance use on its own is not a disability, unless it arises from a disability (e.g., substance use disorder) or gives rise to a perceived disability.[63]

Typically, the most contentious aspect of a person's case is proving that their disability was a factor in the service barrier or denial. Whether or not a disability was a factor (it need only be one factor and not necessarily the primary factor)[64] is assessed on a case-by-case basis. A connection cannot be assumed and must be based on evidence.[65] For invisible disabilities like mental health and substance use-related health issues, proving that disability was a factor in the negative treatment can be especially complex. For example, if someone is denied access to a crucial public service because they are disruptive in the office where the service is provided, which may be related to symptoms of a mental health disability, it might be difficult to prove that is the case.

If an individual can show a connection between their mental health or substance use-related disability and the barrier or service denial, the service provider then has an opportunity to justify the barrier or denial by showing that "accommodating" the person's disability-related needs (removing the barrier or granting support that would allow access to the services) would create "undue hardship" for them.[66] But how far do service providers have to go to make sure everyone can access their services regardless of their disability? They do not have to incur an undue hardship, but they may have to incur *some* hardship in the form of cost, inconvenience or disruption. In the example above, if the person could prove that their behaviour was related to their disability, the service provider would not have to accept the behaviour, but should consider how they might provide the services in a way that better meets the person's needs, perhaps with a one-on-one meeting space.

CREATING SERVICES THAT ACCOMMODATE MENTAL HEALTH AND SUBSTANCE USE-RELATED DISABILITIES

While it is typically up to the person experiencing a disability-related barrier to raise their needs with the service provider, in some situations a service provider may have a duty to inquire about an individual's needs in order to comply with the *Code*. For example, larger, institutional service providers serving marginalized people could be required to inquire about disability-related needs.[67] Further, service providers may have an obligation to inquire about the accommodation needs of people with a history of disability or health-related issues or who are acting outside of what is considered the "norm."[68] Many services that support the social determinants of mental wellness, such as supportive or specialized housing, disability income assistance or supported employment programs, are intended to service people with disabilities and often collect disability-related information to determine eligibility for the service. Such information would likely create an obligation on the service providers to inquire about the accessibility and accommodation needs of those accessing their services.

Service providers are not required to prove that it is impossible to accommodate the person's disabilities

59 *Morris; Sylvester v. B.C. Society of Male Survivors of Sexual Abuse*, 2002 BCHRT 14.

60 *Handfield v. North Thompson School District No. 26*, [1995] B.C.C.H.R.D., No. 4.

61 *Matheson v. School District No. 53* (Okanagan Similkameen) and Collis, 2009 BCHRT 112 at para. 14.

62 *Dow v. Summit Logistics and RWU Local 580*, 2006 BCHRT 158 at para.18.

63 *Middlemiss v Norske Canada Ltd.*, 2002 BCHRT 5; Geldreich v. Whisper Creek, 2009 BCHRT 178; Stephens v Winroc, 2011 BCHRT 269.

64 *British Columbia Hydro and Power Authority*, 2004 BCCA 457 at para. 24

65 *Stewart v. Elk Valley Coal Corp.*, 2017 SCC 30, [2017] 1 S.C.R. 591 at para. 39, citing *Health Employers Assn. of British Columbia v. B.C.N.U.*, 2006 BCCA 57, 54 B.C.L.R. (4th) 113 at para. 41.

66 *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, 1999 3 SCR 3 and *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)*, 1999 3 SCR 686.

67 *Alexander v. Northern Health Authority and others (No. 2)*, 2008 BCHRT 389; *Rezaei v. University of Northern British Columbia and another (No. 2),* 2011 BCHRT 118.

68 *Rezaei v. University of Northern British Columbia and another (No. 2)*, 2011 BCHRT 118 at para 50. This threshold was cited with approval in XS v. YP, 2015 BCHRT 97 at para 63; and *K. B. v. S. S.*, 2016 BCHRT 61 at para 123.

and they do not have to provide perfect access to every person with a human rights-related need, but they do need to prove they have taken reasonable steps to the point of undue hardship.[69] Unfortunately, there is very little additional legal guidance in BC on what service providers need to do to ensure their services are accessible, especially when it comes to ensuring that people with mental health and substance use-related disabilities have equitable access. The majority of existing guidance is in the context of physical disability and mobility-related needs. What might be obvious in the case of a physical disability (for example, ensuring elevator access for people who cannot climb stairs due to mobility limitations) is often far less clear for mental health and substance use-related disabilities.

The importance of ensuring equitable access to services that support the social determinants of mental health is incontestable. It is crucial to gain a better understanding of what service providers can do to support access for people with mental health and substance use-related disabilities; however, the legislation, regulation and policies that govern access to public services and rental housing in BC must also strive to uphold people's positive rights to achieve their best mental health and be free of discrimination. Too often the very services that people need to support and improve their health are inaccessible as a result of their health-related problems. There are barriers built into our social service system that prohibit people from having equitable opportunities to access what they need to be mentally well precisely because of their disabilities. This a primary driver of significant health inequities in BC that should be addressed by the following recommendations.

RECOMMENDATION

1. The BC Human Rights Commission should audit the laws and policies governing the provision of social services to identify and eliminate accessibility barriers that prevent or dissuade people with mental health and substance use-related disabilities from obtaining the supports and services they are eligible for.

2. Alternatively, the Ministry of Mental Health and Addictions should establish an independent Mental Health Advocate to monitor the performance of our public services that impact people with mental health and substance use-related health issues, receive and act on systemic disability-related complaints and protect the human rights of people living with illness who access services.

3. The Ministry of Social Development and Poverty Reduction should ensure that its commitment to develop and pass comprehensive accessibility legislation will go beyond physical notions of accessibility and ensure that people with invisible disabilities, in particular people with mental health or substance use-related disabilities, can fully participate in their communities.

Our right to basic necessities and our right to our best possible health are related to and dependent on each other.

69 *Hydro-Quebec v. Syndicat des Employees de Technique Professionels et de Bureau d'Hydro-Quebec* 2008 SCC 43; *Central Okanagan School District No. 23 v. Renaud*, [1992] 2 SCR 970 at para. 19.

FOCUS GROUP FINDINGS

To develop a better understanding of service barriers and identify further recommendations for improving access for people living with mental illness or problematic substance use, this project focused on three discrete areas of services in BC that are key social determinants of mental wellness: housing, disability assistance and employment supports.

A critical component of the project research involved speaking directly with people who are living with illness and receiving social supports. CMHA BC held seven focus groups across the province and interviewed over 100 frontline staff from mental health and anti-poverty organizations to learn what barriers individuals face. The participants shared their experiences interacting with service providers and public service staff, specifying what made them feel either included/ valued or excluded/ shamed, and the impact such experiences had on their mental health, well-being and use of substances.

METHODOLOGY

The focus groups ranged from 3-10 participants and involved an open-ended discussion around three topics, namely access to subsidised and supported housing, income or disability assistance and WorkBC employment supports. Participants were encouraged to share their stories accessing or being unable to access these services, and how such experiences impacted their health. The format of the group and discussion questions were informed by an advisory committee of eight frontline and peer staff at mental health and anti-poverty organizations and two peer researchers, who provided invaluable input on strategies for engagement and for creating a safe, inclusive environment for participants.

In total, 44 people participated in the focus groups; 40 who self-identified as having a mental health disorder and 17 who self-identified as having a substance use disorder. The information gathered at the focus group was not intended to be representative of every person's experience living with illness and accessing BC's social service system, although the participants in the project came from a diverse range of backgrounds and perspectives. The participants ranged in age from 22 to 68; 23 identified as men and 21 as women. While the majority self-identified with some variant of Caucasian or Canadian, five participants who recently immigrated to Canada identified with their country of origin and seven participants self-identified as Indigenous.

"No one cares about you. You're lost. There is nowhere to turn. It's hard to live like that. I'm not asking for much, only a bit more support. People on disability should be a priority and should get what we need to survive" – *Prince George participant*

Despite each participant accessing BC's social services, their employment backgrounds and current financial stability differed substantially. All except for three participants received some form of income assistance, yet only seven reported that they always had enough income to meet their basic needs. Of the remaining participants, 22 sometimes had enough and 13 never had enough income. Nine participants were employed in paid part-time or temporary work at the time of the focus group and one was self-employed. The majority of participants were designated as either a "person with disabilities" under the *Employment and Assistance for Persons with Disabilities Act* or a "person with multiple and persistent barriers to employment" under the *Employment and Assistance Act*. Others were on regular income assistance or had no income at all.

All participants reported living and accessing services in one of six BC communities: Vernon, Salmon Arm, Prince George, North Vancouver, Vancouver and Nanaimo. Qualitative interviews and focus groups were also carried out with frontline staff from mental health or anti-poverty advocacy non-governmental organizations (NGOs) in each location.

THE MENTAL HEALTH IMPACTS OF A SYSTEM OF EXCLUSION

To gain entry into BC's social service system, participants reported that they had to repeatedly represent themselves and their circumstances at their very worst, and interact with a confusing network of disparate services that were premised on exclusion. We heard that people were screened out, not in, and turned away or placed on waiting lists at the slightest indication that their need was not great enough. This process of excluding all but the most marginalized and clawing back support at the first sign of diminishing need left participants feeling dependent on a system that made them feel worthless; at best a mere number on a government tallying sheet and at worst a burden on the public.

A system premised on exclusion creates a reinforcing cycle of poor health and a heightened need for access to public services. Many participants described distress

when recounting their experiences interacting with staff or vying for government-funded services. Whether the story was about the confusion and frustration of applying for assistance, or the hopelessness of homelessness while waiting for a placement from BC Housing, participants remarked on a decline in their mental health or an increase in their use of substances at the time of the experience, and some improvement of their symptoms or substance use once the help they were seeking was given. Yet every interaction or application had health impacts. If a crisis grant was requested or a cheque needed to be picked up, participants noted a rise in their anxious anticipation, unsure of what the interaction would bring or what kind of treatment they would receive. Many felt they couldn't trust that they would be given the correct information or that they wouldn't be denied due to what they perceived as the whims of the staff.

"The system seems to want people to stay disabled [and] seems only to help people when they are beyond recovery"
– North Vancouver participant

The uncertainty and variability of accessing services undoubtedly caused participants a great deal of stress, but the health consequences of physiological stress were only part of what contributed to their worsening symptoms. Participants repeatedly commented on how "small" their interactions made them feel and described how staff at income support services treated them as if they were "taking money out of their own pockets". The power dynamics between staff who administer the programs and benefits, and participants who receive them reinforced social hierarchies and degraded participants to the point of feeling shame for needing to access the services at all. The intimation of being less-than and the occasional blatant abuse or ridicule by staff incited different responses in different participants, but ultimately lead to an increase in negative emotion that directly contributed to the symptoms of their illness.

While the trajectory of all illnesses is influenced by external factors, there is a strong, direct correlation between mental health and substance use-related conditions and the social and physical environments in which people live. BC's system creates an environment and incites experiences of exclusion that worsen symptoms of illness and heighten the need for public services-neither is good for our system or for the people who require access to its services.

PARTICIPANT-IDENTIFIED PRINCIPLES FOR AN INCLUSIVE SYSTEM

Many participants had opinions, comments and suggestions about what has been and can be done to improve health outcomes and support people to live with dignity. While diverse and reflective of each person's unique circumstances, participants' comments tended towards three themes that can be interpreted as the core characteristics of equitable and inclusive services:

1. **Person-centred:** the abilities and goals of the individual determine what and how supports and services are provided

2. **Accessible:** services and supports are available when, where and how people need them

3. **Flexible:** the process for accessing and participating in services reflects the abilities of the individual and allows for necessary accommodations

Inclusion requires both support and autonomy. While participants acknowledged the necessity of social supports in their lives, the majority strove for as much autonomy and independence as their health and circumstances would allow. To achieve this, they advocated for services that recognized them as individuals and responded to their strengths rather than their limitations.

Meaningful autonomy is possible with the right kind of support. Throughout the province, CMHA BC heard about programs that were working well and enabling people to live independently or progress towards independence. For example, BC Housing partnered with a local CMHA office to provide graduated housing for people living with mental illness. The type of housing a person was placed in and the level of support they received matched their wellness and ability to care for themselves. If and when a person's health improved, they were given the opportunity to progress toward a different kind of housing, one where they were given more autonomy and less surveillance, with easy access to supports if needed. Participants reported positive experiences, not only in terms of access to supports and a path to autonomy, but also as an opportunity to build relationships with staff, fellow residents and neighbours. The program created a sense of community amongst people who previously felt isolated by responding to each person's unique needs and bringing them together in safe, shared spaces.

Similarly, participants identified mental health advocates as a potential solution to the exclusion and depersonalization they experienced. Many felt that their experience would improve if they had a relationship with someone who was knowledgeable about the system and could support them—from applying to BC Housing to accessing Persons With Disabilities (PWD) benefits to utilizing WorkBC programs. There was agreement that such an advocate should have intimate knowledge of the particular challenges people living with mental illness or substance use-related health issues encounter, be trained specifically to support this population and be based in the community organizations where the participants already access programs and feel welcome.

"People are struggling, but more importantly, so many people have been traumatized or homeless for extended periods of time. [You can't] just stick them into housing and expect everything to be fine. There has to be some other kind of treatment to help people get back in the swing of things. There are examples I have heard recently. I know of a gentlemen who had been living on the streets since he was 14 years old and got put into housing in his late twenties and it didn't work. The guy never knew about taking out garbage or doing dishes. If you have never had to do those types of things, you don't know how to do them. This is another thing people need to think about with supported housing, what kinds of supports go along with it? Maybe it's not a building where people are setting out rules, but a worker who comes in once a week and teaches life skills. People should actually get the supports they need. The government will give you a worker and [go through a checklist], but it's not what people actually need. They need to look at the individual and what those individual's needs are. Your needs are different from my needs. We should all be looked at as individuals."
– Nanaimo participant

EXAMPLE 1: RENTAL HOUSING SECURITY

The importance of housing in everyone's life is clear and obvious, but just having a roof over one's head is not enough. The components of secure housing include affordability, security of tenure, desirability and safety of location. James Dunn and colleagues situate housing "as a central locus of everyday life patterns [and]… a crucial component in the ways in which socio-economic factors shape health." A review of the literature by Dunn demonstrates that people who are unstably housed or homeless have a greater incidence of a range of health problems and a reduced life expectancy, and that people who spend a disproportionate amount of their income on housing struggle to purchase other basic necessities and are more likely to experience social exclusion.[70]

Affordable housing is often the most pressing issue for people living in poverty. In BC, high rents and low vacancy rates have widened income inequality and deepened poverty. People are spending more and more of their income to keep their homes and many of them are being pushed into unsafe or insecure housing or onto the streets. The report from BC's Poverty Reduction Consultations demonstrates that people across the province are impacted by high housing costs that limit their opportunities and force them to cut back on food, save on utilities and live more isolated lives.[71]

Poverty, housing insecurity and mental health issues are often co-occurring conditions and can mutually reinforce one another. The stigma associated with mental health issues can lead to discrimination, loss of employment, support networks and even housing. Poverty and its association with prolonged, chronic stress and social exclusion can result in poor mental health. Regardless of whether mental health or substance use issues were precipitating factors or a consequence of housing loss, a significant portion of the population who are unstably housed experience poor mental health. The Mental Health Commission of Canada (MHCC) reports that as many as 520,700 people living with mental illness are inadequately housed and among them, as many as 119,800 are homeless.[72]

In the late 2000s, MHCC initiated At Home/ Chez Soi to investigate the feasibility and efficacy of a large-scale Housing First intervention. The project took place in five sites across Canada and involved 2,285 participants of which 1,325 received the *Housing First* model of intervention. The final report not only confirms that *Housing First* rapidly ends homelessness for individuals and can be effectively implemented in diverse cities, but also demonstrates that having a place to live and the right supports can lead to other positive outcomes and change people's lives.

The acquisition of stable housing gave participants hope and confidence, and provided opportunity for them to take on new social roles and make positive social contacts. Participants who had improved relationships with family or who connected with supportive communities tended toward positive life courses. Many changed their daily activities to include things like volunteering, working, attending school or becoming peer support workers, effectively inhabiting new social roles and expressing a positive social identity.[73]

Among Indigenous people, housing insecurity has been imposed through colonial dispossession of traditional territories, as well as reserve and patriarchal resettlement structures that have led to on-reserve housing shortages, overcrowding and poor living conditions.[74] Inadequate and unsafe housing, along with a lack of basic amenities and geographic isolation, has direct health implications including an increased risk of mental illness, family conflict and violence. This disproportionately affects Indigenous women who often cannot access housing in their communities and are forced into situations of increased risk of violence and social deprivation.[75] Oftentimes the only other alternative is migration to urban areas and potential disconnection from families, communities and ancestral land.

Homelessness in this context is not merely a lack of stable, permanent housing. The Aboriginal Standing Committee on Housing and Homelessness defines the experience as an isolation of individuals, families

70 Dunn, J. et. al. (2006). Housing as a Socio-economic Determinant of Health: Findings of a National Needs, Gaps and Opportunities Assessment. *Canadian Journal of Public Health*, 97(3): 11-15.

71 See note 40, Government of British Columbia.

72 Community Support and Research Unit, Centre for Addiction and Mental Health and the Canadian Council on Social Development. (2010). *Turning the Key: Assessing Housing and Related Supports for Persons Living with Mental Health Problems and Illnesses*.

73 Goering, P. et al. (2014). *National Final Report: Cross-site At Home/ Chez Soi Project*. Mental Health Commission of Canada.

74 Reading, C. & Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health*. National Collaborating Centre for Aboriginal Health.

75 Reading, J.L, Kmetic, A. & Gideon, V. (2007). *First Nations Wholistic Policy and Planning Model: Discussion Paper for the World Health Organization Commission on Social Determinants of Health*. Assembly of First Nations.

"My experience with housing [has been] pretty bad. I lived with my Dad because I couldn't find a place; also stayed in shelters. I stayed in the worst places you could find in Vernon because the rent is so outrageous. It took me having a nervous breakdown and ending up in the psych ward for anybody to help me find housing… There needs to be more communication out there about what's available and more affordable housing"
– Vernon participant

and communities from their "relationships to land, water, place, family, kin, each other, animals, culture, languages and identities" and directly links this condition to the continuation and legacy of colonialist policies and practices that seek to undermine Indigenous social systems, cultures and worldviews, and construct prejudicial systematic and societal barriers to affordable and appropriate housing.[76] In a report published by the Canadian Observatory on Homelessness, the complex dimensions of Indigenous homelessness are further elucidated to include historic displacement, geographic separation from ancestral lands, spiritual disconnection from Indigenous worldviews or connection to the Creator, mental disruption and imbalances, cultural disintegration and loss, community exclusion, and environmental destruction both natural and man-made.[77]

What research essentially illustrates is that housing is more than a physical dwelling. Housing constitutes a home, with all its attendant meanings. A platform for self-expression and identity. A place and position within a community. A foundation on which to build a life. This is why the United Nations' definition of homelessness recognizes social exclusion as central to a person's experience—"homelessness implies belonging nowhere rather than simply having nowhere to sleep"[78]—and why the Special Rapporteur on adequate housing has underlined that not only should housing be physically and economically available, but that housing should support all people to effectively participate in the communities in which they live.[79] The denial of safe, affordable housing is not merely the stripping away of four walls and a roof, it is systematic exclusion.

WHAT WE HEARD

Participants repeatedly commented on the importance of safe, affordable housing that bolsters their autonomy or enables a progression to more independent living. Many pointed to the lack of options in their community or the inadequacy of short-term supports such as modular housing units. While these rapidly built initiatives are a way to provide housing for many people very quickly, which is desperately needed in BC, some participants felt that they did not come with adequate staffing and supports to adjust to living indoors after homelessness and improve wellness in the face of serious mental health and substance use problems. Others commended specific non-profit housing providers holding BC Housing contracts as examples of quality housing options because of the responsiveness of staff and the varying levels of support available based on individual need.

"I live in a garage, been there for over a year. No water. No toilet. I have an electric frying pan. It's my sister-in-law's house. We can use the house until 8pm, then we can't go in again until she gets up in the morning to take her daughter to school. We use a bucket [for a toilet] and dump it. We simply can't afford a place, we don't have the money. We still pay my sister-in-law $400 a month… The floor isn't concrete though. It's wood. I put some carpets down, but we don't have a bed. We sleep on the floor. I don't like it there, but it's a place, it has a heater. We are blessed compared to so many more in the city. It could be worse, could be better… My dream is hot water, a toilet and maybe a shower."
– Nanaimo participant

76 Aboriginal Standing Committee on Housing and Homelessness (ASCHH). (2012). *Plan to End Aboriginal Homelessness in Calgary*.

77 Thistle, J.A. (2017). *Indigenous Definition of Homelessness in Canada*. Canadian Observatory on Homelessness.

78 United Nations Human Rights Council, 2009.

79 United Nations General Assembly. (2018). Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context. *Human Rights Council*, 37th session.

Other themes that emerged from participants included:

- **Lack of affordable housing options.** Participants reported the wait times for subsidized and/or supportive units through BC Housing to be up to 8 years in some cases. Some commented on the triaging process used and how it disadvantaged them because they did not fit within the priority populations (families, single parents, etc.). While participants waited to hear about their housing applications, many reported living in tents, shelters, group homes and makeshift arrangements (for example, one participant lived in a family member's garage without hot water), as well as rough sleeping on the streets and in public spaces. Some reported homelessness because they were unable to navigate the social assistance system and had little or no income to cover housing costs.

"I don't know how much I can complain. There are things [in my apartment] that need doing, but I live on such a narrow line that if anything goes wrong I am screwed and out on the streets." – *Prince George participant*

- **Fear about enforcing rights.** Many participants who were able to find housing noted a power imbalance between themselves and their landlords or property managers given the shortage of affordable units and difficulties in finding and maintaining housing with mental health or substance use-related problems. They spoke of not reporting damage or much needed repairs in their rental units and tolerated demeaning (and sometimes abusive) treatment from other tenants for fear of being evicted. This was especially the case in subsidized or supported housing because participants often faced lengthy waits to get in and remained fearful of losing their units or threatening their tenancy in any way. They were willing to forgo enforcing their tenancy rights in order to ensure they did not make any waves that could negatively impact their housing security.

- **Inadequate supports.** Staff at community organizations and participants flagged the inadequacy of some forms of housing, including some new modular or short-term units. While welcoming the much-needed new housing in their communities, they noted that the ratio of clients-to-staff (40:2) was less than ideal for groups of high-needs clients, many of whom were transitioning from rough sleeping or tent cities and required support during that transition. Staff reported that their colleagues were called upon to go above and beyond their job description from providing emergency medical care in the face of a drug poisoning/overdose crisis, to resolving conflicts between clients, to supporting work placements. There was agreement that low barrier housing for high-needs clients requires interdisciplinary teams with specialized knowledge of best practices in mental health and substance use-related issues.

- **Pets and wellness.** Finally, participants repeatedly spoke of the benefits of pet ownership to their health and well-being, and specifically how a cat or dog could offer companionship, provide a routine and create a sense of comfort. Many faced barriers to getting and keeping an animal in their housing. Some lived in buildings that had strict no pet policies, while others desired a pet, but felt obtaining one would be impossible because of the cost or a fear of losing the animal if their housing situation changed. Despite reporting a keen desire to get a pet and articulating the benefit it could provide for their mental health, many participants reported long-term housing security as a reason not to get a companion animal.

The themes raised by project participants reflect two broad streams related to housing security for people living with mental health and substance use-related disabilities. First, they do not have an equitable opportunity to safe, secure housing because they are often unable to meaningfully enforce their tenancy rights (i.e., the right to have housing in a reasonable state of repair, the right not to be disturbed by other tenants, etc.) because of scarcity of available options and the precarious nature of their health. Second, they often do not have access to the supports (e.g., staffing, integrated or specialized health services, informal support animals, etc.) they need in order to have an equitable opportunity to maintain their housing and health. Both of these issues have a negative impact on their mental wellness because of stress, fear, exclusion and insecurity in relation to what we know is a service that is a key driver of mental health.

ABILITY TO ENFORCE TENANCY RIGHTS

With respect to tenancy and housing security rights, the current state of legal protections in BC makes it difficult for

"I think it's unfair that most subsidized places don't allow pets, especially when you have a mental illness. I don't get along with roommates, but I would like to have a cat or a dog. There needs to be more places because people with mental illness could use the companionship. [Pets] are really good therapy, they are not judgemental, they never argue with you. They make you feel better. Everyone who wants a pet should be able to have one and not be discriminated against when trying to find housing." – *Vernon participant*

people to enforce their right to equitable access to housing and their right to the highest attainable standard of mental health as it relates to housing. Most housing rights, such as the right to have repairs done or the right not to be disturbed by other tenants, are enforced by the Residential Tenancy Branch in BC, which is intended to provide simplified and accessible processes.[80] The Residential Tenancy Branch is not allowed to decide or enforce human rights.[81] Instead, human rights issues related to housing must be determined by the BC Human Rights Tribunal[82] which has a much more complex process that often takes months or years from start to finish.

As a result, a person with a mental health or substance use-related disability who advocates for themselves with respect to unaddressed tenancy issues such as repairs faces considerable risk. Landlords can quickly dismiss tenants as problem-makers, especially if influenced by mental health and substance use-related stigma, and respond with an eviction notice. The tenant's only recourse is to challenge the eviction through the Residential Tenancy Branch. In that process, there is no ability to inquire into whether the landlord's reaction might be based on discriminatory assumptions or fears related to the tenant's disability. In order to address such an issue, the tenant would need to take action through a lengthy, complex and legalistic process that would not be completed in time to stop an eviction if it was upheld by the Residential Tenancy Branch.

Recent amendments to the *Residential Tenancy Act* and changes at the Residential Tenancy Branch certainly strengthen the rights of tenants in some situations, but given the scarcity of affordable, safe housing, many of the issues that participants raised in the focus groups remain an issue.

For example, many participants noted being fearful of losing their housing if they requested repairs or made complaints to their landlords. This was particularly the case if their landlord was aware of their mental health or substance use problems and were likely to consider them problematic tenants. A review of past decisions from the Residential Tenancy Branch confirms the participants' fears around the potential consequences of enforcing their tenancy rights and rights to adequate supports:[83]

80 *Residential Tenancy Act*, SBC 2002, c 78, ss 5 and 58.

81 *Residential Tenancy Act*, SBC 2002, c 78, s. 5.1.

82 *Human Rights Code*, RSBC 1996, c 210, ss 8 and 10.

83 While these cases occurred prior to recent amendments to the *Residential Tenancy Act* and changes at the Residential Tenancy Branch, it is not clear that the changes will address the fears raised by participants given that the fear is based on the power imbalance that comes with the risk of an attempted eviction (even if it has no merit) in the face of being unable to find replacement housing.

Case 1 (2016)[84]

A tenant with mental health problems had been living in his rental unit for three years. The unit had ongoing issues with leaks. The tenant's ceiling began to leak and the landlord did not taken any steps to repair it or offer an alternative place to stay for 13 days. The building manager then arrived abruptly at the tenant's door and told him to move all his furniture to a different unit with no assistance and with no promise that the tenant could stay there until the ceiling was repaired. The tenant became upset and told the manager to leave his unit using profanity. The landlord issued an eviction notice, which was eventually overturned after a hearing before the Residential Tenancy Branch.

Case 2 (2016)[85]

A tenant with mental health problems had been living in his rental unit for eight years. There were numerous issues with maintenance of the rental unit during that time and the tenant had a difficult relationship with the maintenance person. One day the maintenance person began yelling at the tenant's door to enter his unit to fix the toilet, which had needed repairs for six months. The tenant put his hand up to the maintenance person and raised his voice, and then went to the landlord requesting a certified plumber. The landlord issued an eviction notice, which was eventually overturned after a hearing before the Residential Tenancy Branch.

While the evictions were overturned by the Residential Tenancy Branch, the threat of eviction for a low-income tenant, who faces additional, complex barriers to finding new housing, creates immense stress and uncertainty that can have serious impacts on their mental health.

ACCOMMODATIONS TO MAINTAIN HOUSING SECURITY

The current system can fall short for people with mental health or substance use-related disabilities when advocating for their right to the disability-related supports they require to succeed in their tenancy. The needs of someone with a physical disability to have equitable access to housing tend to be more obvious; for example an elevator or ramp, a modified bathroom and kitchen, enough space to turn their mobility device, etc. The needs of and necessary accommodations for people with mental health and substance use-related disabilities can be far less clear. They may include health supports, a companion or support animal, assistance with household tasks or specialized staff to help them transition into secure housing. Some common mental health and substance-related symptoms can create barriers to accessing or maintaining housing in the same way as a lack of physical accessibility can for someone with a physical disability.

In the context of publicly funded low-income or supported housing, which is in incredibly high demand, accessibility should matter more given that people with disability-related needs face additional obstacles to securing housing.[86] In order to have an equitable right to access such housing, and the interrelated right to the highest attainable standard of mental health, people with mental health and substance use-related health issues must have their disability-related needs accommodated through all housing services on an ongoing basis that will allow people to be successful in their tenancies. To do otherwise violates their human rights and amounts to discrimination.

There is, however, no process to support tenants to resolve issues or seek the disability-related supports they need outside of bringing a complaint to the Human Rights Tribunal, which can be viewed by housing providers as very adversarial and can realistically put the landlord/tenant relationship at risk. This lack of more collaborative, proactive and preventative services to support people to identify and voice their disability-related needs, particularly in the face of affordable housing shortages, means that people either do not raise issues that would support their wellness (as we heard from participants) and put their tenancy at risk if their health worsens or their ability to maintain their housing unit is compromised, or they raise them and are thrust into a stressful legal process. Yet the latter remains inaccessible to many people, especially those with mental health and substance use-related disabilities.

84 Residential Tenancy Branch Decision 6207 (022016).

85 Residential Tenancy Branch Decision 6182 (052016).

86 *Watkins v. British Columbia Housing Management Commission*, 2018 BCHRT 39 at 116.

There are also numerous cases before the Residential Tenancy Branch that appear to raise potential human rights issues related to the tenant's disability-related needs such as whether or not a tenant was adequately accommodated with the supports they need to maintain their housing:[87]

Case 3 (2015)[88]

A tenant with mental health problems had been living in her non-profit rental unit for over a year. She had an ongoing issue with accumulating possessions and eventually the landlord became concerned about the emergency exits being blocked and cockroaches. It is not clear if the tenant was ever offered mental health supports. The landlord issued an eviction notice. The decision-maker noted, "[w]hile I understand the tenant suffers from mental health issues, that does not relieve her from her responsibilities as a tenant." The tenant was evicted from her non-profit housing.

Case 4 (2017)[89]

A tenant with schizophrenia and a substance use disorder had been living in a non-profit housing unit for people experiencing mental illness for a year and a half. The landlord found cannabis paraphernalia and harm reduction supplies in the tenant's apartment and one of the tenant's guests experienced a non-fatal overdose in the rental unit. The landlord issued an eviction notice for engaging in illegal activity by using illicit drugs. The tenant was evicted from his non-profit housing.

The current legal context in BC confirms what we heard from participants: if they exercise their rights to have a safe and maintained home, which supports their mental health, they may risk serious consequences and stress. If they struggle to maintain their housing because of reasons directly connected to their mental illness or a substance use-related disability, there is little opportunity to consider their disability-related needs or human rights in the legal processes that apply to tenancies. Without a more practical and meaningful way to voice their accommodation and tenancy-related needs, people with mental health and substance use-related disabilities do not have equitable access to housing services and therefore do not have an equitable right to the highest attainable standard of mental health.

RECOMMENDATIONS

1. Relevant public bodies should continue to build additional affordable housing that offers a flexible and progressive range of supports, specifically designed for people with mental health or substance use-related disabilities. For example, a person should have the option to move from a group home with on-site staff to an apartment managed by a local mental health non-profit as their health improves and if they choose to do so.

2. The Ministry of Municipal Affairs and Housing should develop a neutral, easy-to-use process for tenants to identify and voice their tenancy and assistance needs, with a focus on clients that might experience disability-related barriers doing so on their own (for example, clients in supportive housing arrangements). The service should be contracted out to be delivered by a low-barrier community-based organization where people with disabilities already access services.

3. The Attorney General should create a legal means to consider tenancy and anti-discrimination rights under the BC Human Rights Code when they are raised before the Residential Tenancy Branch. This could include a process for the BC Human Rights Tribunal to issue interim orders once a human rights complaint has been filed and amendments to the *Residential Tenancy Act* that allow for an interim delay in a residential tenancy dispute when such an interim order has been issued.

87 Again, while these cases occurred prior to recent amendments to the *Residential Tenancy Act* and changes at the Residential Tenancy Branch, it is not clear that the changes will address the concerns raised by participants—that they simply do not have (or do not know that they have) the ability to request accommodations to support their housing.

88 Residential Tenancy Branch Decision 6539 (062015).

89 Residential Tenancy Branch Decision 6043-1 (102017).

EXAMPLE 2: DISABILITY ASSISTANCE

Income is often considered the most important social determinant of health since it shapes overall living conditions, affects psychological functioning and influences health-related behaviors such as diet, physical activity and substance use. In *Social Determinants of Health: The Canadian Facts*, Juha Mikkonen and Dennis Raphael argue that income is the determinant of the other determinants of health and gains importance as the accessibility of social services and benefits decreases.

In Canada, where necessary supports such as childcare, housing and resources for retirement are bought and paid for by individuals, low income predisposes people to material and social deprivation. The greater the deprivation, the less likely individuals and families are able to afford the basic prerequisites of health and to experience social inclusion. The simple fact of not having bus fare or a couple extra dollars for a cup of coffee, never mind discretionary funds for meals out, birthday parties or hobbies, means that participation in cultural, educational and recreational activities is near impossible for people living in poverty. This fiscally imposed isolation lessens an individual's ability to find meaning in their daily life, foster relationships and exert control over their own life circumstances.

Furthermore, Mikkonen and Raphael suggest that people may feel ashamed, insecure and worthless on the basis of their living conditions and perceive everyday life as unpredictable, uncontrollable and meaningless. The authors then attribute increased anxiety and hopelessness to high levels of exhaustion and uncertainty about the future,[90] which for some populations is complicated by experiences of discrimination and structural violence.

The National Inquiry into Murdered and Missing Indigenous Women and Girls (NIMMIWG) identified social and economic marginalization that perpetuates colonial and interpersonal violence as a strong determinant of poor mental health and substance use outcomes for Indigenous people. Such marginalization is compounded by public services that are inaccessible to many because of their geographic location, insufficient funding, absence of culturally safe and trauma-informed approaches, and identification with government institutions that are responsible for legacies of colonial harm such as residential schools.[91] Poverty is too often the result. Indigenous peoples annual earnings are considerably lower than the rest of the Canadian population regardless of their type or duration of employment. The median total income of the Indigenous population aged 25 to 54 is just over $22,000, compared to over $33,000 for the non-Indigenous population in the same age group. This differs depending on where Indigenous people chose to live. Indigenous people who live on reserve have a considerably lower median income at only $14,000, while those who live off reserve have a median income closer to the overall average at $22,500 per year.[92]

Poverty is not resolved by applying for and even receiving income assistance. Income on social assistance is thousands of dollars below the cost of living. The rate for basic assistance is $760 per month, for Persons with Persistent Multiple Barriers (PPMB) $807.92 per month and for Persons with Disabilities (PWD) $1,183.42 per month.[93] The inadequacies of this system and its social implications was brought to the fore in BC's poverty reduction consultations: "People spoke about the unfairness and the indignities of our assistance systems, and the ways they were treated as "less than" by people who had power over their lives."[94] The complicated rules

"You almost have to be a clinician or legal expert to know how to fill in the information correctly and give the right key words. The way a normal person would express themselves—saying they are stressed or whatever— is exactly the key words they look for to block you off. It's a maze. You don't have a chance in hell. Even a regular person doesn't, never mind if you are off the scale at the time." – *Prince George participant*

90 Mikkonen, J. & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts*. York University of School of Health Policy and Management.

91 National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming Power and Place: The final report*. Volume 1a. Retrieved from: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf#page=418

92 Statistics Canada. (2015 November 30). Income: Median total income is lower for Aboriginal people. Retrieved from: https://www150.statcan.gc.ca/n1/pub/89-645-x/2010001/income-revenu-eng.htm

93 BC Government. (2019). Income Assistance Rate Table (effective April 2019). Retrieved from: https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/bc-employment-and-assistance-rate-tables/income-assistance-rate-table

94 See note 40, Government of British Columbia.

"I have been in the same position on PPMB for nine years. It just seems like once you get that status and fail twice at getting on disability, you are stuck. It's supposed to be temporary, but once it gets to 8 or 9 years, that's no longer temporary… It makes me feel like I am not validated, I am not worthy. It feels like you can never get out. You continue to struggle on a daily basis to feed and clothe yourself. You are constantly faced with decisions like do you want to buy toilet paper or do you want to eat."
– Salmon Arm participant

and application processes for obtaining assistance and the hierarchal bureaucracy of the Ministry deter people from applying or benefiting from income supports. The Carnegie Community Action Project reports that some people simply give up applying because they feel so ill-treated or run into insurmountable barriers. There are ongoing reports of lost files, requiring people to wait in line for hours at a time and refusing to allow people to consult with case workers about their circumstances. The consequence is that some people claim that dealing with the social assistance system makes them "crazy" or at the very least keeps them entrenched in poverty.[95] The irony is that the system meant to lift people out of poverty and support them in times of adversity is perpetuating the social and material conditions that keep them impoverished and prevent them from becoming mentally well.

WHAT WE HEARD

The greatest barrier to income assistance for most participants was the application process itself. The initial application and the application for status as a "person with disabilities" (PWD) is long, complex and daunting during times of illness. Many participants noted that they could not have completed the application process without the support of an advocate or a peer support worker who was familiar with the process. The identification and online account requirements, strict time frames for submitting documentation, need for a medical assessment, and necessity of seemingly "correct" responses to certain questions left participants anxious and confused. Some had to re-apply multiple times before gaining a PWD designation; others gave up trying to apply and remained on Persons with Persistent Barriers to Employment (PPMB).

Initial application:

- Participants who described themselves as computer literate appreciated the online self-service option and found the option preferable to either in-person or telephone interactions. Others experienced significant barriers to using their online account such as literacy challenges or not having access to a computer. They felt disinclined to conduct private matters on a public computer such as those accessible at a public library or WorkBC centre). These participants expressed a preference for a return to case management and in-person appointments. Participants collectively called for a range of options to suit the differing communication needs of the people accessing services.

"Some of the questions they ask. You really need to focus on the worst day you have had in your life, then put it down on paper. It was really a struggle to get my mind back to a place that wasn't great."
– Prince George Participant

"I applied for assistance four or five times. [It is] the repetition thing, having to apply online and go into the office to do the same thing, sets my anxiety off. I can never make the appointment. The last time I applied was a couple of weeks ago, through the Salvation Army with a worker. She told me to come back the next day and pick up a hardship cheque. I didn't come in the next day, thinking it wasn't a big deal. I went in the day after and waited three hours, only to have them tell me they had no record of me."
– Nanaimo participant

95 gie Community Action Project. (2018). *No Pill for this Ill: Our Community Vision for Mental Health*.

"I struggled with having to get information from a psychiatrist, from a doctor, from different types of professionals. The former psychiatrist I had told me that I didn't fit the protocol of someone who he considers to be disabled; then when I talked to someone who turned out to be my social worker. She said that's not what they are looking for, [rather] they are looking at whether or not you are able to function when you are at your worst. I am not. My psychiatrist provided extremely misleading information. That was a huge obstacle that I found. That took me to a level of distress I can't even describe… I am capable of going to an appointment and looking OK, but that turned out to be something against me…. I ended up many times getting so upset that I would tell my therapist, "what do I need to do to get help, try and kill myself a fourth time? Is that going to be enough for me to get help and have a PWD designation?" I didn't attempt suicide to get help, but after having survived, I realized that four days in intensive care and two days in acute care were not enough to receive a designation of having a disability. That is extremely infuriating, extremely frustrating."
– North Vancouver participant

- The repetition of the application process posed a problem for many participants. They found filling out their application, then confirming the information over the phone unnecessary and anxiety-producing; one participant never gained access to income supports because of this.

- Participants commented on the perceived disorganization of the Ministry. Some had their applications or files mysteriously go missing; others returned to Access Centres only to be told that there was no record of them ever having been there before.

PWD application:

- Participants described filling out the application as representing themselves at their very worst or putting on paper "the worst day of my life." This necessity of emphasizing their limitations, rather than their strengths, not only undercut their ability to maintain a positive outlook, but also reinforced feelings of worthlessness and shame.

- Some participants had difficulty obtaining appropriate medical documentation either because their doctor did not support their view of their illness as debilitating or refused to fill out the application because of the additional work or unfamiliarity with the kind of information requested. The unwillingness of doctors to support participants tended to reinforce self-doubt and exacerbate mental health symptoms.

- Advocates report that the PWD form has been made more onerous by the addition of extra blank pages in the applicant and physician sections, which inadvertently increases the chances of contradictory information appearing on the form and makes the application itself appear even more daunting and labour-intensive than it already is.

In all interactions:

- Participants reported dreading having to attend Access Centres. Many felt that the combination of income assistance together with other provincial services was embarrassing and stigmatizing. There was no privacy for them to speak with a worker without being overheard by others. In addition, the simple act of handing in a form or speaking with a worker often required hours of waiting. Participants described 3–4 hour queues, with only two workers on shift and five or more service windows that remained empty. The staffing shortages meant participants were re-located outside for an hour over lunch, while the doors were locked and they were expected to maintain their position in line.

- Participants similarly disliked the call centre phone lines. Each time a participant called, they were connected to a different Ministry worker, who would be unfamiliar with their case and sometimes give them different (occasionally inaccurate) information from that of the previous worker. The necessity of having to explain their circumstances to each new worker was stressful or even re-traumatizing for some participants. The onus was repeatedly put on them to prove they were deserving of assistance and benefits.

- The perceived dismissiveness and cruelty of the Ministry workers was repeatedly raised by participants. Multiple participants commented that workers ridiculed, misinformed and deprived them of benefits and often acted as if people in need of income supports "were asking for their money." Some had positive experiences with workers who tried to support them, but because of the variability of who they might speak with either over the phone or in-person, participants felt that whether or not they would have a question answered correctly or gain access to benefits was purely chance.

WHO ACCESSES SOCIAL ASSISTANCE?

In BC, social assistance is provided through the BC Employment and Assistance program. There are two main types of benefits: temporary assistance,[96] sometimes called income assistance, and disability assistance for families with a person designated as a "person with disabilities."[97] Social assistance is no longer referred to by the government as an income of "last resort," but remains a system that often supports people when they have no other financial means to survive. People on income and disability assistance typically do not have access to private long-term disability insurance, employment insurance or other forms of financial support and, as a result, social assistance is often accessed in crisis or near crisis-level financial situations. In this context, the importance of being able to meaningfully and equitably access benefits is of particular importance. Barriers to access can have dire and immediate consequences for those who need benefits.

"I went into [the Ministry office] to get a bed voucher because I needed a bed. They make you feel so bad, asking so many questions about why you need this. After a while you question yourself about whether you need it or not…They make you go out and find three different quotes, they take the cheapest one that has rips or bed bugs in it, and give it to you. I would rather sleep on the floor. I understand that they are trying to make us go out and get our own things, but they are there to help, at least give us something that is proper and useable. It's so belittling."
– Vernon participant

"It's hard to communicate over the phone and get the information you need. When you are overwhelmed with a mental illness, trying to get information, trying to write it down, it is very difficult. I consider myself fairly high functioning, but when I need information [related to assistance], I am very emotional. I need the in-person support."
– Salmon Arm participant

ENSURING EQUITABLE ACCESS

What does meaningful and equitable access mean in the context of social assistance benefits? In BC, most people accessing social assistance have some disability-related limitations impacting their lives given that over 71% of families in the BC Employment and Assistance program have a family member designated as a person with disabilities.[98] We know about the scope of limitations experienced because of how the provincial government defines disability in the context of receiving disability assistance. To qualify as a person with disabilities, you must satisfy the Minister that you have a severe physical or mental impairment that restricts your ability to perform "daily living activities" as confirmed by a proscribed professional.[99] BC legislation goes on to define which "daily living activities" must be impacted in order to qualify as a person with disabilities:[100]

For the purposes of the *Act* and this regulation, "daily living activities,"

a) in relation to a person who has a severe physical impairment or a severe mental impairment, means the following activities:

96 *Employment and Assistance Act*, SBC 2002, c 40.

97 *Employment and Assistance for Persons with Disabilities Act*, SBC 2002, c 41.

98 Ministry of Social Development and Poverty Reduction, BC Employment and Assistance Summary Report: Cases by Program and Family Type – April 2019.

99 *Employment and Assistance for Persons with Disabilities Act*, SBC 2002, c 41, s 2.

100 *Employment and Assistance for Persons with Disabilities Regulation*, BC Reg 265/2002, s 2.

i. prepare own meals;
ii. manage personal finances;
iii. shop for personal needs;
iv. use public or personal transportation facilities;
v. perform housework to maintain the person's place of residence in acceptable sanitary condition;
vi. move about indoors and outdoors;
vii. perform personal hygiene and self care;
viii. manage personal medication, and

b) in relation to a person who has a severe mental impairment, includes the following activities:

i. make decisions about personal activities, care or finances;
ii. relate to, communicate or interact with others effectively.

With respect to paperwork and applying for benefits, common disability-related barriers applicants face should be relatively easy to predict based on the very criteria that applicants must satisfy in order to be designated as a person with disabilities. For example, disability-related difficulties managing personal finances and financial documentation, making decisions about finances and communicating and interacting effectively are all very likely to be experienced by people in need of disability benefits. An application process with complex or lengthy requirements, a need to self-manage paperwork, and repeated personal interaction with staff could all be expected to be impacted. These disability-related limitations might be the very reasons that someone with a mental health or substance use-related disability needs to access disability benefits in the first place.

Despite recent improvements,[101] the process to apply for disability benefits remains complex and lengthy. For example, moving to an online process is more accessible for those who are computer literate or who face mobility limitations, but for those who do not have access to a private computer or who struggle with communication and task organization, online processes are complicated and difficult to navigate. If you do not meet very specific criteria,[102] you must complete a process that takes almost 20 steps and several months in order to access disability assistance.

Some participants in this project described being unable to navigate the application process despite experiencing significant health issues and having no housing or income expressly because of their mental health symptoms. For example, one applicant, who had no income or housing, reported attempting multiple times to apply for temporary income assistance, but his severe anxiety led to irritability, impatience and feelings of being overwhelmed, and he simply could not navigate the process. The social exclusion he experienced as a result was evident. He felt immensely frustrated that he was continually asked for the same information over and over again, which triggered significant anxiety. He simply gave up trying to access benefits, instead accepting entrenched homelessness and increasing his use of substances.

Other participants reported giving up trying to get a designation as a person with disabilities—which leads to a higher benefit rate, no employment obligations, and improved health supports—because of the eligibility application. They reported feeling like some questions were "trick" questions and that there was a right or a wrong way to answer them. Others reported difficulties finding a physician who knew them well enough to complete the lengthy form given that the questions focus in large part on daily living activities for which a physician would have no direct knowledge (difficulties housing cleaning and doing dishes, etc.).

The PWD application is a 26-page form that takes a deficit-focused approach by assessing how "severe" the applicant's disability-related limitations are to determine who is eligible and who is ineligible. The more severe the limitation is described, the more likely a person will be approved. While there is reference to mental health or cognitive limitations, the application focuses predominantly on physical limitations (walking, standing, carrying, etc.), which might be confusing for people with mental health and substance use-related disabilities because much of the information collected may not be applicable to their circumstances.

To complete the application process, a person requires the ability to manage and complete paperwork and the ability to communicate effectively in-person and in writing. These are precisely the same limitations that the Ministry accepts in order to be eligible for disability benefits. In other words, the application process requires the very abilities that an applicant must lack in order to qualify.

101 Recently, the online application went from 98 screens of questions to a guided application pathway process that is significantly easier to navigate (you are only taken to questions that apply to your situation based on previous answers, etc.).

102 *Employment and Assistance for Persons with Disabilities Regulation*, BC Reg 265/2002, s 2.1.

Interactions with ministry workers

A common theme we heard from participants was that the culture of the Ministry of Social Development and Poverty Reduction was a barrier in and of itself and had very negative impacts on their mental health. They reported being made to feel shame, worthlessness and stigma. Problems with the Ministry culture have been identified by other anti-poverty advocacy groups.[103] BC's own Together BC Poverty Reduction Strategy recognizes the ongoing stigma and discrimination experienced by people living in poverty.[104] The current Minister has spoken publicly about the need to reform the culture of the Ministry from one of a "payor of last resorts" with a focus on safeguarding funds by excluding or finding people ineligible to moving to a more supportive approach. Based on participants feedback in the project, this is a change that is desperately needed.

An application process that requires applicants to be able to independently communicate complex information and manage paperwork at a time when their mental health or substance use-related disability may be creating barriers to performing those exact activities is not equitable or meaningfully accessible to them. Such an approach results in a system that is inaccessible to people who need it for precisely the same reasons they need financial support in the first place. Meaningful and equitable access to social assistance requires that the province take into account what kinds of disability-related barriers clients are likely to experience and take all reasonable steps to ensure that the provincial government is accommodating those needs by designing services and supports with those barriers in mind.

The Employment and Assistance Appeal Tribunal

Many people who apply and are denied a PPMB status or a PWD designation have limited recourse to dispute decisions of the Ministry. The Employment and Assistance Appeal Tribunal (EAAT) is set up to independently determine appeals of Ministry decisions, including those that result in the refusal, discontinuance, or reduction of income assistance, disability assistance, or a supplement to either. While appeals continue to be made, albeit at a decreasing rate, those that are successful have fallen dramatically. Since 2005/2006, the success rate has declined from 38% of appeals to 10.4%. An all-time low was reached in 2015/2016 when only 7.6% of the appeals filed were successful. The slight increase the following year (3%) coincides with a review of the Tribunal by the EAAT chair and a much lower number of appellants, 614 people appealed their Ministry decision in 2015/2016, while only 395 appealed in 2017/2018. The decline in the number of appeals has been taking place since the early 2000s and arguably reflects the low success rate and the futility of the appeal process.[105]

Some advocates deliberately refrain from supporting clients with their appeals and instead advise them to re-apply for assistance.[106] Many see the appeal process as a waste of time, especially since doctors are not paid by the Ministry for their contributions. Instead appellants are expected to either pay a doctor $80 for a one-page letter or cope with doctors who say they have no time to supply the extra information. The considerable stress this causes appellants is seen as unnecessary by advocates given that there is little chance of success.[107] The EAAT process should be accessible, fair and transparent, providing a real opportunity to appeal Ministry decisions and receive a just outcome.

103 BC Poverty Reduction Coalition. (2018). *Shifting the Culture at the Ministry of Social Development and Poverty Reduction*. Retrieved from: http://bcpovertyreduction.ca/wp-content/uploads/2018/12/Culture-Shift-at-MSDPR-Final.pdf

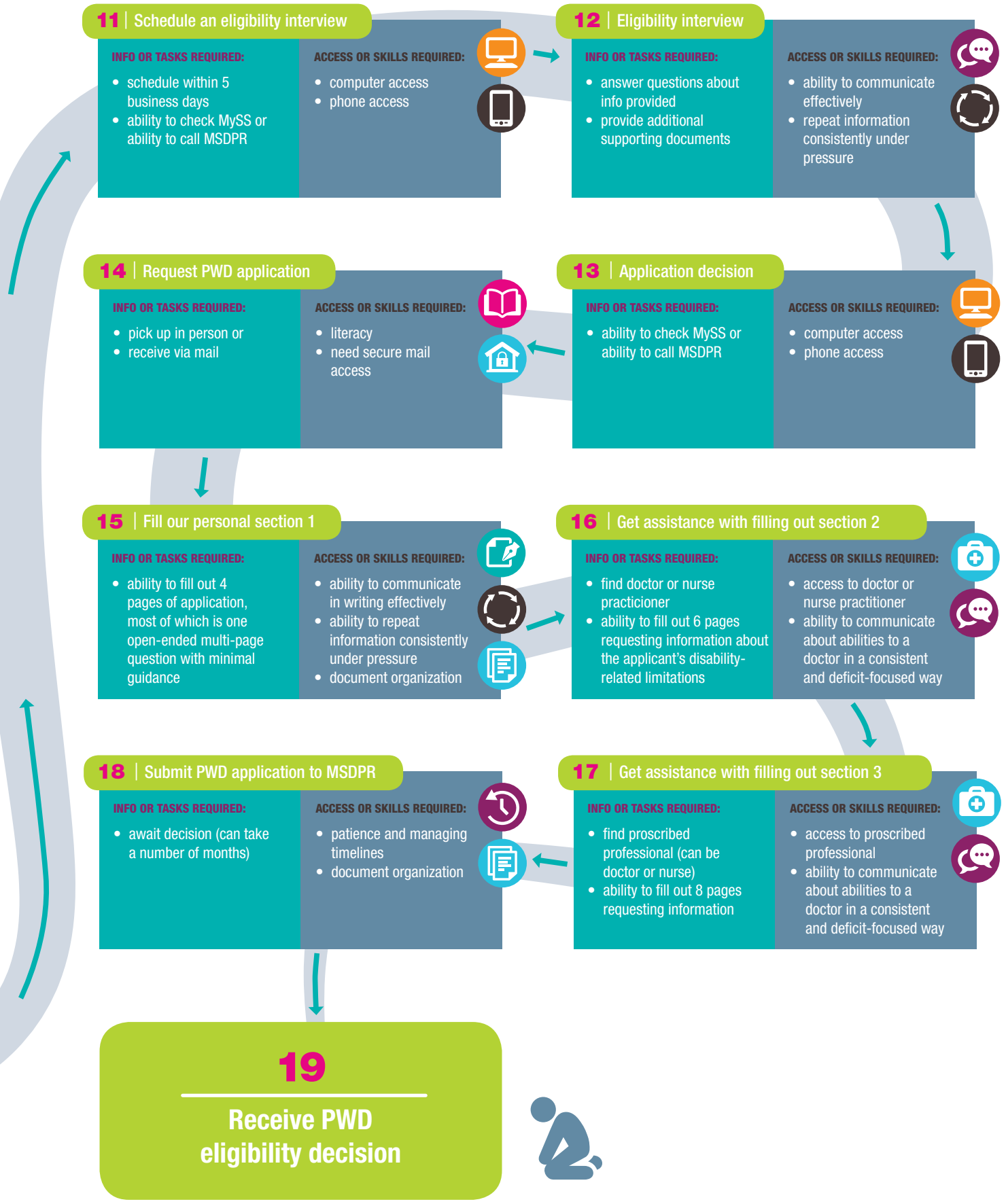
104 Government of British Columbia. (2019). *Together BC: British Columbia's Poverty Reduction Strategy*. Retrieved from: https://www2.gov.bc.ca/assets/download/37C3F286EFED400BBE814DE05B5CBBE6

105 Data has been collected from EAAT's Annual Reports. Retrieved from: http://www.eaat.ca/the-tribunal/annual-report

106 BC Public Interest Advocacy Centre. (2017). *Justice before the Employment and Assistance Appeal Tribunal and Poverty Reduction*. Retrieved from: http://bcpiac.com/employment-and-assistance-appeal-tribunal-and-poverty-reduction/

107 Observations reported by advocates at Disability Alliance BC. 8 August 2019.

THE APPLICATION PATHWAY FOR A *PERSONS WITH DISABILITIES* (PWD) DESIGNATION


11 | Schedule an eligibility interview
INFO OR TASKS REQUIRED:
• schedule within 5 business days
• ability to check MySS or ability to call MSDPR
ACCESS OR SKILLS REQUIRED:
• computer access
• phone access
12 | Eligibility interview
INFO OR TASKS REQUIRED:
• answer questions about info provided
• provide additional supporting documents
ACCESS OR SKILLS REQUIRED:
• ability to communicate effectively
• repeat information consistently under pressure
13 | Application decision
INFO OR TASKS REQUIRED:
• ability to check MySS or ability to call MSDPR
ACCESS OR SKILLS REQUIRED:
• computer access
• phone access
14 | Request PWD application
INFO OR TASKS REQUIRED:
• pick up in person or
• receive via mail
ACCESS OR SKILLS REQUIRED:
• literacy
• need secure mail access
15 | Fill our personal section 1
INFO OR TASKS REQUIRED:
• ability to fill out 4 pages of application, most of which is one open-ended multi-page question with minimal guidance
ACCESS OR SKILLS REQUIRED:
• ability to communicate in writing effectively
• ability to repeat information consistently under pressure
• document organization
16 | Get assistance with filling out section 2
INFO OR TASKS REQUIRED:
• find doctor or nurse practicioner
• ability to fill out 6 pages requesting information about the applicant's disability-related limitations
ACCESS OR SKILLS REQUIRED:
• access to doctor or nurse practitioner
• ability to communicate about abilities to a doctor in a consistent and deficit-focused way
17 | Get assistance with filling out section 3
INFO OR TASKS REQUIRED:
• find proscribed professional (can be doctor or nurse)
• ability to fill out 8 pages requesting information
ACCESS OR SKILLS REQUIRED:
• access to proscribed professional
• ability to communicate about abilities to a doctor in a consistent and deficit-focused way
18 | Submit PWD application to MSDPR
INFO OR TASKS REQUIRED:
• await decision (can take a number of months)
ACCESS OR SKILLS REQUIRED:
• patience and managing timelines
• document organization
19
Receive PWD eligibility decision

International human rights and health research tells us that we need a solid foundation of basic necessities such as income, housing, food and meaningful employment to enjoy mental wellness.

These basic necessities also influence the ways a person experiences either the health promoting effects of social inclusion or the harmful effects of exclusion.

RECOMMENDATIONS

The Ministry of Social Development and Poverty Reduction should implement changes to BC's social assistance programs and access centres, and increase funding to non-governmental agencies to provide or considerably enhance advocacy and support services that assist people with mental health or substance use-related disabilities in completing applications, including:

1. Continue steps to simplify and improve the income and disability application processes with the Ministry's own disability-related "daily living activities" (e.g., decision-making or communicating effectively with others, etc.) in mind. In particular, the application should only collect information that is necessary and relevant; avoid asking for the same information twice; and not focus solely on deficits, but allow applicants to identify positive qualities, abilities or activities such as volunteering without impacting eligibility.

2. Train frontline Ministry workers in trauma-informed service provision to ensure people who access services are treated with compassion, patience and understanding. The training may include education on mental health-related barriers and stigma reduction provided by people with lived or living experience of illness and of accessing assistance.

3. Provide funding for case managers and peer navigation staff in community organizations that serve people with mental health and substance use-related disabilities and complex issues such as homelessness to help them gain access to the system. Trained people with lived or living experience should fill these roles wherever possible to ensure low barrier, empathetic and responsive services.

EXAMPLE 3: INFLEXIBLE EMPLOYMENT SUPPORTS

The effects of employment and unemployment on mental health and well-being have been extensively researched. The key findings are that employment provides income, a sense of identity and purpose, social contacts, a structure for day-to-day life, and status and recognition for our efforts and achievements.[108] Unemployment leads to material and social deprivation, psychological stress and a higher risk of adopting unhealthy coping behaviors such as harmful substance use. People who are unemployed have a reduced life expectancy, experience more chronic health problems such as depression, anxiety and addiction and have increased rates of suicide.[109]

There is a middle ground of under-employment or economically inadequate employment between gainful employment and unemployment. This category includes involuntary part-time workers or low wage workers, who work as many hours as possible for a wage insufficient to meet the cost of living. In his analysis of this continuum of employment, David Dooley suggests that under-employment has only a limited number of the benefits of employment, but many of the disadvantages of unemployment. A person who is under-employed may have some wages, time structure, social purpose and status, but also experiences financial strain and, if part-time, partial loss of time structure, while enjoying fewer coping resources for periods of stress such as unemployment insurance, benefits and paid sick time. Moreover, a person's shift from full-employment to under-employment or acceptance of under-employment due to financial constraints may entail lower job satisfaction in regards relationships with co-workers and lower decision latitude.[110]

Research has shown that workers with low job satisfaction report mental health problems comparable to those who are unemployed.[111] This is attributed to a number of work dimensions that shape health outcomes such as employment security, physical conditions at work, work pace and stress, working hours, and opportunities for self-expression and individual development. High-stress jobs or jobs with an imbalance between demands and rewards predispose individuals to the development of physical and psychological difficulties such as depression and anxiety. Similarly increased mental health problems are seen among workers who experience high demands, but have little control over how to meet these demands.[112]

In some cases, however, some employment is better than no employment. People living with mental illness or substance use-related health issues may accrue benefits from employment irrespective of wage or status if participation in the workforce factors into their goals and aspirations for themselves.[113] In a focus group held by CMHA BC, participants identified paid work as not only an important source of supplementary income, but also a valuable means for participating in community, building a sense of self-worth and confidence, and supporting their mental wellness. This reflects a body of research that highlights the integral role employment can play in psychosocial recovery. A review of the literature by Evans and Repper confirms this positive correlation and concludes that while unemployment can incapacitate a person struggling with mental illness, work can "recapacite" them by tackling their social exclusion and providing an income, status and social contacts. Enforced unemployment for someone with a desire to return to or commence work can further perpetuate stigma and worsen mental health outcomes by circuitously confirming the erroneous assumption that such people are incapable of work and should be kept from working.[114]

The employment rate for Indigenous people is over ten percent lower than for non-Indigenous people across

108 Harnois, G. & Gabriel, P. (2000). *Mental health and work: Impact, issues and good practices*. World Health Organization, Mental Health Policy and Service Development Department of Mental Health and Substance Dependence.

109 Murphy, G.C. & Athanasou. (1999). The effect of unemployment on mental health. *Journal of Occupational and Organizational Psychology*, 72(1): 83-99

110 Dooley, D. (2003). *Unemployment, Underemployment, and Mental Health: Conceptualizing Employment Status as a Continuum*. American Journal of Community Psychology, 32(1/2): 9-19.

111 Butterworth, P., Leach, L.S., Strazdins, L., Olesen, S.C., Rodgers, B, & Broom, D.H. (2011). *The psychosocial quality of work determines whether employment has benefits for mental health: results from a longitudinal national household panel survey*. Occupational Environmental Medicine.

112 Lewchuk, W., de Wolff, A., King, A. & Polanyi, M. (2006). "*The Hidden Costs of Precarious Employment: Health and the Employment Relationship*." In Vosko, L.F. (ed), Precarious Employment: Understanding Labour Market Insecurity in Canada (pp. 141-162). Montreal: McGill-Queens University Press.

113 Canadian Mental Health Association BC Division. (2018). *Helping make ends meet? Understanding the impacts of BC's annualized earnings exemption on people living with mental illness*.

114 Evans, J. & Repper, J. (2000). *Employment, Social Inclusion and Mental Health*. Journal of Psychiatric and Mental Health Nursing, 7: 15-24.

"WorkBC, I am not necessarily pleased with them. I did go a couple of months ago to look into going back to work. I haven't worked for years, other than volunteering. They wanted me to do so many things. It was too much. I started to get sick, really sick. It was overwhelming. There were three days in a row, where it was a lot of information. I then had to see this person and that person. It happened within a space of three weeks, seeing all these different people and doing all these things. Emotionally, it was very taxing."
– Salmon Arm participant

Canada,[115] and their communities face significant barriers to work that reflect the colonial histories that shape their socio-economic realities. The most recent Aboriginal Peoples Survey reports that 52% of Indigenous people living off reserve aged 15 or older were employed in 2016. Among the employed, 82% of Indigenous people worked a permanent job. Indigenous women were more likely to work multiple jobs and hold part-time positions than Indigenous men. Nearly a third of part-time workers reported that this was not a choice and that a leading reason was childcare responsibilities. Otherwise the barrier to work most commonly experienced was a shortage of jobs. Additional barriers included not having work experience, enough education or training for available jobs and a means of transportation. Indigenous people who were not employed reported illness or disability as the leading reason why they are not looking for work despite wanting to work.[116]

WHAT WE HEARD[117]

Participants described WorkBC skills assessments, employment coaching and service centres as overwhelming and sometimes demoralizing. The strict schedule of appointments and assessments for job placements was experienced as overly rigid. Some who completed the program commented on their employment coach's disregard for their own goals when selecting a placement and the quick withdrawal of supports post-placement. There appeared to be an emphasis on checking boxes and tallying placements, rather than supporting individuals. Many did not remain employed. Without additional support, they felt they could not advocate for themselves and obtain accommodations for their mental health needs. The result was loss of employment and either complacency without work or a return to WorkBC for another round of assessments. The service centres themselves were described as a stack of newspapers and a couple of computers for self-directed job searching.

Participants called for:

- Self-paced assessments and appointments
- Work placement based on their goals rather than simply what jobs are available
- Employment coaches who have a better understanding of mental health and substance use-related conditions
- More follow up with their employment coach after work placement to support them to transition and acquire workplace accommodations

WHO ACCESSES WORKBC SERVICES AND WHAT CAN THEY ACCESS?

WorkBC Self-Serve Services, both in-person and web-based, are available to anyone who registers online. Other Employment Services, which include case management, are restricted to BC residents who are legally eligible to work in the province, unemployed or precariously employed, seeking employment, and assessed as requiring services to successfully achieve employment.[118] Anyone who meets these criteria or has employment-related obligations due to social assistance requirements can walk into a WorkBC office to access a range of resources to support their job search; however,

115 Statistics Canada. (2017). *Labour in Canada: Key results from the 2016 Census*. Retrieved from: https://www150.statcan.gc.ca/n1/daily-quotidien/171129/dq171129b-eng.htm

116 Statistics Canada. (2018). *Labour Market Experiences of First Nations people living off reserve: Key findings from the 2017 Aboriginal Peoples Survey*. Retrieved from: https://www150.statcan.gc.ca/n1/pub/89-653-x/89-653-x2018003-eng.htm

117 The focus groups took place January 2019 and do not reflect recent changes to WorkBC that came into effect the following April. Some of the concerns raised by participants have been addressed through those changes. Please refer to the discussion on pages 44-47.

118 Province of British Columbia. (2019). *Who Should Visit A Workbc Centre*. Retrieved from: https://www.workbc.ca/Employment-Services/WorkBC-Centres/Who-Should-Visit-a-WorkBC-Centre.aspx

higher intensity services such as customized job placement and work experience placement are reserved for people who have complex barriers to employment.

Barring certain circumstances,[119] people who apply for income assistance are required by the Minister to conduct a three-week work search. A referral by the Ministry for employment-related obligations to a WorkBC contractor is followed by a Client Needs Assessment (CNA) whereby a client's employment-related strengths, needs, abilities, skills and all other relevant factors are collected to determine their level of employment readiness and employment service needs. If a client is deemed unable to obtain employment independently, they are eligible for case management and meet with a case manager to develop an action plan, which includes employment goals and objectives, key activities, services and supports, and an agreed upon schedule and method of contact. The case manager is then responsible for supporting and monitoring the client's progress, revising their action plan if their circumstances or needs change and reporting on the completion of their plan. Alternatively, if a client is capable of obtaining employment on their own, they may access Self-Serve Services and conduct their job search independently, providing regular updates to the Ministry on their activities and progress for the three week period.[120]

Some clients referred to case management may require additional support for disability-related employment needs. If a client presents with or self-discloses a disability, they are given the option to complete a Disability-Related Employment Needs Assessment (DRENA) to access specialized, disability-related supports and services. The assessment is conducted by a qualified WorkBC contractor. An external third party organization or individual with particular expertise may be requested to identify and confirm a client's specific employment-related disability factors through additional specialized assessments such as a learning disability assessment or a functional capacity assessment. The confirmation of a disability is based on a definitive, observable disability; a referral from a local mental health team; other credible, verifiable evidence or related assessments of disability; a Persons with Disabilities (PWD) designation; a Persons with Persistent Multiple Barriers (PPMB) status; or confirmed usage of Community Living BC services.[121]

"Work is different for people with mental health issues. If I go to work, I want to be honest with my employer that I have a mental health issue, but I don't know how to go back to work, how to tell an employer and what kinds of supports I need – that's why I went to WorkBC, but I never made it that far [in the program]. A peer advocate would have been helpful." – ***Salmon Arm participant***

Notably, the criteria for obtaining a PPMB status has recently been revised. Clients no longer need to be on assistance for 12–15 months, may report an addiction as an eligible health condition and do not have to complete a multi-stage application process that previously included an employability screen and an employability profile to determine if a client's health condition "seriously impedes" or "precludes' their ability to search for, accept and continue in employment. As of July 1st, 2019, PPMB status will be determined by an assessment completed by a health professional and an application that identifies barriers to employment. Furthermore, the two-year mandatory review period has been removed.[122]

119 Ministry of Social Development and Poverty Reduction. (2019). Work Search. BCEA Policy & Procedure Manual. Retrieved from: https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/application-and-intake/work-search. The following circumstances exempt an income assistance applicant from fulfilling the three-week work search requirement, but are not exhaustive. Please refer to the BCEA manual for further information:

- fleeing an abusive spouse or relative
- a sole applicant with a dependent child or provides care for a child under the age of 3 years
- has a physical or mental condition that precludes the applicant from completing a search for employment
- cannot legally work in Canada
- has reached 65 years of age
- facing a direct and imminent life-threatening health need
- currently resides in a hospital or continuing care facility

120 Ministry of Social Development and Poverty Reduction. (2019). WorkBC Employment Services. BCEA Policy & Procedure Manual. Retrieved from: https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/eppe/workbc-employment-services

121 See note 120, Ministry of Social Development and Poverty Reduction.

122 Ministry of Social Development and Poverty Reduction. (2019). *Persons with Persistent Multiple Barriers*. BCEA Policy & Procedure

People who receive a PWD designation or PPMB status do not have employment-related obligations, but may choose to access WorkBC and pursue employment through Self-Serve Services or case management with additional disability-related supports and services if needed. An additional WorkBC offering for this population, who may require more intensive supports is Customized Employment (CE). An individualized approach, CE aims to create unique employment opportunities for clients based on their strengths, needs and interests, and personalized employment relationships. The process involves four components, namely identifying client strengths and goals; creating an Employment Profile to determine best-match scenarios between work environments, supports and job duties; supporting clients and working with employers to create suitable job opportunities; and negotiating job placement details with employers to include workplace accommodations if necessary. There is also an emphasis on maintaining clients' "natural supports" such as family, friends and co-workers both outside and inside the workplace to enable ongoing job retention.[123]

The eligibility criteria for WorkBC employment services and the services themselves have undergone significant changes in recent months. The intake assessments, CNA and DRENA, have been standardized and streamlined from previous iterations, the criteria and process for obtaining PPMB status has been simplified and CE has opened up to any case-managed person who requires intensive supports. These revisions and expansions reflect a broader set of changes to WorkBC contracts that looks towards supporting clients to reach their employment goals, rather than simply placing them into jobs to get them off assistance.

RECENT CHANGES TO WORKBC CONTRACTS

The rationale given by the BC government for recent changes to WorkBC is "improving services for people who need support to re-enter the workforce, access training opportunities and find good jobs". There is a clear focus on creating financial incentives for contractors to work with and find employment for persons with barriers and to make the centres more accessible to a broader range of people, including offering services to people who were formerly ineligible and increasing the number of service centers overall.[124]

The Ministry of Social Development and Poverty Reduction has stated that "significant changes to the employment services contracts… will include an enhanced focus on flexibility in services to ensure the most effective and positive outcomes for clients. Sustainable employment is the key goal of the new program."[125] All WorkBC suppliers who successfully bid for contracts offer some combination of a self-service centre, with computers and internet access, printers, telephones, fax machines, photocopier and scanning services, community service resource information, self-serve job search and employment-focused workshops; job postings or listings of local opportunities; wage subsidies; financial supports, apprenticeships; training programs; and case management, with employment planning and skills assessments for eligible clients. The latter is primarily focused on people who have barriers to employment.[126]

There are now 97 communities across BC with a local WorkBC office, but only 45 providers. Some have multiple communities. What this means for clients is an increase in the number of WorkBC centres, from 84 to 103 locations; changes in hours of operation at certain centres, some with restricted opening times; and the possibility of a new service provider given that the administrative catchment areas have changed to align with economic regions. The majority of WorkBC suppliers remain the same, but may be responsible for different areas; only one organization is new to the program and the proportion that are local non-profits has increased from 49% to 57%.[127]

The greatest difference in the provision of service is the extension of eligibility criteria and changes to the funding model. The criteria for specialized WorkBC services will now include anyone who has paid into employment

Manual. Retrieved from: https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/eppe/persons-with-persistent-multiple-barriers

123 Ministry of Social Development and Poverty Reduction. (2019). *Employment Programs, Planning and Exemptions*. BCEA Policy & Procedure Manual. Retrieved from: https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/eppe

124 Government of BC. (2019). *WorkBC improvements help people get training, find good jobs*. Ministry of Social Development and Poverty Reduction. Press Release. Retrieved from: https://news.gov.bc.ca/releases/2019SDPR0003-000173

125 BoardVoice. (2019). *WorkBC procurement: Successful proponents*, Shane Simpson response. Website. Blog Post. Retrieved from: http://boardvoice.ca/public/2019/02/27/workbc-procurement-successful-proponents-shane-simpson-response/

126 Information collected from WorkBC suppliers' websites and program descriptions.

127 Government of BC. (2019). Improving services at WorkBC. Retrieved from: https://news.gov.bc.ca/factsheets/improving-services-at-workbc

insurance for five of the last ten years and people who aspire to better employment because their hours are unstable or their work is not in line with their skills. In addition to this wider scope of clientele, service providers have reason to prioritize their client's long-term success in the job market, especially those who experience barriers to employment. Previously providers received funding for operations and received payment for each client interaction; now service providers still receive a monthly payment for operational costs such as facilities and staff, but instead receive a performance payment when they successfully help someone find and maintain employment. Payments will vary depending on individual people and their barriers to work. The more barriers a client has and the longer they retain employment, the higher the payment. Service providers are incentivized to focus their efforts on supporting people with complex needs to not only find education and employment opportunities that match their goals and abilities, but also remain employed, with continued support if eligible for and receiving case management.[128]

BUILDING AN EVIDENCE-BASED MODEL FOR EMPLOYMENT SUPPORTS

Previous employment programs provided through WorkBC had low levels of success for people with serious mental health or substance use-related issues.[129] The one-size-fits-all employment support model was inadequate and left many people struggling to find work; but recent changes to WorkBC prioritize individualized support and build on well researched, evidence-based supportive employment programs with much higher success rates.

The Individual Placement and Support (IPS) employment model is considered the gold standard of employment supports in many jurisdictions. It has a strong evidence base, with at least 25 randomized controlled trials that demonstrate a positive outcome in the lives of people experiencing serious mental illness, problematic substance use and homelessness.[130] Similar to the Housing First model, IPS uses a zero-exclusion approach that focuses on self-determination, choice and the assumption that everyone can work in the competitive job market if they choose without any employment readiness assessment. The model also utilizes rapid job searches and integrated employment supports that may include employer support if the individual participating chooses to disclose their health issues.[131] IPS has significantly higher success rates for people with serious mental illness than traditional vocational supports if fidelity is maintained. IPS also has an evidence base for provision to youth, people with substance use-related illness, people experiencing homelessness, and people living in rural areas.[132] In addition to improved success in work placements, IPS has been shown to contribute to reduced psychiatric hospitalizations, fewer symptoms, longer work tenures, more hours worked and higher wages.[133]

There are some similarities between the IPS model and WorkBC Employment Services, although no one program can offer a direct comparison. Job Search

"I am going to WorkBC once a week. My [employment coach] is trying to design a job for me. She wants to know the things I can't do and some of the things I can do, my skills and the like. The problem is that the more details she has, the harder it is to find something that fits. I started going there before Christmas and we're still working on it. The more needs you have, the more limitations you have, the harder it is to find a job that suits you. Plus the kind of things I thought I wanted to do, I found out aren't the right fit for me because of my illness."
– Vernon participant

128 See note 127, Government of BC.

129 Panagio C. *Adapting the Individual Placement and Support Employment Program for Vancouver's Homeless Population*. Published 2016.

130 The IPS Employment Center. *Evidence for IPS*. Published 2018. https://ipsworks.org/index.php/evidence-for-ips/

131 The IPS Employment Center. *What is IPS*. Published 2018. https://ipsworks.org/index.php/what-is-ips/

132 Ferguson, K. et al. (2012). *Adapting the Individual Placement and Support Model with Homeless Young Adults. Child Youth Care Forum* 41: 277–294; Bond, G.R. et al. (2016). *Effectiveness of individual placement and support supported employment for young adults*. Early Intervention in Psychiatry 10: 300–307; Haslett, W.R. et al. (2011). *Individual Placement and Support: Does Rurality Matter?* American Journal of Psychiatric Rehabilitation 14: 237–244.

133 Campbell, K. et al. (2011). *Who benefits from supported employment: an meta-analytic study*. Schizophrenia Bulletin 37(2): 370–380; O'Connor, D. et al. (2008). *Individual placement and support for people with severe mental illness wishing to enter competitive employment improved vocational outcomes and reduced hospital admissions*. Australian Occupational Therapy Journal 55: 291–296; Bond, G.R. et al. (2011). *Is Job Tenure Brief in Individual Placement and Support (IPS) Employment Programs?* Psychiatric Services 62(8): 950-953.

Services support clients with competitive employment opportunities and provide resources, training and one-to-one job coaching based on the individual needs of the client; whereas, Customized Employment offers a more intensive process focused on creating a job opportunity for a client based on their strengths, interests, abilities and ideal working conditions. While Job Search Services are open to anyone who qualifies for case management, CE is only offered to clients who have complex or developmental disabilities. Regardless the most notable distinction between the two types of service is whether clients are supported to find a job in the competitive workforce or encouraged to create a job tailored to their unique circumstances.

The goal of IPS is for clients to "achieve steady, meaningful employment in mainstream competitive jobs."[134] Customized Employment, while closely paralleling the program components and entry criteria of IPS, does not, but should share this same goal. The analysis that follows discusses how CE can be modified to align with IPS in both objective and delivery.

Clients who are eligible for CE are given the opportunity to pursue employment based on their preferences and cultivate an employment relationship that accommodates their disability-related needs. This occurs with the support of a case manager, who assists with the identification of individualized job goals, selects and negotiates with potential employers and facilities an integrated system of supports that includes positive social relationships.[135] In this respect, CE adheres to a number of principles exemplified by IPS, namely worker preference, systematic job development and integrated services; however, there remain areas where CE and the preceding eligibility screening fall short of the IPS model.

Before clients are identified as needing intensive supports and are placed in the CE program, they complete multiple stages of assessments that include online questionnaires, an interview and specialized assessments. The client has to have completed a CNA and/or DRENA, and be identified as a person with a disability or as having significant, multiple barriers to employment. Upon entering the program, a client starts with a "discovery process" that involves compiling information about their skills, preferences and employment goals through qualitative assessment and observation of their behaviour in a variety of work and social environments. While such a strength-based approach is positive, clients are asked to repeat similar processes of information gathering two, sometimes three times before job placement is even considered.[136] This stands in stark contrast to the IPS approach of rapid job search, where face-to-face contact with employers is prioritized over assessments and occurs within 30 days of clients entering the program.[137] The repetitive nature of CE eligibility and assessments delay a client's entry into the workforce and reinforce notions that they are not yet ready for employment; whereas IPS reaffirms a client's abilities and promotes immediate social integration through expediting any pre-placement planning.

How can clients receive continued support if job placement occurs soon after they enter the program? IPS offers much more than job coaching. The program is integrated with mental health treatment teams and includes employment specialists who not only support job placement, but also help clients obtain personalized and understandable information about their social assistance and benefits. Such time-unlimited and wraparound supports mean clients do not fear losing the supports that enabled their employment in the first place.[138] CE offers a type of sustained and comprehensive support, but enforces greater restrictions. Case managers are tasked with facilitating an integrated system of supports and funding sources, and can offer successful clients access to job sustainment services[139] that include mediating conflict with employers, arranging health-related accommodations and assisting with workplace orientation and task instruction. Case managers do not commonly communicate with other professionals on a client's care team, although WorkBC contracts do not restrict them from doing so, and clients are only eligible for such support for a maximum of 52 weeks post-placement.[140] While this is a significant improvement over basic job coaching, it remains below the standard set by IPS and cannot guarantee the same levels of success.

134 Bond, Gary; Drake, Robert; Becker, Deborah (2008). *An Update on Randomized Controlled Trials of Evidence-Based Supported Employment.* Psychiatric Rehabilitation Journal. 31 (4): 280–290

135 See note 123, Ministry of Social Development and Poverty Reduction

136 See note 123, Ministry of Social Development and Poverty Reduction.

137 See note 130, The IPS Employment Centre.

138 See note 130, The IPS Employment Centre.

139 Please note that WorkBC job sustainment services are available to any client who achieves employment, whether through CE, Job Search Services or other employment services.

140 See note 128, Ministry of Social Development and Poverty Reduction.

IPS is a solid model that supports long-term paid employment for people living with mental illness or problematic substance use and experiencing significant barriers to work. An established evidence base validates its particular approach to individualized support. WorkBC services should align their program requirements and offerings with the IPS model, especially for clients who require more intensive supports and connect them with both primary health care networks and specialist mental health teams.

ACCESSIBILITY OF WORKBC CENTRES

WorkBC contractors are required to provide services that are accessible for every client. In practice this means that all clients are "able to approach, enter and make use of an area and its facilities… without assistance."[141] The Accessibility Standards set by the Ministry are intended to outline how this should be achieved and focus primarily on meeting clients' physical disability-related needs. There are requirements for ramps, handrails, tactile signage and other modifications to the built environment, as well as for specialized software, devices, and personnel such as sign language interpreters to support people who have visual, speech and hearing impairments.[142] In short, there is a requirement for universal design, except there is a notable absence of accommodations for mental health and substance use-related disability needs. This is unsurprising given the lack of research as to what constitutes such an accommodation.

While there are no evidence-based guidelines on which to base mental health and substance use-related accessibility standards, there are simple changes to physical and social environments that can have a positive impact on people living with illness and meet their disability-related needs. Participants spoke of the lack of privacy at service centres, citing a reluctance to use facilities because of their exposure, and minimal or no staff literacy on mental health conditions, reporting that workers often conflated cognitive impairments with symptoms of mental illness. These experiences left participants feeling shamed and dissuaded them from accessing WorkBC services; in other words, they were prevented from being "able to approach, enter and make use of [the] area and facilities."[143] Minimal changes or accommodations such as varying levels of openness in communal areas and mental health literacy training for staff can create a more accessible environment. The Accessibility Standards included within the WorkBC Employment Services policy should include such considerations of mental health and substance use-related needs.

RECOMMENDATIONS

1. The Ministry of Social Development and Poverty Reduction should align the provision of WorkBC's customized employment (CE) program with the Individual Placement and Support (IPS) model that prioritizes strength-based, rapid job search and placement, and reduce barriers to entering the program for people living with mental health or substance use-related disabilities such as repeat information gathering and skills assessments.

2. The Ministry of Health in partnership with health authorities and the Ministry of Social Development and Poverty Reduction should integrate the modified CE program within primary care networks and specialist mental health teams to ensure clients receive wrap-around supports that meet their needs.

3. The Ministry of Social Development and Poverty Reduction should include mental health and substance use-related accommodations in accessibility guidelines given to WorkBC service providers such as varying levels of privacy and openness in waiting or Self-Serve areas, flexibility in pace and frequency of programs, and mental health literacy training for all staff.

141 Government of British Columbia. (2018). *British Columbia Building Code Review of Proposed Changes: Accessibility*. Retrieved from: https://www2.gov.bc.ca/assets/gov/farming-natural-resources-and-industry/construction-industry/building-codes-and-standards/other/accessibility_proposed_code_change.pdf"

142 Information recorded in conversation with WorkBC contractor. 27 June 2019.

143 See note 141, Government of British Columbia

CONCLUSION

We all have a human right to achieve our best physical and mental health, and that right is closely related to and dependent on the realization of other rights such as a right to an adequate standard of living, housing and healthy occupational and environmental conditions. These rights underscore research that demonstrates that certain material and social conditions or determinants of health are required to attain mental wellness and highlight the need for equity-based approaches to the provision of public services that dismantle barriers and alleviate health disparities between different groups of people.

All people should have what they need to live with dignity and be included in the communities and social structures that inform their lives – only when the opposite occurs and people are withheld their rights, denied social goods and economic participation, degraded on the basis of stereotyped attributes and deprived of positive social contact are poor mental health and substance use outcomes the result. The increasing prevalence rates of mental illness in unequal societies such as BC demonstrate how material and social conditions, where people are disconnected from one another and reliant on appraisals of status to confirm identity and perceptions of worth, lead to anxiety, insecurity, low self-esteem and depression. This is particularly true for people who are low income and access social services, and who contend with discrimination or exclusion associated with poverty, stigma, racism or ongoing colonialism.

Poverty creates further barriers to mental well-being. Many people who find themselves living in poverty report being caught up in the downward spiral that loss of income can initiate. Without sufficient financial resources, people are unlikely to find secure housing, meaningful employment, and a place within a community. Instead they are left on the margins of society with little recourse for re-entry. Our public services, which include subsidized and supported housing, income assistance, employment supports and community spaces, are intended to provide the resources to prevent this. The mere provision of such support demonstrates that each person has value and the potential to contribute to a community. An absence or inadequacy of supports conveys the exact opposite and leads to feelings of hopelessness and a loss of control over life circumstances that precipitates mental illness and coping behaviors such as problematic substance use.

Stigma and discrimination experienced by people living with mental health and substance use-related illness further entrenches poverty by erecting even more barriers both interpersonal and systematic to acquiring the resources and relationships necessary for a place and position within society. The impact is magnified for those who experience overlapping forms of discrimination or exclusion on the basis of other aspects of their identity, including race, indigeneity, gender, migration status or others. Both poverty and mental health-related discrimination reinforce one another and create conditions of abject social exclusion, which perpetuate and worsen both material deprivation and symptoms of illness. The intersection of further stigmatized attributes of gender, sexual orientation, indigeneity and race only intensifies this process and increase the risk of poor mental health outcomes and harmful substance use.

BC's public services should interrupt this reinforcing cycle and provide access to supports and programs that uphold human rights and foster social inclusion, but oftentimes the policies and procedures that govern access create insurmountable barriers for people living with mental health and substance use-related disabilities. The irony is that the reasons people apply for services are often the causes of them being denied. To demonstrate need for social supports and services, people have to demonstrate the disabling effects of their health condition, while successfully filling out lengthy forms and navigating complicated bureaucratic processes. If someone manages to do so on their own, they risk demonstrating that their symptoms of illness are not disabling to the extent that is required to receive assistance and may be denied; whereas, if the symptoms of their disability are too severe to attempt the process and no one is available to assist them, they may be denied the opportunity to even try to gain access.

Such barriers and failures to accommodate within our public system not only worsen health disparities, but also create a cycle of poor health and heightened need for those who successfully gain access. People report that every interaction, whether for a crisis grant, a tenancy issue, or job coaching, constitutes another opportunity for either inclusion and support or exclusion and denigration. The power dynamics between staff and service providers who administer programs, and the people who are receiving them reinforce social hierarchies and exacerbate feelings of shame. The intimation of being less-than leads to further marginalization that directly contributes to symptoms of illness. The realities of living on assistance and accessing public services, or trying to return to work and experiencing failure because of service design, or being unable to enforce your basic tenancy rights, further contributes to poor mental health and substance

use outcomes. The result is a system that creates an environment of exclusion that keep people mentally unwell and deepens their need for public services.

The cycle can be interrupted. The provision of accessible services can be achieved if barriers are dismantled and tailored supports are provided to people with disability-related needs. BC's *Human Rights Code* affirms that service providers have a duty to accommodate individuals who face health-related accessibility barriers and their efforts to accommodate must be considered "reasonable" within each circumstance. In some cases, if a service provider collects disability-related personal information, they may also have a duty to inquiry about accessibility-related needs and provide relevant accommodation to ensure equitable access. The latter holds true for service providers who adjudicate or respond to applicants about PWD or PPMB applications or administer disability benefits. The former applies to all service providers who control access to housing, income assistance and employment supports.

All publicly available services should be person-centred and equitable, upholding each person's right to access the supports that promote their highest attainable standard of health and fulfilling service providers' obligations to provide accessible services and accommodate disability-related needs. The 12 recommendations that follow outline necessary steps towards achieving this:

HUMAN RIGHTS

1. **The BC Human Rights Commission should audit the laws and policies governing the provision of social services** to identify and eliminate accessibility barriers that prevent or dissuade people with mental health and substance use-related disabilities from obtaining the supports and services they are eligible for.

2. **Alternatively, the Ministry of Mental Health and Addictions should establish an independent Mental Health Advocate to monitor the performance of public services** that impact people with mental health and substance use-related health issues, receive and act on systemic disability-related complaints and protect the human rights of people living with illness who access services.

3. **The Ministry of Social Development and Poverty Reduction should ensure that its commitment to develop and pass comprehensive accessibility legislation will go beyond physical notions of accessibility** and ensure that people with invisible disabilities, in particular people with mental health or substance use-related disabilities, can fully participate in their communities.

HOUSING

4. Relevant public bodies should continue to build additional affordable housing that offers a flexible and progressive range of supports, specifically designed for people with mental health or substance use-related disabilities. For example, a person should have the option to move from a group home with on-site staff to an apartment managed by a local mental health non-profit as their health and if they chose to do so.

5. The Ministry of Municipal Affairs and Housing should develop a neutral, easy-to-use process for tenants to identify and voice their tenancy and assistance needs, with a focus on clients that might experience disability-related barriers doing so on their own (for example, clients in supportive housing arrangements). The service should be contracted out to be delivered by a low-barrier community-based organization where people with disabilities already access services.

6. The Attorney General should create a legal means to consider tenancy and anti-discrimination rights under the BC Human Rights Code when they are raised before the Residential Tenancy Branch. This could include a process for the BC Human Rights Tribunal to issue interim orders once a human rights complaint has been filed and amendments to the Residential Tenancy Act that allow for an interim delay in a residential tenancy dispute when such an interim order has been issued.

DISABILITY ASSISTANCE

The Ministry of Social Development and Poverty Reduction should implement changes to BC's social assistance programs and access centres, and increase funding to non-governmental agencies to provide or considerably enhance advocacy and support services that assist people with mental health or substance use-related disabilities in completing applications, including:

7. **Continue steps to simplify and improve the income and disability application processes** with the Ministry's own disability-related "daily living activities" (e.g., decision-making or communicating

effectively with others, etc.) in mind. In particular, the application should only collect information that is necessary and relevant; avoid asking for the same information twice; and not focus solely on deficits, but allow applicants to identify positive qualities, abilities or activities such as volunteering without impacting eligibility.

8 **Train frontline Ministry workers in trauma-informed service provision to ensure people who access services are treated with compassion, patience and understanding.** The training may include education on mental health-related barriers and stigma reduction provided by people with lived or living experience of illness and of accessing assistance.

9 **Provide funding for case managers and peer navigation staff in community organizations that serve people with mental health and substance use-related disabilities** and complex issues such as homelessness to help them gain access to the system. Trained people with lived or living experience should fill these roles wherever possible to ensure low barrier, empathetic and responsive services.

WORKBC EMPLOYMENT SERVICES

10 **The Ministry of Social Development and Poverty Reduction should align the provision of WorkBC's customized employment (CE) program with the Individual Placement and Support (IPS) model** that prioritizes strengths-based, rapid job search and placement, and reduce barriers to entering the program for people living with mental health or substance use-related disabilities, such as repeat information gathering and skills assessments.

11 **The Ministry of Health in partnership with health authorities and the Ministry of Social Development and Poverty Reduction should integrate the modified CE program within primary care networks** and specialist mental health teams to ensure clients receive wrap-around supports that meet their needs.

12 **The Ministry of Social Development and Poverty Reduction should include mental health and substance use-related accommodations in accessibility guidelines** given to WorkBC service providers such as varying levels of privacy and openness in waiting or self-serve areas, flexibility in pace and frequency of programs, and mental health literacy training for all staff.

If a person has friends and healthy relationships, feels they are a part of a community and can meet their basic needs, they are less likely to experience anxiety, depression or problematic substance use.

People in recovery who are living with mental illness or problematic substance use are deeply impacted by barriers they face getting and keeping the resources and relationships they need to feel included.

In other words, social inclusion and the factors that either promote it or deny it are important to having an equal chance at mental wellness.