

# **Discrimination Against People with Mental Illnesses and their Families:** Changing Attitudes, Opening Minds

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## ***Executive Summary and Major Recommendations***

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A Report of the BC Minister of Health's Advisory Council on Mental Health  
— April 2002 —



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## Why This Report

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On June 1<sup>st</sup> 2001, in partnership with the Vancouver/Richmond Health Board, the Minister's Advisory Council on Mental Health hosted a community forum on discrimination against people with mental illnesses and their families. The forum provided an opportunity for people with mental illnesses, their family and friends, as well as mental health service providers, professionals and advocates, to share their various experiences of discrimination and to brainstorm creative ways to address the problem. As outlined in Appendix A (a summary of experiences and advice gathered from forum participants), this community event provided the springboard for the executive summary you are now reading and its soon-to-be-released comprehensive report. The forum made clear that to do justice to the reality of discrimination in the lives of people with mental illnesses and their family members, research and recommendations must be rooted in and informed by people's direct experiences of prejudice and discrimination in this province.

Contained within this summary report are 27 recommendations, directed to various people, the Council hopes will have the effect of reducing discrimination against people with mental illnesses and their family members. Your comments and remarks are welcome and can be sent to the Council via its web site at [www.healthservices.gov.bc.ca/mhd/advisory/](http://www.healthservices.gov.bc.ca/mhd/advisory/). Copies of the comprehensive report will soon be made available.

## Why We Care

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Both the community forum and similar international research demonstrate that discriminatory attitudes and behaviours have enormous and far-reaching impacts on people with mental illnesses, their families and even the mental health system itself. People with mental illnesses and their families are forced to cope with two simultaneous burdens: a debilitating illness *and* the societal reactions to that illness that deny them respect and dignity. Research shows that seventy per cent of people with mental illnesses and their families report discrimination. Furthermore, discrimination usually ranks higher than actual symptoms of mental illness in terms of what contributes most to the level of distress experienced by people with mental illnesses. Discrimination is complicated further and can be heightened by a person's age, gender, race, socio-economic status, sexual orientation, community type (rural vs. urban), and/or the presence of other disorders such as an addiction or other mental illnesses.

People with mental illnesses are among the most devalued of all people with disabilities and have to endure hearing hurtful comments, being treated as less competent, being told to lower their expectations in life, and being shunned and avoided. Beyond just being ostracized, however, people with mental illnesses are routinely excluded from social life and civil rights. They are denied basic rights in the areas of housing, employment, income, insurance, higher education, criminal justice, and parenting, among others. People with mental illnesses also face rejection and discrimination by service providers in both the mental health and physical health care systems and discrimination by policy makers and the media. Discrimination leads many people with mental illnesses and family members to internalize what is said about them, leading to lowered self-esteem, a reduced quality of life and negative effects on health.

Discrimination seems to be contagious, as it hurts those who love and support a person with a mental illness as well. Families are a core group of caregivers and a key support system for people with mental illnesses. Not only do families of people with mental illnesses have to cope with the financial, practical and emotional stressors of caring, but they face a kind of 'discrimination by association.' They have to deal with strained relationships with other family members or friends, fear, violence, anxiety, conflict, lowered self-esteem, and guilt. Discrimination against family members stems from misconceptions about the family's role in the causes of mental illness, guilt for failing to recognize symptoms earlier, and/or the stress of advocating for treatments against the wishes of their ill relative and in the face of inadequate services.

The mental health system also feels the brunt of discrimination. Discriminatory attitudes in the community toward people with mental illness foster feelings of shame in a person, shame which in turn impacts that person's help-seeking and treatment behaviour, recovery and relapse rate. Both the clinical effectiveness and cost-effectiveness of a mental health service is compromised when it does not take discrimination into account in its rehabilitation planning and does not recognize that some consumers even admit to 'retreating' to hospital psychiatric wards to escape community discrimination. In addition, mental health professionals often feel treated as second-class citizens by their professional peers, and mental health services, programs and research themselves are still routinely underfunded and given a lower priority than physical health care issues.

## Where Discrimination Comes From

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We cannot hope to eradicate discrimination without first understanding what it is and how it has come to be entrenched in our cultural imagination. Discriminatory attitudes and behaviours against mental illness have deep sociohistorical, symbolic and emotional roots. We cannot forget that people with mental illnesses, and their family members, have been discriminated against for at least 2000 years. Our current attitudes towards people with mental illness are all grounded in the past.

What are the essential symbolic and emotional roots of discrimination itself that have persisted throughout history? Research has identified four major stereotypes or emotional reactions to people with mental illnesses that fuel discrimination:

- 1) **Fear:** fear of violence and unpredictability, and fear of what mental illness represents in the way it attacks the faculties (emotions, thoughts, behaviours, self-concept) and the parts of us (the brain and mind) that define our very humanity
- 2) **Blame:** the view that people with mental illnesses have brought their problems upon themselves
- 3) **Poor prognosis:** the view that there is little hope for recovery from mental illness
- 4) **Disruption in social interaction:** the view that people with mental illnesses are not easy to talk to and have poor social skills.

Though other groups of people with disabilities have managed to reduce the discrimination that they have experienced in the past, society still views people with mental illnesses through a lens of fear, ignorance, pessimism, apathy and suspicion.

## **Recommendations to Reduce Discrimination**

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The Minister's Advisory Council on Mental Health, after carefully considering the many suggestions and ideas offered at the community forum held in Richmond last June, and based on a careful and detailed review of the literature, offers the following recommendations to the Minister of State for Mental Health to reduce discrimination against people with mental illnesses in BC. Additional recommendations and a more detailed background discussion are offered in the comprehensive report that will soon be available on the Council's web site.

We have organized these recommendations into three categories: general recommendations, recommendations to reduce discrimination within the health care system, and recommendations reducing discrimination in the community.

### **I. General Recommendations**

#### **Adopt a Discrimination Model**

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It is the belief of the Minister's Advisory Council on Mental Health that using more appropriate and potent words like 'discrimination,' 'prejudice,' 'social exclusion' and even 'hate crime' will be more effective in terms of defining the problems faced by people with mental illnesses. We need to learn from the experiences of the disability rights movement. Several people have argued that people with disabilities, generally, have not found the concept of stigma to be a useful one because stigma tends to put the focus on the 'branded' person while the concept of discrimination puts the focus where it more appropriately belongs: on the individuals and institutions that practice it. For this reason, 'stigma' has not proved an effective rallying point for strategies to improve access or challenge prejudice.

Disabilities movements have made effective use of the legally defined and validated notions of discrimination and oppression. Rather than new words like 'sanism' and 'mentalism' which haven't been widely picked up, discrimination is a useful word that has currency and creates alliances with other movements where it has already been established as unethical treatment. Linking the disability, human/civil rights, and mental illness advocacy movements together must become a key strategy in our efforts to reduce the discrimination against people with mental illnesses in our province. To do this, we need to adopt an approach that clearly identifies the issues faced by people with mental illnesses as evidence of discrimination.

To address this, the Minister's Advisory Council on Mental Health recommends:

1. That the Minister of State for Mental Health, and all the Ministers of Health, endorse and use an approach to public and professional communication in dealing with the issues faced by people with mental illnesses that is consistent with the concept of discrimination as opposed to the concept of stigma.
2. Encourage the BC Human Rights Commission to increase its level of understanding and sensitivity to the needs of people with mental illnesses and adapt their policies and procedures to accommodate these needs.
3. Implement a Charter of Rights for people with mental illnesses and require that all agencies that provide service to people with mental illnesses and family members reconcile their policies and procedures with the tenets of the Charter.
4. Develop and implement a province-wide orientation and education workshop to introduce the Charter and assist in its implementation. Ensure that any and all directly or indirectly government-funded workers complete an orientation to working with people with mental illnesses and family members, to the Charter and to discrimination issues prior to full assumption of duties.
5. Require that regional health authorities provide advocacy services to assist people with mental illnesses and family members to address instances of discrimination.
6. Implement an Annual Anti-Discrimination Award (with small cash award and trophy/plaque) for individuals or groups who fight against discrimination against people with mental illnesses and their family members. This award is to be presented by the Minister of State for Mental Health.

## **Reduce Discrimination through Education**

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There is a great need for an education program that will help members of the public to develop a positive and accurate understanding of people with mental illnesses and their family members. The effectiveness of advertising campaigns is not good. Results are more promising, however, when media campaigns are backed by ongoing community-based education and action.

Stereotypes are complex phenomena. They have components that are somewhat changeable and therefore subject to change and yet there are also components that are fiercely resistant to change. The general consensus internationally seems to be that public education campaigns are most effective when they are conducted “locally and focally.” To help British Columbians better understand people with mental illnesses and the experience of family members, the Minister's Advisory Council on Mental Health therefore recommends:

“Old and young, country and city dwellers, rich and poor, men and women, bright and dull, all regard people with mental disorders as fundamentally tainted and degraded.”

— Amerigo Farina, professor and stigma researcher

7. That the Adult Mental Health Division develop an Anti-Discrimination kit (a package of educational materials) that could be used by consumer groups, family groups and mental health agencies to educate professionals, workers in other agencies or other community groups about mental illness, family issues and discrimination. A model stressing the partnership of people with mental illnesses, their family members and care providers should be used.
8. The Minister of State for Mental Health work with the Ministers of Education and Advanced Education to develop curriculum materials for use in schools to introduce children to basic information about mental illness, and the process and effects of discrimination (the video and educational materials produced by the BC Schizophrenia Society entitled “Reaching Out” provide an excellent example of appropriate materials for this purpose). Include the Charter of Rights as an element in the basic curriculum for these education initiatives.

## **Address the Role of the Media in Discrimination**

About a third of people identify the media — including print, radio, television, and internet-based news, advice, entertainment and advertising — as their main source of information about people with mental illnesses. Unfortunately, the media often reinforces myths and stereotypes about people with mental illnesses. It often sensationalizes stories about people with mental illnesses and family members exaggerating the negative and bizarre aspects of the experience of being mentally ill. Research has shown that negative media portrayals, particularly ones associating mental illness with violence, have direct impacts on attitudes and behaviours of the public. As a result, media coverage of events involving people with mental illnesses and their family members has a profound effect on shaping community attitudes and, in turn, public policy. Also, misinformation in the media about the nature of mental illness can contribute to confusion and inattention to emerging symptoms of mental illness in family members or friends who don't fit the stereotype.

To reduce the negative impact of the media on discrimination against people with mental illnesses and their family members, the Minister's Advisory Council on Mental Health recommends:

9. The Ministry of Health work with the appropriate government agencies to develop a mechanism that identifies instances of discrimination, bias or misrepresentation of people with mental illnesses and their families in the media; addresses repeated violations (legally or through administrative means); and re-educates the offenders.
10. The Minister of State work with regional health authorities to identify, support and train people with mental illnesses and family member volunteers at the local level to be available to speak to their local media about mental health issues as well as to advise concerned citizens about using existing complaint processes within press bodies, broadcast standards councils or advertising standards councils in BC and Canada to deal with instances of discrimination in the media.

“To reach a mass audience, one needs mass media. And media professionals control access to those media... If we wish to have destigmatizing materials compete successfully with the powerful images that currently pervade the media, those materials will have to be polished and professional. [Therefore], media professionals need to be included in efforts to develop new and more accurate images of people with mental illnesses.”

— Otto Wahl  
professor, media researcher

## Reduce Discrimination Against People with Mental Illnesses and Family Members from other Cultures

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The 1996 Census reveals that almost one in every five British Columbians is a member of a visible minority. People learning English as an additional language and who also experience mental illness are at a clear disadvantage in this province. Discrimination against people with mental illnesses and their family members from other cultures occurs through a lack of multilingual, culturally- and spiritually-sensitive mental health services. Appropriate services for immigrant and refugee populations need to consider different cultural worldviews, and conceptions of health, illness and healing and must involve extended families and community groups in their service delivery and promotion. Furthermore, services that are culturally relevant to First Nations communities are also in short supply or non-existent. To assist people with mental illnesses and family members from other cultural groups to get the service they require in a form they can access and use, the Minister's Advisory Council on Mental Health recommends:

11. The Minister of State for Mental Health require health authorities to identify the specific mental health needs of the major ethnocultural groups in their region and develop a strategy to meet the mental health needs of individuals and family members in a way that respects their cultural differences and language.

“Cultural concepts, values, and beliefs shape the way mental symptoms are expressed and how individuals and their families respond to such distresses. Clearly, effective mental health care cannot be separated from the cultural context in which the formation and expressions of psychic distress occur.”

— Karin Rai,  
Surrey/Delta  
Immigrant Services  
Society Multicultural  
Liaison Counsellor

## 2. Recommendations To Reduce Discrimination in the Health Care System

There is much evidence, Canadian and international, that mental health professionals and health professionals in general can be among those who show discriminatory attitudes and behaviour toward their own clients. People with mental illnesses frequently note that often their views are neither listened to nor respected and that mental health workers tend to focus on the clinical issues of care to the exclusion of the social issues. The areas people with mental illnesses most want help with after the positive symptoms are under control, are the secondary consequences of the illness like joblessness, lack of friends or weight gain and psychological issues like anxiety and a lack of self-confidence. Studies have pointed out that many clinicians ignore natural healing processes, giving people too little time and attention to recover and heal from traumatic events or deal with transitions in their lives or their illness. Clinicians also often forget that navigating the mental health system can be traumatic in and of itself.

Study after study identifies a lack of respectful treatment by GPs and emergency room clinicians as the most common complaint among people with mental illnesses. Up to 80% of people with mental illnesses also suffer from concurrent physical illnesses, yet a common occurrence is to assume that any complaint of distress from this group must be a symptom of his or her mental condition.

Another major area of concern among consumers and families is the lack of respect and compassion given by professionals towards people who have attempted suicide. These concerns about the standard of care for patients with mental illnesses extend to

“The emergency physicians were just (terrible). She got kicked out anywhere she went. They need to know that for everybody who comes in, there’s a family who loves them and they are people... People with mental illnesses are second class citizens in the health care system.”



concerns about treatment protocols. For example, many consumers report that there is an over-reliance on medication for treatment even in the face of obvious discomfort from the consumer and/or environmental circumstances which perhaps deserve more attention. There have also been comments made in surveys of people with mental illnesses that family doctors seem particularly resistant — or perhaps just unaware — of the need to refer people to self-help networks, support groups or consumer-run services from which many would receive great benefit. To address these issues, the Minister's Advisory Council on Mental Health recommends:

12. The Ministry of Health base funding formulae for programs, research and services on the morbidity and mortality rates for mental illness, including anxiety disorders, addictions and eating disorders.
13. Monies intended for programs and services for people with mental illnesses should be protected as designated funds and not lumped in to general revenues for health.
14. The Ministry of Health revise Medical Services Plan (MSP) billing structures to encourage and allow general practitioners and psychiatrists to provide the kinds of services and supports actually required by people with mental illnesses: for example, attendance at case management meetings, multidisciplinary team meetings, more time for counseling of the individual and family, follow-up services, and outreach and home visits. Hire GPs on a sessional basis to provide services to people with mental illnesses in rural and remote areas or in inner city areas.
15. The Ministry of Health fund general counseling services for people with mental illnesses and their family members to assist in dealing with the psychological pressures and stresses of living life with a disability.
16. The Ministry of Health work with health authorities to properly clarify and reduce the discrimination against certain mental disorders within the mental health system itself and make services available to people living with these disorders. For example, anxiety disorders, substance abuse problems, and eating disorders do not receive the same kind of support as other disorders receive despite the higher morbidity rates involved.
17. The Ministry of Health require professional associations to allow third-party complaints on behalf of people with mental illnesses against registered members of the associations. People with mental illnesses often do not have the resources to articulate and then pursue a complaint against a professional.
18. The Minister of State for Mental Health work with the Minister of Advanced Education to develop materials on the issues of discrimination to be incorporated within the core curriculum for those professional training programs that prepare people to work with people with mental illnesses (for example, doctors, social workers, nurses, psychologists, occupational therapists, etc.). Use these same materials to target people already working in the field in order to upgrade their skills and examine their values. Target emergency room staff at hospitals and other health professionals who work with people with mental illnesses in crisis.

“I needed a peer counselor or any counselor to explain what this was all about and what kind of help was available.”

### 3. Recommendations To Reduce Discrimination in the Community

#### Access to Housing and Increasing Choices

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In a Canadian survey of people with mental illnesses, half said the area in their life most affected by discrimination was housing. Research shows that a person's status as a psychiatric patient means he or she is less likely to be leased an apartment. Even if a person with a mental illness can access market housing, landlords do not necessarily provide accommodations for consumers in the same way as they do for other people with disabilities. In addition, there are often few safeguards to protect housing for people who have needed hospital care for longer than a month. People in this situation often return home to find they have been evicted and their possessions placed in storage. As well, some housing options are 'bundled' with treatment services and are therefore subject to all kinds of additional restrictions and regulations. This lack of choice in housing coupled with income constraints means that an increasing number of mental health consumers are settling for housing that would not normally meet their criteria (or anyone else's) for decency and safety but which meet the criteria for affordability, for example, boarding homes or single-room occupancy hotels.

Even if consumers give up on the idea of a regular house or apartment, the situation is no better in the social housing world. It is possible to 'sneak' a mental health facility or group home into the community, undetected. Yet without the acceptance of neighbours, people with mental illnesses find it difficult to find a place in community life. So after being *de-institutionalized* from the hospital, they are often then *re-institutionalized* in the community. Opposition to mental health facilities by community groups — commonly known as NIMBY (i.e., 'Not In My Back Yard') phenomena — is still a major concern in all kinds of neighbourhoods even though opposition almost always fades once homes are opened. Fear is usually the primary focus of concern: fear for children's safety, fear of violence in general, and fear of falling property values. None of these fears are based on real experiences or borne out by research. Inside the facilities or group homes, other problems exist for people with mental illnesses. For instance, overcrowding issues and rules that discriminate against the needs and realities of couples and parents are common.

To reduce discrimination against people with mental illnesses and their family members in the key area of housing, the Minister's Advisory Council on Mental Health recommends:

"(My client) was told his rent would be paid while he was in hospital, but this wasn't done. A month later when he was discharged, he found he had no apartment and no belongings."

"Another parent told me that a professional said to her 'they've found a 'slot' for this person.' Well, I don't want him in a slot, I want him in a home."

19. The Ministers of Health work with the appropriate provincial and federal ministries to develop and implement a housing strategy to address the substandard living conditions of people with mental illnesses living in market housing.
20. The Ministers of Health require that each health authority conduct an audit or quality review of directly or indirectly government-funded housing used by people with mental illnesses in each region. Any substandard housing must be improved or replaced, where substandard is defined using the recommendations of the BC Community Living Association which urge, for example, a maximum of 4 people living in a home.
21. The Minister of State for Mental Health will ensure that health authorities, in partnership with other government ministries and agencies, provide adequate respite accommodations for family caregivers.

## Income

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Income usually means the finances needed to support a standard of living that allows a measure of dignity. However, in this province, income increasingly means just enough money for survival. Like employment, housing, and education, income is a primary social determinant of health. Low income, unpredictable income and/or lack of control over income are strongly related to depression, anxiety and stress. Also, for those unable to find work, the process of applying for income assistance can feel confusing, demeaning, intrusive, stressful and emotionally exhausting. This is true for a person *without* mental health problems. It is not difficult, therefore, to imagine how much worse the process can be for people who are struggling with mental illnesses.

Income security is such a big issue for people with mental illnesses that one-fifth of all the contacts made with the Provincial Mental Health Advocate's office in 2000 were about problems accessing income support programs and disability entitlements. Complicating the process are frequent policy changes, funding cutbacks, red tape, confusion around eligibility for the several different types of income assistance, limited access to individual advocates, differing definitions of disability between provincial and federal benefits programs, and monthly allowances that are out of pace with the cost of living. In general, it is perceived that the disability benefits system is based on a person's level of sickness rather than on what they need to achieve recovery, or on maintaining dependence rather than on supporting their movement towards self-sufficiency.

To reduce the negative effects of financial insecurity on the lives of people with mental illnesses and their family members, the Minister's Advisory Council on Mental Health recommends:

"My boyfriend is paranoid and won't leave the apartment. (The Ministry) won't come to the apartment so he could fill out the forms, so we are both living on my Disability Benefits."

"To say that poverty robs people's dignity is to state the obvious, but well paid bureaucrats are often far removed from the reality of life in a single room occupancy hotel."

22. The Minister of State for Mental Health work with other ministers and the federal government to reconcile pension and disability program requirements to allow for fluctuating levels of disability and for people to move more easily from work to income support eligibility and back again. Increase payment levels to more closely approximate the Statistics Canada poverty lines and allow people with mental illnesses who have the ability to earn some money to develop and maintain their skills and level of independence (perhaps to poverty line levels) without penalizing them by deducting these funds from their regular pension benefits.
23. The Minister of State establish a committee made up of cross-ministry personnel and key stakeholders to monitor the issue of poverty and mental illness and to make recommendations to reduce discrimination against people with mental illnesses in this area.

## **Employment Opportunities and Discrimination**

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The vast majority of people with serious and persistent mental illness identify work as a key life goal and report improved quality of life and decreased use of hospital and crisis services when they are working. Unfortunately, this knowledge has not helped alleviate a frightening amount of discrimination in the workforce, by both employers and coworkers, towards people with mental illnesses. Surveys show that employers and workers still feel justified distrusting and discriminating against people with mental illnesses. As a result, people with serious mental illness have the highest rate of unemployment and underemployment of all people with disabilities, at a rate of around 85%. When people with mental illness find work, that work tends to be sporadic, poorly paid and lacking employee benefits. They all too often find themselves involved in the “three F” occupations: food, filing and filth. Research shows that mental illness is the second leading source of workplace discrimination complaints.

This can partially be explained by a lack of awareness and understanding about mental health issues. Employers admit that they are uncertain how to create supportive environments for people with mental illnesses and lack understanding about the capability of disabled people, lack knowledge about financial and technical assistance, and approaches to access and accommodation. Building a ramp and special washroom for someone in a wheelchair is easier to conceptualize than an accommodation for a person with a mental illness. Such accommodations are usually less concrete and require more thought, flexibility and creativity.

From the consumer’s perspective, three different surveys have consistently found that anywhere from one-third to one-half of people with mental illnesses report being turned down for a job for which they were qualified after their illness was disclosed, or had been dismissed from their jobs, and/or forced to resign as a result of their mental illness. Surprisingly, the figures are not dramatically lower for employment within mental health agencies or for volunteer positions both inside and outside the mental health field. Many people with mental illnesses fear even applying for jobs because of often-justified fears of rejection. Other people with mental illnesses try to avoid discrimination by simply concealing their illness. In doing so however, they usually incur more stress from the

“I have been stabilized and cleared to go back to my job in a law office. The people that don’t know I was on leave for psychiatric reasons treat me OK, but the people that know treat me like I’m dangerous or freaky. When a lawyer runs down the hall, everyone says, He must be late for Court. When I run, everyone says, She must be manic.”

continuous fear of being discovered, from endangering their mental health by tending not to take time off even when they need it, and from remaining ineligible for appropriate accommodations for their disability that might have made their working lives easier and more enjoyable.

To assist people with mental illnesses gain improved access to work opportunities, the Minister's Advisory Council on Mental Health recommends:

24. The Minister of State for Mental Health work with relevant ministries to implement a province-wide supported employment program for people with mental illnesses as part of a rehabilitation and recovery oriented model of treatment.

“(A program) where you tailor supported employment just for him would’ve helped...When he felt useful, that’s when he did his best.”

## **Discrimination within the Post-secondary Education System**

Late adolescence and early adulthood are perhaps the most vulnerable times for young people to experience their first episode of mental illness. Despite this, there seems to be little knowledge or understanding of mental health issues and few accommodations in schools, colleges or universities. The Disability Services Offices in colleges and universities generally focus on providing support and accommodations for students with physical disabilities. In addition, most students with mental illnesses are unaware of the supports that do exist or have difficulty accessing them. Administrative policies regarding course admissions, grading and course withdrawals are not sensitive to the needs and circumstances of people with mental illnesses and result in difficulties in gaining admission to programs and in increased failure rates. To assist people with mental illnesses and family members to experience more success in the post-secondary system, the Minister's Advisory Council on Mental Health recommends:

25. The Adult Mental Health Division of the Ministry of Health Services assist student support programs and service departments at colleges and universities to become more sensitive to the needs of students with mental illnesses and require that they recognize mental illness as a legitimate disability and provide appropriate supports. It is also necessary to produce information about supports and accommodations available in the post-secondary system for people with mental illnesses, their family members and for mental health workers.

“I just thought that school was important so I tried to go back to school and in their eyes that was just complicating things.”

## **Discrimination within the Criminal Justice Systems**

A great many people with mental illnesses find themselves in conflict with the law as a result of their symptoms and situations. Research in BC shows that there is a significantly greater proportion of provincial jail inmates with a serious and acute mental illness than is true for the general population (3-5% vs. 1%). A recent study of federal prisoners in the Pacific Region found that 8% of newly admitted offenders had a current mood disorder, 3% were diagnosed with acute schizophrenia or psychotic disorders and 17% were experiencing acute anxiety disorders. In prison, there are few resources to treat these people and most get little or no specialized psychiatric care while in custody.

The correctional system also discriminates in the way decisions are made about parole opportunities, placement in less restrictive facilities, and opportunities to participate in programs. Contrary to popular opinion about the so-called 'free ride' afforded by the not-criminally-responsible-on-account-of-mental-disorder defense, people with mental illnesses are actually more likely to be discriminated against than treated preferentially, with studies suggesting that people with mental illnesses are more likely to be falsely charged for violent crimes. In the end, being identified as someone with a mental illness is not a preferred status in the criminal justice system just as it is not a preferred status in society as a whole. To reduce discrimination against people with mental illnesses in prison, the Minister's Advisory Council on Mental Health recommends:

26. The Minister of State for Mental Health ensure that protocols exist between provincial and federal correctional services and the mental health system to ensure that people with mental illnesses in prison and jails receive the treatment they need, that appropriate release planning takes place with access to a full range of community services, and that institutional and community corrections staff receive training with respect to mental illness.

"My son was turned away from care because the mental health centre and his private GP considered him too sick. In his psychosis, he assaulted me. Now he's at FPI and I am having to act as his advocate at the same time as I am his victim."

## **Reducing Discrimination Against Parents with a Mental Illness**

The legacy of parenting-rights discrimination for people with a mental illness began with the complete elimination of those rights through forced sterilization in men and women, boys and girls in Western nations including Canada. Though the days of legalized sterilization programs in the Western world are over, discrimination against people with mental illnesses who have children continues to exist. For instance, it is frequently implied or even stated that people diagnosed with severe mental illnesses should not marry or have children because they are too psychologically fragile, carry a genetic predisposition for illnesses that they will pass onto their children, or are incapable of providing a stable home environment. Moreover, despite the lack of evidence suggesting that people diagnosed with a mentally illness are unable to parent — like everyone else, they have an equal shot at being good, bad, or indifferent parents — research has shown that parents so diagnosed lose custody for reasons that would rarely constitute grounds for termination of custody for non-consumer parents.

"My ex-husband got custody of the kids when I went into the hospital, even though he was abusive."

Barriers to access with children include struggling to reconnect with children who are placed in foster care during a parent's extended hospitalization, seeing children while the parent is in a secure hospital psychiatric unit with strict visitation rules, and being allowed to visit children after adoptive parents have taken custody. Even vocational rehabilitation tends to ignore parenting, probably because it has had a greater focus on male conceptions of work above the 'work' of parenting. And although studies continue to investigate the degree of hereditary connections of mental illness, little commentary is made on the value, comfort and support a parent with a mental illness can provide for a child who may end up dealing with their first experience of mental illness. Non-custodial parents who have a mental illness also experience difficulties gaining access to their children after divorce due to misconceptions about their abilities to participate in parenting tasks. To help people with a mental illness exercise their rights and

"It was a good thing I didn't know my diagnosis, because that way welfare couldn't take away my kids."

responsibilities as parents without being fettered by discriminatory practices, the Minister's Advisory Council on Mental Health recommends:

27. The Minister of State direct the Adult Mental Health Division of the Ministry of Health Services to implement, on a province-wide basis, the recently-developed community training program entitled *Supporting Families with Parental Mental Illness* in order to reduce the discriminatory practices of child protection agencies and the Courts.

## **Conclusion**

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Discrimination disables people with mental illnesses and their families to a greater extent than the symptoms of the mental illness itself. If we are to learn the lessons taught by other social movements, this climate of prejudice and inequality will not go away with the passage of time; it will only get worse with prolonged inattention. Clearly what is needed now is a concerted effort, led by the provincial government and the newly-configured health authorities, together with advocacy groups representing mental health consumers and their families, to reduce, and ultimately eliminate, discriminatory ideas and practices within government agencies, communities and in human relationships affecting people with mental illnesses and their family members. The Minister's Advisory Council on Mental Health strongly believes that if the recommendations proposed in this paper are implemented, BC communities will benefit greatly from the increased ability of people with mental illnesses and their family members to participate positively in community life. The time for action is now and we dedicate ourselves to assisting the Minister of State for Mental Health to reduce discrimination against people with mental illnesses in this province.

## Complete List of Recommendations

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- 1.** That the Minister of State for Mental Health, and all the Ministers of Health, endorse and use an approach to public and professional communication in dealing with the issues faced by people with mental illnesses that is consistent with the concept of discrimination as opposed to the concept of stigma.
- 2.** Encourage the BC Human Rights Commission to increase its level of understanding and sensitivity to the needs of people with mental illnesses and adapt their policies and procedures to accommodate these needs.
- 3.** Implement a Charter of Rights for people with mental illnesses and require that all agencies that provide service to people with mental illnesses and family members reconcile their policies and procedures with the tenets of the Charter.
- 4.** Develop and implement a province-wide orientation and education workshop to introduce the Charter and assist in its implementation. Ensure that any and all directly or indirectly government-funded workers complete an orientation to working with people with mental illnesses and family members, to the Charter and to discrimination issues prior to full assumption of duties.
- 5.** Require that regional health authorities provide advocacy services to assist people with mental illnesses and family members to address instances of discrimination.
- 6.** Implement an Annual Anti-Discrimination Award (with small cash award and trophy/plaque) for individuals or groups who fight against discrimination against people with mental illnesses and their family members. This award is to be presented by the Minister of State for Mental Health.
- 7.** That the Adult Mental Health Division develop an Anti-Discrimination kit (a package of educational materials) that could be used by consumer groups, family groups and mental health agencies to educate professionals, workers in other agencies or other community groups about mental illness, family issues and discrimination. A model stressing the partnership of people with mental illnesses, their family members and care providers should be used.
- 8.** The Minister of State for Mental Health work with the Ministers of Education and Advanced Education to develop curriculum materials for use in schools to introduce children to basic information about mental illness, and the process and effects of discrimination (the video and educational materials produced by the BC Schizophrenia Society entitled “Reaching Out” provide an excellent example of appropriate materials for this purpose). Include the Charter of Rights as an element in the basic curriculum for these education initiatives.
- 9.** The Ministry of Health work with the appropriate government agencies to develop a mechanism that identifies instances of discrimination, bias or misrepresentation of people with mental illnesses and their families in the media; addresses repeated violations (legally or through administrative means); and re-educates the offenders.



- 10.** The Minister of State work with Regional Health authorities to identify, support and train people with mental illnesses and family member volunteers at the local level to be available to speak to their local media about mental health issues as well as to advise concerned citizens about using existing complaint processes within press bodies, broadcast standards councils or advertising standards councils in BC and Canada to deal with instances of discrimination in the media.
- 11.** The Minister of State for Mental Health require health authorities to identify the specific mental health needs of the major ethnocultural groups in their region and develop a strategy to meet the mental health needs of individuals and family members in a way that respects their cultural differences and language.
- 12.** The Ministry of Health base funding formulae for programs, research and services on the morbidity and mortality rates for mental illness, including anxiety disorders, addictions and eating disorders.
- 13.** Monies intended for programs and services for people with mental illnesses should be protected as designated funds and not lumped in to general revenues for health.
- 14.** The Ministry of Health revise Medical Services Plan (MSP) billing structures to encourage and allow general practitioners and psychiatrists to provide the kinds of services and supports actually required by people with mental illnesses: for example, attendance at case management meetings, multidisciplinary team meetings, more time for counseling of the individual and family, follow-up services, and outreach and home visits. Hire GPs on a sessional basis to provide services to people with mental illnesses in rural and remote areas or in inner city areas.
- 15.** The Ministry of Health fund general counseling services for people with mental illnesses and their family members to assist in dealing with the psychological pressures and stresses of living life with a disability.
- 16.** The Ministry of Health work with health authorities to properly clarify and reduce the discrimination against certain mental disorders within the mental health system itself and make services available to people living with these disorders. For example, anxiety disorders, substance abuse problems, and eating disorders do not receive the same kind of support as other disorders receive despite the higher morbidity rates involved.
- 17.** The Ministry of Health require professional associations to allow third-party complaints on behalf of people with mental illnesses against registered members of the associations. People with mental illnesses often do not have the resources to articulate and then pursue a complaint against a professional.
- 18.** The Minister of State for Mental Health work with the Minister of Advanced Education to develop materials on the issues of discrimination to be incorporated within the core curriculum for those professional training programs that prepare people to work with people with mental illnesses (for example, doctors, social workers, nurses, psychologists, occupational therapists, etc.). Use these same materials to target people already working in the field in order to upgrade their skills and examine their values. Target emergency room staff at hospitals and other health professionals who work with people with mental illnesses in crisis.

- 19.** The Ministers of Health work with the appropriate provincial and federal ministries to develop and implement a housing strategy to address the substandard living conditions of people with mental illnesses living in market housing.
- 20.** The Ministers of Health require that each health authority conduct an audit or quality review of directly or indirectly government-funded housing used by people with mental illnesses in each region. Any substandard housing must be improved or replaced, where substandard is defined using the recommendations of the BC Community Living Association which urge, for example, a maximum of 4 people living in a home.
- 21.** The Minister of State for Mental Health will ensure that health authorities, in partnership with other government ministries and agencies, provide adequate respite accommodations for family caregivers.
- 22.** The Minister of State for Mental Health work with other ministers and the federal government to reconcile pension and disability program requirements to allow for fluctuating levels of disability and for people to move more easily from work to income support eligibility and back again. Increase payment levels to more closely approximate the Statistics Canada poverty lines and allow people with mental illnesses who have the ability to earn some money to develop and maintain their skills and level of independence (perhaps to poverty line levels) without penalizing them by deducting these funds from their regular pension benefits.
- 23.** The Minister of State establish a committee made up of cross-ministry personnel and key stakeholders to monitor the issue of poverty and mental illness and to make recommendations to reduce discrimination against people with mental illnesses in this area.
- 24.** The Minister of State for Mental Health work with relevant ministries to implement a province-wide supported employment program for people with mental illnesses as part of a rehabilitation and recovery oriented model of treatment.
- 25.** The Adult Mental Health Division of the Ministry of Health Services assist student support programs and service departments at colleges and universities to become more sensitive to the needs of students with mental illnesses and require that they recognize mental illness as a legitimate disability and provide appropriate supports. It is also necessary to produce information about supports and accommodations available in the post-secondary system for people with mental illnesses, their family members and for mental health workers.
- 26.** The Minister of State for Mental Health ensure that protocols exist between provincial and federal correctional services and the mental health system to ensure that people with mental illnesses in prison and jails receive the treatment they need, that appropriate release planning takes place with access to a full range of community services, and that institutional and community corrections staff receive training with respect to mental illness.
- 27.** The Minister of State direct the Adult Mental Health Division of the Ministry of Health Services to implement, on a province-wide basis, the recently developed community training program entitled *Supporting Families with Parental Mental Illness* in order to reduce the discriminatory practices of child protection agencies and the Courts.

## **APPENDIX I:**

### **Community Forum on Discrimination Against People With Mental Illnesses (June 2001): Summary of Advice from Participants**

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The community forum provided an opportunity for participants to discuss the issues concerning discrimination against people with mental illnesses and their family members, share experiences of discrimination and think creatively about ways to reduce discrimination. What follows is a summary of the experiences and ideas that came out of the small discussion groups. These summaries were taken from the handwritten notes as recorded by group participants as well as from the feedback forms filled out at the end of the day.

#### **The Meaning and Experience of Discrimination:**

- Not being able to act independently: for example, a 24-year-old woman who had to get her father to co-sign for a loan.
- Emergency room staff show little patience or understanding for people with mental illnesses. They allow this to show in their verbal and nonverbal behaviour and sometimes making people wait lengthy periods of time for much-needed attention. There was some discussion of the need to bypass this part of the hospital in order to gain admission for an acute episode of illness. In Richmond, the policy is to use a quiet room. The person is seen by a nurse immediately and never left alone; follow-up with a mental health worker is done as soon as possible.
- Concern was expressed by a person who wants to be a police officer and feels sure that she will not be able to realize this dream due the beliefs of others about her mental illness.
- Several people spoke of degrading comments and treatment by general practitioners who clearly demonstrated a lack of understanding for the unique needs of their mentally ill patients. An example was given of a woman with an eating disorder being told to “just eat” by her GP. Another example was provided of a person who went in for a physical examination and had her psychotropic medications changed without appropriate consultation.
- It is important to reduce discrimination in the health care system first in order to be able to affect the attitudes of the broader community towards people with mental illnesses.
- Many consumers do not know they have rights in certain situations and it is important to make people with mental illnesses generally aware of their rights.
- Concern was expressed about the discrimination towards the building or establishment of group homes for people with mental illnesses: the ‘Not In My Back Yard’ (NIMBY) phenomenon.
- Several people talked about the crossover in negative stereotypes that happen for people with mental illnesses. For example, a home for people with mental illnesses being labeled by neighbors as a “crack house.”
- It was reported that people with mental illnesses with drug addictions are discriminated against by drug treatment agencies. They are denied service by virtue of the fact that they have a psychiatric diagnosis.
- Examples were given of people who had lost their jobs as a result of having a mental illness and requiring treatment.
- Discrimination means not being seen as an individual human being, not belonging to a community, having to be ever-vigilant about what you say and do in order to avoid being labeled, not being believed, and being denied certain things that other people accept as basic parts of life.

- Discrimination means being poor, feeling isolated, being treated as incompetent, losing your children or being denied access to your children, not being able to receive certain modern medications when required, not having access to alternative treatment methods, being treated as different.
- Discrimination means not receiving recognition for strengths, talents and abilities.
- Families often feel blamed in various ways when a member develops a mental illness. Family members often don't get much-needed support in dealing with their own feelings.
- Service providers who also have a psychiatric diagnosis are often placed under the microscope by other service providers and sometimes are quickly judged or criticized.
- Little tolerance is shown for habits or behaviours that are really only minor eccentricities.
- The first reaction many consumers have experienced from health care staff and others is fear simply because they are known to have a psychiatric diagnosis.
- Assistance from hospitals or other care providers is not given unless a person is considered to be in real danger. People are often not taken seriously when they express the extent of their painful feelings.
- Consumers and family members encounter discriminatory practices when dealing with immigration officials. Mental illness becomes a significant barrier in entering a country and trying to get status.
- Discrimination means not having a choice about doctors or services.
- Some people have felt “experimented upon” by doctors who try things without properly discussing the treatments with the person.
- Once diagnosed, it is difficult to shake the “label” even after full recovery is achieved.
- Sometimes, consumers and family members act in discriminatory ways and show prejudices depending on the diagnosis and level of wellness, that is to say, they can take on the same attitudes towards people with mental illnesses as the general public.
- Discrimination means not receiving the information you need about medications, treatments, support services and alternatives. Among some health care workers, there appears to be the belief that consumers or family members cannot “handle” the information.
- People who begin to recover and have less acute needs often experience a significant reduction in service and support, which then jeopardizes their recovery.
- Disability income levels are too low to allow for participation in community life. Financial aid workers often lack training or an understanding of the needs of people with mental illnesses.
- People with mental illnesses do not receive prompt physical attention for legitimate ailments due to care providers making the assumption that the complaint is symptomatic of the mental illness, not the physical illness.
- Legitimate anger on the part of consumers and family members is invalidated and discounted as a symptom of their illness or dysfunction.
- Drug companies use their power to limit research and access to herbal and alternative remedies. For example, the herbal supplement SAM-e is no longer available in Canada.
- Discrimination has resulted in people having to move from their homes or communities to escape the labeling process that takes place. This can happen in small towns and in large cities.
- Consumer and family member leadership skills are not well recognized.
- Many participants talked about the role of the media in promoting negative stereotypes about people with mental illnesses and the importance of using the media to counter and correct these stereotypes.
- Inability to get insurance coverage following a psychiatric diagnosis.

## Suggestions for Reducing Discrimination

In the second round of discussions, the small groups were asked to generate ideas that would have the effect of reducing discrimination against people with mental illnesses. What follows are the results of this discussion:

- A concerted, well planned and creative approach to public education using the full power of the media to increase awareness and understanding about mental illness and the needs and strengths of people with mental illnesses. Should be undertaken with government funding and the sponsorship of the Minister of Health.
- Educational materials should be included in the basic curriculum in schools to promote understanding and tolerance.
- Alternatives to incarceration in prisons and jails should be developed to prevent the jailing of people with mental illnesses who require treatment, not punishment, for their problems and issues.
- Review income security, housing, employment and education policies to ensure they are consistent with the rights and privileges that are supposed to apply to all Canadians regardless of disability and to ensure that they provide the support needed to allow the full participation of people with mental illnesses in community life. The figure of \$1450 was given by one group as the minimum support level required monthly to live a dignified lifestyle.
- Provide training to police and other justice officials in order to prevent harm from coming to people with mental illnesses in crisis.
- Provide training to health care workers — particularly those who work in key areas such as emergency rooms — about the needs of people with mental illnesses and how to meet those needs respectfully and effectively. Medical schools need to incorporate education materials and supervised experiences that will promote understanding and knowledge among GPs.
- Integrate services so that people with multiple problems (e.g. mental illness and addictions or HIV/AIDS) get the service they need promptly and efficiently.
- Develop a comprehensive and province-wide early intervention program to provide prompt attention to individuals and family members encountering a mental illness for the first time and to limit the degree of disability experienced by the person concerned.
- Fund general counseling services for people with mental illnesses and their family members. Currently the bulk of these services are available only on the private market and are prohibitively expensive for most people.
- Ensure continuity of care throughout the lifespan so that people don't experience breaks or reductions in service as they move from childhood through adolescence into adulthood and then into their senior years.
- More initiatives to fund consumers in educational, training and business opportunities. This would include supported employment opportunities.
- Allow flexibility in disability programs to allow people to earn money when they are well and return to benefits when they experience a relapse. Provide wage subsidies to encourage the hiring of people with mental illnesses. Provide assistance to employers for people who require accommodations in the workplace.
- Encourage positive media coverage regarding consumer and family achievements.
- Ensure that people with mental illnesses receive appropriate dental and optical care.
- Fund appropriate legal assistance for people with mental illnesses in conflict with the law and/or being housed in prison.
- Immediate access to the most effective medications available.
- More funding for research into mental illness with the goal of developing more effective medical treatments and rehabilitative/recovery strategies.

- Ensure that people with mental illnesses, and family members where appropriate, are given choices about their treatments and care and get all the information they need to participate effectively in that choice process.
- Hire only staff that adhere to practices that are respectful of the rights and abilities of people with mental illnesses and their family members and who are able to work to facilitate recovery and full inclusion in community for people with mental illnesses.
- Develop a strategy to deal effectively with poverty and mental illness.
- Implement a Charter of Rights for people with mental illnesses and ensure that all policies, public and private, operate in a manner that is consistent with this Charter.
- People with mental illnesses, family members and care providers need to assert themselves and confront prejudice when and wherever it occurs. We need to act as role models for others in terms of treating others with respect.
- Improve the coordination of decision making at the very top, i.e., Ministers of Health, Education, Attorney General, Labour, Human Resources, etc. need to work together to improve services for people with mental illnesses.
- Care needs to be closer to home — wherever home is.

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We were also very fortunate to have two excellent keynote speakers at the forum. Though we could not possibly recapture the full impact of their talks, we have summarized them as best we can in what follows:

Lenny Gagnon emphasized the importance to her of being accepted by and connected to other people. She told her personal story of discrimination growing up as a member of a poor family, a vulnerable and exploited child, and later as a person with a mental illness. Mental illness, she said, was powerful in terms of isolating her from potential sources of support and caring. When she was able to get to a place in her life when she could again reach out and be available to others, her recovery accelerated tremendously. She realizes now that she held some of the same attitudes and beliefs about mental illness that other people hold and these self-defeating thoughts and feelings were as great an obstacle to her as were the thoughts and feelings of other people. Having learned this painful lesson, she supports her own wellness by ensuring she is active in her community and stays connected with the many people who care about her. She continues to encounter discrimination; however, her strength of will, supported by the people in her life who offer validation and support sustain her in her work. Power over stigma, she said, belongs to her now. She determines who she is and works hard at reframing society's negative views of her as a person with a mental illness. She makes choices rather than simply reacting to life's challenges. She is winning and achieving excellence in her life because of her positive approach to life.

Dulcie McCallum, former Ombudsman for the Province of BC and author of the *Listening Report* on Riverview Hospital, expressed the view that discrimination against people with mental illnesses is endemic to our culture. Popular media supports the negative stereotypes of people with mental illnesses and these powerful cultural messages must be seen as a significant causal factor in discrimination. The health care system contributes to discrimination by artificially separating physical health from mental health. Physical problems receive priority and mental illnesses are shunted to one side. Government makes the fundamental error of focusing its attention on the very small percentage of people who have serious mental illnesses and ignores the challenges everyone faces in maintaining

mental health in the face of a stressful society. This causes people with serious mental health problems to be further separated from us all. She noted the US Surgeon General's study, which shows that discriminatory attitudes have been on the rise since the process of deinstitutionalization began. In part, this is because people with mental illnesses have not received the support they need in the community and as a result end up in the public eye (both via homelessness and an irresponsible media) portrayed as violent and unpredictable. People then rush to disassociate themselves from mental illness as they struggle with depression, anxiety and other mental health problems of their own. Dulcie said the solutions are complex but offered the following suggestions:

1. Reject the misconceptions and refuse to tolerate the misinformation and prejudiced information flowing from the media. Require that government and the media speak the truth about mental illnesses and the issues faced by people who live with these issues.
2. Design a health care system that is holistic, inclusive and respectful.
3. Become intimate and develop relationships with people who we consider different and in this way foster inter-connectedness and unity among us all.

In addition to these many excellent ideas from our guest speakers, panel members also contributed valuable ideas. We have summarized their ideas as follows:

Roy Johnson, the Human Rights Advisor for the Vancouver Richmond Health Authority, made many very interesting points about discrimination against people with mental illnesses and family members. He defined discrimination in relation to mental health as:

“a distinction, whether intentional or not, based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed on others, or which withholds or limits access to opportunities, benefits or advantages available to other members of society.” *Andrews v. Law Society of BC.* (1989) Supreme Court of Canada.

Roy asked the question ‘why do people discriminate?’ and said that most people do not, in their hearts, set out or intend to discriminate. They may be wanting to help, support or protect a person and be unaware that the manner in which they are putting these positive intents in action is discriminatory. Because of this, he said it was important to focus on the impact of the actions being taken rather than upon the intent. This will help systems and people gain greater awareness of how their actions negatively affect others. He suggested choosing strategies that are consistent with our own values, respectful of others, use persistence (whittling away at the problems) in working towards change, and focus on interests (the underlying needs wishes and desires) rather than on positions (specific outcomes).

Paul Bhushan, another panel member, spoke from his experiences as a person living with a mental illness, of the importance of remaining positive about life and the future. He was fortunate, he said, to have encountered people who had faced their own problems successfully and who believed in him and his ability to overcome his challenges. With that support, he was able to develop the confidence to move forward in his own life.

Bev Gutray, Executive Director of the Canadian Mental Health Association’s BC Division, shared with forum participants the experiences that CMHA has had with public education about discrimination against people with mental illnesses. She talked about the ads for TV and radio that were produced and aired as a result of the BC Association of Broadcasters 1998/99 Humanity Award. The ad that

had the most impact in terms of public response was the one that depicted a young father playing with his baby and then telling the audience that he had a mental illness. The ad then said that what was truly sick was the way in which your (i.e., the viewer's) attitudes towards him suddenly changed. Though some of the public reactions to the ad were negative, Bev felt that they had achieved their goal of getting people to think about their own attitudes toward people with mental illness.

Nancy Hall, Provincial Mental Health Advocate, spoke of her work throughout the province identifying the systemic issues that impinge on the quality of life for people with mental illnesses. She spoke at length about the Charter of Rights that is being developed presently under the auspices of the Mental Health Division and her office. This Charter, when it is completed, should serve as a basic reference point for all those who serve the needs of people with mental illnesses in this province. To be effective, it will require considerable commitment from government to ensure its provisions are respected and built into all aspects of the service system. Once this process is completed, it should unmask discrimination when it occurs and provide remedies. Nancy also spoke of the importance of individual advocacy. She said we have to stand up and complain and work with advocates to ensure that the individual experiences of injustice and discrimination are addressed. It is important to ensure that a network of individual advocates be established in all health regions.

Another way to deal with discrimination is to promote the recovery model in mental health. This model emphasizes the abilities and the rights of people with mental illnesses. It is a very natural and appropriate way to discourage discriminatory practices. Finally, Nancy suggested the promotion of real mental health reform. The fact that the mental health system is restricted to caring for the 2% of the population with serious mental illnesses is artificial and driven by a lack of resources rather than by good practice or common sense. This narrow focus actually seems to reinforce stereotypes and stigma. There is a need for a full spectrum approach to mental disorders. Specifically, she felt that the treatment of "concurrent disorders" should be included in the system. The mental health system should also include, she argued, a significant effort towards the promotion of mental health.

### **Concluding Comments from Minister's Advisory Council on Mental Health**

In conclusion, we would like to add that the proceedings from this forum will become part of a larger report that is being written on the topic of discrimination against people with mental illnesses in this province. This report will identify the key issues and make recommendations to the Minister of State for Mental Health to reduce the problem of discrimination in BC. When the report is completed it will be made available on the Council's web site as well as in printed form.

Patrick Storey  
Chair, Minister's Advisory Council on Mental Health