

TAKING ACTION ON STIGMA AND SOCIAL INCLUSION IN BRITISH COLUMBIA

Report to the Healthy Minds Healthy People Directorate recommending key first steps to address the stigma and discrimination experienced by people with moderate to severe mental health and substance use issues and towards a more socially inclusive British Columbia.

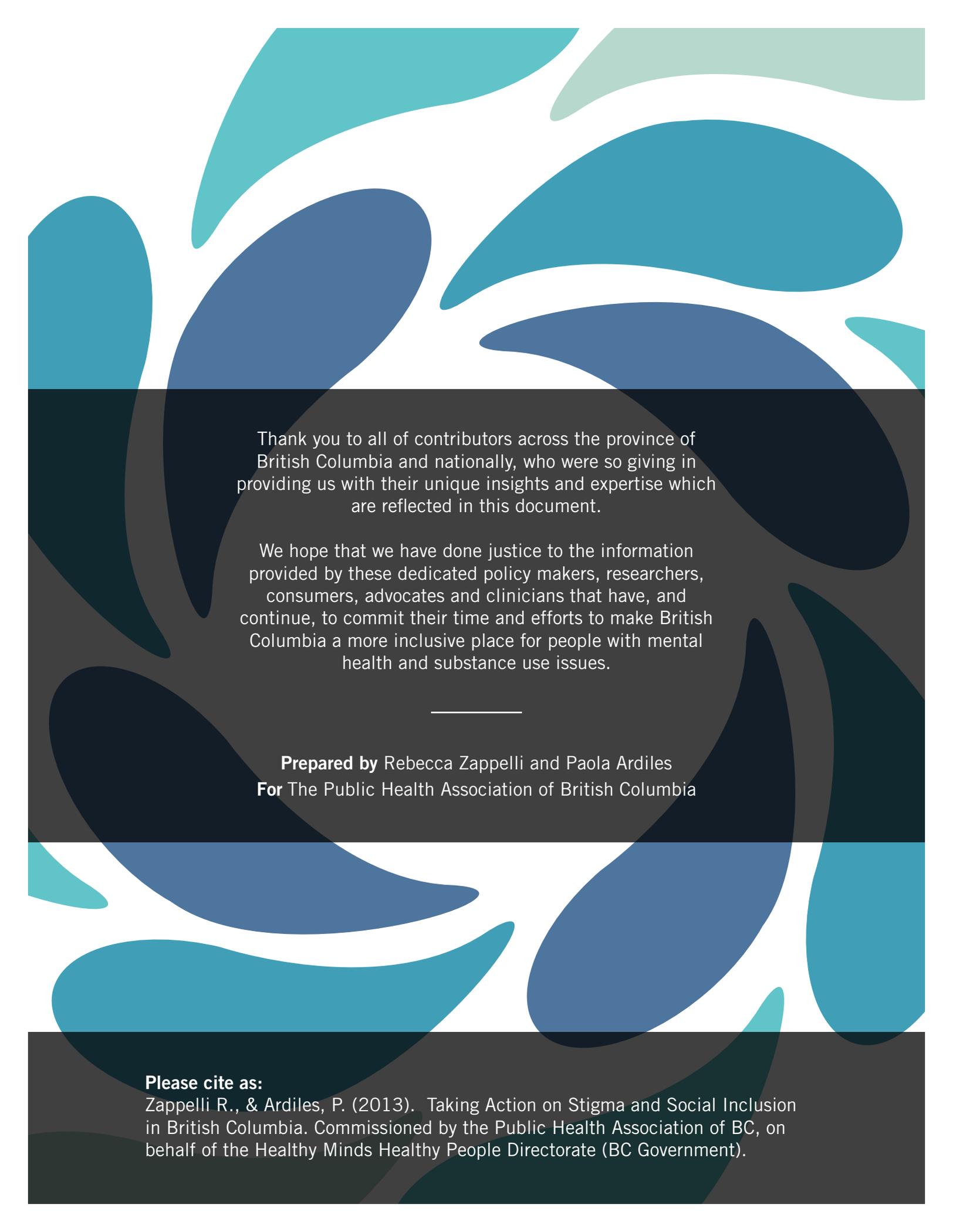


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Thank you to all of contributors across the province of British Columbia and nationally, who were so giving in providing us with their unique insights and expertise which are reflected in this document.

We hope that we have done justice to the information provided by these dedicated policy makers, researchers, consumers, advocates and clinicians that have, and continue, to commit their time and efforts to make British Columbia a more inclusive place for people with mental health and substance use issues.

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For The Public Health Association of British Columbia

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EXECUTIVE SUMMARY

The purpose of this report is to provide a number of first steps for the HMHP Directorate and partners across BC to address the issues of stigma and discrimination, and enhance social inclusion for people experiencing moderate to severe mental health and/or substance use problems in BC. Addressing stigma and discrimination and its impacts on people with mental health and substance use issues is an essential step in creating a system that is inclusive, accessible and equitable for people with mental illness and/or substance use issues.

A key strategic objective identified in Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (HMHP) states that by “2015, more people living with mental illness and/or substance dependence will report that they feel a sense of belonging within their communities” (Ministry of Health Services, 2010, p. 18). While the Healthy Minds, Healthy People Directorate (HMHP Directorate) has undertaken a number of actions to address the issues of stigma, discrimination and social inclusion as a part of its ten-year strategy, there is a need to gain a broader understanding of the current environment in which stigma, discrimination and social inclusion operate in British Columbia (BC).

Stigma, in relation to mental health and substance use, is perhaps best understood as a complex social and cultural process in which particular groups of people are devalued, rejected and/or excluded on the basis of their mental health and/or substance use issues. For people experiencing significant mental health and/or substance use issues, the manifestations of stigma can result in discrimination or further social marginalization. As a result, stigma can become a hindrance to their quality of life, ability to recover and/or successfully manage their condition and their ability to fully participate as active and engaged citizens. It creates obstacles for people experiencing significant mental health and/or substance use issues impacting their participation in treatment, ability to access social, financial and human capital through education and employment, access to adequate housing and basic health and social services. Researchers, collaborators and partners are starting to recognize that social inclusion is a powerful means to reduce the impact of stigma and discrimination for people living with moderate to severe mental health and/or substance use issues, increasing their potential to live as active, engaged citizens in BC. The findings in this report demonstrate a pressing need for BC to move towards approaches that create socially inclusive communities, environments, policies and practices.

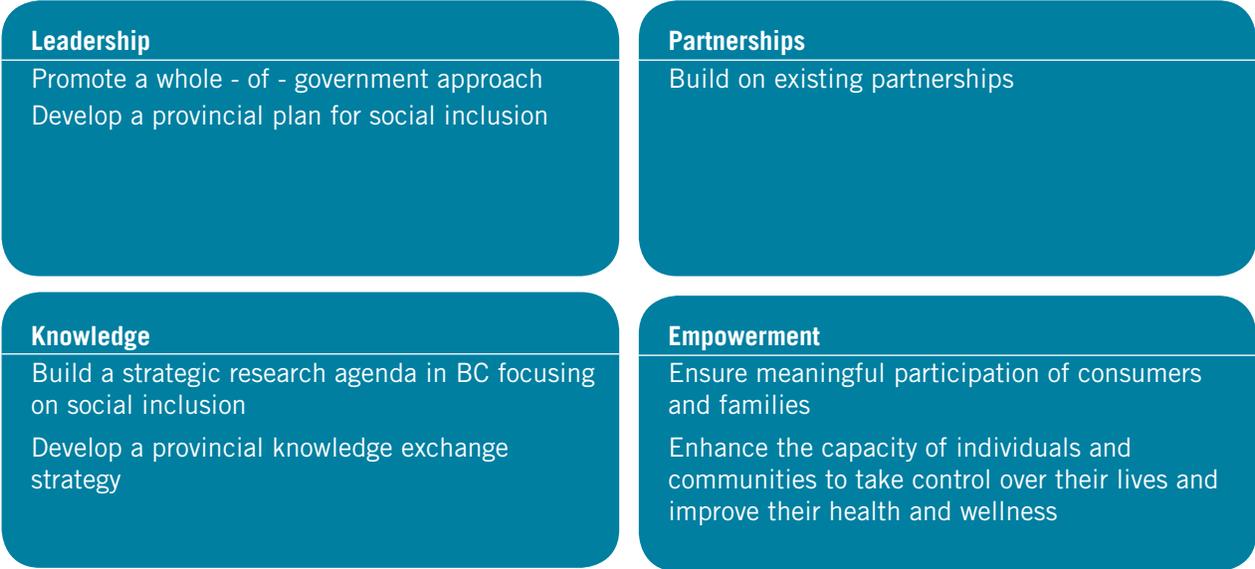
Social inclusion is commonly understood as an individual feeling that they are valued and have opportunities to fully participate in the BC community and is closely tied with the notions of belonging, participation and citizenship. Systems-wide change is required to reduce stigma and discrimination through a social inclusion agenda. This will require whole-of-government collective action because of the complex human systems and intersecting ministerial mandates that interact on these issues. There is also a need to integrate a human rights-based approach into future activity because of the ability to conceptually and practically disentangle stigma, prejudice and discrimination from people's rights to quality care and support.

The area of stigma, discrimination and social inclusion is an ever-evolving field that is moving towards definitions and models that describe stigma as a complex social process. The findings of this report describe an emerging shift towards understanding stigma as more than an isolated variable or risk factor that needs to be mitigated or reduced. Rather, stigma is a complex social process that requires a new approach to traditional models. Therefore, determining appropriate solutions to contribute to positive change for vulnerable and marginalized groups and individuals experiencing moderate to severe mental health and/or substance use problems, needs to be ongoing, systems focused and long term. The findings highlight that we need to be strategic in our approach and appreciate the influence that systems, organizations, agencies, families and individuals have to impact changes across BC society at large. Therefore, the HMHP Directorate and its partners cannot work alone to contribute to change but do have a key role in supporting and advocating for collaboration, partnerships and innovation.

BC has demonstrated leadership across a variety of approaches related to work in stigma, discrimination and social inclusion in mental health and substance use, however there is a great need for provincial level advocacy and strategic leadership in promoting a social inclusion agenda. Based on discussions with key informants it is clear that a normative and operational understanding of how to address the issue of stigma and discrimination is required from a strategic level. Central to the opportunities for leadership is the need for approaches that support grassroots action and local innovation. Such leadership should not be prescriptive and must be supportive of developmental opportunities to impact change. Additionally, there is a major gap in our knowledge of the costs associated with action - and conversely inaction - in the area of stigma, discrimination and social inclusion. The presence of an economic rationale for approaches to stigma, discrimination and social inclusion has helped other international

jurisdictions to develop comprehensive social inclusion strategies and identify where resources are best directed and would add considerable value to any future activities undertaken in BC.

This report proposes a Circle of Belonging: Social Inclusion Model for Mental Health and Substance Use that employs the concepts of hope, knowledge sharing, building community connectivity and supporting collective action. The model aims to support a common understanding of social inclusion amongst key stakeholders. This is achieved by identifying the various domains (from socio-political to the individual) and four pillars (or key strategies) that could support long term, incremental changes towards social inclusion: leadership, partnerships, knowledge and empowerment.



Recommendations: Next Steps

Based on the research undertaken for the environmental scan, the following recommendations for short, mid and long terms steps for a roadmap towards a social inclusion model in BC aims at reducing stigma and discrimination and enhancing social inclusion.

Short Term

- 1 Development of social inclusion tools and/or resources** to support a common understanding of the key principles and promising practices that address social inclusion for people living with moderate to severe mental health and/or substance use issues. This could also be broadened to include the needs of people living with mild mental health and/or substance use issues. These tools/resources should be aimed at increasing capacity of diverse stakeholders including justice, social and health service providers, consumers and families and ensure cultural safety for groups and individuals.
- 2 Development of brief policy papers** based on reliable research evidence, to help decision-makers implement informed public policy, to reduce stigma and, discrimination and enhance social inclusion for people living with moderate to severe mental health and/or substance use issues. This could also be broadened to include the needs of people living with mild mental health and/or substance use issues. The choice of topics for these policy papers would be guided by justice, social and health service providers, consumers and families, policy-makers, as well as emerging trends in the field, including barriers and enablers.
- 3 Development of a paper that outlines the economic case for a social inclusion approach** to address mental health and/or substance use issues. This paper would build on existing literature in order to address the gaps and opportunities for the HMHP Directorate and its partners, on moving towards a research agenda that presents an economic argument towards social inclusion.

Mid Term

- 1 **Create a Provincial Advisory/Steering group** with diverse stakeholders and partners to start the development of a Social Inclusion Plan based on the following key principles: a) do no harm; and b) meaningful engagement and participation of people with mental health and/or substance use issues. Some first steps to consider in creating an advisory group include:
 - * Ensuring common definitions of stigma and discrimination are shared and articulated across the province;
 - * Articulating a clear vision for promoting social inclusion that can be shared across sectors and organizations.
- 2 **Build a knowledge-exchange strategy** to engage stakeholders, communicate, and create a collective vision towards a Social Inclusion Model for BC. This should link to two other projects, Privacy, Confidentiality and Information Sharing with the Mental Health and Substance Use Systems of Care Project.
- 3 **Establish an education fund to support the development and implementation of school-based programs** towards building socially inclusive schools, by linking to IMinds, MindUp, BC School-based Mental Health Coalition, school based health programs within the Health Authorities across BC and other partners.
- 4 **Enhancement of current initiatives aimed to educate, support and improve responses of front line justice, social and health service providers.** This will promote quality care and approaches that focus on compassion and hope for people with mental health and/or substance use issues while supporting the notion of collective responsibility for the process of recovery. This should build on promising and emergent initiatives that are comprehensive, ongoing and apply a systems focus. CAP, Motivational Dialogue and DVD production with first line responders in Fraser Health are examples of where this work is already taking place.
- 5 **Support the creation of a dedicated research funding mechanism** to make the economic case for social inclusion (exploration of the cost benefits associated with social inclusion agenda (cost of action vs. inaction, and best buys).

Long Term

Develop a comprehensive Provincial Social Inclusion Plan for BC that:

- 1 Uses a health promotion approach that allows consumers, community and treatment based services and public health services to have a key role in its implementation.
- 2 Builds strategic intra-provincial partnerships and collaborative approaches;
- 3 Supports practitioners in training to better integrate stigma, discrimination and social inclusion issues into new training modules (medical, nursing, pharmacy, social workers, police, lawyers);
- 4 Engages and empowers key justice, social and health care service providers to address issues of stigma, discrimination and social exclusion within their organizations and internal practices;
- 5 Promotes and incentivizes strategic inter-provincial partnerships and collaboration on issues related to stigma, discrimination and social inclusion;
- 6 Embeds evaluation components into any activity, initiative or intervention.

INTRODUCTION

British Columbia's (BC) Ministry of Health estimates that over any 12-month period, approximately one in five individuals in BC will experience significant mental health and/or substance use issues (Healthy Minds, Healthy People, 2010, p. 2). Whilst some people will receive the support they need to recover or better manage their condition, a proportion of people experiencing mental health and/or substance use problems will experience personal suffering and interference with their life goals (p. 2).

A key strategic objective identified in Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (HMHP) states that by "2015, more people living with mental illness and/or substance dependence will report that they feel a sense of belonging within their communities" (Healthy Minds, Healthy People, 2010 p. 18). In recognition of the importance of continuing to improve the mental health and wellbeing of British Columbians, the Healthy Minds, Healthy People Directorate has identified a need for an environmental scan to assess and recommend future strategies that align with key themes raised in HMHP.

The issue of stigma and its impact on people with mental health and/or substance use issues continues to be a key concern for health authorities, people with a lived experience of mental illness and problematic substance use, their families, service providers, policy makers and researchers across the province. This concern is due to the relationship and manifestations of stigma across multiple social and structural levels and its impacts on individuals with mental health and/or substance use problems and their quality of life. Furthermore, reducing stigma and discrimination is identified as one of thirteen key strategic priorities identified in Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia (HMHP).

Addressing the issues of stigma and discrimination has been identified as an essential step in creating a system that is inclusive, accessible and equitable for people with mental illness and/or substance use issues. Some significant headway has been made towards building an evidence base for effective interventions to address stigma and discrimination across various sectors, and across the continuum of care. In BC and nationally however, there is still no clear consensus as to where efforts and investments are best directed to address the issues of stigma and discrimination.

While the HMHP Directorate continues to work on these issues, there is a need to get a better understanding of the current environment in which stigma, discrimination and social inclusion operate in BC. Current emerging trends in both scientific literature and in practice need to be better understood to inform recommendations that foster a culture and systems that promote equity, equality and inclusion amongst some of the most marginalized populations in BC.

The Public Health Association of BC (PHABC) (funded by the Healthy Minds, Healthy People Directorate) was commissioned to conduct an environmental scan into the issues of stigma, discrimination and social inclusion as they relate to people experiencing moderate to severe mental health and/or substance use problems. The environmental scan sought to analyze the key themes and trends described in the literature and identified in key informant interviews and provide a summary of the current work in BC. The result of the analysis would identify a number of key first steps in addressing the issues of stigma, discrimination and enhancing social inclusion for people experiencing moderate to severe mental health and/or substance use problems in BC.

This report defines moderate mental health and/or substance use problems as those that may significantly interfere with functioning at home, school, work and the community (Healthy Minds, Healthy People, 2010). Severe disorders include psychotic disorders, schizophrenia, delusional disorders, major depression, severe eating disorders and substance dependence or addictions, and are highly debilitating and can affect all aspects of daily life (Healthy Minds, Healthy People, 2010). This report's findings also align with key themes raised in HMHP including; building the capacity of the community; promoting social inclusion; recognizing the importance of mental health and wellness across the lifespan, and inclusive of the role of families and people's informal support networks.

The objectives of the environmental scan required the research consultants to:

- a) Analyze the current context including gaps and emergent practices;
- b) Provide recommendations for comprehensive health promotion and/or programmatic approaches moving forward;
- c) Identify key stakeholders and possible partnerships within BC, as well as relevant key national stakeholders.



People with moderate to severe mental health and/or substance use disorders were identified as key population groups on which to focus. This is because of these groups acute vulnerability to the expression of stigma, discrimination and social exclusion by people and systems (i.e. healthcare, legislative, social care) and the interference this can cause to this groups treatment participation and quality of life. Research suggests that many people who would benefit from mental health and/or substance use services may opt not to pursue them or alternatively, are unable or fail to participate once they start receiving care as a result of stigma (Corrigan, 2004). Even if services are available in the community, some individuals may find them inaccessible due to structural and/or psychosocial barriers. For instance, some may avoid seeking support as they are motivated by label avoidance (not wanting to be identified as being someone with a mental health and/or substance use condition) or fear of public stigma and the discrimination that can result in accessing care (Thornicroft, 2006; Corrigan, 2009; Queensland Alliance for Mental Health (2010); see Section 1: Defining the Issues).

In acknowledgement of the evolving nature of this work, this report will identify emergent approaches that demonstrate promising results in addressing issues associated with stigma and discrimination. This includes analyzing approaches and opportunities that promote and integrate socially inclusive strategies. This report acknowledges that the issues of stigma, discrimination and social inclusion (or conversely, exclusion) run along the fault lines of broader systemic issues and complex human systems. The issue of stigma is complex, challenging to define and difficult to measure changes overtime. Therefore determining appropriate solutions to contribute to positive change for individuals experiencing moderate to severe mental health and/or substance use problems will need to be ongoing, systems focused and long term. If we understand stigma as a complex social process, we need to be strategic in our approach and appreciate the influence that systems, organizations, agencies, families and individuals have to impact changes across BC society at large. Therefore, the HMHP Directorate and its partners cannot work alone to contribute to change but do have a key role in supporting and advocating for collaboration, partnerships and innovation.

Key first steps to tackling the issue of stigma and social inclusion will be provided via a series of recommendations based on a selected review of literature relating to the issues of stigma, discrimination and social inclusion and the analysis of the trends and insights gained from key informant interviews. It will take into consideration the social, political and economic context in BC and nationally where appropriate, and provide recommendations that draw from the key themes raised in HMHP such as promoting good mental health, preventing harms, whole systems approach, health across the lifespan and aboriginal people. Additionally, the environmental scan will utilize the HMHP Systems Transformation Frameworks key levers (i.e. leadership, knowledge and partnerships) (see Appendix A).

Research Methods

The research consultants undertook an iterative process from which to conduct a high level selected review of literature relating to the issues of stigma, discrimination and social inclusion; and gathered information on trends and insights from experts and key stakeholders across the province and nationally where appropriate. The following summarizes the methods used to inform this report.

Document Scan

A primary document scan was conducted using internet search engines (Google, Google Scholar) linked with scientific databases (PubMed, PsychInfo, Medline), to search for relevant and selected published and grey literature on foundational research and/or interventions in the area of mental health and substance use. Key words for the search included: stigma, anti-stigma, social inclusion, social exclusion, discrimination, health literacy, mental health literacy, mental health promotion, mental illness prevention, harm reduction, social marketing, public education, public perceptions and stereotypes. The search was conducted across various population groups (children, youth, adults, women, men, seniors, families, Aboriginal, multicultural) and also included the identification of key messages and target audiences (e.g., justice, social and health care providers, youth, workforce, media).

The key informants also provided published and grey literature to the consultants to provide relevant and formative research from internationally based experts that informed their knowledge and practice. A secondary scan was conducted using internet search engines (Google, Google Scholar) linked with scientific databases (PubMed, PsychInfo, Medline), to search for relevant and selected published and grey literature of foundational research and/or interventions following key informant interviews which raised two additional themes; human rights approaches and belonging. The primary and secondary document scan yielded a total of 150 articles that were originally selected based on the search criteria. Of the 150 articles, 77 were later identified as foundational documents either by the key informants or due to their relevance in the current literature and BC context, and therefore were reviewed in detail.

Organizational Scan

Building on the findings from the key informant interviews, an organizational scan was conducted in parallel to the document scan. This enabled the identification of numerous relevant organizations and interventions across the province. This also included organizations specifically identified by the Mental Health Commission of Canada Opening Minds initiative in order to identify key stakeholders and key partnerships as outlined within the parameters of the rationale of the environmental scan.

Limitations of the Scan

Based on the parameters defined by PHABC, the HMHP Directorate and its partners, the environmental scan did not include:

- a) Exploration of stigma, discrimination and social inclusion interventions/activities experienced by British Columbians with mild mental health and/or substance use issues or the broader general population in British Columbia.
- b) Exploration of stigma, discrimination and social inclusion interventions/activities in other areas beyond mental health and/or substance use issues.
- c) Legislation and/or organizational employment policies in the area of stigma, discrimination and social inclusion related to mental health and/or substance use issues.
- d) Exploration of stigma, discrimination and social inclusion interventions/activities in other provincial/territorial jurisdictions.

Key Informant Interviews

A key informant questionnaire was developed and distributed (see Appendix B) to 6 key informant interviewees whom were originally identified as key researchers and/or stakeholders for the purposes of the Scan. Due to the expertise in the province and the breadth of work that has been undertaken in the area of stigma, discrimination and social inclusion in British Columbia and nationally, the number of interviewees to be involved in the scan was expanded to include 22 key informant interviews and numerous informal conversations undertaken with professionals and experts across BC (and nationally where appropriate). Participants to be included were determined by the Healthy Minds Healthy People Directorate and their stakeholders to capture the breadth of expertise and knowledge in the area of stigma, discrimination and social inclusion across the province and nationally where appropriate (see Appendix C).

Report Structure

To meet its objectives, this report is structured as follows:

Section 1: Defining the Issues

A synthesis of the high-level literature review and working understandings of stigma, discrimination and social inclusion across the province of BC (and nationally where relevant), and how it is defined in order to develop the report's conceptual foundations.

Section 2: Current Approaches

Identification of leadership, key stakeholders, organizations and programs currently conducting stigma, discrimination and social inclusion activities in British Columbia and nationally (where relevant) relating to people experiencing moderate to severe mental health and/or substance use problems.

Section 3: Key Trends, Themes and Emergent Practice

This section will provide a high level synthesis of key trends, themes and emergent practices related to stigma, discrimination and social inclusion activities tailored to people experiencing moderate to severe mental health and/or substance use issues. This will draw from the literature and current approaches identified.

Section 4: Recommendations

Following the synthesis and analysis provided in the previous sections, a series of recommendations will be provided.

Section 5: Next Steps

This final section will outline a number of key first steps identified by the authors based on the results of the environmental scan and analysis for a comprehensive approach moving forward.



SECTION 1: DEFINING THE ISSUES

1.1 Navigating The Complexities of Stigma, Discrimination and Social Inclusion

It is important to highlight the contested nature of the term stigma across the health and social sciences and understand how this impacts working definitions and anti-stigma practices in BC. There is still no consensus on the usefulness of only one standard definition for the term stigma (Dalky, 2011). The conceptualization of social inclusion is equally complex, often complicated by the lack of a theoretical core (Queensland Alliance, 2010) and rapidly evolving definitions over time.

The authors appreciate that the definitions used in this report may not be agreeable to all stakeholders and will be subject to scrutiny, but aim to provide a synthesis of the academic literature and working understandings of these terms across the province (and nationally where relevant) to develop the conceptual foundations for this report and its subsequent recommendations.

1.2 Conceptualizing Stigma

Stigma has various meanings and definitions and has been conceptualized by scientists from diverse disciplines. Since Erving Goffman's (1963) book *Stigma: Notes on the Management of Spoiled Identity*, there has been a proliferation of study in the area. This has expanded our understanding of stigma, how it is interpreted and experienced and more recently, the relationship of stigma to the concepts of discrimination and social inclusion. Alternatively, the proliferation of research has resulted in stigma fatigue and, despite the huge amounts of analysis and critique of the definition and conceptual models related to stigma, there has been a limited focus on developing and assessing effective interventions.

Goffman first presented the notion of stigma being based on a set of discredited attributes determined by a social group that sets one apart (Arboleda-Florez and Stuart, 2012; Goffman 1963). However, understandings of stigma have evolved, and Goffman's model is now seen as one that places too much emphasis on the attributes of the individual and not enough focus on complex power relationships that not only underlie the creation of these inequities, but also act to maintain them through socio-political structures (Arboleda-Florez and Stuart, 2012; Link and Phelan, 2001).

In contemporary literature, stigma is best understood as a complex social process. Rooted in its own unique set of social power relations, stigma often follows the socially constructed fault lines that produce marginalization and social exclusion (Deacon, 2006; Link and Phelan, 2001). The social and individual dimensions of stigma run deep and influence an individual's self-concept, esteem and behaviors, and also the broader social structural issues such as equity and social inclusion. For people experiencing significant mental health and/or substance use issues, the manifestations of stigma can result in discrimination or further social marginalization and as a result, can become a hindrance to their quality of life, civic participation and ability to recover and/or successfully manage their condition. This can result in obstacles to their participation in treatment, and their ability to access social, financial and human capital through education and employment and access to adequate housing and basic health and social services. Obstacles can be the result of deep-rooted misconceptions and prejudice towards people with mental health and/or substance use issues across and within social and political structures, services and organizations, and even within an individual's family and their informal networks (i.e. neighbours, colleagues, school community). Additionally, families, friends and care-givers of people experiencing significant mental health and/or substance use issues can also report being negatively affected by the issues of stigma, discrimination and social exclusion related to their loved one's mental health and/or substance use issues: this is commonly identified as courtesy stigma (Corrigan, 2009).

All of the key informants identified the conception of stigma as a complex social process. Key informants acknowledged that stigma had numerous manifestations and was pervasive across individual, social and structural levels. They also acknowledged that understanding the complex interplay between these levels is essential to better understand how stigma is experienced by people with moderate to severe mental health and/or substance use conditions.

Health-related stigma has also been conceptualized in the literature as a socio-cultural process in which social groups are devalued, rejected and excluded on the basis of a socially discredited health condition and may be understood in terms of the different ways it manifests at the self, social and structural levels (Livingston et al., 2012; Weiss, Ramakrishna & Somma, 2006). This description of health-related stigma was determined to be an appropriate working definition of stigma as it relates to people with moderate to severe mental health and/or substance use issues. However to further understand the manifestation of stigma and its forms, the literature commonly identifies

two key models: the cognitive behavioral model (Corrigan, 2009), describing the forms of stigma, and the attribution model (Link and Phelan, 2001), outlining how stigma manifests itself. In Corrigan's cognitive behavioral model, there are four forms of stigma identified:

1. **Public stigma:** when the general population endorses the prejudice and discrimination of people with mental health and/or substance use issues;
2. **Self - stigma:** when people internalize the negative stereotypes, resulting in self-blame and feelings of hopelessness and helplessness;
3. **Label avoidance:** those who seek to avoid stigma by not seeking services from which labels are often attained (i.e. mental health and substance use services) and;
4. **Courtesy stigma:** experienced by caregivers and professionals who are devalued because of their association with people with mental health and/or substance use issues.

Link and Phelan's attribution model (Arboleda-Florez and Stuart, 2012; Queensland Alliance, 2010; Link and Phelan, 2001), describes how stigma is socially constructed as a four step process:

1. **Labeling:** the process of individual characteristics being more salient amongst others and thus made a point of difference;
2. **Stereotyping:** the characteristics that make people different are linked to misconceptions or undesirable attributes;
3. **Separating:** the labeled group from the dominant group assigning the label;
4. **Status loss:** the process whereby the labeled group is devalued, excluded and marginalized.

Whilst these models are not without their critics, they are largely congruent with the key informants' understanding of the forms of stigma and contemporary understandings of stigma represented in the literature. Therefore these two stigma models provide easy working definitions of the forms of stigma and how it manifests and is complimentary to the Livingston et al. (2012) definition of stigma as a socio-cultural process. Such conceptualizations and understandings can work towards developing a shared understanding of stigma as a complex social process across BC in both mental health and substance use arenas (See Figure 1: Conceptual model of stigma forms, processes and outcomes). Key informants also reported an additional piece to the forms of stigma not explicitly described in the models mentioned above - the notion of structural stigma. This refers to the rules, policies and procedures of institutions that restrict the rights and opportunities for members of stigmatized groups. Examples of structural stigma can be policies which compromise rights to privacy and confidentiality for people with mental health and/or substance use issues or restrictions of individual rights and freedoms on the basis of a persons mental health and/or substance use issues. Stigma can also be enacted as a result of the negative attitudes and behaviors of some representatives of public institutions, such as people who work in the health and criminal justice sectors (Corrigan et al., 2005; Livingston et al., 2012).

All key informants often referred to the terms and concepts of self and public stigma, however a smaller proportion discussed the terms and concepts relating to courtesy stigma. This is not surprising as only a few key informants discussed the experiences of professionals, families and caregivers as recipients of stigma by association. Instead, many key informants raised the issue of professionals, families and caregivers as sources of stigma towards people with moderate to severe mental health and/or substance use issues who may be their clients, family members or friends. This is often a result of professionals, families and caregivers reflecting public forms of stigma, prejudice and discrimination in their professional and caring roles.

Corrigan's cognitive behavioral model is largely consistent with key informants' understanding of stigma at the individual level. However, it was the terms and concepts described in Link and Phelan's attribution model that were commonly referred to and explored in discussions with key informants as a conceptual framework to understand stigma as a social process. Terms such as labelling, stereotyping, separation and status loss were frequently identified in a way that was consistent with this model. There was almost no variance between the terms and concepts used to describe stigma in mental health compared to stigma with substance use. There was however, a variance described in relation to how substance use and mental health is experience by individual because of socially constructed notion of health, illness and risky behaviours.

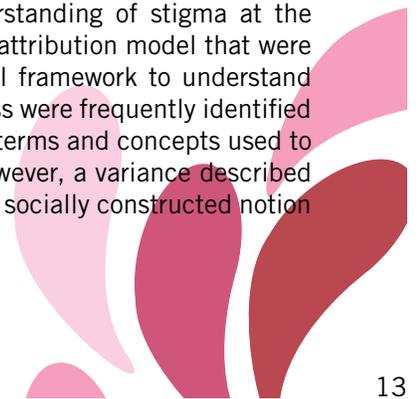
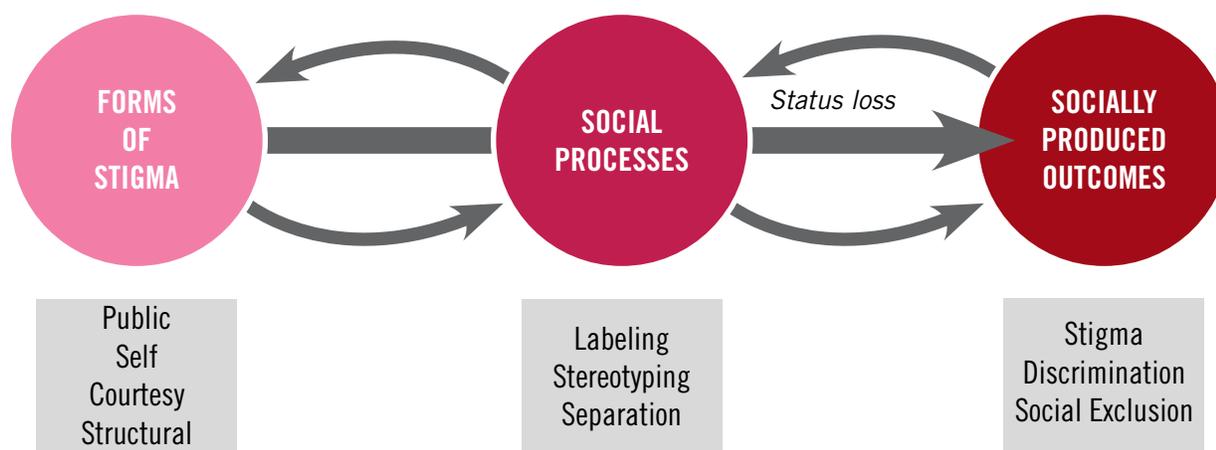


Figure 1: Conceptual model of stigma forms, processes and outcomes



Adapted from the research of Link & Phelan, 2001; Dalky 2011; Corrigan et al., 2005; Livingston, et al., 2012.

1.3 Stigma and Substance Use

Key informants commonly reported that the issue of stigma in the area of substance use was more pronounced and perhaps more stigmatized compared to mental health. Whilst there is a need for caution so as to not understate or devalue the experience of stigma in mental health, this is an important point for exploration. A number of studies have found that substance use is more stigmatized than other health conditions (Schomerus et al., 2011; Roa et al., 2009; Room, 2005), as a result of substance use being socially constructed as preventable and immoral. Such view is often criticized for its failure to appreciate the complexity of substance use. Key informants frequently stated that stigma as it relates to substance use is often marred by these issues. Informants also reported the increasing criminalization of substance use across some Canadian jurisdictions adding a complex dimension to the issue. Other key factors associated with substance use related stigma, include a greater social distance (perceptions of fear of personal safety), and more attribution tendencies (“he or she can just quit – and doesn’t want to because…”).

Unavoidable or intentional stigma has historically been an effective tool in traditional public health approaches as a means to discourage unhealthy behaviors such as substance use in the case of tobacco control (Bayer, 2008; Kim and Shanahan, 2003). The stigmatization of substance use is generally seen as culturally acceptable because of its symbolic link to other unsafe behaviours, undesirable health conditions (HIV/AIDS, mental illness) and social problems such as violence and crime (Livingston et al., 2012). The cultural acceptability of stigmatizing substance use is perpetuated by some policies and practices which seek to criminalize behaviour and exists across Canadian jurisdictions (Canadian Drug Policy Coalition, 2013). Despite the lack of empirical evidence, these policies and practices are based on the notion that by somehow reducing substance use stigma, we may observe increases in substance use (Livingston et al., 2012; Satel, 2007). However, there is increasingly more evidence to support the contrary; criminalization and stigmatization of substance use makes help seeking more difficult (Livingston et al., 2012) and encourages high-risk behaviours such as unsafe injecting poly-drug use and bingeing; and needs to shift towards practices that are less stigmatizing and focus on harm minimization (Canadian Drug Policy Coalition, 2013).

In BC the approach of harm minimization is at the forefront of many policies and practices and was frequently described by key informants as providing a strong foundation for action on stigma, discrimination and social inclusion in the substance use arena. A recent report from the Canadian Drug Policy Coalition (2013) noted that BC’s strategic plan to address substance use (Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia) is “exemplary for promoting efforts to alter its system of services and supports (rather than just focusing on changing people’s behaviours), and it explicitly includes harm reduction in its system of services” (p. 28).

1.4 Discrimination and Human Rights

Discrimination, as it relates to stigma is perhaps best understood as when more powerful groups act on their firmly entrenched stigmatizing attitudes and beliefs towards people with mental health and/or substance use issues, limiting their access to treatment and social, financial and human capital. Shifting the stigma dialogue to be inclusive of

discrimination also allows for research, policies, and practices to embed a human rights lens into their approach. This is particularly important considering the restriction of human rights so often experienced by people with moderate to severe mental health and/or substance use issues (Canadian Drug Policy Coalition, 2013; Queensland Alliance, 2010; Corrigan et al., 2004). Much of the literature on discrimination points to the need to move away from a dialogue that focuses on stigma reduction, and instead works towards approaches that are rooted in civil and human rights paradigms. The importance of civil and human rights approaches was also supported by key informants who reported that the integration of a human rights lens was integral for future initiatives. This approach views the prejudice and discrimination against people with mental health and/or substance use issues as a social inequity issue. This view prevents people from seeking help and participating in treatment and in reaching their potential as active and engaged citizens of BC due to exclusionary policies and practices across socio-political, community and individual levels.

Focusing on discrimination shifts the responsibility for change (Queensland Alliance, 2010). This view allows a move away from developing interventions that focus on the individual affected as the source of change, towards changing the behaviours and actions of those who stigmatize. There is also an inherent difficulty in measuring the impact of stigma interventions alone, due to the contested nature of stigma and the various theoretical perspectives. The expressions of stigma are often a product of firmly entrenched stigmatizing attitudes and beliefs framed by complex human systems, and are therefore wrought with complexity. Key informants noted that this has often resulted in a push back at a grassroots level for a need to refocus the issues of stigma towards its manifestations, such as discrimination. However there needs to be a degree of caution here. Only focusing on discrimination can limit our ability to recognize the other factors that contribute to marginalization, which can be the product of stigma and a barrier to treatment participation and quality of life (Deacon, 2006). For example, access to safe and stable housing, educational opportunities and/or employment may be denied because of a persons health status, ethnicity, gender or socio-economic status, therefore we need to understand people's multiple stigmatized identities to develop holistic responses and design effective interventions (Pauly, 2013; Stuber et al., 2008).

Another important concept that emerged in the key informant interviews and in the literature was the issue of the powerlessness and the oppression experienced by people with mental health and/or substance use issues, as a result of social and structural stigma and discrimination (Holley et al., 2012; Corrigan et al., 2004). Entrenched negative attitudes and beliefs held about the mental capacity of people with moderate to severe mental health and/or substance use issues can often create further discrimination in how we design interventions that aim to address stigma. For example, discrimination may occur when interventions fail to involve or empower people with a lived experience in the design, development and implementation. This can occur by creating (either directly or indirectly), inequality in the decision-making processes, little to no access to project resources and/or inflexibility in scheduling and role allocation. Discrimination and human rights approaches can assist us in developing health promoting strategies that are focused on collaboration, partnerships and participation. Consumers, service providers and policy makers can collectively engage in a dialogue that is focused on actions that may prevent help-seeking, treatment participation and promote access to social, financial and human capital, rather than focusing solely on shifting firmly held attitudes and beliefs.

1.5 Understanding Social Exclusion

To understand the context of stigma as a social process, it is integral that we must first understand the practices that exclude people with moderate to severe mental health and/or substance use issues.

The adoption of both inclusionary and exclusionary practices is very much a part of society and our desire to belong. These practices may seek to maintain particular ideals, beliefs or features of particular familial, cultural, or social groups. However these social processes can become destructive and dysfunctional when more powerful groups perceive they are different (the process of othering), and create social distance between groups. This results in individuals or groups being excluded and/or marginalized from accessing the social, physical, economic and human capital required to be active and engaged citizens. In the case of people with moderate or severe mental health and/or substance use issues, their condition is the subject of difference and they are often labeled and as a result of their exposure to discrimination and social exclusion. This can impact their participation in treatment and their ability to achieve life goals.

Social exclusion is a complex and multi-dimensional process (Levitas et al, 2007) and as a result, is not a fixed state. The exclusion of particular individuals and groups may be transient, recurrent or in some circumstances a long-term experience (Burgess and Propper, 2002). Complex human systems are fluid; hence the particular features of an

individual or group that is the subject of difference may become less important overtime. This can be seen in the historical and systematic exclusion of women, people with disabilities or on the basis of sexual orientation.

There are valuable lessons to be learnt from the disability and HIV/AIDS movements because of their health related stigma congruencies with mental health and substance use (i.e. mental capacity, risky behaviours) and their adoption of approaches which aimed to challenge stigma, discrimination and social exclusion (see Section 2: Current Approaches).



1.6 Towards Social Inclusion

Key informants consistently raised the importance of reframing the issue of stigma, discrimination and social exclusion towards social inclusion. All of the key informants raised this as an essential new direction that should be taken by the HMHP Directorate and its stakeholders to reduce the negative impacts of stigma and discrimination experienced by people with moderate to severe mental health and/or substance use issues in the province.

The notion of social inclusion was commonly understood as an individual feeling that they are valued and have opportunities to fully participate in the BC community. In this way, social inclusion was closely tied with the notions of belonging. Social inclusion has been described as the journey towards greater participation and citizenship (Queensland Alliance, 2010). Conversely, social exclusion is often defined as the position of an individual or group in relation to others, that lack, or are denied access to the benefits of a particular society such as physical security, adequate nutrition, shelter, family life, employment, social support, community participation and political involvement (Levitas et al., 2007; Schneider and Bramley, 2008).

Importantly, social inclusion does not take an illness-based focus but acknowledges that people with mental health and/or substance use issues may be more vulnerable and more likely to experience social exclusion within the community because of their illness/condition. Social inclusion therefore has the potential to provide a useful framework for researchers, policy makers and practitioners to shift the focus towards understanding the processes and mechanisms whereby people become marginalized and socially excluded (O’Gorman, 2000).

Social inclusion should be understood as a key protective factor for those individuals experiencing positive mental health and healthy decision-making around substance use issue that can contribute to reducing the negative impacts of stigma and discrimination (Cook et al. (2011). A social inclusion lens also enables a focus on active, participatory approaches that integrate the unique skills, knowledge and capacity of people with mental health and/or substance use issues as partners in reducing stigma and discrimination and enhancing social inclusion.

Social inclusion also aligns with the empowerment and strength-based principles and participatory practices outlined in the Ottawa Charter for Health Promotion (WHO, 1986), which aim to foster the creation of supportive environments, healthy public policy, strengthening community action and community based care. These strategies are inherent in BC’s newly released public health guiding framework that supports the following Ministry of Health goals: a) effective health promotion, prevention and self-management to improve the health and wellness of British Columbians; b) British Columbians have the majority of their health needs met by high quality primary and community-based health care and support services; and c) improved innovation, productivity and efficiency in the delivery of health services (BC Ministry of Health, 2013).

SECTION 2: CURRENT APPROACHES

The issue of stigma and its impact on people with mental health and/or substance use issues continues to be a key concern for health authorities, consumers, families, service providers, policy makers and researchers across the province. Many of these stakeholders have initiated programs that attempt to take action on the issues of stigma, discrimination and more recently, relating to social inclusion. Leadership on these issues can be observed across BC at multiple levels, and at the national level through the efforts of the Mental Health Commission of Canada.

BC has demonstrated leadership across a variety of domains related to work in stigma, discrimination and social inclusion in the mental health and substance use field. BC's richness in this field is often acknowledged and replicated across policy and programmatic levels across Canada. This section will provide a high level summary of current approaches undertaken by key stakeholder programs to reduce stigma and discrimination and enhance social inclusion activities in BC and nationally (where relevant) targeting people with moderate to severe mental health and/or substance use issues.

Whilst this is not an exhaustive list of all possible approaches being undertaken in the province it provides a high level synthesis of key approaches and current interventions to reduce stigma and discrimination and enhance social inclusion. Additionally, this list focuses on those that specifically relate to people with moderate to severe mental health and/or substance use issues in BC. As social inclusion is a relatively new approach to reducing stigma and discrimination it will be explored in Section 3: Key Trends, Themes and Emergent Practice.

2.1 Policy Context: Framing Stigma And Discrimination In The Province Of BC

In addition to Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia, there are a number of other key policy documents which frame the issues of stigma, discrimination and social inclusion, both provincially and nationally. These include:

- * **BC First Nations and Aboriginal People's Mental Wellness and Substance Use - Ten Year Plan** (First Nations Health Authority, BC). This foundational policy document was recently released by the First Nations Health Authority to begin to transform systems and improve capacity to better meet the needs of First Nations and Aboriginal infants, children, youth, adults and Elders. Whilst there is a commitment to stigma reduction and discrimination articulated, it is understood that a clear strategy will be articulated in future documents as the plan is further implemented.
- * **Changing directions, changing lives: The Mental Health Strategy for Canada** (MHCC). This Strategy outlines six key strategic directions for mental health system improvement in Canada at a national level, one of which is focused on the issue of stigma. The approach articulated in the strategy reflects a focus on communicating the benefits of positive mental health and its contribution to Canada's social and economic prosperity; supporting community action; training front-line service providers and contact-based education.
- * **Nothing about us without us** (Canadian HIV/AIDS Legal Network). Key informants regularly raised this policy paper, as it is seen as an integral document in providing a guide for community participation and inclusion of people who use illicit drugs. This document uses a human rights perspective and findings from the key informant interviews reveals that it is still widely used in the province. The involvement of BC-based organizations such as Vancouver Area Network of Drug Users (VANDU) and the British Columbia Centre for Excellence in HIV/AIDS in its development is perhaps a factor which contributes to its uptake and relevance in the BC context.

Although not a policy, YIMBY (Yes in my backyard!): Welcoming inclusion, upholding human rights (Pivot Legal Society) provides a useful toolkit that is influential in the policy context. This document was frequently referenced by key informants as an important tool for advocating at a community level for people to better understand the value of inclusion and addressing homelessness, addictions, and mental illness in a proactive and positive way through safe and supportive housing.

2.2 Synthesis Of Current Approaches

Based on the approaches identified in this scan, there are several dominant models that are applied in the province: a bio-medical model, health promotion and prevention (including health literacy initiatives) and cause (or systemic) advocacy. These models are discussed to synthesize and establish a framework from which to describe the dominant

approaches undertaken in the province and the resulting interventions (see Section 2.3).

Bio-medical

This model is focused on defining a 'condition' as a diagnostic entity based on the presentation of specific signs and symptoms which align to particular diagnostic categories (e.g. Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD)). The use of this model is often applied with the hope of bringing public knowledge into alignment with medical opinions by presenting mental illness and substance use as standard illnesses (Queensland Alliance, 2010). This view postulates that increasing public awareness of mental illness and substance use as diseases will ultimately impact stigma by reducing the processes of othering and social distance. This approach is often applied to shift attitudes and beliefs at an individual or group level through contact-based education, with the aim to reduce social distance towards people with mental illness and substance use issues, or through broad based population level education and awareness programs.

The bio-medical approach that is widely used today continues to receive considerable criticism in both the literature (Read et al., 2006; Phelan et al., 2002; Cormack and Furnham, 1998) and from a number of key informants. Adoption of a solely bio-medical model fails to take into account stigma and discrimination as a complex social process, with numerous manifestations pervasive across individual, social and structural levels. Importantly, at an intervention level, it is unable to effectively target the social structures and political relationships that influence the trajectories and stigmatization of mental illnesses (Thachuk, 2011).

Health promotion

In BC, both mental health and substance use fields utilize the practices of health promotion and mental health promotion to reduce stigma and discrimination and enhance social inclusion. The World Health Organization (WHO) defines health promotion as “the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions” (WHO, online). This occurs through health promotion strategies that focus on healthy public policy, creating environments that foster positive mental health, community empowerment, development of skills and health service re-orientation (WHO, 1986). By contrast, the practice of mental health promotion (MHP) in Canada is defined as “a process of enabling individuals and communities to take control over their lives and improve their mental health. It seeks to increase self-esteem, coping skills and capacities, and family and community supports, as well as to modify the broader social and economic environments that influence mental health” (Centre for Health Promotion, 1997, p. 1). MHP uses strategies that foster supportive environments and individual resilience whilst respecting culture, equity, social justice, interconnections and personal dignity. Mental health promotion initiatives focus on improving the mental health and wellbeing of populations and/or individuals through multi-level, multi-disciplinary interventions that aim to produce changes in systems, community organizations, and individual behaviours (Centre for Health Promotion, 1997, p. 1).

Health literacy

Within BC there are a wide range of projects, services, networks and initiatives that address significant needs for information and improved health literacy in various areas of mental health and substance use across the province. Health literacy focuses on the degree to which people are able to access, understand, evaluate and communicate information to engage with the demands of different health conditions in order to promote and maintain good health across the life course. In the context of mental health and substance use, health literacy also refers to the knowledge and beliefs that assist people to prevent, recognize, or manage mental health or substance use issues or disorders (Rootman, 2007).

Much of the health literacy work in work in mental health and substance use within the province is guided by the Integrated Provincial Strategy to Promote Health Literacy in Mental Health and Addiction in BC (Rootman, 2007). Led by BC Mental Health & Addiction Services, the Strategy was created in 2007 to improve public understanding and reduce stigma related to mental health and/or substance use issues (including mental health promotion, prevention, early recognition, help seeking, self management and recovery). The establishment of the BC Mental Health and Substance Use Provincial Health Literacy Network in 2009 facilitated the implementation of the Strategy across the province to promote the health literacy model in the mental health and substance use fields.

A health literacy approach is not widely used in the area of substance use because of the prevailing fears associated with increasing use, (particularly amongst youth) despite the lack of empirical evidence (Livingston et al., 2012). However, in BC a health literacy approach is being applied via the iMinds school-based substance use program developed by the Centre for Addictions Research BC (CARBC). CARBC is one of the BC Partners for Mental Health & Addictions Information, a coalition of seven non-profit agencies engaged in educating the public in the mental health and substance use fields. The projects and activities of the BC Partners align with priorities identified in the Integrated Strategy to Promote Health Literacy in Mental Health and Addiction in BC (Rootman, 2007). In addition to developing innovative resources for schools, CARBC contributes to the work and mandate of the BC Partners to support mental health literacy in a number of ways. Examples include creating and updating substance-use information materials for distribution on the HeretoHelp website, actively participating in the Healthy Minds/Healthy Campuses initiative, and developing alcohol screening tools and a variety of educational and brief intervention materials for both adults and youth.

In BC, mental health literacy initiatives are not only aimed at increasing knowledge about mental illness, but also integrate public engagement and personal skills development (i.e. fostering resilience) into models. In the substance use field, health literacy is still in its infancy. It will require further evaluation of its effectiveness as an intervention to support evidence informed practice to reduce stigma and discrimination, and enhance social inclusion.

Cause (or systemic) advocacy

This form of advocacy is unique from other forms of advocacy, as it is driven by an individual or group of advocates, and their identified need to bring about changes to a structure, system, policy or legislation (Health and Disability Commission, 2009; Psychiatric Patient Advocacy Office, 2009). Compared to other forms of advocacy that might be undertaken in the interests of an individual, systemic advocacy represents the rights and interests of a group with similar concerns and issues.

In the context of BC, systemic advocacy is currently the dominant approach used by consumer organizations in order to advocate for human rights, equitable access to services (i.e. mental health, substance use, housing) and/or harm reduction policies and initiatives. Although it is not their sole work, an important feature of their role in BC is tackling stigma and discrimination, which is complementary to the work these groups often undertake in relation to peer and/or family support, education and the development of personal skills. In BC, this work is often (but not exclusively) focused on the issue of discrimination within a human rights paradigm.

It is important to note that this approach is inherently complicated due to the uneven power dynamics between decision makers, service providers, and marginalised and/or excluded groups such as people with moderate to severe mental health and substance issues and their families.

2.3 Current Interventions

In BC and nationally, there are a number of interventions that utilize the current approaches identified above. Whilst these aim to reduce stigma and discrimination, many interventions do not have people with moderate to severe mental health and/or substance use issues as their primary focus. Table 1: Active or recently completed Stigma and Discrimination Interventions in B.C. (see pages 21–24), attempts to capture the most recent breadth of work that is most likely to intersect with this population group (moderate to severe mental health/substance use) based on the collection methods applied in the environmental scan.

In order to help conceptualize these interventions, based on the information obtained during the key informant interviews, the authors have categorized them into four domains to reflect the interconnected nature of interventions whilst also reflecting their efforts to intervene at different levels of the system:

- * **Culture and environment** – dominant public beliefs and attitudes;
- * **Socio-political level** – involving both political and social activities (or the interplay between the two) at a population level and its impact on people with moderate to severe mental health and/or substance use issues (e.g. justice and legislation, public policy, civil and human rights, economy);
- * **Community level** – focused on the organizations, programs and services operating at a community level (i.e. regions/municipalities) targeting people with moderate to severe mental health and/or substance use issues (e.g. health services, local government, community services and cultural and interest groups);

- * **Interpersonal networks** – association between people with moderate to severe mental health and/or substance use issues and their family, friends, neighbors, schools and workplaces;
- * **Individual level approaches** – focused on the individual level beliefs, attitudes and behaviours of people moderate to severe mental health and/or substance use issues (e.g. mental, physical, emotional and spiritual).

The interventions identified in Table 1 (below) reflect a diversity of activity that aims to address the issues of stigma and discrimination across the province, with a concentration of initiatives operating at the community level (11 of the total 15 initiatives identified). The table describes an emphasis on mental health literacy approaches, with almost half of the interventions identified at the community level applying this as the dominant approach.

At the interpersonal level, the two initiatives identified place peers at the center of their health promotion approaches. These initiatives have a focus on promoting good health in addition to supporting people to foster the personal skills and knowledge required to manage their conditions. These initiatives focus on the empowerment and participation of peers in delivery and design, promoting a social inclusion agenda. Whilst these two initiatives employ health promotion approaches and a focus on health literacy, there is also an inherent relationship with advocacy and a human rights perspective embedded into the program structure and operations.

The two initiatives identified at the socio-political level differ greatly in their reach and delivery but both seek change at a socio-political level. Both initiatives seek to bring about changes to the structure, system and policies that impact the issues of stigma and discrimination while applying different modalities and approaches to system change.

Opening Minds, a national initiative, places an emphasis on mental health promotion approaches and emphasises building community and organizational capacity to reduce stigma and discrimination through providing programmatic and evaluation support. In the case of Maladjusted (a recent production of Theatre for Living), this provincial initiative seeks to promote a community dialogue through interactive theatre. The cast members actively engage with the diverse audience composed of consumers, families, health and social service providers and policy-makers. The interactive nature of this initiative is aimed to draw out specific policy recommendations to improve the life of people living with mental illness. Although the focus of the theatre productions varies year to year, they often highlight the need to address issues of stigma and discrimination of the most vulnerable people in society.



Table 1: Active or recently completed (last 6 months) Stigma and Discrimination Interventions in B.C.

Stigma and Discrimination Interventions						
Program(s)/ Intervention/ Policy	Organization	Jurisdiction	Summary	Domain	Model (if applicable)	Evaluated
Mental Health Anti - Stigma Training for HealthCare Professionals	Mood Disorders Society of Canada	National	This initiative aims to improve health care services for people with mental illnesses, a new continuing medical education (CME) program to support family physicians and specialists to combat the stigma of mental illness within the profession. The course is web-based, uses contact-based education and provides anti-stigma tools and resources for physicians. The program has been accredited by the College of Family Physicians Canada and the Royal College of Physicians and Surgeons of Canada.	Community	Bio - medical/ Mental Health Promotion	Yes
MindUP	Healthy Schools of BC	BC	School based program that provides children with emotional and cognitive tools to help them manage emotions and behaviors, reduce stress, sharpen concentration, and increase empathy and optimism.	Community	Mental Health Promotion Literacy	Yes
iMinds	Centre for Addictions Research of BC	BC	iMinds is an online resource designed to help educators and their partners take an effective, comprehensive school-based approach to addressing alcohol, tobacco and other drug use and promoting students' health and learning.	Community	Mental Health Literacy	Yes
Summer Institute	BC Mental Health and Addiction Services and BC School - Centred Mental Health Coalition	BC	Available to teachers, school counselors, school support staff, school administrators, district staff, parents, students and school community partners from districts all across BC to: exchange knowledge and ideas for fostering healthy, connected school environments that enhance student mental health and well-being; learn practical information and strategies for addressing mental health challenges in classrooms and school communities; network with colleagues and partners in mental health and education.	Community	Mental Health Literacy	Yes
Photovoice Project	Fraser Health Authority	Fraser Health Region	Project with at risk youth (homeless or at risk for homelessness) involving displaying photographs that describe their narratives. This involved a community display at the Arts Centre and Theatre, Maple Ridge. A subsequent project followed with a number of residential treatment clients and aboriginal young women in treatment (Spirit Bear Lodge).	Community	Health Promotion	Yes
Here to Help	BC Partners for Mental Health and Addictions Information	BC	HeretoHelp is the flagship communication vehicle for the BC Partners for Mental Health and Addictions Information. The website aims to help users to access mental health and substance use information, resources and tools in an accessible way.	Community	Mental Health Literacy	Yes

COMMUNITY

Table 1 (continued): Active or recently completed (last 6 months) Stigma and Discrimination Interventions in B.C.

Stigma and Discrimination Interventions						
Program(s)/ Intervention/ Policy	Organization	Jurisdiction	Summary	Domain	Model (if applicable)	Evaluated
BC Practice Support Module for Family Physicians - Mental Health	BC Ministry of Health and BC Medical Association	BC	An accredited continuing medical education program for family doctors in BC which includes contact-based education and provides family doctors with tools to treat patients through alternative methods to pharmaceuticals. A third of BC family physicians have been trained (3300) with 40% of physicians self-reporting that the number of prescriptions they write have reduced as a result of the training program.	Community	Bio - medical/ Mental Health Promotion	Yes
mindcheck.ca	BC Mental Health and Addiction Services and Fraser Health	BC	A website to assist youth and young adults to identify and understand mental distress they may be experiencing and to link them to sources of help that will enable them to learn skills and strategies to manage these problems. Being able to recognize early signs and finding ways to deal with them increases the chances of better long-term outcomes and positive mental health across the lifespan.	Community	Mental Health Literacy	Yes
Healthy Minds/ Healthy Campuses	Canadian Mental Health Association, BC Division and the Centre for Addictions Research of BC	BC	A community of practice to promote campus mental health. Healthy Minds/Healthy Campuses aims to improve overall mental health, reduce suicidal behaviours and reduce student substance use harms among students on BC campuses. The project uses a Community of Practice approach to share and generate knowledge and promising practices.	Community	Mental Health Promotion	Yes
Core Addictions Practice (CAP)	BC Mental Health and Addiction Services	BC	This training program has been implemented by Fraser Health, Vancouver Coastal Health and Northern Health to increase access to evidence informed substance use practice as a key workforce development initiative. To date the program has been delivered to 549 services providers across 24 sectors that work with people with mental health and/or substance use issues. As a result of CAP participants report; increases in skills, knowledge and confidence, stronger connections with other service providers, increased morale and being more inclusive and compassionate in their professional roles.	Community	Health Promotion	Yes
Mental Illness and Addictions: Understanding the Impact of Stigma	Ontario Central Local Health Integrated Network	Ontario	An education and awareness strategy targeted to hospital emergency department employees and Ontario Works (OW) and Ontario Disability Support Program (ODSP) staff. Changes were observed in attitudes questions <i>(continued on next page)</i>	Community	Bio - medical/ Mental Health Promotion	Yes

COMMUNITY

Table 1 (continued): Active or recently completed (last 6 months) Stigma and Discrimination Interventions in B.C.

Stigma and Discrimination Interventions						
Program(s)/ Intervention/ Policy	Organization	Jurisdiction	Summary	Domain	Model (if applicable)	Evaluated
Mental Illness and Addictions: Understanding the Impact of Stigma	Ontario Central Local Health Integrated Network	Ontario	before and after the program however, there was also a significant change in these attitudes in a negative direction after three months follow-up. Aspects of this project were implemented by Interior Health BC however finding were complicated as a result of the program not being implemented in its entirety.	Community	Bio - medical/ Mental Health Promotion	Yes
	Canadian Mental Health Association	National	Mental Health Works is a nationally available program of the Canadian Mental Health Association that builds capacity within Canadian workplaces to effectively address the many issues related to mental health in the workplace. The program is currently operating nationally and available in both official languages.	Community	Mental Health Promotion	No
Mental Health First Aid	Mental Health Commission of Canada	National	Mental Health First Aid (MHFA) is the help provided to a person developing a mental health problem or experiencing a mental health crisis. Just as physical first aid is administered to an injured person before medical treatment can be obtained, MHFA is given until appropriate treatment is found or until the crisis is resolved. The MHFA Canada program aims to improve mental health literacy, and provide the skills and knowledge to help people better manage potential or developing mental health problems in themselves, a family member, a friend or a colleague.	Community	Mental Health Promotion	Yes
Youth Summit	BC Mental Health & Addiction Services	BC	The Youth Summit is organized by youth and young adults who work in the area of mental health and are passionate about breaking down barriers and creating connections! It is a free, one-day workshop for students from across BC to build awareness about mental health and engage in fun activities and thoughtful dialogue about how to break down barriers and create connections.	Community	Mental Health Literacy	Yes
Parent in Residence (PiR)/ Youth in Residence (YiR)	BC Mental Health & Addictions Services and The FORCE Society for Kids' Mental Health	BC	These four roles are based at the Kelty Mental Health Resource Centre, two PiR's and three YiR's. The PiR's primary role is to act as a navigator and support for families of children and young people. The YiR's acts as a navigator and support specifically for young people. Both roles work with systems to enhance services and find solutions where challenges may exist and also promote the sharing of mental health information to families and youth to promote prevention and early intervention of mental health challenges. Positions have also been established across BC.	Interpersonal	Mental Health Literacy	Yes

COMMUNITY

INTERPERSONAL

Table 1 (continued): Active or recently completed (last 6 months) Stigma and Discrimination Interventions in B.C.

Stigma and Discrimination Interventions						
Program(s)/ Intervention/ Policy	Organization	Jurisdiction	Summary	Domain	Model (if applicable)	Evaluated
Eating Disorders Peer Support Worker	BC Mental Health & Addiction Services	BC	The Eating Disorders Peer Support Worker is based at the Kelty Mental Health Resource Centre. The primary role of the Peer Support Worker is to assist and support people of all ages who are struggling with eating disorders from the perspective of having fully recovered from eating disorder herself. The Peer Support Worker also works for the Jessie's Legacy Eating Disorder Prevention Program, where she goes to schools and present about eating disorders, self-esteem, and body image, as well as coordinates the Provincial Eating Disorders Awareness (PEDAW) campaign.	Interpersonal	Mental Health Literacy	Yes
			Street College engages people who use(d) illicit drugs in an educational process that confronts stigma related to drug use, HIV & Hepatitis C (HCV), and poverty; increases self-awareness and supports; and builds skills in peer support, advocacy, prevention and leadership. There are several streams of street college including Anti-Stigma, Trauma, and Leadership and Creative Writing. Peers are the key decision-makers, leaders and facilitators of Street College programming making the program fully peer-led.	Interpersonal	Mental Health Promotion	No
Opening Minds	Mental Health Commission of Canada	National	The Commission launched Opening Minds in 2009 and is currently the largest systematic effort to reduce the stigma of mental illness in Canada. Opening Minds works with partners across Canada to identify and evaluate existing anti-stigma programs to determine their effectiveness and potential to be rolled out nationally. Opening Minds is addresses stigma within four main target groups: healthcare providers, youth, the workforce and the media.	Socio-political/ community	Mental Health Promotion	Yes
			This theatre program aims to explore the personal stories of people struggling with various aspects of the stigmatization issue at different levels of the mental health systems to challenge dominant beliefs and attitudes that result in stigma and re-personalize the issues to challenge the processes of social distance and 'othering'.	Socio-political/ community	Cause (or systemic) advocacy	Yes
Maladjusted	Headlines Theatre	Vancouver				
INTERPERSONAL						
SOCIO-POLITICAL/ COMMUNITY						

SECTION 3: KEY TRENDS, THEMES AND EMERGENT PRACTICE

Based on the evidence gathered from the literature, the themes reported by the key informants and the current approaches identified in Section 2, this section aims to highlight some key trends and emergent practices related to stigma, discrimination and social inclusion for those people experiencing moderate to severe mental health and/or substance use issues.

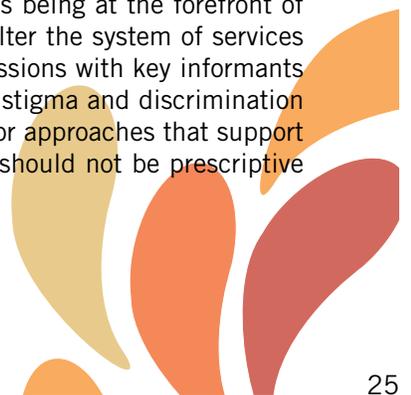
3.1 Building Our Evidence Base

Although there is a lack of consensus on how to best reduce stigma and discrimination and enhance social inclusion internationally, there are concerted efforts to build this evidence base. Canada is leading many of these efforts to build an evidence base and evaluate interventions addressing stigma and discrimination as they relate to mental health and substance use issues. The MHCC's Opening Minds initiative is designed to change the attitudes and behaviours held by some Canadians towards people with mental health issues (MHCC, 2012). Through its pilot projects, the MHCC has evaluated a number of initiatives across the country to determine effective approaches to stigma reduction that have focused on four target groups, children and youth, healthcare providers, the workforce, and the media. Much of this work has placed a high value on contact-based education that has been highlighted as a promising practice for changing attitudes and beliefs associated with mental illness (MHCC, 2012; Queensland Alliance, 2010). However, contact-based education is a complex issue and requires a high degree of sensitivity. Additionally, the evidence base relating to the effectiveness of contact based education to reduce stigma related to mental ill-health has often failed to show sustained changes over time. In addition, its effectiveness in relation to substance use is relatively untested.

The extensive research and evaluation that has been undertaken in the area of stigma and discrimination continues to be wrought with complexity and subject to ongoing debate. There is a need to develop flexible approaches to measuring the impact and outcomes of interventions that are conducive to working in dynamic human environments. BC's Drug Treatment Funding Program provides one example of an initiative that is attempting to apply more flexible outcome and evaluation measures that also reflects a shift from stigma reduction to multi-levelled strategies which support compassionate, engaging and welcoming services (BC Mental Health and Addiction Services, 2012). Their application of an Outcome Mapping methodology allows for a flexible and organic approach to planning and measuring change that honours the concept of stigma as a social process. Outcome Mapping is described as providing "not only a guide to essential evaluation map-making, but also a guide to learning and increased effectiveness, and affirmation that being attentive along the journey is as important as, and critical to, arriving at a destination" (quote from Michael Quinn Patton cited by, BC Mental Health and Addiction Services, 2012, 17). This approach is still in its early development but is an emerging approach that has seen promising findings in relation to its ability to capture multi-dimensional changes relating to change in compassionate behaviours, engagement and inclusion. For example, projects such as Photovoice (mentioned in Table 1) and the Welcoming Spaces Strategy (which looks to improve patient/client experiences in clinics and hospital waiting rooms), report qualitative shifts in practice towards compassionate behaviours, engagement and inclusion which may not have been captured by traditional measures.

3.2 An Opportunity For Leadership

BC has demonstrated leadership across a variety of domains related to work in stigma, discrimination and social inclusion in mental health and substance use, however there is a great need for provincial level advocacy and strategic leadership in promoting a social inclusion agenda. BC is often acknowledged as being at the forefront of progressive policy and practice in mental health and substance use efforts that aim to alter the system of services and supports for people with mental health and/or substance use issues. Based on discussions with key informants it is clear that a normative and operational understanding of how to address the issue of stigma and discrimination is required from a strategic level. Central to the opportunities for leadership is the need for approaches that support grassroots action and local innovation. Key informants highlighted that such leadership should not be prescriptive and must be supportive of developmental opportunities to impact change.



3.3 Whole-Of-Government Approaches

Based on the literature and key informant interviews, it is clear that systems-wide change is required to reduce stigma and discrimination through a social inclusion agenda. This will require whole-of-government collective action because of the complex human systems and intersecting ministerial mandates that interact on these issues. Internationally, there is a great emphasis on the importance of whole-of-government approaches to government policy and practice in mental health, substance use and social inclusion, particularly in jurisdictions such as the UK and Australia. For example, in Western Australia, there is a statewide commitment to mental health and substance use reform, which includes a whole-of-government approach being led by the Mental Health Commission of Western Australia. This includes the integration of budgets, inter-ministry strategic planning across education and service delivery, and a commitment to working together to build the capacity of the community sector, underpinned by the Delivering Community Services in Partnership Policy (Government of Western Australia, 2011).

A whole-of-government approach requires systematic and horizontal strategic coordination across traditional ministerial boundaries (Keon and Pépin, 2009). Collaborative action reduces the potential for duplication in efforts and resources, and draws on the specialized expertise within ministries (Anderson et al., 2010). In Canada, much of the conceptualization of whole-of-government working at a federal level is focused on mapping the financial and non-financial contributions of federal organizations receiving appropriations against outcome areas for the government as a whole (Treasury Board of Canada Secretariat, 2013). Provincially, there is a precedent for whole-of-government efforts towards working on improving population-level health through the now completed ActNowBC initiative that may be built on in the future (Anderson et al., 2010).

3.4 Human Rights-Based Approach

The criminalization of possession of certain psychoactive substances continues to be a barrier to treatment participation and quality of life for some people. This perspective is one that prevents people from seeking help and participating in treatment and in reaching their potential as active and engaged citizens of BC due to exclusionary policies and practices across socio-political, community and individual levels. As mentioned in earlier sections, a human rights-based approach is rooted in civil and human rights paradigms and provides an opportunity to move beyond the prejudice and discrimination against people with mental health issues and/or those who use certain psychoactive substances and reframe them as social inequity issues.

Key informants highlighted the importance of integrating a human rights-based approach into future activity because of the ability to conceptually and practically disentangle stigma, prejudice and discrimination from people's rights to quality care and support. Such an approach will provide an opportunity to analyze inequalities which lie at the heart of stigma and discrimination and redress discriminatory practices and unjust distributions of power that impede opportunities for individual and community development (Office of the United Nations High Commissioner for Human Rights, 2006). This is a relatively new paradigm shift for mental health treatment systems and even more so for substance use treatment systems. However, it does have proven results in reducing the stigma and discrimination previously associated with highly stigmatized health conditions such as HIV/AIDS and disability.

The other strength of this approach may be that it moves away from interventions that focus solely on behavior change of specific groups and individuals (such as direct service providers who are commonly targeted in stigma interventions) and moves towards provincial wide policies and practices. Such a move has a great potential to tangibly uphold human rights and access to quality care and support. Nothing About Us Without Us (Canadian HIV/AIDS Legal Network, 2005) and YIMBY! (Yes In My Backyard!): Welcoming Inclusion, Upholding Human Rights (Pivot Legal Society, 2011) provide rich examples of how the integration of a human rights based approach can impact change at a provincial level. Furthermore, they provide tangible tools for the inclusion of people with a lived experience in decision-making, system design and the community. Importantly, such policies describe the operational possibilities inherent in human rights based approaches in implementing interventions that are compassionate, socially inclusive and strengths based.

3.5 A Need For A Paradigm Shift

The evidence base obtained through both the scientific literature and in practice recognizes an emerging shift towards understanding stigma, as more than an isolated variable or risk factor that needs to be mitigated or reduced. Rather, stigma is a complex social process that requires a new approach to traditional models that despite considerable effort still have yet to produce a consensus on the most effective approaches to address stigma.



Based on key informant interviews, it is clear that the movement towards social inclusion as an approach to address multi-faceted and multi-dimensional aspects of stigma and discrimination is already happening at a community level. This offers a unique opportunity to the HMHP Directorate and its partners to strategically capitalize on this grassroots momentum and further support connections at different levels across the system. However in doing so, the HMHP Directorate and its partners are encouraged to support the community control that is currently mobilizing these local efforts.

Key informants reported that they felt a paradigm shift towards a social inclusion agenda would:

- * Value the role of people with a lived experience in decision making and system design;
- * Conceptually be more supportive of creativity and innovation in creating multi-faceted approaches to deal with stigma and discrimination (and the social inequities that underpin them) in a way that can be dynamic and fluid considering the complexity of human systems;
- * Build on the strengths that already exist between individuals, communities and systems;
- * Move beyond a dialogue of blame and towards one of empowerment and participation that is integrative and complimentary of diverse contexts, experiences, values and beliefs;
- * Provide spaces for intersectoral partnerships whereby everyone has a responsibility to be agent of change.

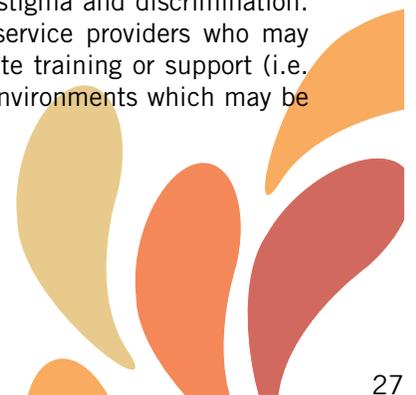
3.6 Valuing Knowledge

A significant knowledge base has been established in B.C., with strong models of partnership and knowledge exchange already in existence with leading research organizations such as the Centre for Addictions Research BC (CARBC) at the University of Victoria, and the Centre for Applied Research in Mental Health and Addictions (CARMHA) at Simon Fraser University. BC is also home to dynamic, inclusive and innovative consumer based organizations such as the Vancouver Area Network of Drug Users (VANDU), Society of Living Illicit Drug Users (SOLID) and Families Organized for Recognition and Care Equality Society for Kids' Mental Health (F.O.R.C.E). On the strength of these organizations, BC has a rich environment of evidence-based research and practice that can be integrated to provide a solid knowledge base to inform the development of a social inclusion agenda.

Despite the extensive knowledge base that exists in the province, there is a major gap in our knowledge of the costs associated with action – and conversely inaction – in the area of stigma, discrimination and social inclusion. The presence of an economic rationale for approaches to stigma, discrimination and social inclusion has helped to focus UK and Australian social inclusion strategies and identify where investments are best directed (Queensland Alliance, 2010).

3.7 Promoting Hope And Recovery

The recovery model is a key feature of contemporary mental health and substance use policy and practice and, in principle, is applied across the province. Despite the policy and practices that promote a model of recovery, health and community services do not occur in a vacuum. Key informants discussed that practice on the ground can often be complicated by public stigma and the dominant stereotypes and labels that are assigned to people with mental health and/or substance use issues. These labels and stereotypes can be characteristically pessimistic about the possibility of recovery for people with mental health and/or substance use issues. For example, a number of key informants raised issues associated with people with mental health and/or substance use issues presenting to emergency departments and reporting they felt vulnerable, stigmatized and in some cases treated unjustly by health care providers on the basis of their condition. Conversely, key informants also raised issues associated with direct service providers experiencing barriers and challenges to their practice, which impacts stigma and discrimination. Examples of these barriers and challenges raised by key informants included direct service providers who may be expected to deliver mental health and substance use services without the appropriate training or support (i.e. emergency departments, police and schools) and working in highly stressful roles and environments which may be contributing to their own mental health and/or substance use issues.





On the basis of this finding there is a need for the model of recovery to permeate treatment models in a way that instils hope and a collective responsibility for the process of recovery. For instance, we can draw from early results from the Welcoming Spaces Strategy reporting qualitative shifts in practice towards a model that promotes compassion and caring.



SECTION 4: RECOMMENDATIONS - KEY STRATEGIES FOR FUTURE PRACTICES

The evidence base, both in the scientific literature and in practice, recognizes an emerging shift towards an understanding of stigma as much more than a variable or risk factor that needs to be mitigated or reduced, but rather as a complex social process. Researchers, collaborators and partners are starting to recognize that social inclusion is a powerful means to reduce the impact of stigma and discrimination for people living with moderate to severe mental health and/or substance use issues, and equally important to increase their ability to meaningfully participate in their community and seek the care and support required to reach their potential as active, engaged citizens in BC. The findings in this report demonstrate a pressing need for BC to move towards approaches that create socially inclusive communities, environments, policies and practices.



We can learn much from indigenous traditions around the world that employ circles to understand the world as an egalitarian method of sharing power and sharing decisions inclusively (First Nations Health Authority, 2013). As is pointed out in the newly established A Path Forward: First Nation's Mental Wellness and Substance Use – 10 Year Plan, circles provide a space for truth, reflection and decision or reconciliation, in politics and in justice. Circles are known to be powerful vehicles to involve communities to enhance control over their lives, to share knowledge and relay stories of hope and most fundamentally, to build connections. This concept can be applied to create a socially inclusive society for people with moderate to severe mental health and/or substance use issues who may be experiencing stigma and discrimination. Importantly, circles create a sense of belonging. This is critical as one of the HMHP's milestones for 2015 is that “more people living with mental illness and/or substance dependence will report that they feel a sense of belonging within their communities” (p. 18). Therefore, if we conceptualize belonging within a circle by creating a Circle of Belonging, there is a focus on partnerships and collaboration. Additionally, there is also a focus on sharing knowledge and power across policy domains, the lifespan, and across the continuum of care - from promotion to recovery.

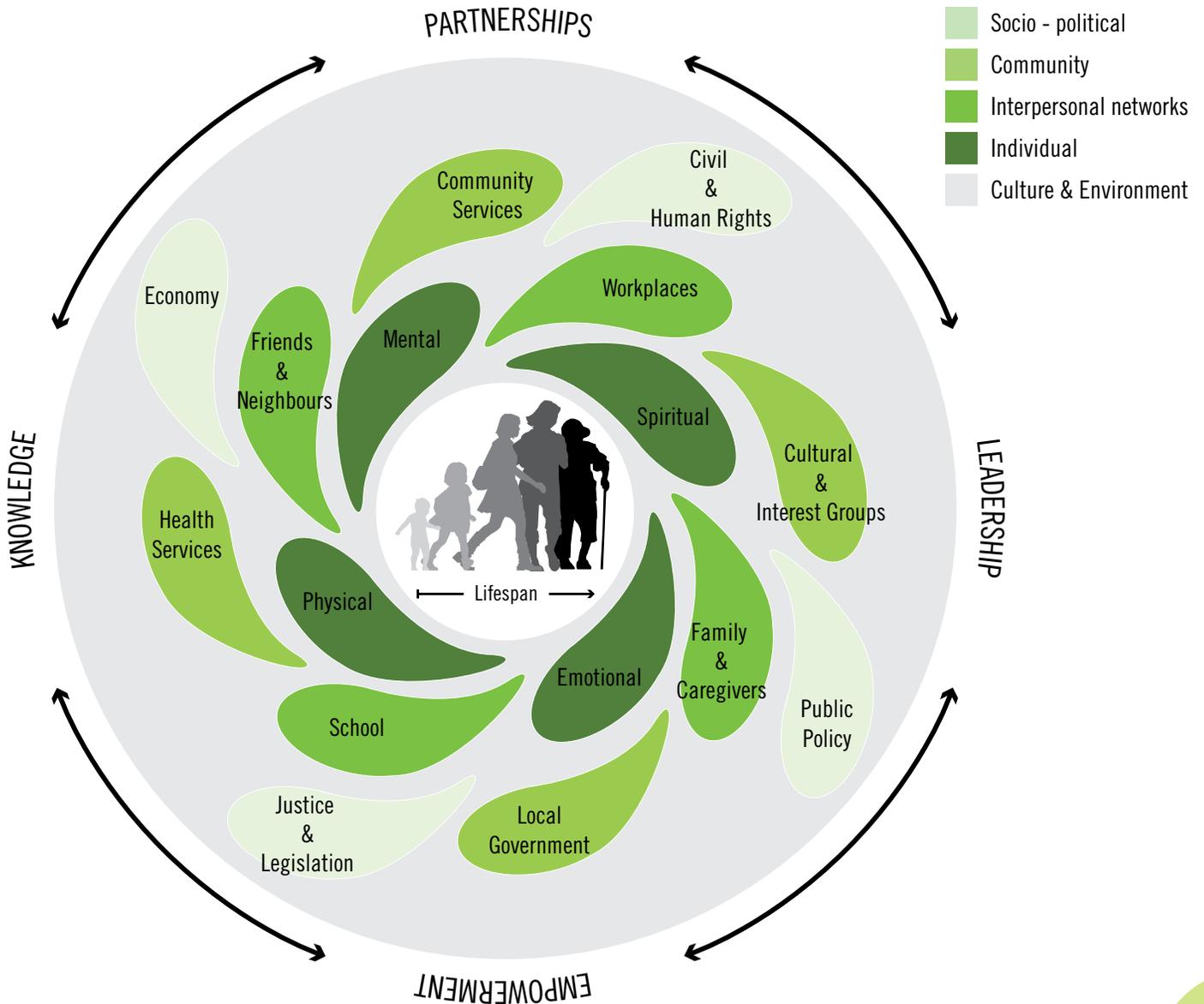
As mentioned earlier, according to BC's newly released Promote, Protect, Prevent: Our Health Begins Here: Guiding Framework for Public Health (2013) the primary goals of our health systems are:

1. Effective health promotion, prevention and self-management to improve the health and wellness of British Columbians;
2. British Columbians have the majority of their health needs met by high quality primary and community-based health care and support services; and
3. Improved innovation, productivity and efficiency in the delivery of health services.

While understanding that the issues around stigma, discrimination and social inclusion lie well beyond the scope of the public health system, we can use comprehensive health promotion approaches to deal with the interplay of complex socially adaptive systems to address the needs of people living with moderate to severe mental health and/or substance use issues in BC. This type of approach is aligned with both provincial mental health and substance use plans; HMHP and A Path Forward: BC First Nation's Mental Wellness and Substance Use – 10 Year Plan, that focus on strength-based solutions and approaches that not only prevent illness, but also promote health and wellness. This approach is also inherent in BC's new Guiding Framework for Public Health, which states that one of its main goals is to support a population health approach and the public health role in health equity (BC Ministry of Health, 2013). These provincial plans and frameworks focus on upstream approaches to better understand the cultural and environmental context that influences the determinants of health across the life course. These plans

also integrate interrelated factors at individual, intrapersonal, community and socio-political levels when developing policies, programs and services. A focus on social inclusion as a strategy to reduce stigma and discrimination amongst people with moderate to severe mental health and/or substance use issues requires extensive social change that cannot be achieved by the HMHP Directorate and their partners alone. This cultural shift requires incremental changes over time across multiple sectors, and more importantly it requires the system to actively engage people living with mental health and/or substance use issues. Based on the evidence gathered in this environmental scan, and the HMHP strategic levers identified in the Systems Transformation Framework (see Appendix A), the research consultants developed the Circle of Belonging: Social Inclusion Model (see Figure 2).

Figure 2: Circle of Belonging: Social Inclusion Model



Rebecca Zappelli and Paola Ardiles, 2013 ©
Design by Amelia Sissons

This model aims to support a common understanding of social inclusion, by identifying the various domains (from socio-political to the individual) described earlier in this report, as well as the four pillars or key strategies that could support long term, incremental changes towards social inclusion:



4.1 Leadership

- * **Promote a whole-of-government approach** across government working in justice, education, employment, housing and health and looks to increasing government efficiencies and pooling resources to best support marginalized population groups. Currently, there are strong examples of this cross-sectoral approach at the health authority level through the BC Mental Health and Substance Use Health Literacy Network, and the Drug Treatment Funding Program in BC, which intersect and collaborate with community, research and consumer based organizations.
- * **Develop a provincial plan for social inclusion** that articulates a clear long-term vision for social inclusion in the province. To create culture shifts towards social inclusion, a plan needs to be supported by leadership, partnerships, knowledge exchange, evaluation, consumer and community engagement, and most importantly designated financial and human resources to ensure it's successful implementation.

4.2. Partnerships

- * **Build on existing partnerships.** B.C. has already established a wide range of community and health service based, academic partnerships, as well as networks in the area of mental health and substance use such as: the Community Action Initiative (CAI), BC Mental Health and Substance Use Provincial Health Literacy Network, Drug Treatment Funding Program, BC Partners for Mental Health and Addictions Information, which include partnerships with dynamic and innovative consumer based organizations such as VANDU, SOLID and The F.O.R.C.E. Other research partnerships in BC include the Centre for Addictions Research BC (CARBC) at the University of Victoria; the Centre for Applied Research in Mental Health and Addictions (CARMHA) at Simon Fraser University; and other public health research program such as Equity Lens in Public Health (University of Victoria), as well as the partnerships through the work funded through the Michael Smith Foundation. All of these partners are integral in the development of a social inclusion plan for BC, as they all play a distinct and critical role in a cultural shift towards social inclusion.

4.3 Knowledge

- * **Build a strategic research agenda in BC focusing on social inclusion.** Although many gaps exist in this research area, it is critical to build an economic case for social inclusion in order to support the implementation of a provincial plan. Research is needed to better understand the economic costs of business as usual and recommend where the investment of provincial resources are best directed, in order to improve community-based support and treatment participation, as well as enhance the quality of life for people with moderate to severe mental health and/or substance use issues.
- * **Develop a provincial knowledge exchange strategy** to create and communicate a collective vision towards a socially inclusive BC.

4.4. Empowerment

The concepts of belonging and empowerment go hand in hand and are integral features of a social inclusion agenda and should be undertaken with considerations for the cultural safety of vulnerable groups. Therefore it is recommended that as a province we:

- * **Ensure meaningful participation of consumers and families.** The Circle of Belonging: Social Inclusion Model is built on a health promotion approach that acknowledges that in order to enhance quality of life for people with moderate to severe mental health and/or substance use issues, they themselves must be involved in the process of developing community based supports, treatment and recovery options.
- * **Enhance the capacity of individuals and communities to take control over their lives and improve their health and wellness.** Leadership, partnerships and knowledge need to be oriented towards actively engaging consumers, families and community members, respecting their rights and freedom, and building on their strengths, in order to foster supportive environments and individual resilience to promote social inclusion in B.C.



SECTION 5: NEXT STEPS

Currently, many provincial policy initiatives including HMHP and BC's new Guiding Framework for Public Health have recognized the need to shift the focus towards upstream solutions to increase the level of health and wellness experienced by all British Columbians. Whether the focus is on promoting mental health in early childhood, or taking action to prevent and reduce the costs associated with hazardous alcohol consumption amongst youth/young adults, there is an increasing need to build sustainable systems for wellbeing.

The implementation of HMHP and the Public Health Guiding Framework relies on collaboration with key partners; reinforcing continuous quality improvement and ensuring effective and efficient resource use to support the overall health and well-being of British Columbians and a sustainable (public) health system well into the future (Ministry of Health, 2013). HMHP and the Guiding Framework for Public Health also reinforces the importance of effective partnerships and strategic connections within the health system (particularly with the primary and community care sectors) and with external partners to support a broader population health approach (Ministry of Health, 2013). The next steps recommended in this report continue the work towards enhancing social inclusion and reducing stigma and discrimination in BC. These next steps build on the four pillars and the Circle of Belonging: Social Inclusion Model outlined in Section 4, proposing a roadmap towards a social inclusion model in BC in the short, mid and long term.

5.1 A Roadmap Towards A Social Inclusion Model In BC

The paradigm shift towards social inclusion has already begun. A number of schools, families and consumers are already engaged in the shift towards social inclusion in relation to mental health and substance use in BC. The question is – how can we foster collaboration and engagement to further support this shift?

The following section highlights some key action areas that the HMHP Directorate and their stakeholders can take in order to foster accountability, capacity building, and contribute to provincial and national agenda towards promoting social inclusion for people living with moderate to severe mental health and/or substance use issues.

Short Term

- 1 Development of social inclusion tools and/or resources** to support a common understanding of the key principles and promising practices that address social inclusion for people living with moderate to severe mental health and/or substance use issues. This could also be broadened to include the needs of people living with mild mental health and/or substance use issues. These tools/resources should be aimed at increasing capacity of diverse stakeholders including justice, social and health service providers, consumers and families and ensure cultural safety for groups and individuals.
- 2 Development of brief policy papers** based on reliable research evidence, to help decision-makers implement informed public policy, to reduce stigma and, discrimination and enhance social inclusion for people living with moderate to severe mental health and/or substance use issues. This could also be broadened to include the needs of people living with mild mental health and/or substance use issues. The choice of topics for these policy papers would be guided by justice, social and health service providers, consumers and families, policy-makers, as well as emerging trends in the field, including barriers and enablers.
- 3 Development of a paper that outlines the economic case for a social inclusion approach** to address mental health and/or substance use issues. This paper would build on existing literature in order to address the gaps and opportunities for the HMHP Directorate and its partners, on moving towards a research agenda that presents an economic argument towards social inclusion.

Mid Term

- 1 Create a Provincial Advisory/Steering group** with diverse stakeholders and partners to start the development of a Social Inclusion Plan based on the following key principles: a) do no harm; and b) meaningful engagement and participation of people with mental health and/or substance use issues. Some first steps to consider in creating an advisory group include:
 - * Ensuring common definitions of stigma and discrimination are shared and articulated across the province;
 - * Articulating a clear vision for promoting social inclusion that can be shared across sectors and organizations.
- 2 Build a knowledge-exchange strategy** to engage stakeholders, communicate, and create a collective vision towards a Social Inclusion Model for BC. This should link to two other projects, Privacy, Confidentiality and Information Sharing with the Mental Health and Substance Use Systems of Care Project.
- 3 Establish an education fund to support the development and implementation of school-based programs** towards building socially inclusive schools, by linking to IMinds, MindUp, BC School-based Mental Health Coalition, school based health programs within the Health Authorities across BC and other partners.
- 4 Enhancement of current initiatives aimed to educate, support and improve responses of front line justice, social and health service providers.** This will promote quality care and approaches that focus on compassion and hope for people with mental health and/or substance use issues while supporting the notion of collective responsibility for the process of recovery. This should build on promising and emergent initiatives that are comprehensive, ongoing and apply a systems focus. CAP, Motivational Dialogue and DVD production with first line responders in Fraser Health are examples of where this work is already taking place.
- 5 Support the creation of a dedicated research funding mechanism** to make the economic case for social inclusion (exploration of the cost benefits associated with social inclusion agenda (cost of action vs. inaction, and best buys).

Long Term

Develop a comprehensive Provincial Social Inclusion Plan for BC that:

- 1** Uses a health promotion approach that allows consumers, community and treatment based services and public health services to have a key role in its implementation.
- 2** Builds strategic intra-provincial partnerships and collaborative approaches;
- 3** Supports practitioners in training to better integrate stigma, discrimination and social inclusion issues into new training modules (medical, nursing, pharmacy, social workers, police, lawyers);
- 4** Engages and empowers key justice, social and health care service providers to address issues of stigma, discrimination and social exclusion within their organizations and internal practices;
- 5** Promotes and incentivizes strategic inter-provincial partnerships and collaboration on issues related to stigma, discrimination and social inclusion;
- 6** Embeds evaluation components into any activity, initiative or intervention.

Currently, innovative and cross-sectoral work in mental health and substance use knowledge-exchange initiatives in B.C. are adopting Outcome Mapping as key tool to support development, implementation and evaluation. This type of approach is well suited for the development of a province-wide plan, as it is an iterative model that can be used to support large-scale system change in complex environments. Below are some of the key components of Outcome Mapping that may be employed in the development of a provincial plan towards social inclusion (see Table 2).

Table 2: Outcome mapping process

Vision Setting	Describe the large-scale development changes this project aims to contribute to.
Boundary Partners	Identification of the individuals, groups and organizations that the program directly interacts with and can anticipate opportunities for influence.
Outcome Challenge	Detail the ideal changes in behaviour, relationships, activity/s and or actions of a boundary partner/s.
Markers	Select indicators of changed behaviour, relationships, and activity/s for the boundary partners which a focus on depth/quality of change. These need to be gradated to offer multiple opportunities to identify shifts in behaviour, relationships, activity/s.
Strategy Mapping	A matrix that categorizes six strategy types that aim to inspire, encourage and support to influence a boundary partner. These strategies should be aimed at the boundary partner directly or the environment in which they operate.
Monitoring	Identification of the process and sources of data collection of about the project overtime that is systematic and regular.
Organizational Practices	Identify eight practices that will ensure the project remains relevant, innovative, sustainable and connected to both context and environments.

(Adapted from the BC Mental Health and Addiction Services (2012) BC's Drug Treatment Funding Program (DTFP).

Conclusion

Shifting a culture and systems may seem insurmountable. Yet, the move towards social inclusion has already begun. The question is how can we best support this transformation?

B.C. has a tremendous amount of knowledge and skills available from people with a lived experience of mental health and substance use issues as well as from families, researchers and its justice, social and health care service providers. However, we need to encourage more collaboration and engagement across diverse sectors and actors if we are to achieve sustainable, long-term change.

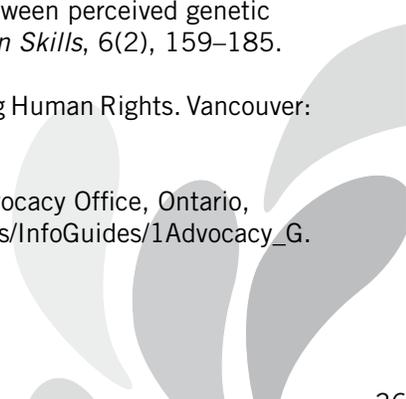
Everyone has a role in systems transformation. With effective leadership, partnerships, and knowledge we can strive towards systems that are socially inclusive, that engage community members, and are accountable and well resourced. Such efforts can result in policies and practices that allow people living with mental health and/or substance use issues to receive the support they need and ultimately live a dignified life free of stigma and discrimination.



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APPENDIX A

HMHP Systems Transformation Framework

Healthy Minds, Healthy People

A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia

Provincial Direction
Strategic Direction and Accountability Requirements

Innovation & Change Agenda	Tripartite First Nations Health Plan	Government Letter of Expectations (GLEs)	Key Results Areas (KRAs)
Service Plans	Families First		GNPI

Systems Transformation Framework

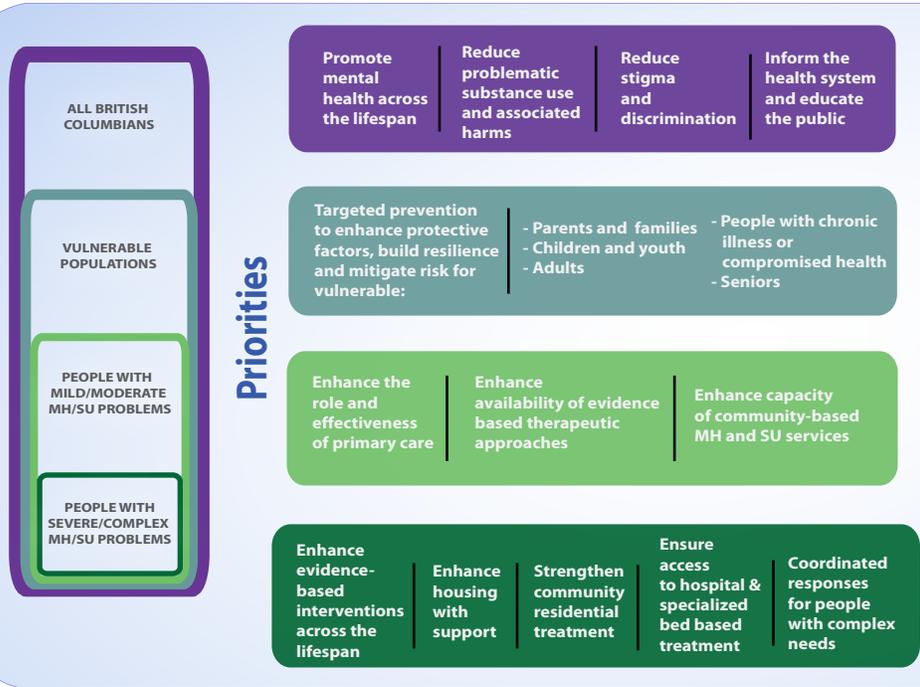
Context

Social Determinants, Population Demographics
Ecology & Economy, Legislation, History,
National/International Developments, Provincial Initiatives

Governance Stewardship and Key Levers

- Leadership
- Partnerships
- Regulatory Framework
- Systems, Structure, Culture
- Knowledge
- Accountability

Population



Milestones 2012-2018

2012

2013

2014

By 2014, 10% fewer BC students will first use alcohol or cannabis before the age of 15.

Activities *

- Promote social and emotional development in early childhood
- Implement core public health programs
- Create health-promoting environments & healthy public policy

- Implement core public health programs
- Address risk factors for children, youth, adults and families
- Work with employers to create workplace supports

- PSP physician training on MH/SU, practice guidelines, care plans
- Shared care models
- Training and support for MH/SU clinicians to deliver EB care

- Early psychosis intervention
- Evidence-based, crisis intervention, meds, ACM
- Improve access to specialized Rx for severe/complex

* To review a complete list please visit:
www.health.gov.bc.ca/healthy-minds

Systems Outcomes

- Mental health and substance use responses reflect a common understanding and shared responsibility, resulting in coordinated and, where appropriate, integrated planning and delivery.
- Mental health and substance use responses address opportunities and needs across the health promotion, prevention, identification, care, treatment and recovery continuum.
- Mental health and substance use responses are lifespan-oriented, with emphasis on promoting healthy early childhood development and intervening early before or when problems occur.
- Mental health and substance use responses address common risk and protective factors in places where people live, work and learn.
- Mental health and substance use responses are based on the best available evidence, generate new knowledge through evaluation and research, and value and apply knowledge from lived experience.
- Mental health and substance use responses are available at various levels of intensity in relevant settings using modern delivery models.
- Mental health and substance use resources are allocated to programs and services that are effective and efficient.
- Mental health and substance use responses strive to improve well-being and psychosocial functioning for all individuals and families including people with severe and complex problems.

Goals

Improved mental health and well-being among the general population

Improved access and quality of services for people with MH/SU problems

Reduced economic costs to the public and private sectors resulting from MH/SU problems

2015

2016

2017

2018

The number of young BC children vulnerable in terms of social-emotional development will decrease by 15% by 2015.

The proportion of British Columbians 15 years or age or older who engage in hazardous drinking will be reduced by 10% by 2015.

By 2015, the number of British Columbians who receive MH/SU assessments and planning interventions by primary care physicians will increase by 20%.

The number of British Columbians who experience positive mental health will increase by 10% by 2018

By 2018, through integrated primary and MH/SU services, there will be a 20% reduction in the # of days MH/SU patients occupy inpatient beds while waiting for appropriate community resources

APPENDIX B

Key Informant Information Form

STIGMA, DISCRIMINATION & SOCIAL INCLUSION ENVIRONMENTAL SCAN

KEY INFORMANT INFORMATION FORM

Background

A key strategic objective identified in *Healthy Minds, Healthy People: A Ten-Year Plan to Address Mental Health and Substance Use in British Columbia* (HMHP) states that by “2015, more people living with mental illness and/or substance dependence will report that they feel a sense of belonging within their communities” (Healthy Minds, Healthy People, 2010, p.18). Social inclusion and participation are recognized as key protective factors for mental health and wellbeing internationally and is similarly articulated in HMHP. Being active, having a sense of belonging and purpose in life all contribute to good mental health and wellbeing.

In recognition of the importance of continuing to improve the mental health and wellbeing of British Columbians, the BC Ministry of Health has identified a need for an environmental scan that assesses future strategies that align with key themes raised in HMHP. These include:

- * Building the capacity of the community;
- * Promoting social inclusion;
- * Recognizing the importance of mental health across the lifespan;
- * Inclusive of the role of families and informal networks.

Goals and Objectives

The Public Health Association of British Columbia (PHABC) is conducting an environmental scan of initiatives related to stigma and social inclusion as they relate to mental health promotion, mental illness prevention and problematic substance use efforts within the province of British Columbia, and across Canada more broadly.

The objectives of the environmental scan are to:

- d) Analyze the current context including gaps and promising practices with recommendations for a comprehensive health promotion and/or programmatic approaches moving forward;
- e) Assess key stakeholders and possible partnerships both provincially and nationally.

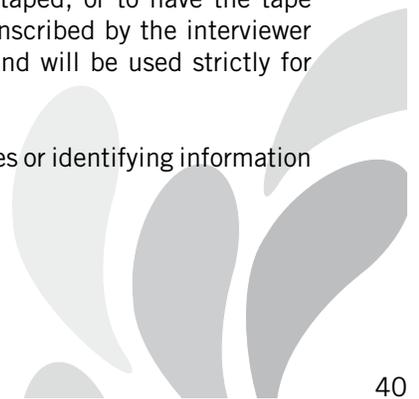
Key Informant Consent

On behalf of the PHABC, you are invited to participate in a one-hour key informant interview, as part of the Stigma, Discrimination & Social Inclusion Environmental Scan that will take place between March and April 2013.

Your participation in the interview is completely voluntary and will imply your consent. You can refuse to participate or withdraw at any time without any consequences. You may answer all, some, or none of the questions that arise during the interview. Your presence and the information you provide during the discussion are confidential. Information provided by participants will be analyzed to determine common trends between responses and any information provided will not be identifiable to specific participants.

With your consent, the interviews will be audiotaped. You may choose not to be audiotaped, or to have the tape stopped or erased at any time during the interview. The audiotape recording will be transcribed by the interviewer and will then be erased. The transcription will not include any personal information, and will be used strictly for analysis and report writing. All transcriptions will be destroyed at the end of the project.

To ensure confidentiality, all information obtained will be held in strict confidence. No names or identifying information will be used in any publications or presentations unless consent is first obtained.



Key Informant Interview Guide

1. Can you please share some of the current initiatives that you are aware of related to stigma, discrimination and social inclusion in relation to mental health and/or substance use?
2. What would you recommend is a useful way of defining stigma given complexity of the issue in relation to mental health and substance use?
3. What are some of the common challenges experienced when working in stigma, discrimination and social inclusion related work in relation to mental health and substance use?
4. From your perspective, is there a need to delineate approaches to stigma, discrimination and social inclusion related efforts as they relate to mental health compared with substance use or are efforts better served when issues are addressed together? Why/not?
5. Can you please recommend essential documents and key actors supporting work in stigma, discrimination and social inclusion work in BC and nationally in relation to mental health and substance use?
6. From your perspective who would be the most beneficial audience to target for future stigma, discrimination and social inclusion work in BC policy, consumers, families, health care providers etc.?
7. From your perspective what would be the most beneficial comprehensive approach to use for future stigma, discrimination and social inclusion work in BC i.e. policy, service delivery, education, social marketing etc.?
8. Can you identify any priority areas, future opportunities and/or partnerships for BC the Ministry of Health's, aligned with the Healthy Minds Healthy People Strategic Plan, as they move forward with future initiatives in relation to stigma, discrimination and social inclusion in mental health and substance use?

Thank you for your time.



APPENDIX C

Key Informant List

Name	Role	Agency
Jamie Livingston	Researcher, Forensic Psychiatric Services Commission	BC Mental Health and Addictions
Kenneth Tupper	Director, Problematic Substance Use Prevention	BC Ministry of Health
Stephen Smith	Director, Mental Health Promotion and Mental Illness Prevention	BC Ministry of Health
Heather Stuart	Senior Consultant, Opening Minds Program	Mental Health Commission Canada
Mike Pietrus	Director, Opening Minds	Mental Health Commission Canada
Sandy Da Silva	Regional Director, Tertiary Mental Health Services	Interior Health Authority
Connie Coniglio	Provincial Executive Director	BC Mental Health and Addictions
Meredith Woermke	Project Manager, Health Literacy	BC Mental Health and Addictions
Dan Reist	Assistant Director (Knowledge Exchange)	Centre for Addictions Research BC
Hertha Holland	Health Actions Coordinator	First Nations Health Authority
Marika Sandrelli	Addiction Knowledge Exchange Leader	Fraser Health
Jane Collins	Program Manager	BC Mental Health and Addictions
Ashley Mollison	Coordinator	Society of Living Illicit Drug Users
Connie Carter	Senior Policy Analyst	Canadian Drug Policy Coalition
Hing Tse	Manager	Kelty Mental Health Resource Centre
Shaylyn Streach	Program Coordinator	Canadian Mental Health Association BC Division
Keli Anderson	Founder F.O.R.C.E & Executive Director of the Institute of Families	Institute of Families
Allison McLeod	Mental Health Consultant – Senior Nurse	Ministry of Children and Family Development
Rob Axsen	Addictions Clinical Supervisor	Pacific Community Resources Society

