Courage My Friends Podcast Series III – Episode 10
Capitalism and the Mental Health Crisis

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ANNOUNCER: You're listening to *Needs No Introduction*.
Needs No Introduction is a rabble podcast network show that serves up a series of speeches, interviews and lectures from the finest minds of our time

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COURAGE MY FRIENDS ANNOUNCER: COVID. Capitalism. Climate. Three storms have converged and we're all caught in the vortex.

STREET VOICE 1: I was already worried about my job, food and housing. So now I have to worry about healthcare as well?

STREET VOICE 2: Seems like we wanna jump back to normalcy so bad that we're not even trying to be careful at this point.

STREET VOICE 3: This is a 911 kind of situation for global climate crisis. This planet is our only home and billionaires space-race is not a solution. The earth is crying for survival. It is time for action.
[music]

COURAGE MY FRIENDS ANNOUNCER: What brought us to this point? Can we go back to normal? Do we even want to?

Welcome back to this special podcast series by rabble.ca and the Tommy Douglas Institute (at George Brown College) and with the support of the Douglas-Coldwell-Layton Foundation. In the words of the great Tommy Douglas…

VOICE 4: Courage my friends; 'tis not too late to build a better world.

COURAGE MY FRIENDS ANNOUNCER: This is the *Courage My Friends* podcast.

RESH: What is the relationship between the current crisis in mental health and capitalism? Is capitalism good for our mental health? And is mental wellness bad for neoliberal capitalism?

I'm your host, Resh Budhu.

In this episode of The Courage My Friend's podcast, *Capitalism and the Mental Health Crisis*, social worker, researcher and writer, Madeleine Ritts, researcher on mental health of Black communities, Michelle Sraha-Yeboah, and historian, researcher and educator in labor issues, Jon Weier, discuss the ways in which the current mental health crisis is a symptom of the deeper crisis of capitalism.

Michelle, Maddie, and John, welcome. Thanks for joining us.

JON: Thanks.

MADELEINE: Thank you for having us.

MICHELLE: Thanks.

RESH: We are in the grip of a national and a global mental health crisis. Maddie, as a clinician and researcher in mental health and addictions and long-term care, what have you been seeing?

MADELEINE: At the moment I think we are seeing a really concerning spike in demand for mental health services and in mental distress. And this is a real and pressing issue that our mental healthcare system is unable to address, both because it's been systematically underfunded and poorly designed.

And because we're asking mental health services to respond to far greater, more complicated problems than they're equipped to address. So we're asking EDs to become shelters. We're asking GPs to be primary providers of psychiatric care. We're asking social workers and other health workers to connect people to supportive housing and mental health programs that either don't exist or have prohibitively long wait times.

We know that one in four Canadians are thought to be experiencing moderate to severe anxiety, depression, or loneliness. And those who are most impacted include healthcare workers, unemployed workers, migrants and non-permanent residents, people with low income, youth, people who use drugs and women. And we're also seeing some race-based disparities as well.

And even prior to the pandemic, available data which is scarce suggests that, you know, referrals to psychiatric services can take a really long time. In Saskatchewan, someone might wait 12 weeks. In Nova Scotia, the average wait time is 53 weeks. And for children and youth, it's especially abysmal. So in Ontario, a 2020 report found that children between ages 6 to 18 with serious mental health needs, will wait anywhere between. two to three months to actually two and a half years for professional support.

So demand is at an all-time high. And the mental health system is just not equipped to, to deal with it for all of the variety of reasons I just outlined.

RESH: As you mentioned, there are of course, disproportionate impacts on particular groups, which include low income, racialized, Indigenous, the list goes on.

Michelle, through your research on the mental health of Black communities, how is this crisis manifesting?

MICHELLE: It's manifesting because the number of oppressive and exploitive conditions are increasing, right? And these are enforced by capitalist, neoliberal

market rationality, which are proving by and large to be the root causes of mental health issues. And so we see this impacting Black communities in particular who are disproportionately impacted by incarceration, wage gaps, substandard schooling, police brutality, all of these social injustices. And as a result it's eroding the mental wellbeing of Black communities and the mental health of Black communities.

RESH: According to the Center for Mental Health and Addictions, every year, 1 in 5 Canadians experience mental illness. And just to add in some more statistics. By the age of 40 one in two have or have had a mental illness. Since the beginning of the pandemic, as you mentioned, Maddie, feelings of anxiety, depression, loneliness have increased. They're in fact at their highest levels. But even before the pandemic, mental health issues were the leading cause of reduced life expectancy behind cardiovascular disease and cancer.

Now, the reasons for this crisis are certainly many and complex, but - and as you've both been saying so far - dig deep enough and we find that this is indicative of a deeper crisis. And to borrow a line from one of your articles, Maddie, "Capitalism is the disorder. Mental illness, the symptom".

MADELEINE: So, just to expand on the quote from my article the systematic privileging of accumulation over human need in a capitalist system like ours ensures that nothing will take precedence over the imperatives of commodification and profit.

So, poverty, exploitation, alienation, these are inherent features of capitalism. So the degradation of physical and mental health is inevitable as long as we continue to live under the domination of the market. And I think in our system of racialized capitalism those forces will continue to disproportionately impact racialized people.

For some people, both episodic and chronic feelings of sadness, anxiety and stress are actually best understood as logical responses to the structural forces at play in everyday life under capitalism.

I would like to make a really important distinction I think between mental health and mental illness. We really don't want to medicalize social ailments that are caused by the dehumanizing conditions of life under capitalism and that have been greatly exacerbated by the COVID-19 crisis and all of the attending financial strain that that's placed on workers and on families and on individuals.. Medicalizing psychological suffering that's so clearly caused by social and political and economic factors, risks depoliticizing, the social injustice that causes the distress that people experience. I think it also risks medicalizing these experiences as if they're a personal dysfunction which can undermine our sense of solidarity and collective political power.

I do also wanna highlight that I think there are limits to explaining everything through capitalism. While economic, precarity, violence and trauma are all absolutely necessary considerations for understanding psychological distress, none are entirely sufficient. They can't entirely explain why one person who lives in poverty and has survived severe trauma, may experience psychosis while another person similarly situated, doesn't.

So we can talk a bit about the contentious and sometimes harmful nature of diagnoses. And I think we can also talk about the very disturbing relationship between the pharmaceutical industry and psychiatry, but also medicine in general and how that exacerbates these deep-seated problems within our mental health system.

But I think the difficulty of organizing experiences of mental disturbance and suffering into discreet diagnostic categories doesn't make those experiences any less real. There are people who struggle genuinely to care for themselves in more extreme cases to dress or bathe or eat.

So I think we need a both and approach where we are able to accept that people face challenges of such a magnitude that we have a social responsibility to remedy the social isolation, material deprivation, and absence of professional care that those people need. And we need to apply a critical anti-capitalist analysis to how social determinants of mental health impacts psychological suffering and to invest in the social infrastructure that is needed to meaningfully improve everyone's mental health and wellbeing.

RESH: Indeed. So we don't want to just put such a manifold issue under a single umbrella because it's not going to be able to adequately address the full depth and complexity of the issue.

Now, to get into a bit of history, Jon, I once read that an early name for psychoanalysts was "alienists", and this had to do with the rise of the profession during early industrial capitalism when they were largely dealing with conditions of alienation.

JON: Yeah, so you bring up the idea of the Alienist and this idea of alienation, and this is one of the ideas that Marx talks about, right? The alienation of workers from their labor. So rather than having workers producing goods. Specifically, rather than having workers as craftspeople; you alienate workers from their skills, from this idea of production that they have control over. And fundamentally, capitalism seeks to take control over labor, over production from workers and give that power to capital effectively. And so, I think a fundamental part of the capitalist revolution, the Industrial Revolution, is the alienation of workers.

And I was just teaching a couple of weeks ago about the Luddites. The Luddite reaction to the Industrial Revolution is of course, partly about losing their jobs, losing income. But it's also about losing control over their trades, over their skills; over the things that they have historically and often as part of a family or part of community been doing.

And so a fundamental part of capitalism is this idea of taking control of labor away from workers, of alienating workers from what they do and giving that control to capitalism. So it's almost like this idea of alienation is a fundamental prerequisite of capitalism, rather than a side effect.

RESH: So just to continue with you, Jon, in his book, the Great Transformation Karl Polyani wrote about the transition from pre industrialized societies when economies served communities to the Industrial Revolution where communities were forced into submission and servitude to economies or markets. So what does that do to the sense of self of workers where now their labor, the fruits of their labor, the meaning of their labor has in a sense been extracted from them?

JON: Yeah, that's a really interesting question, Resh. I don't think capitalism has been absolute in its ability to alienate labor. And I think we've had moments as well where workers have been able to take control over their labor more effectively, or there's been a compromise, right? A compromise between capital and labor over who controls that? You know, the post-war labor compromise of the 1940s to the 1980s.

And I think one of the things that we've really seen, especially with the ascendancy of capitalism beginning again in the 1980s and then strengthening in the 90s and 2000s, is we've really seen a return to this ability of capital to operate increasingly without the input or increasingly without the empowerment of workers.

So I think especially of the rise of gig and contract work in the last decade or the last decade and a half, what we've really seen is we've seen a renewed alienation of workers from labor, right? We had, for example, journalists who'd be employed by a newspaper, who'd have some editorial and artistic and intellectual control over their product.

And increasingly as we move to a contract or a gig work model in journalism, in academia, in many other places, you see workers again, losing control, being alienated from their labor, forced essentially to sell their labor to the highest or to the, I guess the lowest bidder. And again, losing control over that output, over the work that they do

RESH: Michelle, for non-white populations, this goes even further back into colonial systems that fueled modern capitalism. And this is also a strong focus of your work. So could you speak to this intersection of racial and colonial violence on Black populations?

MICHELLE: So racial and colonial violence has been documented in the literature as playing a significant role in shaping Black communities relationship to the field of psychology. And I think when we look at the field of psychology and we see how it has historically addressed and made space or excluded Black communities, you recognize why there's an unwillingness or a hesitation or a mistrust to sort of engage in formal mental healthcare services.

The field of psychology was born at the height of imperial expansion and colonial conquest. It was created to reinforce and serve the interests of the state. And so we see a lot of colonial rhetoric being processed through some of the methodologies and ideologies used in the field to reinforce a narrative about Black communities as

being less than, as being subhuman, as misrepresenting their racial suffering. And these things have an impact today.

These narratives are still really prevalent and despite all the work that has been done to speak against that.

Colonialism has impacted how black communities are treated within society. And we still see that mistreatment through anti-black racism. And it's impacts on social and political institutions, right?

We continuously have legislation that's coming out that is not looking to address the inequities that Black communities are disproportionately facing. We have calls for expanded police budgets despite Black communities discussing that police enforcements aren't in favor of protecting Black lives, right? And so we continue to see policies that support colonial rhetoric through these different means.

RESH: The Oxford Textbook of Social Psychiatry points out that, you know, capitalism, it's so ubiquitous. It's all around us. It's the air we breathe. And it can therefore be difficult to link a broad political and economic ideology to a mental health diagnosis. However, the Social Determinants of Health may offer us a way to sort of pin it down. Maddie, what are the social determinants of health, and why is this so crucial to an understanding of health and specifically mental health.

MADELEINE: The social determinants of health and of mental health play a very important role in our understanding of the psychosocial and material causes underlying forms of mental distress, like depression, like anxiety.

These factors include: poverty racism, discrimination, exploitation precarity the history of colonialism and cultural genocide and dispossession, that feeling of displacement. Refugees and newcomers are also at higher risk of experiencing mental distress, especially in the context of our incredibly bureaucratic and labyrinthine systems that make it very difficult for people to build a new life in Canada.

Some of the things that Jonathan spoke to as well, like just the feeling of alienation and feeling of disconnection from community. You know, capitalism actually makes social connection with others so difficult. Even social connection with one's own family; should someone be lucky enough to have a loving family who they feel supported by and want to support.

RESH: Right? So the social determinants offer more of a social and systemic lens on mental health. Beyond the body there is also the body politic and you know, we really shouldn't be trying to disconnect the two. But this is not something that we've always done. They're fairly new.

MADELEINE: Yeah, I will say that a recent development in the field of mental health, what is becoming like a very oft-cited model for understanding mental distress is called the biopsychosocial model.

And I think the biopsychosocial model does represent some advancement in our understanding of mental distress that moves a bit beyond very narrow biomedical models. But one of the problems of the biopsychosocial model is it itself is very poorly defined. It's not very coherent. It doesn't offer a systematic framework for prioritizing between biological, psychological, and social factors. So it still leaves a lot of room for clinicians to either ignore or overstate the importance of particular determinants. And that obviously has an impact on care delivery and an impact on the risk of pathologizing experiences that might be best explained by someone's material circumstances.

RESH: Right, and despite its shortcomings, the social determinants or a biopsychosocial model does open the door to a more systemic analysis of health and mental health. And for racialized populations this would obviously include the mental health impacts of Michelle, what you were talking about, systemic racism. So could you speak more to this?

MICHELLE: We see systemic racism manifesting in negative mental health outcomes for Black Canadians in a number of ways, right? Increased alienation, feeling, isolated, feeling not heard. And then not only feeling these things, but also experiencing the material conditions that result because of the erasure or silence that systemic racism enforces for Black communities. And I think what happens in the mental healthcare system where there is such an intense focus on sort of fixing the individual, that communal concerns and systemic and structural issues don't get accounted for.

And these are things that are largely impacting the mental wellbeing of black communities. And so we have to move beyond individualizing and fixing the individual to focus on sort of the pathogenic social conditions that are resulting in deprivation and discrimination and marginalization that Black communities are experiencing.

And so we can get these sort of new drugs, but we don't have new policies. You know, we have new educational and workplace resources that advocate for mental health, but employers aren't offering a fair number of paid sick days, or HR is requiring three times the amount of paperwork to get your leave approved.

We have real social issues that are the result of systemic racism that aren't being accounted for in our discussions and in the discourse of mental health. And I think we need to move beyond that to really make way for more ethical and accountable mental healthcare research.

And so I think the direction for mental healthcare has to be aligning itself with a more activist, informed approach so that it is creating research that speaks to marginalized

and disenfranchised communities and rings urgent and authentic to these communities as well.

RESH: Now of the social determinants income and employment across all communities are fairly major ones. Jon, you just completed research on the *Mental Health in the Workplace Report* that was recently put out by the Douglas Coldwell Layton Foundation, and which was the focus of an earlier episode of this podcast. What were some of the major findings.

JON: Initially it was a very much a literature scan, a scan of existing research. And then we did some polling through Abacus research of Canadian workers effectively. And one of the things that we really heard in this research through the polling and through discussions especially with people within the labor movement was that there was this real frustration with the way that mental health is treated in the workplace, right?

This frustration that a lot of it becomes about sort of employers talking about coping strategies or how to take care of oneself without really addressing fundamental issues, right? Issues like precarious work, issues like outsourcing issues like job losses or stagnant wages. And one of the things that we really heard, especially in the polling, the consultation we got back was that these kinds of interventions were really not addressing the fundamental issues. And the fundamental issues for working people were around questions of insecurity, questions of inadequate pay questions of inadequate sick days. You know, these are, policy changes. Changes around how the world of work should be organized, rather than post facto attempts to sort of address questions of mental health within the workplace. And so there's this real frustration, I think.

And one of the things that's also . Interesting or maybe not interesting, problematic, or worrying is we're really in a period, sort of a sustained economic crisis. We're in a period of relatively stagnant wages. We're in a period of increasing cost of living, of increasing wealth inequality. And these are all situations created by this new capitalist supremacy that we're experiencing. And so we can talk a lot about workplace mental health, but a lot of the conditions that people are expressing concern about that impact them are conditions that are essentially built into this, capitalist moment that we're experiencing.

RESH: So in terms of this period of sustained economic crisis that, as you said earlier, really began in the eighties, which is when we moved into neoliberalism, into all of its social erosions, the increasing mental health issues then really align with the growth of neoliberal capitalism.

JON: I think so. I think in the era of the labor compromise, there's a recognition that for capitalism to sort of work successfully, and this comes out of the crisis of capital experience during the Great Depression, there needs to be buy-in. Labor needs to be, workers need to be a part of this discussion. Government needs to be a part of this discussion. Employers need to be a part of this discussion. And what we really see with the advent of neoliberalism in the 1980s is increasingly pushing the

concerns of working people to the side. Undermining the power of labor, undermining the ability of working people to organize.

And I think gig work, contract work has been a huge part of that move. Breaking down the bonds that can exist at a workplace. Turning workers even more into atomized components of a capitalist system. And breaking up, breaking down the solidarity that at least exists within sort of more conventional workplaces.

It's very hard to build solidarity. It's very hard to build a response or resistance to neoliberalism as these traditional sites of community and solidarity are being undermined in favor of an increasingly atomized workforce.

RESH: And many of these workers within the gig economy, sort of subcontracted labor, contract labor, very short term, are from low income racialized and newcomer communities. And Michelle, how much does capitalism continue to depend on racism within this gig economy?

MICHELLE: Yeah, I don't think you can separate the two. I think they are inextricably linked together and that, as long as there continues to be an emphasis on maintaining some sort of social hierarchy, there's always going to be a push to have racialized communities at the bottom.

Again, the, mental healthcare field, which is aware of these factors impacting mental health outcomes needs to do more in addressing these things. I mean, they're not new or novel in any particular respect, and yet the research of mental healthcare still remains, maintains sort of an apolitical posture still. And I think there needs to be more advocacy in targeting these factors if we're going to make mental healthcare more inclusive, more equitable, more ethical.

RESH: Right, because the dominant lens on mental health diagnosis and care is still very much a white lens.

MADELEINE: To build off of really excellent points that Michelle made., I just wanted to highlight from my clinical experience how race-based disparities in the mental health system play out in terms of the kind of care that's provided and the opportunity for healing that people are offered. So we know that young black people in Canada actually wait twice as long for mental health services and are less likely to access mental health services voluntarily.

That means that young black Canadians are far more likely to enter care through a hospital emergency department or through the criminal justice system than they are through a referral from a General Practitioner, from their doctor or through a community-based clinical service. And I will say that in my time as a clinician in a community-based clinic, I saw firsthand how often it was the case that our Black clients were far more likely to be arrested and charged with public disturbance or arrested because of some kind of violent or threatening incident owing to an acute mental health crisis and actually incarcerated, than our white clients who are far more likely to be brought into hospital when something like that happened.

And were far more likely to be given the chance to receive better quality mental healthcare. We know that healthcare that's offered in prisons is abysmal, and the mental healthcare that's offered in prisons is especially abysmal. Because there's virtually no communication between the healthcare that's provided in prisons and the outpatient teams or clinicians or family members who are supporting the person who has been incarcerated. So just building off of Michelle's point, we need culturally safe programs. Culturally appropriate programs. And we also need programs that are rooted in community, that are community-based to address the violence and mental health issues that these same communities are experiencing.

We need publicly supported and funded peer support programs and culturally specific health service options to meet diverse needs. The unfortunate reality is that even now, something as simple as just finding a translator is so difficult. And obviously so much gets lost in translation, especially if you're conducting a mental health interview with someone or if you're trying to just understand why someone is suffering.

MICHELLE: That's why it's so important when we're talking about the disparities that Black communities and Black Canadians particularly face when interacting with formal mental healthcare services that we sort of trace the genealogy of Black Canadian's relationship to the field of psychology. Once you do that, we're able to better understand the relationship to the field and why there is hesitation and again, mistrust and apprehension.

Historically psychologies ideologies data analysis were being used as an instrument for social control and surveillance. And because of that we still are dealing with anti-Black racism, not only within the field of psychology and the discipline of psychology more generally, but trickling into relationships with service providers as well. Right? And so when we look back, we're able to understand what needs to be done. And as Maddie is discussing, there is a need for more community-led, community-driven interventions and options for service provision where Black communities feel safe, where they feel heard, and they are going to be able to find healing within these places.

We have to look at the fact that there is a need also for greater Black counseling professionals in the field of mental health, right? As one means of addressing sort of the disparities that Black Canadians are facing in mental healthcare. We know that there is a shortage of Black counseling professionals, but we don't have the data .

In the States, they are more likely to collect race-based data. For instance, in the US 86% of psychologists are White compared to 4% of Black psychologists. And I think the statistic offers important implications for service provision. Right? And in Canada, the Canadian Psychological Association doesn't attract the numbers of Black psychologists in Canada.

And I think we need to have race-based data to get specific about who is being included when we talk about progress regarding mental health and who is left out. And then hopefully with these numbers we will be in a better position to push for

policy changes that address the disparity and create more initiatives and incentives to have more Black counseling professionals in the field willing and able to serve Black community members and continue to identify service strategies for service delivery and inform once again a community-led approach in driving interventions for more effective mental health delivery

RESH: Even though we don't have the specific data when it comes to Black populations, is mental health being dealt with more as a health issue, a systemic issue or a criminal issue.

MICHELLE: I think it's often that mental illness is pathologized and criminalized among Black community members. And again, this has been happening for a long time when racial suffering was misdiagnosed as *draptomania* and things of that nature.

RESH: I found that a really interesting, term. So could you just say, What is *draptomania*?

MICHELLE: So, *draptomania* was an alleged mental illness that sort of hypothesized why African descendants who were enslaved were fleeing captivity, right?

They said, you know, they're fleeing because they're unwell, they're not thinking well. And they attributed it to a mental illness rather than accounting for the fact that no human being wants to live and exist under the institution of slavery. This was a scientific and at that point accredited diagnosis, right? Which forces us to really contend with what do we value as scientific discourse and recognize how much scientific discourse serves and reinforces again, the sort of hegemonic beliefs and ideologies of the state, right? We had science that reinforced and perpetuated stereotypes about Black people. About their humanity or lack thereof, and that was used to justify the mistreatment and enslavement of Black people.

And so the type of attention and dominance and authority that we accredit to science because we think it's this objective discipline, I think really needs to be challenged at its core.

Science has always been entangled with the interests of the State.

RESH: And in the case of enslaved Black populations, a colonial capitalist state that, again, grew its fortunes off their labor.

Now, this has been a frequent critique of mental health systems - it's already come up a couple of times in this conversation - that they're stuck in a tradition that has pathologized and punished difference and non-conformity and political resistance. Labeling, sexually liberated women as "nymphomaniacs", targeting gay and lesbian populations for so-called "conversion therapy", "drapetomania". So essentially enforcing Michelle, as you say, social conformity to an often oppressive status quo.

Maddie, is mental health care currently still focused within more of a biomedical model as opposed to a social model?

MADELEINE: Yes, I think that largely it is. I think that that's in part owing to some of the longstanding issues in the field around, you know, medicalizing difference or medicalizing material circumstances. The influence of the pharmaceutical industry again to build off of Michelle's comment, it's easier to get new drugs rather than new policies. And I completely agree. It's more expedient to maintain the status quo to medicalize rather than politicize these issues.

It also doesn't help that we don't have alternative models of care, that we don't have the social and material resources to refer people to that would offer something beyond a biomedical model a model that's also informed by material analysis of someone's circumstances. And a social analysis of someone's experience of things like systemic injustice and racism and colonialism.

There is a lot of really interesting work happening right now in the field of critical psychiatry which is informed by often a Marxist, but also just an anti-capitalist, feminist and racial justice lens. Sort of arguing for rethinking the entire diagnostic system. And also rethinking how the kinds of professional mental health supports that we have, need to be improved,

RESH: You also urge that it's not really a case of having to get rid of one and supplant it with another. When it comes to the anti psychiatry movement, you've asked the question, "At what point does the struggle against social control align with the politics of social neglect?"

So it seems that there has to be a bit of a balance or a tightrope between the biomedical and the social models. Right?

MADELEINE: Yes, I absolutely agree with that. You know, there are many social and economic transformations that are needed to improve everyone's mental health.

At the same time, I think even in a perfectly egalitarian world, we will still see psychological suffering of some kind or another. We just don't know enough about what causes psychological suffering to be able to say that it's going to be cured by some magical drug that hasn't yet been invented or that it's going to be cured by social revolution. And even I use the word cure in a very cautionary way. I would just say properly attended to.

RESH: So it's clear that mental health issues are on the rise. Jon, are mental health services, keeping up with demand.

JON: You know, we're now in our, I guess our fourth decade probably of living under various forms of government austerity. The result being that government is committing less money generally to healthcare of all types. It's committing less

money to many different kinds of social services. The social safety-net, of course is very, very frayed after these last four decades. Things like ODSP are stagnant.

You know, there are a lot of things I think that we can attribute to austerity that have a negative impact on the emotional, mental and physical health of Ontarians, of Canadians and of people around the world.

It's not just the reduction of resources that are going towards healthcare broadly; it's also failure to take the next steps when it comes to public healthcare In Canada. We sort of stopped in the 1980s with a certain version and haven't continued to expand it. Although there are attempts now to do so, but obviously in much more difficult financial times.

But I also think one of the things that we're really seeing in healthcare that's a real struggle and that could further undermine this, is that we're also seeing an attempt of much more forcefully insert profit motives into healthcare as well. And so we're seeing a kind of capitalization of healthcare that's following a more American model. That's inserting profit motives into this system that are not only gonna pull resources out - resources that will go towards ensuring profits for companies involved in healthcare - but we're also gonna see, I think a continued lack of adequate funding in the healthcare system because of this continued emphasis and a renewed emphasis even in the last year or two on a return to austerity,

RESH: So we're moving it more and more out of the public sector and creating opportunities for the private sector to come in and, as you say, capitalize on a very real need. And this is sort of the, the logic of capitalism, right? That if there's a lot of something, then make a buck off it, even if that's something is suffering. I mean, self-help is big business now and as has been brought up the pharmaceutical industry even more so.

MADELEINE: The unfortunate reality is that our research systems and medical education systems are actually so compromised by the pharmaceutical industry that we can't even get new drugs. It's really shocking actually. You know, pharmaceutical companies spend far more money on marketing than research and design, and this is because it's far more profitable for companies to tweak and repatent and rebrand existing medications than it is to engage in the much riskier business of creating novel treatments.

RESH: When we're talking about, mental healthcare within Canada there has always been a bit of an issue here, right? Maddie, how does mental healthcare fit into the framework of universal healthcare in Canada? Does it? Has it?

MADELEINE: Great question. In short, it, it has not really no.

Already accessing mental health services in Canada requires that you either have decent employer benefits, the ability to pay privately or the ability to wait for support that's covered by public insurance. And most of the support that's covered by public insurance is acute care in hospitals. But outside of emergency situations your

options again are either to pay for it yourself. Rely on your employer to pay for it. Or be willing to wait for months or sometimes years for treatment.

So this is something that is deeply rooted in the Canada Health Act and the Canada Health Act's failure to really adequately have a rigorous process for evaluating which goods and services ought to be covered in Canada's Medicare basket. So as it stands, the great majority of mental health services, along with dentistry, optometry, prescription medication, and others, fall largely outside of Medicare's ambit and so remain largely inaccessible.

The funding priorities outlined in Medicare's legislative framework also produced really powerful financial incentives to close the very problematic but psychiatric hospitals that did exist throughout the 1970s and 80s and transitioned to community care that actually totally failed to ever materialize.

And so instead we saw a huge slash to mental health funding that has almost always been the purview of the provinces. And that funding was never really replaced. ,

RESH: And probably not made any better by the recent spate of cuts and growing privatization that we've seen happening in Ontario.

And Michelle, I wonder if you could come in on this as well

MICHELLE: I think sometimes what we see happening is when they make these cuts, there's sort of this underlying assumption that communities will be able to do without; whether it's cuts to community services and things of that nature. And so there's sort of this expectation of resiliency that's placed on these communities and that expectation has impacted help-seeking behaviors of Black communities in particular.

If you are constantly being told that you have to be resilient and you have to persevere despite the neoliberal government continuing to cut social services , then the expectation is sort of enforced. And I think what that does is we really have to think critically about, you know, who is asked to be resilient, to persevere, to make due, and why is it always the least resourced?

And I think for these individuals, you know, to what end must they be resilient? And who is benefiting from our resilience?

The continuing of spending cuts on sort of communal services when there is a call and need for an increase in them, casts no doubt on where the government stands largely on mental healthcare issues for racialized communities.

RESH: And that's an interesting point, right? I mean, neoliberal capitalism is both antisocial and hyper-individualistic. One of its greatest champions. Margaret Thatcher once said, "there's no such thing as society, only individual men and women."

Now where health systems within capitalist society have long favored individual over social analysis. Have we started to internalize this? Has this become part of collective culture in expressing social ills as personal anxieties, emphasizing as you say, Michelle, personal resilience over solidarity and collective political action? Are we in a sense sacrificing social advocacy for self-care?

MICHELLE: Absolutely. There's an intense focus on person-centered approaches to wellness and to within the market to fix the individual. And the problem becomes, you can't get well within the micro context of therapy if once you leave the doors of your session and the sort of systemic and institutional barriers are still present.

And so we can't self-care our way through systemic abuse and the pervasiveness of anti-Black racism.

You know, we need political mobilization and we need collective change if we're going to work towards really radically restructuring the social and political arrangements of our society.

JON: I really like how you brought in that Margaret Thatcher quote. I was actually thinking about Margaret Thatcher when we were talking about austerity. There's this idea in capitalism that it's not about a community. It's not about a society, it's about an economy. That the sort of perfect capitalism is envisioned by economists and others who really love it- they see it as sort of this perfect collection of individual economic actors all acting in their own best self-interest, right?

And so it's not about community. It's not about society, it's about individuals acting individually and some kind of collective purpose being mobilized through the market.

And it's a really fascinating thing, right? Because. What you have then is you don't have society; in Margaret Thatcher's words, you have a collection of individuals, atomized individuals working towards their own individual self-interest. And this is sort of the pure form of capitalism.

And one of the things then as well is that if you can't succeed in this system - if you can't get a job, if you can't be successful economically, if you don't conform - it becomes a personal failing, right? The system becomes the goal rather than the individuals or the communities that make up that system.

It's one of the things I think that capitalism lacks. It lacks any sense of the individuals having value in and of themselves. It lacks a concern or an idea of a collective action that's not motivated by individual self-interest. And it also really sort of downloads failure. It means that, you know, if you can't fit within this system, it's not that the system isn't working, it's that you can't make yourself fit within it. It's your fault. It's up to you to make sure that you can work in this system.

RESH: And so where we have had this social neglect, communities, as they always do, they pick up the slack, right? They start to bring in these alternative approaches.

Michelle, could you give us some examples of community-based approaches to mental healthcare?

MICHELLE: So, one example that we see is actually the role of Black churches, faith communities and how they historically have played a role in mental wellbeing and currently have also stepped in to sort of continue that sort of tradition, right? And it's been an important line of inquiry and site of intervention in my research. Exploring the role of community-based faith leaders and the work they do to maintain mental wellbeing in Black communities.

Black communities are still more likely to report higher levels of religiosity and spirituality than their White counterparts. And faith and spirituality are often documented as a protective factor of one's mental health.

And I think we need to think about how have religious and spiritual leaders played a role in helping to advocate for mental health and maintain mental wellbeing in Black communities? If Black communities are more likely to access spiritual faith leaders in times of crisis, what does that mean when we are thinking through interventions?

Are community faith leaders being asked to contribute to discussions about mental health initiatives? Are they equipped? Is there education and resourcing that needs to be put in place to help support them as they do this work within their communities?

Historically Indigenous African healing traditions have placed a particular emphasis on spirituality. So it's worth when looking into how am I attending to this historical cultural practice, advance mental wellbeing.

And so when we're thinking about community interventions, I do feel religious leaders, community and spiritual leaders play an important role there and worth interrogating.

RESH: So the social capital that already exists within the community is part of this social approach to mental health and mental illness.

And Maddie, I wonder if you could come in on this as well in terms of alternative community-based interventions.

MADELEINE: You know, there are a couple examples that just come right off the tip of my tongue. One of them is the clubhouse model. There's a really wonderful place in Toronto called Progress Place. Clubhouses are essentially organized to support people living with mental illness.

The membership is comprised entirely of people who identify as struggling with their mental health. And in clubhouses people have the opportunity to build a sense of community. There are often employment training programs for those who are interested in that, but that's absolutely not mandatory.

At Progress Place in Toronto, they have a radio station that's run by the members of Progress Place. They have a kitchen where people volunteer to cook meals, and then those same meals that they make are sold at incredibly affordable rates for members to purchase themselves.

And so it's this beautiful example of self-organization that I think demonstrates that people living with mental illness can absolutely lead flourishing and meaningful and socially connected lives. if, If the right conditions are in place and if the right social supports are in place.

There are other examples of peer LED initiatives. I'll just mention one more which is the Hearing Voices Cafe. There are several different iterations across the globe including really rich online communities. But in Toronto the Hearing Voices Cafe is specifically for people who hear voices to come together and just to talk about their experiences, whether positive or negative. And it's a really beautiful example of just totally organic Peer and community-led support.

Communities, and Michelle alluded to this as well, are often at the forefront of devising these really creative and novel responses to unmet needs - and this also includes violence and alternatives to policing - that you know, would really benefit from more funding and support to be able to expand off of these really promising programs that we have already demonstrated to be really effective in so many different ways.

RESH: Now there is currently a debate on the expansion of the medically assisted suicide bill or MAID to include those who are suffering solely from mental illness. What connections should we be making between that discussion and the one we're having here about capitalism as a cause of, not all, but many of the increasing mental illnesses that we're seeing?

MADELEINE: So opening pathway to medical assistance and dying for mental illness is incredibly contentious for several reasons.

Reasons that more specifically have to do with social justice and economic justice and capitalism are shared by Track II MAID.

Currently there are two pathways to accessing medical assistance in dying. The first, which is generally referred to as Track I, is if you have a death that is immediately foreseeable. So for example if you have breast cancer and you decide, the treatment is worse than the effects of the illness just taking its course and you would rather be able to determine when you are going to die and the kind of death you're able to have. So that's Track one MAID,

Track 2 MAID is essentially available to people who have a serious physical illness that impedes their quality of life to such a degree, that they find it untenable and unacceptable. I think the issue with that has proven to be that a lot of the resources that people need, like housing or even like adequate access to a care team, to a family doctor, to social assistance rates that give you enough money to live off of - in

the absence of those things, it's really difficult to determine what is actually contributing to someone's quality of life. Is it their illness or is it these broader social injustices? And how perverse is it that it's potentially easier for someone to access medical assistance in dying than it is to access affordable housing. Affordable housing that is also accessible housing where they have the kinds of supports that they need given the limitations or struggles that they face owing to their physical illness.

With respect to the current socioeconomic system that we live under; is it going to be the case that especially some of these mental health struggles and kinds of psychological distress that people are experiencing that are largely fueled by unfair, unequal and unjust circumstances. You know, are we going to see more investment in opening a new pathway to MAID than we are in robust social and welfare programs that would give people a real option to have their quality of life improved?

RESH: Yeah, it's a good question and a difficult one, and also a really important one.

Now in a conversation about capitalism, obviously we have to bring in Karl Marx - and Jon, I think you brought him in earlier anyway. But in the 19th century, Marx wrote about how Industrial Capitalism "increases efficiency and productivity and profit by degrading and de-skilling labor." He also pointed out that it induces powerlessness and apathy even as it sacrifices meaningful work for wage labor.

Now, at the beginning of this conversation, we said that mental illness is an inevitable outcome of capitalism. Coming at this from a different direction, Jon, in the current context, is good mental health, good for neoliberal capitalism?

JON: Oh gosh, that's an interesting question. I think one of the fixations, the thing that keeps your neoliberalist economist up at night right now is the question of productivity. This idea of how hard people are working. You know, how able people are to work to their full economic potential. And often when you see discussions from that perspective around mental health, it's often framed as an issue of productivity.

So it's worthwhile for employers to invest in the mental health of workers as long as it doesn't undermine other economic considerations in order to ensure or encourage higher productivity. I guess in a roundabout way, what I'm saying is I think it does serve neoliberalism to have a workforce that is willing to work hard. I guess that has the mental capacity or the mental ability to work hard. But I also would say that it does not offset the desire for a de-skilled, low wage, atomized workforce. And along with that a surplus of labor so that labor force can be forced to compete for wages.

RESH: Right, so a disempowered, but not necessarily dysfunctional labor force.

JON: Yeah

RESH: Okay. Recently, Toronto Mayor John Tory, called for a national summit on mental health. So given everything we've been discussing, what must a social, just

systemic and anti-capitalist approach to mental health involve, and Michelle, let's start with you.

MICHELLE: I think we need to be proactive. I think we should have a mental healthcare system that is not just merely responding to mental health concern, but is actively working against and advocating for better mental health conditions and addressing the fundamental roots of mental health issues. Which then would in fact require including socio historical and political factors in the creation of a mental healthcare strategy, especially for Black Canadians.

I think a totalizing mental health campaign for Black Canadians must include challenging structural injustices and targeting institutional barriers that maintain and perpetuate anti-Blackness.

And it's not impossible to conceive of either. The precedent has already been set. Mamie Phipps Clark and Kenneth Clark, the couples work on racial identity helped to overturn segregation policies in the US South, right. And so I think there is room for more mental healthcare workers and researchers to take on the social justice work. And apply more studies to addressing the psychological violence of racial oppression.

The field also requires an epistemological shift if it's going to address the sort of absences and gaps around Black wellbeing.

And I think there's other places to turn outside of the sciences that have really struggled and worked through and unpacked and thought of innovative ways to resist colonialism, racial capitalism, and other forms of state sanctioned violence. There have been other places in which it's been done, and I think including those voices, including those actors into the discussion can be really transformative for the mental healthcare field.

And so Black feminism, the tradition of Black studies more generally, I think there are important insights that can help create the change that we wanna see and allow for radical transformation of the field.

MADELEINE: I agree with a lot of what Michelle said, so I'm gonna do my best not to repeat the points that she already raised.

I think that there are certain things that would improve everyone's mental health that should not be offered through the mental health system.

Ensuring decent and affordable and stable housing should not necessarily be incumbent on whether or not one carries a mental health diagnosis. We need broad change with respect to our social welfare programs. We need to see broad social and economic change to meaningfully improve the mental health of everyone.

Egalitarian, social and economic policies are good mental health policies. But when acute mental health needs arise in the context of situational stressors for those who just need them, targeted social services and healthcare programs are also necessary. And so too is the need to improve quality of life and outcomes for people with a severe and persistent mental illness.

So, you know, the basic components of comprehensive care already exist to some extent, but public funding and publicly run programs will be required to really expand provision to the point that these services are available to anyone when needed. And to ensure that culturally safe and culturally specific programs are equally available.

We can look to the UK and Australia, both countries just recently expanded public coverage for certain psychotherapy services.

In Canada's highly decentralized federation, there are gonna be significant legislative and political challenges to coordinating a sufficiently robust and humane approach to care. And without strong leadership and funding commitments from the federal government ,very little is likely to change. But ideally we would expand a vast array of mental health care services so they're universally available. And that would also help us reduce our reliance on crude and paternalistic treatments.

I think that we also need to wrest power from the pharmaceutical industry that's currently profiting off of their monopoly over a mental suffering. And the road to democratizing scientific research is sure to be an uphill battle, but it's really critical that we reclaim publicly funded and democratic inquiry into the nature of mental suffering and possible treatments, which center assessments of what is important to the people who are actually suffering.

And a social commitment and social acknowledgement of our responsibility to care for people who are struggling with their mental health.

RESH: So good mental health care depends on good social welfare. And John?

JON: Just to take off one of the things Madeleine said, I think it's really important to talk fundamentally about a reallocation of resources and power in society. I think the way resources are portioned out the way we privilege certain things, funding for certain things. The way we have our tax system structured. I think too much of the resources or too many of the resources that need to go into this and other issues around health, around community and society fundamentally need to be reexamined. So too little money going to public health, too little money going to mental health, too little money going to housing, healthcare more broadly. I think we need to really start looking at how we allocate those resources.

We live in a very wealthy society. We have the resources to create a truly fair, equitable, and healthy society. And I think we need to reallocate those resources in order to do that.

RESH: Michelle, Maddie, and John, thank you so much. It has been a pleasure.

MICHELLE: Thank you.

MADELEINE: Thank you.

RESH: That was Michelle Sraha-Yeboah, researcher on mental health of Black communities, Madeline Ritts, social worker, researcher and writer, and John Weier, historian, researcher, and educator in labor issues.

I'm Resh Budhu, host of The Courage My Friends' podcast.

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