

SOCIAL INCLUSION:

The key determinant of mental wellness



LITERATURE REVIEW

OCTOBER 2019

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October 2019

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We would like to acknowledge the Law Foundation of BC for funding this work.

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Information is current as of October 2019.



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Mental health for all



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The CMHA BC office is located on the traditional, unceded lands of the xʷməθkʷəy̓əm (Musqueam), Skwxwú7mesh (Squamish) and sə̓lilwətaʔt (Tseil-Waututh) Nations

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INTRODUCTION

There has been consensus in the public health community for some time that income, housing, food security, employment and social inclusion all have a role to play in determining health outcomes for individuals. But what is not yet fully understood is how each determinant influences and intersects with the others and how each determinant impacts mental health differently than physical health. While no definitive answer has been proposed, the literature reveals a single, consistent theme in connection to mental health and substance use. At the core of mental well-being and healthy relationships with substances is **social inclusion**.

The ways people experience social exclusion in their day-to-day lives is multi-layered and complex. At the societal level, people who are assigned lower status because of their relative poverty face recurrent social evaluation that places pressure on them to prove their self-worth and position in the social hierarchy. While the wealthy can rely on signifiers of high status such as well-paying jobs and luxury consumer goods, people who are economically disadvantaged are called upon to prove their worth at every turn and experience the exclusionary practice of being looked down upon or dismissed as less than. More income equality means fewer people can claim the status of wealth and a higher percentage of the population is vulnerable to social evaluation anxieties and the threat of social rejection.

In addition to where an individual ranks in the social hierarchy, financial resources determine the extent to which they are able to participate in their community and support basic social interaction. People whose incomes hover at the poverty line may find themselves with little to no discretionary money for time out with friends, bus fare for social outings or the pursuit of hobbies. This exclusion from social, cultural and recreational activities enforces isolation and inhibits an individual's ability to foster meaningful relationships and cultivate a sense of belonging, which are protective for mental health.

Isolation is oftentimes worsened by a struggle to meet basic needs. People whose incomes are insufficient to secure housing, food and other necessities are caught in a downward spiral of deprivation, whereby the loss of income or employment leads to a loss of housing and a lack of food that leads to marginalization and difficulty accessing social and health services. The chronic stress of not knowing where or how to procure the basics for survival not only takes up a person's energy and deprioritizes social connection, but also increases their

vulnerability to chronic mental health and substance use-related illness. If and when a person does access services, they are often called upon to ask for help repeatedly, go through rigorous application procedures and be turned away multiple times. This process of iterant help seeking followed by rejection reinforces the concept that people who have little to no income and who are not self-sufficient are in some way less valuable.

The final layer of social exclusion is stigma and discrimination. People who are identified as different and devalued because of their race, gender, sexual orientation and/or ability encounter additional barriers to inclusion from prejudicial views in daily social interactions to systemic practices and policies that function to exclude and reject them from receiving the same treatment, accessing the same services or having the same opportunities as others.

Mental wellness depends on community and connection to others. All the social determinants of mental health from socioeconomic status to housing to employment to discrimination operate in relation to multiple layers of social inclusion. Whether or not a person can meet their basic needs, cultivate friendships, secure a sense of place within a community and maintain a correspondingly stable position in the social hierarchy determines their vulnerability to anxiety, depression and problematic substance use. Recovery potential of people living with mental illness or problematic substance use is deeply impacted by the barriers they face obtaining and maintaining the resources and relationships necessary for social inclusion. The discussion that follows will endeavour to outline the current literature on the social determinants of mental health and demonstrate why creating conditions for meaningful social inclusion is the single, most effective means for supporting mental wellbeing.

METHODOLOGY

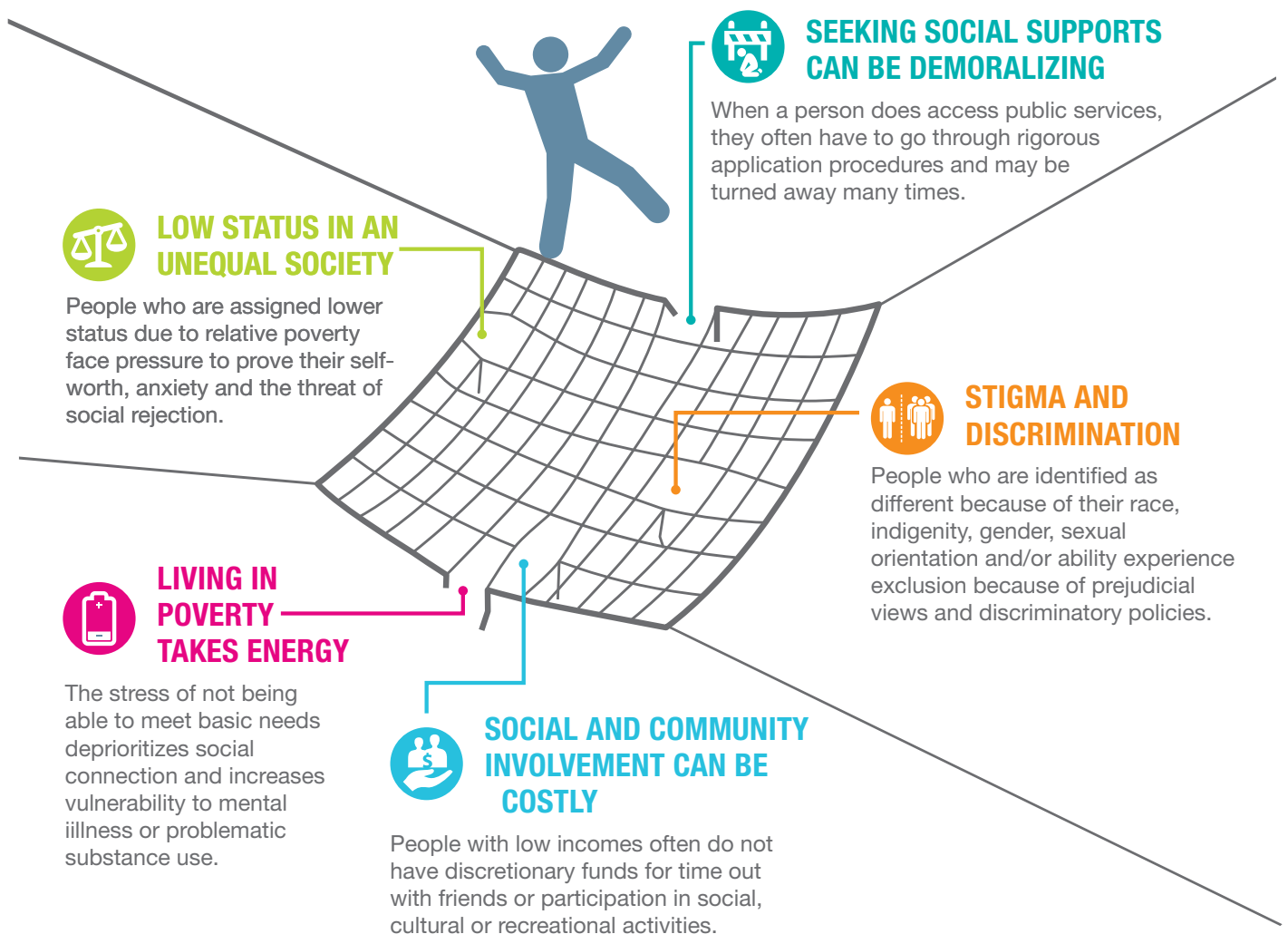
The research process was initiated in July 2018 and proceeded from a high-level investigation of social determinants of mental health and substance to a detailed analysis of specific determinants. The literature search was conducted by entering keywords such as social determinants, health inequities, poverty, income, among others into several databases (e.g., Lancet, PubMed, Jstor, Project Muse, Google Scholar). All articles, books or reports with a publication date between 1980-2019

pertaining to mental health, mental illness, substance use and addiction were included. Additionally grey literature was sourced from federal and provincial government websites and Canadian mental health organizations (e.g., Mental Health Commission of Canada, Centre

for Addiction and Mental Health, Canadian Institute of Substance Use Research, Canadian Centre on Substance Use and Addiction). This process generated 93 articles, books and reports, many specifically addressing the socio-economic conditions British Columbians face.

The literature on the social determinants of health reveals a single, consistent theme in connection to mental health and substance use: social inclusion.

Whether or not a person can meet their basic needs, cultivate friendships, secure a sense of place within a community and maintain a stable position in the social hierarchy determine their vulnerability to anxiety, depression and problem substance use. Recovery potential of people living with mental illness or addiction is deeply impacted by the barriers they face obtaining and maintaining the resources and relationships necessary for social inclusion.



PART I: THE EXPERIENCE OF LOW STATUS

IN AN UNEQUAL SOCIETY

Recent and growing evidence shows that mental health and many common mental disorders are shaped to a great extent by social, economic and physical environments across the life span.¹ Risk factors for many common mental disorders are heavily associated with social inequalities, whereby the greater the inequality, the higher the inequality in risk. A review of global evidence by Vikram Patel and colleagues for the WHO Commission on Social Determinants of Health reports that low socioeconomic position is systematically associated with increased rates of depression and anxiety disorders.² This increased prevalence correlates to socioeconomic status such that middle-income citizens are at a greater risk than high-income citizens and low-income citizens are at the greatest risk of all. The implication is that relative poverty and not absolute poverty is a key determinant of mental health.³

Richard Wilkinson and Kate Pickett take the correlation between income and mental health a step further. Their epidemiological study of health and social problems, *The Spirit Level*, makes the case that income inequality is a causative factor for increased rates of depression and anxiety when situated within our shifting paradigm of social relations. Referencing population-level data published by the World Health Organization,⁴ Wilkinson and Pickett explain the dramatic increase in mental health problems in high income countries by correlating “insecure narcissism” to widespread experiences of chronic stress. More and more people report a false sense of self-esteem that manifests as an all-consuming preoccupation with one’s own identity and how others perceive them in response to iterative “social evaluative threats” or incidences where they feel their worth and value is being judged by others.⁵

The psychological impact of near constant evaluation is validated by Sally Dickerson and Margaret Kemeny, who after collecting findings from over 208 published reports, documenting people’s cortisol levels in response to environmental stressors, found that “threats to self-esteem or social status, in which others could negatively judge performance, particularly when the outcome of the performance was uncontrollable, provoked larger and more reliable cortisol changes than stressors without these particular threats.”⁶ This psychosocial correlation corroborates a similar biomedical body of research that demonstrates a causative relationship between physiological indicators of chronic stress and increased rates of chronic illness that includes mental health and substance use problems.⁷

Wilkinson and Pickett go on to situate this modern predicament within our social milieu, suggesting that our disconnected, digital society precipitated our preoccupation with self. People are moving away from the community in which they are born, having minimal interaction with their neighbors, peers and colleagues and maintaining personal relationships online at the expense of a coherent, stable identity. Historically a person’s sense of self was embedded in a community and confirmed by people’s real knowledge of each other; whereas now a growing majority of us are anonymous in mass society. As a result, Wilkinson and Pickett argue, who we are—identity itself—is endlessly open to question and our modern psychological condition has adapted to be a constant, anxiety-producing fixation with social evaluations and judgements.

But not everyone is equally effected by this modern social condition. Our vulnerability is directly correlated to our position in the social hierarchy. People of higher

- 1 World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*; Allen, J., Balfour, R., Bell, R. & Marmot, M. (2014). Social determinants of mental health. *International Review of Psychiatry*, 26(4): 392-407.
- 2 Patel V, Lund C, Hatheril S, Plagerson S, Corrigan J, Funk M, et al. (2010). *Mental disorders: equity and social determinants*. World Health Organization: 115-34.
- 3 Compton, M.T. & Shim, S.S. (2015). The Social Determinants of Mental Health. *Focus*, 13(4): 419-425; Fisher, M. & Baum, F. (2010). The social determinants of mental health: implications for research and health promotion. *Australian and New Zealand Journal of Psychiatry*.
- 4 Kessler, R.C. et al. (2004). Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. *Journal of American Medical Association*, 291(21): 2581-2590.
- 5 Wilkinson, R. & Pickett, K. (2010). How inequality gets under the skin. *The Spirit Level: Why Equality is Better for Everyone* (pp. 31-45). London, England: Penguin Books.
- 6 Dickerson, S.S. & Kemeny M.E. (2004). Acute stressors and cortisol responses: a theoretical integration and synthesis of laboratory research. *Psychological Bulletin*, 130(3): 355-91.
- 7 Taylor, S. E. (2010). *Mechanisms linking early life stress to adult health outcomes*. Proceedings of the National Academy of Science of the United States, 107(19):8507-12.

status carry connotations of being better, superior, more successful and more able and can comfortably rely on displays of wealth to reaffirm their own identity and other's perceptions of their value. People who are economically disadvantaged are more regularly called upon to demonstrate their worth and win other's esteem. In consequence, greater income inequality between rich and poor, whereby fewer people can claim the status of wealth, equates to a higher percentage of the population who are vulnerable to social evaluation anxieties and depression.⁸

There are exceptions, of course, some high-income citizens may feel inadequate, while other low-income citizens are full of confidence and self-assurance. In addition to low social status, lack of friends and stress in early life have been shown to be seriously detrimental to mental health and longevity.⁹ Both factors are inherently social and affect the extent to which we are able to cultivate and maintain positive relationships. Insecurities from early experiences of trauma or parental neglect have similarities to the insecurities that can come from low social status;¹⁰ whereas, friendship has a protective effect in that friends reaffirm our sense of worth and value, bolster our self-esteem and confirm that we possess positive attributes.¹¹

Unsurprisingly a much higher percentage of the population suffer from mental illness in more unequal countries. The proportion of mental illness in Canada is one in five people each year and stands in close comparison to other unequal countries such as United States where more than one in four people are affected. Data from WHO surveys indicates that sub-types of mental illness such as anxiety disorders, impulse-control disorders and severe illness have the strongest links to inequality. Similarly the use of illegal drugs such as cocaine and heroin is more common in more unequal societies.¹²

The distribution of prevalence rates in Canada aligns with the correlations drawn out in the research. Income inequality is contained within larger urban centers, where over 80% of the population resides. Montreal, Toronto, Calgary and Vancouver include almost all of the country's very rich and very poor citizens¹³ and the vast majority of people receiving services for mental health or substance use problems. BC's rate of service usage is 167 per 1000 population, with a range from 39 per 1000 population in rural districts to over 200 per 1000 population in densely populated urban areas such as Vancouver's Downtown Eastside. The highest concentrations of people living with poor mental health are found in BC's lowest income neighborhoods. Overall 800, 000 people or 17% percent of the population are affected, with the vast majority reporting anxiety (30%) and depression (50%) and many possessing multiple diagnoses that include personality, psychotic and bipolar disorders, as well as trauma, substance use and self-harm-related conditions.¹⁴

8 Wilkinson, R. & Pickett, K. (2010). Mental Health and Drug Use. *The Spirit Level: Why Equality is Better for Everyone* (pp. 63-72). London, England: Penguin Books.

9 Yang, Y.C., et al. (2016). Social relationships and physiological determinants of longevity across the human life span. *Proceedings of the National Academy of Sciences*, 113:578;

10 Mock, S.E. & Arai, S.M. (2010). Childhood Trauma and Chronic Illness in Adulthood: Mental Health and Socioeconomic Status as Explanatory Factors and Buffers. *Frontiers in Psychology*, 1: 246.

11 Thoits, P.A. (2011). Mechanisms linking social ties and support to physical and mental health. *Journal of Health and Social Behavior*, 52:145.

12 Wilkinson, R. & Pickett, K. (2010). Mental Health and Drug Use. *The Spirit Level: Why Equality is Better for Everyone* (pp. 63-72). London, England: Penguin Books.

13 Fong, F. (2017). Income Inequality in Canada: The Urban Gap. *Chartered Professional Accountants Canada*; Please note that census data does not include Indigenous people who live on-reserve. The statistics stated here do not account for this particular population.

14 BC Ministry of Health. (2016). Establishing a System of Care for People Experiencing Mental Health and Substance Use Issues. *Unpublished draft*.

PART II: THE DENIAL OF SOCIAL CONNECTION

AND ECONOMIC EXCLUSION

While income inequality is a strong predictor of prevalence rates of mental illness and harmful substance use, modern life in a low-income bracket is characterized by more than a constant fear and experience of social judgement and censure. The realities of living without social esteem and financial resources contribute to experiences of chronic stress due to the sheer difficulty of maintaining an adequate standard of living. Poverty, homelessness, unemployment and food insecurity keep people at the margins of society through the denial of social goods and economic exclusion. Many people report how poverty is self-reinforcing. The loss of employment results in loss of income and housing.¹⁵ Homelessness—oftentimes reduced to the administrative detail of not having an address—can mean people are turned away at food banks,¹⁶ unable to fill out applications for government assistance or attend job interviews and denied participation in civic activities.¹⁷ The actual experience of homelessness is worse still. People who have unstable or insecure housing or no housing struggle to keep warm, find food, access health services, attain employment and maintain connection to others, oftentimes losing all sense of place and community. The paradox of needing stable housing to find a job or apply for income assistance and a regular income to obtain housing often keeps people from breaking out of the cycle of social deprivation and exclusion, which increases their risk of developing mental health and substance use-related health problems.¹⁸

INCOME: THE KEY THAT UNLOCKS THE DOOR TO SOCIAL INCLUSION

Income is often considered the most important social determinant of health since it shapes overall living conditions, affects psychological functioning and influences health-related behaviors such as diet, physical activity and substance use. In *Social Determinants of*

Health: The Canadian Facts, Juha Mikkonen and Dennis Raphael argue that income is the determinant of the other determinants of health and gains importance as the accessibility of social services and benefits decreases. In Canada, where necessary supports such as childcare, housing and resources for retirement are bought and paid for by individuals, low income predisposes people to material and social deprivation. The greater the deprivation, the less likely individuals and families are able to afford the basic prerequisites of health and to experience social inclusion. The simple fact of not having bus fare or a couple extra dollars for a cup of coffee, never mind discretionary funds for meals out or hobbies, entails that participation in cultural, educational and recreational activities is near impossible for people living in poverty. This fiscally imposed isolation lessens an individual's ability to find meaning in their daily lives, foster relationships and exert control over their own life circumstances.

What is more, Mikkonen and Raphael suggest that people may feel shame, insecure and worthless on the basis of their living conditions and perceive everyday life as unpredictable, uncontrollable and meaningless. The authors then attribute increased anxiety and hopelessness to high levels of exhaustion and uncertainty about the future,¹⁹ which supports Wilkinson and Pickett's observations about the strong correlation between income inequality and increased prevalence of mental illness and problematic substance use.

An exception to the inverse relationship between income and mental health and substance use-related illness is what researchers have called “the alcohol harm paradox.” People of higher socio-economic status (SES) consume similar or greater amounts of alcohol than people of lower SES, but people of lower SES bear a disproportionate burden of alcohol harm.²⁰ Recent data from the Canadian Institute for Health

15 Government of British Columbia (2018). What We Heard About Poverty in B.C. Retrieved from: https://engage.gov.bc.ca/app/uploads/sites/242/2018/07/WWH_Report-PovertyReductionStrategy_FINAL.pdf.

16 Pivot Legal Society. (2019). Project Inclusion: Confronting anti-homeless and anti-substance user stigma in British Columbia. Retrieved from: http://www.pivotlegal.org/project_inclusion_service_gaps_and_barriers.

17 Carnegie Community Action Project. (2018). *No Pill for this Ill: Our Community Vision for Mental Health*.

18 Dunn, J. et. al. (2006). Housing as a Socio-economic Determinant of Health: Findings of a National Needs, Gaps and Opportunities Assessment. *Canadian Journal of Public Health*, 97(3): 11-15.

19 Mikkonen, J. & Raphael, D. (2010). Social Determinants of Health: The Canadian Facts. *York University of School of Health Policy and Management*.

20 Collins, S. (2016) Associations between socioeconomic factors and alcohol outcomes. *Alcohol Research*.

Information provides evidence of this phenomenon in Canada. The highest rates of heavy drinking are observed among men in higher-income groups. The same yet less pronounced pattern is observed for women. But rates of hospitalizations for the lowest-income neighbourhoods is 2.5 times higher than for the highest-income neighbourhoods. British Columbia has the highest provincial rate for hospitalizations entirely caused by alcohol, ranging from 540 per 100, 000 in the lowest income bracket to 241 per 100, 000 in the highest.²¹ While many reasons for this have been proposed, consensus centers on greater susceptibility due to the confounding circumstances of living on a low income such as higher stress levels, fewer social support networks, fewer resources to cope and exposure to unsafe drinking settings.²² In other words, the life circumstances that create, reinforce and result from the social and economic exclusion of people who live in low-income neighbourhoods.

The lowest income neighbourhoods have the highest risk for multiple forms of harm. The suicide rate in the poorest neighborhoods has been found to be almost twice that seen in the wealthiest neighborhoods.²³ Violence has been established and accepted as an effect of inequality. The rate of violent victimization (which includes physical assault, sexual assault and robbery) for individuals from households in Canada's lowest income grouping is at least 1.5 times greater than the rate for any of the higher income groupings.²⁴ A significant portion of that violence takes place in the home. Research indicates that intimate partner violence and persistent poverty co-occur at high rates, produce parallel effects and constrain coping options for victims. Lisa Goodman et al. discuss the realities of living at the highly vulnerable intersection of poverty and partner violence and the profound costs this location has for women's mental health. Poverty not only contributes to and results from partner violence, but also creates conditions of stress, powerlessness and social isolation that can lead to post-traumatic stress disorder, depression and other emotional difficulties.²⁵

People who live in poverty experience high levels of physiological and psychological stress that arises from conditions of low income, and its counterparts, poor quality housing or homelessness, food insecurity, insufficient employment and various forms of discrimination based on race, indigeneity, gender, sexual orientation or ability. The following sections detail how each counterpart of poverty contributes to and reinforces the experience of social exclusion and its impacts on mental health and substance use.

INSECURE HOUSING AND HOMELESSNESS: A CONDITION OF BELONGING NOWHERE

The importance of a physical house to live within for health is clear, but secure housing requires more than a roof and four walls. Some components include affordability, stability of tenure, desirability and safety of location. James Dunn and colleagues situate housing "as a central locus of everyday life patterns [and]... a crucial component in the ways in which socio-economic factors shape health." A review of the literature by Dunn demonstrates that people who are unstably housed or homeless have a greater incidence of a range of health problems and a reduced life expectancy and that people who spend a disproportionate amount of their income on housing struggle to purchase other basic necessities and are more likely to experience social exclusion.²⁶

Affordable housing is often the most pressing issue for people living in poverty. In BC, high rents and low vacancy rates have widened income inequality and deepened poverty. People are spending more and more of their income to keep their homes and many of them are being pushed into low-income neighborhoods or onto the streets. The What we Heard report from BC's Poverty Reduction Consultations demonstrates that people across the province are impacted by high housing costs that limit their opportunities, force them to cut back on food, save on utilities and live more isolated lives.²⁷

21 Canadian Institute for Health Information. (2017). Alcohol Harm in Canada: Examining Hospitalizations Entirely Caused by Alcohol and Strategies to Reduce Alcohol Harm. *CIHI*.

22 Lewer, D., Meier, P., Beard, E., Boniface, S. & Kaner, E. (2016). Unravelling the alcohol harm paradox: A population-based study of social gradients across very heavy drinking thresholds. *BioMed Central Public Health*.

23 See note 19, Mikkonen and Raphael.

24 Statistics Canada. (2015 November 30). Canadians living in low-income households experience higher rates of violent victimization. <https://www150.statcan.gc.ca/>.

25 Goodman, L.A., Smyth, K.F. & Borges, A.M. & Singer, R. (2009). When Crises Collide: How Intimate Partner Violence and Poverty Intersect to Shape Women's Mental Health and Coping? *SAGE Publications*.

26 Dunn, J. et. al. (2006). Housing as a Socio-economic Determinant of Health: Findings of a National Needs, Gaps and Opportunities Assessment. *Canadian Journal of Public Health*, 97(3): 11-15.

27 See note 15, Government of British Columbia.

Poverty, housing insecurity and mental illness are often co-occurring conditions and mutually reinforce one another. Oftentimes it is not clear which came first. Mental illness, with its attendant stigma and discrimination, can lead to loss of employment, support networks and housing. Poverty and its association with prolonged, chronic stress and social exclusion can result in poor mental health. Regardless of whether mental illness or problematic substance use was a precipitating factor or a consequence of housing loss, a significant portion of the population who are unstably housed experience poor mental health. The Mental Health Commission of Canada (MHCC) reports that as many as 520, 700 people living with mental illness are inadequately housed and among them, as many as 119, 800 are homeless.²⁸

In the late 2000s, MHCC initiated At Home/Chez Soi to investigate the feasibility and efficacy of a large-scale Housing First intervention. The project took place in five sites across Canada and involved 2,285 participants of which 1,325 received the Housing First model of intervention. The final report not only confirms that Housing First rapidly ends homelessness, can be effectively implemented in diverse cities and constitutes a sound investment, but also demonstrates that having a place to live and the right supports can lead to other positive outcomes and change people's lives.

The acquisition of stable housing gave participants hope and confidence and provided opportunity for them to take on new social roles and make positive social contacts. Participants who had improving relationships with family or who connected with supportive communities tended toward positive life courses. Many changed their daily activities to include things like volunteering, working, attending school or becoming peer support workers, effectively inhabiting new social roles and expressing a positive social identity.²⁹

What Cross-Site At Home/Chez Soi Project illustrates is that housing is more than a physical building. Housing constitutes a home, with all its attendant meanings. A

platform for self-expression and identity. A place and position within a community. A foundation on which to build a life. This is why the United Nations' definition of homelessness recognizes social exclusion as central to a person's experience—“homelessness implies belonging nowhere rather than simply having nowhere to sleep”³⁰—and why the Special Rapporteur on adequate housing has underlined that not only should housing be physically and economically available, but that housing should support all people to effectively participate in the communities in which they live.³¹ The denial of safe, affordable housing is not merely the stripping away of four walls and a roof, it is systematic exclusion.

FOOD INSECURITY: NO SEAT AT THE TABLE

Food is an important determinant of mental health and human dignity. People who experience food insecurity are unable to have an adequate diet in terms of quality or quantity. Many are uncertain if they will be able to acquire food in socially acceptable ways.³² The consequence is that both physical and mental health suffer.

In BC, food insecurity is recognized as a key public health issue. There are approximately half a million people or 11.8% of the population who worries about or lacks the financial means to buy healthy, safe, personally acceptable foods. Adults who are food insecure are at an increased risk of chronic diseases, have greater difficulty managing their illness and are more likely to experience depression, distress and social isolation. Children and youth are more vulnerable to developing micronutrient deficiencies and being diagnosed with chronic conditions.³³

Researchers from The Centre for Addiction and Mental Health investigated the relationship between household food insecurity status over a 12-month period and adults' use of publicly funded health care services for mental health reasons in Ontario. Their study found that food insecure adults accounted for 37.9% of people admitted to hospital, 34.9% of those treated

28 Community Support and Research Unit, Centre for Problematic substance use and Mental Health and the Canadian Council on Social Development. (2010). *Turning the Key: Assessing Housing and Related Supports for Persons Living with Mental Health Problems and Illnesses*.

29 Goering, P. et al. (2014). National Final Report: Cross-site At Home/ Chez Soi Project. *Mental Health Commission of Canada*.

30 United Nations Human Rights Council, 2009.

31 United Nations General Assembly. (2018). Report of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context. *Human Rights Council, 37th session*.

32 See note 19, Mikkonen and Raphael.

33 Li, N., et. al. (2016). *Priority health equity indicators for British Columbia: Household food insecurity indicator report*. Provincial Health Services Authority and PROOF Food Insecurity Policy Research.

in emergency departments, 27.2% of those who saw psychiatrists and 20% of people who visited primary care doctors for mental health reasons. Food insecurity was a strong predictor of mental health service use, with high levels of food insecurity being associated with higher use of services.³⁴

The clear correlation between food insecurity and poor mental health necessitates a consideration of why so many people lack access to nutritious food. While low income and high housing costs can leave little funds for food, social deprivation is worsened by the failures of our social safety net. In their latest report on BC's service barriers, Pivot Legal Society brings to light the exclusion criteria of many food banks across the province. Some BC food banks require people to show a government-issued photo identification, a secondary form of identification, proof of address to show they live in the municipality in which the food bank is located and a proof of income such as a pay cheque or social assistance documentation.³⁵ The result is that people who are homeless or deeply impoverished and require the service the most are discriminated against and turned away. These people are not only left hungry; they are socially rejected. The exclusion criteria of food banks is a good example of how people without income or stable housing are kept at the margins of society and how each determinant of health is intricately related and dependent on each other.

People who are food insecure also face social exclusion on an interpersonal level. Food sharing and eating together is the basis for social affiliation and friendship. Wilkinson and Pickett contend that the simple act of sharing a meal carries the symbolic message of reciprocity, co-operation and a recognition of each other needs. This is true of food, above all other forms of gift exchange or supportive care, simply because it is the most fundamental of all material necessities.³⁶ The inability to provide and share food within familial and community settings places severe limits on a person's capacity to cultivate and sustain meaningful relationships. The self-reinforcing effects of poverty whereby low

income is coupled with insecure housing can heighten this experience of exclusion by depriving people of both the food to share and the place to eat.

UN/EMPLOYMENT: A RECOGNITION OF PRIDE AND PLACE

The effects of employment and unemployment on mental health and well-being has been extensively researched. The key findings are that employment provides income, a sense of identity and purpose, social contacts, a structure for day-to-day life and status and recognition for our efforts and achievements. Unemployment leads to material and social deprivation, psychological stress and a higher risk of adopting unhealthy coping behaviors such as harmful substance use.³⁷ People who are unemployed have a reduced life expectancy, experience more chronic health problems such as depression, anxiety and problematic substance use and have increased rates of suicide.³⁸

There is a middle ground of under-employment or economically inadequate employment between gainful employment and unemployment. This category includes involuntary part-time workers or low wage workers, who work as many hours as possible for a wage insufficient to meet the cost of living. In his analysis of this continuum of employment, David Dooley suggests that under-employment has only a limited number of the benefits of employment, but many of the disadvantages of unemployment. A person who is under-employed may have some wages, time structure, social purpose and status, but also experiences financial strain and, if part-time, partial loss of time structure, while enjoying fewer coping resources for periods of stress such as unemployment insurance, benefits and paid sick time. Moreover, a person's shift from full-employment to under-employment or acceptance of under-employment due to financial constraints may entail lower job satisfaction in regards relationships with co-workers and lower decision latitude.³⁹

34 Tarasuk, V., Cheng, J., Gundersen, C. de Oliveira, C. & Kurdyak, P. (2018). The Relation between Food Insecurity and Mental Health Care Service Utilization in Ontario. *The Canadian Journal of Psychiatry*, 63(8): 557-569.

35 Pivot Legal Society. (2019). Project Inclusion: Confronting anti-homeless and anti-substance user stigma in British Columbia. Retrieved from: http://www.pivotlegal.org/project_inclusion_service_gaps_and_barriers.

36 Wilkinson, R. & Pickett, K. (2010). Our Social Inheritance. *The Spirit Level: Why Equality is Better for Everyone* (pp. 197-216). London, England: Penguin Books.

37 Murphy, G.C. & Athanasou. (1999). The effect of unemployment on mental health. *Journal of Occupational and Organizational Psychology*, 72(1): 83-99.

38 Canadian Centre on Substance Abuse. (2014). Systems Approach: *Socioeconomic Determinants of Health*.

39 Dooley, D. (2003). Unemployment, Underemployment, and Mental Health: Conceptualizing Employment Status as a Continuum. *American Journal of Community Psychology*, 32(1/2): 9-19.

Research has shown that workers with low job satisfaction report mental health problems comparable to those who are unemployed.⁴⁰ This is attributed to a number of work dimensions that shape health outcomes such as employment security, physical conditions at work, work pace and stress, working hours, and opportunities for self-expression and individual development. High-stress jobs or jobs with an imbalance between demands and rewards predispose individuals to the development of physical and psychological difficulties such as depression and anxiety. Similarly increased mental health problems are seen among workers who experience high demands, but have little control over how to meet these demands.⁴¹

In some cases, however, some employment is better than no employment. People living with mental illness or problematic substance use may accrue benefits from employment irrespective of wage or status if participation in the workforce factors into their goals and aspirations for themselves. In a focus group led by CMHA BC, participants identified paid work as not only an important source of supplementary income, but also a valuable means for participating in community, building a sense of self-worth and confidence, and supporting their mental wellness.⁴² This reflects a body of research that highlights the integral role employment can play in psychosocial recovery. A review of the literature by Evans and Repper elucidates this positive correlation and concludes that while unemployment can incapacitate a person struggling with mental illness, work can “recapacitate” them by tackling their social exclusion and providing an income, status and social contacts. Enforced unemployment, whereby return to work is desired yet denied persons living with a mental illness, can further perpetuate stigma and worsen mental health outcomes by confirming the erroneous assumption that such people are incapable of work and should be kept from working.⁴³

Although not every person living with a mental illness or problematic substance use wants to work and those who have a Persons with Disabilities (PWD) designation are not expected to work. Over 50% of people with a PWD designation under the Employment and Assistance for Persons with Disabilities Act have a mental health or substance use-related diagnosis.⁴⁴ Many more are likely to be relying on social assistance and living in poverty. Income on basic social assistance is \$760 per month, for Persons with Persistent Multiple Barriers (PPMB) is \$807.92 per month and for PWD is \$1,183.42 per month.⁴⁵ The inadequacies of this system and its social implications was brought to the fore in BC’s poverty reduction consultations: “People spoke about the unfairness and the indignities of our assistance systems, and the ways they were treated as “less than” by people who had power over their lives.”⁴⁶ The complicated rules and application processes for obtaining welfare and the hierarchal bureaucracy of the Ministry deter people from applying or benefiting. The Carnegie Community Action Project reports that some people simply give up applying because they feel so ill-treated or run into insurmountable barriers. There are ongoing reports of lost files, people waiting in line for hours at time and not being allowed to consult with case workers about their circumstances. The consequence is that some people claim that dealing with welfare makes them “crazy” or at the very least keeps them entrenched in poverty.⁴⁷ The irony is that the system meant to lift people out of poverty and support them in times of adversity is perpetuating the social and material conditions that keep them impoverished and prevent them from becoming mentally well.

40 Butterworth, P., Leach, L.S., Strazdins, L., Olesen, S.C., Rodgers, B., & Broom, D.H. (2011). The psychosocial quality of work determines whether employment has benefits for mental health: results from a longitudinal national household panel survey. *Occupational Environmental Medicine*.

41 Lewchuk, W., de Wolff, A., King, A. & Polanyi, M. (2006). ‘The Hidden Costs of Precarious Employment: Health and the Employment Relationship.’ In Vosko, L.F. (ed), *Precarious Employment: Understanding Labour Market Insecurity in Canada* (pp. 141-162). Montreal: McGill-Queens University Press.

42 Canadian Mental Health Association BC Division. (2018). Helping make ends meet? Understanding the impacts of BC’s annualized earnings exemption on people living with mental illness.

43 Evans, J. & Repper, J. (2000). Employment, Social Inclusion and Mental Health. *Journal of Psychiatric and Mental Health Nursing*, 7: 15-24.

44 Data provided by the Ministry of Social Development and Poverty Reduction to the Supporting Increased Participation table.

45 BC Government. (2019). Income Assistance Rate Table (effective April 2019). Retrieved from: <https://www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/bc-employment-and-assistance-rate-tables/income-assistance-rate-table>.

46 See note 15, Government of British Columbia.

47 Carnegie Community Action Project. (2018). *No Pill for this Ill: Our Community Vision for Mental Health*.

PART III: STIGMA AND DISCRIMINATION

The onset of mental illness or problematic substance use is followed by additional barriers of stigma and discrimination. A review of the literature on mental illness-related structural stigma by James D. Livingston reveals that people with mental health disabilities often contend with arbitrary restrictions on their rights and opportunities. Inequities and injustices are manifest in policies and practices of most institutional systems and evident in everyday interactions between people who possess status or power over people who do not. As subjects of stigma, people living with mental illness have their identities engulfed, their relationships transformed and the directions of their lives shifted because they are marked with a stereotyped attribute that has been deemed socially unacceptable or deserving of condemnation. In practice this entails that such people are systematically excluded, rejected, shamed, and devalued, which produces a decline in social status and a worsening of physical and mental health outcomes.⁴⁸ Regardless of whether a mental illness or problematic substance use led to poverty or poverty and its association with chronic stress and low social status led to poor mental health and harmful coping behaviours, the conditions of material deprivation, isolation and social exclusion predispose someone for the entrenchment and perpetuation of both.

But if both poverty and mental illness reinforce one another and result in delimiting identities and social exclusion, what about further intersections with gender, sexual orientation, race, indigeneity and/or ability? Laura Guidry-Grimes and Elizabeth Victor contend that when a diagnostic label of a mental illness targets a historically marginalized and disadvantaged population, that diagnosis compounds the vulnerability to which the population is already subject. The consequence is that such people encounter stereotypes in daily interactions, experience constraints on their agency and social rejection, have a lower quality of life and confront multiple barriers to accessing health and social services.⁴⁹

PEOPLE WITH DISABILITIES

Inequities and injustices are woven into society causing certain groups of people to have unequal access to social, economic and political resources. The process by which this occurs has been extensively studied. Bruce Link and

Jo Phelan conceptualize stigma as a multi-component process of privileging certain groups over others, whereby human differences such as gender, race, sexual orientation and ability are marked as socially undesirable, people are stigmatized through a social separation that differentiates between an aberrant “them” and a socially cohesive “us” and such people encounter discrimination and lose status as a function of this continual process of socially rejection. Stigma is considered to be dynamic, changes over time and operates in accordance with prevalent social norms and ideologies.⁵⁰

Medical conditions or disabilities vary dramatically in the extent to which they are socially significant. While visual or mobility impairments are often seen as socially neutral, mental health and substance use-related conditions are laden with stigma. A possible reason Livingston proposes for this distinction is the degree to which mental illness and problematic substance use effect cognition, social relations and functioning. An example he offers is a person with schizophrenia, who may be unable to form and maintain friendships because their symptoms can increase social withdrawal, decrease motivation or cause them to exhibit socially aberrant behaviour.⁵¹ Stigma can compound impairment-related restrictions since both direct and structural discrimination prevent full participation in society and collude to enforce social exclusion on the level of relationships and access to resources.

While the direct phenomena of being looked down on, excluded or victimized by others is seriously harmful to a person's well-being, the structural form of discrimination is much more insidious and damaging for the life chances of that person. Instances of structural discrimination can range from the practice of keeping opportunities for career advancement within a privileged group to segregating stigmatized groups into low-income neighborhoods to legislation that condones punitive treatment for certain health conditions. These external forces limit the opportunities a person can access and impact their internal conception of self. A particularly invidious form of discrimination occurs when stigmatized individuals recognize that a negative label has been applied to them and feel as though other people are likely to devalue or discredit them on the basis of that label. The result is self-devaluation that leads to lower levels of hope, empowerment, self-esteem, self-efficacy, quality of life,

48 Livingston, J.D. (2013). Mental illness-related structural stigma: The downward spiral of systemic exclusion final report. *Mental Health Commission of Canada*.

49 Guidry-Grimes, L. & Victor, E. (2012). Vulnerabilities compounded by social institutions. *International Journal of Feminist Approaches to Bioethics*, 5(2): 126-146.

50 Link, B. & Phelan J.C. (2006). Stigma and its public health implications. *Lancet*, 367: 528-29.

51 See note 48, Livingston.

and social support.⁵² Since poverty contributes to and perpetuates mental health and substance use-related illness, stigmatized people who live with a mental illness or problematic substance use are oftentimes trapped in a self-sustaining cycle of disadvantage and ill health.

Chronic stress manifests differently for stigmatized persons. While poverty, social rejection and isolation are all sources of stress, people who experience illness-related stigma also report a constant anticipation or threat of being stigmatized or discriminated against that generates fear and can lead to an avoidance of health care. Stigma influences the decision to seek care and the type of engagement a person encounters in a clinical setting. In her discussion of biomedical models of mental illness, Angela K. Thachuk describes recurrent dismissal of physical health concerns as an example of how stigmatizing attitudes influence the kind of treatment mental health service users receive. Their symptoms are very often viewed through the lens of their psychiatric disorder and any additional complaint that does not fit within their diagnosis is dismissed. As a result, people may choose to conceal their psychiatric histories when presenting with new and potentially unrelated symptoms or avoid medical encounters all together.⁵³ This pattern of discrimination and dismissal, then avoidance is detrimental to health not only because it deprives people in need of the healthcare they have a right to access, but also because it constitutes yet another form of exclusion whereby a person is denied the authority to speak on their own behalf and marked as incapable.

Stigmatized characteristics and statuses do not act in isolation. Multiple attributes cohere to determine a person's identity, subjective experiences, social relationships and life chances. Since people who experience any form of discrimination are at a higher risk of mental health and substance use problems, the intersections between gender, sexual orientation, race, indigeneity and ability are important for understanding how discrimination is experienced by people in their day-to-day lives.

WOMEN

Women in Canada experience more adverse social determinants of mental health than men. Some of the reasons that have been proposed for this disparity are that women carry more responsibilities for raising children and taking care of housework, are less likely to be working full-time, are less eligible for unemployment benefits, typically employed in lower paying occupations and experience more discrimination in the workplace.⁵⁴ In BC, women are more likely than men to be impoverished, limiting their access to social determinants such as housing, food and adequate employment that are necessary to achieve and maintain good mental health. Poverty is even more common for women who are single mothers. Thirty-seven percent of female-led single parent households live in poverty as opposed to only 10% of two-parent families.⁵⁵

The burden of mental illness is not shared equally. Women experience depression nearly twice as often as men; major depression is experienced by 10-25% of women.⁵⁶ Women are also more affected by stress-related disorders⁵⁷ and are at a particular risk of eating disorders.⁵⁸ The only mental health concern where the severity of illness affecting men is greater than that affecting women is suicide. Men have a mortality rate due to suicide that is 4 times higher than women, yet women are hospitalized for attempted suicide at 1.5 times the rate of men.⁵⁹ This reflects the overall trend in health disparities and the variance in life expectancies between men and women. Women live longer than men, but men live healthier lives.

Problematic substance use tells a somewhat different story. Historically men have had higher rates of alcohol consumption and illicit substance use and have accessed treatment services 2-to-3 times more frequently than women. The only substance women consume at higher rates than men is licit substances (other than alcohol) such as prescription opioids. Despite their lower rate of

52 Livingston, J.D., & Boyd, J.E. (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis. *Social Science & Medicine*, 71: 2150-2161.

53 Thachuk, A.K. (2011). Stigma and the politics of biomedical models of mental illness. *International Journal of Feminist Perspectives on Ethics in Psychiatry*, Spring Ed: 140-163.

54 See note 19, Mikkonen and Raphael.

55 Provincial Health Services Authority & BC Centre of Excellence for Women's Health. (2009). Taking a Second Look: Analyzing Health Inequities in British Columbia with a Sex, Gender and Diversity lens.

56 Centre for Addiction and Mental Health. (2009 Feb 26). Mental Health Fact Sheet: Depression. https://members.drps.ca/upload_files/Depression_Mental_Health_Fact_Sheet_200929142258.pdf.

57 Tolin, D. & Foa, E. (2006). Sex Differences in Trauma and Post-Traumatic Stress Disorder: A Quantitative Review of 25 Years of Research. *Psychological Bulletin*, 132(6): 959-92.

58 Statistics Canada. (2002 October 3). A Report on Mental Illnesses in Canada – Eating disorders. <https://www.canada.ca/en/public-health/services/reports-publications/report-on-mental-illnesses-canada/eating-disorders.html>.

59 Canadian Institute for Health Information. (2002). A Report on Mental Illnesses in Canada. *Health Canada*.

consumption, women experience greater stigma and discrimination. Women experience more judgement on the part of family and friends for their use of substances and more negative consequences for entering treatment. This impacts women's willingness to report their substance use and related health concerns, the rates at which women are screened for substance use problems in healthcare settings and their access to treatment. The discrimination women experience, combined with biological risk factors, entail that women are more susceptible to the adverse health effects of all substances.⁶⁰

Women are also a greater risk for interpersonal victimization, including childhood abuse, sexual assault and intimate partner violence, and often present with co-occurring substance use and mental health problems when their histories include violence and trauma.⁶¹ As many as two thirds of women with a substance use disorder report a concurrent mental health condition such as PTSD, anxiety or depression and an experience of physical or sexual abuse either as children or adults.⁶² Given the higher rates of violent victimization in low-income neighborhoods,⁶³ women in poverty are particularly susceptible to the vicious cycle of violence contributing to poor mental health and poor mental health limiting capacity to escape the circumstance where the violence occurs.

The prevalence of mental illness and problematic substance use, in consequence of and alongside women's increased risk of interpersonal violence and trauma, compound and lead to the discrimination mothers with disabilities face when caring for or fighting to care for their children. In a study conducted by West Coast Leaf to investigate the intersections of parenting, disability and law, all of the 25 participants reported a mental health issue, with 11 reporting co-occurring substance use disorders. The personal accounts of these women reaffirm the realities that mothers with mental health diagnoses are 3 times more likely to have been involved with the child protection system, face increased scrutiny of their capacity to parent and encounter pervasive misconceptions and stereotypes that are used to justify the removal of their children in

the absence of any evidence of maltreatment. A mother with a mental health-related disability who is involved in a custody dispute is "expected by doctors and the mental health system to take every measure possible to improve her mental health, while at the same time, she may be prejudiced in her legal dispute precisely for prioritizing her own mental health needs."⁶⁴

Poverty and economic disadvantage are further confounding factors for child protection cases in which a mother has a mental health or substance use diagnosis. In BC, a recent investigation of 40 child protection trial judgements found that every case where a mother with a mental disability is one of the parties involved poverty and all but one resulted in the permanent removal of the child.⁶⁵ This reality of poverty and discrimination, followed by a denial of parental rights is reflected in the experiences of mothers with substance use disorders as well. In 2002, a survey of BC child protection workers revealed that an estimated 70 percent of child protection cases include harmful substance use by the mother.⁶⁶ Mothers who use substances face an impossible dilemma to either seek help for their illness and risk losing custody of their children or stay silent about their substance use and forgo the benefit of treatment and support. While there are some treatment facilities that allow children to stay with their mothers, the majority do not and mothers are required to place their children in the care of family or the province in order to access services.⁶⁷

The need to prove and ameliorate one's disability in order to be considered fit to parent is contradicted by the fact that disability can wrongly be perceived as synonymous with a lack of ability to parent. In their paper *Disabled Women*, Michelle Fine and Adrienne Ash take this a step further and contend that women with disabilities are "roleless" in that they face an absence of socially sanctioned roles and/or the institutional means to achieve them. Women with disabilities are perceived as inadequate to fulfill either the economically productive roles traditionally considered appropriate for males or reproductive roles reserved for females. In consequence, disability is more severely limiting for women than men and produces an erasure of place

60 Salmon, A., Poole, N., Morrow, M., Greaves, L., Ingram, R. & Pederson, A. (2006). *Improving Conditions: Integrating Sex and Gender into Federal Mental Health and Problematic substance uses Policy*.

61 Logan, T.K. et al. (2003). *Victimization and Substance Abuse Among Women: Contributing Factors, Interventions, and Implications. Review of General Psychology*, 6(4): 325-397.

62 Zilberman, M.L. et al. (2003). *Substance Use Disorders: Sex Differences and Psychiatric Co-morbidities. Canadian Journal of Psychiatry*, 48(1): 5-13.

63 See note 24, Statistics Canada.

64 Track, L. (2014). *Able Mothers: The intersection of parenting, disability and the law. West Coast Leaf*.

65 Mosoff, J., Grant, I., Boyd, S.B. & Lindy, R. (2016). *Intersecting Challenges: Mothers and Child Protection Law in BC. UBC Law Review*, 50(2).

66 Representative for Children and Youth. (2014). *Children at risk: The case for a better response to parental problematic substance use*.

67 See note 64, Track.

and purpose in society as neither economic contributor nor mother. This is evident in higher rates of unemployment, poverty, child protection cases and social rejection. Women with disabilities are perceived in less favorable ways, are more likely to be a victim of hostility, report a more negative self-image and are more likely to identify as “disabled.” Fine and Ash conclude that this absence of social roles eventuates in a sense of invisibility, self-estrangement and powerlessness that is psychologically damaging.⁶⁸ In other words, the systematic exclusion of women with disabilities produces and perpetuates mental health and substance use-related illness.

LGBTQ2+

Many people who identify as LGBTQ2+ experience stigma and discrimination across their life spans, and are targets of sexual and physical assault, harassment and hate crimes. Statistics Canada reports that police-reported hate crimes targeting sexual orientation have continued to increase in Canada and continue to be the most violent hate crimes reported. While British Columbia has the second highest rate of such crimes, second only to Quebec,⁶⁹ the problem undoubtedly persists across the country in equal measure due to the likelihood that not every crime is reported and not every report is fully investigated. People who identify as non-binary experience similar levels of violence. An Ontario-based study of trans people found that 20% had experienced physical or sexual assault due to their identity and that 34% were subjected to verbal threats. This level of harassment is then amplified by the discrimination they face when seeking stable housing, employment or health and social services.⁷⁰

Lesbians, gay men and bisexuals (LGB) are more likely than heterosexuals to consult mental health professionals⁷¹ and experience higher rates of substance use disorders,

affective disorders and suicide. In his discussion of the connections between prejudice, stress and mental health, Meyer offers the conceptual framework of “minority stress” to explain the higher prevalence rates of mental illness amongst LGB populations. He explains that stigma, prejudice and discrimination create a hostile social environment that includes prejudicial events, expectations of rejection, hiding and concealment of identity, internalized homophobia and ameliorative coping mechanisms. This complex interplay of factors creates the conditions for social exclusion, low self-esteem and negative self-evaluation that are at the root of mental health problems.⁷²

Trans people similarly experience disproportionately high levels of depression and suicide. Researchers estimate that more than half of trans people in Ontario have depressive symptoms consistent with clinical depression, while 43% have a history of attempting suicide, including 10% within the past year.⁷³ In alignment with Meyer’s conception of minority stress amongst LGB populations, research by Trans PULSE demonstrates that discrimination and violence towards trans people can result in avoidance of public spaces and exclusion from communities. Approximately two-thirds of trans people in Ontario had avoided public spaces or situations because they feared harassment, being perceived as trans or being “outed” as trans. Ninety-seven percent of those who had previously experienced physical or sexual violence avoided at least one type of space.⁷⁴ Some trans people were even forced to leave their communities and neighborhoods of origin. Thirty-two percent of trans Ontarians left their homes due to safety concerns or lack of accessible services.⁷⁵

RACIALIZED AND IMMIGRANT GROUPS

Racism, similar to other forms of discrimination based on ability, gender or sexual identity, can take multiple forms, ranging from structural racism, codified in institutions of

68 Fine, M. & Ash, A. (1981). Disabled Women: Sexism without the Pedestal. *The Journal of Sociology & Social Welfare*, 8 (2): 233-248.

69 Statistics Canada. (2017 November 28). Police-reported hate crime, 2016. <https://www150.statcan.gc.ca/n1/daily-quotidien/171128/dq171128d-eng.htm>.

70 Bauer, G.R. & Scheim, A.I. (2015). Transgender People in Ontario, Canada: Statistics from the Trans PULSE Project to Inform Human Rights Policy. *Trans Pulse*.

71 Statistic Canada. (2015 July 17). Health care use among gay, lesbian and bisexual Canadians. <https://www150.statcan.gc.ca/n1/pub/82-003-x/2008001/article/10532-eng.htm>.

72 Meyer, I.H. (2003). Prejudice, Social Stress, and Mental Health in Lesbian, Gay and Bisexual Populations: Conceptual Issues and Research Evidence. *Psychological Bulletin*, 129(5): 674-697.

73 Bauer, G.R., Pyne, J., Francino, M.C. & Hammond, R. (2013). La suicidabilité parmi les personnes trans en Ontario: Implications en travail social et en justice sociale // Suicidality among trans people in Ontario: implications for social work and social justice. *Revue Service Social*, 59(1):35–62.

74 Scheim, A., Bauer, G., & Pyne, J. (2013). Avoidance of public spaces by trans Ontarians: The impact of transphobia on daily life. *Trans PULSE E-Bulletin*, 4(1).

75 Marcellin, R.L., Bauer, G.R., & Scheim, A.I. (2013). Intersecting impacts of transphobia and racism on HIV risk among trans persons of colour in Ontario, Canada. *Ethnicity and Inequalities in Health & Social Care*, 6(4):97–107.

practice, law and governance; to social prejudice, evident in everyday interactions that display lack of respect, suspicion, devaluation, scapegoating and dehumanization; to internalized racism, whereby people who are stigmatized because of their skin colour accept derogatory intimations about their own abilities and lack of worth. This multitude of discrimination can lead to stress, resignation, loss of control over life circumstances and hopelessness.⁷⁶

Immigrants and refugees—most of whom are people of colour—may be exposed to stressors both pre- and post-migration such as refugee camp internment, catastrophic experiences, separation from family, unemployment and poverty that put them at a heightened risk for mental illness.⁷⁷ Many are faced with multiple adjustment challenges including integration pressures, identity changes, and racism⁷⁸ that when coupled with a lack of social support, decreases psychological well-being and leads to low self-esteem or depression. In their study of Southeast Asian refugees, Noh et al. demonstrate a relationship between perceived discrimination and depressive symptoms. Refugees who reported that they had experienced racism had higher levels of depression than those who did not.⁷⁹ Similarly discrimination during resettlement among immigrant and refugee women has been shown to increase anxiety and depression. Numerous studies demonstrate how gendered dimensions of migration, specifically those that enforce dependency and restrict access to services can increase risk for mood disorders.⁸⁰

Another illustration of how discrimination and prejudice damage people's well-being is the "group density" effect on immigrant communities. Research shows that the health of ethnic minority groups is sometimes better if they live in areas with people of a similar race or cultural background as opposed to more affluent areas composed

of the dominant ethnic group.⁸¹ The most compelling evidence for this effect comes from a series of studies on rates of schizophrenia,⁸² self-harm⁸³ and suicide⁸⁴ that illustrate a higher incidence of mental health symptoms among ethnic minorities living in neighborhoods with few people like themselves. Yet people from an ethnic minority group who live in areas apart from the majority of their community tend to have higher incomes and live in neighborhoods that reflect that. Since living in a low income neighborhood is associated with worse mental health, the fact that racially isolated individuals who live in higher income neighborhoods experience poorer mental health is unexpected. By way of explanation, Wilkinson and Pickett suggest that such individuals are aware of the lower social status attached to their race and encounter more frequent discrimination with less social support to counteract its effects. The psychological impact of racism effectively overrides the health benefits of material advantage.⁸⁵

The importance of social support for mental health outcomes in ethnic communities aligns with the literature on protective factors for stress and well-being. Immigrants who are fluent in the host country language, possess ethnic pride and social resources such as family and community support are associated with better mental health status.⁸⁶ In their case study of multilingual health promotion, Simich et al. found that "social support enhances coping, moderates the impact of stressors and promotes health" and empowers individuals to cope with and overcome the challenges in their lives.⁸⁷ The degree to which immigrants are connected to others, who reinforce their identities and place within communities, determines whether or not they will experience the negative psychological impacts of social exclusion, which often follow from experiences of poverty and racism.

76 Jones, C. (2000). Levels of Racism: A Theoretic Framework and a Gardner's Tale. *American Journal of Public Health*, 90(8): 1212-1215.

77 Fenta, H., Hyman, I. & Noh, S. (2004). Determinants of Depression among Ethiopian Immigrants and Refugees in Toronto. *The Journal of Nervous and Mental Disease* 192 (5): 363-372.

78 Beiser, M. and Edwards R. G.(1994). Mental health of immigrants and refugees. *New Directions for Mental Health Services* 61: 73-86.

79 Noh, S., Beiser, M., Kaspar, V., Hou, F. and Rummens, J. (1999). Perceived Racial Discrimination, Depression and Coping: A Study of Southeast Asian Refugees in Canada. *Journal of Health and Social Behavior* 40: 193-207.

80 See note 60, Salmon, Poole, Morrow, Greaves, Ingram and Pederson.

81 Pickett, K.E., & Wilkinson, R.G. (2008). People like us: ethnic group density effects on health. *Ethnicity and Health* 13(4): 321-34.

82 Boydell, J., van Os, J., McKenzie, K., Allardyce, J., Goel, R. McCreadie, R.G. & Murray, R.M. (2001). Incidence of schizophrenia in ethnic minorities in London: ecological study into interactions with environment. *British Medical Journal* 323(7325): 1336-8.

83 Neeleman, J., Wilson-Jones, C. & Wessely, S. (2001). Ethnic density and deliberate self-harm: a small area study in south east London. *Journal of Epidemiology and Community Health* 55: 85-90.

84 Neeleman, J. & Wessely, S. (1999). Ethnic minority suicide: a small area geographical study in south London. *Psychological Medicine* 29(2): 429-36.

85 See note 81, Pickett and Wilkinson.

86 See note 77, Fenta, Hyman and Noh.

87 Simich, L., Scott, J. & Agic B. (2005). Alone in Canada: A Case Study of Multilingual Health Promotion. *International Journal of Mental Health Promotion* 7 (2): 14-22.

PART IV: INDIGENOUS PEOPLES

Indigenous peoples—First Nations, Metis and Inuit—encounter adverse conditions in their physical, social and emotional environments, which correspond to poor mental health outcomes. BC's Provincial Health Officer reports that rates of hospitalization for delusional disorders, stress-related disorders, schizophrenia and somatoform disorder are significantly higher for Indigenous people than the rest of the Canadian population. Suicide remains the fourth highest overall cause of death. Youth between the ages of 10-19 are four to five times more likely to take their own lives compared to their non-Indigenous peers. Similarly BC's Indigenous population has five times the rate of alcohol-related deaths.⁸⁸

The First Nations Health Authority (FNHA) identifies a number of factors that contribute to the current mental health and substance use realities for Indigenous people: residential schooling; physical, emotional, mental and sexual abuse; assimilation; systemic discrimination; child apprehension; over-representation in the criminal justice system; and a loss of tradition, territories, language and culture.⁸⁹ This set of factors is deeply rooted in the ongoing process of colonialization and influences how the core determinants of mental health—income, employment, housing, food, discrimination and social inclusion—are experienced by Indigenous peoples.

FNHA's policy on mental health and wellness correspondingly specifies five core principles: focus on the conditions for mental health and address root causes; foreground culture and traditional approaches to healing; provide equitable, culturally-safe, trauma-informed and person-centred programs and services; integrate system design and delivery; and prioritize First Nations self-determination. Their paradigm shift for transforming the mental health system for Indigenous populations recognizes that “facilitating supportive environments for individuals, families and communities to enjoy positive mental health and wellness... requires working not just with health system partners but also with partners spanning social and environmental sectors and beyond.”⁹⁰

INCOME AND EMPLOYMENT

The National Inquiry into Murdered and Missing Indigenous Women and Girls (NIMMIWG) identified social and economic marginalization that perpetuates colonial and interpersonal violence as a strong determinant of poor mental health and substance use outcomes. Such marginalization is compounded by public services that are inaccessible to many because of geographic location, insufficient funding, absence of culturally safe and trauma-informed approaches, and identification with government institutions that are responsible for legacies of colonial harm such as residential schools.⁹¹ Poverty is too often the result. Indigenous peoples annual earnings are lower than the rest of the Canadian population regardless of their type or duration of employment. The median total income of the Indigenous population aged 25 to 54 is just over \$22,000, compared to over \$33,000 for the non-Indigenous population in the same age group. This differs depending on where Indigenous people chose to live. Indigenous people who live on reserve have a considerably lower median income at only \$14,000, while those who live off reserve have a median income closer to the overall average at \$22,500 per year.⁹²

The employment rate for Indigenous people is over ten percent lower⁹³ than for non-Indigenous people across Canada, and their communities face significant barriers to work that reflect colonial histories. The most recent Aboriginal Peoples Survey reports that 52% of Indigenous people living off reserve aged 15 or older were employed in 2016. Among the employed, 82% of Indigenous people worked a permanent job. Indigenous women were more likely to work multiple jobs and hold part-time positions than Indigenous men. Nearly a third of part-time workers reported that this was not a choice and that a leading reason was childcare responsibilities. Otherwise the barrier to work most commonly experienced was a shortage of jobs. Additional barriers included not having work experience, enough education or training for available jobs and a means of transportation. Indigenous people who were

88 British Columbia. Provincial Health Officer. (2009) Pathways to Health and Healing – 2nd Report on the Health and Well-being of Aboriginal People in British Columbia. *BC Ministry of Healthy Living and Sport*.

89 First Nations Health Authority. (2013). A Path Forward: A Provincial Approach to Facilitate Regional and Local Planning and Action. *First Nations Health Authority, Government of British Columbia and Health Canada*.

90 First Nations Health Authority. (2019). FNHA's Policy on Mental Health and Wellness. Retrieved from: <http://www.fnha.ca/wellnessContent/Wellness/FNHA-Policy-on-Mental-Health-and-Wellness.pdf>.

91 National Inquiry into Missing and Murdered Indigenous Women and Girls. (2019). *Reclaiming Power and Place: The final report*. Volume 1a. Retrieved from: https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Final_Report_Vol_1a-1.pdf#page=418.

92 Statistics Canada. (2015 November 30). Income: Median total income is lower for Aboriginal people. Retrieved from: <https://www150.statcan.gc.ca/n1/pub/89-645-x/2010001/income-revenu-eng.htm>.

93 Statistics Canada. (2017). *Labour in Canada: Key results from the 2016 Census*. Retrieved from: <https://www150.statcan.gc.ca/n1/daily-quotidien/171129/dq171129b-eng.htm>.

not employed reported illness or disability as the leading reason why they are not working.⁹⁴

HOUSING

Among Indigenous people, housing insecurity has been imposed through colonial dispossession of traditional territories, as well as reserve and patriarchal resettlement structures that have led to on-reserve housing shortages, overcrowding and poor living conditions.⁹⁵ Inadequate and unsafe housing, along with a lack of basic amenities and geographic isolation, has direct health implications, including an increased risk of mental illness, family conflict and violence. This disproportionately affects Indigenous women who often cannot access housing in their communities and are forced into situations of increased risk of violence and social deprivation.⁹⁶ Oftentimes the only alternative is migration to urban areas and potential disconnection from families, communities and ancestral land.

Homelessness in this context is not merely a lack of stable, permanent housing. The Aboriginal Standing Committee on Housing and Homelessness defines the experience as an isolation of individuals, families and communities from their “relationships to land, water, place, family, kin, each other, animals, culture, languages and identities” and directly links this condition to the continuation and legacy of colonialist policies and practices that seek to undermine Indigenous social systems, cultures and worldviews, and construct systematic and societal barriers to affordable and appropriate housing.⁹⁷ In a report published by the Canadian Observatory on Homelessness, the complex dimensions of Indigenous homelessness are further elucidated to include historic displacement, geographic separation from ancestral lands, spiritual disconnection from Indigenous worldviews or connection to the Creator, mental disruption and imbalances, cultural disintegration

and loss, community exclusion, and environmental destruction both natural and man-made.⁹⁸

The statistics documenting Indigenous homelessness are not surprising given these inter-related dimensions that contribute to a lack of safe, culturally appropriate housing. Indigenous people are 8 times more likely to experience homelessness than non-Indigenous people: 1 in 15 Indigenous people in urban centres experience homelessness, compared to only 1 in 128 for the general population.⁹⁹ While homelessness is often conceived of as a condition affecting the individual, amongst Indigenous populations it affects entire families, especially women and children.¹⁰⁰ Most likely the same families who have to leave their homes because of housing shortages, for fear of violence or for need of socio-economic opportunity.

FOOD

Indigenous peoples living in remote, rural and reserve communities face considerable food insecurity related to challenges acquiring both market and traditional foods. The cost of transporting fresh produce and packaged goods to remote communities means that healthy, nutritious food is not affordable for most families, while poverty and land use restrictions make costs associated with hunting prohibitive.¹⁰¹ In consequence, 54% of First Nation on-reserve households are either moderately or severely food insecure, compared to only 8% of other Canadian households.¹⁰²

RACISM & DISCRIMINATION

Indigenous people in Canada experience both systematic and interpersonal discrimination that stems from and continues on the basis of colonialism. In their discussion of Indigenous health inequities, Charlotte

94 Statistics Canada. (2018). *Labour Market Experiences of First Nations people living off reserve: Key findings from the 2017 Aboriginal Peoples Survey*. Retrieved from: <https://www150.statcan.gc.ca/n1/pub/89-653-x/89-653-x2018003-eng.htm>.

95 Reading, C. & Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health*. National Collaborating Centre for Aboriginal Health.

96 Reading, J.L., Kmetc, A. & Gideon, V. (2007). *First Nations Wholistic Policy and Planning Model: Discussion Paper for the World Health Organization Commission on Social Determinants of Health*. Assembly of First Nations.

97 Aboriginal Standing Committee on Housing and Homelessness (ASCHH). (2012). *Plan to End Aboriginal Homelessness in Calgary*.

98 Thistle, J.A. (2017). *Indigenous Definition of Homelessness in Canada*. Canadian Observatory on Homelessness.

99 Belanger, Y. D., Awosoga, O., & Head, G. W. (2013). Homelessness, urban Aboriginal people, and the need for a national enumeration. *Aboriginal policy studies*, 2(2): 4-33.

100 Gulliver-Garcia, T. (2015). Putting an End to Child & Family Homelessness in Canada. *Raising the Roof*.

101 See note 95, Reading and Wien.

102 Government of Canada. (2016). *Health Status of Canadians 2016: A Report of the Chief Public Health Officer*.

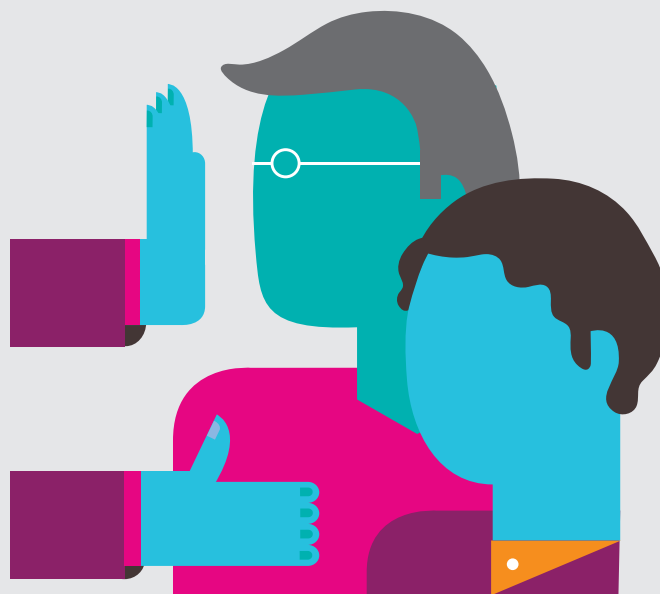
Reading and Fred Wien contend that racism and social exclusion have been a reality for Indigenous people since colonial contact. The usurpation of land, decimation of communities and imposition of western systems of governance created “social stratification along racial lines, with a consequent hierarchal distribution of resources, power, freedom and control, all of which detrimentally affected Aboriginal health.” This discriminatory positioning of Indigenous people at the bottom of the social hierarchy is evident in social policies that restrict, limit or neglect to enforce equitable access to education, income, economic opportunities and healthcare.¹⁰³

The healthcare system provides a good example of how systemic discrimination operates in the lives of Indigenous people. Many encounter linguistic and cultural barriers, as well as racism and stereotypes when trying to seek treatment. The misunderstandings and frustrations that follow can lead to misdiagnosis, inadequate care and poor health outcomes. The medical model of illness further complicates healthcare interactions by making social problems into diagnoses that divert both blame for illness and responsibility for

recovery to those who are suffering. Sarah Nelson argues that colonial conceptions of mental illness, predicated on notions of aberrant or abnormal behaviour, fail to take into consideration different norms and standards of Indigenous cultures, while willfully ignoring the impact adverse physical and social environments can have on mental wellness. Anxiety, depression or substance use disorder can be seen as normal human reactions to conditions of deprivation and oppression. Instead the medicalization of difference and disparity amounts to placing the burden of health and social problems on individual people who are simultaneously denied the resources with which to address them.¹⁰⁴

Discrimination is felt by a significant percentage of Indigenous people in Canada. In 2008/2010, the RHS reported that 32.6% of First Nations experienced racism in the past 12 months. This percentage was even higher for Indigenous people living on-reserve, with almost 40% experiencing racism and 27% reporting that it had an effect on their self-esteem.¹⁰⁵ Such negative consequences are intensified for Indigenous youth, whose use of alcohol and substances increases with experiences of social exclusion.¹⁰⁶

Indigenous people in Canada experience both systematic and interpersonal discrimination that stems from and continues on the basis of colonialism.



103 See note 95, Reading and Wien.

104 Nelson, S. (2012). Challenging Hidden Assumptions: Colonial Norms as Determinants of Aboriginal Mental Health. *National Collaborating Centre for Aboriginal Health*.

105 First Nations Information Governance Centre. (2012). First Nations Regional Health Survey (RHS) 2008/10: National report on adults, youth and children living in First Nations communities. *Assembly of First Nations*.

106 Mignone, J. & O’Neil, J. (2005) Social capital and youth suicide risk factors in First Nations communities. *Canadian Journal of Public Health*,

SOCIAL INCLUSION

The social exclusion experienced by Indigenous populations operates on multiple levels. Poverty and discrimination conspire to keep First Nations people at the margins of Canadian society. Inequitable distribution of and access to income, employment, housing and food, in combination with both systematic and interpersonal discrimination, create the conditions for anxiety, insecurity, low self-esteem and feelings of hopelessness that are linked to increased prevalence of depression, violence, problematic substance use and suicide. This patterns holds true for any marginalized population, but has particular salience for Indigenous peoples who have experienced generations of systematic interference and who are often called upon to navigate between two differing socio-cultural spheres that of Canadian society and that of their Indigenous community.

The importance of cultural identity and cohesion for mental wellness of Indigenous populations has been well documented. A series of epidemiological studies by Chandler and Lalonde have revealed that among First Nations people in British Columbia rates of suicide vary dramatically and are associated with the level of social and cultural cohesion within the community. This factor was termed 'cultural continuity' and identified as traditional intergenerational connectedness, maintained by intact familial relationships and autonomous self-governance. The communities with low suicide rates or an absence of suicide possessed land title, control of education, deliverance of social policies and programs, and security and cultural resources.¹⁰⁷ The most influential of cultural resources being language. Indigenous languages communicate traditional knowledge, stories and ceremonies, and constitute the means through which cultural inheritance of values, traditions and beliefs are passed on from one generation to the next.¹⁰⁸ The revitalization of language and cultural activities is an integral component of social cohesion and inclusion within Indigenous communities, yet, as Chandler and Lalonde demonstrate, can only take place within the context of land sovereignty and self-governance.

96(1): 51-4.

107 Chandler, M.J. & Lalonde, C.E. (2008). Cultural continuity as a moderator of suicide risk among Canada's First Nations. In Kirmayer, L. & Valaskakis, G. (Eds.). *Healing traditions: The mental health of Aboriginal peoples in Canada* (pp 221-248). University of British Columbia Press.

108 McIvor, O. & Dickie, K. (2009). Language and Culture as Protective Factors for At-Risk Communities. *Journal of Aboriginal Health*, 5(1): 6-25.

CONCLUSION

All people want to be seen and valued for who they are and included in the communities and social structures that inform their lives—only when the exact opposite occurs and people are denied social goods and economic participation, degraded on the basis of stereotyped attributes and deprived of positive social contact do poor mental health and substance use outcomes proliferate. The increasing prevalence rate of mental illness in unequal countries such as Canada demonstrate how our modern social condition, where people are disconnected from one another and reliant on appraisals of social status to confirm identity and personal worth, leads to anxiety, insecurity, low self-esteem and depression. This is particularly true for people who are economically disadvantaged and who contend with discrimination associated with poverty and stigmatized attributes such as mental health disability, gender, sexual orientation, indigeneity or ethnicity. Without the power, prestige and status that wealth conveys, people living in poverty are caught within a censorious social environment, where value and worth must be proven at each opportunity and dismissed and denied by others at the next.

Poverty creates further barriers to mental well-being. Many people who find themselves living in poverty report being caught up in the downward spiral that loss of income can initiate. Without sufficient financial resources, people are unlikely to find secure housing, meaningful employment, nutritious food and a place within a community. Instead they are left on the margins of society with little recourse for re-entry. Our social safety net, which includes income assistance, social housing, food banks and community spaces, are intended to provide the resources to prevent this and lift people out of poverty. The mere provision of such support demonstrates that each person has value and the potential to contribute to a community. An absence or inadequacy of supports conveys the exact opposite and leads to feelings of hopelessness and a loss of control over life circumstances that precipitates mental illness and harmful coping behaviors such as problematic substance use.

Stigma and discrimination experienced by people living with mental health and substance use-related illness further entrenches poverty by erecting even more barriers both interpersonal and systematic to acquiring the resources and relationships necessary for a place and position within society. Both poverty and mental health-related discrimination reinforce one another and create conditions of abject social exclusion, which perpetuate and worsen both material deprivation and symptoms of illness. The intersection of further stigmatized attributes

of gender, sexual orientation, indigeneity and race only intensifies this process and increases the risk of poor mental health outcomes and problematic substance use.

The single, most effective means for supporting mental wellbeing and stopping the downward spiral of poverty and discrimination is meaningful social inclusion, which can be fostered through policy interventions and a shift in culture that places value on equality and social cohesion above all else.