

**THE STATE AND COMMUNITY: ISSUES IN MENTAL HEALTH REFORM IN
ONTARIO**

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Table of Contents

Introduction	1
Purpose.....	4
Additional Value.....	6
Background	7
Role of Governments, Law, and Courts.....	7
Access to Mental Health Care.....	10
<i>Primary Care</i>	10
<i>Hospital Care</i>	11
<i>Community Care</i>	14
Methods	15
Research Questions.....	15
Criteria for Literature.....	16
Search Methods.....	16
Method of Analysis.....	17
Methodology	19
Theoretical Framework.....	19
Policy Change	21
Prospects for Mental Health Reform.....	21
<i>Sociopolitical Context of Mental Health Policies (1985-1995)</i>	21
Common Sense Revolution.....	27
<i>Sociopolitical Context of Mental Health Policies (1995-2003)</i>	27
Common Sense Neoliberalism.....	35
<i>Sociopolitical Context of Mental Health Policies (2003-2016)</i>	35

Policy Drift	43
Welfare Cuts and Inclusion of Workfare Policies.....	44
Personal Recovery.....	46
The Epidemic of Pharmacotherapy.....	46
Evidence for Psychological Services.....	48
Wrongful Influence from the Pharmaceutical Industry.....	49
Evidence for Better Treatment Settings.....	50
Inaction from governments.....	50
Future Directions	51
Towards Critical Recovery.....	51
Role of Governments.....	53
Role of the Court-System.....	57
Conclusion	59
References	65
Appendix A: Terminology	86
Appendix B: Summary of Policy Reports from 1988-2012	90
Appendix C: Tables	98
Appendix D: Figures	108

Abstract

Mental health reform in Canada is imperative. Evidence shows that nearly half of Canadians with mental health and addiction problems are unable to access the care they require. Inequities to mental health and addictions care have been created by the passive privatization of critical mental health and addiction supports and services, not protected under the Canada Health Act, such as psychological services. The two-tiered system of care fosters inequities, as individuals of lower income, often with poorer social determinants of health, are denied access. The public and personal costs associated with unmet mental health and addiction needs are too significant to ignore. Mental health and addictions cost the Canadian economy \$51 billion annually, and rates of suicide and homelessness amongst individuals unable to secure access to care are high. Decades of policy reports have endorsed investing in community mental health to provide a comprehensive continuum of services for individuals with mental health and addiction problems. Despite an increase in mental health funding, investments in the community have not been prioritized. This paper explores transformations in forms of governance of the liberal state and the impact on mental health reform. Using Ontario as a case study, the paper employs the Power Resource Theory guided by Quality of Government to examine the neoliberal influence on welfare state retrenchment, in order to expose the delay in mental health reform and resulting inequities to care.

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Introduction

Canada's fragmented mental health care system is failing too many people. Each year, 20% of Canadians will experience a mental health and addiction problem (Smetanin et al., 2011). While the other 80% will experience the effects indirectly, through care for "afflicted loved ones" (Kirby and Keon, 2006, at 157, as cited in Flood and Thomas, 2016, p. 29). It is estimated that mental health and addiction problems cost the Canadian economy \$51 billion per year (Smetanin et al., 2011). This economic burden includes health care costs, lost productivity, and reductions in health-related quality of life (Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008; Smetanin et al., 2011). The World Health Organization (2011), reports that Canada spends 7.2% of its health care budget on mental health. While other high income countries, such as Sweden and the United Kingdom, invest 10% or more in mental health spending (WHO, 2011, as cited in Lurie, 2014). Since 2004, the federal government has increased health care transfer payments to the provinces (Lurie, 2014). However, investments in mental health have not been prioritized (Lurie, 2014; Hartford, Schrecker, Wiktorowicz, Hoch, & Sharp, 2003). For example, from 2004-2011, the Ontario government invested \$220 million in community mental health services compared to \$18.5 billion in health care (Lurie, 2014, p. 686). This equates to a per capita investment of about \$16.45 in mental health compared to \$1,361 in health care (seen in Figure 1 in Appendix D) (Lurie, 2014). Although a recent analysis of Ontario expenditures indicates that from 2010-11 to 2015-16 funding of community mental health increased by 31.4 per cent (more than twice the increase for healthcare), the increase accounts for 0.36% of current healthcare spending, thus revealing a paradox (Government of Ontario Public Accounts, 2016). Despite the prevalence and impact of mental health and addiction problems, only one in three Canadians, and as a

few as one in four youth, report that they receive the mental health and addictions treatment and supports they require (Mental Health Commission of Canada, 2012).

The significant gaps in access to mental health and addiction care have been created by the exclusion of critical mental health services from “Medicare,” Canada’s universal public health care system (Romanow and Marchildon, 2003). Most often, Canadians seeking mental health and addiction care will receive a form of pharmacotherapy usually involving psychotropic medications (Anderssen, 2015b). While there is substantial evidence indicating that psychological therapies can lead to better treatment outcomes (fewer rates of relapse) than pharmacotherapy alone (DeRubeis, Gelfand, Tang, & Simons, 1999; Hunsley, Elliott, & Therrien, 2013; Nathan and Gorman, 2015), the cost of such services is a major deterrence (Canadian Psychological Association, 2001). Furthermore, the Canada Health Act (CHA) does not ensure access to psychotropic medications taken outside of hospitals, home care, and various community supports (Kirby and Keon, 2004, at 373, as cited in Flood and Thomas, 2016). Consequently, the “patchwork of private insurance and public coverage” for mental health and addiction services has promoted two-tier care, where individuals without health coverage, often of lower-socioeconomic status, are unable to access the supports and services they need (Flood and Thomas, 2016, p. 29; Anderssen, 2015b).

Gaps in Medicare coverage for mental health and addiction services place pressure on emergency departments, hospitals, police services, and families (Wiktorowicz, 2005; Luxton, 2010; Gandhi, Chiu, Cairney, Guttman & Kurdyak, 2016). The Institute for Clinical Evaluative Sciences (2012) shows that one-third of Ontarians visiting the emergency department for mental health and addiction problems have not received previous assessment or treatment (Ratnasingham, Cairney, Rehm, Manson, & Kurdyak, 2012). Furthermore, Ontarians of lower income discharged from the hospital for mental illness and addiction are

less likely to receive follow-up within a week of their discharge from family physicians (Ratnasingham et al., 2012). Premature discharge from hospitals can result in higher rates of readmission within 30 days to the emergency department for mental illness and addiction as well as loss of life (Office of the Auditor General of Ontario 2015; Rush and Saini, 2016; Ontario Council of Hospital Unions, 2014). Insufficient access to community supports has also led many people with mental health and addiction problems to become “over-represented” in the criminal justice system – often referred to as the “criminalization” of mental health (Centre for Addiction and Mental Health, 2013). For instance, half of incarcerated women and 26% of men were identified as having a mental health need (Correctional Investigator of Canada, 2010). While “informal” care for loved ones with mental health and addiction problems saves the health care system billions of dollars each year, families continue to be “unsupported, unpaid, and ignored” in providing the “bulk of mental health and addictions care” (Kirby and Keon, 2006, at 47). Further personal costs, such as homelessness and suicide, among people unable to secure treatment for mental health and addiction problems are devastating (Goodwin, 1997; Anderssen, 2015b).

It is critical to improve the system of mental health and addiction care in Ontario, to secure timely access to services as to prevent the ramifications of unmet needs. As early as 1959, proposals for mental health reform in Ontario have urged for the development of greater mental health services provided at the community level (Hartford et al., 2003, p. 66). Likewise, governments, which have come to form political parties in Ontario, have been unified in the need to overcome system fragmentation among services provided by provincial psychiatric hospitals, general hospitals, community mental health programs, and services provided by family physicians and psychiatrists on a fee-for-service basis – termed the “four solitudes of mental health” (Canadian Mental Health Association, 2004; Mulvale, Abelson,

& Goering, 2007, p. 379). Despite such consensus, investments in mental health reform have been slow to occur. Wiktorowicz (2005) attributes the delay to a number of “obstacles” involving “arm’s length” governance processes with differing levels of authority, absence of political will to allocate funds to the community, and limited involvement of the policy community in policy implementation (p. 386).

While the publication of *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (2012), by the Mental Health Commission of Canada (MHCC), represents a landmark in mental health policy, governments have been slow to act on its recommendations. In order to improve access to mental health care, the MHCC recommends increasing the mental health share of health spending to nine per cent and social spending by two per cent, to secure investments in housing, employment and income support (Lurie, 2014, p. 388). Lurie (2014) states that these recommendations are attainable, as “increasing spending in Ontario by \$160 million per year would add 0.3% to health spending increases and offset costs in hospitalization, hostels and jails” (p. 688). Therefore, mental health reform is imperative. As the under-investment in mental health and addiction care in Ontario has resulted in persistent access gaps and inequities to services. Consequently, too often people with mental health and addiction needs ‘fall through the cracks’ at significant economic and human cost (Anderssen, 2015b).

Purpose

The aim of the research is to provide a critical assessment of welfare state retrenchment and mental health reform in Ontario (refer to Terminology in Appendix A). It is situated in a broader discussion of transformations in forms of governance of the liberal state, involving the rise of neoliberalism and ‘new public management,’ and the impact on the mental health service-delivery system (Carney, 2008).

The welfare state can be conceptualized as “interventions by the state in civil society to alter social and market forces” in order “to achieve greater equality” (Orloff, 1993; Ruggie, 1984). According to Esping-Andersen’s (1990) three-fold typology of welfare state regimes – liberal, conservative, and social democratic – liberal welfare states (which include Canada) are argued to be less decommodified, have higher levels of social stratification, and place greater emphasis on the market than the family or state in distributing economic and social resources (seen in Table 1 in Appendix C) (Esping-Andersen, 1999; Navarro and Shi, 2001; Bambra, 2005; Raphael and Bryant, 2015). Correspondingly, liberal welfare states are argued to have higher levels of income inequality and spend less on public social expenditures (refer to Table 2 in Appendix C and Figure 2 in Appendix D) (Olafsdottir and Beckfield, 2011).

Since the mid 1990s, neoliberal governance has fostered free market capitalism by deregulating the role of the state in distributing social and economic resources to the public (Coburn, 2000; Carney, 2008). Accordingly, neoliberalism has led to the retrenchment of the welfare state (Harvey, 2005). Such neoliberal governance has been most apparent among liberal welfare states (Raphael and Bryant, 2015). The result of this neoliberal restructuring of the welfare state is an unequal distribution of economic gains where populations of lower socio-economic status have poorer quality social determinants of health (Coburn, 2006; Raphael and Bryant, 2015).

In the case of mental health care, neoliberalism has removed responsibility from the state for the delivery of mental health services (Teghtsoonian, 2009; Morrow, 2013). Since, neoliberalism endorses policies that emphasize the ‘individual’ and their “economic independence regardless of social circumstances” (Morrow, 2013, p. 328). Consequently, the neoliberal influence in the welfare state, which promotes “private solutions to social

problems,” has widened inequities in accessing mental health and addiction services (Morrow, 2013, p. 328).

Decades of reports concerning mental health reform in Ontario have endorsed moving psychiatric care into the community, so to provide effective and accessible services for people with mental health and addiction problems. The early years of mental health reform (1985-1995) represented a significant paradigm shift away from the traditional biomedical approach towards an empowering-community integration approach to mental health and addiction care (Nelson, Lord, Ochocka, 2001; Everett, 2000). The resulting paradigm shift increased “psychiatric consumer/survivor” participation in mental health planning (Nelson et al., 2001, p. 87). This period also reflected great “coherency between provincial policy and regional planning” (Nelson et al., 2001, p. 88). As the favourable sociopolitical context helped establish partnerships between political elites and emerging mental health “claim-makers” (Nelson et al., 2001, p. 73). While this period marked significant advances towards mental health reform, there was still a great deal of work to be done to improve community integration and access to resources.

The rising dominance of neoliberal governance (mid-1990s) in Ontario, however, once again, led to the re-emergence of the biomedical focus in mental health. Consequently, mental health reform under neoliberalism has come to endorse an individualistic concept of recovery, which ignores social injustices that cause people to become mentally distressed (Whitaker and Cosgrove, 2015). At the core of this paper is how the mental health and addiction service-delivery system in the restructured welfare state reflects a dynamic tension between “social justice imperatives and public policy retrenchment” (Wipond, 2013, p. 268).

Additional Value

The focus of the research is to critically assess how the retrenchment of the welfare state has influenced the process of mental health reform in Ontario. Previous research has examined the trajectory of mental health policies in Ontario, as well as, barriers to mental health reform (Hartford et al., 2003; Wiktorowicz 2005; CMHA, 2011). Research has also examined paradigms that have been used to frame mental health reform (Nelson et al., 2001; Morrow, 2013; Poole, 2011). As well, research has discussed the psychiatric consumer/survivor movement and its influence on the rhetoric of reform (Everett, 2000; Reaume, 2002). Furthermore, research has explored the intersections of mental health law and policy in Canada (Flood and Gross, 2014; Chandler and Flood, 2016; Carney, 2008).

However, there remains a gap in the literature with very little research exploring the influence of the welfare state on mental health and addictions care. Similarly, research pertaining to neoliberalism and mental health reform is limited. This research hopes to fill this gap by employing theoretical perspectives from the Power Resource Theory (PRT) (Stephens 1979; Korpi 1983; 1998) and Quality of Government (QoG) (Rothstein and Teorell, 2008), to address how the restructured welfare state has influenced reform of the mental health and addiction service-delivery system in Ontario. The research will also explore prospects for reform under a new paradigm of mental health and addiction care.

Background

The Role of Governments, Law, and Courts in Mental Health/Addictions Care

The Canadian federalist system of government is highly decentralized (Flood, 2014, p. 83; Hartford et al., 2003). In Canada, both the federal and provincial levels of government “share responsibility for the regulation and financing of health care” (Flood, 2014, p. 83). However, the majority of the responsibility for the organization and delivery of health care is assigned to the provinces, as outlined in the Constitution Act (1867) (Flood, 2014, p. 83).

Medicare, the Canadian system of public health insurance, introduced in 1957, comprised of a 50/50 cost sharing arrangement between the federal government and the provinces for hospitals (Hartford et al., 2003; Bryant, 2009). Since 1977, however, the federal contribution has gradually declined (Hartford et al., 2003, p. 65). This is evident by the replacement of the federal and provincial cost sharing arrangement for Medicare with federal block grants (under the Established Programs Financing ACT in 1977); with the Canada Health and Social Transfer (CHST) in 1995; and with the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) in 2004, which were established to promote greater “transparency” and “accountability” for federal health funding (Bryant, 2009; Government of Canada, 2014). Currently, the provinces administer health insurance and abide by the principles for public health insurance, as established in the Canada Health Act (CHA) (1985), in order to receive federal transfer payments (Bryant, 2009).

The five principles for public health insurance, as specified in the federal CHA, include: public administration; comprehensiveness; universality; portability; and accessibility (GC, 1985). These principles are to ensure that Medicare provides “medically necessary” hospital care and “medically required” physician services (Flood, 2014, p. 79). However, there is no legal definition for deciding what constitutes “medically necessary” care (Flood, 2014, p. 79). Consequently, provinces and territories (provinces) are left to “determine standards of care and decide what services will be covered” under public health insurance (Hartford et al., 2003, p. 65). Since the CHA gives priority to hospital and physician services, many of the services for people with mental health and addiction needs (i.e., community care, prescription drugs taken outside of hospitals, and psychological services) are excluded from Medicare (Flood and Thomas, 2016, p. 33). As a result, services “deemed not to be medically necessary” are often left to the “free market to determine who has access” (Flood, 2014, p.

80). Coyne (2010) asserts that the CHA is a “dead letter,” as provinces spend close to 50% of their budgets on health care, making it difficult for the federal government to restrict the outsourcing of public health services (as cited in Flood, 2014, p. 98). While some provinces have “stepped up” to fund services not covered by the CHA, there remains “persistent gaps in access to services” for people with mental health and addiction needs (Flood and Thomas, 2016, p. 33).

The Charter of Rights and Freedoms (Charter), the bill of rights, forms the first part of the Constitution Act (1982) (Flood, 2014, p. 86). While the CHA requires that provinces meet certain standards to receive federal transfers, “the CHA does not issue citizens a right to challenge their provincial government’s noncompliance with the five principles” (Choudhry, 1996, as cited in Flood, 2014, p. 85). Flood (2014) argues, while the Charter does not provide an “explicit guarantee of a right to health,” many Canadians are using the Charter, specifically s. 7 on the right to “life, liberty, and security of the person” and s. 15 on equality rights (protection against discrimination), to “contest governments limits on publicly funded health care” (p. 86). In the judicial system, Carney (2008) asserts that there is greater focus on ensuring “negative rights” of citizens, not to be “detained or treated against their will,” than their “positive rights” to “access to treatment or social services” (pp. 104, 109). Furthermore, Flood (2014) notes that most successful health claims involving the Charter have been based in negative rights, which are argued to be less successful in advancing equality and access to health (pp. 87, 98). It is reasoned that courts are less likely to make rulings in positive rights cases, in which citizens make direct claims to resources, as courts are “reluctant to direct governments on how to allocate scarce public resources” (Chandler, 2016, pp. 22-23). Subsequently, governments and courts have yet to prioritize access to mental health and addiction services.

Access to Mental Health Care

Primary Care

In Canada, family doctors/general practitioners (GPs) are usually the first contact within the health care system for individuals with mental health and addiction problems (Public Health Agency of Canada, 2012). Within the primary care system, GPs can provide drug therapy and/or generic counseling (Moulding et al., 2009). However, a report by the Institute of Health Economics, found from 2007-2008, only 55% of psychotropic medications prescribed were covered by Medicare, leaving the other 45% to be paid for privately (Jacobs et al., 2010, as cited in Flood and Thomas, 2016, p. 39). As a result, an estimated 10% of Canadians without private health insurance are unable to access prescribed treatment (Morgan, Law, Daw, Abraham, & Martin, 2015, as cited in Flood and Thomas, 2016, p. 39). Similarly, the counseling/psychotherapy that GPs can provide is limited, as GPs report that it can be time consuming and that they are not adequately reimbursed under the fee-for-service payment system (Flood and Thomas, 2016). Consequently, many GPs indicate lacking the skills and knowledge to manage patients with mental health and addiction problems (Kirby and Keon, 2004). Psychologists can also effectively treat mental health and addiction problems in the primary care system. Patients can be referred by GPs to see a psychologist (Moulding et al., 2009). However, in 2001, approximately 80% of psychological consultations occurred in the private sector (Romanow and Marchildon, 2003). Consequently, in recent surveys, GPs reported cost to be the greatest barrier to referring patients to psychologists (Grenier, Chomienne, Gaboury, Ritchie, & Hogg, 2008).

People with more severe mental health and addiction problems, within the primary care system, can be referred by GPs to specialized mental health services. However, there is a serious equity gap in accessing specialized mental health care. A 2014 study assessing

psychiatric supply and practice patterns in Ontario shows that in areas with high psychiatric supply (often urban areas), psychiatrists often see fewer patients (Kurdyak et al., 2014). For example, the study found that 10% of psychiatrists in central Toronto saw fewer than 40 unique patients while, 40% saw fewer than 100 unique patients each year (Kurdyak et al., 2014, p. 95). Furthermore, the study indicates that the majority of patients accessing psychiatric services in urban areas are more likely to be of higher income (Kurdyak et al., 2014). Integrating psychologists into primary care would help improve access to mental health services. Since psychologists would help reduce time spent by psychiatrists on administering psychotherapy, thus enabling psychiatrists to see more patients with greater symptom severity. Consequently, under the current system, psychiatrists are often criticized for treating the “worried well” (Swenson and Bradwejn, 2002).

Lengthy wait-times for mental health care can act as a serious access barrier within the primary care system for individuals with mental health and addiction problems (Flood and Thomas, 2016, p. 36). In 2015, it was reported that 6,000 children and youth seeking mental health services in Ontario waited over a year to access services (Children’s Mental Health Ontario, 2015). Additionally, an estimated 52% of emerging adults, ‘fall through the cracks,’ due to poor coordination between pediatric and adult mental health services (Carver et al., 2015, as cited in Flood and Thomas, 2016, p. 46). This is extremely problematic as suicide is the leading cause of non-accidental death among children and youth (Ickowicz and Schachar, 2015, as cited in Flood and Thomas, 2016, p. 45). Therefore, under-diagnosis, misdiagnosis, and under-treatment of mental health and addiction problems often leads to poor outcomes for patients within the primary care system (Public Health Agency of Canada, 2012).

Hospital Care

Historically, patients with severe mental health problems were admitted, sometimes involuntarily, to psychiatric hospitals located in isolated areas across the country (Kirby and Keon, 2004). Following World War II, however, psychiatric hospitals became overcrowded (Kirby and Keon, 2004). Consequently, the quality of care began to decline as treatment came to depend more on chemical and physical restraint (Kirby and Keon, 2004). Advances in psychotropic drugs as well as a desire to enhance the autonomy of mentally distressed patients, encouraged the process of “deinstitutionalization” (Flood and Thomas, 2016, p. 40). The deinstitutionalization of psychiatric hospitals beginning in the 1960s, thus moved patients from psychiatric hospitals into the community (Flood and Thomas, 2016, p. 40). However, the implementation of psychiatric deinstitutionalization, without adequate community support, resulted in a number of negative consequences for former patients and their families. As the CMHA (2001) summarized in its report to the Commission on the Future of Health Care in Canada:

For many former hospital residents, the new system meant either abandonment, demonstrated by the increasing numbers of homeless mentally ill people; ‘trans-institutionalization’: living in grim institution-like conditions such as those found in the large psychiatric boarding homes; or a return to family who suddenly had to cope with an enormous burden of care with very little support (p. 8).

During 1960-1980, former patients were ‘trans-institutionalized’ from psychiatric hospitals to psychiatric wards in general hospitals (Flood and Thomas, 2016, p. 39). Kirby and Keon (2004) note, that trans-institutionalization was developed in part to combat the problem of two-tier mental health care (as cited in Flood and Thomas, 2016, pp. 39-40). The problem was that middle-high income patients were more often referred to general hospital psychiatric units, which enabled early detection and treatment of a range of less serious psychiatric disorders, while patients of lower income were more often consigned to existing psychiatric institutes (Kirby and Keon, 2004). Therefore, trans-institutionalization was

established to reduce inequities as patients would be given comparable hospital care. Additionally, it was believed that integrating the delivery of psychiatric care with medical care would help to lessen stigma faced by people in accessing mental health services (Kirby and Keon, 2004, as cited in Flood and Thomas, 2016, p. 40).

Currently, individuals in need of hospitalization for mental health and addiction care are treated in both psychiatric hospitals and general hospital psychiatric units (Flood and Thomas, 2016, p. 41). However, the majority of hospitalizations for mental health and addiction problems in Canada occur in general hospitals. From 2009-2010, 87% of patients with mental health and addiction problems were hospitalized in general hospital psychiatric units (Canadian Institute for Health Information, 2012, as cited in Flood and Thomas, 2016, p. 41). Additionally, from 2009-2010, the most common primary diagnosis for patients treated in general hospital psychiatric units were mood disorders followed by schizophrenia and psychotic disorders and substance-related disorders (CIHI, 2012, vi). While the most common primary diagnosis category for patients treated in psychiatric hospitals from 2009-2010 were schizophrenia and psychotic disorders, followed by mood disorders, and substance-related disorders (CIHI, 2012, vi).

Due to poor access to mental health services in the primary sector, dependency on the acute care sector, i.e., emergency department visits, has increased among patients seeking needed mental health and addiction care. A recent article published in the *Canadian Journal of Psychiatry*, found that from 2006-2011, there was a 32.5% and 53.7% increase among ED visits and hospitalizations respectively, among Ontario children and youth, aged 10-24 (Gandhi et al., 2016). Flood and Thomas (2016) note, even if patients visiting the ED are able to secure a bed in a general hospital's psychiatric unit, the care they receive is often substandard, as staff are under a tremendous pressure to free up bed space (p. 42).

Consequently, patients may be discharged early (Flood and Thomas, 2016, p. 42). This is problematic as it may result in loss of life. For instance, from 2011-2012 in Windsor, Ontario, two patients sent home from Hôtel-Dieu Grace Hospital committed suicide within weeks of each other (Ontario Council of Hospital Unions, 2014, as cited in Flood and Thomas, 2016, p. 42). Therefore, the current mental health system, which Anderssen (2015b) states “responds best to crisis,” is unacceptable as it continues to fail too many patients (Anderssen, 2015b).

Community Care

In Ontario, the Ministry of Health and Long-Term Care (MOHLTC) funds a variety of community supports and services for people with mental health and addiction needs (as seen in Figure 3 in Appendix D). These community supports and services can include, psychotherapies, housing support, or case management (Ontario Mental Health Helpline, 2016). There are 14 Local Health Integration Networks (LHINs) located across Ontario that manage six health care sectors, including community mental health and addiction agencies (refer to Table 3 in Appendix C) (AGO, 2015). LHINs are funded by the MOHLTC and were established under the *Local Health Systems Integration Act* (2006) to better coordinate health care and access to services (AGO, 2008). However, in a 2015 annual report, the auditor general of Ontario shows that, since their inception in 2006, LHINs “have not been consistently assessing” whether their services have been effective in promoting a more efficient integrated health system (p. 317). Furthermore, it is reported that the MOHLTC has not held the LHINs accountable for poor target performances, i.e., meeting wait times for services (AGO, 2015). Thus, the MHCC in Canada’s National Mental Health Strategy indicated that community and primary care services are “poorly coordinated” and “very

challenging to navigate” for people with mental health and addiction problems (MHCC, 2012, p. 65).

Ontario has also adapted many shared care models to improve community access to coordinated care (refer to Table 4 in Appendix C). Results from Ontario’s Community Mental Health Evaluative Initiative (2004) show that interdisciplinary care teams have improved access to supports and services for populations with mental health and addiction needs in the community. Furthermore, that the services and supports provided by interdisciplinary care teams have been cost-effective (OCMHEI, 2004). For instance, data from Intensive Case Management (ICM) programs found that, on average, it costs \$68 per day to provide community support and services to patients in the community, while it would cost \$481 per day to treat the same patient in the hospital (OCMHEI, 2004, p. 9). Despite the cost-effectiveness of community interdisciplinary care, recent reports from the auditor general of Ontario show that, the services these teams provide are operating above capacity with lengthy wait-times (2009; 2015). Furthermore, access to interdisciplinary care teams is highly dependent on where one lives; interdisciplinary care teams are less prevalent in rural and remote areas (AGO, 2015). As well, the success of interdisciplinary models of care depend on many economic and contextual factors such as funding, remuneration differentials, provider supply, and population needs (Mulvale, 2007).

Methods

The Research Questions

The study is guided by the overarching research questions: What forces have shaped the welfare state? (i.e., “ideological change, shifts in the influence of business and labour, decline of equality-seeking civil society organizations, decentralization in the federation”

Banting and Myles, 2013, p. 2). How has their reshaping of the welfare state influenced mental health reform?

The study will address (a) why it has been so difficult to achieve mental health reform in Ontario; (b) how the state has influenced the policy-trajectory towards mental health reform; (c) what degree governments have consulted with the policy-community; (d) and prospects for reform (a concept of recovery embedded in social equality).

Criteria for Literature

The literature search was conducted to explore the range of research on mental health reform and changing politics (neoliberal governance) in Ontario. Primary and secondary research from both peer-reviewed and grey literature was assessed from 1980-2016. The analysis of government policies and reports spans from the release of the Graham Report (1988) to the most recent release of Canada's National Mental Health Strategy (2012) (refer to Summary of Policy Reports from 1988-2012 in Appendix B).

The literature search was organized according to the pre-determined categories: (1) selected theoretical paradigms; (2) Canadian politics, the welfare state, and neoliberalism; (3) mental health policies and the structure of the mental health and addiction service-delivery system in Ontario; (4) social determinants of mental health, human rights, and the concept of recovery. To refine my search, inclusion criteria were applied. In order to be deemed relevant for this paper, articles had to pertain to the four categories listed; statistical information had to be reported from reputable Canadian health agencies; and, articles had to be available in English. The exclusion criteria for this paper was information only accessible via audio or video content. Based on these criteria, the paper includes primary and secondary studies from both peer-reviewed and grey literature.

Search Methods

The following search parameters and keywords identified all pertinent studies.

Search Parameters. Peer-reviewed journals were found on electronic search engines such as, PubMed, PsycINFO, and Google Scholar. Scholarly books and reports were accessed through libraries at York University. Canadian based news outlets like the Globe and Mail, were used to gather news reports pertaining to the Canadian mental health care system. Grey literature, including policies, government documents, fact sheets, and dissertations, were explored using the Google search engine. The following organizations have published reports on mental health reform in association to the Ministry of Health and Long-Term Care: Canadian Mental Health Association, Canadian Psychological Association, Centre for Addiction and Mental Health, Addictions and Mental Health Ontario, and the Institute for Clinical and Evaluative Sciences.

Keywords. The electronic search was guided by the following terms: mental health reform in Ontario; the mental health and addiction service-delivery system in Ontario; social determinants of mental health; treatment gap; welfare state; neoliberalism; passive privatization; mental health recovery; Power Resource Theory

Method of Analysis

The research is guided by the qualitative approach of thematic analysis. The method of thematic analysis is used to identify, analyze, and report patterns (themes) in data (Braun and Clarke, 2006, p. 79). Its process of identifying themes involves “careful reading and re-reading of the data” (Rice and Ezzy, 1999, p. 258). Thematic analysis can involve both inductive and deductive themes. Braun and Clarke (2006) assert, the inductive approach (bottom-up) is data-driven, while the deductive approach (top-down) is theoretically-driven (pp. 83-84). For this paper, the deductive themes of the research will involve *policy change* and *policy drift*. These elements, along with system maintenance, have been identified by

Banting and Myles (2013) as influencing policy trajectory and weakening the redistributive state (p. 3).

Banting and Myles (2013) assert, the Canadian process of policy change is one of “punctured equilibrium,” in which a “pattern of long continuity gives way to a sharp burst of radical change, which in turn, locks in a new trajectory that persists for a long time” (p. 22). During the 1990s the federal and provincial government began making dramatic changes (Banting and Myles, 2013). Their weakening of the redistributive welfare state, meant the state was “no longer offsetting the growth in inequality generated by the market” (Banting and Myles, 2013, p. 1). Consequently, benefits for unemployed and vulnerable Canadians experienced “deep cuts” (Banting and Myles, 2013, p. 22). Banting and Myles (2013) note, the “intensity of retrenchment” was most pronounced in Ontario during the Harris Conservative government (1995-2003), which cut benefits by 20% (p. 23). The Harris government justified cuts to social services by arguing that people in Ontario should rely less on government services and more on their families, friends, and communities to provide care (Luxton, 2001; Luxton 2010, p. 167). Therefore, neoliberal policy change has resulted in a form of ‘passive privatization,’ with the outsourcing of state services and supports to private providers.

Policy drift refers to the failure of governments to respond to emerging social problems (Banting and Myles, 2013, p. 24). Many provinces failed to adjust benefit levels for inflation during the mid-1990s to the mid-2000s (Banting and Myles, 2013, p. 24). Similarly, while governments in Ontario have directed funding at the community level for mental health and addictions care, there remain significant gaps in care. Consequently, community supports and services have been insufficient in offsetting the passive privatization of mental health care. Therefore, the reality of the neoliberal re-regulation and a privatization is an

individualized approach to care, where a significant proportion of individuals are unable to access adequate supports and services in a timely manner. Despite a breadth of evidence supporting alternative forms of mental health and addiction service-delivery, governments fail to respond to growing inequalities and prioritize reform. Instead, governments continue to support a concept of recovery that ignores prevailing social injustices and results in inequitable access to services and supports.

Methodology

Theoretical Framework

Drawing on the framework of the Power Resource Theory (PRT) (Stephens 1979; Korpi 1983), which claims that “politics matter” when explaining distributive policies in society, the research seeks to explore issues in mental health reform in the liberal welfare state (Myles and Quadagno, 2002, p. 37). The PRT asserts that the level of inequality in society and degree of redistribution by the state are functions of working class mobilization (Kellerman, 2005). In the post-war era, PRT theorists observed that countries with “strong left political parties” and “powerful trade unions” developed more expansive welfare states (Banting and Myles, 2013, p. 6). Alternatively, countries with weak trade unions and stronger governance by parties of the ‘right and centre’ developed more modest welfare states (Banting and Myles, 2013). Rooted in a class-based conception of politics, PRT focuses on how labour/the working class, “organizes to face” capitalists/the business class, the most powerful members in society, given their control over capital and exploitation of the labour class (Coleman, 2013, p. 97). Coleman (2013) asserts, “the political organizations of the business and labour class are crucial to their success or failure in influencing public policy” (p. 95). Accordingly, the balance of power between labour and business is fluid (Coleman, 2013, p. 97). If labour can organize effectively, it can form a political party, where once in

power, can develop greater redistributive policies (Coleman, 2013). Thus, labour can pursue greater equality through political action (Kellermann, 2005). Johnston (2013) claims, the Canadian welfare state conforms to the power resource model via the influence of major political theories in its growth and ensuing retrenchment in the 1990s.

The Quality of Government (QoG) theory is used to complement PRT, in order to support the argument that both political mobilization (PRT) and a high level of government (QoG) are needed to promote policy change (Rothstein, Samanni, & Teorell, 2012). The QoG hypothesis (Rothstein and Teorell, 2008) asserts that without high QoG, there would be less political mobilization to develop more expansive welfare policies (Rothstein et al., 2012). Therefore, the QoG theory (or 'good governance') argues, in order for labour to turn to the state to respond to their demand for redistribution, they must have a high degree of confidence in their state (Rothstein et al., 2012, p. 4). Subsequently, trust in the state has a positive impact on political mobilization for greater redistribution or equitable welfare state policies (Rothstein et al., 2012, p. 11). The theory is used to complement PRT, as both a high level of QoG and political mobilization are "necessary but are not on their own sufficient" for creating a more redistributive welfare state (Rothstein et al., 2012, p. 11). Rothstein and colleagues (2012) assert there are three issues "political representatives" encounter when deciding to support a social policy (p. 8). These include: whether the policy is considered to be a good thing or not; whether the enactment of the policy will affect taxes and if so, if the taxation system is run in a "fair" and "transparent" manner; and the perceived level of "substantial fairness" and "procedural fairness" of the institution/authority enacting social policies (Rothstein et al., 2012, pp. 8-9). Subsequently, citizens that perceive the government institution as fair and unbiased, have greater trust in the institution's ability to enact a policy (substantial fairness) in a just manner (procedural fairness) (Rothstein et al., 2012).

The analysis will aim to illustrate that despite a high level of government and political mobilization among mental health stakeholders during the early years of mental health reform (1985-1995), the rising dominance of neoliberal governance (mid-1990s) negatively impacted working class mobilization for welfare policies and level of QoG. The neoliberal policy agenda of “privatization, consumerism, fiscal restraint, privileging of the ‘free’ marketplace, and wholesale retrenchment of social services,” has created a “new shallow relationship between the individual and the state” (Rose, 1990, as cited in Menzies, LeFrançois, & Reaume, p. 16). Consequently, government institutions are less likely to implement redistributive welfare policies, and as a result, individuals are to depend less on their state for social supports, i.e., access to community-based mental health services.

Policy Change

Prospects for Mental Health Reform

Sociopolitical Context of Mental Health Policies (1985-1995)

The period between 1985-1995 can be seen as a “window of opportunity” for mental health policy change (Nelson et al., 2001, p. 77). The Liberal government came to replace the Conservative government in Ontario, which had ruled for forty-two consecutive years (Nelson et al., 2001). The Liberal party held power from 1985-1990 and was succeeded by the New Democratic Party (NDP), which governed from 1990-1995 (Nelson et al., 2001). In Canada, the NDP, followed by the Liberal party, have traditionally held policy positions supporting more progressive social agendas than the Conservative party (Nelson et al., 2001; Raphael, 2007). During this period, policies began to reflect views from psychiatric consumers/survivors, who had emerged as a new group of mental health stakeholders in the early 1980s (Nelson et al., 2001).

During the mid 1980s, the Ontario Federation of Community Mental Health and Addiction Programs “lobbied governments” to reallocate resources from institutions to the community (Nelson et al., 2001, p. 82). In 1987, the Federation developed a “province-wide education and advocacy intervention” with Members of Provincial Parliament to double the community mental health share of the provincial health budget from .5 to 1 per cent within three years (Nelson et al., p. 82). Thus, there was a ten-fold increase in provincial spending on community-based services from 1981 (\$13 million) to 1991 (\$130 million) (Nelson, 1994). Similarly, there was a three-fold increase in overall health expenditure from 1981 (\$4.9 billion) to 1991 (\$15.3 billion) (Nelson, 1994). The intervention’s success stemmed from new linkages between government elites and mental health stakeholders, including the growing psychiatric consumer/survivor movement.

In 1987, the new Liberal Minister of Health appointed Robert Graham, a retired engineer and former volunteer of the Canadian Mental Health Association, to lead a committee in the development of a preliminary report on mental health care in Ontario (Everett, 2000; Nelson et al., 2001). The report was the result of an “extensive community consultation process” and was to aid in the development of a government policy statement (Nelson et al., 2001, p. 77; Everett, 2000). The Graham Report, *Building Community Support for People: A Plan for Mental Health in Ontario* (Graham, 1988), marked a new phase in mental health policy (Mulvale et al., 2007). The report established a shift away from an “institutional-medical approach” towards a “community-based approach” to mental health care (Nelson et al., 2001, p. 77). For the first time, views from consumers/survivors and their families were included in the Committee’s report (Mulvale et al., 2007). The Graham Report noted that although funding for mental health services had increased, it had “declined relative to other areas of government spending” (Hartford et al., 2003, p. 69). The Graham committee

reiterated challenges identified with the mental health care system, i.e., gaps in service availability and poor continuity of care (Everett, 2000; Hartford et al., 2003, p. 69). The report also stressed the need for a “management strategy” to allow the government to assess its funding of a “decentralized and much-expanded” mental health system (Everett, 2000, p. 72). Most significantly, the Graham Report created a “partnership” among psychiatric consumers/survivors, their families, service providers, and the government (Everett, 2000, p. 72). Greater participation from these new mental health stakeholder groups helped to establish a new “form of power-contract between government and consumers” (Everett, 2000, p. 65). Everett (2000) notes, their participation helped to ‘admit’ them into the “inner circle of political decision making” (p. 65).

Following the release of the Graham Report (1988), in 1993, the government released its policy statement, *Putting People First: The Reform of Mental Health Services in Ontario* (Ontario Ministry of Health, 1993). While the Graham report was a recommendation to government, *Putting People First* was a formal policy document released by the Ministry of Health under the NDP governance (Nelson et al., 2001). The document outlined a 10-yr strategy for mental health reform (Hartford et al., 2003). The policy called for “new linkages” to promote greater integration and continuum of care (Everett, 2000, p. 75). *Putting People First* recommended that new mental health services be confined to the four areas: case-management, 24-hour crisis intervention, housing and supports, and programs led by consumers/survivors and their families (Everett, 2000, p. 75). The policy also called for the reallocation of funds in order to promote a “comprehensive human resources strategy” (Ontario Ministry of Health, 1993, p. 14, as cited in Everett, 2000, p. 74). Therefore, *Putting People First* set the goal of shifting the proportion of funds from 80% for institutions and 20% for community programs in 1993, to 40% and 60% respectively, by 2003, so to create a

“balanced mental health system” (Everett, 2000, p. 74). Furthermore, building on Graham’s recommendation, the policy stated that the Ministry of Health would act as “system manager” (Ontario Ministry of Health, 1993, p. 20, as cited in Everett, 2000, p. 75).

Greater stakeholder participation in mental health policy resulted in greater government support for initiatives led by consumers/survivors and their families (Nelson et al., 2001). In 1991, the NDP government provided \$3.1 million to the Consumer/Survivor Development Initiative (CSDI) (Nelson et al., 2001). The CSDI developed self-help organizations and small business projects “run for and by psychiatric consumers/survivors” (Everett, 2000, p. 75). The government also provided funding for self-help organizations led by families (Nelson et al., 2001). Everett (2000) notes, *Putting People First* “confirmed the government’s commitment” to its new partners (p. 75). As the policy stressed the importance of initiatives led by consumers/survivors and their families that emphasized “support rather than service” (Nelson et al., 2001, p. 80). Therefore, recovery came to be shaped by a concept of empowerment, which reflected an ecological process involving “person, organization, community settings, and social policy” (Nelson et al., 2001, p. 21). Recovery as personal empowerment is succinctly expressed as “self in community” (Lord, 1997, p. 26, as cited in Nelson et al., 2001, p. 21). Thus, recovery and empowerment promoted ‘improved quality of life and personal growth’ for the betterment of mental health (Nelson et al., 2001, p. 35).

As well, housing for psychiatric consumers/survivors increased and the concept of “de-linking” housing from supports emerged (Nelson et al., 2001, p. 81). Nelson (1994) attributes the increase of available housing to joint funding initiatives developed by the Ministry of Housing and the Ministry of Health (as cited in Nelson, 2001, p. 81). Changes to the provincial housing policy, in 1986, also enabled psychiatric consumers/survivors to

become eligible for public housing (Weisberg 1994, as cited in Nelson et al., 2001, p. 81). Additionally, in the 1990s, the concept of de-linking housing and supports appeared in housing policy documents (Nelson et al., 2001). De-linking endorsed more “flexible” and “portable supports” tailored to the needs of consumers/survivors (Weisberg, 1994, as cited in Nelson et al., 2001, p. 81). The de-linking concept instilled greater empowerment among consumers/survivors as they were given more “control” in their own housing (Nelson et al., 2001, p. 81). As a result, consumers/survivors were becoming seen as “agents of policy change, rather than being seen as policy objects” (McCubbin and Cohen, 1999, p. 67).

Despite progressive changes towards mental health reform, growing business interests came to diminish support for the NDP governance. Bradford (2003) notes, the NDP partnerships with “organized labour” and its connections with “social equity movements” was paralleled by a lack of “business community linkages” (p. 1011). Consequently, in the late 1970s, the electoral victories of Ronald Reagan and Margaret Thatcher, in the U.S. and the U.K., respectively, shifted global political discourse in social policy (Banting and Myles, 2013). As their governance endorsed a tax system based in “efficiency” (Banting and Myles, 2013, p. 13). Thus, their conservative ideologies supported the “liberalization of markets,” “free trade,” and “downsizing of governments” (Harvey, 2000, p. 176, as cited in Keil, 2002, p. 580). By 1993, in Ontario, a growing provincial deficit had led the NDP government to introduce a “New Social Contract,” which sought to “negotiate cost-saving” in the public sector (Bradford, 2003, p. 1029). Based in the NDP’s “social partnership model,” the government invited various stakeholders to participate in devising fiscal targets (Bradford, 2003, p. 1029). However, due to political influences from the Reagan and Thatcher governments, the business sector opposed the NDP’s intentions to “introduce higher taxes and strengthen union rights” (Caplan, 2010). In an attempt to ‘marry’ business and labour

interests, the NDP government consistently tried to appease the business sector in many of its commitments and policies (Rae, 1991; Caplan, 2010). As a result, the NDP government lost many of its own supporters “without ever appeasing business interests” (Caplan, 2010).

Therefore, unlike the Graham Report (1988), which instilled a sense of “intense optimism” among various mental health stakeholders, mental health reform as outlined in *Putting People First* (1993) left many “worried” (Everett, 2000, p. 179). The Ministry of Health did not consult the policy community prior to its release (Wiktorowicz, 2005). It also became apparent, that the call to partnership had “pitted” consumers/survivors against medical professionals and labour unions representing hospital workers (Everett, 2000, p. 179). Everett (2000) notes, many informants felt that because the policy was developed at a bureaucratic level it was too far removed from the “realities of the direct service interface between professional and patient,” argued to be the “most salient power contract” in the mental health care system (p. 181). It would be difficult to change the nature of the power contract, due to friction between mental health interests. Since consumers/survivors wanted greater “autonomy” and “respect” in their services, while professionals insisted they knew best as “experts” (Gadacz, 1994, as cited in Everett, 2000, p. 182). Everett (2000) asserts, before mental health reform could succeed, “how power is used” needed to be addressed (p. 182).

Putting People First (1993) was criticized for being an “administrative document concerned mainly with system management and cost-effectiveness, relegating... how services are to be delivered to a secondary status” (Everett, 2000, p. 184). The policy did not address how jobs would be reallocated to the community, (the training and education involved), nor did it provide a “strategy to address remuneration differentials” (Everett, 2000, p. 183). Unionized workers noted, community mental health agencies, which were to become

the “new employers of reallocated institutional staff,” were “rarely unionized,” “underfunded,” and given “benefits and working conditions inferior to those of public service employees” (Ontario Public Service Employees Union, 1991, p. 2, as cited in Everett, 2000, p. 76). Furthermore, *Putting People First* (1993) did not discuss the 25% wage gap between institutional and community workers (Everett, 2000, p. 76). Despite an increase in funding for community mental health, the majority of funding was still going to psychiatrists and unionized hospital workers (Nelson et al., 2001, p. 82). As identified in Nelson et al., (2001), informants claimed that the NDP government “lacked the will to reallocate resources” because it did not want to “antagonize” labour unions and medical professionals, argued to be their “traditional supporters” (pp. 82-83). Conclusively, informants attributed “the reluctance of the government to create systemic change” to a “slippage” in Graham’s (1988) “definition of community” (Nelson et al., 2001, p. 83).

While the Liberal and NDP governments made significant progress in mental health planning, from 1985-1995, a provincial deficit along with growing influence from conservative economic policies inhibited reform. Increased participation from various mental health stakeholders as well as a committed government, helped to move mental health reform into the public spotlight. However, the NDP government, in an attempt to balance labour and business interests, lost the ‘public consumer support’ needed for community-based mental health reform. Consequently, the end of the NDP leadership was followed by the re-emergence of a biomedical focus to mental health. Therefore, community care came to reflect a “treatment perspective” where “institutional staff worked out in the community” (Nelson et al., 2001, p. 83).

“Common Sense Revolution”

Sociopolitical Context of Mental Health Policies (1995-2003)

During 1995-2003, the Conservative government held power in Ontario (Everett, 2000). Its platform composed of the “Common Sense Revolution,” which blamed “self-interested public service” for the fiscal debt resulting from former governments (Everett, 2000, p. 219). The ‘Common Sense Revolution’ involved “cutbacks to health, education, and social services” (Nelson et al., 2001, p. 88). In its first term, the Conservative government cutback welfare payments by 21.6% and reduced personal income tax by 15% (Everett, 2000, p. 219). Echoing the neoliberal transformation of economic and social global politics, as observed by the Reagan and Thatcher governments, the Harris Conservative government in Ontario sought to promote free market capitalism by reducing the role of the state in social and economic activities (Braedley and Luxton, 2010). As neoliberal ideologies declared that de-regulating state measures would ‘free up’ markets and produce economic growth, which in turn was believed to be the “basis for all human well-being” (Coburn, 2006, p. 66). Therefore, as the well-known rowing metaphor asserts, under neoliberal influence, the state was transformed from “one which did both the steering and rowing, to one which merely steers” (Carney, 2008, p. 102).

With the election of the Conservative government in 1995, the Ministry of Health requested that District Health Councils (DHCs) include Assertive Community Treatment (ACT) teams in their mental health system designs (Wiktorowicz, 2005, pp. 390-391). Under the NDP government, DHCs were asked to “reconfigure the mental health system” by developing plans for mental health service delivery specific to the population needs within each region (Wiktorowicz, 2005, p. 390). DHCs acted as “regional advisory and planning agencies without fiscal authority” (Wiktorowicz, 2005, p. 390). Nelson et al., (2001) note, that the decision to incorporate ACT teams was faced with much opposition from psychiatric consumers/survivors, as they argued that its values undermined the recovery empowerment

paradigm (Nelson et al., 2001). Subsequently, those in opposition maintained that ACT teams have a “biomedical bias,” which emphasizes “social control” rather than “natural supports” (Nelson et al., 2001, pp. 92-93). Although ACT teams helped to improve access to mental health services in the community, their treatment-rehabilitation approach displaced previous notions of empowerment and community-integration for recovery.

In 1996, the District Health Councils (DHCs) released their recommendations for the mental health system (CMHA, 2004). The recommendations incorporated perspectives from both the Ministry of Health and the policy community to improve coordination between mental health services (Wiktorowicz, 2005; CMHA, 2004). The DHCs proposed strategies such as “joint networks,” “joint protocols,” and “tracking with a clear point of access into the system” (CMHA, 2004). The DHCs also recommended that the mental health care system offer a “continuum of services, involving case management” and provide models of service delivery based on “best practices” (CMHA, 2004). In Toronto, the DHC encouraged the development of “regional mental health authorities” to help coordinate institutional and community organizations (Ontario Metropolitan Toronto District Health Council, 1998, as cited in Wiktorowicz, 2005, p. 391). However, unlike the other provinces, in Ontario, the Ministry of Health “resisted devolving power to regional health authorities” (Wiktorowicz, 2005, p. 391). Alternatively, the Ministry aimed to create a “systems” approach to mental health care by providing financial incentives via the Community Investment Fund (CIF) (Wiktorowicz, 2005, p. 391). The CIF aimed to integrate services between “community service agencies” and “general hospitals,” by making funding for their programs dependent on their ability to coordinate services, i.e., “client assessment, intake and referral” (Wiktorowicz, 2005, p. 391). Wiktorowicz (2005) notes, despite completion of the DHCs recommendations, their vision of “community service networks...developed sporadically” (p.

391). Fundamentally, the DHCs had no “fiscal authority to alter patterns of service delivery” (Wiktorowicz, 2005, p. 401). Thus, the DHCs would later be replaced with Local Health Integration Networks (LHINs), under the McGuinty Liberal leadership in 2004 (Wiktorowicz, 2005).

During the first term of the Conservative government, the Ministry of Health established the Health Service Restructuring Commission (HSRC) (Nelson et al., 2001). The HSRC was given a mandate to restructure health services in Ontario (Hartford et al., 2003). The restructuring commission did not include psychiatric consumers/survivors nor did it engage in community consultation (Nelson et al., 2001). Wiktorowicz (2005) notes, since the Ministry of Health “owned and operated” psychiatric hospitals, the commission could only “advise on their restructuring” (p. 391). However, in 1996, the government enacted the Ontario Savings and Restructuring Act (Bill 26), giving the HSRC authority to “close, amalgamate, and transfer programs among general hospitals” (Wiktorowicz, 2005, p. 391). This enabled the government to “deflect any criticisms... concerning hospital closures, while maintaining the right to intervene in their interventions” (Wiktorowicz, 2005, p. 391). Despite prior commitments by the Harris government not to “cut hospitals,” the HSRC, by late 1997, had made significant cutbacks ‘closing and merging hospitals across Ontario’ (Harden, 1999, p. 215).

In 1999, the HSRC released their recommendations to the Ministry of Health and Long-Term Care (MOHLTC) (referred to as the Ministry of Health prior to 1999) in the report, entitled *Building a Community Mental Health System in Ontario: Report of the Health Services Restructuring Commission* (CMHA, 2004). The commission urged the MOHLTC to “divest Ontario’s nine provincial psychiatric hospitals to the public hospitals” and provide “transitional funding so that the services could be established before the beds were closed”

(CMHA, 2004). While the HSRC recommendations did not include community care, the restructuring commission “reiterated the Toronto DHC’s advice to establish regional mental health authorities” (Wiktorowicz, 2005, p. 393). Subsequently, the HSRC advocated for the establishment of mental health implementation task forces (MHITFS), which would make recommendations to the MOHLTC concerning “priority areas for reinvestment in the community” (Hartford et al., 2003, p. 70).

Based on the recommendations of the HSRC, the MOHLTC decided to “divest and close six psychiatric hospitals” and “disperse a portion of their beds among renovated general hospitals” (Wiktorowicz, 2005, p. 393). However, the MOHLTC was unable to secure transitional funds for community services as general hospitals had experienced “massive debts arising from renovations and employment terminations” (Wiktorowicz, 2005, p. 393). Furthermore, in regards to regional authorities, Wiktorowicz (2005) notes, “the Ministry would face serious opposition” from the Ontario Medical Association (OMA) and the Ontario Hospital Association (OHA) (p. 393). Since, regional authorities would need to be included in the Ontario Health Insurance Plan (OHIP) budget and “could lead to further hospital integration,” thereby challenging the “control” of hospital boards and management (Wiktorowicz, 2005, p. 393). Subsequently, “perceiving the community to be... less politically charged than the hospital sector,” in 2001, the MOHLTC implemented nine MHITFS and seven regional ministry offices (Wiktorowicz, 2005, p. 394). Wiktorowicz (2005) claims, regional offices, task forces, DHCs, and health service agencies were to work together to “consolidate rather than devolve the ministry’s authority” (p. 394). Therefore, community mental health was given little attention during this time due to the Conservative’s cost-cutting platform, which was reluctant to devolve control to local networks.

In 1998, during the HSRC's mandate, Dan Newman, a Member of Provincial Parliament and parliamentary assistant to the MOHLTC, led "a comprehensive 5-week consultative review of mental health reform in Ontario" (Hartford et al., 2003, p. 70). The resulting report, entitled *2000 and beyond: Strengthening Ontario's mental health system*, found that although the Conservative government supported a vision for community-focused care, the government "failed to provide the necessary dollars" to implement reform (Newman, 1998, p. 29). Based on an extensive consultation with mental health interest groups, Newman (1998) found that while "groups acknowledged that a great deal of time and effort has gone into planning mental health reform, these efforts have resulted in little change from past government" (p. 31). As a result, Newman (1998) claimed, "any further conceptual planning is unacceptable, and the time for implementation is now" (p. 31).

Due to "extensive and persistent family lobbying," the Newman Report (1998) also insisted that the government review the Mental Health Act (Everett, 2000, p. 220). This review was attributed to a general belief that the Act placed too much emphasis on "individual liberties" and needed "to give psychiatrists increased powers to treat patients on an involuntary basis and to write community treatment orders" (Everett, 2000, p. 220). As a result, the Newman Report (1998) led to Bill 68, referred to as "Brian's Law," which amended the MHA and the Health Care Consent Act (Wiktorowicz, 2005, p. 394). The amendments removed the word "imminent" in the phrase "imminent harm to self and others" from the involuntary examination, thereby enabling "health professionals to initiate the committal process at an early stage" (Wiktorowicz, 2005, p. 394). The revisions also provided for "compulsory outpatient treatment" (Hartford et al., 2003, p. 70). Community Treatment Orders (CTOs) were to facilitate involuntary treatment outside of the hospital (Hartford et al., 2003). Under clearly stated conditions, a CTO could be "imposed" on a

patient (Hartford et al., 2003, p. 68). However, the amendments ensured that patients have “access to rights advisers” if a CTO is presented (Hartford et al., 2003, p. 68). Still, the Bill represented a “significant defeat” for many psychiatric consumers/survivors (Everett, 2000, p. 220). Since, it reasserted the medical power in mental health care. As the institutional sector was simply placed in the community, thus leading to more of a “treatment perspective” than a “community living perspective” (Nelson et al., 2001, p. 83).

The Newman Report (1998) was followed by the MOHLTC’s release of an implementation plan and operational framework for mental health reform under the title, *Making It Happen* (Hartford et al., 2003, p. 70). The plan outlined the Ministry’s strategy “to increase the capacity” of the mental health system “for comprehensive and integrated treatment” (MOHLTC, 1999a, p. 3). The Ministry noted that community services would support “levels of need” (first line, intensive, and specialized) (MOHLTC, 1999a, p. 15). As well, that access to services would be based on a “triage protocol based on referral relationships” that would “create fewer points of entry and facilitate access to psychiatric consultation” (MOHLTC, 1999a, p. 17, as cited in Wiktorowicz, 2005, p. 395). The Ministry committed to “a comprehensive continuum of supports and services” (MOHLTC, 1999b, p. 8). These supports and services were to include: “intensive case management, inpatient and outpatient services, mobile outreach, assertive community treatment teams, safe beds, crisis services, community health centres, housing, health promotion and education, employment and forensic services” (MOHLTC, 1999a, p. 8). Additionally, in 2000, a policy framework for employment supports for people with serious mental illness was released, under the title *Making It Work* (CMHA, 2004). The report emphasized the need for employment initiatives, which were not adequately provided in the 10-yr plan outlined in *Putting People First* (1993) (CMHA, 2004). Similar to the *Making It Happen* (1999) reports, the Harris government

committed to investing in community mental health (CMHA, 2004). However, Wiktorowicz (2005) notes, “the government’s modest funding and limited operational plans to support its policies challenged its commitment and credibility” (p. 395).

In 2002, the MHITFS submitted their final reports for a reformed mental health system in Ontario to the MOHLTC (CMHA, 2004). The reports were released a year later, however, under the Liberal government in Ontario (Wiktorowicz, 2005, p. 396). The MHITFS were convened, beginning in 1999 by the MOHLTC, following the HSRC’s recommendation for “nine task forces based on the divestment of nine provincial psychiatric hospitals” (CMHA, 2004). For over three years, the regional task forces consulted with numerous members of the policy community (CMHA, 2004). The Ministry asserted that the task forces’ recommendations would be implemented after being approved by the Conservative government (CMHA, 2004). The final report, *The Time is Now*, of the Provincial Forum of Mental Health Task Force Chairs embodied eleven key themes (CMHA, 2004). The themes were: “increase the profile and funding of mental health care; focus on recovery; ensure a range of community-based supports that encompass the broader determinants of health (affordable housing, employment opportunities, income supports, peer and self-help supports); and, eliminate stigma and discrimination” (Wiktorowicz, 2005, p. 396). The Provincial Forum of Task Force Chairs also “reiterated DHC’s and HSRC’s advice to devolve the funding and authority for mental health service reconfiguration to regional mental health boards” (Wiktorowicz, 2005, p. 396). However, Wiktorowicz (2005) notes, by the time the task forces’ final reports were released, most of the hard work in getting hospital and community agencies to agree to coordinate services had already occurred (pp. 395-396). Although, Wiktorowicz (2005) claims, “many regions made little progress... in developing a coordinate approach to community care” (p. 396). Nonetheless when the Liberals came to

power, the government “essentially set the reports aside” (Wiktorowicz, 2005, p. 396). Instead, the McGuinty Liberal government announced its platform to “transform the health sector through local health integration networks (LHINs)” (Wiktorowicz, 2005, pp. 396-397).

“Common Sense” Neoliberalism

Sociopolitical Context of Mental Health Policies (2003-2016)

By the time the Liberal government came to power in 2003, the conservative neoliberal cost-cutting agenda had already swept through the province with the aim of creating a ‘systems’ approach to mental health care. Consequently, the Conservatives, resistant to devolve control to local authorities, established “successive arms-length governance processes,” which were rarely given the power to act on their recommendations (Wiktorowicz, 2005, p. 386). Therefore, the de-regulated state, ‘steering’ rather than ‘rowing,’ lacked the political will to “reallocate funds to the community and to delegate control for them on a regional basis” (Wiktorowicz, 2005, p. 389). Subsequently, by 2003, the government’s commitment to invest 60% of mental health spending in community programs was not realized (CMHA, 2004). As the conservative “fiscal rationalization” most often involved “cutting beds and funding community treatment orders” rather than “improving quality of life” (Mental Health Professional, as cited in Poole, 2011, p. 76). Furthermore, the conservative platform reasserted the power of the medical-institutional sector in mental health and addiction care under the guise of a ‘treatment’ perspective. As a result, the medical model was “re-packaged and relabeled as recovery” (Poole, 2011, p. 68). Thus, the neoliberal restructuring had created “a generalized mood of apathy, mistrust in government, and overall democratic decline” (McBride and Whiteside, 2011, p. 108).

Three important sets of studies, however, released during the McGuinty Liberal leadership in Ontario, were significant for guiding mental health reform. The Provincial

Psychiatric Hospital and Community Comprehensive Assessment Projects (CAPs), the Community Mental Health Evaluative Initiative (CMHEI), and the Systems Enhancement Evaluative Initiative (SEEI), were all funded by the MOHLTC to assess the effectiveness of community-based mental health care in Ontario (CMHA, 2011). The CAP (1998-2002), was the first study to collect data on community mental health services and supports in Ontario (CMHA, 2011). While the initial projects focused on services from psychiatric hospitals, the project was expanded to include community mental health programs (CMHA, 2011). The main findings from the CAP projects were that hospital and community systems lacked the capacity to meet the intensity of provincial needs; that greater hospital patients could be served in the community if more services and supports were made available; and that more intensive community supports were needed (Koegl, Durbin, & Goering, 2004).

The CMHEI (1998-2004), was the first “multisite evaluation of community mental health programs in Canada” (CMHA, 2011 p. 11). The CMHEI found that government investments in community mental health services and supports had been positive (CMHA, 2011). The results indicated that community mental health services and supports were cost-effective, as researchers found that it “could cost up to five times less to provide an individual with community-based services, than to keep them in the hospital for the same length of time” (Goering, 2004, p. 6). As well, that peer support could reduce symptom severity and rates of hospitalization (Goering, 2004). Additionally, that intensive case management (ICM) and Assertive Community Treatment (ACT) programs reduced dependency on institutional care (Goering, 2004). Like CAP, the CMHEI identified the need for a range of community supports and services (i.e., employment, income, and health care supports), to provide a continuum of care to meet individual needs (CMHA, 2011).

In 2004, due to some extent from the CAP and CMHEI findings, the MOHLTC provided a 52% increase in funding for certain mental health community supports and services (CMHA, 2011). The investments came from the two provincial initiatives: Federal Health Accord for Home Care, which provided \$117 million over four years for ICM, ACT, crisis intervention, and early intervention services; and the Service Enhancement Initiative, which provided \$50 million from 2005-2006 for court support programs, ICM, crisis intervention, supportive housing, and safe beds (CMHA, 2011, p. 12). The SEEI (2005-2009), comprised of “nine research studies in two phases,” that assessed the impact of these new government investments (\$167 million) in Ontario’s community mental health sector (CMHA, 2011, p. 12). As well, the SEEI led to the creation of the Ontario Mental Health and Addictions Knowledge Exchange Network (OMHAKEN) (CMHA, 2011). The SEEI found that more people were accessing community mental health services and at an earlier rate (Goering, 2011). However, the SEEI found that additional services and supports were needed, as “expanded services in one part of the system increased case finding, and ultimately identified client needs for other services” (CMHA, 2011, p. 12). Subsequently, from 2010-2011, OMHAKEN, in collaboration with 17 mental health and addictions organizations, led to the initiative *Creating Together* (CMHA, 2011). *Creating Together* consulted with the policy community to identify the six priorities for mental health and addictions in Ontario: “social determinants of health; risk and resilience; health promotion and prevention; stigma and discrimination; continuity of care; and vulnerable populations” (OMHAKEN, 2011, pp. 6-7).

In 2003, the federal government of Canada, established the Standing Senate Committee on Social Affairs, Science and Technology to provide a three-year study of mental health, mental illness, and addictions in Canada (White and Pike, 2013, p. 243). In

2006, the Committee released their findings in the report, entitled *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, also referred to as the Kirby report (White and Pike, 2013, p. 243). The report recommended that a Canadian Mental Health Commission be developed as well as a Mental Health Transition Fund to aid in the shift from an institution-based to a community-based mental health system over the next 10 years (Kirby and Keon, 2006; CMHA, 2013b). The transition fund would be used to support a “Mental Health Housing Initiative,” which would “provide federal funds for the development of new affordable and appropriate housing units;” and a “Basket of Community Services,” to “assist provinces in providing to people living with mental illness a range of services and supports in the community” (Kirby and Keon, 2006, at 5.6). The Kirby report provided 118 recommendations, which included the development of a national mental health strategy, a national anti-discrimination strategy, and a Knowledge Exchange Centre that “would facilitate the exchange of the best available knowledge between mental health services knowledge producers and users across Canada” (Kirby and Keon, 2006, at 16.4.3). Subsequently, in 2008, the Harper Conservative government provided funding for the Mental Health Commission of Canada (MHCC), with a mandate to provide a national mental health strategy, a 10-yr anti-stigma strategy, and a knowledge exchange centre (CMHA, 2013b).

Based in a commitment by the McGuinty Liberal government to improve mental health and addiction services in the province, in 2008, the MOHLTC established an Advisory Group consisting of psychiatric consumers/survivors, their families, mental health service providers, and researchers to develop a 10-yr strategy for mental health and addictions in Ontario (Minister’s Advisory Group, 2009). In 2009, the Advisory Group released their discussion paper, *Every Door is the Right Door* (CMHA, 2013a). The report placed significant emphasis on prevention and mental health promotion (Minister’s Advisory Group,

2009). The Advisory Group stated that it was critical to make ‘every door the right door’ for people with mental health and addiction problems, as Ontario’s fragmented system of services caused many people to “struggle” to find appropriate services (Minster’s Advisory Group, 2009, p. 11). Therefore, in order to provide integrated and coordinated care, the Advisory Group established seven directions for mental health and addictions services: “act early; meet people on their terms; transform the system; strengthen the mental health and addictions workforce; stop stigma; create healthy communities; and, build community resilience” (Minister’s Advisory Group, 2009, p. 11).

In 2009, the Legislative Assembly of Ontario, gave “unanimous consent to a motion to appoint a Select Committee on Mental Health and Addictions” (Select Committee on Mental Health and Addictions, 2010, p. 2). The Committee was to provide recommendations for a “comprehensive provincial mental health and addictions strategy” (Select Committee on Mental Health and Addictions, 2010, p. 2). From 2009-2010, the Committee consulted with psychiatric consumers/survivors, mental health providers, and other interest groups to address provincial mental health needs (Select Committee on Mental Health and Addictions, 2010). In 2010, the Committee released their *Interim Report* (2010a), which outlined major issues with the mental health care system as identified through the Committee’s public hearings (CAMH, 2013). Significant issues raised were: long wait times in the emergency department and less than ideal treatment settings; inappropriate incarceration; and, poor service integration (i.e., transitioning from: children, youth, and adult services; adult and senior services; addiction and mental health services; and addiction and mental health and the health care system in general) (Select Committee on Mental Health and Addictions, 2010).

Subsequently, in 2010, the Select Committee on Mental Health and Addictions released their *Final Report* (2010b), which outlined recommendations to improve Ontario’s

mental health and addictions system (CMHA, 2013a). Building on its consultation with the policy community, the Committee stated that “radical transformation of mental health and addictions care” was necessary to ensure that Ontarians get the “care they need and deserve” (Select Committee on Mental Health and Addictions, 2010, pp. 1-2). The Committee reported that approximately one in ten people suffering from a highly treatable condition, such as anxiety, were “overlooked” within the provincial mental health care system (Select Committee on Mental Health and Addictions, 2010, p. 2). Furthermore, that the reality of “community support” was individuals being cared for by families that were “stressed,” “overburdened,” and “struggling along without assistance” (Select Committee on Mental Health and Addictions, 2010, p. 2). Therefore, the Committee provided 23 recommendations, by which they urged “the Legislature to endorse” and “advocate for their implementation” (Select Committee on Mental Health and Addictions, 2010, p. 2). These recommendations including: the creation of an umbrella organization, the Mental Health and Addiction Ontario, to manage and coordinate the mental health and addictions system; the consolidation of all mental health and addiction services in the MOHLTC; and, that the MOHLTC consider alternate remuneration models to improve access to and quality of primary care for people with mental health and addiction problems (Select Committee on Mental Health and Addictions, 2010, pp. 19-21). The Select Committee also advised the Legislative Assembly of Ontario to review the recommendations within two years of their implementation (Select Committee on Mental Health and Addictions, 2010).

Therefore, in 2011, Ontario released its 10-yr Comprehensive Mental Health and Addictions Strategy, entitled *Open Minds, Healthy Minds* (CMHA, 2013a). The Strategy was guided by the four goals: “improve mental health and well-being for all Ontarians; create healthy, resilient, inclusive communities; identify mental health and addictions problems

early and intervene; and, provide timely, high quality, integrated, person-directed health and other human services” (MOHLTC, 2011). The Strategy outlined a plan to provide integrated mental health and addiction supports and services to all Ontarians (CMHA, 2013a). The first three years (2011-2013) of the Strategy were targeted at improving access to services for children and youth, as reported that 70% of mental health and addiction problems have their onset during childhood or adolescence (MOHLTC, 2011). In 2011, the government committed to investing \$257 million over the three years (MOHLTC, 2011). However, a 2014 assessment, indicated that over the three years, the government had invested only \$93 million focused in children and youth (MOHLTC, 2014). Nevertheless, in 2014, more than 50,000 additional children and youth were receiving mental health services, while more than 770 new mental health workers were hired in communities, schools, and courts (MOHLTC, 2014). Additionally, the Moving on Mental Health plan, part of the Strategy, was launched in 2012 to help children and youth and their families navigate mental health services, so to ensure appropriate access to care (MOHLTC, 2014). In 2014, the MOHLTC began expanding on the first phase of the Strategy to improve transitions between youth and adult services and to improve services and care for all Ontarians via “additional investments of over \$65 million in 2014-2015, growing to about \$83 annually by 2016-2017” (MOHLTC, 2014). Subsequently, the MOHLTC committed to “linking” these investments “to the quality of care that is needed” (MOHLTC, 2014).

Similarly, in 2012, the MHCC, appointed by the Harper Conservative Government in 2008, released Canada’s first national mental health strategy, entitled *Changing Directions, Changing Lives* (CMHA, 2013b). The Strategy, a “blueprint for change,” included 109 recommendations regarding the implementation of mental health policies (Fitzpatrick, 2012). The Strategy’s recommendations were “aimed at governments, the private sector, health

professionals, social services providers, and all Canadians” (Fitzpatrick, 2012). The document is divided into six strategy areas: “promotion and prevention; recovery and rights; access to services; disparities and diversity; First Nations, Inuit, and Métis; and, leadership and collaboration” (MHCC, 2012, pp. 4-5). In order to reduce “funding inequities,” the Strategy proposed increasing the proportion of health spending allocated to mental health from seven to nine per cent and increasing the proportion of social spending for mental health by two percentage points (CMHA, 2013b). The Strategy also recommended identifying whether mental health spending should be reallocated to improve efficiency and outcomes (CMHA, 2013b). Furthermore, the Strategy encouraged contribution from private and philanthropic sectors (CMHA, 2013b). Although, the former Chair of the MHCC, Michael Kirby, urged both the federal and provincial government to make mental health a priority, he believed that the Strategy’s implementation was an area of provincial responsibility and “absolutely not a role for the federal government” (as cited in Fitzpatrick, 2010). As Kirby argued that it depends on what services provinces have available – “gaps in some provinces are totally different from the gaps in others” (as cited in Fitzpatrick, 2010). However, the MHCC, operating at the federal level, is unable to direct provinces in the resourcing of or priority for mental health services as rooted in Canadian federalism and the constitutionally-based division of powers (Teghtsoonian, 2009, p. 28). Morrow (2013) asserts, that the MHCC “can only attempt to foment change through national consultations and moral suasion” (p. 324). Therefore, in order for both governments to truly make mental health funding a priority, the system of mental health and addictions funding needed to change.

With the return of the Liberal governance in Ontario (2003), a significant amount of change in mental health care has been achieved. Greater funding in community-based care has meant that more people with mental health and addiction needs are receiving care. As

well, greater lobbying from the policy community in planning for a better mental health and addictions system has led to the creation of both a national and provincial mental health strategy. Despite such growth, inequities to mental health care persist. As policies and reports since 2003 have indicated, the demand for mental health and addiction needs simply exceeds the supply (Rush and Saini, 2016). Consequently, investments from governments have not been enough to offset 'passive privatization,' which has placed a greater role on the market and families for providing mental health and addiction supports and services.

Governments operating under a 'locked in' business agenda, lack the political will to respond to growing inequities, by prioritizing funding for community mental health and addictions care. Consequently, the liberal government is often criticized for 'campaigning from the left but governing from the right' (Raphael, 2016). As an excerpt from a psychiatric survivor shows: "If you want to see where the government's heart and soul is and if you want to really check out where government's commitments are policy-wise, don't listen to the words, look at where they spend the money" (as cited in Poole, 2011, p. 76). Although labour has mobilized to support Graham's (1988) vision for better mental health and addictions care, governments have not been responsive in transforming the mental health and addictions system (its funding, organization, and delivery). Instead, governments continue to respond to unmet mental health needs through inappropriate and outdated measures (i.e., delegating responsibility to 'powerless' successive governance processes and providing incremental funding investments). Therefore, as clearly expressed by Banting and Myles (2013), the shifting of powers within governments from social policy departments to departments of finance and between governments from the federal to the provincial level have weakened the politics of redistribution in Canada (p. 19).

Policy Drift

The neoliberal transformation of governance and the welfare state, that weakened the politics of redistribution, has widened inequities to mental health care. The effects of neoliberalism in mental health care is an offloading of state responsibility for care to the private sector. The reality of the neoliberal 'passive privatization' is an individualized approach to mental health care, where differences in social determinants of mental health, such as income and access to services, are overlooked. Consequently, the two-tiered system of mental health care in Ontario exposes persistent social inequities. As mental health and addiction care is most accessible to individuals with more advantageous social determinants of health that are able to afford costly psychotropic medications and psychologists' services not protected by the Canada Health Act (1985). Consequently, populations with more severe mental health and addiction problems, whose social determinants of health are less privileged, who are too poor or unwell to absorb private costs associated with medications and good housing, are denied access. Pedlar and Hutchinson (2000) refer to this as "creaming," or providing services to people that are seen as "easy to service" (p. 646). As a result, neoliberal restructuring has influenced not only who provides mental health and addiction care but also the form that this care takes (Armstrong and Armstrong, 2002).

Welfare Cuts and Inclusion of Workfare Policies

During the Harris governance (1995-2003) in Ontario, major cuts were made in welfare rates and government programs in order to address deficit reduction (Chouinard and Crooks, 2008). The implication was that welfare recipients with disabilities were expected to live off of lower income assistance (Chouinard and Crooks, 2008). Lalonde (1997) comments that psychiatric consumers/survivors suffered considerably under the Harris welfare restructuring, as they faced incredible difficulty in qualifying for disability income support. Similarly, in British Columbia, under the Liberal governance in 2002, individuals applying

for income-assistance had to demonstrate activity in the paid labour market for at least twelve of the past fifteen months prior to even applying for assistance (Chouinard and Crooks, 2008). Therefore, neoliberal policy shifts involving cuts in social service funding, has made eligibility stricter for social benefits, including for people with mental health and addiction problems (Swain, French, & Cameron, 2003; Chouinard and Crooks, 2008; Teghtsoonian, 2009; Morrow, 2013). Teghtsoonian (2009) asserts, neoliberal political governance places “a normative and analytic emphasis on the individual, and a preference for private sector funding and delivery of services” (p. 29). As a result, those marginalized in society are stigmatized as ‘abusing’ social assistance because of a choice to not compete in the market (Braedley and Luxton, 2010). Luxton (2010) asserts, these beliefs ignore the impact of social and economic factors on an individual’s choice. To assume that everyone has equal choice in the market denies the current capitalist social formation and its effect on social determinants of health. However, employment became critical for social integration due to neoliberal emphasis on individualism (Pinto, 2010).

The inclusion of welfare-to-work policies sought to address ‘dependent’ and ‘abusing’ welfare recipients. The welfare-to-work policy regimes reflected the leaner and stricter requirements in receiving government support. In the U.K., the welfare-to-work regime was initiated during the New Deal for Disabled People (NDPP) under the 1997-2007 Blair’s elected Labour Government (Swain et al., 2003). The NDPP sought to include individuals into society through labour market activity (Roulstone, 2000). The welfare-to-work regime embraced the Labour party’s slogan “no rights without responsibilities” in which stricter requirements were established to claim unemployment benefits (Swain et al., 2003). The goal of such policies was to create an “active welfare” (Swain et al., 2003). Similarly, in Ontario, the Harris Conservative government implemented a ‘Workfare’

program, where people on social assistance were expected to remain active in the labour market (Nelson et al., 2001, p. 89). Such welfare-to-work policies disregard the changing nature of employment, i.e., the increase in part-time and short-term contractual jobs, and the fact that some individuals are unable to work even if employment is available (Galvin, 2006). Conclusively, these reforms ignore democratic principles in collective responsibility and redistributive wealth via state public services. As a result of this democratic destruction, those marginalized face greater challenges in response to waning state support.

Personal Recovery

The neoliberal paradigm shifts in mental health and addiction care, from a collective social responsibility to a private individual responsibility, promotes recovery as a “personal journey,” where ultimately the ‘consumer’ is responsible for their own recovery (Morrow, 2013; Braslow, 2013). Braslow (2013) asserts, “independence for both recovery and welfare reform is the desired and assumed outcome” (p. 800). Neoliberalism encourages individuals and their families to take greater responsibility in their own care, as public services are argued to be “inefficient and costly” (Luxton, 2010, p. 163). Neoliberalism argues that “reliance on state services weakens individual initiative and undermines family and community ties” (Luxton, 2010, p. 163). Neoliberalism fits closely with the biomedical framing of mental health and addiction problems, as it “locates the principle sources of mental health challenges within individuals” (Teghtsoonian, 2009, p. 31). Therefore, the biomedical focus masks the “social, political, cultural, and economic context in which people become mentally distressed” (Morrow, 2013, p. 325). Consequently, the neoliberal “healthification of social problems” produces a psychiatric consumer whose mental health and addiction problems is an individualized responsibility (Morrow, 2013, p. 329).

The Epidemic of Pharmacotherapy

The psychopharmacological revolution, beginning with deinstitutionalization in the 1960s, has shaped the way mental health and addiction problems are viewed and treated. Although, the psychiatric survivor movement saw psychotropic medications as going against their ‘recovery,’ by the 2000s, psychotropic medications transformed many patients into “recovered consumers” (Braslow, 2013, p. 795). As the multibillion-dollar market of psychopharmacology, keeps patients’ dependent on “commodities named after the symptoms they treat” (Braslow, 2013, p. 795). Consequently, the largest expenditure for mental health services in Canada is pharmaceuticals (Jacobs et al., 2010). For example, from 2007-2008, Canada spent \$85 per person on pharmaceuticals, of which only \$38 was publicly funded (refer to Table 5 in Appendix C) (Jacobs et al., 2010). Consequently, in all provinces except Saskatchewan, private funding for pharmaceuticals exceeded the public funding for populations with mental health and addiction problems (Jacobs et al., 2010). Pharmacotherapy fits neatly with the business-agenda of governments that hopes to expedite the process of recovery. As a result, pharmacotherapy has become the first-line of treatment for populations with mental health and addiction problems, with the use of psychiatric medications said to range from “womb to grave” (Whitaker and Cosgrove, 2015).

The biomedical focus of mental health treatment normalizes an ideal body. This focus isolates the body from its geographic context, where ‘normalcy’ is subjective to one’s spatial and social environments (Chouinard, Hall, & Wilton, 2010). As a result, medicalizing the brain obscures ‘normality’ and ignores the geographic context of the body and its relation to sources of power (Chouinard et al., 2010). Approximately, 7.2% of the Canadian population is consuming a psychotropic drug (Beck et al., 2005). While, more than one in twelve youth were dispensed a psychotropic medication from 2013-2014 (CIHI, 2015). The commercialization by large transnational pharmaceutical companies of the “dysfunctional

brain” in relation to psychiatric disorders, promotes consumerism of mental health pharmaceuticalization (Robertson and Walter, 2003). Hamilton (2003) comments this commercial activity of the “dysfunctional brain” increases the amount of people who circumscribe themselves as mentally ill. As the “chemical imbalance theory,” implies that there is an optimal brain functioning that involves an ideal neurochemical state (Moncrieff, 2006). People are driven to achieve this idealized state, although never scientifically proven, by taking psychotropic drugs (Shimrat, 2013). Consequently, the drugs, which themselves create chemical imbalances, transform a “first-time customer into a longer-term user” (Whitaker, 2010, p. 319). As a result, the “dysfunctional brain” theory commercialized by pharmaceutical companies encourages consumerism to distract individuals from the larger social and political forces that may be breeding their sense of “inadequacy” and “anxiety” (Moncrieff, 2006). Moncrieff (2006) asserts, “the pharmaceutical industry therefore not only helps to expand markets for psychotropic drugs but also helps to create conditions in which neoliberal policies can thrive and in which resistance to them is curtailed” (p. 302).

Evidence for Psychological Services

Neoliberal ideologies that promote profit and short-term gains, at the expense of long-term savings, continue to grant the pharmaceutical industry power to commercialize on bodily functions. Canada spends less on physician services than it does on pharmaceuticals and over-the-counter medications (Romanow and Marchildon, 2003; Jacobs et al., 2010). However, evidence shows that integrating psychological therapies into primary healthcare can be a cost effective solution to treating mental health and addiction problems (Romanow and Marchildon, 2003). For example, psychotherapies, including cognitive behavioural therapy and interpersonal psychotherapy, are evidenced to be just as effective as pharmacotherapy in treating patients with prevalent mental health problems, like depression,

and more effective in preventing rates of relapse (Hunsley, Elliott, & Therrien, 2013). Subsequently, combined psychotherapy and pharmacotherapy has led to better treatment adherence than pharmacotherapy alone in the treatment for addictions (Jhanjee, 2014; Amato et al., 2008). Moreover, psychotherapies are shown to be cost-effective alternatives, costing less than one-third of pharmacotherapy and offsetting medical costs associated with use of hospital services and medications (Chiles, Lambert, & Hatch, 1999; Hunsley, 2003).

Wrongful Influence from the Pharmaceutical Industry

Yet, the pharmaceutical influence in psychiatry continues to preserve markets at the expense of population health as was evident in the Treatment for Adolescents with Depression Study (TADS) funded by the National Institute for Mental Health (NIMH) (Whitaker and Cosgrove, 2015). In 2004, the U.S. Food and Drug Administration declared that pediatric drug trials of Selective Serotonin Reuptake Inhibitors (SSRIs), used in the treatment of depression, had failed, as SSRIs were shown to double the risk of suicide in youth (Whitaker and Cosgrove, 2015). TADS sought to preserve the market for pediatric use of fluoxetine, a type of SSRI (Whitaker and Cosgrove, 2015). The study randomly allocated 439 youth to placebo, fluoxetine (Prozac), CBT, or a combination of CBT plus fluoxetine (Whitaker and Cosgrove, 2015). Results from the TADS (2009) found that there was no evidence for “medication-induced behavioural activation as a precursor” to a suicidal event (shown in Table 6 in Appendix C) (Whitaker and Cosgrove, 2015, p. 131). Upon further review, however, it was identified that during the first 12 weeks many in the placebo and CBT-alone groups opted for treatment with fluoxetine (Whitaker and Cosgrove, 2015). Consequently, it was shown that only after going on fluoxetine did the placebo and CBT-alone youth groups become suicidal (seen in Table 7 in Appendix C) (Whitaker and Cosgrove, 2015). Therefore, while the TADS researchers did publish all the data, the

researchers diverted attention by focusing on how CBT enhanced the safety of the drugs and thus how the drugs did not increase the risk of suicide (Whitaker and Cosgrove, 2015). However, the main results were that “17 of the 18 suicide attempts had been in youth taking the antidepressant” (Whitaker and Cosgrove, 2015, p. 133). Due to the safety of drugless therapies and their clinical and cost-effectiveness, psychological therapies should be the first line of treatment for all Canadians with mental health and addiction problems.

Evidence for Better Treatment Settings

Despite the neoliberal focus on pharmacotherapy, there has been a substantial amount of evidence indicating positive outcomes from community-based mental health and addiction supports and services. As evident that community-based care involving psychological services, addictions therapy, case management, and supportive housing can prevent the trajectory of increased illness severity and reduce hospital admissions (Goering, 2004; Kirby and Keon, 2006; Forchuk et al., 2008; MHCC, 2013; Hunsley et al., 2013). For instance, a community housing intervention that made first and last month’s rent available to patients discharged from psychiatric wards to shelters was effective in preventing re-hospitalization and homelessness (Forchuk et al., 2008). While LHINs provide access to community-based supports, poor accountability from the Ministry has meant that LHINs continue to report low performance targets (i.e., wait times) each year (AGO, 2015). Consequently, insufficient capacity of LHINs has meant that they have been unable to meet the growing demand for mental health and addiction services and supports (AGO, 2015). As a result, it is unclear whether LHINs have improved continuity of care within the local health system (AGO, 2015). Therefore, although effective treatments for mental health and addiction problems exist, access remains a significant barrier.

Inaction from Governments

Growing inequities in access to mental health and addiction care reflects the neoliberal influence in mental health, which “empowers patients while cutting costs and offloading government responsibility for their care” (Poole, 2011, p. 68). Although federal health transfers increased by \$6.6 billion from 2005-2011 (Lurie, 2014), the federal government was unable to direct provinces in resource allocation. Subsequently, although Ontario’s share of transfers increased by \$2.9 billion, only a small proportion was allocated to new mental health investments (Lurie, 2014). While alternative forms of treatment and settings of care have been shown to reduce personal and public costs associated with unmet mental health and addiction needs, governments lack the political will to direct resources away from the Ontario Medical Association (OMA). Consequently, recovery operating under a biomedical lens places responsibility on individuals rather than publicly funded services for responding to mental health and addiction needs. Due to the powerful influence of the pharmaceutical industry in psychiatry, individuals are encouraged to ‘buy into’ a system that perpetuates consumerism while, the pharmaceutical industry continues to mask the social determinants that shape mental health. Therefore, governments inaction to growing inequities has weakened the redistributive state (Banting and Myles, 2013, p. 3). The creation of the neoliberal “self” (Rose, 1990) ignores the context in which people become mentally distressed (Morrow, 2013). As Whitaker and Cosgrove (2015) note, “society is no longer prompted to ask what happened...instead a diagnosis is made to designate what is wrong” (p. 169).

Future Directions

Towards Critical Recovery

The Kirby Report (2006), the first national government report regarding the state of Canada’s mental health system, identified recovery as the “guiding principle for mental

health reform” (Piat and Sabetti, 2012). Since its release, the concept of recovery has been implemented throughout national and provincial mental health policies (Piat and Sabetti, 2012). However, since the concept of recovery can be understood in various ways (Morrow, 2013), provinces differ in how they have used the concept to transform their mental health systems (Piat and Sabetti, 2012). Piat and Sabetti (2012) note, generally provincial policies have focused on either “recovery” or “population-based wellness” to guide reform. Population-based strategies are said to differ from a recovery orientation by placing emphasis on evidence-based mental health services to achieve ‘wellness’ (Piat and Sabetti, 2012). Therefore, it is argued that evidence-based practices “privilege quantifiable findings around the medical or scientific condition of service users” while, recovery is concerned with issues of individual empowerment and self-determination (Piat and Sabetti, 2012, p. 25). However, among both the recovery and population-based orientations for mental health reform there is an issue of social equality (Piat and Sabetti, 2012). Social equality concerning equality rights and social determinants of health is rooted in section 15.1 of the Charter of Rights and Freedoms (Piat and Sabetti, 2012). It is recognition of equality rights under Canadian law that enables individuals with mental health and addiction problems to be included in transforming mental health systems (Piat and Sabetti, 2012).

The involvement of psychiatric consumers/survivors in mental health reform can transform the recovery process from an “exclusively individual responsibility to a shared societal responsibility,” thereby enabling social justice (Piat and Sabetti, 2012, p. 21). Both the federal and provincial (Ontario) mental health strategies, place emphasis on involving “service users” and their families in making decisions for the mental health system (Piat and Sabetti, 2012). The provincial strategy even refers to ‘service users’ as “essential partners in system design” (MOHLTC, 2011, p. 9, as cited in Piat and Sabetti, 2012, p. 24). However,

the strategy does not address how this partnership will be implemented (Piat and Sabetti, 2012). Furthermore, consumer-survivor self-help and peer support initiatives, which have been critical in advancing principles of empowerment and justice in the mental health system, are absent in the strategy (Piat and Sabetti, 2012). This is problematic, as it was through these initiatives that ‘macro’ level changes flourished during the early years of mental health reform. As consumers/survivors “began the dialogue about recovery” (Morrow, 2013, p. 330). This ‘dialogue’ centered on recovery as an ‘empowering community integration’ process. However it was “sidetracked in Ontario when the government changed policy directions” (Nelson et al., 2001, p. 253). Consequently, recovery took a biomedical focus that fed into “individualistic discourses... of chemical imbalances...which work against social change” (Morrow, 2013, p. 323). In order to promote change, facilitating the social integration of populations with mental health and addiction problems, it is important to expand the dialogue of recovery. Poole (2011) asserts, we must expand the discourse towards “critical recovery” (p. 109). Critical recovery involves “explicit recognition of the impact of structural barriers on mental health” (Morrow, Jamer, & Weisser, 2011, p. 2). It is through critical recovery, that social structures can be made more inclusive. Poole (2011) states:

From a critical recovery perspective, the talk changes. It means we can be disquieting, we can resist the resistance and pay attention to social pressures and “have-to’s” in recovery. We can alert each other in slogans and trends, we can question intentions and we can carry on whatever it was that we were doing locally to heal and not call it recovery. We can name racism and discrimination in recovery and work for rights, funding and housing. We can know that this healing does not have to be spiritual. It does not have to be made into a model, and it does not have to be evidence-based to matter. (pp. 109-110).

Role of Governments

Governments must invest in mental health care to reduce gaps in accessing mental health and addiction treatment. Ontario’s Institute for Clinical Evaluative Sciences (2012) shows that “the burden of mental illness and addictions is more than 1.5 times that of all

cancers and more than seven times that of all infectious diseases” (shown in Figure 4 in Appendix D) (Ratnasingham et al., 2012, p. 7). However, a 2012 survey by Statistics Canada found that, about 600,000 Canadians reported having an unmet mental health or addiction need in the last year, while more than 1,000,000 reported having partial met mental health and addiction needs (Statistics Canada, 2012). Furthermore, of these Canadians with mental health needs, 91% reported that their needs for medication were met, while only 65% felt that their needs for counselling were met (refer to Table 8 in Appendix C) (Statistics Canada, 2012). It is argued that Canadian physicians bill provincial governments \$1 billion a year for “counselling and therapy,” of which one-third goes to family doctors (Anderssen, 2015a). Furthermore, mental health and addiction problems are suggested to account for 50% of family doctors time (Anderssen, 2015a). Despite many family physicians, those without specialized training in psychotherapy, lacking the training and time to manage patients with mental health and addiction problems under the fee-for-service payment system (Kirby and Keon, 2004).

Psychological services have been shown to be cost-effective treatment alternatives to pharmacotherapy for patients with prevalent mental health problems; and have been shown to reduce rates of relapse and promote greater treatment adherence when used in combination with pharmacotherapy for addiction problems (Amato et al., 2008; Hunsley et al., 2013; Jhanjee, 2014; Nathan and Gorman, 2015). However, the Mental Health Surveillance Project by the Canadian Psychological Association (CPA) of registered psychologists in Canada, shows that while practicing patterns of psychologists vary between public and private sectors, there are more psychologists practicing exclusively in the private sector than exclusively in the public sector (Ronson, Cohen, & Hunsley, 2011). While the provincial government does not track wait-times for psychiatric care in Canada’s public health care system, evidence

from the CPA indicates that wait-times for outpatient mental health services may range from months to years (Ronson et al., 2011). Yet, individuals able to, may access psychological services in the private sector.

Similarly, community-based mental health services and supports involving Assertive Community Treatment (ACT) teams, supportive housing, and psychological and addiction therapies have been shown to alleviate human and economic costs associated with unmet mental health care needs by reducing symptom severity and rates of hospitalization (Goering, 2004; Kirby and Keon, 2006; Forchuk et al., 2008; MHCC, 2013). In Ontario, Local Health Integration Networks (LHINs) are funded by the MOHLTC to provide an array of community supports and services. However, Ontario Auditor General Reports (2003-2015) expose lengthy wait-lists for LHIN provided services. For instance, in 2008, wait-times for community mental health and addictions services ranged from a minimum of eight weeks to a year or more (AGO, 2008). Furthermore, in 2015, some people waited up to two years for supportive housing/assisted living programs (AGO, 2015).

In Canada's National Mental Health Strategy (2012), the Mental Health Commission of Canada (MHCC) advised provinces to increase their mental health share of health spending from seven to nine per cent and social spending by two per cent. However, since the strategy has no binding force on the provinces, real investment in mental health has not been prioritized, despite increased federal fiscal health transfers. The MHCC (2013) predicts that without further investments in mental health, the cumulative cost to the economy for mental health and addiction problems will exceed \$2.5 trillion over the next thirty years. In order to secure provincial investments in mental health, a new direction may be to "leverage federal investment by getting the provinces to agree on where the money will be targeted" (Mulvale, 2007, p. 131). For instance, in Australia, targeted federal transfers have helped to

improve access to psychologists within the primary care system through the Access to Allied Psychological Services program, a component of the government's Better Outcomes in Mental Health Care Initiative (Moulding et al., 2009). The concept of targeted federal mental health transfers has been proposed previously in Canada, by the Health Services Restructuring Commission (HSRC) in 1999, and the Standing Committee on Social Affairs, Science and Technology (Kirby committee) in 2006. In both cases, transitional funds were to support the development of greater community-based mental health care. Lurie (2014) notes, if the transition fund proposed by the Kirby Committee (2006) was implemented, the federal government would have transferred over \$530 million per year to the provinces. This would represent only a small fraction (0.29%) of what the federal government spends annually on health care in Canada (\$182 billion), and would have increased investments in mental health services (Lurie, 2014, p. 687).

Targeted federal mental health transfers would ensure provinces invest in mental health and reach the goal set by the MHCC (2012). New investments could be targeted in expanding the scope of mental health care by increasing access to psychologists in the public health care system and the capacity of LHINs to meet supply demands. In Canada, the number of psychologists outnumber psychiatrists by about 4:1 (CPA, 2016). By including more psychologists into the public health care system, bottlenecks in care could be reduced. As psychological services could improve access to care and therefore decrease emergency department repeat visits and wait-times. This may ultimately lead to legislative changes in the Canada Health Act, which has produced inequities to accessing mental health and addiction care by discriminating psychologists from the public health care system, despite their extensive training in "assessing, diagnosing, and treating" (CPA, 2016) mental health and behavioural conditions. Targeted federal investments could also lead to the establishment

of service targets set by the MOHLTC, thereby holding LHINs accountable for poor performance. Overall, targeted federal investments in mental health would reduce inequities to mental health and addictions care produced by the flawed, inefficient mental health system.

Role of the Court-System

In Canada, 'positive' rights to access to mental health care have been secondary to 'negative' rights to individual liberty (Carney, 2008; Flood and Gross, 2014). Under international law, the 1948 Declaration of Human Rights split into two covenants in 1966, one including civil and political rights and the other social and economic rights (Flood and Gross, 2014, p. 2). Subsequently, the 1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR), recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (ICESCR, 1966, article 12.1, as cited in Flood and Gross, 2014, p. 7). However, social and economic rights were not explicitly included in the Canadian Charter of Rights and Freedoms (1982) (Porter, 2005). Although the Charter does not "explicitly guarantee a right to health," it does ensure that individuals may apply to the courts to contest violated rights (s. 24) (Flood, 2014, p. 86). Consequently, many Canadians are using s.7 of the charter on the right to 'life, liberty, and security' to "impose a positive obligation on government...[for] access to the necessities of a secure and autonomous life" (Flood, 2014, p. 87). However, as seen with the implementation of Community Treatment Orders (CTOs), most successful health rights litigations are rooted in 'negative' rights (Flood and Gross, 2014, p. 457). This is reasoned because 'positive' rights challenge government inaction, which the judicial system is reluctant to do, based on its interaction with the political system.

Compulsory Community Care (CCC) or Community Treatment Orders (CTOs) are a fairly controversial topic in mental health discourse regarding the relation between human rights and treatment for mental health disorders (Carney, 2008). CCC is a legislation that facilitates compulsory care for individuals with mental health problems outside of hospital settings (Sjöström et al., 2011). Research by Sjöström and colleagues (2011) compares the social and legal context of CCC integration among liberal (Canada) and social democratic welfare regimes (refer to Table 9 in Appendix C). It is argued that legislative frameworks between the welfare states impact how CCC was implemented (Carney, 2008; Sjöström et al., 2011). Traditionally, social democratic welfare states have placed a greater focus on ‘positive’ rights (such as treatment) than liberal welfare states that maintain strong respect for ‘negative’ rights (liberty) (Carney 2008; Sjöström et al., 2011). Therefore, while the intention of CCC was to address high re-admission rates to hospitals for patients with mental health problems, findings indicate opposing rationale for CCC implementation between welfare states. As evident that CCC was implemented as a measure for “protection” in liberal states; while, implemented as a measure for “integration” and “treatment” in social democratic states (Sjöström et al., 2011, p. 427). This difference is attributed to the “risk-liberty” rationale emphasized in liberal states (Carney, 2008). As a result, the underlying rationale for CCC in liberal welfare states was to provide social control for risk, as rooted in ‘negative’ rights (Carney 2008; Sjöström et al., 2011).

In order to advance equality of access to mental health and addiction care, more judicial weight should be placed on relational (citizenship) rights of people with mental health and addiction problems (Carney, 2008, p. 112). Marshall’s classical enunciation of citizenship theory (1963), articulates that social rights of citizenship embedded in the welfare state, join with civil and political rights to comprise “full citizenship” (as cited in Carney,

2008, p. 108). Carney (2008) asserts, the social rights of citizenship “encompass social and health services, and the balancing off of markets and civil society” (p. 108). It is through conceptualizing social citizenship rights that the ‘personal can be re-imagined as the relational’ (Carney, 2008, p. 109). Therefore, by realizing ‘relational’ rights, courts can ‘police’ the neoliberal power in mental health (Carney, 2008). As failure to include social and economic rights in health rights litigations discriminates people most in need of judicial protection (Porter, 2005). It is the judicial responsibility as embedded in the Charter to make governments accountable to securing the rights of its citizens. While health rights litigation may not be able to equalize social determinants of health, it can “draw public attention to gaps in Medicare” (Flood, 2014, p. 106). This in turn can leverage governments to advance equality in mental health and addiction care by measures such as targeted federal investments.

Conclusion

Changed politics produced policy changes and policy drift, and a weakening of the capacity of the welfare state to narrow growing gaps in income and life chances in Canadians.

– Banting and Myles, 2013, p. 32

It is critical to address the demand for mental health and addiction services in Canada. About one in five Canadians experience a mental health and addiction problem each year (Smetanin et al., 2011). In Ontario, the burden of mental illness and addictions is 1.5 times that of all cancers and seven times that of all infectious diseases (Ratnasingham et al., 2012, p. 7). Yet the proportion of health care spending that is allocated to mental health does not equate to its burden on the Canadian economy at \$51 billion annually (Lurie, 2014; Smetanin et al., 2011). In 2012, 600,000 Ontarians reported having an unmet mental health or addiction need, while more than 1,000,000 reported having partial met mental health and addiction needs (Statistics Canada, 2012). There is reason to believe that the proportion of unmet

mental health and addiction needs have increased (AGO, 2015; ConnexOntario, 2016). These needs are a result of persistent access gaps to publicly funded mental health and addiction services (i.e., hospitals, primary care, and community). As well, to the creation of a two-tiered system of mental health care, fostered by neoliberal governance, which has produced inequities to mental health. While, there is a greater prevalence of mental health and addiction problems among individuals in the lowest income quintiles (Kirby and Keon, 2006), the mental health and addictions system is designed to benefit populations with more advantageous social determinants of health.

The two-tiered system for mental health and addiction care was created from the systemic discrimination of psychological therapies from the Canada Health Act (1985). Although psychological therapies are evidenced to be cost-effective alternatives to pharmacotherapy (Chiles et al., 1999; Hunsley, 2003; Hunsley et al., 2013), the majority of these therapies can only be accessed in the private sector (Romanow and Marchildon, 2008; Ronson et al., 2011). Consequently, gaps in access have had negative effects on emergency departments, hospitals, families, and the criminal justice system (Ratnasingham et al., 2012; Rush and Saini, 2016; Kirby and Keon, 2006; CIC, 2010). Not to mention the detrimental effects associated with homelessness and suicide, with suicide affecting 4,000 Canadians annually (CAMH, 2012).

Since the deinstitutionalization of psychiatric hospitals, beginning in Canada in the 1960s, reports and policies have focused on shifting funds into the community. This redirection in mental health policy, referred to as mental health reform, sought to successfully integrate psychiatric survivors into the community by providing a continuum of mental health supports and services. However, decades later, this vision of mental health reform has not been implemented. The goal of this paper was to critically examine why mental health

reform has been so difficult to achieve. By employing the theoretical frameworks of the Power Resource Theory (Stephens 1979; Korpi 1983; 1998) and Quality of Government (Rothstein and Teorell, 2008), the paper wished to explore how politics have shaped mental health policies. Guided by Banting and Myles (2013) themes of *policy change* and *policy drift* – “action” and “inaction” of government – it is evident that the neoliberal restructuring of the welfare state in the mid 1990s has obstructed mental health reform.

Mental health policy in Ontario reflects a period of ‘punctured equilibrium’ (1985-1995) followed by ‘incremental change.’ From 1985-1995, more equitable changes in mental health policy were made. The Conservative government, which had ruled for forty-two consecutive years, was replaced by the Liberal and NDP parties. Traditionally, these political parties support more progressive social agendas. Based in the Graham report (1988), a partnership was established among psychiatric consumers/survivors, community mental health professionals, and provincial bureaucrats. This partnership involved the policy community in mental health planning, which pushed for changes in the mental health and addictions system. It also shifted mental health policy towards an empowering-community integration framework. Thereby, challenging the dominance of the medical-institutional sector in the mental health field. However, rising influence from neoliberal governance came to defy the NDP governance.

While on the “threshold of implementation,” the reform process came to a halt during the Conservative’s return to power (1995-2003) (Everett, 2000, p. 219). Its cost-cutting agenda involved cutbacks to health and social services. Under neoliberal influence, the state was transformed. Consequently, free market capitalism was allowed to flourish. The Conservatives, reluctant to devolve power to local authorities, established “successive arms-length governance processes with varying bases of authority,” which rarely represented the

policy community (Wiktorowicz, 2005, p. 386). Furthermore, reports endorsed a concept of recovery as embedded in a medical model that ignored social determinants of mental health. By the end of the Conservative rule, there was little hope for mental health reform. The call to partnership had abated and there was an overall mistrust in governments.

When the Liberals came to power in 2003, neoliberalism had come to influence all aspects of everyday life. Governments operating under a 'locked in' business agenda, were guided by expediency. While, new investments in community mental health and addiction supports and services were shown to be effective in preventing hospital readmissions and reducing symptom severity (Goering, 2004; Kirby and Keon, 2006), the demand for these services simply exceeded the supply (Brien, Grenier, Kapral, Kurdyak, & Vigod, 2015; Rush and Saini, 2016). Similarly, reports consistently advocated that no further planning but rather real investments in community-based care was necessary for reform (CMHA, 2004). Nevertheless, both federal and provincial mental health strategies were released, which are tremendous accomplishments for mental health and addiction care. While the MHCC proposed increasing provincial spending on mental health; operating at the federal level, it lacked the ability to mandate such changes. Although the Ontario government has made investments in prevention and early detection targeted at youth, in order to facilitate a 'comprehensive' mental health and addictions system further work needs to be done. Furthermore, while the strategy makes reference to partnerships with 'service-users,' how this partnership is to operate is absent.

Governments inaction in the face of growing inequities in access to mental health and addiction care has enabled the 'passive privatization' of mental health. The retrenchment of the welfare state made it more difficult to receive income assistance. As well, the inclusion of welfare-to-work policies disregarded the changing nature of employment among individuals

with mental health and addiction problems. Governments assertion of an individualistic notion of recovery eroded collective responsibility for mental distress and ignored the “social, political, economic, and cultural contexts” shaping mental health and recovery (Morrow, 2013, p. 325). As well, the re-emergence of the biomedical focus in mental health, facilitated power of the pharmaceutical industry in psychiatry. Consequently, by making the brain a commodity, the pharmaceutical industry perpetuates consumerism. While psychological therapies are shown to be safer and cost-effective solutions to pharmacotherapy, they are not the first-line of treatment. Similarly, community-based mental health and addiction therapies, evident to alleviate significant personal and public costs, are not a financial priority. Governments, lacking the political will to reallocate resources and disturb power relations with the medical industry, therefore have not responded to growing inequities in access to mental health and addictions care.

In order to advance a more equitable and just system of mental health and addictions in Ontario, ‘all partners’ (i.e., policy community, governments, and courts) must work cohesively and coherently. The policy community must be able to dictate their own ‘recovery.’ After all, only individuals with mental health and addiction problems can determine what they need to be included in the community. Governments must support their inclusion by equalizing access to mental health and addiction services. To make provincial governments more accountable in prioritizing investments in mental health, targeted federal transfers that expand the scope of mental health and addictions care are a solution. By realizing the ‘relational’ rights of citizens, courts can shift the mental health paradigm towards a ‘collective responsibility,’ once again. The judicial system can also play a role in ‘policing’ targeted federal transfers in provincial mental health. The current system of mental health and addictions cannot continue. It is immoral and unjust to allow inequities in

accessing mental health and addiction services to persist. It is through closer adherence to values embedded in the Charter that macro and micro level changes may occur – essential to transforming the mental health and addictions system.

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Appendix A:

Terminology

Terminology

Before assessing how the restructuring of the welfare state has influenced mental health reform in Ontario, it is important to discuss the significance of terminology referenced throughout the paper. These terms include: mental health and addiction problems; psychiatric consumer/survivor; reform; and recovery.

Mental health and addiction problems, refer to a “range of disorders affecting mood, thinking, and behaviour,” (CAMH, 2012). Examples include: anxiety disorders, depression, schizophrenia, and substance use disorders (CAMH, 2012). Mental health and addiction problems are also called “mental illnesses,” “mental disorders,” “mental health disabilities,” or “psychosocial disabilities,” and are represented under the broader category of “mental disabilities” (Carver, 2011, p. 399, as cited in Chandler, 2016, p. 3). This paper will use the term ‘mental health and addiction problem.’ As unlike the labels ‘illness’ or ‘disorder,’ the chosen term implies that medical treatment is not always necessary and thus removes the focus from “fixing or curing the individual” (Chandler, 2016, p. 4).

Psychiatric consumers/survivors refer to people who are in contact, or have been in contact, with psychiatric institutions or the mental health system as a patient, client, or consumer (Usar, 2014). People accessing mental health services may also identify with other labels, (“mental health services consumer,” “person with a psychiatric disability,” “service user/client,” “Mad”), or choose not to identify with any labels (Usar, 2014). People may also switch between labels, (i.e., “user” or “ex-patient”) (Corrigan, Roe, & Tsang, 2011). Additionally, certain labels (‘ex-patient’ and ‘survivor’) may be used by advocate groups to reflect injustices or express anger (Corrigan et al., 2011). For example, someone may identify as an ‘ex-patient’ because they feel that “breaking off” from mental health services was critical to their process of recovery (Corrigan et al., 2011). Similarly, someone may associate

with the term “survivor” to reflect the treatment, rather than the illness, they ‘survived’ (as people were often subjected to forceful psychiatric interventions) (Corrigan et al., 2011; LeFrançois, Menzies, & Reaume, 2013). The selected term, ‘psychiatric consumer/survivor,’ represents the diversity of labels used by people with mental health and addiction problems.

Reform, in terms of mental health policy, is generally defined as a redirection in policy from an “emphasis on institutionalization of people with mental illness to a system that depends on effective and accessible services delivered in the community” (CMHA, 2012). For over 20 years in Ontario, government reports have been planning mental health reform. The main principles of reform include: transferring care from institution-based to community-based settings, reducing the ratio of mental health spending for institutional vs. community-based services, and improving coordination among services and settings (CMHA, 2012; MOHLTC, 1993, as cited in Mulvale et al., 2007). Since 1998, however, reports have consistently advocated that “real investment into community-based care, and not further study, was necessary for mental health reform to succeed” (CMHA, 2004). While there has been some progress directed at reducing stigma and improving coordination among healthcare providers, the vision of mental health reform has yet to be attained.

The concept of recovery became prominent in mental health policies during the 1980s and 90s (Morrow, 2013). However, recovery has been “taken-up unevenly in policy” (Adams, Daniels, & Compagni, 2009; Piat and Sabetti, 2009, as cited in Morrow, 2013, p. 324), as recovery is conceptualized in “myriad ways with no agreed-upon definition or framework for supporting people” (Morrow, 2013, p. 324). Piat and Sabetti (2013) identify three conceptualizations of recovery from the literature. These include: *recovery as personal empowerment* as reflected in the ex-patient movement and community mental health tradition in Canada; *personal recovery*, emerging from the consumer-narrative literature; and,

recovery as an issue of social equality (Piat and Sabetti, 2013, p. 20). The paper will draw on these three conceptualizations to describe how forms of governance in Ontario have ‘taken-up’ the concept of recovery to guide mental health reform.

Appendix B:
Summary of Policy Reports from 1988-2012

Provincial (Ontario) Mental Health and Addiction Policy Reports

Report Title	Year	Provincial Governing Party	Emphasis	Impact
<i>Building Community Support for People: A Plan for Mental Health in Ontario</i> (Graham Report)	1988	Liberal Party	<ul style="list-style-type: none"> Proposed guidelines for the development and implementation of a comprehensive community mental health system. Outcome of an extensive community consultation process. 	<ul style="list-style-type: none"> Marked a paradigm shift from an institutional-medical approach to a community-based approach to mental health. Created a partnership among psychiatric consumers/survivors, family members, service providers, and the government. First time psychiatric consumers/survivors and their families were given a voice in mental health policy.
<i>Putting People First: The Reform of Mental Health Services in Ontario</i>	1993	New Democratic Party	<ul style="list-style-type: none"> Proposed a 10-yr plan for mental health reform in Ontario – shifting the proportion of funds from 80% for institutions and 20% for community programs in 1993, to 40% and 60% respectively, by 2003. Called for new linkages among the four solitudes of mental health – provincial psychiatric hospitals, general hospitals, community mental health programs, and services provided by family physicians and psychiatrists on a fee-for-service basis. Confirmed the government's commitment to its new partners by emphasizing supports and programs run by consumers/survivors and their family members. 	<ul style="list-style-type: none"> Criticized for being an administrative document – too far removed from the direct service interface between patients and professionals. Pitted psychiatric consumers/survivors against medical professionals and labour unions. Failed to address how funds would be reallocated to support the development of community based mental health and addiction services. The Ministry of Health did not consult the policy community prior to the report's release; many argued about the lack of employment supports.
District Health Council (DHCs)	1996	Conservative Party	<ul style="list-style-type: none"> The District Health Councils recommended that community mental 	<ul style="list-style-type: none"> Ministry of Health resistant to devolve authority, therefore DHCs

<p>Recommendations</p>			<p>health services be coordinated through strategies such as joint networks.</p> <ul style="list-style-type: none"> Proposed that models of mental health service delivery be based on best practices to ensure that a continuum of services is provided, including case management. Incorporated perspectives from both the Ministry of Health and the policy community. 	<p>lacked the fiscal authority to act on their recommendations – mental health system designs.</p>
<p><i>1998-2000 and Beyond: Strengthening Ontario's Mental Health System</i></p>	<p>1998-2000</p>	<p>Conservative Party</p>	<ul style="list-style-type: none"> Based on extensive consultation with mental health interest groups, Dan Newman noted that implementation was needed and that any further planning was unacceptable. The Newman Report noted that at the five-year mark of the strategy outlined in <i>Putting People First</i> (1993), funding had not been reallocated to implement reform. 	<ul style="list-style-type: none"> Newman, a Parliamentary Assistant to the MOHLTC, drew attention to the government's lack of investment in community mental health. The Newman Report also led to Bill 68, <i>Brian's Law</i>, which made amendments to the Mental Health Act and the Health Care Consent Act.
<p><i>Building a Community Mental Health System in Ontario: Report of the Health Services Restructuring Commission (HSRC)</i></p>	<p>1999</p>	<p>Conservative Party</p>	<ul style="list-style-type: none"> The Health Services Restructuring Commission recommended that the MOHLTC divest nine of the provincial psychiatric hospitals to general hospitals. As well, that the MOHLTC provide transitional funding to ensure access to community-based services prior to hospital closures. The report outlined the MOHLTC's strategy to increase the capacity of the mental health care system. The report was to guide investments in mental health over the next three years to support a comprehensive continuum of services. The government committed to investing 	<ul style="list-style-type: none"> Based on the HSRC recommendations, the MOHLTC divested six psychiatric hospitals and dispersed their beds among general hospitals. The MOHLTC failed to provide transitional funding to ensure access to supports and services. Government did not provide transitional funding nor adequate investment in community mental health and addiction supports and services over the following three years.
<p><i>Making It Happen: Implementation Plan for Mental Health Reform</i></p>	<p>1999</p>	<p>Conservative Party</p>		

<p><i>Making It Work:</i> Policy Framework for Employment Supports for People with Serious Mental Illness</p>	2000	Conservative Party	<p>in community mental health care prior to the divestment of psychiatric hospitals.</p> <ul style="list-style-type: none"> The report emphasized the need for employment supports, that were not adequately addressed in the 10-yr strategy outlined in <i>Making It Happen</i> (1993). Goal was to develop a coordinated response at both the federal and provincial levels for income and employment supports over the next three years. 	<ul style="list-style-type: none"> Policy report was never implemented. In 2009, the Systems Enhancement Evaluative Initiative (SEEI) found that individuals with mental health and addiction problems were at high risk for unemployment and poverty.
<p><i>Making It Happen:</i> Operational Framework for the Delivery of Mental Health Services and Supports</p>	2001	Conservative Party	<ul style="list-style-type: none"> The document followed from the <i>Making It Happen: Implementation Plan for Mental Health Reform</i> (1999) and provided a framework for mental health system reform. The report endorsed a continuum of services and re-affirmed the government's commitment to invest in community mental health care to reduce the consequences resulting from psychiatric hospital closures. 	<ul style="list-style-type: none"> Investments did not occur.
<p><i>The Time is Now:</i> Final Report of the Provincial Forum of Mental Health Task Force Chairs</p>	2002/2003	Conservative/Liberal Party	<ul style="list-style-type: none"> The Mental Health Implementation Task Forces (MHITFS) were convened in 1999, following the HSRC's proposal that these task forces provide recommendations to the MOHLTC concerning the implementation of a reformed mental health system. In 2002, the MHITFS submitted their reports for a reformed mental health system in Ontario to the MOHLTC. The reports were released in 2003 under the Liberal party's governance. 	<ul style="list-style-type: none"> MHITFS lacked the authority to act on their recommendations. The MOHLTC stated that the recommendations would be implemented after approval from the Conservative government. However, by the time the reports were released (during the Liberal governance in Ontario), Local Health Integration Networks had come to replace the task forces. Essentially the reports were set outside.

<p><i>Every Door is the Right Door</i>: by the Ministry's Advisory Group on Mental Health and Addictions</p>	2009	Liberal Party	<ul style="list-style-type: none"> The MHITFS consulted with various mental health stakeholders over a three-year period. The final report embodied 11 key themes for mental health reform, including: adapting a recovery framework, securing employment supports and housing, and early intervention and treatment. 	<ul style="list-style-type: none"> While public consultations from the Advisory Group were to aid in the development of a new mental health and addictions strategy, Ontario's mental health and addictions strategy released in 2011 failed to address how the Ministry's 'partners' (the policy community) would participate in reforming the mental health and addictions system in Ontario.
<p>Select Committee on Mental Health and Addictions <i>Interim Report</i></p>	2010	Liberal Party	<ul style="list-style-type: none"> The Advisory Group on Mental Health and Addictions was appointed by the MOHLTC to consult with the policy community to aid in the development of a new 10-yr provincial mental health and addictions strategy in Ontario. Based on its public consultations, the Advisory Group established seven directions for mental health and addiction services, including early prevention and treatment. The Select Committee on Mental Health and Addictions was appointed by the Legislative Assembly of Ontario in 2009 to provide recommendations for a comprehensive mental health and addictions strategy for Ontario. From 2009-2010, the Committee consulted with psychiatric consumers/survivors, mental health providers, and other interest groups to address provincial mental health needs. In 2010, the Committee released their <i>Interim Report</i>, which outlined major issues with the mental health care system (as identified through the Committee's public hearings), 	<ul style="list-style-type: none"> Drew attention to psychiatric consumer/survivor needs not being addressed in the mental health and addictions system.

<p>Select Committee on Mental Health and Addictions <i>Final Report</i></p>	<p>2010</p>	<p>Liberal Party</p>	<p>including lengthy wait-times in the emergency department and poor service integration.</p> <ul style="list-style-type: none"> Building on its consultation with the policy community, the Committee released their <i>Final Report (2010)</i>, which outlined 23 recommendations to transform mental health and addictions care in Ontario, such as the creation of the organization, Mental Health and Addiction Ontario to manage and coordinate the mental health and addictions system. 	<ul style="list-style-type: none"> The Committee found that about 1/10 people with a treatable mental health and addiction problem were overlooked within the mental health and addictions system in Ontario. The Committee also stated that community care referred to family members who were overworked and unsupported in caring for loved ones with mental health and addiction needs.
<p><i>Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy</i></p>	<p>2011</p>	<p>Liberal Party</p>	<ul style="list-style-type: none"> In 2011, the government released the 10-yr comprehensive mental health and addictions strategy for Ontario. The Strategy outlined a plan to provide integrated mental health and addiction supports and services to all Ontarians. The first three years (2011-2013) of the strategy, were aimed at improving access to youth. The Moving on Mental Health Plan (part of the Strategy) was launched in 2012 to assist children, youth, and families in navigating the mental health and addictions system. In 2014, the MOHLTC expanded on the first phase of the Strategy to improve service transitions (youth-adult) and quality of services for all Ontarians. 	<ul style="list-style-type: none"> Over the first three years of the Strategy, the government invested \$93 million in children and youth. In 2014, more than 50,000 additional children and youth were receiving mental health services, while more than 770 new mental health workers were hired in communities, schools, and courts. In 2014, the government committed to additional investments of \$65 million in 2014-2015, growing to about \$83 annually by 2016-2017. Although the Strategy makes reference to its partners, (psychiatric consumers/survivors and their families), it is not clear how this partnership will play out in reforming the mental health and addictions system.

Federal (Canada) Mental Health and Addiction Policy Reports

Report Title	Year	Federal Governing Party	Emphasis	Impact
Standing Senate Committee on Social Affairs, Science and Technology (Kirby Committee) Final Report: <i>Out of the Shadows at Last</i>	2006	Conservative Party	<ul style="list-style-type: none"> The Standing Senate Committee on Social Affairs, Science and Technology was established by the Federal governments in 2003 to provide a three-year study of mental health, mental illness, and addictions in Canada. In 2006, the Committee released their final report, which recommended that a Canadian Mental Health Commission be developed as well as a Mental Health Transition Fund to aid in the shift from an institution-based to a community-based mental health system over the next 10 years. The report provided 118 recommendations, concerning issues such as peer support, employment, tele-mental health and research. The report also called for the creation of a national mental health strategy, a national anti-discrimination strategy, and a Knowledge Exchange Centre. 	<ul style="list-style-type: none"> While the transitional funding did not occur, the federal government invested \$110 million in a "At Home/Chez Soi" – a housing first service development initiative aimed at reducing homelessness among people with mental health and addiction problems. In 2008, the government also established the Mental Health Commission with a 10-yr mandate and an annual budget of \$15 million to devise a national mental health strategy, a 10-year anti-stigma strategy and a knowledge exchange centre.
<i>Changing Directions, Changing Lives: The Mental Health Strategy for Canada</i> by the Mental Health Commission of Canada (MHCC)	2012	Conservative Party	<ul style="list-style-type: none"> In 2012, the Mental Health Commission released Canada's first national mental health strategy. The strategy includes 109 recommendations regarding the implementation of mental health policies. The Strategy is divided into six strategy areas: promotion and prevention; recovery and rights; access to services; disparities and diversity; First Nations, Inuit, and Métis; and, leadership and 	<ul style="list-style-type: none"> The MHCC, operating at the federal level, is unable to direct provinces in the resourcing of/ priority for mental health services as rooted in Canadian federalism and the constitutionally-based division of powers. Since the strategy has no binding force on the provinces, real investment in mental health has not been prioritized, despite increased federal fiscal health transfers.

			<p>collaboration.</p> <ul style="list-style-type: none">• The Strategy proposed increasing the proportion of health spending allocated to mental health from seven to nine per cent and increasing the proportion of social spending for mental health by two percentage points; identifying whether mental health spending should be reallocated to improve efficiency and outcomes; and encouraging contribution from private and philanthropic sectors in order to reduce funding inequities.	
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Appendix C:

Tables

Table 1: Esping-Andersen's welfare state typology

	Social democratic	Conservative	Liberal
De-commodification	Maximal	Medium	Minimal
Target group	Entire society	Working population	Low income households
Transfers	Highest possible	Status-dependent	Modest
Rights based on	Universalism	Employment status	Means tests
State-market relation	Primary focus on state	Market with state support	Primary focus on market
Welfare tradition	Beveridge	Bismarck	Beveridge
Real types	Scandinavia	Continental Europe	Anglo-Saxon countries

This table distinguishes Esping-Andersen's (1990) three-fold typology of welfare state regimes – Social democratic, Conservative, Liberal – by levels of decommodification, social transfers, and the balance of state, market, and family roles in providing economic and social resources.

(Source: Hurrelmann, Rathmann, & Richter, 2011)

Table 2: Total public social expenditure as a percentage of GDP, selected OECD countries, 1960-2007

Country	1960	1980	1990	2000	2007	2012*
<i>Anglo-Saxon countries</i>						
Australia	7.4	10.6	13.1	17.3	16.0	18.7
Canada	9.1	13.7	18.1	16.5	16.9	18.2
United Kingdom	10.2	16.7	16.8	18.6	20.5	23.9
United States	7.3	13.1	13.5	14.5	16.2	19.4
<i>Mean</i>	<i>8.5</i>	<i>13.5</i>	<i>15.4</i>	<i>16.7</i>	<i>17.4</i>	<i>20.1</i>
<i>Scandinavian countries</i>						
Denmark	10.6	25.1	25.1	25.7	26.1	30.5
Finland	8.8	24.1	24.1	24.2	24.8	29.0
Norway	7.8	22.3	22.3	21.3	20.8	22.1
Sweden	10.8	30.2	30.2	28.4	27.3	28.2
<i>Mean</i>	<i>9.5</i>	<i>25.4</i>	<i>25.4</i>	<i>24.9</i>	<i>24.8</i>	<i>27.5</i>
<i>Continental Europe</i>						
Austria	15.9	23.8	23.8	26.7	26.4	28.3
Belgium	13.8	24.9	24.9	25.4	26.3	30.0
France	13.4	24.9	24.9	27.7	28.4	32.1
Germany	18.1	21.7	21.7	26.6	25.2	26.3
Netherlands	11.7	25.6	25.6	19.8	20.1	24.3
<i>Mean</i>	<i>14.6</i>	<i>24.2</i>	<i>24.2</i>	<i>25.2</i>	<i>25.3</i>	<i>28.2</i>
<i>Southern Europe</i>						
Italy	13.1	20.0	20.0	23.3	24.9	28.1
Spain	3.2	19.9	19.9	20.4	21.6	26.3

* Projected

Sources: Data for 1960 from OECD, "New Orientations for Social Policy" *Social Policy Studies* 12 (Paris: OECD, 1994). Data for 1980-2012, downloaded from OECD, Social Expenditure Database (SOEX), March 2013.

The table tracks the growth in total social expenditures on income transfers and health care (excluding education) among democratic countries between 1960-2012. The table shows that liberal welfare states (Anglo-Saxon countries) are characterized by relatively low levels of welfare spending.

(Source: Banting and Myles, 2013)

Table 3: Expenditures of LHINs and health sectors managed by LHINs for fiscal year ending March 31, 2015

	Expenditures (\$million)	% of Overall Provincial Health Expenditures
LHIN Operational Expenditures	90	0.2
Health Sectors Managed by LHINs		
Hospitals	16,942	33.8
Long-Term Care Homes	3,545	7.1
Community Care Access Centres	2,495	5.0
Community Mental Health and Addiction Agencies	936	1.9
Community Support Services Agencies	834	1.6
Community Health Centres	378	0.8
Other LHIN Expenditures (for electronic health records)	7	<0.1
Total Health Funding Managed by LHINs, including LHIN Operational Expenditures	25,227	50.4
Health Funding Not Managed by LHINs	24,786	49.6
Total Provincial Health Expenditures	50,013	100.0

This table provides information on LHINs funding to health-care organizations within six sectors for the year ending March 31, 2015; funding represented slightly over half of the provincial health-care budget for that year.

(Source: Auditor General of Ontario, 2015)

Table 4: Ongoing collaborations at the systems level.

Name	Description	Source Information
Family Health Teams (FHT)	The Ontario government provides support for over 200 Family Health Teams across the province. FHTs are primary health care organizations that include a team of family physicians, nurse practitioners, registered nurses, social workers, dietitians, and other professionals to ensure that people get the care they need in their communities. Each team is set-up according to the local health and community needs.	Ministry of Health and Long-Term Care. (2016). <i>Family Health Teams</i> . MOHLTC. Retrieved from http://www.health.gov.on.ca/en/pro/programs/fht/
Assertive Community Treatment Teams (ACTT)	Assertive Community Treatment teams provide 24-hour intensive support in the community for individuals with serious mental illness and complex needs. ACT teams are multidisciplinary, each including a social worker, nurses, vocational specialist, occupational therapist, psychiatrist, peer support worker, and an addictions specialist. They provide psychiatric treatment, monitor medications, help to access community services, and assist individuals in activities of daily living.	Canadian Mental Health Association. (2016). <i>Assertive Community Treatment (ACT) Teams</i> . Ontario: Canada. Retrieved from http://toronto.cmha.ca/programs_services/assertive-community-treatment-act-teams/#.V7Er5VeMDL8
Intensive Case Management (ICM) Teams	Intensive Case Management teams provide intensive support to individuals often for a shorter period of time. ICM teams provide a case-management approach to help individuals maintain housing and achieve an optimum quality of life through addressing mental health needs and building social and community relations. There is generally one case manager per 20 individuals with the duration of the service determined based on individual needs.	Canadian Observatory on Homelessness. (2016). <i>Intensive Case Management (ICM) Teams</i> . The homeless Hub. Retrieved from http://homelesshub.ca/solutions/supports/intensive-case-management-icm-teams

Table 5: Per capita costs for reporting mental health services, by province from 2007-2008 across Canada

PER CAPITA	NF	PEI	NS	NB	QC	ON	MB	S.K	AB	BC
Inpatient										\$82.2
Inpatient - general	\$49.03	\$72.25	\$49.24	\$91.13	\$62.87	\$36.79	\$88.49	\$49.02	\$55.54	\$56.92
Inpatient - psychiatric hospitals	\$61.04	\$36.48	\$16.84	\$13.52	\$26.50	\$40.06	\$18.21	\$10.04	\$39.11	\$12.23
Long term care					\$5.74					\$5.7
Physicians										\$37.7
General practitioners - fee for service	\$2.17	\$6.44	\$0.36	\$5.62	\$6.61	\$14.02	\$2.57	\$8.17	\$13.08	\$6.62
Specialists - fee for service	\$10.20	\$5.36	\$7.77	\$7.80	\$10.83	\$24.80	\$19.75	\$8.49	\$24.30	\$21.87
Psychiatrist - alternative payments	\$16.74	\$22.89	\$13.11	\$17.66	\$14.67	\$22.07	\$9.85	\$13.48		\$18.3
Community and social services										\$151.89
Outpatient - emergency rooms						\$3.56			\$5.36	\$3.9
Community mental health		\$49.36		\$43.36	\$72.95	\$51.19	\$36.42	\$48.33	\$28.95	\$33.5
Supportive housing										\$35.8
Employment support		\$12.88			\$0.70		\$1.99			\$1.42
Other community / social support						\$39.19				\$18.26
Addictions services		\$50.79	\$27.71	\$22.48	\$12.88	\$15.19	\$18.46	\$40.06	\$28.45	\$18.1
First Nations - mental health & addictions	\$5.40				\$1.51	\$2.52	\$18.28	\$19.19	\$7.67	\$4.88
Pharmaceuticals										\$84.8
Public	\$31.32	\$31.68	\$40.58	\$34.77	\$50.54	\$34.26	\$38.84	\$35.24	\$37.31	\$31.96
Private	\$51.76	\$63.46	\$60.88	\$69.34	\$50.74	\$41.88	\$43.28	\$31.88	\$44.51	\$49.36
Other services										\$58.2
Non profits (exc. Prov. Gov't.)	\$4.92	\$8.58	\$2.45	\$1.61	\$1.74	\$9.74	\$2.73	\$17.52	\$18.97	\$3.06
Other housing (shelters, temporary)										\$11.55
Educational mental health services									\$32.91	\$32.9
Employee assistance plans	\$5.91	\$7.15	\$6.93	\$6.96	\$7.23	\$7.14	\$7.20	\$7.28	\$7.78	\$7.14
Income support										\$127.9
Canada Pension Plan - Disability	\$44.30	\$58.66	\$61.92	\$47.77	\$0.52	\$36.72	\$31.04	\$16.73	\$25.05	\$33.53
Workers Compensation			\$0.21		\$1.99	\$0.38	\$0.41	\$2.56	\$0.42	\$2.33
Provincial income support	\$14.37	\$58.63			\$25.10	\$75.81	\$52.32	\$8.27		\$53.5
Insurance - disability payments										
Long term disability										\$9.2
Short term disability										\$7.2
Totals (\$ per capita)										\$249.3

This table provides information regarding costs for public vs. private funding for pharmaceuticals in Ontario from 2007-2008. Canada spent approximately \$85 per person on pharmaceuticals, of which approximately \$38 was publicly funded.

(Source: Institute of Health Economics - Jacobs et al., 2010).

Table 6: The TADS suicide data by initial randomized groups

Initial Randomization	At 12 Weeks			12 to 36 Weeks			Total		
	Suicidal Ideation	Suicidal Attempts	Suicidal Attempts	Suicidal Ideation	Suicidal Attempts	Suicidal Attempts	Suicidal Ideation	Suicidal Attempts	Suicidal Attempts
Non-Drug									
Placebo	5	0	6	1	6	6	6	6	6
CBT	4	1	2	0	2	4	4	3	3
Total Non-Drug	9	1	8	1	8	10	10	9	9
Fluoxetine									
Fluoxetine	9	3	3	1	3	10	10	6	6
Fluoxetine Plus CBT	3	2	1	3	1	6	6	3	3
Total Fluoxetine	12	5	4	4	4	16	16	9	9

In the TADS study, there was 439 youth aged 12-17 randomized into one of four groups: placebo (112); CBT (111); fluoxetine (109); and fluoxetine plus CBT (107). This chart shows suicidal events according to initial randomization, which was data used by the investigators to report that fluoxetine didn't increase the risk of suicide. It appears that there are nine suicide attempts in both the non-drug and Prozac groups. *Source:* B. Vitiello. "Suicidal events in the treatment for adolescents with depression." *J Clin Psychiatry* 70 (2009): 741-7.

(Source: Whitaker and Cosgrove, 2015)

Table 7: The TADS suicide data based on drug exposure

	At 12 Weeks		12 to 36 Weeks		Total	
	Suicidal Ideation	Suicidal Attempts	Suicidal Ideation	Suicidal Attempts	Suicidal Ideation	Suicidal Attempts
Non-Drug						
Placebo	3	0	0	0	3	0
CBT	4	1	0	0	4	1
Total Non-Drug	7	1	0	0	7	1
Fluoxetine						
Randomized to Placebo	2	0	1	6	3	6
Randomized to CBT				2		2
Randomized to Fluoxetine	9	3	1	3	10	6
Randomized to Fluoxetine Plus CBT	3	2	3	1	6	3
Total on Drug	14	5	6	12	19	17

Many of the youth initially randomized to placebo or CBT went on fluoxetine during the 36 weeks, and only became suicidal after exposure to the drug. This chart groups suicide events according to drug exposure, which reveals that 17 of 18 suicidal attempts – and 82 percent of all suicidal events – occurred in youth on fluoxetine. But this bottom-line finding was not represented in the abstract or discussed in the text. It had to be dug out from the data presented in a table.

Source: B. Vitiello, “Suicidal events in the treatment for adolescents with depression.” *J Clin Psychiatry* 70 (2009): 741-7.

(Source: Whitaker and Cosgrove, 2015)

Table 8: Percentage distribution of mental health care (MHC) need status, by type of MHC need, household population aged 15 or older with perceived MHC need, Canada excluding territories, 2012

Type of MHC need	MHC need status			
	Unmet	Partially met	Met	Total
	%			
Any	12.2	21.1	66.7	100.0
Information	24.5	6.3	69.2	100.0
Medication	4.2	4.9	90.9	100.0
Counselling	19.8	15.7	64.5	100.0
Other	0.0	17.3 ^E	82.7	100.0

^E use with caution

The Table displays that Canadians aged 15 and older with a mental health care need report that their needs for counselling are least likely to be met.

(Source: Statistics Canada, 2016)

Table 9: Key features of CCC discourse in Sweden, Norway, England/Wales, and NY

	Sweden	Norway	England/Wales	NY
Controversy	Some	No	Yes	Yes
Violence	Yes	No	Yes	Yes
Evidence	Agreement	No	Disagreement	Disagreement
Ideology	Integration	Treatment	Protection	Protection
Control	Broad	Broad	Risk	Risk
Rights	Positive	Positive	Negative	Negative

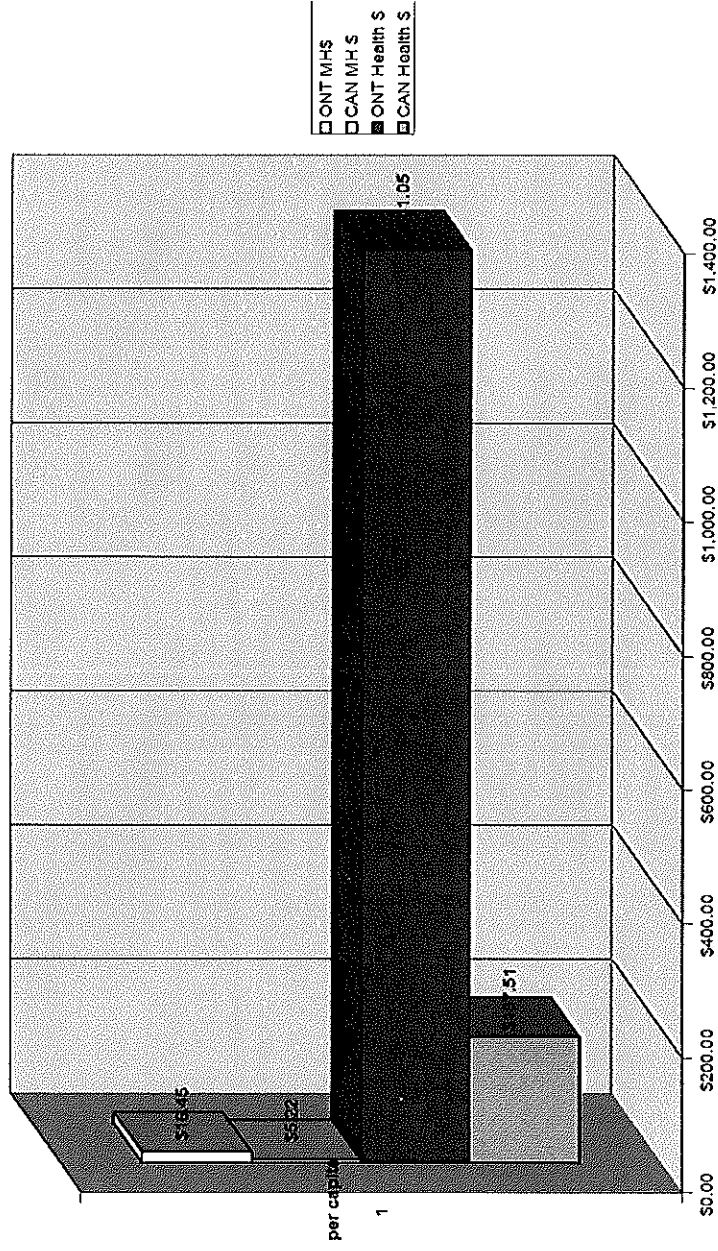
This table compares Compulsory Community Care discourse among Esping-Andersen's social democratic and liberal welfare state typologies (Social democratic – Sweden and Norway; Liberal – England/Wales and New York). It is argued that legislative frameworks between the welfare states impact how CCC was implemented. CCC was implemented as measures of 'integration' and 'treatment' in social democratic states, while implemented in liberal states as a measure of 'protection.' Correspondingly, social democratic states place more emphasis on 'positive' rights (access to treatment) while, liberal states on 'negative' rights (not to be detained against one's will – liberty).

(Source: Sjöström, Zetterberg, & Markström 2011)

Appendix D:

Figures

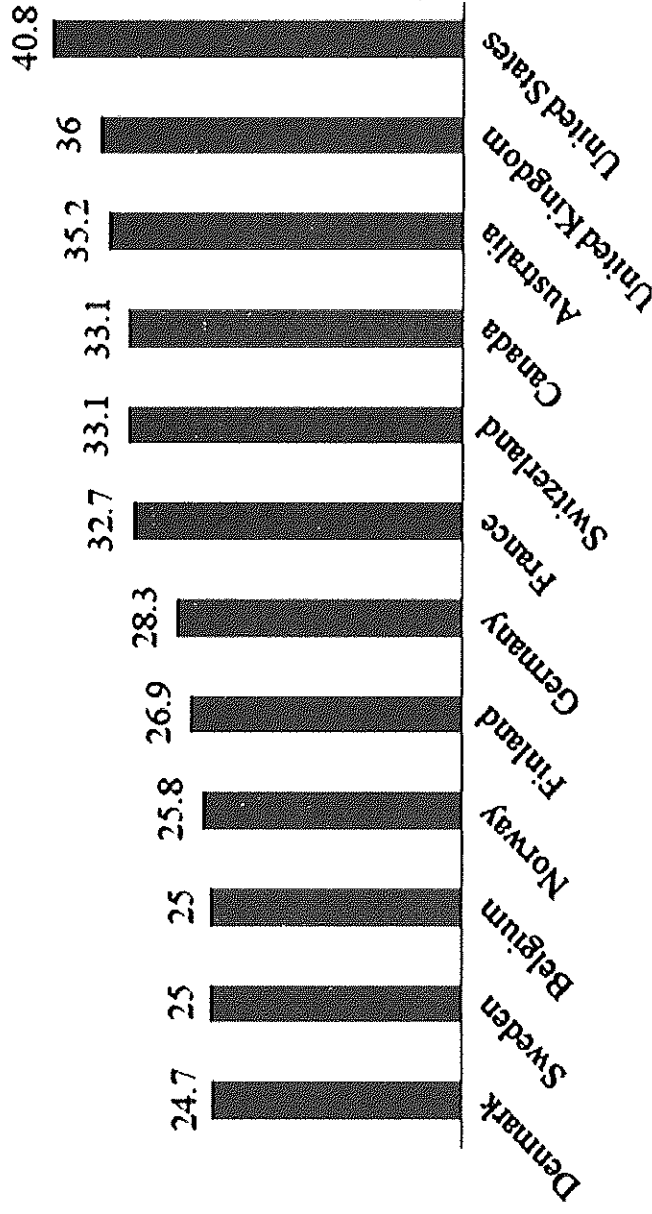
Figure 1: Per capita investments on health, mental health: Ontario compared with Canada



Between 2004-2011, the government of Ontario invested \$220 million in the expansion of community mental health services and \$18.5 billion in health care. This works out to a per capita investment of \$1361 in health care compared to \$16.45 in mental health.

(Source: Lurie, 2014)

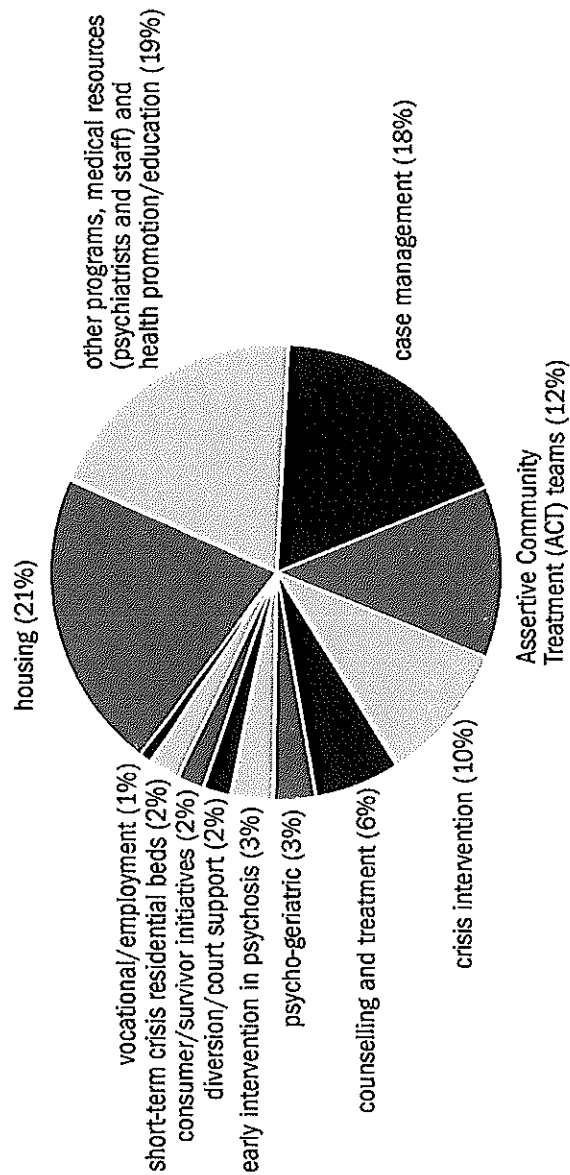
Figure 2: Income inequality in 12 advanced, industrialized nations



The figure shows that income-inequality is lowest in social democratic welfare states (Denmark, Sweden, Belgium, Norway, Finland), followed by conservative welfare states (Germany, France Switzerland), with liberal welfare states (Canada, Australia, United Kingdom, United States) having the highest levels of income inequality. This figure is used to show that welfare states influence the levels of income distribution within a country, which are argued to impact the health of citizens.

(Source: Olafsdottir and Beckfield, 2011)

Figure 3: Components of community mental health expenditures, 2006-07 %

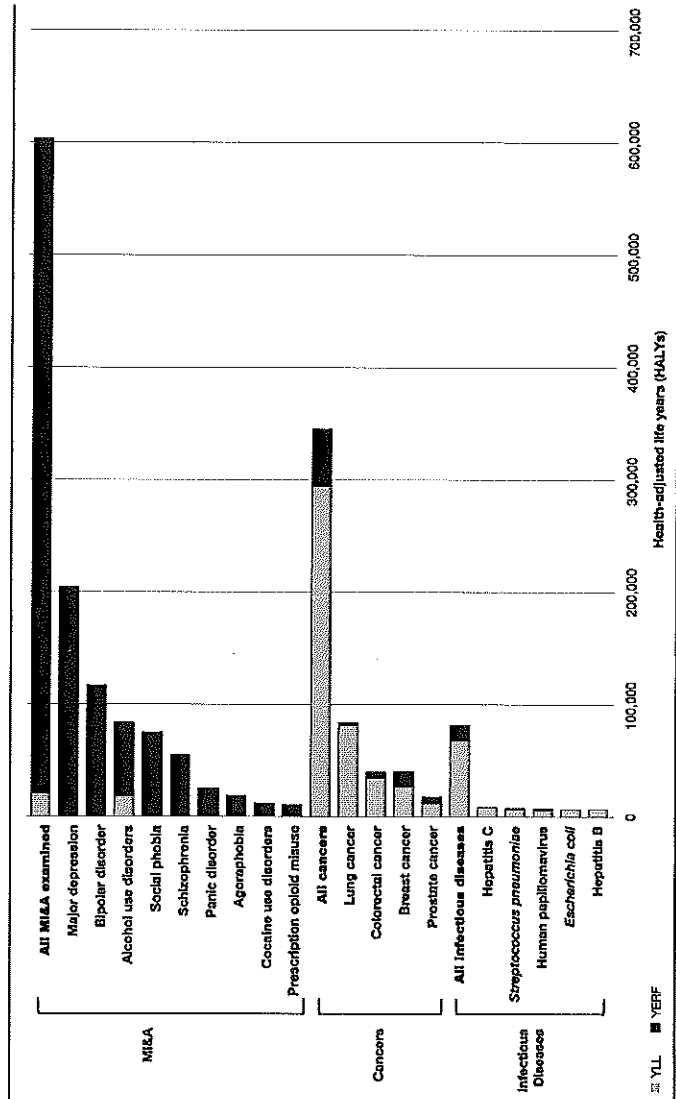


Source of data: Ministry of Health and Long-Term Care

The figure illustrates the 2006-07 community mental health expenditures in Ontario according to type of service.

(Source: Office of the Auditor General of Ontario, 2008)

Figure 4: Burden of mental illness and addictions (MI&A) compared to cancers and infectious diseases in Ontario, by years of life lost due to premature mortality (YLL) and year-equivalents of reduced functioning (YERF)



Source: Opening Eyes, Opening Minds: The Ontario Burden of Mental Illness and Addictions Report Executive Summary

The figure shows that the burden of MI&A in Ontario is more than 1.5 times that of all cancers and more than seven times that of all infectious diseases. MI&A contribute to the loss of more than 600,000 health-adjusted life years (HALYs), a combination of years lived with less than full function and years lost to early death in Ontario.

(Source: Ratnasingham et al., 2012)