NO PILL FOR THIS ILL

OUR COMMUNITY VISION FOR MENTAL HEALTH

Carnegie Community Action Project

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

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.

©artwork by Andy Morning Star, photo by gallery gachet

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.

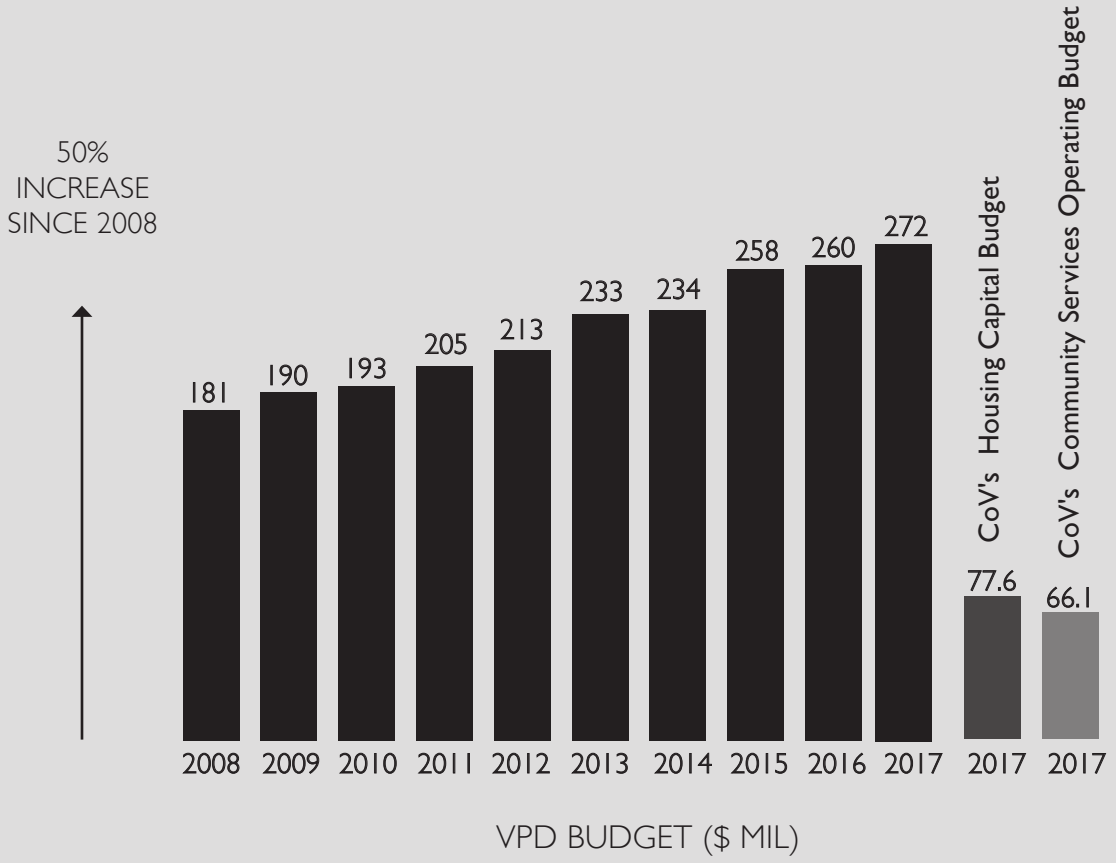
The moral panic about mental illness and its link to danger has been used to justify increased expenditures on policing of the "mental health crisis". The police are now the first responders to people in mental distress. In 2014, mental health arrests (under section 28 of the BC Mental Health Act) also 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.

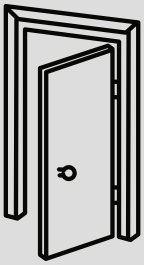
The Drug Users' Resource Centre (DURC) did not have their contract renewed, and the funding was re-allocated to a new service run by Lookout. In other words, this strategy has resulted in significant upheaval to the lives of the most marginalized people in the neighbourhood. In the case of DURC, users 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.

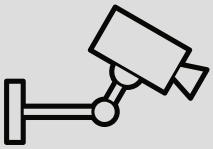
This control can be most clearly seen in the regimes of "supportive housing," which is in turn funded through this same source. In practice, supportive housing means that people don't have rights under the RTA. Staff regularly enter rooms without notice (citing "room checks," which are arbitrary), guests 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,

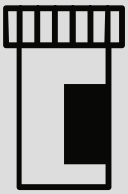
LIVING IN SUPPORTIVE HOUSING



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.

VOICES FROM THE COMMUNITY: DANIEL

"BEING APPREHENDED MADE MY MENTAL HEALTH WORSE"

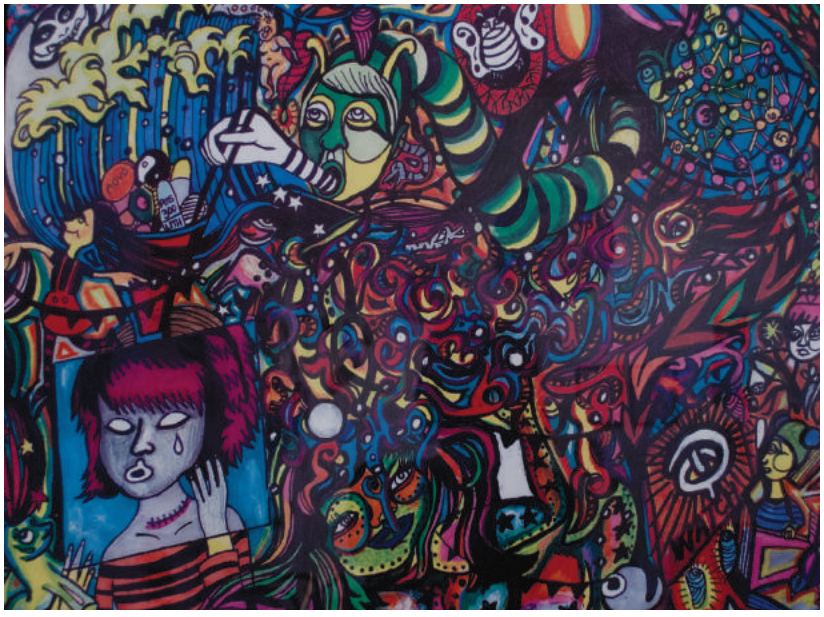
About three years ago I went to St. Paul's hospital to seek help. I had been drinking too much and I wanted to get into treatment. They gave me a bed to sleep for the night, and the next morning I woke up strapped down. I asked what was going on and they said they had certified me and they were going 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

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.