NO PILL FOR THIS ILL

OUR COMMUNITY VISION FOR MENTAL HEALTH

Carnegie Community Action Project

THANK YOU!

Thank you to everyone who participated in the Our Community Vision for Mental Health working group including Alan Lee, Alanna Mulholland, Anthony Meza-Wilson, Caitlin Hurley, Debra McNaught, DJ Joe, Emma, Harold Lavender, Hendrik Beune, Herb Varley, Keya, James, Jean Swanson, Joanne, Karen Ward, Lama Mugabo, Phoenix Winter, Scott Harrison, Tracey Morrison, Maria Wallstam, Cecily Nicholson, Victoria Bull and the many others who came to our meetings and events over the last year. Special thanks to Alanna who helped coordinate the project and to Gallery Gachet for inspiration, support and space.

CCAP acknowledges that we organize and work on the occupied, unceded traditional territory of the Coast Salish peoples, including the territories of the Musqueam, Skwxwú7mesh (Squamish), Stó:lo and Selilwitulh (Tsleil–Waututh) peoples.

ABOUT CCAP

Carnegie Community Action Project (CCAP) is a project of the board of the Carnegie Community Centre Association, which has about 5,000 members, most of whom live in the Downtown Eastside (DTES) of Vancouver. CCAP works on housing, income, and land use issues in the DTES so that the area can remain a low-income friendly community. CCAP works with DTES and Chinatown residents in speaking out on their own behalf for the changes they would like to see in their neighbourhood.

ABOUT THE REPORT

Thank you to Vancouver Foundation for supporting CCAP's work. Support for this project does not necessarily imply that funders endorse the findings or contents of this report.

If you find any inaccuracies in this report please contact info@carnegieaction.org

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"Some people, even elders say, this is sick land, meaning it's bad land, right. And well, it could be, but you know, how sick could it be when this is where I found compassion, friendship, family, love, hope, faith in people. This is where I found it. This is the best neighbourhood in the whole world, I swear it."

-Tracey Morrison, July 2015

IN MEMORY OF TRACEY MORRISON

This report is dedicated to Tracey Morrison, president of Western Aboriginal Harm Reduction Society and beloved community member, who passed away in July 2017. Tracey was a critical urban Indigenous, drug user and low-income community leader. What she brought into and upheld in every room she ever walked into was the best hopes and good from the street community. She was inseparable from the powerful love she felt for the community that, as she always said, saved her life.

Tracey saw collective struggle and the transformative potentials of community as a way through the dehumanization, self-hate, and alienation that capitalist society and the historical trauma of colonialism, determine for us. In this spirit, she worked to end stigma against drug users, and to protect and improve the community she loved and fought for until the end. She dreamed of an Aboriginal Healing and Wellness Centre in the Downtown Eastside.

- Extract from Ivan Drury's speech at memorial

PREFACE

OUR MENTAL HEALTH IS POLITICAL

"I also think another thing that is really important is keeping this low income community strong. If I'm in a bad mood or if something is upsetting me, I can just talk to somebody. And even a stranger sometimes, and they'll tell me their problem and we'll share our problems, and that's really really helpful. And with this condo community moving in, they're not use to that and they don't do that. And I think keeping this community strong is really important."

- Survey answer

In 2013 the City of Vancouver declared a mental health crisis and set up a task force on Mental Health and Addictions to come up with an action plan. The declaration was preceded by a record high number of apprehensions under Section 28 of the Mental Health Act. Yet of over sixty members, only three members of the task force were representatives of community groups. The rest were government officials, directors and professionals.

Soon after, we found out that West Coast Mental Health Network's Peer Support Bridge Program, Gallery Gachet, Rainier Hotel, the Drug Users Resource Centre (DURC) and Action Research and Advocacy Association of Greater Vancouver (ARA) Mental Health, all beloved and busy community spaces, were going to lose their funding from Vancouver Coastal Health. These were all peer-led, social, alternative, advocacy and non-institutionalizing spaces. Many in the community certainly felt we were in a crisis, but not the kind the City imagined.

To this day, the government hasn't asked the community what we need and want for our mental health. People with mental illness continue to be marginalized and excluded from political decision-making processes which impact their lives and their wellbeing. And the social determinants of mental health, the housing crisis and poverty, continue to worsen.

The purpose of this project is to build our own vision for mental health in the Downtown Eastside (DTES). A vision that centers and builds on the voices and experiences of community members and sees mental health as political, inseparable from the society we live in, not as an individual 'disorder' that can be cured with a pill.

While the goal of the community vision is to shed light on the social and political determinants of mental health, we want to acknowledge that the report is just a starting point for a broader vision of mental health. It doesn't do justice to the depth and diversity of factors that impacts DTES residents mental health, including colonialism, the pain and trauma caused by racism, transphobia, violence against women, sex work antagonism, the war on drugs, homelessness, capitalism, and the accelerating exclusion of DTES residents from their neighbourhood as it gentrifies.

HERB VARLEY

TO UNDERSTAND MENTAL HEALTH YOU NEED TO UNDERSTAND COLONIALISM

On a surface level of analysis, the DTES is in the midst of a mental health crisis as a result of decades of neglect from all levels of government. This is true enough, but it doesn't capture much of the story.

If one wants to find out how homelessness and mental health became such serious issues in what we now call Vancouver's DTES you would have to go to the very foundation of the town itself. The simple fact of the matter is there were people here for at least 10,000 years before Vancouver was even an idea. The dispossession and displacement of the Coast Salish Peoples' (and every other First Nation for that matter) has certainly had lasting mental health effects that last to this very day.

It is not the mental health of the colonized that I want to examine here, I want to focus on that of the colonizers themselves. In order to displace the First Peoples' of this land the "settler" had to first dehumanize them.

In order to do this, they had to live with overcome some inconsistencies in their ideology, or worldview. On the one hand, they had to believe that all men were created equal, on the other hand, they had to convince themselves that the so called Indians were nothing more than brutes and savages. Ponder that for a moment, believing that "all men are created equal, but some are more equal than others," is inherently an absurd thought. Then think about how this "truth" was used to brutally subjugate, displace, racialize, criminalize, institutionalize, and otherwise colonize, whole groups of people should be a sure fire sign of very sick minds.

I believe that when one person dehumanizes another, that two people are actually lost. The one that is brought to the level of subhuman in the first place, and the one that elevated himself to the level of god or demigod status. The person that decides that he is the arbiter, or decider, of what is humane and what is not, is certainly a sociopath, probably a psychopath, and dare I say a ruthless savage. Delusions of grandeur, or an inflated sense of self worth is not the only mental sickness that the colonizer brought with him, nope, not at all.

One of the first words that the Nisga'a used for the "visitors that never left" was Gumseewah or wood maggot. This was the only word we could think to make up for these strange hairy people that came off of these giant wooden ships. We called them that because not only did they come off the aforementioned wooden sea vessels, but when we shared a bit of land with them they proceeded to chop down tremendous amounts of wood. These men seemed to literally destroy everything that they touched, in short, they were greedy.

Perhaps most ominously the mental sickness of greed seemed to be contagious. To further demonstrate how twisted the thoughts of the colonizers were, they had the audacity to blame us for this sickness. This is a trend that lasts to this very day.

WHAT AFFECTS YOUR MENTAL HEALTH?

"How VPD stigmatize and traumatize me everyday by checks stopping me to ask questions. VPD don't listen to me. "

"The media potrayal of the dtes"

"No privacy"

"How in the DTES at any moment, a notice can show up saying, "you need to move out of the building" Move to where?? There are no other places to move too as they also are being torn down or renovated then made available at much higher price"

"Being without friends, family or art makes life seem empty and pointless."

"No money, nothing to do, nowhere to go, sitting in my room alone, being stagnant"

"Lack of funds to live on"

"I find it difficult to cope with lack of money when I need it. This is my main problem."

"When I ask someone for the time and they don't answer -- they just assume I am begging"

"Completely alone, no money, no help, no safety"

"My housing, poverty, lack of supports, feeling of isolation."

"My disabilities aren't visible and people often ask why can't you just get a normal job? But they don't understand. People also often ask, why don't you move to a better hood?"

"When I feel I'm not being heard when I try to express how serious my situation is. no one listens"

"Lack of $ and sunshine causes depression. Difficult to hope for a better future"

"Stigma is a constant weight on my mind. I am always wondering what people really think of me and its hard to tell if I'm discriminated against because I am low-income or if because i'm indigenous"

"The stigma of being native affects my mental health"

"Big stigma, negative impact, people look at me like i am naive and a sex object"

"Isolation and fear surrounding my housing situation"

"Ignored by higher income people"

"I feel less than worthy of acceptance in society"

"Social inequality. Capitalism, and the dominance of capitalist values. The destruction of the environment and communities. The lack of a much larger vibrant movement to change the world. "

"Simply poverty in and of itself, without access to money all activities and decisions are made moot because you can't make any. At that point you realize everything is useless."

"The creeping feeling of powerlessness brings me down."

"All my problems stem from a lack of money. There simply isn't enough money on this planet for the amount of people on it. Rich people are like vaccuum cleaners, it reaches them and gets stuck there indefinitely."

"How everyone thinks you are a sex worker"

"Staying in those religious homeless shelters with gazoonies saying prayers all the time"

"Dealing with bureaucracy, going to welly is depressing"

"Discrimination causes my mental health to become worse"

©artwork by Andy Morning Star, photo by gallery gachet

INTRODUCTION

UNDERNEATH THE MENTAL HEALTH CRISIS

On September 2013, Vancouver Mayor Gregor Robertson and the Vancouver Police Department (VPD) held a joint press conference announcing a "mental health crisis" in Vancouver. This press conference and a series of press releases and associated reports could have addressed the barriers and stigma facing people with mental health issues in our communities. Instead, the press release painted a terrifying picture of people with mental illness as violent and unpredictable.

Since January 2012, the Mayor wrote, "the VPD has identified 96 serious incidents ranging from suicides to random, violent attacks inflicted upon innocent members of the public" [1]. Without specifying the actual number of suicides versus attacks, the Mayor added, "It is a miracle that many of the people involved in these random attacks have not died." The City report, which does not convey a complex understanding of mental and public health issues, resorts to graphic images and anecdotes, repeating the notion that people with severe mental illness are a "threat" to the public.

The VPD's background document echoed Robertson's position that people with mental health issues currently pose "the greatest risk of an unprovoked attack on everyday citizens in Vancouver" [2]. The document was a sensational anecdotes of a dozen detailed and gory anecdotes of specific attacks to make gross generalizations of what mental illness can lead to. Taken together the document tries to build a problematic connection between violence, dangerousness and mental illness.

Yet, there is no single mention in the Mayor's press release or in the background report of the stigmatization, discrimination, evictions, sexual violence or other forms of violence, that many people with mental health issues are subject to on a regular basis in Vancouver. Importantly—given the Mayor's decision to co-release the report with the VPD rather than public health officials—this list fails to mention police brutality and shootings.

Vancouver Police Chief Constable at the time, Jim Chu alluded to the situation only in passing. "Those apprehended under the Mental Health Act are 15 times more likely to be the victim of crime and 23 times more likely to be a victim of violent crime than people without the illness." But despite the significance of this statistic, the Mayor chose to exclude it entirely from his public statements, along with any other references to the complex social, historical and political determinants of mental health, including the unprecedented housing and homelessness crisis.

Managing the 'mental health crisis'

With the declaration of a mental health crisis, the City also announced that they would renew their effort to improve people's mental health and support people with mental illness. Soon after the announcement they created a Task Force on Mental Health and Addictions in an attempt to address this issue. The stated goal of the Task Force was to "convene researchers, senior government, community partners, people with mental health and addictions issues, and DTES residents to address the critical need for a continuum of supports for the most seriously addicted and mentally ill."

Yet the Task Force, comprised of 60 individuals, only included three DTES community members. The rest of the body was made up of mostly CEOs, psychiatrists and executive directors of nonprofit associations. Following nine meetings throughout 2014, the Task Force released its final report in September that year, with its recommendations to the provincial government [3]. As a result, the recommendations were drafted with almost no involvement from affected communities and individuals.

The final recommendations were:

1) more funding for the institutionalization of people with mental illness through the creation of 300 long-term and secure mental health treatment beds

2) more staffing at supportive housing sites to support tenants with psychiatric issues

3) more significant support through Assertive Community Treatment (ACT) teams for psychiatric patients living in the community

4) the development of an enhanced form of urgent care centre (crisis centre) and

5) a joint treatment model between the VPD and VCH.

None of the recommendations speak to the social determinants of mental health. In fact, the report barely mentioned the underlying and systemic causes of mental illness and distress. It doesn't mention poverty, the housing crisis, homelessness, or the fact that welfare rates haven't increased since 2007 (FN, increase). Instead the report proposed measures towards re-institutionalization, and more clinical, medicalized and institutional approaches to manage the 'mental health crisis.'

At best these measures might temporarily help a few people, or become a survival strategy of last resort, but it will not change the conditions of inequality and poverty that may have led to the initial feelings of distress. More mental health treatment beds or any of the other recommendations will not change the pain, the feeling of hopelessness and isolation, the depression, trauma caused by poverty, violence, abuse and residential schools. In fact, by diverting attention and resources away from underlying causes it may actually allow underlying conditions to persist or worsen.

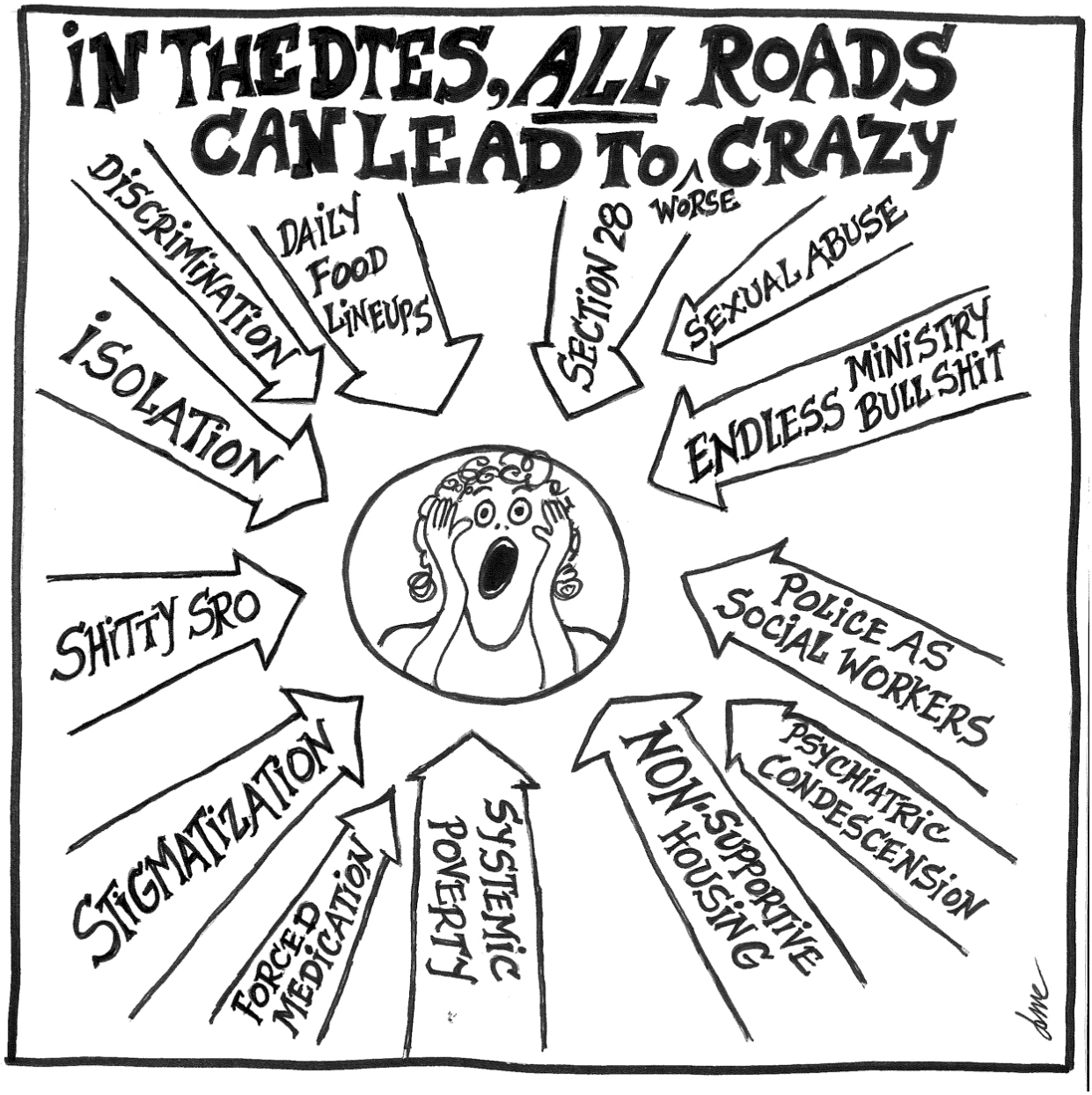
Moreover, the VPD's linking of mental illnesses to social problems, including 'the visibility of homelessness, addictions and poverty in downtown Vancouver,' reinforced the idea that the mental health crisis was synonymous with the DTES where these 'problems' are most visible.

This framing blurred the difference between addiction, poverty, homelessness and mental illness, framing all low-income people-regardless of circumstances-as mentally ill and unstable. Poverty becomes seen as a mental health problem rather than a social issue.

In other words, this blurring pathologizes poverty and low-income people generally. One expression of this is the change in the provision and management of social housing. Since the early 2000s, the only type of social housing built and funded by the Province has been supportive housing, a type of highly institutional and regulated housing, where tenants have little control over the basic conditions of their homes. For many homeless people, regardless of their mental health status, this is the only housing option they have.

Pills won't solve this ill

The City's Task Force report on Mental Health and Addictions relies on an individualized model of mental health, which fails to address and understand the social determinants and societal structures that impact people's mental health. In this framework, rather than addressing root causes, individuals with mental illness and addiction become seen as problems that have to be "fixed". And while normal reactions to longstanding conditions of poverty or inequality can often appear as symptoms of mental illness, the "solutions" are radically different and can't be solved with pills.



We want to turn this framework on its head. How can people expected to be healthy when they don't have access to housing, income and basic supports to deal with trauma. Mental health and mental illness are inseparable from the society we live in. On the Unceded Coast Salish territories of Vancouver the conditions of mental illness are also linked to colonialism, and the ongoing violence inflicted upon Indigenous people as contemporary society has been built upon the dispossession and the ongoing destruction of Indigenous lands and communities.

The government has not asked the DTES community what they need or want for their mental health. The purpose of this project is to fill that gap and to build a community vision for mental health in the DTES–a vision that addresses what people want and need for their mental health and that takes into account the community's reality. And a vision that values what keeps the community healthy, the networks of love and survival in the DTES, the deep sense of belonging and acceptance, the groups organizations, communities and families where people are able to survive and thrive as creative human beings.

VANDU'S OPEN LETTER ON THE MENTAL HEALTH EMERGENCY IN VANCOUVER

When the Mayor and city council voted to approve the recommendations of the Mental Health and Addictions Task Force, several Vancouver Area Network of Drug Users (VANDU) members spoke against the City's emerging police-led approach to mental health in the Downtown Eastside and city-wide. The following is an open letter issued by the VANDU Tuesday Education Group on Wednesday, September 17th, 2014.

The Mayor of Vancouver and Chief of Police have recently declared a mental health crisis in Vancouver. In response to this perceived crisis, the Mayor and council voted in October 2013 to create a Task Force on Mental Health and Addictions. As a group of observers and participants in the Task Force, we are writing this letter to express our deep concern about the process, and about the larger implications of a declared "mental health crisis" in Vancouver. We would like to speak openly about the direction of the city's mental health campaign, and about the larger trends within our city which exacerbate the problems a Task Force might seek to resolve.

To mark the launch of the city's mental health campaign this past fall, the Mayor and Chief released Vancouver's Mental Health Crisis: An Update Report (September 2013). The report put forward graphic images and anecdotes portraying people with mental illness as a "threat" to the public. The document might have been a chance to address complex issues facing the one in five Canadians who will personally experience a mental illness each year, including systematic barriers to support, housing and health services. But this opportunity to communicate to a broader public, and in particular the opportunity to emphasize the socio-economic determinants of mental health, was replaced with sensationalized images of violence and deteriorating public safety, with unfounded assertions by the Mayor that mentally ill individuals are "endangering the lives of innocent victims of random attacks."

These initial statements established a tainted foundation and a stigmatizing framework within which we are now forced to work as advocates, community organizers, and individuals facing mental health and addictions issues. From the outset we therefore questioned the motivations of this project and its stated goal of embarking on a path to address questions on behalf of–rather than alongside–our communities.

The City has taken the Vancouver Police Department as its primary partner in the long process of addressing overlapping mental health and addictions issues in our community. From the perspective of our lived-experience, however, a police-based approach to social problems can only worsen the crisis. The central role given to the police in this process will only entrench the problematic stereotyping and criminalization of marginalized people–people who need real community supports and real economic and social empowerment. Yet it is the police, rather than the people most affected, who continue to be empowered in today's political climate.
A shift in government priorities would mark a first step in addressing the mental health challenges we face. In particular we envision real moves in the direction of de-funding the police arm of the State and start funding real housing and social supports–for people's empowerment rather than people's oppression. A recent

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Canada-wide study has established that housing is most cost-effective treatment for mental illness. Our municipal government has full powers over the housing market–through zoning by-laws, area plans, permitting restrictions, the Property Endowment Fund, development levies and other housing regulations.

It is unacceptable for the municipal government to fail to use those powers, and to then blame the victims of its own failed policies. How can we address the stigmatization, discrimination, evictions, sexual violence, other forms of violence, that many people with mental health issues and concurrent disorders are subject to on a regular basis in Vancouver? These should be areas of concern, and yet the City of Vancouver continues its ruthless gentrification agenda, most recently in the DTES neighborhood, with a Local Area Plan that puts the housing of marginalized people on the chopping block.

It is unacceptable for the City to create a housing crisis and then reframe it as a mental health crisis. The framework of the Task Force labels "mental health" and "addictions" with vague and carelessly overlapping terminology, with little nuance or regard for the actual complexity embedded at multiple levels of the social and political system. The Task Force seems to make no genuine effort to separate issues, and so the goal seems to be to trade on the SAMI label ("Severe Addictions and Mental Illness"), aimed at visibly stigmatized populations in Metro Vancouver. Instead of taking the opportunity to highlight how common and frequent it is for people to experience mental illness in our current society, the Task Force has isolated a handful of violent incidents, ignoring the systemic difficulties people with mental health issues face in accessing services, housing and supports.

We are writing this letter not as mental health professionals or well-paid politicians, but as people who feel the pressure of a system that marginalizes us on a daily basis. We experience intersecting oppressions that extend far beyond simple questions of personal health, as the terms "mental health" and "addictions" too often imply. The mental health crisis, if it can be called that, is not for medical professionals or psychiatrists to resolve. It is for us alone to make the change we want to see in the world.

METHODOLOGY

WHAT WE DID

In 2015, CCAP decided to start a project about mental health. This decision was preceded by many discussions at the weekly CCAP volunteer meetings about the City's declaration of a mental health crisis, the rising number of police apprehensions under the Mental Health Act, and the impact of poverty, homelessness and inadequate housing conditions on people's wellbeing and mental health. People were also upset that Gallery Gachet, which provides a creative outlet to so many community members, had lost its funding from Vancouver Coastal Health, and that other organizations like the Drug Users Resource Centre (DURC) and ARA Mental Health, which some CCAP members used, were also losing funding.

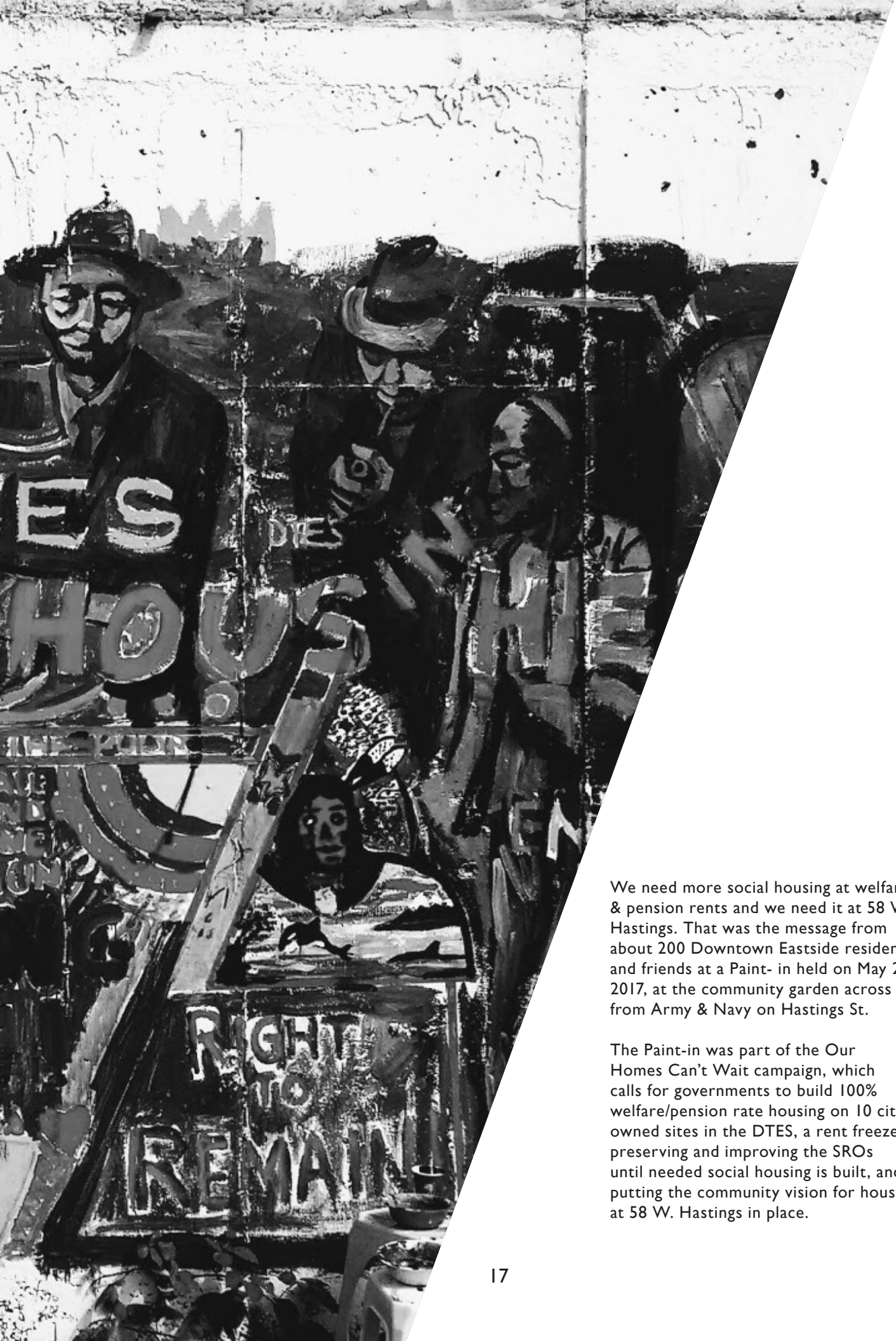
To start the project CCAP set up a mental health working group of low-income DTES residents, that met frequently throughout 2016 and led the research process. Most of the members of the working group had experiences with the mental health system, and either lived in the DTES or felt at home in the neighbourhood. The group collectively drafted questions for focus group discussions and a mental health survey. It also trained low-income residents to facilitate focus group meetings and conduct surveying.

While taking leadership from those with direct experiences in the mental health system or who had been diagnosed with a mental illness, the scope of the study was not limited to this community alone. The working group took a broader approach to mental health, recognizing that mental health and illness occur on a wide spectrum which impacts everyone. Part of this decision was made because the working group also wanted to take a proactive, instead of a reactive, approach towards mental health. Rather than just being concerned with how to support people whose mental health has deteriorated to a crisis point, the group was interested in exploring questions of how to address the social determinants of mental health in the community in the first place.

We also decided to limit the scope of our surveys to the key questions that CCAP has worked on over the years: namely housing, homelessness and poverty. The social determinants of mental health are broad, and include colonialism, violence against women, racism, trauma from forced displacement and so much more. These are all essential aspects of the mental health crisis, questions which many groups in the community are all already working on, and questions which deserve more work and resources.

The data was collected through focus group discussions and surveys. Street surveys were filled out at a table on the corner of Main and Hastings Streets, at Oppenheimer Park, and at Carnegie. Focus groups were conducted at Carnegie (2), the Living Room, Gallery Gachet, Vancouver Area Network of Drug Users, Western Aboriginal Harm Reduction Society, Carnegie African Descent Group, Drug Users Resource Group and Downtown Eastside Women's Centre. In all, over 150 people participated in the focus groups and 87 questionnaires were filled out.

After going through notes from the focus groups and questionnaire answers, CCAP grouped the results of our survey and focus group discussion into categories. Each section will include a "voice from the community," a story or interview that provides a narrative of lived experience to provide context for the responses in questionnaires and focus groups, some facts, the actual findings, and quotes about each topic from people who participated.



We need more social housing at welfare & pension rents and we need it at 58 W. Hastings. That was the message from about 200 Downtown Eastside residents and friends at a Paint- in held on May 21, 2017, at the community garden across from Army & Navy on Hastings St.

The Paint-in was part of the Our Homes Can't Wait campaign, which calls for governments to build 100% welfare/pension rate housing on 10 city owned sites in the DTES, a rent freeze, preserving and improving the SROs until needed social housing is built, and putting the community vision for housing at 58 W. Hastings in place.

STRESS, AND DEPRESSION: THE IMPACT OF POVERTY ON MENTAL HEALTH

Virtually everything about poverty affects mental health adversely, especially the lack of resources, the stigma, and the lack of respect that the welfare system has for people who need it. Most of the people who were consulted for this study lived on welfare rates of $610 a month or disability rates which were, at the time, $906 a month. The lack of money leads to housing precarity and homelessness because there simply isn't enough money for rent. Or they can pay a lot for rent and not have any left over for food and other necessities. Regardless of rent, people on welfare and fixed incomes often must line up in free food places for basic sustenance, for several hours every week or even daily

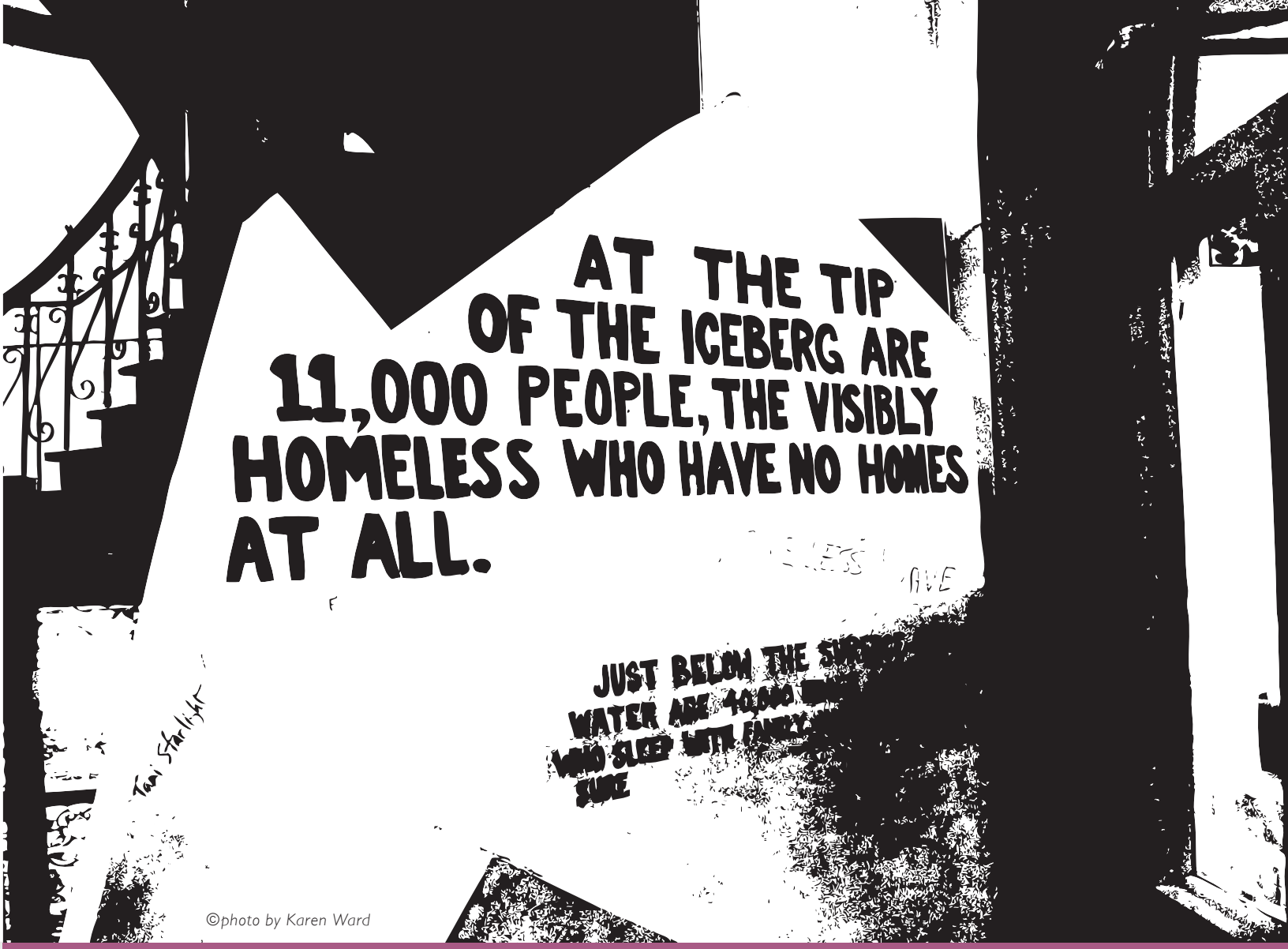
The public nature of free food line-ups makes those who require these resources vulnerable to stigma and harassment. Available food is often of low quality and therefore lacking in necessary nutrition, further diminishing mental health. Many are forced to choose between basic necessities such as food and clothing and simple recreational/social experiences such as coffee with a friend, seeing a movie, or going for a hike; activities that improve mental health and sociability, but are taken for granted by those who don't live in poverty. All of these simple activities that help people lead balanced and healthy lives are impossible on a welfare budget.

In addition, by using complicated rules and application processes, the system of obtaining welfare is deliberately designed to deter people from applying or benefiting from it. Some people simply give up applying because they feel so ill-treated in the welfare system which has closed offices, cut down on service hours that offices are open, told people who can't afford phones that they have to phone a 1-800 number for service, and then put them on hold for more than an hour. The welfare office regularly loses files, makes people wait hours in line, and denies them the opportunity to speak with case workers about their issues. The more vulnerable people are, the harder it is to go through the complicated 91-page application form and other processes that the welfare bureaucracy has established and which deters people in need from realizing their legal right to access financial help when in crisis. Some people report that dealing with welfare makes them feel "crazy." CCAP researchers met people who preferred to be destitute rather than having to deal with the welfare ministry.

The stigma attached to welfare is harmful to people's mental health. For centuries people who are poor have been looked down on by others. Discrimination and stereotyping of people on welfare has also been perpetuated by governments and corporate think tanks. People who have to use welfare indicate experiences of stigma whenever they go out. It's hard to imagine that this wouldn't have a huge impact on mental health, especially when combined, as it often is, with racism, sexism, discrimination based on gender, sexual orientation, or even just for being a resident of the Downtown Eastside.

Did you know?

Higher income has a positive effect on mental health. A recent UK study found that raising the national minimum wage was had a similar effect to prescribing antidepressants. Through statistical modelling, researchers found a significant improvement in the overall level of mental health in those receiving the national minimum wage. Published in the journal Health Economics, the papers conclusion supports the claim that wage increases for low-paid workers reduce feelings of anxiety and depression partly, at least, because they are under less financial strain.



©photo by Karen Ward

INCOME FACTS

$2

Up until September 2017, residents surviving on social assistance had only $610 to live on, and paying the average SRO rent of $548 have only $62 a month, or about $2 a day, left for everything else including food, hygiene, laundry, transportation, etc..

$375

In September, 2017, social assistance rates were increased by $100 after having been frozen for over a decade. Yet the shelter part of welfare is still a mere $375 a month, not enough to pay rent in anything but social housing.

10,000

There are about 9,000-10,000 people in DTES surviving on welfare and disability. And there are also about 4,000 seniors with about $433 a month for rent or less.

VOICES FROM THE COMMUNITY: JOEY

"BEING ON WELFARE MAKES ME FEEL DISPOSABLE"

Joey didn't want to be identified "... because it's entirely possible that the Ministry will read this and retaliate, find some way of interfering in my life and making it even more difficult. When a government office holds complete power over whether a person will be homeless or have food to eat, people forced to depend on it don't want to risk speaking out against the relentless injustice. Joey is a woman in her 60's with several health issues.

Not having enough money to live on negatively affects my mental health. Too many days are spent sitting in my room: no food, no money and nothing to do. Where I'm living now is isolated, and I can't afford bus fare because on welfare who can? I get dirty looks from the bus drivers when I ask for a ride. Being on welfare destroys your self-esteem. My only entertainment is the Carnegie and the library. Being on welfare makes you feel isolated from the lives other people are having. You're cut off from the world of "normal" people because you can't afford to take part in it.

Being poor means you spend a lot of time chasing bargains, and to buy real food in the DTES means a bus to a real grocery store. It used to be worse when I paid $500 of my $610 for rent. Now I'm in social housing paying shelter rate ($375). It sounds like an improvement but it's gone just as fast. If you need "luxuries" like deodorant or aspirin you're forced to choose between soap and food.

There's a stigma to being on social assistance and I'm constantly being treated as though I have no rights. You have to stand in line for everything; if you're on welfare you're in line at least once a day. It makes me want to not deal with the rest of the world sometimes for days on end and interrupts my sleeping patterns, makes me feel powerless and depressed. I feel like I'm disposable, unnecessary, redundant. The impression you get from the government is that they'd just prefer it if you died. Less paperwork.

Dealing with Ministry is terrible for my mental health. I'm already depressed and anxious and dealing with those assholes just makes it so much worse. And when you go to Welly they talk down to you like you're stupid, like you're a child. They also have a new rule about only having 8 clients at a time in the welfare office. Do they do this all over the province or just in V6A? Yesterday, I had to stand outside for 25 minutes just to stand in the lineup inside.

Totally horrible; I call it the Ministry of Despair. I feel like shit being forced to stand in line because of deliberate bureaucratic inefficiency. Lineups to get your stub can take an hour and a half out of your day and it only takes 30 seconds to fill out.

I tried to apply for disability but failed. There are no doctors so you deal with a clinic; trying to get a psychiatrist was torturous. My first application got shot down and when I went to ARA Mental Health (which has since this was written lost their funding) they said the advocate

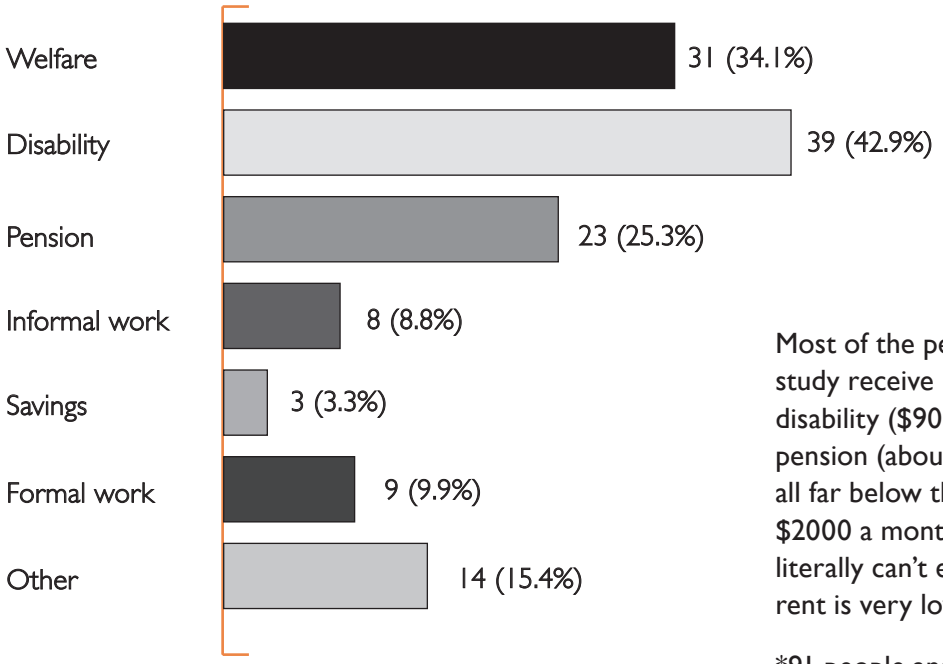
©artwork by Leef Evans, photo by gallery gachet

I'd used made a complete mess of the application and it was best to start all over. But they closed the Outpatient clinic at St Paul's and the psychiatrist lost my file and won't return calls. We called the places the file might have gone to and no one has seen it. That shrink wasn't very good anyway. I walked in on a cane and she wrote "unknown" when asked if I had mobility issues.

Now I'm dealing with a doctor who renews my prescription one month at a time so I have to keep going back. Plus, she will only prescribe one medication per visit, so every time I need something renewed I have to go to the clinic and stand in line. It's a method of control because I'm on welfare.

The way the Ministry treats me makes me feel inconsequential, powerless, enraged that some organization can make you grovel for so little in return. Raise the Rates! Yesterday. Ten years without an increase is inhuman!

SOURCE OF INCOME



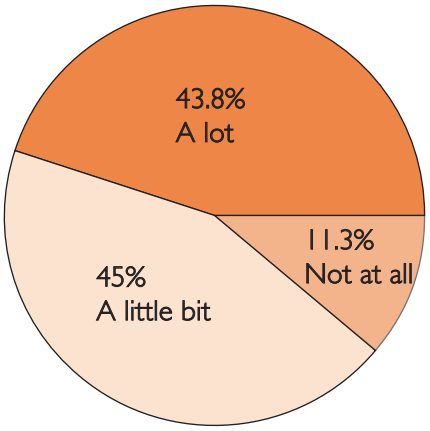
Most of the people interviewed in this study receive basic welfare ($610/month), disability ($906 at the time), or old age pension (about $1400), putting them all far below the poverty line of nearly $2000 a month. People on basic welfare literally can't eat and pay rent unless their rent is very low.

*91 people answered this question, but several people ticked several boxes.

IMPACT OF INCOME ON MENTAL HEALTH

Eighty-seven people who answered the questionnaire said what their source of income was. Of those, 25 said their income was from welfare ($610 a month at the time), with 21 of those saying that their income (or lack of it) affected their mental health a lot or a bit. Only 3 said it didn't matter.

In summary, of the 76 people who said they survived on welfare, disability, or pension, 69 said it affected their mental health. No one said their income actually helped their mental health.



QUOTES FROM SURVEYS: HOW DOES POVERTY IMPACT YOUR MENTAL HEALTH?

"It throws up so many barriers individually. Prohibits a goodnight sleep. Beats down my sense of self-worth. Forces me to live in squalor I never thought possible."

"A lot of [stress and anxiety] simply has to do with not having enough money or worrying about money or not being able to do things because I don't have the money."

"You're just cycling. It's like you're a little hamster on a wheel going: "When's cheque day? When's cheque day? When's cheque day?"

"Stressful, worrisome. Can't do anything. But disability is secure which I'm grateful for"

"Stress, don't feel like I can make it another day. I can't afford much anymore, it hurts me to ask for helping hand. Poverty makes me want to go back to drugs as it gets rid of all my problems."

"Inability to do any activity other than watch television or read due to insufficient amount of money. You're basically "trapped in a cage" for your entire life.

"Low income causes no sense of control, despair. At times I literally stay indoors... for days, cause I don't want to see anything...depressed"

"It's hard to eat well, which makes it hard to think at times. I also can't enjoy many leisure activities like movies, sports etc. Also being stressed about food all the times, makes it hard to plan ahead"

HOUSING AND MENTAL HEALTH:

HOW CAN INADEQAUTE HOUSING NOT CONTRIBUTE TO POOR MENTAL HEALTH?

Since 2013, homelessness has skyrocketed from 1,600 to 2,138. With only 950 year-round shelter beds, over half of the homeless people in Vancouver don't have access to basic shelter. On the streets, homeless people are criminalized for the sole reason of being homeless. They face constant displacement and harassment by police officers, by-law officers and members of the public. Survival is an everyday struggle.

If you haven't had the experience, take a minute to imagine what it's like being homeless. No place to sleep. Having to find a spot that's dry and warm, where you won't be kicked out. Being spit at and kicked by people who walk by. Not having a bathroom to use. If you have a tent, being forced to take it down by bylaw officers every day. Having to pack it and all your possessions around with you all day. Not having a comfortable chair to sit it, a nice bed to sleep in, a sink to wash in, a machine to wash your clothes in or an address to give someone who wants to contact you.

Being homeless means never being or feeling safe, and it also likely means dying prematurely. In their annual report on homeless deaths, Megaphone Magazine, estimates that homeless people have half the life expectancy as other BC residents and the number of homeless deaths are on the rise. Despite this unprecedented housing and homelessness crisis, almost no new social housing units are under construction. And in 2016, only 11 new social housing at welfare rate ($375) opened in the Downtown Eastside.

For many thousands of people the only housing option they have is the private SRO hotels.

©artwork by Diane Wood, photo by gallery gachet

It is not an exaggeration to note that some of the hotels are actually worse than staying on the street. Without your own bathroom or kitchen, all you have to yourself is a tiny room sometimes without a window. Bed bugs, rats, cockroaches, failing fire safety systems, lack of hot water and heat, and violence are just the tip of the iceberg in these hotels. These kinds of housing conditions have a tremendous impact on people's mental health and well being. The impact is more significantly detrimental for women and trans women who are less safe in SRO hotels, as well as for people with disabilities and health issues.

FACTS

- About 1 in 18 people who live in the DTES is homeless.
- Homeless people have half the life expectancy of other BC residents.
- Almost 3,500 people live in private SRO hotels. SRO units are tiny, often only 10 by 10 ft. Many of the hotels are in deep state of disrepair, and have bed bug, cockroach and rat infestations.
- Many people use up all their income paying rents so have to bin, sell things on the street or do sex work to make ends meet.
- Many of the hotels are not safe, especially for women.
- SRO hotel tenants have to share bathrooms with many people on their floor which isn't safe or healthy.
- SRO tenants don't have private cooking facilities.

VOICES FROM THE COMMUNITY: KEYA

"I AM AT RISK FOR TRANSPHOBIC VIOLENCE EVERYDAY"

I am a 43 year old transgender woman. As a child, I endured physical and verbal abuse, and was forced to act straight and masculine. If I walked a certain way or held my cup a certain way, I would be beaten by my father. At 15 I ran away from home to escape the abuse. In order to support myself, I joined a gang, sold drugs, and worked as a sex worker. In the same year, I became addicted to drugs. Since then, I've never had a real home.

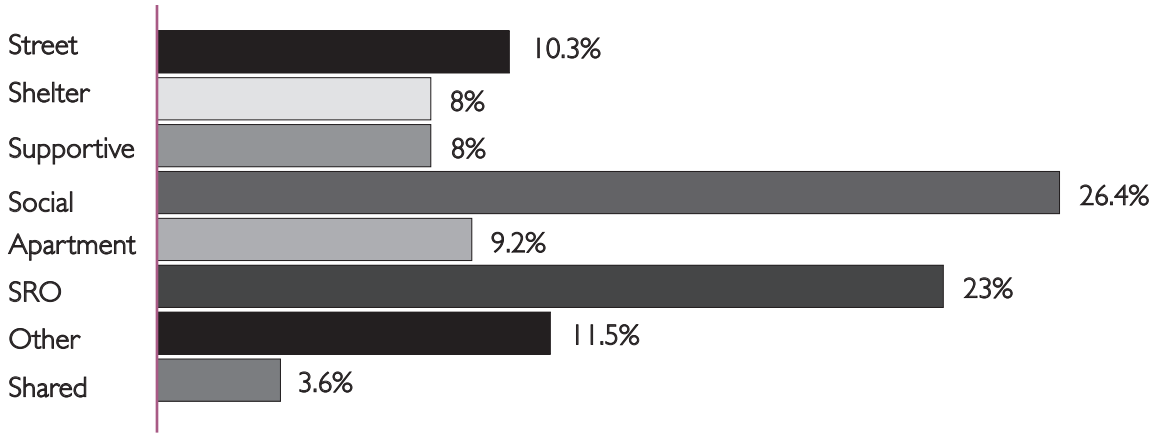
On the streets, my safety is constantly threatened. Every day, I am harassed and people yell transphobic slurs at me. I've been raped and beaten in the streets. I am also diagnosed with Hepatitis C, which gives me chronic fatigue. It makes it difficult for me to stay awake, leaving me vulnerable on the streets.

Shelters are not safe for transgender people. There aren't any trans-dedicated shelters available for transgender people. Many women's shelters are trans-exclusionary and force me to go to the men's shelters where it is dangerous for trans women and puts me at risk of assault and abuse.

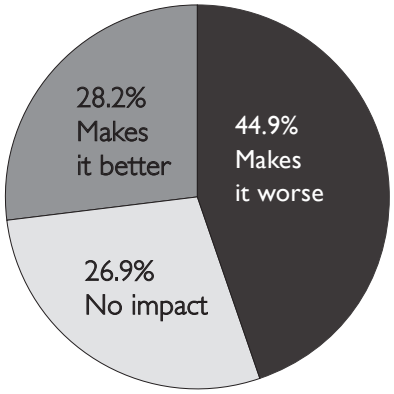
At the women's shelters that do allow me to stay, I still face transphobic abuse, bullying, and harassment and I do not feel safe. Living in an SRO is also dangerous and not an option.

On the street, when you're by yourself you're always a target. Things are constantly stolen and I am at risk for transphobic violence everyday.. At the tent city I feel safe and have a sense of security. If I got back on the street, I will not make it. As a transgender woman diagnosed with a chronic illness, it is life threatening to be on the streets or in shelters where I am always afraid and at risk for violence. I need a safe place to get treatment. I need a safe place to live.

HOUSING SITUATION



IMPACT ON MENTAL HEALTH



Eighty-four people answered the questionnaire about what type of housing they had. About 45% of respondents said their housing situation made their mental health worse, and only 28.2% said it made it better. Unsurprisingly, there was a strong correlation between quality, stability and affordability of a respondent's housing situation and the impact it had on their mental health.

HOUSED

"Affordable, stable, supported housing is like one pillar that holds up my mental wellness."

"Makes my mental health better, only because its BC housing from the provincial government."

"If I didn't have social housing, I would be very unhappy and unhealthy. I can't afford market rents."

HOMELESS

It's pretty obvious that people who are homeless, whether they are on the street or in a shelter, believe that homelessness makes their mental health worse. Of the 18 people who answered the questionnaire and said they were homeless or lived in a shelter: 14 said it made their mental health worse; 3 said it had no impact or didn't answer. One person said being homeless improved their mental health because they could avoid bedbugs, reflecting the housing choices that low income people have to make. Another said they felt safer on the streets than in a SRO hotel.

SRO HOTELS

Of the 24 people who said they lived in an SRO or hotel: 13 said it made their mental health worse; 5 said it made their mental health better (1 of these said it was better than being homeless) and 6 said it had no impact or didn't answer.

SOCIAL HOUSING

Of the 24 people who said they are living in social housing: 7 said it made their mental health worse; 9 said it made their mental health better and 8 said it had no impact or didn't answer. Of the 5 people who said they lived in supportive housing, 2 said it made their mental health worse and 3 said it made their mental health better.

DID YOU KNOW?

Contrary to a lot of popular assumptions, mental health problems are often a consequence–not a cause—of homelessness. This is what a study from California just found. The Health Outcomes of People Experiencing Homelessness in Older Middle Age, or HOPE-HOME, has studied how 350 older adults move into and out of homelessness, how they do or don't manage to find housing again, and how living on the street affects the body and mind.

HOMELESS

"It's a disgusting dump, I defy anyone to live in an SRO and not be impacted."

"I get to choose between sleeping outside, or living with bug infestations. It is sucking the life out of me. Motivation levels sink with each day in this situation."

"Not knowing when to sleep or where at all times makes my mental health a lot worse."

POLICING AND SUPPORTIVE HOUSING:

POLICING THE MENTAL HEALTH CRISIS

"Police treat me like i am worthless when they find out my postal code. Police treat me like I deserve abuse. Police think i am unreliable witness. Police treat me like I am the perpetrator, not the victim, as if i am asking for people to hurt me by simply being a female in the dtes.."
- Survey respondent

The VPD's linking of mental illnesses to social problems, including 'the visibility of homelessness, addictions and poverty in downtown Vancouver', has reinforced the idea that the mental health crisis is synonymous with the DTES This framing blurs the difference between addiction, poverty, homelessness and mental illness, framing all low-income people, regardless |of circumstances, as mentally ill and unstable.

While these ideas are not new, the mental health crisis contributed to an increased moral panic about mental illness, which framed people with mental illness and by extension all low-income people, as dangerous and in need of being controlled and managed. This has contributed to an erasure of the social determinants of mental health and increased public critiques of deinstitutionalization policies. In this framework mental illness appears as the "problem" and cause of poverty, and institutionalization and increased policing appear as the "solutions".

As a result of this shift, most of the new social housing in the Downtown Eastside and across the Province has been supportive housing. Supportive housing is a highly policed and surveilled housing model. Residents of supportive housing are typically forced to rescind their legal tenant rights and grant desk clerks the power to enter and search residents' rooms at any time, to regulate visitors arbitrarily, and to monitor and enforce residents' eating, medication, and drug and alcohol habits.

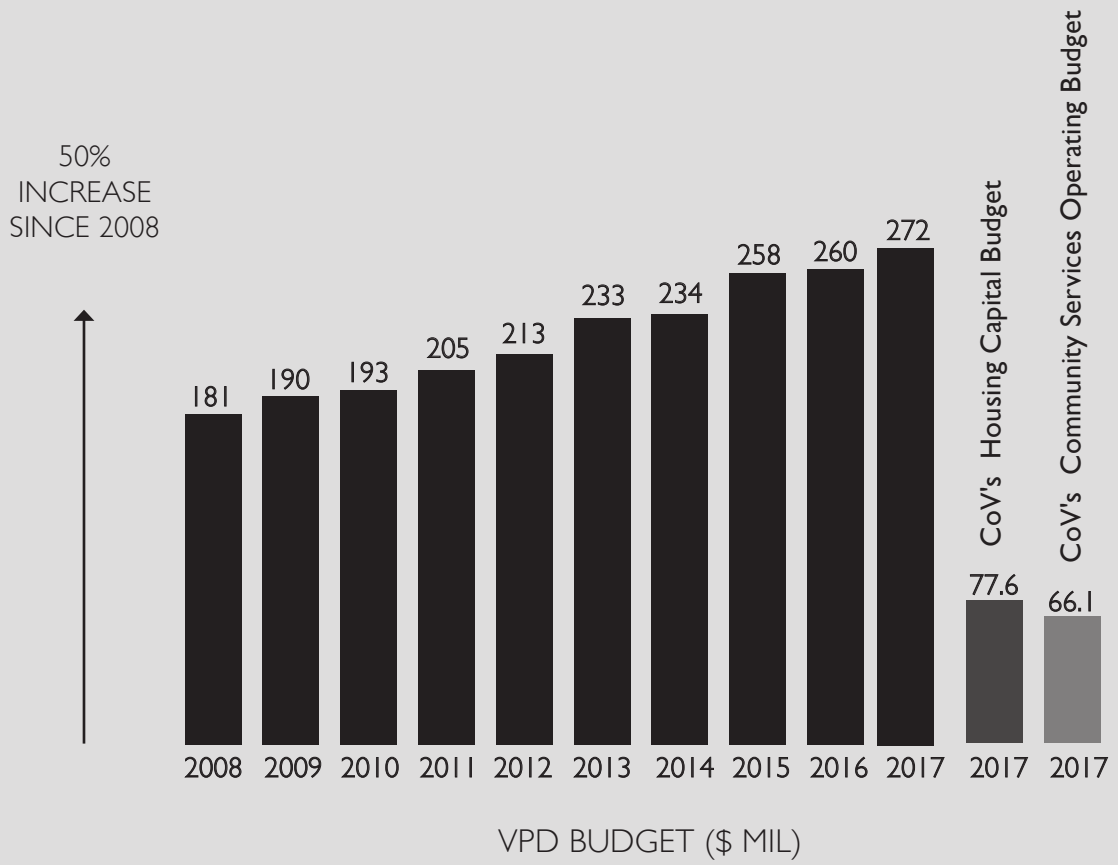
The moral panic about mental illness and its link to danger has been used to justify increased expenditures on policing of the "mental health crisis". The police are now the first responders to people in mental distress. In 2014, mental health arrests (under section 28 of the BC Mental Health Act) also climbed to a five-year high in Vancouver, with 3,010 apprehensions made by the police.

That means that there was an average of eight apprehensions every day in Vancouver. But since 2015, Section 28s, as they're referred to, have fallen sharply, to 2,822 in 2016 and to a projected 2,754 in 2017. While this may indicate a positive development the numbers remain disturbingly high.

Under Section 28, an officer can arrest a person without charge if they are deemed a risk to self or others. Or as Karen Ward, artist and activist, explains it: apprehension under section 28 occurs "when the police decide you have a mental illness." Yet, rather than reversing this worrisome trend of having police diagnose people in mental distress the VPD is advocating for increased support and funding to continue as first responders to people in mental distress.

In addition to the longstanding Car 87 program, police officers are now also embedded within new mental health outreach teams: the Assertive Community Treatment (ACT) teams, the Assertive Outreach Teams (AOT). Police were embedded in ACT teams in 2012, and since then the number of ACT teams have increased from three teams to five.

FACTS



- 34% is the increase in the number of apprehensions under the mental health act, from 2276 in 2010 to 3050 in 2016.
- 40% is the increase in the VPD budget, from $180mil in 2008 to $260m in 2016
- In 2014 makes up 20 per cent of the total capital and operating budget for the City of Vancouver. In contrast, community services make up five per cent of the budget.

The AOT teams is a VPD mental health program created in March 2014, and is more police-intensive than ACT with the involvement of four full-time police officers. What this means is that there is hardly any mental health outreach in Vancouver that does not involve police officers. If you are experiencing mental distress or encounter someone who is and not connected to an outreach team, chances are that police officers will still be the first responders.

The trend towards increased police involvement in mental health is concerning given their track record of dealing with people with mental illness—which includes killings—their lack of training and expertise, and given that encounters with police often have a negative impact on people's mental health. This is especially the case in the DTES where many have direct experiences of police violence and brutality.

VOICES FROM THE COMMUNITY: KAREN WARD

"I WAS EXPECTED, ON ENTERING SUPPORTIVE HOUSING, TO TRADE MY DIGNITY AND PRIVACY FOR A SELF CONTAINED UNIT"

VCH has publicly described the funding changes made through the Second Generation Strategy as a "redeployment", rather than as cuts to services. On closer examination on the ground level, however, what this has meant is that funding has been cut to services that are peer-led and/or peer-driven, most notably in mental health and addictions. ARA Mental Health, the West Coast Mental Health Network, and Gallery Gachet have had their funding eliminated, and only Gachet has survived in any meaningful way.

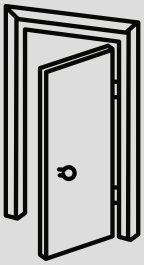
The Drug Users' Resource Centre (DURC) did not have their contract renewed, and the funding was re-allocated to a new service run by Lookout. In other words, this strategy has resulted in significant upheaval to the lives of the most marginalized people in the neighbourhood. In the case of DURC, users are now dealing with a new service model that is far more clinical and is organized as a top-down model: people are emphatically told what they need, rather than being asked and included as participants and members of a community organization.

"Health Service Integration" is the watchword of the Strategy. Clients at Strathcona Mental Health are now dealing with a re-organization of services at an Integrated Health Unit, which, it is claimed, will provide wrap-around service designed to encompass psychiatry, general practice, home care, and an array of social work service. In practice, however, this is a massive extension of biomedical control over people's lives.

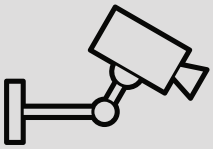
This control can be most clearly seen in the regimes of "supportive housing," which is in turn funded through this same source. In practice, supportive housing means that people don't have rights under the RTA. Staff regularly enter rooms without notice (citing "room checks," which are arbitrary), guests are restricted and are subject to ID checks, and residents are expected to cede their ability to administer their own medication regimes to staff. To resist these or any other expectations means being labelled a troublemaker and the situation is reportable to psychiatric authority. Indeed, simply being placed in supportive housing is a psychiatric label.

That control is essentially the price of housing: you agree to these infringements and indignities in exchange for a decent place to live. In my case, I was worn down after years of living in marginal housing, SROs without a toilet or security or a stove. I was chronically sleep-deprived,

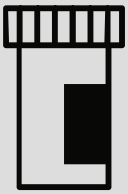
LIVING IN SUPPORTIVE HOUSING



Privacy is comprimised by mandatory daily rooms checks.



Residents are monitored and tracked by surveillance cameras and digital key fob systems.



Medications are managed, distributed and arbitrarily controlled by desk clerks.

Supportive housing providers claim that it is a form of transitional housing, not covered under the Residential Tenancy Act.

Housing providers work closely with the police, and often provide police with information about residents without warrants.

There are arbitrary guest rules. Family members are often not allowed to stay the night, and visitors are restricted certain hours and days.

over-medicated, and fundamentally unable to function. But I was expected, on entering supportive housing, to trade my dignity and privacy for a self-contained unit.

This divides people on assistance into the deserving and undeserving, or rather, the controlled and uncontrollable. Some people take their pills, allow staff access to their rooms, visit the in-house nurse, use food programs, and are actually rewarded when staff make things like food–or free wifi!–available to them. Some people are given furniture, some are given work opportunities–and some are not.

The saddest thing is the feeling, however, of living in a hospital or jail, surrounded by unnecessarily overmedicated people who rely entirely on what the building management and its under-trained staff decides to provide.

Their "illness" is re-enforced every day, their dependence is cultivated. And for me-well, I feel trapped. I won't trade my toilet back to return to an SRO, I don't need or want "support"–I just want a decent place to live, and to allow guests of my choosing to share it with me. And I feel that I've been dumped here–"problem solved"–for the rest of my days.

POLICE KILLINGS OF PEOPLE IN MENTAL DISTRESS

On November 22nd, 2014, a Vancouver Police Department (VPD) officer shot and killed a 51 year old man at the intersection of East 41st Avenue and Knight Street. The man was Phuong Na (Tony) Du. Within one minute of arriving at the scene, one of the officers drew his gun and shot Du to death. Before the shooting, Du was visibly distraught. According to eyewitnesses, Du who had been diagnosed with schizophrenia in his 20s, was talking to himself while waving a piece of two-by-four wood on an empty sidewalk.

Seconds before the murder, one witness texted to a friend that Du's behavior was "amusing." Based on the texts, it is clear that Du presented no threat to the officers or anyone else in the area. According to one witness interviewed by the CBC: "A police car pulled up and police started asking the man to come towards them across the crosswalk and to put down the stick. Right when they say put down the stick, they opened fire on him." The officer, who shot Du, said he fired because he feared for the other officer's life. On Feb 9th, 2017, it was announced that the Vancouver police officer involved in the 2014 shooting death of Phuong Na (Tony) Du will not be charged. The murder of Tony Du is not an isolated incident, and between 1992 and 2002, police encounters with mentally ill people led to at least eleven deaths.

From 2003 to 2010, seven more individuals who suffered from mental illness lost their lives to police encounters. Among these people were Paul Boyd, who was shot eight times on Granville Street in Aug 2007; Robert Dziekanski, who was tasered to death at YVR airport in Oct 2007; Michael Van Hubbard who was shot in downtown Vancouver in March 2009; and Darell Elroy Barnes, who was shot by police on Powell Street in July 2011. All these deaths were avoidable and all the police officers involved in the murders of the people were exonerated. Yet despite this track record, police are increasingly the first responders to people in mental distress.

Forty-eight people commented when asked their opinion of police being the first point of contact for people experiencing mental distress and/or crisis. Only 10 comments supported police involvement in this role, the majority of comments were negative.

"The police tend to aggravate situations, not de-escalate them."

"Police aren't helpful; people are scared of them; have had traumatic experiences with police."

"Too many overzealous cops and too little training on how to successfully defuse situations with people experiencing a mental break or crisis."

"Health issue should have a health representative"

"Less white cops and more native peer support"

"I want to see cops out of the mental health game"

"Get rid of the cops."

"There are very few police that I can actually talk to or have any respect for."

"I can see how low income people, specifically low income First Nations people are treated while leaving the bar versus white middle class....and that makes me very angry."

"The police make my mental health worse. They're going out there and picking people up and harassing people on the street"

"They use excessive force."

"I don't like the way the police take care of you."

I don't like the way the police take care of you.

"I feel that the VPD and RCMP have to deal with problems outside their expertise. Not personally targeted, But I've seen violence to others that makes me angry and stresses me out"

"Lots of social profiling."

"Men and women with guns should not be dealing with people in agitated mental states."

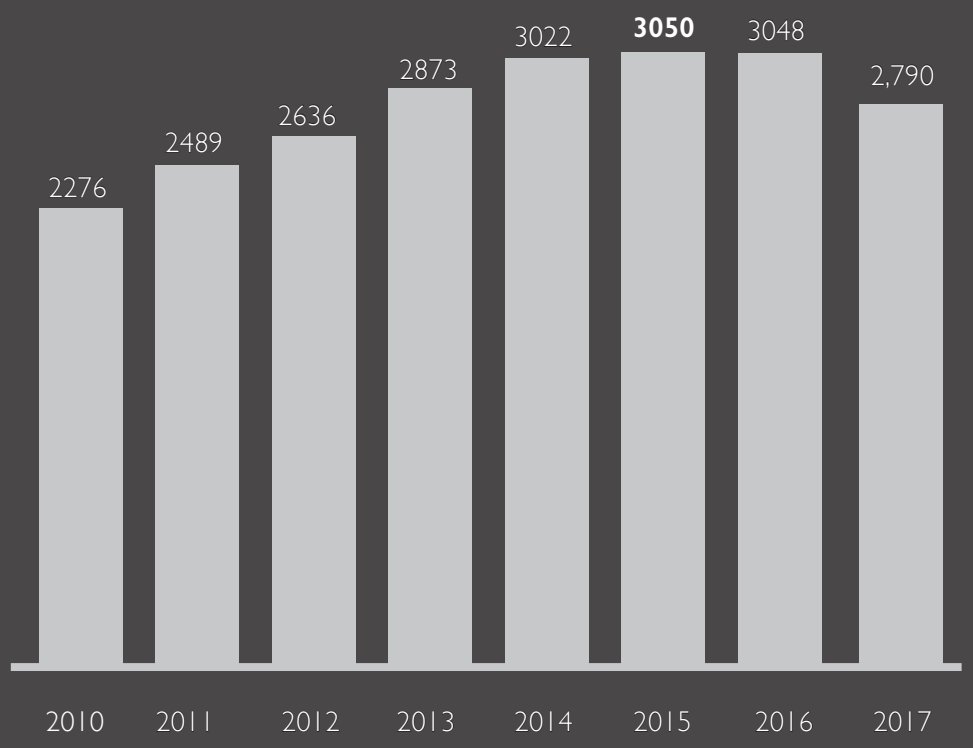
"Many cops are openly racist"

"Been beaten by VPD 8 times, RCMP twice."

"They don't care."

"Aggressive behavior, flexing, demonstrations of physical presence. hand on pistol"

SECTION 28: MENTAL HEALTH APPREHENSIONS



Twenty-six people who answered the questionnaire said that they had been apprehended under the Mental Health Act or institutionalized against their will.

Of those, 8 people said it made their mental health better, for example:

- "It really helped me a lot to get off drugs."
- "It made it better. I passed out on the road and VPD took me home. They treated me decently."
- "At the time I needed the help to get better."

But most people (15) said the apprehension made their mental health worse:

- "I get PTSD when I'm near cops."
- "Food to eat. Harassment."
- "Detention without formal warning or explanation. Being in hospital for mental healthkeeps me sick."
- "Scary. I was fearful I wouldn't be released."
- "HELL! Dehumanizing."

VOICES FROM THE COMMUNITY: DANIEL

"BEING APPREHENDED MADE MY MENTAL HEALTH WORSE"

About three years ago I went to St. Paul's hospital to seek help. I had been drinking too much and I wanted to get into treatment. They gave me a bed to sleep for the night, and the next morning I woke up strapped down. I asked what was going on and they said they had certified me and they were going to keep me for a 30 day mental health assessment. I didn't understand what was going on. I asked if I had done anything wrong, and they said I hadn't done anything wrong. I was not given a choice.

They put me on Ativan right away, which sedated me. I was forced to take a 8-10mm Ativan every four hours for the duration of the stay. I don't do drugs, so I felt uneasy about being on Ativan but again I didn't feel like I had a choice. I saw what happened to another man at the ward who refused to take his meds. He was pinned down by four workers, and forcibly injected and subdued. After having seen this I was traumatized and scared, and so I complied with the meds.

I wanted to leave on the first day, but I couldn't and it didn't matter what I said or how I felt.

For the 30 days, I didn't get to see a psychologist or a counsellor–only a psychiatrist. I was homeless at the time, and I am still homeless. For the duration of the stay, they did not check in about my housing situation or provide any support for me to access housing once the assessment was completed. After 30 days I was finally released. I didn't have any housing, so I had to go back to staying at the shelter. By the time I left I was also addicted to Ativan. They refused to write a prescription for Ativan, and I really struggled with the withdrawal symptoms.

Taken together, the experience worsened my mental health. I felt traumatized by my stay there, and I didn't receive any support in getting into treatment or getting housing. I feel like the money it cost to assess my mental health could have been better used. Many people at the ward had the same experience as me. They diagnosed me with schizophrenia, but no one followed up with me. I still don't receive any mental health supports. And I still stay at the First United shelter.

If they really wanted to support my mental health, getting me into good and proper housing would be a first step. Homelessness affects my mental health. I feel self doubt. It makes me feel sad, hopeless and depressed. The stigma attached to being homelessness makes it worse. I also receive disability, but it's not enough to live on.

©artwork by Janice Jacinto, photo by gallery gachet

WHAT IS YOUR EXPERIENCE OF THE MENTAL HEALTH SYSTEM?

"Doctor made me feel like I was evil."

"Indifference, condescension, academic snobbery."

"I have pretty much lost my mental health support since being off probation."

"Bi-polar. No help."

"People say that they are qualified but they are not qualified. They have been reading books. We know the street life. We know how to judge and maybe to assist."

"Judgement"

"Disaster. Worst experience of my life."

"Staff are on a power trip."

"Cutbacks"

"They lost my file."

"There is not great access to helpful counselors because so much of it is NOT free and here the focus is on controlling crisis extreme psychotic behavior."

"Ativan helped with extreme anxiety"

"I enjoyed my counselling with the Aboriginal Program...."

"I have been blessed by an appropriate diagnosis (bipolar) and a good response to medication."

"It felt good to be accountable and to have support to help with my depression and addiction issues."

"It's pretty good. I can see someone to help right away. I am very thankful for them when I need help."

"There is not much support for people with milder but real mental health problems."

Twenty-five people answered the question asking if their interaction with the formal mental health system made them feel healthier or better. Of those, 8 said the experience was positive. Twelve said their interactions with the formal mental health system were negative, and many at the focus groups expressed similar sentiments.

"You go to see the doctor and they want you out so quick they don't really get chance to know what's going on. They just throw pills at you."

"They're very heartless and without feeling. They're pill pushers. Give you the pill, shove you out the door and treat the next one."

"They give you medication and then you get hooked on it."

"Not heard or understood."

"I was abused by the health system. The street people help me."

"The mental health system is geared to making people adapt to the system....It refuses to [deal with] the underlying factors which may cause unhappiness in people's lives."

"They're drug dealers. Here's a prescription."

"When you're so out of it and staggering down the street on the meds you get arrested and you tell them its because of your medication and the police call you a liar."

"They see the patient through their academic eyes, not from the patient's needs and experience."

"They treat the symptoms not the causes."

"One thing is torture in psychiatric hospitals where they tie you down or lock you in a room."

"Too quick to put people in the psych ward."

"Apprehensions made me feel paranoid in the psych ward at St. Pauls."

"THE DTES HELPED ME REDISCOVER GIFTS THAT I HAVE AND THAT EVERY PERSON HAS THEIR OWN GIFTS."

I've been to psych wards all across Canada and the US. In Vancouver, I have been at the psych ward in Vancouver, at VGH, St. Paul's and at UBC. In a state psych ward in Maryland I saw a patient get assaulted by staff. They disempower you and it's so hard to get back the sense that you exist under your own initiative. There's a running joke in the psych ward. If you call it home, they kick you out, but it is home; it's where your friends are.

In the shelter in Montreal I was crying in my sleep so they woke me up in the middle of the night and told me that I needed to go to the hospital. So they took me there and 6 security guys strapped me to a bed and threw me in the psych ward for a month.

In Welland, Ontario they tried to talk me into the psych ward by saying I could sleep there. And I was going, "yeah, right do you think I'm stupid?" They told me that to stay at the shelter after a few days, you need to go to the hospital psych ward, so I did. But I wasn't certified after 3 days, so then I checked myself out and they wouldn't take me back to the shelter, so when. I didn't know where to go, they said go back to the hospital.

When I first ended up in a psych ward in Vancouver I was homeless and suicidal and it was pouring rain. I went to Dunsmuir House to get out of the rain. I asked if they knew where a pharmacy was they asked why. When I said I wanted to take pills to kill myself they called 911. When I found out the cops were coming I took off but they caught me across the street. One of the cops actually said, "Let us help." And I was like OK, maybe. But they still put me in handcuffs which was a little strange. At least I ended up in St. Paul's.

And I was homeless at St. Paul's so they kept me there because they couldn't discharge me, but after a month they sent me to Venture House and, because I'm on the wrong form of disability, they kicked me into the Yukon shelter instead.

This is why I have such emotional difficulties talking about the psych ward. In almost every city I would end up in the psych ward eventually. That's why the DTES was so important. When I was not well people would say to me, "Yeah, I thought you should see a doctor but I wasn't going to say anything," and they would support me where I was at.

One of my friends said I threatened to blow up the Aboriginal Front Door (AFD) and now it's something we just joke about because they didn't take me seriously which is good. The other problem I ran into was my Ontario Medical Card. I was having problems with it but St. Paul's agreed to let me stay there and I didn't have to worry about who was paying. The Ontario Medical Card people wanted me to go to Ontario to prove I was living there. At one point they said having the shelter state I was staying there would be OK but the Ottawa shelter refused to do that.

Counsellors in the DTES are just ordinary people; it's the people down here who are my counsellors. There's always people to talk to. The DTES helped me rediscover gifts that I have and that every person has their own gifts. Friends are really really important too, and having regular contact with my son helps a lot too.

Wendy and CCAP helped a lot too. I was being consulted and the idea that my opinion has value and being able to influence change in some small way, like going to Terry Hui's office and getting

interviewed by CBC afterwards and somebody heard the interview and said you sounded really knowledgeable, and it was like, oh really? It was giving me positive feedback for a change.

Having friends at the Carnegie and going there and the AFD helped too. The people at the healing circles, we'd laugh and joke about our situations and wouldn't take ourselves really seriously. And going for hikes and the Listening Post was a really good place to go and get healing touch and talk to people.

Cutbacks are affecting me. I can only see my counsellor a half hour every week. It used to be an hour, and now they want to transition me out of counselling altogether. Don't know if they still want to do that or if I've talked them out of it. She's not very medical so it's easier to talk to a counsellor than a psychiatrist. When I was homeless I didn't have friends, now I do. And it's OK to have been a psych patient, I don't have to hide it.

Stable housing has helped hugely. For 10 years I've been living in the same place. I have sunshine, a balcony, beautiful oak trees outside my window. It's helped my mental health because I can retreat at the end of the day and just hole up. I can actually hold down a volunteer position. And I can also speak out again.

I feel bad cause so many people are sitting in SRO's and feeling depressed.

Would mental health be better if you had more money?

I get around $740 a month and pay around $220 for rent. Being able to eat at Carnegie leaves a doable amount of money to play with. Compared to people on welfare it's better. That's why I'm thinking we should push for a third of people's income going to rent.

It's not just attitude I'm grateful for what I have. One of my friends who was living at the Y in Ottawa said, "no matter what happens I'm grateful". It can be overrated if you're depressed but sometimes if you can do it, it makes a difference.

To do list for govt:

They shouldn't just fund dealing with people in crisis; it's important that people in crisis get dealt with, but also needs to be preventative care for people who are minourly depressed.

If people need support they should get it. Raise the rates so people can live decently; give power back to people in psych wards. Don't take away all their power.

Peer run organizations are really important to fund. Gallery Gachet has really helped me a lot; having peers come on the psych ward is really good and having housing available if you're homeless.

To do list for individuals:

Be open to listening about psych ward stories and not judging. Advocate for more housing, non judgmental housing, where you're not going to lose your place if you end up in the hospital again.

Phoenix is now president of the Carnegie Centre Community Association; a sometime member of Mayor's task force on mental health; on the adjudication panel for an arts granting organization; leads a writing group and has been published; co-founded a native hand drum group; part of the national lived experience advisory council on homelessness; co-chair of a City of Vancouver Community Economic Development group; exhibits photographs at Gallery Gachet. Phoenix has worked as a radio announcer, in a provincial court, for the US embassy, as a playground leader and did media summary reports. She has a Bachelor of Journalism and Political Science and a Masters of Arts in International Affairs. Phoenix also won the first ever slam poetry contest at the Carnegie and the J Michell Sharp award from the UBC 101 program for activism and a book she contributed to was shortlisted for the Vancouver Book Award.

WHAT MAKES YOUR MENTAL HEALTH BETTER?

"Downtown Eastside, Wetsuwet'en territory, the Women's Memorial March and the Heart of the City Festival"

"I feel I have support from my reserve"

"Getting out (briefly) of the DTES, a good book, something nice to look at"

"The forests and trees, flora and fauna, oceans and rivers, inlets and streams, the mountains ... and the sun"

"Feel better when high. I can deal with situations better. Small amounts help me meditate."

"Cultural activities, canoeing, feasting, hearing drums and songs. Friends help by talking about our struggles. We also go buy drinks to forget about our issues."

"Oppenheimer, Carnegie, binning and walking around."

"Working, talking to people, and staying in touch with my village and culture"

"Native culture and singing. I like that. It helps my mental health."

"Fellow activists at Carnegie, people in the dive bars, people at Oppenheimer Park"

"Friends, family, culture, being outside and playing the piano at Oppenheimer park"

"Family, love, friends help, social contacts"

"Having friends to socialize with and different activities. I also enjoy watching movies, TV and reading good books and magazines."

"Native culture and learning, back to the roots, button blanket, music, dance, medicinal learning, cats, pets are the best medicine, friends if you can find one, organizations in the downtown eastside."

"Sharing food, singing in a choir, volunteering in media and doing community radio."

"Music, writing song(s), performing when I had a band, writing poetry, spirituality gives me a sense of peace We can share."

WHAT CHANGES WOULD YOU LIKE TO SEE?

"Some of the personal things and the social factors are connected. If you're not dealing with the social issues people are going to end up suffering and have all sorts of related problems."

"Less judging by medical people."

"Aboriginal healing center needs to be built."

"Women's only spaces, for me, makes me feel sane and grounded to know I am surrounded by people who experience the world and to know what that means."

"Get rid of involuntary detainment. More justice. Doctors are so arrogant and insulting to people. And the whole controlling. I'd like to get rid of that. And just have a world where people get their needs met. Whether it's housing, whatever it is."

"Make services readily available so we wouldn't have to kiss ass."

"Less white cops, more native peer support."

"Want to see more community members in stable housing with strong social support."

"We are people. We need safe housing, affordable. Stop feeding us with medication. It drains my life a little each day. We are all equal, all have problems."

"Continue with Gallery Gachet and bring back the aboriginal program to the Downtown Eastside."

"I think we need to create something that's based on a wide definition of mental health rather than a narrow, pathologized definition. I think we could draw on some really good practices like some of the work that WAHRS does, or VANDU."

"Maybe just treating us like humans, a lot more like humans and not like patients."

"Shift gently from capitalism to socialism; connect the dots from housing out of reach leads to stress, broken families, addiction, poverty crime... We are caretakers.

RECOMMENDATIONS

ADDRESS CAUSES, NOT SYMPTOMS

"The mental health system is geared to making people adapt to the system.... It refuses to [deal with] the underlying factors which may cause unhappiness in people's lives."

Prevailing approaches to mental health and mental illness rely on an individualized model of care, often failing to address and understand social determinants and societal structures that impact people's mental health. In this framework, the social determinants and societal structures that impact people's mental health are erased and individuals with mental illness and addiction become seen as problems that have to be "fixed."

We want to turn this framework on its head. How can people expected to be healthy when they don't have access to housing, income and basic supports to deal with trauma. We see mental health and mental illness as inseparable from the society we live in. On the unceded coast salish territories of Vancouver this is also inseparable from colonialism, and the ongoing suffering and violence it is inflicting on Indigenous peoples.

We want root causes dealt with, not bandaids.

STOP THE CRIMINALIZATION OF MENTAL HEALTH

"The police make my mental health worse. They're going out there and picking people up and harassing people on the street"

Instead of helping people in mental distress, apprehensions under the Mental Health Act are traumatizing for individuals who are subject to them and often contribute to a deterioration of a person's mental health. Relying on the police also ignores the real harms done by police and makes people fearful of coming forward if they need assistance for fear they will be forced to engage with cops.

We believe that real safety comes not from surveillance and criminalization of marginalized people, but rather building community-based prevention and response strategies. To this end, funding for mental health outreach and support should go towards peer led initiatives and other mental health supports–not cops.

RECOMMENDATIONS

SUPPORT AND EXPAND PEER LED SUPPORTS

"I think it's important that people be involved in being able to get well and that's also a community debate. I also think that people share their experiences. People are often off in their corner but in fact there could be much more interchange about what's going on. By building connections that's how we build a movement."

As a result of "The Second Generation Health Strategy", a new health strategy in the DTES, some existing spaces and peer run services that provide supports in the DTES are losing their funding, in favour of more clinical and institutional approaches to mental health. This is part of a larger 'political tide' in Vancouver, that is applying pressures toward increased psychiatric institutionalization, marked by the announced reopening of Riverview.

Access to medicine, doctors and psychiatrists is crucial, but needs to be accompanied by an expansion of alternative therapies, counselling and supports. The government needs to provide a variety of services that can support people's mental wellbeing, including places for respite, time spent outside the DTES, and other supports already available to more affluent people. It is crucial that mental health services and supports are provided in a variety of languages and that culturally appropriative mental health supports are provided for Indigenous people.

RAISE WELFARE RATES AND INCREASE MINIMUM WAGE

"[Poverty] throws up so many barriers individually, prohibits a goodnight sleep, beats down my sense of self-worth, and forces me to live in squalor I never thought possible."

Higher income has a positive effect on mental health. The federal government sets its Market Basket Measure of how much money a person needs for bare necessities at about $1600 a month for a single person in a city. With this much income a person would be able to buy nutritious food, hang out for a coffee with friends, and participate in community events. Forcing people to survive on $710 a month means they often have to choose between food and housing.

We also call for a raise minimum wage to at least $15 an hour with regular increases after that up to a Living Wage (about $21/hour in Vancouver.) A recent UK study found that wage increases for low-paid workers reduce feelings of anxiety and depression partly, at least, because they are under less financial strain.

RECOMMENDATIONS

BUILD SOCIAL HOUSING! HOMES NOT JAILS!

"Not knowing when to sleep or where at all times makes my mental health a lot worse."

In 1972, over 30,000 social housing units were built per year across Canada. In 2010, that number had decreased to only about 1,000 per year. To end homelessness and housing precarity we need to reverse this trend and start with building 10,000 social housing units per year in BC. We need those units to be self contained units, minimum 250 sqft with bathrooms and kitchen.

It is essential that all social housing units are covered by the Residential Tenancy Act and that tenants privacy and independence is respected. We therefore reject supportive housing as a model of social housing.
We think that people living with mental illness, addictions, and poverty should be able to make basic decisions concerning the day-to-day activities in their lives and homes.

RECOGNIZE PEOPLE WITH MENTAL ILLNESS AS EXPERTS OF THEIR OWN WELLBEING

"*People are emphatically told what they need, rather than being asked and included as participants and members of a community organization.*"

Representations of the "Mental Health Crisis" have been negative and have contributed to increased stigma and discrimination of people with mental illness, especially in the DTES. These representations are also often framed by outside spokespersons rather than from people within the community, often reproducing detrimental pathologized stereotypes of people with mental illness and of low–income residents in the DTES more generally.

This project operated on a fundamental belief that people living with mental illness, addiction and poverty should be able to make basic decisions concerning the day-to-day activities in their lives and homes–and that they also be included in decision making about funding for services and supports.

RECOMMENDATIONS

PROTECT DOWNTOWN EASTSIDE AS A LOW–INCOME COMMUNITY

"I also think another thing that is really important is keeping this low income community strong. If I'm in a bad mood or if something is upsetting me, I can just talk to somebody. And even a stranger sometimes, and they'll tell me their problem and we'll share our problems, and that's really really helpful. And with this condo community moving in, they're not use to that and they don't do that. And I think keeping this community strong is really important."

Gentrification not only forces people out of the neighborhood through increasing land value and higher rents, it also produces a kind of internal displacement for low-income residents by creating zones of exclusion, spaces where low-income residents become alienated from their own community. Gentrification breaks up and disperses the low-income community, and creates isolation and alienation.

Develop and implement a plan to preserve the assets and secure the tenure of the existing Aboriginal and low-income community before more unaffordable condos are built (condos increase property values and speed up economic and social forces that displace low-income residents).

END THE WAR ON DRUGS

"We live in the most racialized, criminalize, infantilized, institutionalized neighbourhood, certainly in Vancouver, maybe in Canada, and we need to show that yes, we deal with addiction, but the streets are our living rooms."

While there has been some efforts towards expanding harm reduction programs and opening more safe injection sites, low-income community members and peer workers have been provided with little support to deal with the daily trauma of living in ground zero of the opioid crisis. And low-income drug users continue to be criminalized for using drugs by federal drug laws but also by municipal law enforcement.

In addition to a variety of harm reduction services that support people to use safely, access to both detox and addictions treatment on demand is necessary.

All drugs need to be decriminalized.

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CARNEGIE COMMUNITY ACTION PROJECT

UNCEDED COAST SALISH TERRITORIES