Manufactured Margins: Accessibility Renovations for Art Therapy

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September 2022 Cohort, Toronto Art Therapy Institute (TATI)

Major Project Proposal (Thesis)

September 1st, 2025

APA 7

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This thesis proposes to examine interconnected barriers limiting equitable access to Art Therapy for multiply-marginalized individuals who experience severe stigmatization. Advocating for improved service within one-on-one, private practice spaces under the regulatory scope of the College of Registered Psychotherapists of Ontario (CRPO). Practical ameliorations will be proposed at levels of policy, training, and therapeutic practice.

The proposal's structure prefaces multifaceted matters with a gradual approach rather than an itemized list. Proposal outline requirements are addressed in a woven way. The expansive scope of this inquiry is justified by the interconnectedness of relevant institutional systems. Consolidating the demographic I eventually hone is a process that requires terminology to be attuned throughout. Asserting substantiations for Art Therapy service provision beyond institutional confines for the most multiply-marginalized is advocated for by balancing the field's complicity in structural inequities with a defence for its potential to acclimate. Unlike a controlled study, survey, or limiting the project to a theoretical critique, I propose a thesis which leads to a *Blueprint*; actionable implementations of progress informed by emergent strategies that can be taken up by the field. While thesis proposals typically outline future research plans and justify methodological choices, the breadth and urgency of this topic necessitated substantial investigation in advance. Instead, I work to name the forms of looking I have undertaken and articulate methods for how to *present* such information for sensitive mobilization.

Origins of Thesis Topic

This thesis topic arose organically from my own questions as a student attending the Toronto Art Therapy Institute. While seeking regulatory clarity for serving clients with layered, multiply-marginalized identities, existing guidance proved minimal and stigmatizations became apparent. Instructions for service acquisition did not account for many of those who fall outside generalized practice frameworks.

Protocols for individuals with ‘severe’ mental health needs and intersecting marginalizations, especially precarious housing, were not readily available for my instructors to reference. Barker & Maguire (2017) maintain that individuals who experience “homelessness” are qualitatively different from other populations, containing some of the most complex, multi-morbid identities to consider (Introduction section, para 5). I questioned the permissibility of efforts towards their inclusion. For instance, offering no-cost therapy sessions and proper methods for documenting such. Or, skills to differentiate between overlapping presentations of acquired brain injuries, psychosis, and substance usage. I requested references for private practices deliberately serving the utmost multiply-marginalized populations, such as those with adaptations for clients experiencing hallucinations alongside other comorbidities. Yet, those engaged in independent radical work often don’t (or can’t) publicize their methods plainly. These issues cannot be ethically navigated through trial and error. They are precisely why regulations exist.

My questions were typically met with evasion. Supposedly rare hypotheticals were dismissed or bypassed on the grounds of minimal personal experience. The absence of clarity in servicing complexities of acute mental illness and intersecting marginalizations are not the fault of individual instructors, nor a lack of specificity on my part. It evidences systemic, regulatory neglect. Despite the ubiquity and vulnerability of this population, coherent guidelines addressing nuanced clinical realities weren’t practically established. Certain individuals were implied as best left to institutional settings, as if unfit for Art Therapy outside of medical-model psychiatry. This attitude prevails from an exclusionary logic rooted in uncertainty and inconvenience; not data, not heart. If mental health professionals aren’t prioritizing mental health care for critical mental illnesses, has the praxis not become antithetical to what is truly therapeutic? Services for people with substance-use health concerns have been separated from mental health supports at large, regarded instead as “social or criminal issues” (*Canadian Mental Health Association (CMHA)*, 2022, p. 4).

Luckily, my investigations were sometimes met with encouragement from instructors to probe further. That I did. The regulatory frameworks governing Art Therapists do not simply overlook multiply-marginalized identities as if these are recent, yet-to-be-integrated concerns. Their exclusion is intentional and structurally embedded. Art Therapy's complicity in sustaining (and at times constructing) the very marginalizations it claims to remedy has materialized in my research. Enmeshed with institutional power, and subordinated to that power, entire populations are neglected in private practice considerations due to a favoring of inaction over accommodation. I am unprepared to serve the demographics I am passionate about providing Art Therapy to and conscious of repercussions for attempting to do so given the present logistics. More troubling are the likely outcomes if I don't try, given the trajectory we're on, and the behaviours of adjacent fields which function as metaphor.

Improving The Field

Significant strides pursuing inclusivity are frequent within the field of Art Therapy. We cannot afford stagnancy now. Continual reassessments are imperative to keep pace with emerging needs. The CRPO (particularly within distinctions made by Art Therapy) deliberately position its regulatory objectives as advocating for accessible, diversified, trauma-informed, and inclusive efficiency (*Annual Report*, 2023, p. 3-5). Consequently, it must hold itself accountable to populations it neglects through measured actions that rectify the discrepancies, according to its own professed standards. At the very least, it ought to cease appropriating activist language to falsely imply such capacity. *It has imposed this thesis on itself.*

Unaddressed mental health inequities are not novel discoveries awaiting controlled studies to prove. Subjects systematically bypassed in much academic discourse is a phenomenon built into hierarchical systems. Categorical invisibility and attributed devaluation enables the systemic continuation of their maltreatment, which, my research has found to be profitable and useful for larger configurations

of social control (Grecco & Chambers, 2019, Dual Diagnosis section). The therapeutic relationship amplifies differentials between therapist and client because it begins at a particular moment of vulnerability for those who use the service. As phrased by Peel et al., (2021) “Locating both parties in their specific matrix of privilege and oppression must be a deliberate act of work” (From Clinical to Collegial section, para. 2). Aside from the qualities Art Therapy possesses that may uniquely improve accessibility for neglected demographics, our own practice standards already prompt alterations.

Complexity of “Nothing About Us Without Us”

My personal lived experience as a multiply-marginalized individual with a history of mental illnesses, precarious housing, disability, illness, and poverty are worth outlining where relevant. My identity walks a tightrope between the professional, therapeutic realm and that of the neglected clientele; though belonging wholly to neither. I am only a student and not a practitioner, I have just as many privileges as marginalizations. I find a right of passage as mediator by having partial stakes in both departments, and an informed will to advocate for their reconciliation. I am situated in so-called-Ontario, the heart of Art Therapy’s formal establishment in so-called-Canada; integral terms my thesis will address given the jurisdictions of the regulations and their history.

My loose situatedness is not alone qualification for research contribution involving extremely vulnerable people. Certain experiences do not translate to a comprehensive understanding of the spectrum of unhoused, marginalized realities. In line with Freire’s influential *Pedagogy of the Oppressed*, I recognize that research ought to adhere to the lived experiences of oppressed groups in order to articulate their own problems and co-develop meaningful solutions without being alienated from their own liberations (Feen-Calligan et al., 2018, Introduction section). In theory, someone with more extensive lived experience would be better suited as researcher and author of this work. Yet it's unlikely they would be as academically privileged, informed on therapeutic practicalities, or provided the

opportunity to present a thesis that may be considered by the regulating college. I cannot embody the lived experiences of all marginalizations that I make reference to. Nobody can. Just as Art Therapists hold therapeutic space for identities they do not themselves possess or yet have experience with.

Limitations of Methods and Findings

In activist and academic processes, privileged people anticipate deferring to marginalized people on issues of oppression or experience. Philosopher Olúfẹ́mi Táíwò (2022) argues that this norm kills solidarity and replaces effective politics with endless "navel-gazing" (as cited in Denvir, 2022). Failing to adequately defer, in this case, reigns more ethically lasting. Automatic deference pressures vulnerable people to educate their privileged, ignorant counterparts to a point of exploitation. As measured by Peel et al. (2021), when considering the most marginalized, verbal or written communication is not straightforwardly accessible (Art and Co-production section). Sensibility, sentence structures appropriate for academic papers, and consistent opinions are furthermore ableist expectations. Interviews cultivate bias from the "interactively produced meanings and emotional dynamics of the interview itself" (Ellis et al., 2011, p. 6), which gets me no closer to sharpened truths. Quoting someone during active psychosis, for instance, risks misrepresentation immeasurably. Externalized mental health symptoms may complicate obtaining informed consent. Barker et al. (2018) consider the vulnerability of people experiencing precarious housing as being perpetually on high guard in order to avoid being taken advantage of (p. 219). Merely approaching folks in survival mode can be a transgression inconsistent with ethical research production. Financial compensation for participation becomes coercion when any scarcity is involved. Incentives can distort consent and become manipulation. While larger, well-funded studies may be equipped to engage participants with long-term care and support, this thesis as a preliminary exploration is not.

Though I intended to speak with my unhoused neighbors personally, after drafting surveys, interviews, and art engagement ideas while digesting aforementioned research, I was unable to avoid the patronising, coercive aspects of provoking their direct opinions on therapeutic access. Peel et al. referenced the principle asserted by disability rights advocates: “Nothing about us without us”(Defining the Principles section, para. 4), which generates an unsolvable tension given the practicalities involved in data construction from a population that cannot be competently categorized in the constraints of a proposal. I do not intend to speak for my neighbors or reduce the complexity of their intersecting (and often, conflicting) interests, preferences, or opinions. Attempts to standardize their inclusion demands coherence where none should be expected. Instead, I emphasize the pluralities and take them up with practitioners, educators, and the regulatory bodies indebted to commitments of accessibility. I can do that with them because I am them.

I do not endorse the opinion that multiply-marginalized individuals *should* be therapized. I commend instincts that reject uninformed, unsafe spaces of ‘healing.’ As Philosopher Martha C. Nussbaum (2000) advocates in her *Capabilities Approach*: emphasizing an individual’s interest and capability towards involvement in an activity, rather than necessarily participating in an activity, supports the notion that accessibility is what defines ‘good’ facilitation of services and activities. *I am interested in the procurement of equitable capability, not participation*. The right to disengage or reject therapeutic intervention is equally important to one’s autonomy and wellbeing. A genuinely inclusive client base would comprise only those who *want* to be there, not who managed to get there despite systemic barriers. Radical inclusion of mental illness in the field of mental health can be better regulated without vulnerable populations needing to laboriously instruct us as to how. I recognize it is unorthodox for a thesis to insist on change not necessarily proven to be desired by the researched group. Desire is a privilege known only by those offered sincere, comprehended choices.

Methodology

I could not locate a practical research term for what I have been up to. Essentially scouring for buried topics to utilize fragments surviving the "hegemony of traditional archival institutions" (*Archive/Counter-Archive*, n.d., What Is section, para. 2) which routinely neglect the marginalized. These sources often fall outside peer-reviewed, conventional standards. A critical lens is necessary when interacting with dated, biased accounts of this population's interests. I am transcribing in the realm of *counter-archival methodology,* as Alsaden (2023) positions to be a re-discovering what institutions have omitted, silenced, or erased; even ideologically. This process involves methods of *digital scavenging* as Niang (2024) considers an adaptation to subjects scarcely researched by way of amplification (Abstract section). This disrupts conventional narratives which often biasedly archive history. It holds that knowledge from marginalized (though epistemically privileged) groups may be sourced through unconventional or illicit means and still be meaningfully engaged with. Sibley et al. (2022) even claims that well-conceptualized grey literature can effectively push policy adjustments affecting diverse subjects for which comprehensive, academic reviews have not yet been conducted for (pp. 7-8).

As a student of Art Therapy, I am intrigued by tactics of scavenging for how they foster creativity and wonder (e.g., Note 1 section; Niang, 2024) while maintaining doxastic weight. Scavenging decentralized purist, scholastic ideas of methodological processes by prioritizing the implications of research *outputs*; such as how findings are framed and who can later take hold of their narratives. Interrogating the ideological foundations of Art Therapy regulations uncovers what we claim to know and how we came to know it. But also, as Hitt (2012) grapples with, what we claim to *not know* (Critical Imagination section, para. 1). Faulkner's (2021) writing asks me to move beyond the obvious critical analysis when demanding institutional accountability. My position as an insider student must be tended to since I am a beneficiary from complicit frameworks. Green's (2019) naming of "freedom dreaming"

terms which offer “otherwise possibilities” (Abstract section, para. 1) is an inspiring method for encouraging practitioners to envision and implement meaningful adaptations within their clinical practices as well as my own. I partly adopt an *autoethnographic* perspective to achieve this since my emotional entanglements cannot be discounted amid the intimate reflexiveness prompted (Ellis et al., 2011, Doing Autoethnography section). I make no attempt to provide an illusion of academic neutrality. I am grateful to be influenced and motivated by this research on both personal and professional levels. Unconventional thesis topics sometimes require unconventional methods. I offer this *cornucopia of methodologies* as I work to uncover repressed epistemologies in order to remedy forwards.

Terminology and Scope: Severely-Stigmatized-Neighbours

The ramifications of lexicons can profoundly impact vulnerable people and uphold dominant narratives. Much of the invented terminologies for marginalizations have been shaped and maintained by mental health professionals aiming to diagnose or classify. Positions of such power can also be harnessed to shift narratives toward greater care and accuracy. Laliberté et al. (2019) outline how inconsistent definitions of "homelessness" across studies obstruct comparative analysis (Limitations section). Resistance against adopting standardized terminology is equally significant. Dowd (2024) asserts from experience that many unhoused individuals reject gestures of person-first language bestowed upon them, viewing them as superficial (Worrying About Language section). Researchers like Palmer (2018) argue that in academic discourse, however, person-first terms such as “individual experiencing homelessness” more accurately convey the circumstantial nature while avoiding totalizing labels like “homeless” (Introduction), which shifts blame from individual failure to systemic neglect.

Throughout my writing, I incorporate direct quotations from a range of sources, while maintaining my own conscientious phrasing as contrast. These juxtapose linguistic inaccuracies, prevailing ideologies, and biases embedded in common terminology still used in therapeutic spaces. Art

Therapists and researchers alike ought to concern ourselves with real solidarity and relationships built with vulnerable groups more than how we refer to them distantly in writing. 'Advocacy' that begins and ends with terminology is virtue signaling at best. I do not intend to get caught up in semantics.

Unhoused individuals in Ontario disproportionately represent other marginalized identities within its margin. CMHA (2022) statistics indicate that individuals with concurrent mental health and substance use disorders face significant barriers to care (p.7). 2SLGBTQ+ individuals, (im)migrants, and racialized individuals are particularly affected by housing and income insecurity (p.7). Relevant services are presently siloed in legislative funding, gearing to only one component at a time. This population contains too many needs to address conveniently, as said by Sampson (2022), so individuals are forced to decide between essential services (Intersectionality section, para. 4). This fractured structure also limits research on co-concurrent realities. Ironically, cataloging each intersection of marginalization within this community is too lengthy for the permitted page count of this proposal. Despite deficient data on unhoused individuals in Canada (see Ahmed et al., 2022, p. 26 for examples), my thesis will address as many neglected nuances as it can compound into its preliminary purposes. Palmer (2018) rather empathetically suggests that humanity's proclivity towards categorical labeling is an attempt to resolve the "impossible complexity of the environments we grapple to perceive" (Categorical Labelling section, para. 2). Interesting how this may explain the neglect of complex marginalizations for which no precise categorization can be summoned.

Severe Mental Illnesses are categorical catch-alls for externally 'impairing' presentations of mental illness utilized in the therapy community. This can unhelpfully generalize distinctive diagnoses and attribute to stigmatization. All mental health experiences can range in severity. They may be better defined as mental illnesses that are severely misunderstood or severely stigmatized against. Hazell et al. (2022) revealed rampant clinician biases in medical and mental health care service providers. "Fear"

against mental health presentations related to psychotic and personality disorders (AKA 'severe mental illnesses') was cited and found to negatively impact service quality (Discussion section). These diagnoses are overrepresented in unhoused populations and heavily stigmatized in public contexts as well as clinical (Discussion section). The false assumptions of safety afforded to clients who lack formal diagnoses or externalized psychiatric symptoms are equally dangerous. Such distorted risk perceptions undermine client and clinician safety while dismissing inner experiences of acute mental health crises by over-stigmatizing more externally pathologized symptoms.

For clarity and ethics, I introduce the provisional term *Severely-stigmatized-neighbours* (SSNs) to refer to multiply-marginalized individuals with mental health challenges who lack housing security (safety) and community support (belonging). This term may evolve. It underscores their equitable right to accessible services, capacity for healing, protection, and accommodation while guiding my research with a prioritization of dignity through relation. This abbreviation is not a unification of the diverse identities it encompasses. It is a tool to facilitate clear discussion in my thesis with more heart and leveling than existing research terms presently capture.

Why Severely-Stigmatized-Neighbours Concern the Field of Art Therapy

It takes more than just a house to help those experiencing homelessness thrive. Sibley et al. (2022) concur that people provided homes will "languish" without social integration and support since their psychosocial needs remain unmet, thus coping at a level of survival (p. 27). Beyond accessibility commitments through self-proclaimed standards, we carry an additional, reparative responsibility toward the SSN community, as do numerous other institutions for the perpetuation of their oppression. Psychiatric facilities, healthcare, pharmaceuticals, the prison-industrial complex, governmental austerity, MAiD, the war on drugs, and so forth. My thesis will outline their connected culpability in order to reinstate Art Therapy's untapped superpowers for alternate possibilities moving forward.

The norm of mental health intervention through massive public institutions was rather ineffectively dismantled in Canada between the 1960s and early 2000s. The deinstitutionalization movement had three propellers for moving people with “severe mental illness from [psychiatric] hospitals into the community: the belief that mental hospitals were cruel and inhumane; the hope that new antipsychotic medications offered a cure; and the desire to save money” (Yohanna, 2013, How Did section, para. 1).The appalling history of psychiatric institutions is well documented but not necessarily common knowledge; enabling a broad acceptance of psych wards as default environments for SSNs. Hand (2008) reconciles the origins of Art Therapy within psychiatric settings before the field was named or independently regulated (p. 37-40). For time, Art Therapy was permitted only as an auxiliary intervention within the psychiatric, curative model, producing medically desirable results through its own experiments on imprisoned psychiatric patients. Successful Art Therapy techniques incidentally rendered inhumane psychiatric practices obsolete over time, which is not to say that early Art Therapists were functioning in outright opposition to harmful psychiatric practices.

I have begun researching atrocities of institutional violence to better understand the positioning of psychiatric facilities presently and our ontological tension with its primacy. Practices like lobotomies and shock therapy eventually rebranded under clinical legitimacy. Richman et al. (1984) brilliantly outlined the shift through which curative logic remained, but “chains and straitjackets now come in chemical form” (p. 4). Psychiatric wards, having never disappeared, mildly restructured for new funding models, many of which contemporary Art Therapists still work in or previously trained from. SSNs remain disproportionately routed into these spaces, often so with tacit endorsement from psychotherapists, despite incompatibilities with the therapeutic ethos as we know it.

Art Therapy’s growth away from psychiatric institutions has both upheld and resisted institutionalization. Neither trajectory has served SSNs effectively. They can be systematically recognized

as *misplaced psychiatric patients* in a society shaped by post-institutional norms thanks to a poorly organized deinstitutionalization movement. They never received the simultaneous build-up of supportive housing, social services, or outpatient-community mental health infrastructure required for comprehensive support. The unprecedented level of people surviving outside, crudely put, “forced the criminal justice system to assume the role of mental healthcare, as untreated, unsheltered individuals were relabeled as ‘criminals’ ”(Grecco & Chambers, 2019, The Penrose Effect section, para 3). Kallen et al. (2010) found concurrently marginalized individuals more likely to be incarcerated and, upon release, more likely to become unhoused (Executive Summary section). Art Therapy accessibility for SSNs *beyond institutional care* is not necessarily wholly de-institutional. Art Therapy may be too underdeveloped to adequately meet the needs of SSNs comparatively. Perhaps the best approach would be in conjunction with psychiatric efforts, as proposed by Laliberté et al. (2019) and Yohanna (2013) to more deliberately assist outpatient aftermaths. Regardless, “[the art therapist] must take into account the illness of that institution, not merely that of those individuals in her care. She must accept that her presence there as a caregiver does not inoculate her against the pathology of the system” (Allen, n.d., Art Therapist as Social Activist section, para. 4).

Feasibility and Facades: Financial Barriers

Government parsimony largely dictates who receives services and how they’re made possible. Sustainably providing affordable services to SSNs without relying on institutionalized funding requires creativity in the face of destitution; of which I have plenty. As explored by Ahad et al. (2023), conceptualizing stigma at a systemic level is crucial in motivating authorities to invest in accessibility for the most marginalized (Review section, paras. 1-8). While the ethical impetus is not primarily to reduce government spending, demonstrating the cost-efficiencies of inclusive mental health services beyond in-patient care may encourage legislative support. Socially-inclusive programming investments can

become derailed by "public safety" rhetoric which discriminate against SSNs participation (Sibley et al., 2022, p. 11). Ahmed et al. (2023) noted blanks in the government's resolution data for unhoused populations which failed to generate statistics involving positive outcomes (p. 8). This is consistent with the *Legislative Assembly of Ontario*'s (2023) overall confusion regarding service-locating for various tiers of mental health referrals (Ontario Budget section). Accounting for precarious housing status during psychiatric discharge is an accurate "predictor of recurrent use of acute mental health care services as well as discontinuity of care" (Laliberté et al., 2019, Acknowledgements section). Failing to publicize service usage statistics mystifies the efficacy of solutions and devalues the meaningful work of providers.

The issue of cost is a deflective facade. When spending is scrutinized, financial reallocation toward equitable mental health care is not only feasible, but cost-effective. Ahmed (2023) found "homelessness" costs the Canadian economy over $7 billion annually (p. 8) not counting "hidden homelessness" or undocumented cases. Studies from other regions cited by the CMHA (2022) funding mental health care preventatively show a reduced strain on hospitals, prisons, shelters, and morgues (p. 11). The barrier is ideological, not fiscal. Providing SSNs individualized, non-institutional therapy risks catalyzing wider public demands for accessible mental health care. Reformed funding, regulations allowing greater financial lenience, or even sponsorships are threats against exploitative norms of colonial capitalism. Offering practicing Art Therapists clever ways to improve services for SSNs will coincide in my thesis regardless of whether policy changes actualize.

Transinstitutionalization as Scope

The deinstitutionalization movement has more honestly resulted in *transinstitutionalization*: a feedback loop in which SSNs are tossed between psychiatric institutions, hospitals, jails, or inevitably left on the street to perish. Transinstitutionalization renders no institution as wholly capable of fulfilling the needs of those thought to be deinstitutionalized, nor wholly responsible for their ostracization. Averill et

al. (2024) highlight systemic inertia as extremely dangerous for those with severely-stigmatized-against mental illnesses, contributing to additional and exacerbated comorbidities (Findings section, para. 3). The complicity evidences them all relevant for examination within my research.

Grecco & Chambers (2019) unravel the inverse relationship between mental health treatment infrastructure and criminal incarcerations as an augmented *Penrose Effect* (Abstract section). Visibly mentally ill individuals become susceptible, as Roebuck (2007) found, by being frequently arrested for minor social infractions or disruptive behavior, not for actual threats to public safety (p. 21). Police often perceive incarceration as a genuine access point to medical care and psychiatric services(p. 21). Balfour et al. (2022) argue that this belief disproportionately harms unhoused, racialized individuals with visible symptoms of mental illness (Abstract section).

SSNs may distrust the authority of health and social service professionals given discrimination, profiling, and deficient cultural competency confirmed across comparable studies (Canavan et al., 2012, Barriers section; Gilmer & Buccieri, 2020, Barriers and Facilitators section; Sampson, 2022, Housing is Healthcare section). Canavan et al. (2012) emphasized responsibility confusion reported by service providers regarding complex rules involved in catchment areas and treatment for unhoused individuals overall (Barriers section). Even *shelters* grapple with the blurred lines of service acquisition, contributing to the insufficiencies of transinstitutionalization. Huff (2019) details the replicated structures, rules, and culture of psychiatric and prison institutions felt in shelter formats. This reminiscence potentiates institutional trauma; an important consideration for therapists operating inside institutional confines. Canham et al. (2019) notes high congregation levels in shelters trend premature discharge of patients with complex needs from hospitals (p. 21). Shelters routinely struggle to provide adequate beds and food, let alone medical or mental health support needs well beyond their scope of care (Ahmed et al.,

2022, p. 11). The marginalization of SSNs is what Yohanna (2013) considers both semiotic and material, since stigma shapes public perception and, in turn, restricts funding and institutional resources (p. 5).

Professional disengagement and policy ambiguity regarding unhoused clients directly reinforces their exclusion. Regulatory bodies and therapeutic institutions contribute as agents of surveillance and deployers of terminologies. The CRPO offers vague directives for treating clients “at risk of harm”(Professional Practice Guideline, 2018), yet fails to clarify distinctions between types or levels of risk. This professionally justifies punitive, exclusionary responses in practice. Regulatory documents reference hypothetical *diverse clients* in abstract terms without offering actionable standards for engagement with those experiencing structural neglect. I will posit examples thoroughly in my thesis as bases for change. The field must contend with the epistemic gaps created by institutional insularity. Without direct relationships with SSNs, knowledge is left to be shaped by dated textbooks, clinical case studies, or media portrayals which routinely sensationalize visible mental illness and reinforce deficit-based narratives (Leichter, 1989; Sibley et al., 2022, p. 22; Yohanna, 2013, Introduction section). If Art Therapy is to remain ethically grounded and socially relevant, it must critically assess whose realities it ignores, and then *engage.*

Private Practice, 1:1 Art Therapy, Outside of Institutions

Erving Goffman (1961) coined the term *Total Institution* to explain the effects of mental hospitals and similar places that occupy and confine a person's whole life (p. xi). The institutionalization process socializes new members into a dull, harmless, inconspicuous, ‘good’ patient. This can be weaponized to reinforce notions of chronicity in mental illness (p. 14-19). Early in my research, I wrongly assumed group spaces to be robust, safe, and cost-effective for the therapeutic needs of SSNs. Especially in collaboration with adjacent, experienced organizations like Alcoholics Anonymous (A.A). As detailed by Grecco et al. (2019) however, many of them rely on psychiatric or institutional partnership, triggering

‘total institution’ (The Science section). Non-regulated organizations cannot provide tailored, trauma-informed, harm-reductive care (Taiwo et al., 2023, Elements section). The abstinence requirements of participants for programs like A.A. are especially harmful in cases where withdrawal can be life-threatening (Zwarenstein, 2022). Similarly, insistences of psychological submission to a higher power prompt religious coercion and retraumatization for survivors of spiritual abuse (Mitchell, 2023; *Social Recovery Center*, 2024; Vytell, 2023).

My thesis will advocate for increased accessibility in 1:1 private practice Art Therapy spaces. Dominant, institutionally-backed programs and group-based support for SSNs have serious limitations. Canhem et al. (2019) articulates how they pertain almost exclusively to topics of survival where only immediate physical needs are considered (p. 20). Nonprofits rely heavily on volunteers, perpetuating a broader issue of *volunteerism,* which lends to “structural dimension of homelessness by recasting it as a problem for those individuals concerned” (Min, 1999, p. 6-7). This ameliorates only the immediate problems of SSNs and is ultimately “complicit with the policy that has produced the condition” (Min, 1999, p. 7). Peer support programs are championed due to the glorification of impact from those with lived experience of homelessness. Barker & Maguire (2017) found this dynamic to only marginally positively impact those with “severe mental illness”(Introduction section, para. 7).

Multi-use spaces for groups are often tucked away, segregated from society. Room layout, lighting, noise, and cleanliness all shape therapeutic experience and are often neglected in institutional or makeshift settings (Saurette, 2015, p. 20; Taiwo et al., 2023, Elements section). Reports from Saurette (2015) indicated interruptions of noise from adjacent rooms or peering eyes were barriers for sharing safely (p. 20). Millard, et al., (2021) similarly credit support groups with less comparable opportunities for vulnerability in disclosure due to the audience present (Results section, paras. 8-11). Support groups socially unite individuals on the commonality of a particular oppression or trauma. *But Severely*

Stigmatized Neighbours have more to them than their capacity to commiserate on shared misery. Despite blames of costs, SSNs deserve equal opportunities of comprehensive analysis, individualized treatment plans, and client confidentiality than currently standardized (*American Addiction Centers*, 2025; *The Recovery Village*, 2020). Emerging U.K. Art Therapy research illustrated participants at risk for psychosis advocating for greater access to community-based, drop-in Art Therapy services beyond inpatient settings (Brooker et al., 2007, pp. 22–23). This calls for culturally competent therapists in private practice, as advocated for by Ahad et al. (2023), not clinicians with lived experience of each concurrent marginalization (Cultural Competency section).

Life-Saving Intervention as Time Sensitive Substantiation

This thesis will investigate the function of Medical Assistance in Dying (MAiD) within transinstitutionalization. Additionally, the extent to which Art Therapy services can provide meaningful, alternative resources amid societal positioning of premature death as an accessible outcome for society's most marginalized. MAiD's eligibility criteria widening beyond terminal illness is dangerous and time-sensitive. I echo concerns of many activists regarding access granted solely from "severe" mental illness(es) that involve "irreparable psychological grievance" (T. Lemmens, 2023, Institutional section, para. 6) so long as paired with what *Health Canada* (2023) calls "non-terminal comorbidities" perhaps better defined as minor health issues, ordinary in the process of aging: frailty, vision and hearing loss, arthritis, fractures, diabetes, and chronic pain (Chart 4.1D). The *Government of Canada's* (2024) postponement of singular mental illnesses as a stand-alone criterion will soon expire in 2027 (Important section). The present criteria is broadly, inconsistently interpreted. People with non-terminal conditions ongoingly die from MAiD. I myself meet the criteria twice over. T. Lemmens (2023) critiques MAiD's legislative updates for accelerating despite the explicit objection of nearly all disability advocacy organizations, various Indigenous organizations, and international human rights experts (The Rhetoric

section). The government disregarded its commitments to evidence-based policy and sanctioned MAiD in cases of mental illness alone, whereby vulnerable groups such as SSNs were “treated as intended ‘beneficiaries’ of an expanded MAiD law” (The Rhetoric section, para 2). But psychiatric patients requesting euthanasia often do so “under the influence of a detrimental social situation and existential isolation” (W. Lemmens, 2021, 3.2 section).

There is also the risk that MAiD becomes a cost-saving measure offered in place of long-term, comprehensive physical and mental health care. Statistics explored by Pizzol et al. (2023) indicate SSNs make “burdensome” treatment costs due to decreased treatment compliance, increased risk of treatment failure, heightened likelihoods of relapsing disease, and worsening prognoses (Discussion section). Contrastingly, MAiD is quite lucrative, accounting for our global leadership in organ sales in recent years Griffith (2023). According to *Health Canada*'s (2023) statistics, non-terminally ill MAiD users (with their viable organs) contributed far greater organ donations than their terminally ill counterparts (Underlying section, Chart 4.1D). “Loneliness” (Coelho, 2025, para. 8) and “profound hopelessness” (Sandalic, 2023, para. 3) are evidently significant factors in non-terminal, MAiD euthenasia requests. This is the sort of bureaucratic dehumanization I’m up against. Mental health services may very well absolve the social and existential distress MAiD currently risks medicalizing as ‘irremediable’. In cases reviewed by Stradiotto (2024), individuals who sought MAiD later opted for pain management or other care options almost exclusively when connection and relational support were re-established (para 8).

Suicidal ideations, risk of suicide, unknown deaths, and premature deaths are overrepresented among SSNs (Ambar Aleman, 2016; Barker & Maguire, 2017; *Homes First*, 2023). It is telling how many have been persuaded towards MAiD rather than dying by suicide. There is currently no requirement to screen for suicidality during the MAiD application process despite research such as Sharrif & Ross (2023) determining its clear relevance (Insufficient Safeguards section). It is a cruel paradox: a society that

pathologizes suicidality, constructs the very conditions that sustain it, and then offers assisted death as if it were a more dignified alternative. Seeing as psychiatry sets the bar for diagnostic criteria and involuntary institutionalization, I can't help but reiterate the ironic collusion underscored by Komrad (2021) that psychiatrists (and psychotherapists, closely following) now face: Deciding which suicides should be prevented and which should be abetted (Concluding Thoughts section). MAiD and *Dying With Dignity Canada* (2021) will continue to co-opt therapeutic language for propagandistic offerings as "an end to suffering and discrimination" or an expression of "personal autonomy" (Background section) so long as SSNs remain unconsidered in equal access to individualized, therapeutic care.

Why Art Therapy?

While critical of systemic shortcomings, I also recognize Art Therapy's history of bold, progressive departures as proof that radical inclusivity is encouraged from within. As *Act for Mental Health Care* (2022) recently published on, the absence of disaggregated data on service access impedes equitable care (p. 15). The CRPO reports on various marginalized identities and corresponding adaptations. Comorbidities concerning SSNs are hardly mentioned, especially not in layers. Even the *Diversity, Equity and Inclusion* working group references no semblance of lived experience required by its members of precarious housing, institutionalization, or severely stigmatized mental illnesses (CRPO, 2024, Terms of Reference, p. 2). We need hard skills that don't automatically defer to shoving clients into psychiatric facilities or calling the police. "I think art therapists have to use all of their creativity and again not to feel boxed in by the institutional model. Interestingly, we've moved the client out of it, let's move the therapist out of it too"(Durst, 1999, pp. 46–47).

This thesis will identify how Art Therapy, when decoupled from rigid institutional norms, can explicitly support SSNs through competent care models and improved regulations. Proceeding from the position that SSNs should not be expected to conform to inaccessible, (re)traumatizing systems. The

CRPO (2023) claims current practices uphold commitments to equity, diversity, and inclusion (Annual Report, p. 7). If Art Therapy cannot evolve to encompass their needs, regulations must address the boundaries of inadequacies and develop harm-reductive referrals elsewhere. Presently, these remain critically insufficient. If certain diagnoses, forms of intoxication, or cognitive disorientations are incompatible with private practice Art Therapy, *they must be most explicitly articulated in regulations*. However, I believe Art Therapy can better bridge de-institutional efforts and community-accessible services due to its clinical and community intersections. As well as its unique, creative traits equipped to better encompass those under-serviced. I will delve into those superpowers fully in my thesis.

Blueprint

I will ultimately propose a three-part *Blueprint* to elicit actionable change. Firstly through policy and regulatory reform within Ontario's Art Therapy landscape based on current phrasing and limitations. Secondly, addressing improvements for educational training programs for instructors and students. The final section will provide practical strategies for current Art Therapists to enhance accessibility for SSNs, even in the absence of institutional or regulatory shifts. *Blueprint* is a deliberately rudimentary framework, not a robust instruction manual. This thesis arose from a personal need to access tools currently lacking. I hope to support others facing similar restrictions and provoke deeper developments by those with greater institutional authority. I do not believe in remaining immobilized, complacent, or convinced we are not revolutionarily equipped. I reject ambiguity that leaves my neighbours on the outskirts of care. An Art Therapist's paraphrasing of teachings from the Jewish sage, Rabbi Tarfon, has stuck with me during my research as a viable concluding remark: "We cannot refrain from work in the world because it is too big for us to finish. Neither can we wait until we are ourselves complete, for it is in engagement with the world that we are completed" (Allen, n.d, Toward Resolution section, para. 9).

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