Health

Exploring the Relevancy of Narrative in Forging Anti-Oppressive Mental Health Policy

Abiola Sulaiman

This paper will explore the intersectionality of mental health disability among the homeless and incarcerated populations. It aims to provide support for the view that a lack of comprehensive, patient-centered recovery methods accounts for why persons with mental health disabilities (PWMHD) fall out of care settings and into patterns of criminal non-violence based recidivism. To illustrate significant points, this study will apply firsthand narratives extracted from existing participatory research literature on the experiences of consumer-survivors in both the medical and social mental health care systems. A key focus here is mental health care integration concerning access to, and quality of, community care resources along the mental health care continuum. This paper seeks to answer why certain persons fall through the gaps within the health system.

Introduction

Studying the nature of mental health disability and substance abuse within any particular demographic requires a framework of the social determinants of health model (hereinafter referred to as “the model”). The model applies a qualitative, comparative, and highly analytical approach to health policy analysis and supports consumer-survivor narratives, especially narratives of those in the criminal justice system and homeless populations. In doing so, provides a critical breakdown of an individual’s socioeconomic circumstances and how these relate to health outcomes. This model probes farther than the dominant health care approach of “biomedicalism” by taking advantage of the “permeability of boundaries” it has created (Ogden, 1997).

Biomedicalism has been referred to in health care literature as “mechanistic”
in its approach to disability, as it works to isolate the “diseased” body part and attributes medicine as the ultimate cure. In creating a split between the normal and the abnormal, and in placing significant emphasis on risk behaviours, this framework unintentionally promotes an ableist mentality in diagnosis and cure (Davis, 1999). However, biomedical research has spearheaded many advancements in the health care field, including various advancements in organ transplants, and the system’s ability to defend against new and potentially deadly disease outbreaks.

The predominant critique of this approach is that it stops short of addressing the various meso and macro factors that ultimately impact health and well-being (such as housing conditions, community safety, availability of jobs, and etc.). Due to the dominance and influence of the biomedical perspective on health discourse, policy tends to be limited by this approach. In contrast, the model of social epidemiology takes one step further, building upon the former to illustrate that vulnerable populations (such as homeless and incarcerated persons) do not have the same resources available to them to engage in active lifestyles, or to afford daily recommended intakes of food or even medicine. This paper will argue that social epidemiology should be the dominant narrative for policy-makers in the health policy arena, as it aims to analyze the health care system through the perspectives of those most affected by social inequalities.

**Focusing on the Narratives of Homeless and Incarcerated Persons**

Mad, insane, lunatic, deranged, abnormal, unhinged, aberrant, unbalanced, diseased, unsound, batty, cracked, cuckoo or just simply crazy. These are hardly empowering or affirming words, yet this language and imagery are still often associated with a distinct oppressed minority who have very poor or no permanent housing (Forchuk, Csiernik & Jensen, 2011).

The language used in the above quotation is disparaging, yet common. This stigmatization is an underlying reason for why homeless and incarcerated persons are generally an afterthought within the dialogue of health policy reform. To get a better sense of health trends and realities, these vulnerable populations should be priority focus groups, as comprehensiveness and organized delivery systems in health care have never been more popular topics in Canada. Homeless and incarcerated persons make up two of the least socially integrated subgroups of the Canadian population, and
face comparatively high mortality rates stemming in large part from unattended mental health disabilities and substance abuse issues. As it is beyond the scope of this paper to address the varying levels and forms, of mental health disability, mental health will be discussed in more general terms. It will being by defining what it means to be incarcerated or homeless in Canada, so as to move beyond the unfounded myths associated with these two groups and to identify intersectionalities between them.

**Homelessness and Mental Health**

I don’t know because I can’t really feel safe because I’m out here in this world...You can’t really feel safe because you don’t know what’s going to happen next. You don’t know if this drunk is going to come up and punch you in the face for no reason just because he’s drunk or if this guy’s going to start something with you, and you cant really feel safe there (Haldenby, Berman & Forchuk, 2011).

The Canadian Homeless Research Network’s (CHRN) definition of homelessness pertains to those persons without access to affordable “stable, permanent, appropriate housing.” These individuals have an increased likelihood of developing physical, emotional, and mental disabilities (CHRN, 2012). Lacking shelter, homeless persons are often exposed to volatile weather, violence, and inadequate sleeping spaces. While there are no reliable national figures on homelessness in Canada, upwards of 30,000 individulas rely on shelters every day in the city of Toronto alone (Institute for the Prevention of Crime). Men dominate the inherent gender demographics, although homelessness among women is on the rise.

The common definition of homeless persons extends beyond the living destitute — those sleeping on the streets — to include those individuals who have shelter, but who are unable to afford their current living arrangements. It is unsurprising that an increasingly number of Canadians find themselves among what social policy researchers have dubbed the “hidden homeless”, given that the costs of housing in Canada today can account for more than 50 per cent of net family income. The bulk of those affected tend to be recent immigrants to urban centre such as Toronto and Vancouver, where the costs of housing are particularly high (CHRN, 2012).

Gaetz et al. (2013) presents a four-group homelessness-typology as follows: unsheltered, emergency sheltered, provisionally accommodated, and at risk
of homelessness. Being visibly homeless or unsheltered can have significant impacts on physical health. Studies have shown that living and sleeping on the ground can lead to musculoskeletal deformations, and that it is also a risk factor for various other complex physical disabilities that lead to deterioration of the nervous system (Schofield, Forchuk, Jensen & Brown, 2011). This includes traumatic brain injuries, which affect approximately 53 per cent of homeless persons in Toronto, compared to 8 per cent of the general public (Canadian Broadcasting Corporation, 2008).

One way the social epidemiological model can explain how physical disability leads to mental health disability is through a consideration of daily stress. It should not be surprising that homeless persons are exposed to greater levels of stress than the general population as a result of the magnitude of socioeconomic deficits they face (Massoglia, 2008). For example, the daily inability to acquire basic food and shelter that can lead individuals to a dependency on coping mechanisms, such as alcohol or drugs. This in turn can lead to bouts of significant depression and even thoughts of suicide.

Though slightly better equipped in terms of basic needs, the “hidden” homeless are also exposed to a higher than average level of daily stress. Shelter facilities and other living arrangements in which the person-per-room, or per-unit, ratio is high (known as overcrowding) commonly produce unclean and unsafe living conditions. This in turn precipitates higher risk of communicable diseases such as tuberculosis, meningitis, and influenza (Schofield et al., 2011). Moreover, when children are subject to the aforementioned types of living arrangements, early growth and development problems can result from increased stress and depression.

Incarceration and Mental Health

My emotional state [after solitary confinement], I was very humiliated not being able to get out and exercise, my body was sore, but it is really humiliating, because you go to them visits and the people see you with chains and stuff on, it was like you are degraded.  
[ During the noncontact visits, were you able to communicate with your family? ]
Not really... because the phones are bugged and you don’t know if you are going to say the wrong thing (Kupers, 1999).

Relative to Canada’s homeless population, its population of incarcerated
persons offers an interesting dichotomy, as inmates are typically housed in individual cells and have access to a sufficient amount of food. However, like homeless persons, they face elevated physical and emotional stressors, and are thus susceptible to declining health. Numerous studies have correlated severe and chronic stress to incarceration. The cumulative toll on the human body from an elevated use of physiologic systems, commonly incurred by a prison workload, has been shown to lead to a severe weakening of the immune system (Massoglia, 2008). This, coupled with a lack of emotional support, leads to a greater risk of physical and mental health disabilities.

Incarceration rates in Canada have trended upward since 2006 and the country’s prison population is now larger than ever, despite a steadily decreasing over the past two decades (Brosnahan, 2013). In 2010, there were approximately 163,000 Canadian adults imprisoned in Canada on any given day (Dauvergne, 2013). Every one of those individuals are faced with an environment that threatening to precipitate mental health and physical health disabilities, even in those who had no record of such disabilities at the time of their incarceration. Solitary confinement in particular is a major concern of mental health policy analysts, as represented by the above quote. While the lack of adequate health care within Canada’s prisons is often a subject of public and media concern, policy-makers must first look at addressing those factors within the prison system that have been shown to lead to the development of both physical and mental health issues.

A recent study in the United States observed that, of country’s 7.3 million incarcerated adults in 2007, approximately 2.1 million suffered from a severe mental health disability. The most common disabilities included bipolar disorders, schizophrenia, and various psychotic disorders (PEW Center, 2009). Many, including those critical of Canada’s recent “tough-on-crime” sentencing policies for drug offenders, contend that incarcerating those persons in need of mental health care paints the prison system as a “dumping ground” for the mentally disabled. Even as incarceration rates of PWMHDs grow, the resources of care continue to be lacking, preventing prisoners from being assessed upon intake.

In an interview with a Pelican Bay State Prison inmate, Kupers (1999) had the inmate recounted his medical history and any altercations he had as a PWMHD in prison. During his sentence, the inmate had attempted suicide on multiple occasions, partly due to a lack of resources to address his mental health needs. Although he had been scheduled to meet with a psychiatrist,
those appointments had not been kept. Kupers recounts the inmate’s near-death experience, observing that in one occasion, his mind drifted so far from the situation at hand that he missed a yell from a guard with a rifle to get down and was very nearly shot (Kupers, 1999).

The Continuum of Access to Mental Health Care Services

During a period of deinstitutionalization in the 1960s, the government of Ontario relocated homeless persons and PWMHDs who had been forced into psychiatric hospitals into non-profit, community-based supportive housing. The province made a deliberate shift from assuming custody and care of PWMHDs to the idea of delivering personal well-being through community settings; it also aimed to allow homeless persons to rehabilitate more quickly and effectively. These community settings ranged in terms of both quality and level of support. Mainstay Housing, for example, provided supportive housing as well as the chance at rehabilitation and reintegration well into the mid-1990s, creating more than 800 units of supportive housing (Mainstay Housing, 2011).

Despite the laudable aims of the Ontario government, significant concerns emerged, most notably regarding freedom of choice over residential setting and housemates. Relocation would often occur when the organization — and not necessarily the person — felt it to be necessary, and some group-based settings were small-scale and isolated, defeating the purpose of community integration. These issues stemmed from placing too much emphasis on the role of supportive housing, rather than incorporating the perspective of the affected individuals. Nelson et al., (2001) outline three key principles that sets supportive housing apart and ensures an effective continuum of service access: 1) choice and control over living arrangements must consult and the person affected; 2) there must be an emphasis on community integration; and 3) the person must be financially and socially supported to keep their choice housing. None of these principles were effectively implemented or enforced in Ontario.

A Case Study

As noted above, Nelson et al. (2011) have outlined three key principles for the successful integration of homeless and incarcerated persons into the design of policies directly affecting them. This paper suggests a fourth principle in order to ensure that these individuals have sufficient and
consistent access to comprehensive services: that there be an open
dialogue between the policy makers, administrators, and Canada’s homeless
and incarcerated populations. This is particularlry pertinent for individuals with
acute mental health disabilities, as PWMHDs require an external source to
monitor rehabilitation and accountability. One case study by Owczarzak et al
(2013) addresses the importance of this fourth principle in an interview with
“Dave,” who over the course of his adult life dealt with re-incarceration and
moving from shelter to shelter while coping with a mental health disability. At
the time of the interview, “Dave” was living in a supportive housing unit and
has been assigned a case manager. He expressed that the relationship with
his case manager was limited to filing paperwork.

I mean, I still kept in touch talking to her, asking her how she was
doing, and she would ask me how I was doing and stuff like that.
But, that was really it. It wasn’t like an every week thing. I would see
– I would talk to her, like we would talk mostly when they had events
– stuff like picnics… We didn’t talk much. There wasn’t much to talk
about really… I told her earlier that I was homeless, and, you know,
I worked and I was on drugs and stuff like that. I was slowing up
then. I was on my way away from drugs then. (Kupers, 1999).

Too often a reality, this type of detached relationship between Dave and the
case manager defeats the purpose of integrated care. In Dave’s case, casual
visits from his case manager may have helped to ensure that an
appropriate regimen was being followed, and would have delivered key
emotional support. In a study on the types of anchors needed for supportive
housing conducted by Nelson et al. (2001), 70 per cent of respondents with
mental health disabilities said 24-hour access to staff by telephone was a
priority, while 12 per cent expressed a need for greater assistance in
managing medications. While autonomy is important to recovery, the
continuum of access is broken when the four key principles of supportive
living outlined herein are not met.

Policy Recommendations

PWMHDs are over-represented within both the homeless and prison
communities in Canada, and access to necessary mental health care
services is a major concern. Recent statistics have observed that only six per
cent of the Canadian prison population receive outpatient services, which
include addiction rehabilitation and therapy (Sapers, 2011). Too often, mental
health disabilities are ignored. As this paper has noted, the intersectionality of mental health disabilities, homelessness, and incarceration are well documented, and there is a growing need for them to be addressed. Three broad policy recommendations stemming from issues pertaining to access to key services and social supports are herein presented to better manage, and perhaps reduce the number of PWMHDs in Canada.

1. Increase Subsidies for Supportive Housing

Supportive housing aims to promote affordable and independent living for vulnerable populations while delivering the various support services that make that independence a possibility. Housing choice should be respected, and quality of living space should not range so widely that those in under subsidized supportive housing units are subject to below average living conditions. Increased government subsidies will be required to ensure consistency of -- transitional housing. While this represents a significant cost to the public purse, federal, provincial and municipal governments must consider the savings that will be gained from a reduced reliance on emergency shelters, incarceration rates, and health care services such as emergency room visits.

2. Establish National Guidelines for Integrated Community Care

In the provision of supportive services for homeless and incarcerated persons, it should be guaranteed that these services are comprehensive. Comprehensiveness speaks to the blend of social and health services available, as well as the depth of each service provided. Building on the theme of preferences, as in any community, the surrounding area of an integrated care system should feature amenities such as accessible transportation, access to grocery stores, other shopping areas, and access to family, for example. By establishing national guidelines for integrated community care, Canada could ensure that these vital services accompany basic mental health services.

3. Encourage Advocacy Efforts Among PWMHDs

Public perceptions of homeless and incarcerated PWMHDs are often disparaging. Moving forward, policy aimed at addressed social and health service integration for these populations should be guided by community-based research, with case managers and PWMHDs as principle
sources of information. For real social reform to occur, first-hand must drive the discourse in reform efforts. For this to work, the empowerment of the marginalized is essential. Governments should work to build platforms for discussion and decision-making that are open to, and focus on, PWMHDs.

Conclusion

Mental health disability is more prevalent among Canada’s homeless and incarcerated populations due primarily to the deficits inherent in their social, cultural, and economic circumstances. A shift in policy towards an integrated, recovery-based care model for PWMHD, supported by social epidemiology, is needed. This will required policy-makers to engage in decision-making with those affected, and with the guidance of participatory research featuring psychiatric and institutional survivors of these circumstances. This would legitimize the process of care and lead to insights that biomedicalism alone cannot encompass. The importance of narratives in forging mental health policy is quite clear: only after engaging in informed discussion with those who have had first-hand experience can policy-makers truly identify systemic issues, and effectively guide social re-integration.

Abiola Sulaiman is a 2016 Master of Public Policy Candidate at the School of Public Policy and Governance, University of Toronto. He previously completed a Bachelor of Health Studies at York University, specializing in health policy analysis and the social determinants of health. Abiola continues to focus on issues surrounding health care policy in Canada, but also has interests in areas of international relations, immigration, and urban policy.
References


