Health Justice submissions to the BC Human Rights Commissioner's inquiry into hate incidents during the COVID-19 pandemic

March 2022

HEALTH JUSTICE

ACKNOWLEDGEMENT OF TERRITORIES, INDIGENOUS LEGAL ORDERS, AND THE IMPACTS OF COLONIZATION

Health Justice's work focuses on provincial laws that apply throughout the area that is colonially named British Columbia. These colonial laws impact Indigenous people living on the traditional, ancestral, and unceded First Nation territories as well as land that is governed by treaties. Currently in BC, 198 distinct First Nations, 39 chartered Métis communities, and many First Nations, Métis, and Inuit people living away from home in communities across British Columbia hold their own unique ancestral legal orders, justice systems, well-established health practices, concepts of health, and traditional healers.

Colonization, including land theft and the application of colonial laws, have disrupted these sovereign legal and health care systems in numerous ways. The ongoing intentional displacement of communities from their traditional territories and the separation of children from their families and communities undermine protective factors and interrupt ways of sharing knowledge, families, communities, cultural land-based practices, and languages. The colonial dynamics continue today in many public systems, including the health and legal systems. Involuntary mental health and substance use treatment, enforced by the colonial health and legal systems, can be experience as yet another source of control over Indigenous people that pathologizes and criminalizes the impacts of colonialism. Recognizing this systemic context is foundational to understanding the impacts of genocide, colonization, and racism in colonial health and legal systems on First Nations, Métis, and Inuit people, as well as their resistance and resilience to those systems.

Health Justice is a virtual organization with a registered office address located on the traditional, ancestral, and unceded territory of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and səl̓ílwətaɬ (Tsleil-Waututh) Nations. Staff, board members, Lived Experience Experts Group members, and Indigenous Leadership Group members live and work on the lands of many different First Nations. Health Justice staff live and work on the traditional, ancestral, and unceded territories of the xʷməθkʷəy̓ əm (Musqueam), Sḵwx̱ wú7mesh (Squamish), səl̓ílwətaɬ (Tsleil-Waututh), Lək̓ʷəŋən (Lekwungen) peoples (including the Songhees and Esquimalt), kʷikʷəƛ̓əm (Kwikwetlem), QayQayt, Sinixt, and Ktunaxa Nations.

INTRODUCTION

Public debates about community perceptions of and supports for people experiencing mental health and substance use-related disabilities and/or homelessness existed well before COVID-19, including debates that frame people directly experiencing these issues in stereotypical or discriminatory ways. The pandemic has only increased tensions in public debate related to these issues, including rhetoric that targets people experiencing mental health and substance use-related disabilities and/or the social condition of homelessness and fit the Inquiry's definition of "hate incidents."

We may feel reluctant to frame this public rhetoric as hate given that some comments appear to be made with the intention of helping people who experience inequity. However, regardless of intention, we must learn from the impacts of the pandemic, including how they have mirrored deeply entrenched and longstanding structural discrimination. Doing so is necessary to take meaningful steps to uphold the human rights of people experiencing mental health and substance use-related disabilities and/or homelessness.

ABOUT HEALTH JUSTICE

Health Justice was established in 2020 to undertake research, education, and advocacy to improve the laws and policies that govern coercive mental health and substance use health treatment in BC. We work using a participatory engagement governance model that centres those most impacted by our work. In addition to our Board of Directors, our work is governed by the Lived Experience Experts Group, made up of individuals with lived experience of involuntary mental health or substance use treatment, and the Indigenous Leadership Group, made up of individuals with expertise in the impacts of our work on First Nations, Métis, and Inuit people. Health Justice brings together human rights, lived experience, cultural, clinical, family, and community-based expertise to inform our work.

INCREASE IN HATE INCIDENTS DURING THE PANDEMIC

During COVID-19, debates about how to address concerns faced by communities have increased. These relate to issues including debates related to increases in visible distress in communities, perceived increasing dangerousness, encampments flowing from housing insecurity, proposed new supportive or subsidized housing developments, harm reduction services, and others. Causes of these issues are often inaccurately attributed to the closure of Riverview,[1] overly complex procedures that create barriers to involuntary mental health treatment,[2] and assumptions about the capacity and agency or people experiencing mental health and substance use-related disabilities and/or homelessness.[3]

“Call the military in, load them onto a bus and give them a choice... jail/institutionalization or a 30 minute trip out of town with a promise to never come back to the city - the penalty for breaking that promise is of course, jail. We want to sit on clean benches in the parks, wear nice clothes and feed the birds. Get Out.”

- Online comment, “Homeless encampment residents at CRAB Park face intimidation, advocates say” *Vancouver Sun*, 11 October 2021

“Why is it that we have no trouble as society — and we know it’s the right thing — to place seniors with dementia in locked-down facilities? But we do not do that for a 45 year-old, brain-injured schizophrenic with an addiction living in the streets like a stray dog and getting about as much love?”

- Mayor of Nanaimo, quoted in "Governments need to act with compassion or cities will sink into 'lawless barbarism’” *Vancouver Sun*, 4 December 2020

“Select an operator that works with low-acuity people.

Central Saanich does not have the support systems or infrastructure in the community to support those with high-acuity needs including opioid addictions or mental health issues.”

- www.letsactuallytalk.ca, a website by Central Saanich community members opposing a proposed supportive housing development. Instead, the website recommends housing for "low-acuity people", published March 2021

"I believe this proposal is out of step with this community. Medical resources for this area are barely meeting the needs of community members and RCMP are overworked and overburdened. This initiative is important and worthwhile, however I truly believe it needs to be revisited and it should not come at a price to others. It isn't fair for us to expect nearby businesses to just cope with 52 new neighbours dealing with all different stages of recovery."

- Councillor, District of Hope, during a council vote to reject a rezoning application for a supportive housing development, November 23, 2020

"If something isn't done soon about the growing homeless/drug addict problem there will start to be vigilantes taking the law into their own hands as is happening in quite a few failed American cities."

- Online comment, "New overdose prevention site in Yaletown generates support and criticism", *Vancouver Sun*, October 21, 2020

"I can't believe the court's decision to leave the homeless camps as is where is, because there is not adequate housing. Adequate housing for who? People are coming here from who knows where, with no identification, active drug addiction, no records, no application requirements. That is very scary – the safety and health of Prince George Residents should be No. 1. Can our police and our hospital handle the influx of the homeless coming here? What about COVID? Who is going to take responsibility for the consequence of this ruling?"

- Letter to the Editor, *Prince George Citizen*, November 6, 2021

During the pandemic, it has become common for public or elected officials to discuss the community impacts of the barriers faced by people with mental health and substance use-related disabilities and/or experiencing homelessness in a way that locates the problems in the individuals facing barriers. This includes talking about people as hard or impossible to house, wreaking havoc on communities, creating health and safety risks, harming business and tourism, and creating nuisance. People with mental health and substance use-related disabilities and/or who are experiencing homelessness are often spoken of as outsiders who are unable or unwilling to access services to support their needs, with little attention paid to whether existing services are adequate, safe and accessible.

This rhetoric and way of understanding and debating complex policy issues has become more entrenched during the COVID-19 pandemic. While we are not in a position to definitively pinpoint the cause, the following may be relevant:

- Inequitable health impacts of the pandemic: The health impacts of the pandemic are not experienced equally across communities and social locations. Structural inequity that existed prior to the pandemic has gotten worse and more visible. The greatest mental impacts have been on people with pre-existing mental health issues, Indigenous people, the LGBTQ2S+ community, people with disabilities, and people living in poverty.[4] In addition, the pandemic has only heightened the catastrophic loss of life resulting from a toxic illicit drug supply.[5] People who were already marginalized are experiencing devastating impacts on their health and wellbeing.

- Reduced access to mental health and substance use services: The public health restrictions put in place to limit the spread of COVID-19 has led to service reductions when health services for people with mental health and substance use-related disabilities and/or experiencing homelessness were already inadequate.[6] Congregate indoor spaces like shelters, harm reduction sites, drop-in spaces, and other support services may have reduced capacity and they may not have been or felt safe during the pandemic. We heard anecdotal reports that psychiatric units engaged in widespread discharge of patients to free up hospital beds for potential incoming patients with COVID-19. In addition, those who were discharged may have experienced heightened isolating and challenging conditions while detained under the *Mental Health Act* in hospitals and facilities that took measures such as restricting/prohibiting visitors and confining COVID-19 positive psychiatric patients in seclusion rooms on psychiatric units, all of which can have significant negative impacts on mental wellbeing.[7]

  As a result, access to service was reduced and people in need of support may have been more likely to be outdoors and visible in communities. At the same time, many people stayed close to home and may have been paying closer attention to what was happening in their communities.

- Increased strains on communities: The pandemic also created new pressures on the health system, as well as on businesses that were subject to public health measures. Public rhetoric seems to show that communities became more willing to say they could not accept people perceived as having higher needs into their community and less willing to accept any potential impacts (taxes, public spending, impacts on businesses or tourism) because communities already felt under strain. This appears to have been the basis for a number of the quotes above supporting exclusion from communities throughout the province.[8]

- Increased fear, decreased empathy: The COVID-19 pandemic caused stress and fear across populations.[9] In particular, it created a heightened sense of danger related to threats to health and safety. We were forced to treat others as a danger or potential contagion and keep our distance. These fears likely exacerbated existing fear and lack of knowledge about people experiencing mental health and substance use-related disabilities and/or homelessness rooted in deeply entrenched discriminatory stereotypes related to violence and danger.

While all of these causes existed well before the pandemic, restrictions and fear resulting from COVID-19 exacerbated them dramatically.

WHY IS THIS HATE?

The Inquiry has defined "hate incidents" as follows:

> **Definition of "hate incident"**
> For the purposes of this Inquiry, "hate incidents" are actions and speech rooted in prejudice that, in the view of the person who experiences or witnesses it, are:
>
> - aimed at a person or a group of people because of their actual or perceived individual, collective or intersecting characteristics including age, disability, gender expression or identity, ethnicity, Indigenous identity, place of origin, race, immigration status, religion, sex, sexual orientation and social condition, and
>
> - intended to, or does, significantly dehumanize, humiliate, degrade, injure, silence and/or victimize the targeted individual or group.

The rhetoric described and quoted above is clearly directed at people with mental health and substance use-related disabilities, and people who experience homelessness and poverty. In addition, because of compounding experiences of systemic marginalization, this group of people is also disproportionately Indigenous, gender diverse, and identify as having additional disabilities. [10]

IMPACTS

This has an impact on us. It's not about a theoretical person who isn't human or part of the community. You're talking about real human beings.

- Health Justice Lived Experience Experts Group

It's hurtful and dehumanizing to see people saying these things in a flippant way. It's disguised as the language of care – that we're trying to take care of people. But care is relationship and community. It's not treating people as less than human or putting them behind closed doors.

- Health Justice Lived Experience Experts Group

Just because I'm ill or have an altered perception of reality, doesn't mean I'm incapable. When people communicate unusually or express unusual ideas, we're still a person with feelings and thoughts.

We feel it when we're treated in dehumanizing ways. We read the comments. Our families and the people that love us read the comments.

- Health Justice Lived Experience Experts Group

When you experience it all the time, you get desensitized to it. You start to believe you deserve to be treated like this.

- Health Justice Lived Experience Experts Group

The rhetoric described and quoted above has a significant and negative impact on the people it targets. It leaves them feeling dehumanized, and often quite literally suggest they are not physically welcome in their communities. It also reflects long-entrenched and discriminatory stereotypes and assumptions about people with mental health or substance use-related disabilities. These include stereotypes about people who use drugs that frame drug use as a safety threat and moral failing that may harm the general public. This understanding of substance use is deeply entrenched in racist history of drug policy that criminalized and prohibited drug use because of connections to racialized communities that were perceived to be a threat to white communities.[11]

Many of longstanding discriminatory stereotypes about people with mental disabilities are reflected in the increased hateful rhetoric during the pandemic:

- They are inherently flawed. By continuing the historic and ongoing pattern of locating the problem in individuals experiencing marginalization and discrimination, we fail to understand and address the impacts of systemic policy decisions that create distress and unmet needs.
- They are inherently dangerous. The examples of rhetoric continually conflate mental health and substance use issues with public safety issues and dangerousness despite data confirming that people with mental disabilities are more likely to be victims of violence than to perpetrate it.[12]
- They are burdens. Many of the statements frame the people they target increasing police/security/maintenance costs, creating community nuisance and discomfort, or creating additional pressure on already stretched services.
- They are incapable. Many of the statements reflect discriminatory assumptions about the capacity and agency, suggesting solutions that come with serious human rights impacts with no apparent attempts to include those experiencing marginalization in deciding what is “best” for them.
- They are outsiders. A deeply held belief that people experiencing marginalization are not real members of the community, or that they have a lesser right to inclusion and services.

These kinds of discriminatory assumptions are the same as those that were relied on in the past while people with mental disabilities experienced significant human rights violations. For example, the Royal Commission Report that led to BC’s *Sexual Sterilization Act* rationalized eugenics based on the need to control the spread of an inherent biological flaw in people who were disproportionately outsiders in the face of increasing public costs of institutionalization.[13]

The discriminatory assumptions set out above reflect deeply entrenched ableism, which Talila “TL” Lewis defines as:

> a system that places value on people's bodies and minds based on societally constructed ideas of normality, intelligence, excellence, desirability, and productivity. These constructed ideas are deeply rooted in anti-Blackness, eugenics, misogyny, colonialism, imperialism and capitalism.[14]

Settler community debates about which people are desirable and therefore "allowed" to live in communities, with no attention paid to the systemic oppression that led to the situation, perpetuates colonial dynamics. Terry Teegee, the Regional Chief of the British Columbia Assembly of First Nations, has noted in relation to the City of Prince George's response to an encampment in the community:

> All of this should put municipalities on notice that the unhoused are not a nuisance to be removed.
>
> But it also points to a much larger issue that municipalities in B.C. seem blinded to: their responsibility to be good-faith partners in reconciliation.
>
> The latest "point in time" report on homelessness in Prince George states that 70 per cent of homeless people are Indigenous. Targeting the homeless is equivalent to targeting Indigenous people.
>
> […]
>
> It was over 100 years ago that the village site of the Lheidli T'enneh was forcibly relocated by colonial governments. If municipalities don't start paying attention to their responsibilities to enact the UN declaration and the calls to action, they are simply using the same violent colonial tools their predecessors used.[15]

RECOMMENDATIONS

In order to prevent the hate incidents described in this submission, Health Justice recommends the following:

(1) Create law, policy and services that combat discriminatory stereotypes and fulfill people's human rights to an equal opportunity to achieve the highest attainable standard of health *before a crisis*. It is well documented that the pandemic did not create inequity; rather, it highlighted and intensified inequities and human rights issues that already existed.

Prior to the pandemic, BC was in the midst of a housing crisis, a drug toxicity crisis, mental health and drug laws were outdated, and there were well known gaps in access to culturally safe and accessible mental health and substance use supports.

Addressing these issues in a proactive way will prevent hate and discrimination during a crisis. Ensuring the equitable fulfillment of every person's human rights will create more resilient communities and hate will have less opportunity to thrive.

When creating law, policy and services that support human rights and combat discriminatory stereotypes, people with lived and living experience of mental health and substance use-related disabilities and people who have experienced homelessness must be part of the design, delivery and evaluation.[16] Their leadership and expertise is crucial to ensuring that we are truly "helping" and not simply reinforcing entrenched power imbalances.

(2) Ensure that governmental public engagement processes do not become a platform that legitimizes hate and discriminatory stereotypes about people with mental health or substance use-related disabilities and/or who experience homelessness. Many of the examples of hateful rhetoric included in this submission relate to governmental community engagement processes that essentially allow people with relative power to express who they think should be welcome in communities and where people experiencing systemic marginalization should be allowed to exist.

These processes often share general information about the disabilities or social condition of the people in need of a service, and then lend official legitimacy to hate incidents in the form of discriminatory comments that dehumanize people with mental health or substance use-related disabilities or who experience homelessness. There is often no counter education or attempt to prevent or limit the harm inflicted by these processes, particularly related to mental health and substance use-related disabilities.[17]

(3) Elected and public officials must proactively and aggressively rebut the deeply entrenched, discriminatory stereotypes about people with mental health or substance use-related disabilities and/or who experience homelessness.

Constituents may locate the problem in the people experiencing marginalization when expressing concerns about the impacts of inequities in their communities. For example, they may express concerns about the burden on their health and policing systems. However, elected and public officials must reframe these issues to focus on the systems that cause the inequities in the first place in order to actively combat locating the problem in the individuals. For example, instead of talking about people experiencing marginalization as burdens on services, which reinforces longstanding, discriminatory stereotypes, they can talk about the impacts of inequity on the rights of the person. They can reinforce that every person has the right to live with dignity, and it is barriers in our current systems that create inequities.

(4) There must be a system of accountability and education for elected and public officials who make intentional or unintentional comments that dehumanize people with mental health or substance use-related disabilities and/or who experience homelessness.

SOURCES

[1] See for example Daphne Braham, "Hundreds with mental illness are falling through the gaps" *Vancouver Sun* (7 February 2021). However, a tracking study was conducted over a two-year period following its closure found that nobody discharged from Riverview during its contemporary closure period ended up homeless: Alain Lesage, David Groden, Patrick Ohana & Elliot Goldner, *Seven Oaks and South Hills projects: Year 2 assessment report* (Vancouver and Montreal: Riverview Hospital and Louis-H. Lafontaine Hospital 2006).

[2] See for example Editorial, "No easy solutions to the mental health crisis" *Victoria Times Colonist* (26 November 2021). However, the current procedure for involuntary treatment, and widespread facility non-compliance, was recently documented by the Office of the BC Ombudsperson, *Ombudsperson's Special Report No. 42, Committed to Change: Protecting the Rights of Involuntary Patients under the Mental Health Act* (March 2019).

[3] See for example Kevin Falcon, "Misguided policies are undermining the quality of life in urban centres" *Vancouver Sun* (17 January 2021). However, it is problematic to make generalized assumptions about legal capacity in relation to any specific disability or diagnosis. Capacity assessments must be individualized and decision specific.

[4] Emily K. Jenkins at al, "A portrait of the early and differential mental health impacts of the COVID-19 pandemic in Canada: Findings from the first wave of a nationally representative cross-sectional survey" Preventative Medicine Volume 125 (April 2021).

[5] BC Coroners Service, "Illicit Drug Toxicity Deaths in BC January 1, 2012 – January 31, 2022" (11 March 2022).

[6] *Prince George (City) v Stewart*, 2021 BCSC 2089 at para 78.

[7] Office of the United Nations High Commissioner for Human Rights, *COVID-19 and the Rights of Persons with Disabilities: Guidance* (29 April 2020).

[8] For example, see quotes related to Prince George, Hope, and Central Saanich on pages 4 and 5.

[9] See note 4.

[10] The Homelessness Services Association of BC, *2020/21 Report on Homeless Counts in B.C.* (2021).

[11] Susan Boyd, Connie I Carter, and Donald MacPherson, *More Harm Than Good: Drug Policy in Canada* (Fernwood Publishing, 2016) at 17.

[12] Marta Burczycka, "Violent victimization of Canadians with mental health-related disabilities, 2014", Statistics Canada (18 October 2018).

[13] Report of the Royal Commission on Mental Hygiene (28 February 1927).

[14] Talila A. Lewis, "Working Definition of Abelism" (1 January 2021).

[15] Terry Teegee, "Municipalities in B.C. seem blinded to their responsibility to be good-faith partners in reconciliation" Vancouver Sun (16 March 2022).

[16] World Health Organization, *Guidance on Community Mental Health Services: Promoting Person-Centred and Rights-Based Approaches* (2021) at 9. Also see Committee on Economic, Social and Cultural Rights, General Comment 14, which requires participation as part of the right to an equal opportunity at the highest attainable standard of health.

[17] For example, BC Housing presents online forums for engagement related to housing developments. The forum etiquette and moderations policy prohibits posting any content "that could be considered intolerant of a person's race, culture, appearance, gender, sexual preference, religion or age." It does not prohibit discrimination or hate on the basis of disability or social condition: https://letstalkhousingbc.ca/moderation.