

Transinstitutionalization: A Feminist Political Economy Analysis of Ontario's Public Mental Health Care System

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Abstract

Feminist political economy (FPE) deepens our understanding of the nature and dynamics of marginalization confronting various social groups in late-capitalism. Scholars adopting an FPE approach have, however, neglected to scrutinize the arrangement of public mental health care systems under neoliberalism or prevailing understandings of mental illness in services and policy. Additionally, despite the recent emergence of Mad Studies, drawing further attention to the challenges facing consumers/survivors/ex-patients/Mad people under neoliberalism, FPE scholars have not substantively addressed this marginalization.

FPE has much to offer studies of mental health care, as mental health care services are primarily services for daily maintenance, a central aspect of social reproduction, and are shaped by the prevailing arrangement of production. This dissertation draws on archival and documentary analysis and interviews in pursuit of an FPE analysis of Ontario's public mental health care system, both filling a gap in this field of inquiry and offering new insights into the state of mental health care in Ontario with the aim for forging positive social change. Drawing on FPE's conception of social reproduction, and focussing on mental health care services as a form of daily maintenance, my central contention is that downloading, privatization and individualization in the areas of mental health policy and service provisioning, together with concomitant changes to definitions of mental illness in policy and practice, have produced a new phase of mental health care in Ontario, namely *transinstitutionalization*.

Transinstitutionalization is constituted through three distinct, but interrelated processes: 1) the application of the neoliberal imperatives of downloading, privatization, and individualization to existing services; 2) the structuring of mental health care services to condition independence in the activities of daily maintenance and, whenever possible, labour force attachment; and, 3) the development in policy and practice of new definitions of mental illness and recovery that encourage economic independence, producing a model of the ideal mental patient as one who can take control of their life and achieve independence. This dissertation first charts transinstitutionalization historically, then examines its constitution and operation in the areas of treatment, income support and housing services, the pillars of Ontario's public mental health care system.

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List of Abbreviations

ACT	Assertive Community Treatment
CAP	Canada Assistance Plan
CAMH	Centre for Addiction and Mental Health
CHA	Canada Health Act
CSD	Canadian Survey of Disability (2012)
CHT	Canada Health Transfer
CHST	Canada Health and Social Transfer
CMHAO	Canadian Mental Health Association of Ontario
CPP	Canada Pension Plan
CSRU	Community Support and Research Unit
CSD	Canadian Survey of Disability, 2012
CST	Canada Social Transfer
c/s/x	consumer / survivor / ex-patient
EI	Employment Insurance
FBA	Family Benefits Act
GWA	General Welfare Assistance
HSC	Homes for Special Care
IHSP(s)	Integrated Health Service Plan(s)
LHIN(s)	Local Health Integration Network(s)
LHSIA	Local Health System Integration Act
MCSS	Ministry of Community and Social Services
MHA	Mental Health Act, 1990
MOHLTC	Ministry of Health and Long Term Care
NDP	New Democratic Party

ODSP	Ontario Disability Support Program
ONPHA	Ontario Non-Profit Housing Association
OMHM	<i>Open Minds, Healthy Minds</i> (2011)
OMHALAC	Ontario's Mental Health and Addictions Leadership Advisory Council
OW	Ontario Works
PPAO	Psychiatric Patient Advocate Office
PU	Psychiatric Unit
PPH	Provincial Psychiatric Hospital
UI	Unemployment Insurance

Introduction

Feminist political economy, as an analytic framework and tool for action, has facilitated the development of new and deeper ways of understanding the impact of contemporary arrangements of production for people experiencing diverse and intersecting forms of marginalization (see, for e.g., edited volume by Bezanson & Luxton, 2006). To date, however, there has been little scholarly inquiry by feminist political economists into the effects of neoliberalism on public mental health care systems or on the predominant construct of mental illness reflected in these services and in mental health policy. This gap may be the result of a perception that mental illness and mental health care are not impacted by the arrangement of the processes of production under capitalism and, therefore, cannot be analyzed through a political economy lens. This perception may stem from the fact that, in the West, people with mental illness labels have historically been forcibly removed from society and even today are often excluded from or marginalized in the labour force, political institutions, the academy, and activist circles. Whatever the cause of this lacuna, people with mental illness labels have not equally benefitted from the political economy lens. Feminist political economy does, however, have many analytic insights to offer scholarship on the state of mental health care under neoliberalism. It is a feminist political economy of the mental health care system in Ontario, Canada under neoliberalism that I offer in this dissertation.

My objective is to interrogate the composition of Ontario's mental health care system under neoliberalism using the tools of feminist political economy, particularly its insights into social reproduction (e.g. Vosko, 2002; Bakker & Gill, 2003 a & b; Cameron, 2006). My discussion is limited to the provincial, or public, mental health care system (i.e., the network of mental health care services that are either provided by the government or that are funded or directed by the

government) and where services are provided for free or on a sliding scale (e.g., rent-geared-to-income supportive housing services).¹ In considering the public system from a feminist political economy perspective, I argue that the neoliberal trends of downloading, privatization and individualization in the areas of mental health policy and the practice of service provisioning, as well as concomitant changes to definitions of mental illness in policy and practice, have produced a new phase of mental health care in Ontario, which I refer to as *transinstitutionalization*. Under transinstitutionalization, the services that support the daily lives of people with mental illness labels are informed by the imperative of accumulation; the transformation of these services involves three distinct but interrelated trends: 1) the application of the neoliberal principles of downloading, privatization, and individualization to existing services, resulting in the on-going placement of many of these services in the non-profit sector; 2) the structuring of mental health care services to condition independence in the activities of daily maintenance and, whenever possible, labour force attachment; and 3) the development in policy and practice of new definitions of mental illness, wellness, and recovery that promote and encourage this economic independence, producing a model of the ideal mental patient as one who is incurably sick, but

¹ The mental health care system in Ontario (and arguably throughout the rest of the country) could broadly be called two-tiered, although such a term may confuse the matter as many of the publically supported or directed services offered for free are provided by non-profit organizations (NPOs), charitable organizations and occasionally for-profit businesses that receive varying rates of government funding. This dissertation is limited to the public tier and does not address the significant number of mental health care services in the province (e.g. private mental health and addiction facilities, private long-term care facilities, and talk-therapy provided by private practitioners) that are only available to those with medical insurance or the funds to cover such treatment or housing arrangements. While there is doubtlessly much work to be done on mental health care services only available to those with substantial employment benefits and/or incomes, I am concerned with the system of mental health care directed at those without these resources and/or whose personal experiences bring them into direct contact with state directed mental health care services (e.g. the correctional arm of the mental health care system). I make the decision to focus on the public system for two reasons. Firstly, as a political scientist I am interested in how governments, through policy and funding arrangements, are addressing issues of mental health care in light of the global neoliberal trends. Secondly, as a social justice advocate, Mad woman and feminist I recognize the importance of analyzing the current government provided, funded and/or guided mechanisms directed at people with a long history of oppression by the state. Keeping all of this in mind, in this dissertation when I refer to the mental health care system, unless otherwise indicated, I am referring only to the public mental health care system as defined above, although certainly there is a need for analysis of the existence of a two-tiered mental health care system.

able to take control of their lives and achieve independence. I refer to this figure of the ideal neoliberal mental patient as the consumer-patient subject. These changing understandings of mental illness and recovery legitimize a mental health care system that operates in the interest of, without necessarily achieving, substantial cost reduction.

The goal of cost reduction is not a new objective in the context of Ontario's mental health care system. The desire to reduce the cost of provincially-funded psychiatric institutions was a significant factor in the decision to initiate the messy process of deinstitutionalization, whereupon responsibility for many of the services once provided in the institutions were downloaded to lower levels of government and to non- and for-profit organizations in the private sector.

Transinstitutionalization is a distinct phase in Ontario's mental health care system, as the techniques for achieving cost savings involve, alongside established patterns of privatization and downloading, establishing service users as partners in achieving cost savings. Under transinstitutionalization, the largely privatized social services for people with mental illness labels are structured to encourage behaviour compatible with cost savings, namely a wedding of independence in the activities of daily living, reduced social service use, and labour force attachment with recovery and wellness. In essence, transinstitutionalization is a phase of mental health care where the social services that make up the mental health care system, the prevailing definitions of mental illness, wellness and recovery, and the daily lives and identities of service users are shaped to be more compatible with limited public expenditures in the area of social reproduction, which is a key element in the global drive towards unfettered accumulation. Far from being a "hands off" phase of mental health care, transinstitutionalization is characterized by the employment of substantial government resources and state regulation concerning where and how services are provided and, by extension, of the daily activities of those using services.

The feminist political economy lens, because it focusses on the interrelated processes of production for surplus (i.e., employment) and social reproduction in the accumulation of capital, reveals how mental health care policy and practices of service provisioning operate with the goal of shaping the whole lives of service users to be more compatible with the prevailing arrangement of production, which includes the work involved in the reproduction of the population. In short, feminist political economy reveals transinstitutionalization.

The Role of Feminist Political Economy

I start from the position that mental health care systems are comprised of supports for daily maintenance, that is, the reproduction of people in the day-to-day. Indeed, mental health care services are often arranged in such a way as to limit the social reproduction needs of service users to their own daily reproduction (e.g., high-support housing is based on a single individual, not a family, and there are various restrictions on biological reproduction). Because people with mental illness are often excluded from or marginalized within production in the labour force (thereby frustrating their access to means of subsistence), their access to everyday needs are regularly negotiated and provided primarily by the state, the community, and the family, and not, unlike many other members of contemporary capitalist society, primarily through labour force attachment. The mental health care system is comprised of services that provide some of the basic necessities of daily maintenance, as well as those treatment services deemed necessary to daily life, to people labelled mentally ill, especially those who are unemployed and underemployed.

Daily maintenance is one aspect of social reproduction (Bakker & Gill, 2003 b; Fudge & Vosko, 2003; Cameron, 2006; Vosko, 2006), and, under neoliberalism, social reproduction is often shaped by the principles of marketization and individualism (see Brodie, 2010). Specifically,

feminist political economy understands social reproduction as part of production and as integral to capitalist accumulation (Vosko, 2002; Cameron, 2006; Luxton, 2006). Analytic frameworks that consider the provisioning of everyday needs to be outside of the processes of production, rather than part of them, do not consider the impact of neoliberal restructuring on the tasks and resources that go into reproducing people. The holistic approach to the economy offered by feminist political economy allows me to study those aspects of production – such as provisioning daily needs, stabilizing social norms and reproducing the population perceived as or unable to reproduce themselves – that are often completed outside of the labour force, but are nonetheless necessary to capitalist accumulation and, as such, are targeted by neoliberal restructuring. While existing literature on social services considers the role of the welfare state in stabilizing and deepening the neoliberal status quo (e.g., Loeppky, 2004; Chouinard & Crooks, 2005; Herd et al., 2005; Chouinard, 2006; McBride & McNutt, 2007; Coulter, 2009), a focussed analysis of social reproduction as an integral element of that status quo is missing from the discussion of neoliberalized social policy and daily life as it applies to mental health care.

In the Ontario experience, the treatment, income support, and housing services that make up the mental health care system, and which provide some of the necessities of daily life to people with mental illness labels, are increasingly informed by political-economic principles of downloading, privatization, and individualization. At the same time, new definitions of mental illness that equate recovery (not cure) and wellness with economic independence are being rolled out in provincial mental health strategies and associated documents. These changes to the mental health care system are promoted as progressive, as reducing state paternalism towards the “mentally ill”, and as promoting resilience, autonomy, and inclusion. Yet, the application of market principles to mental health care services and changing definitions of mental illness, wellness and recovery

work in tandem to legitimize an increasingly privatized, diffuse, and difficult-to-access network of social services. There are also increased demands that people with mental illness labels both participate in employment and protect public funds by reducing service use and/or participating in the work involved in provisioning services. In this context, the ideal mental patient (the consumer-patient subject) mitigates the supposed economic “burden” they place on society by managing their symptoms in a way that permits them to ideally engage in all the processes of production and use fewer services.

In my consideration of the interrelationship between dominant understandings of mental illness and prevailing relations of production, I draw directly on Morrow’s (2004) work. Although she does not advance a feminist political economy analysis of mental health care, Morrow brings to the discussion of public and social policy the critique of static biomedical understandings of mental illness advanced most famously by Foucault (1967), but also by anti-psychiatry scholars (e.g., Szasz, 1961; Scull, 1989), those critical of psychiatry (e.g., Busfield, 1986; Fernando, 1991; Mitchell-Brody, 2007), and, more recently, those in the emerging field of Mad Studies (see LeFrancois et al., 2013). The feminist political economy analysis of the reorganization of the mental health care system offered here is not a Foucauldian analysis, but it does draw on insights into the oppressive nature of the social construct of mental illness and the practice of psychiatry from anti-psychiatry, critical psychiatry and Mad Studies scholars.

Indeed, focussing solely on policy and program restructuring does not capture the current trajectory of mental health care in the province of Ontario. There is also a need to consider dominant views of mental illness and the so-called mentally ill, as well as the shape of the daily lives of people accessing the mental health care system. Widespread assumptions that people labelled as “mentally ill” cannot work for a wage and care for themselves are in direct conflict

with neoliberal policy directives. Specifically, the mythical figure of the unproductive mental patient that underpinned practices of institutionalization and, subsequently, the warehousing of ex-patients characteristic of deinstitutionalization, is incompatible with neoliberal trends towards increased demands for individual independence in everyday life. At the turn of the 21st century in Ontario, the contradiction between long-held notions of the “unproductive mentally ill” and the desire to curtail social programs ushered in a new phase of public mental health care delivery that altered both the way mental illness is defined and how the daily needs of people with mental illness labels are addressed.

This observation about the trends in the provincial mental health care system is not a functionalist political economy analysis. I am not arguing that these trends are necessary or that they will inevitably appear in other jurisdictions. Rather, I am arguing that, when analyzing the specific arrangement of mental health care services in Ontario and properly situating mental health care as part of the infrastructure of social reproduction, particularly as part of the structure of daily maintenance in the province, we can observe the place-specific techniques in mental health policy and practice under neoliberalism. In the case of Ontario, we are seeing a system of daily maintenance that is geared in many ways towards changing service users’ relationships not only with the system of mental health care but also with capitalist production itself in the interest of reducing the substantial amount of public funds spent in this area, thereby freeing these funds for investment in the market, where further capital can be accumulated

Insights from Disability and Mad Studies

Of particular importance to my work is the perspective that both psychiatry and the shifting category of mental illness are used to manage people whose emotional, mental, and spiritual experiences do not fit into the status quo, particularly if they are neither male nor white (e.g.

Szasz, 1961; Chesler, 1972; Fernando, 1991; LeFrancois et al., 2013). This perspective is clearly articulated in the work of reclaiming the language of Mad and Madness by Mad Studies scholars (see edited volumes LeFrancois et al. [2013] and Burstow et al. [2014]). In the context of this project of language reclamation, Mad is used to refer to people who have atypical experiences, perspectives and emotions, while Madness refers to the internal mental state itself. This perspective also recognizes of the existence of difference between Mad people and non-Mad people, or a Mad ontology.

The oppression of Mad people does not arise from difference, but rather from the categorization of atypical positive and negative experiences, perspectives, and emotions as mental illness rooted in individual biochemistry and always in need of correction through psychopharmaceuticals. The biopsychiatric categorization (e.g. labelling of people as having schizophrenia, bi-polar disorder, major depressive disorder) of atypical experiences, and the resultant mental illness label, is viewed by many Mad scholars as an oppressive social construct that is written upon differences that deviate from a historically and geographically specific status quo. Furthermore, such categorization and labelling naturalizes and legitimizes Mad people's social, economic, and political marginalization.

Of most interest here are the scholars who show how the biomedical model of mental illness, wellness, and/or psychiatry itself can be operationalized as a tool that stabilizes and further entrenches capitalist production (e.g. Moncrieff, 2008; Tudor Hart; 2010; Cohen, 2013). By remaining attuned to the definitions of mental illness advanced in policy and through practice, my work shows that the biomedical model as deployed in Ontario under neoliberalism shapes the daily reproduction of the bodies of people with mental illness labels to serve the imperative of accumulation.

Mental Health Care in Ontario

I pay attention to changes in the structure of mental health care services, reflected in housing, income, and treatment policies and programs, as well as in the practice of service provisioning. I argue that the current mental health care system has been reorganized to protect and promote the accumulation of capital, with significant implications for people with mental illness labels.

Specifically, I show that the restructuring, often through retrenchment, of supports for treatment, income support, and housing has deepened the diffusion of services across public and private sectors, a process which began with psychiatric deinstitutionalization and which continues today. This process is indelibly linked to ongoing efforts to reduce the amount of public funds spent on mental health care.

The contemporary phase of the restructuring of mental health care in Ontario, more than simply an application of market principles to services, features an equation of greater independence in the completion of daily maintenance and labour force attachment with recovery and wellness. Specifically, the structure of mental health care programs and practices, as well as the prevailing definitions of mental illness and wellness, promote independence in the activities of daily maintenance, and to a less overt extent, labour force attachment supporting the neoliberal objective of reduced service use. Yet there is little recognition in social and public policies associated with mental health care of the high rates of low wages and/or precarious employment encountered in the labour force by people deemed to be disabled, or of the broader patterns of low wages and declining supports for social reproduction that characterize these later stages of neoliberalism. It is also noteworthy that the neoliberalization of mental health care equates recovery and wellness with labour force attachment rather than with cure, leaving few avenues for service users to shed psychiatric categorization.

These developments in mental health care are touted as progress in relation to treatment practices, and are often difficult to untangle from social justice gains in the area of agency of people labelled mentally ill, especially in relation to access to employment and freedom from practices of institutionalization. Yet the oppression of people living with mental illness labels has not been alleviated by neoliberal policies. While inclusion in society and the opportunity to work and live without state-sanctioned psychiatric confinement is doubtless necessary for the well-being of people with mental illness labels, inclusion in the exploitative relations of production, and the implications of that inclusion, must be questioned and carefully analyzed. Close attention must be paid to class and gender dynamics, and the continued processes of psychiatrization that shape the form of that inclusion. It is precisely the tension between inclusion and oppression that I seek to negotiate in looking at the way mental health care is being reshaped in Ontario.

The specific combination of privatization, downloading, individualization of services, and changing definitions of mental illness, which together promote participation in the processes of production (both in employment and unpaid social reproduction), marks a phase in the history of mental health care in Ontario as distinct as institutionalization and deinstitutionalization. During the institutionalization phase in Ontario (late 1800s to mid-1900s), people with mental illness labels were confined in provincially-funded psychiatric hospitals, and were provided with the basic necessities of everyday life, albeit in situations that also included routine abuse and experimentation (Simmons, 1990). In contrast, deinstitutionalization (beginning in the 1950s) was characterized by a more laissez-faire approach to mental health care, with the focus largely on cost reduction via the creation of a decentralized/privatized network of services (Marshall, 1982; Simmons, 1990). At the time of the beginning of deinstitutionalization, little consideration

was given to the capacities of people with mental illness labels to participate in employment or to care for themselves.

Today, given the coordinated efforts by the provincial government and government-supported or -directed private sector service providers to reduce service use through restructuring and demands for economic independence, a new term is needed to describe this phase of mental health care in Ontario. Transinstitutionalization has been used by scholars to refer to early attempts to move people from almshouses to state facilities (Morrissey & Goldman, 1986), efforts to move people out of institutions (Simmons, 1990), the criminalization and incarceration of people with mental illness labels that resulted from deinstitutionalization (Thakker et al., 2007), and the transfer of care for Mad people from psychiatric institutions to an often insufficient network of community-based services (Slovenko, 2003). But missing from these scholars' discussion is a sustained political economy analysis of why and how the diffusion of services took place, and a close examination of changing definitions of mental illness with the restructuring of mental health care. I am proposing a repurposing of the term transinstitutionalization to capture the combined impact of the application of neoliberal principles to mental health care services and the adoption of new definitions of mental illness and wellness in Ontario's mental health care policy.

The dynamics of the unfettered drive for accumulation under neoliberalism are readily visible in the area of mental health, both in policy language that establishes a direct link between reduced service use and economic growth, and in program design that punishes people who access "too many" services. At other times, the dynamics of neoliberalism – such as the demand for unpaid work to maintain publically funded sites of care or limitations on reproductive freedom – are hard to see, operating as they do within the "private" daily lives of people with mental illness labels and naturalized in medicalized and therapeutic discourses. Because the pressures of

neoliberalism are both visible and invisibilized in the area of mental health care, this dissertation employs case studies of high-support psychiatric housing sites together with policy analysis. In conducting these case studies, I interviewed residents and service providers in more than one but less than six sites. I do not report the specific number of case studies I conducted as, due to the relatively small number of high-support housing sites in the province, doing so might compromise the anonymity of interview participants. The case studies allow for insight into the specific impact of neoliberal demands for independence on service provisioning and on the lives of people who access mental health care services. Policy analysis, meanwhile, provides insights into the restructuring of Ontario's mental health care system and the new understandings of mental illness that work to reduce the perceived economic "burden" created by the "mentally ill" which are now being advanced by the provincial government.

In addition to tracing the changes to mental health care in Ontario, this work brings to feminist political economy a much-needed focus on questions of mental health and "illness." Despite the commitment within this field to understanding and challenging oppression, feminist political economy has yet to contend with Mad oppression and constructs of mental illness. Feminist political economy does, however, have much to offer the growing body of scholarship on psychiatry, mental health and "illness" and to the emerging field of Mad Studies. This dissertation provides readers with a window into the new institutional forms of care that have developed as a result of the crisis of deinstitutionalization, and which have been reshaped by neoliberalism. A feminist political economy examination of new sites of psychiatric care is a timely and significant contribution to understanding the complex arrangement of the mental health care system in Ontario under neoliberalism. In the balance of this introductory chapter, I explain how I position mental health care as daily maintenance, and why high-support housing

sites are an appropriate case study for analyzing the neoliberalization of mental health care in Ontario. I then provide an overview of my methods, and conclude with summaries of the chapters which follow.

Mental Health Care as Daily Maintenance

People with mental illness labels are perceived as sick and in need of psychiatric treatment. Stemming from this pathologization is their substantial exclusion from, and/or their marginalization within, the processes of capitalist production, necessitating assistance in accessing resources for everyday life, namely housing and food, through avenues other than employment. As Morrow (2004) points out, the manner in which these services have been provided reflect prevailing economic ideology and understandings of mental illness.

During institutionalization, patients in Ontario were confined to asylums and, later, provincially-funded psychiatric hospitals (PPHs). The institutions provided room and board but were also sites of abuse and experimentation under the guise of treatment. Around the mid-1960s, deinstitutionalization began in earnest in the province, with insufficient supports for ex-patients resulting in substantial hardship or crisis among the deinstitutionalized population (Marshall, 1982; Simmons, 1990). The failure of the *laissez-faire* approach to deinstitutionalization, as discussed in depth in Chapter 2, necessitated a response from municipal and provincial governments. What emerged was a loosely-coordinated, underfunded network of services that spanned the public and private sector, reflecting the unwillingness of the provincial government to take full responsibility for the daily needs of people once provided within PPHs. In short, the mental health care system in Ontario, while structured around biomedical understandings of mental illness that serve to legitimize psychiatric control over where and how people with mental illness labels live, how they identify vis-à-vis mental illness categories, and whether they

reproduce, is also the site of daily maintenance. That is, the dispensation of resources and activities involved in the reproduction of the population on a day-to-day basis is effected through Ontario's mental health care system. How the provisioning of these resources and supports is structured, in the case of Ontario, reflects prevailing arrangements of production and associated economic ideology.

In examining the state of mental health care in Ontario today, public and social policy analysis allows me to map many of the changes made to the structure of material supports for daily maintenance and the definitions of mental illness advanced by the provincial government. A close reading of the day-to-day lives of people living with labels of mental illness is also necessary if the full effects of transinstitutionalization, a neoliberalized mental health care system which, through the reorganization of the services and practices of daily maintenance, seeks to render both the mental health care system and service users themselves more compatible with the goals of cost-saving, are to be observed and understood. An examination of the day-to-day of service users is necessary precisely because daily maintenance involves, in large part, the intimate work done largely within the home that is required for reproducing people daily, work now structured in large part by, and involved in, the legitimization of government policies and the dominant understanding of mental illness.

While the policies involved in structuring daily maintenance of service users are indeed visible and readily analyzed without attention to the day-to-day, daily maintenance itself cannot be interrogated through policy analysis alone. Nor can the everyday practice of mental health care be understood without attention to policy. The enactment of neoliberal policy design, communication of dominant understandings of mental illness and shaping of individual lives and identities involves a substantial amount of work by both service users and service providers. The

contours of this work, its implications and the perceptions of those doing it, are only visible through engagement with the daily lives of service users.

Given that transinstitutionalization is only fully visible when the day-to-day of service users is considered alongside policy analysis, I chose to conduct case studies of high-support psychiatric housing in Ontario which serve people considered “seriously mentally ill”. I chose these sites for three reasons, which are elaborated upon in the methods section below. I chose these sites because they are spaces where income, housing and treatment policies intersect in the lives of residents. These homes are a kind of microcosm of the mental health care system today. I also chose these sites because, as medicalized spaces which provide services to people who largely experience high rates of economic and social marginalization, they receive little attention in the discussions of social policy in Ontario. This is somewhat surprising given the substantial limitations imposed on residents in exchange for relatively secure housing. While it cannot be concluded that the experiences of the residents in these housing sites represent *the experience* under transinstitutionalization, their experiences, when framed within the context of provincial policy trends and program development, reveal how transinstitutionalization is constituted both through policy design and in the practices of daily maintenance.

When I initially embarked on my field work, I anticipated that the gender of residents within the housing sites would be diverse and the service providers would be largely female. As such, I had expected that this dissertation would allow me to probe the gendered experiences of residents and service providers under the current mental health care system (i.e., to experiences of residents gendered male and female women relationally), as well as contribute new material to existing literature on the feminization of care work (e.g., Tronto, 1993; Arat-Koc, 2006; Armstrong et al., 2008; Duffy, 2011). What I found, instead, were sites that largely housed cisgender men with

cisgender men and women working as service providers. Considering that these housing sites do not have space for children, it is perhaps not surprising that there were few women. As a result, gender relations are not the focus of this dissertation, although I do draw attention to those instances in which gender dynamics impact the experiences of residents and service providers. I also employ a feminist political economy approach, drawing centrally on the concept of social reproduction, specifically daily maintenance as one aspect of social reproduction, in interrogating how the services for daily maintenance that make up the mental health care system are being shaped, how these services condition the daily lives of residents to align with the provincial objective of cost-saving, and how a new understanding of mental illness, compatible with the provincial government's cost-saving objective, is emerging. While these developments doubtlessly have gender implications, this is an issue for future study.

The Sites

The sites I chose to examine are high-support housing programs in Ontario and are run as non-profit organizations. As is the case with all high-support housing sites, residents in the homes I studied receive support for ongoing mental health care treatment, which mainly involves supervised administration of medications and supports for activities of daily living. Broadly, to be considered high-support, sites are staffed 24 hours a day and residents are provided with recovery-oriented services by on-site nurses, mental health support clinicians, and support workers (Suttor, 2016). I observed through my field work that some residents are served by a diverse network of service providers working within and outside the homes. All residents see psychiatrists and/or doctors regarding medication regimes but, according to interviews, rarely talk therapy. Many residents are also attached to caseworkers through other service-providing agencies.

Most residents at the sites receive income through the Ontario Disability Support Program (ODSP) or Ontario Works (OW), from the Canadian Pension Plan (CPP) and/or or part-time paid work (Interviews with Residents and Service Providers). None of the residents I spoke with work full-time. Most residents have experienced periods of long-term institutionalization (more than three months), many have lived in psychiatric institutions for years, and some have been incarcerated in correctional facilities. In the sites where I conducted interviews, the housing population is primarily male, while service providers are both male and female. This gender breakdown, as I discuss later, is not unique to the particular sites where I conducted interviews, but is common in supportive housing.

Explanations offered for this gender disparity in occupancy include “coincidence”, the view that women are more likely to stay in touch and live with their families in times of difficulty, the view that women are more likely to be perceived as useful if kept at home, and the perception that men with psychiatric labels are unable to look after themselves, or are dangerous or threatening (Interviews with Service Providers). In all likelihood, it is a combination of these factors, coupled with the fact that there are no provisions made for childrearing or spousal relationships in these homes, which creates a gendered barrier to entry. The absence of children in these sites is a regular feature of the high-support housing network and not isolated to those sites where I conducted interviews. Suttor’s (2016) discussion of high instances of congregate living within high-support housing programs and a brief examination of other site websites indicate a model of service provisioning based on the individual, not a family. While I explore this topic again in Chapter 5, more research needs to be done on this issue.

To access these supportive housing sites, an individual must have a psychiatric diagnosis. Those who access ODSP or OW pay non-market rent, which is typically calculated as the maximum

amount of the shelter allowance portion of these two income support programs. The homes are part of the privatized, downloaded, and individualized system of supportive (specifically, high-support) housing for people labelled mentally ill in Ontario. The homes are simultaneously a household, a space of social service provisioning, a site of public policy development and delivery, a site of paid and unpaid daily maintenance, and a treatment facility, making them similar to and different from both psychiatric hospitals and other kinds of households – but they remain, nonetheless, sites of daily maintenance.

These sites are neither the total institution of the past (although they share some characteristics with Goffman’s model (1961, 1973), nor the emerging re-inventive / re-inventing institution Scott (2010) identifies in her work updating Goffman. Psychiatric housing programs are key sites where the policies, resources, and energies directed towards service users intersect with dominant understandings of experiences of Madness as pathology. As microcosms of Ontario’s neoliberalized mental health care system, they are spaces where psychiatric categories and the labouring capacities of residents (in particular the labour of daily maintenance) are harnessed to reduce supports for social reproduction, thereby reducing the public cost of the mental health care system in the interest of redirecting these funds towards more “productive” areas (e.g., reducing the tax burden or investing in business to facilitate economic growth).

Methods

To draw out the form and content of transinstitutionalization, my work draws on three research methods: archival policy research, documentary research on contemporary policies, and qualitative interviews. Archival policy research at the CAMH Archives, the Archives of Ontario, the City of Toronto Archives, and the on-line resources provided by the Psychiatric Survivor Archives of Toronto allow me to map the emergence of transinstitutionalization, as well as the

development of high-support homes in Toronto. To supplement my archival research, I conducted documentary and regulatory analyses of the current policies, programs, practices, and institutions governing income support, “treatment,” housing, and other federal, provincial, municipal and non-profit “support” services. These materials are essential to answering my questions about the current organization of transinstitutionalization, the rate and manner of downloading and offloading social services to lower forms of government and the private sector, as well as the discourses and hierarchies reproduced through and in state social policies and programs.

I also conducted qualitative analysis in the form of thirty-eight semi-structured interviews to examine the street-level operations of policies and programs – specifically, I interviewed twenty-two residents and sixteen service providers². I refer to all of the workers simply as service providers, to avoid compromising anonymity given the fact that the community is small and I conducted the interviews on site, so participants may be aware of who else was interviewed. I sent out a network-wide call for participant sites and interviews through a housing network.³

I chose interviews instead of surveys, focus groups, or participant observation because one-on-one interviews allow for the preservation of anonymity, especially when interviewing people who live and work together. One-on-one interviews also ensured that a participant could leave at any time, skip questions, disclose personal experiences, or critique government policies, programs, or institutions (which they may live in, access, or work with) without scrutiny. Furthermore, one-on-one interviews allow interviewees an equal opportunity to contribute to knowledge

² Some service providers worked in the housing sites daily and others were in and out of housing sites.

³ The research presented here has been reviewed and approved by the Human Participants Review Sub-Committee, York University’s Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines (certificate number # stu 2011-143).

production, regardless of their communication style. I draw on Kirby and McKenna's (1989) discussion of interviewing "marginalized groups" and placing "marginalized voices" at the centre of knowledge production. These authors stress the importance of an egalitarian research setting that allows participants (researcher/interviewer and interviewee) to decide on the structure of the interview. They see interviews as an exchange of ideas between participants and researcher, and researchers as located within the project. Kirby and McKenna's (1989) structure is consistent with my goals of bringing the voices and histories of people with mental illness labels to the centre of my work.

To gain access to these personal narratives, I provided a flexible interview time and semi-structured questions organized around the themes of income support, housing, treatment, incarceration, community supports, paid and unpaid work, understandings of Madness, and recommendations. The interviews lasted between ten and ninety minutes. Resident participants received an honorarium, while service providers were offered transit cost compensation. It should be noted that in relaying interview data, and especially when quoting individuals, I have stripped identifying information except in some instances gender when it is a relevant point of analysis. I have also employed square brackets within quotations to remove identifying information (such as names or specific roles), offering instead an anonymized summary of the point being made, and to alter patterns of speech that might identify an individual. The data itself has not been impacted by these alterations.

Finally, as stated above, throughout this dissertation I choose not to name the sites where I conducted the interviews. I have made these decisions to preserve anonymity of interview participants. I also made this choice to refrain from contributing to NIMBY attitudes and the marking of specific spaces as psychiatric housing. Residents and people with mental illness

labels generally are a neglected group in political science research, while policymakers, service providers, and administrators are seen as reliable and capable research participants, and are more often asked to participate in research. It is the latter group whose voices are more often heard, whose perspectives are more likely incorporated and discussed. For this reason, my research focuses on the former. Residents have expertise acquired from their own experiences. Through interviews they were able to give examples about how the design and implementation of income, housing, “treatment,” and other support services impacts their lives. They were able to confirm, elaborate upon, correct, or reject the interpretation I offered of the daily maintenance of people labelled mentally ill under neoliberalism, and the associated discourses of disability/Madness that I identified through my archival and documentary research. This dialogic process allowed participants to alert me to issues or questions that I may have overlooked.

In seeking to map transinstitutionalization through the case study of the homes, I take seriously the experiences and knowledges of those closest to them, their structures and processes. This study is not simply a description of the experiences of high-support homes, however. Instead, drawing on tenets of feminist methodology developed by institutional ethnographers such as Smith (1996), Campbell (1998), and Campbell & Gregor (2002), I understand the experiences of residents as knowledge, a window into the social relations of power intersecting with the lives of people with mental illness labels. My work also draws on insights from sociologists Maynes, Pierce, and Laslett (2008), who understand that the personal narratives emerging from interviews are more than the “idiosyncratic” experiences of individuals; they are indicative of the historically- and geographically-specific organization of the relations of power and the dialectic between ruling relations and human agency. I do not, however, adopt the Goffmanesque view (Goffman 1961, 1973) that the actions and responses of interview subjects are wholly determined

by dominant institutions and power relations. For one thing, the stripping away or mortifying processes that Goffman (1961, 1973) discusses are not practiced in these spaces. If one were to apply a Goffmanesque analysis to the housing sites, such processes (if they indeed occur) would be found to have occurred long before a person becomes a resident in a high-support housing site. If anything, these sites maintain the psychiatric identity of the residents (which may be one reason why the Mad Studies critique has not reached residents or service providers), but they are not the first moment of becoming a mental patient. In addition to refraining from a Goffmanesque approach, I do not analyze interview content in a manner that reifies the actions and understandings of the research participants outside of the very real material conditions that led them to their current residence and economic position. Their voices and experiences, while indeed reflecting the sites where they live, are not dictated by these institutional forms, nor are their insights limited to life within the walls of the housing site.

The lived experiences of those with labels of mental illness provide knowledge about the operation of policies and programs that cannot be captured through archival, documentary, and regulatory analysis, or through interviews with service providers. A record of the experiences of people with mental illness labels contributes to a body of literature that rarely engages with the community of people labelled mentally ill or offers research participants a central role in the analysis.

Chapter Summaries

In this dissertation, I offer a feminist political economy analysis of Ontario's public mental health care system under neoliberalism, arguing that mental health care is a system of daily maintenance. As a system of daily maintenance, mental health care is one aspect of social reproduction situated in, and part of, the processes of capitalist production. This dissertation is

broken into two parts; part one outlines the theoretical framework of the study and the history of mental health care in Ontario, while part two provides an analysis of the treatment, income support and housing policies and programs that constitute transinstitutionalization.

Part One

The first chapter, *Towards a (Mad) Feminist Political Economy of Transinstitutionalization*, advances this framework, explaining how a feminist political economy analysis, when supplemented by insights from Mad Studies, reveals transinstitutionalization in Ontario. I define transinstitutionalization as a mental health care system, and a system of daily maintenance, which is constituted by three trends: 1) privatized services for the daily maintenance of people with mental illness labels, 2) the mobilization of these services to promote participation in daily maintenance and labour force participation among service users, and 3) the emergence of understandings of mental illness and recovery compatible with these other developments.

In elucidating this framework, I conduct a literature review in three parts, arguing that analyses of the mental health care system in Ontario would benefit from a conversation between feminist political economy and Mad Studies. Firstly, I provide a review of critical political economy literature on social policy, define neoliberalism, and situate the state under capitalism. I explain the insights about social reproduction from feminist political economists and their centrality to understanding the mental health care system as consisting of programs and policies for, and conditioning the daily maintenance of, people deemed to be mentally ill. I argue that feminist political economy has yet to pay sufficient attention to questions of mental health, mental illness and Madness. Secondly, I examine literature from Mad Studies and Disability Studies regarding questions of mental illness, health and recovery, the models of disability, and the social determinants of health approach. Thirdly, I consider existing literature on

transinstitutionalization, and show how this term can be repurposed and improved upon using a feminist political economy lens attuned to insights from Mad Studies relating to categories of mental illness and recovery. I contend that, by bringing feminist political economy into conversation with Mad Studies, as well as by drawing on insights into the diffuse nature of mental health care from earlier transinstitutionalization scholars, we can develop an improved understanding of the public mental health care system in Ontario.

Chapter 2, *A Critical History of Ontario's Transinstitutionalization*, is largely a descriptive chapter. It offers a materialist history of Ontario's mental health care system from deinstitutionalization to the present. In this chapter, I closely observe the interactions between dominant views of mental illness, federal and provincial relations and the prevailing economic ideology. This chapter is divided into five historical phases, each of which corresponds to changing economic conditions, decisions made by the provincial government, and views of mental illness. I argue that each of these phases constitutes a discrete step in the development of transinstitutionalization, and its bedfellow, the consumer-patient subject.

Part Two

Chapter 3, *Treatment*, looks at the organization of medical treatment services for those labelled mentally ill in Ontario today. I argue that medical services (largely psychiatric), although not obviously a component of daily maintenance, have become so entwined with addressing the needs of people with mental illness labels that it should be analyzed as such. I consider how treatment services in Ontario contribute to transinstitutionalization. I argue that much of the responsibility for treatment services (both administering and coordinating treatment) are downloaded and privatized within the non-profit sector. Too often funding for these services is insufficient and resulting in intensified demands on service providers. At the same time, service

providers are positioned as those who reproduce the biomedical model, dominant understandings of recovery, and the consumer-patient subject, all which work to shrink the “burden” of the reproduction of people labelled mentally ill.

I then consider the content of treatment work done in the housing sites, demonstrating the importance of medication compliance and the equation of compliance with wellness and recovery. I contend that the focus on compliance as wellness contributes to individualizing responsibility for treatment at the level of service users, and entrenches the consumer-patient subject. I end this chapter with a discussion of how the biomedical model of mental illness and demands for independence are joined under neoliberalism in the recovery approach utilized by the province in *Open Minds, Healthy Minds* (2011) (OMHM). This approach is central to the stabilization of transinstitutionalization.

Chapter 4, *Income Supports*, examines Ontario’s income support programs, considering how they condition recipients to reduce service use and more closely align themselves with the consumer-patient subject model. I offer an analysis of the application processes, which have been refashioned to reduce supports in obtaining access to this service, and the OW and ODSP directives which interact with mental health care law to restrict service use and enforce normalized behavioural patterns. I argue that, together, these trends in OW and ODSP operate to limit the cost of the service itself, thereby acting as a barrier between public funds and those who seek to access them through these income support programs.

I then turn to examine how, in addition to the workfare provisions in OW, people with mental illness labels are encouraged by the provincial government to obtain labour force attachment, which is framed as a social determinant of health. I provide an overview of resident employment

experiences, highlighting low pay and insecure jobs, and contextualizing these observations within literature on work under neoliberalism. I contend that, absent attention to the type of paid jobs generally available for people with mental illness labels, calls for people with mental illness labels to obtain employment cannot be seen as progressive or as a promotion of the social determinants of health. Rather, they are about promoting labour force attachment in the interest of reducing the cost of daily maintenance through employment, and form part of the project of bringing service users more fully into the interrelated processes of production for surplus and social reproduction.

In the fifth and final chapter, *Housing*, I consider the downloading of mental health housing to NPOs and, occasionally, for-profit operators. I argue that these developments are very different from the downloading of social and subsidized housing in the late 20th century and early 21st century in Ontario. I demonstrate that the divestment of much of the responsibility for mental health housing occurred with the beginning of deinstitutionalization, and was motivated by an effort to reduce the cost to the provincial government of housing the deinstitutionalized community. I move on to examine daily life within the housing sites, and map the work of residents within the sites. This work, I argue, contributes to the functioning of the downloaded housing system and the government's goal of achieving cost savings in the mental health care system.

I then examine the rules and policies within and outside the housing sites which place limitations on the romantic, sexual and family life of residents, as well as people labelled mentally ill more broadly. I propose that this control over the bodies of people with mental illness labels reveals the consumer-patient subject to not only be self-sufficient, but also childless. I offer a discussion of the role of these eugenic policies in containing the cost of housing and other supports by

ensuring that service users are directing their time towards work in the homes, towards achieving wellness and recovery; that is, towards becoming the ideal consumer-patient subject. I also argue that these policies reduce social anxiety about the possibility that the genetic underpinnings of mental illness will be passed on and more dependent mentally ill people created. I conclude with a discussion of convergence and divergence of the housing sites and the institution. In its conclusion, I revisit this dissertation's main points, and discuss the new avenues for research this study opens up.

Together and separately, these chapters will show that the mental health care system privatizes services for daily maintenance to the level of NPOs, organizes these services to promote independence in daily maintenance, as well as in employment, while also advancing understandings of mental illness and recovery compatible with these other two developments. I argue that, together, these three aspects of the functioning of the mental health care system operate to reduce the amount of public funds directed towards people with mental illness labels while encouraging their participation in this reduction in spending.

Chapter 1 Towards a (Mad) Feminist Political Economy of Transinstitutionalization

Mental health care, as an element of daily maintenance, is part of the arrangement of social reproduction, and, as such, must be considered as part of the processes of production under capitalism. A feminist political economy analysis of mental health care policy in Ontario reveals the existence and implications of transinstitutionalization – the mental health care system under neoliberalism that involves efforts to privatize the public services for daily maintenance once provided in the institution, the mobilization of services for daily maintenance to promote economic independence in all areas of life, and the development of new definitions of mental illness compatible with privatization and demands for independence. The hitherto invisibility of transinstitutionalization in Ontario among critical political economy scholars arises from a failure of feminist political economists and Mad Studies scholars to speak across disciplinary boundaries and methodological approaches. Both bodies of literature have, however, developed key insights that allow us to make sense of the system of mental health care in Ontario under neoliberalism and challenge the provincial government’s assertion that promoting independence in daily maintenance and, whenever possible, employment, is a liberatory and progressive model of mental health care.

In bringing feminist political economy into conversation with Mad Studies scholarship for the purpose of examining transinstitutionalization in Ontario, I am charting new territory for both fields. Moreover, as both feminist political economy and Mad Studies are sub-disciplines or sister disciplines within critical political economy and Disability Studies, I am encouraging greater attention to Mad and Disability issues in political economy and, *in particular*, feminist political economy, as well as greater attention to political economy within Disability and, especially, within Mad Studies. This move is important because it is likely that the repositioning

of people as productive in all aspects of life has impacted people with a diversity of disability labels, especially people with intellectual disabilities, who have only experienced deinstitutionalization in the late 20th century (Radford & Park, 2003).

The purpose of this chapter is threefold. First, I provide a review of critical political economy literature on social and public policy, and explain how I define neoliberalism and position the state under capitalism. I elaborate on how the particular insights about social reproduction from feminist political economists provide the most appropriate framework for analyzing mental health care in Ontario. Second, I review Mad and Disability Studies literature on categories of mental illness, health, and recovery, focusing on critiques of the dominant approaches to mental illness often present in public and social policy. As noted, Mad Studies is an evolving sub-discipline or sister discipline⁴ within Disability Studies; in the same way that some of the scholarship on public and social policy from more mainstream critical political economists are useful to the feminist political economy analysis offered here, so too are Disability Studies insights into medical and social models of disability and the social determinants of health framework, which I also review. Third, I offer a review of transinstitutionalization literature, arguing that a feminist political economy intervention, supplemented by Mad Studies literature on categories of mental illness and recovery, can expand on and improve the scope and utility of this concept. In the balance of the dissertation, the concept of transinstitutionalization reflects and guides my analysis of the historical and contemporary public and social policy arrangements governing mental health care in Ontario.

⁴ While some Mad people identify as disabled or as a person with a disability, many do not, but understand the similarities among (and overlaps between) people with disabilities and those not living within that designation. Mad studies (LeFrancois et al., 2013) emerged on the Canadian stage in the last decade out of the c/s/x movement and as a sort of sister discipline to Disability Studies.

1.1 Critical Political Economy

Some of the critical political economy literature (broadly defined) that does not explicitly employ a feminist lens provides important insights into the contours of neoliberalism and the role of the state in this late phase of capitalism, especially regarding the history of social and public policy, the position of governments vis-à-vis the market, and the general principles leading policy design today (such as privatization, downloading, and individualization). Canadian political economists also provide useful analyses of changes to the conceptualization and provisioning of health care in the transition from Keynesianism to neoliberalism, trends which contribute to understanding the landscape in which mental health care in Ontario is developing.

1.1.1 Defining Neoliberalism

According to Albo and Fast (2003), the long downturn in accumulation in advanced capitalist countries beginning in the 1960s, coupled with the liberalization of trade and financial markets, has resulted in an unprecedented integration of national economies and the flow of capital to “financial asset holders away from manufacturers, wage-earners, and governments” (p.16). Nation-states must now compete for access to finance capital through the implementation (to a greater or lesser degree) of what is often referred to as competitive austerity, which involves the redesign of public and social policy to benefit the interests of capital. Over the last three or four decades in the West, employment, trade, and welfare policies and regulations have been structured and restructured in accordance with the principles of privatization, downloading, and individualization increasing the ability of the capitalist class to annex larger and larger portions of value produced in the labour force (Albo & Fast 2003; Brodie & Trimble, 2003; Harvey, 2005). This move towards unfettered accumulation is referred to broadly as neoliberalism.

Generally, neoliberalism is understood as the economic ideology that eclipsed Keynesianism in the 1980s in many advanced capitalist countries – the system of ideas advocating the application of market principles to all aspects of life. The neoliberal turn shifted the core state planning focus from encouraging a strong domestic economy and providing a robust welfare-state as the route to economic growth and (greater) social equality, to a focus on the global free market and individualized risk and responsibility (Harvey, 2005). This ideology promotes the penetration of market rule into the economy, the state, and everyday life through political-economic strategies such as the facilitation of global free trade, the retrenchment of state supports and designs, the privatization of state assets, and the development of an ideal self-interested, self-reliant individual citizen through public and social policy (Peck & Tickell, 2002; Harvey, 2005; Luxton & Bezanson, 2006; Wacquant, 2010). Under the neoliberal regime, social policy has evolved as a primary mechanism through which the state can enact these principles in the workplace, the community, and the household. Indeed, the state expends substantial resources and directs substantial energy towards enacting neoliberalism, contrary to popular belief that neoliberalism is a laissez-faire regime. It takes many resources to “[weave] foundational commitments to market logics, individualization, economic calculations of efficiency, and multiple sites of authority into new public policies and regulatory fields and onto existing ones” (Brodie, 2010, p.1588).

The effects of neoliberal restructuring include: a decline in wages, increase in labour flexibility (Albo, 2009), further concentration of wealth in the hands of the elite (Harvey, 2007), deep regulation of individual conduct by the state (Wacquant, 2010), and, as feminist political economists have demonstrated, privatization of social reproduction with the reduction, elimination and/or reorganization of state and employer supports (e.g. Bakker, 2003; Luxton & Bezanson, 2006; Vosko, 2010).

Critical political economists (e.g. Clarke, 2008; Ferguson, 2010; Wacquant, 2010; Peck, 2013) are increasingly concerned about the ambiguity of neoliberalism as a term – in particular, its use as an explanatory concept and a “political-economic and cultural phenomenon” (Peck, 2013, p. 113). There is also debate as to whether neoliberalism is a policy platform, an ideology, or a new form of governance (see Larner, 2000). While neoliberalism is useful in describing broad global economic, political, and social changes, it is important to respect misgivings about the term neoliberalism, and to provide close examination of the specific strategies implemented by different levels of government, financial institutions, institutions of global governance, and economic elites. These effects are also context-specific, and must be studied to gain a deeper understanding of how neoliberalism is enacted in the everyday (Peck, 2013). What is greatly needed, therefore, are analyses at the smallest, most specific levels possible. Such analysis avoids reproducing the “promiscuity, omnipresence, and omnipotence” of neoliberalism (Clarke, 2008). Instead, context-specific analyses allow a richer understanding, along the lines of what Wacquant (2010) refers to as a “thick sociology,” of neoliberalism – a grounded exploration of a seemingly ineradicable force that was supposed to generate our collective material well-being, but has instead resulted in a deepening of poverty and powerlessness (Harvey, 2005).

1.1.2 The Relative Autonomy of the State

Because I am offering an analysis of mental health care policy and practice under neoliberalism, and specifically, how neoliberal logic around individual self-reliance and cost reduction is now embedded in the public mental health care system, it is essential that I explain how the state is positioned in this work. The state is not merely a blunt instrument of capital any more than it is a neutral institution. The state under capitalism is an ever-changing and contested structure, and its “degree of autonomy” from the influence of capital changes across time and place (Jenson &

Albo 1989). Panitch's (1981) definition of the state, which Jenson and Albo (1989, p. 196) also cite, is particularly useful in thinking about mental health care policy under neoliberalism.

Panitch argues that neither

certain or all capitalists rule directly at the political level... rather... the state's role primarily entails maintaining the social conditions for economic growth and the reproduction of classes in a way consistent with the dynamics of the capitalist economy. This means promoting capital accumulation, but within the framework of containing and mediating relations among the various fractions of capital and between the subordinate and dominant classes. (p. 24-25)

The social conditions referred to by Panitch change in relation to, and as part of, the changing dynamics of capitalism. These dynamics are not limited to class (Jenson & Albo, 1989), but involve such constructs as gender, race, and ability that facilitate the exploitation of women, racialized people, and especially racialized women – and, as this dissertation shows, the naturalization of the poverty and unemployment of people with disability labels.

Although the role of the state involves the reproduction and legitimization of the (changing) social conditions beneficial to capitalism this does not necessarily take place through centralized institutional practices. Brown (1992, p. 13) argues that the state is not “an entity or a unity, it does not harbor and deploy only one kind of political power,” but, rather, employs different kinds of power (e.g. police, social workers, and the military). Brown separates the capitalist dimension of the state from other dimensions (e.g. judicial-legislative), a distinction that perhaps overlooks how the legal system, for example, preserves the social conditions of capitalism. Nonetheless, Brown's insight to the effect that the state is comprised of multiple modalities of power is of critical importance. Doubtless, private sector housing programs and treatment sites that receive government funding and direction, as discussed in Chapter 2, are as much of the state as government-run services, such as psychiatric hospitals and income support programs. Each of

these programs is a part of the state which is involved in the production of social conditions favorable to specific phases of capitalism. Indeed, Brown's (1992) insights allow for positioning of those sites of mental health service provisioning that receive public funds and/or are directed by the provincial government as part of the "unbounded...powers and techniques... discourses, rules, and practices" (p. 12) that make up the state. The loci and techniques of power may differ from Ministry to Ministry or service provision site to service provision site, but a common thread of individual self-reliance via labour force attachment and independence in the activities of daily maintenance penetrates the exercise of all forms of state power at the level of policy and/or practice.

In addition to adopting a view of a relatively autonomous state, I take seriously critiques of the assumption of "less state" under globalization (Graefe, 2007) and the "hollowing out" of the state and an international convergence of policy design (e.g. Albo, 2002; Schmidt 2011). The state has generally not been under attack by neoliberalism, but has enacted neoliberalism in historically- and geographically-specific ways. While trends indicate that states are increasingly focused on deepening the legal meaning of private property, increasing the power of financial bodies (such as Canada's Ministry of Finance) in government, reducing supports for social reproduction, and promoting flexibility among the labour force, these trends are neither inevitable nor homogenous across time and place, but rather involve varying policy decisions made by all levels of government. Scholars such as Clark (2002), Graefe (2005, 2016), Herd et al. (2005), and McBride and McNutt (2007) discuss and analyze techniques of neoliberal policy design, framing the particular decisions and strategies of governments, communities, families, and individuals in contexts of economic internationalization, stressing the importance of recognizing the specific (and different) actions and then linking these decisions to wider economic trends.

Particularly useful in examining the role of the government of Ontario in the organization of daily maintenance for people labelled mentally ill is Graefe's discussion of marketization strategies and flanking strategies in his broader consideration of neoliberalism and the social economy (2005, 2016). While this study does not take up the social economy, Graefe's warnings about functionalism bear consideration. Critically engaging with Peck and Tickell's (1994) concept of roll-back and roll-out neoliberalism, Graefe (2005) cautions against a level of abstraction that does not capture geographically- and historically-specific "variation in space and time" (pg. 7), which can result in an almost functionalist political economy of public policy. He argues instead for an analysis that focuses on how specific (local) policies and strategies operate to not only reproduce neoliberal forms of accumulation, but also to provide spaces for contestation/social change. Graefe (2005, 2016) does not necessarily advocate for dismissing the roll-back/roll-out concept, but rather seeks more empirical work that explores different ways in which neoliberalism is rolled-out, stabilized and/or contested.

The review of critical political economy of the state literature reveals that, while privatization, downloading, and individualization are important aspects of neoliberalism, neoliberalism is no longer, if it ever was, a laissez-faire social process. The state is involved not only in deregulation, but also in the reregulation of daily life (Keil, 2002). For example, Brown's (1992) discussion of poor women who require access to state services for survival reveals that state surveillance and regulation mechanisms operate in their lives to reflect gendered, and no doubt racialized, understandings of how men and women should behave. The same control is present in the lives of those with mental illness labels who draw on state services. Service users must constitute themselves in relation to the biomedical model of mental illness and accept surveillance and regulation over their daily lives. Although the oppressive role that the state

plays in the lives of people with mental illness labels has been addressed, most famously by Thomas Szasz (1961, 2007), little has been done to theorize it from a feminist political economy perspective.

I now turn to a discussion of critical political economy interventions into public and social policymaking in Canada to provide some of the context for transinstitutionalization, to review existing literature on health care and mental health, and to highlight the need for a feminist political economy intervention.

1.1.3 Neoliberal Public and Social Policymaking in Canada

In the area of the social and public policy, the neoliberal turn has meant increasingly restricted access to social programs and goods in Canada (Brodie & Trimble, 2003) (and in other parts of the industrialized world [Teepie, 1995]). Whereas, in the post-war context, social programs in Canada were based on the rights of citizens and universal entitlement, the decline of the post-war compromise has seen access to these programs reframed as needs-based. Moreover, the provisioning of these, and other government services, is being contracted out to the private sector (Evans & Shields, 2002; Fudge & Cossman, 2002). Increasingly, under neoliberalism, assistance is provided only to those characterized as the most deserving. Teeple (1995) refers to this as the “revivification” of the “deserving” and “undeserving” poor of the Elizabethan Poor Laws.

Critical political economy scholars from both mainstream and feminist traditions have traced and debated the trajectory and implications of social policy under neoliberalism, providing substantial evidence that there is indeed a neoliberal shift occurring, and that it is impacting social provisioning and support (e.g. Colderley, 1999; Clarkson & Lewis, 1999; Albo, 2002; Clark 2002; Bradford, 2003; Hackworth & Moriah, 2006; Patten, 2006; Brodie, 2010; Braedley 2012).

Addressing health care, Redden (2002) and Whiteside (2009) frame changes to Canadian health care policy in the context of the rise of concerns around social spending. Redden (2002) looks at changing citizenship entitlements, while Whiteside (2009) focuses on the implications of the neoliberal response to the crisis of overaccumulation for Canadian health care. Leyes (2010) links the retrenchment of publically funded health care popular in Fordist economies with the rise of the deindustrialized and flexible labour of post-Fordist economies, which do not require as healthy and robust a labour force. Loepky (2004), examining the impact of multilateral trade agreements on health care, makes clear that health care is a contested domain which can be insulated from global trends in marketization by government policy choices. While mental health care remains largely marginal to the works discussed above, the insights into the marketization and privatization of care (Sandall et al., 2009), the impact of health care restructuring on visible minorities (Spitzer, 2004), and the role of institutions of global governance in directing Canadian health care (Loepky, 2004) all frame the broad trajectory of health care trends in Canada in late capitalism.

Alongside a political economy analysis of health care is scholarship which, without discussing transinstitutionalization or daily maintenance specifically, charts and analyzes the effects of the neoliberalization of social policy in Ontario for people labelled mentally ill and people with disabilities (e.g., Wilton, 2004a, 2004b; Chouinard & Crooks, 2005; Wilton & Schuer, 2006). This literature demonstrates how changes to social policy have forced people with mental illness labels to identify as impaired, and have resulted in challenges with employment, reduced housing choices, and reduced access to case workers, and indicates that their freedom from state intervention has been deeply jeopardized.

Scholars writing on health care, or mental health care specifically, are careful to use precise examples of policy design from advanced capitalist countries, avoiding a rote application of neoliberal principles while drawing links between health care design and global trends. Though much of the critical political economy scholarship discussed here does not address issues raised by Mad Studies, these works demonstrate that a critical study of transinstitutionalization requires attention to both the general neoliberal trends and place-specific analyses that account for the location of the provincial government in the global economic order, as well as the history of social policymaking, political parties, dominant discourses, social movements, urban development and, in the case of Canada, federalism.

Political economy traditions demonstrate that neoliberalism in Ontario can be understood, in part, by paying attention to public and social policy changes that seek to increase international competitiveness by removing labour regulations, as well as those social services that alleviate some of the worst effects of the market. These policy strategies legitimize the increased share of surplus-value being accrued by capitalists, and the corresponding decrease in the cost of the wages and benefits allocated to workers. The critical political economy framework is useful when examining the specific ways that governments enact neoliberal employment policy and the implications for workers and their families who are dependent upon wages for their reproduction. Yet without a feminist lens, this framework fails to capture the impact of neoliberal restructuring on the work involved in the reproduction of the population in light of this squeeze on the resources required to maintain the self and family (both those provided by wages and worker benefits and state-funded income support/replacement). This neglect of social reproduction results from a focus among traditional political economists solely on production for surplus rather than understanding surplus production to be constituted through both employment and the unpaid

work involved in reproducing the population (Fudge & Vosko, 2003). In short, social reproduction, the work involved in the daily and intergenerational reproduction of the population, is not considered.

1.2 A Feminist Political Economy Analysis

While critical political economy literature that does not adopt a feminist lens is helpful in understanding the trajectory of social policy under capitalism, it cannot reveal the extent to which everyday life is being regulated in the interest of capital accumulation. Feminist political economists demonstrate that the capitalist economy is formed through the interrelated processes of production for surplus and social reproduction. Social reproduction is the paid and unpaid work of fulfilling bodily, emotional, and social needs that makes use of resources acquired through individual labour, state provision, and communities to reproduce workers, future workers, and unemployed people, as well as the social order necessary to sustain capitalist society (Bezanson & Luxton, 2006). Bakker & Gill (2003 b) identify three components of social reproduction: “biological reproduction of the species, reproduction of the labour force and the reproduction of provisioning and caring needs” (p. 32). I would add to this list the reproduction of, and resistance to, stabilizing social norms, which Bezanson (2006a) identifies as “social assets...integral to coordinating the activities of the economy” (p. 26) and which contribute to the social conditions necessary to capitalism that Panitch (1981) discusses in relation to the state. This reproductive work is performed primarily by women, as well as, increasingly, by immigrants in paid and unpaid capacities, and contributes to the creation of value through the use of wages to acquire and consume necessary resources to maintain daily life by: the reproduction of the worker, who is able to continue participating in the labour force; the care of and social provisioning for those people who are not employed, such as children, the elderly, the

unemployed, the sick and, often, those labelled mentally ill or disabled; and by reproducing dominant social norms – such as dominant understandings of mental illness – that stabilize the status quo. The daily maintenance of people with mental illness labels that I consider in this dissertation comprises one element of social reproduction, being the reproduction of this particular group on a day-to-day basis, and in a manner that sustains the status quo.

Feminist political economists recognize the temporally- and geographically-contingent nature of the organization of social reproduction under capitalism (e.g. Katz, 2001; McKeen & Porter, 2003; Vosko, 2006; Brodie, 2010), and seek to “make sense” of shifts in the organization of the biological and social work necessary to “maintain[ing] existing” and future life (Laslett & Brenner, 1989, p. 383). At the center of the organization of social reproduction under capitalism is the tension between labour and capital and the various strategies employed by governments in mediating this tension (Vosko, 2000, 2006; Bezanson, 2006b). Social reproduction scholars argue that this tension is not solely related to the extraction of surplus-value that occurs in the workplace, but extends to encompass the wages, resources, energies, and state policies, programs and tax revenue involved in the reproduction of the population (Cameron, 2006).

Within the feminist political economy tradition, the state is understood to provide varying rates of services for social reproduction (e.g. childcare, eldercare, and maternity leave), which direct, alleviate, or intensify the demands on families, communities, and individuals to complete this necessary work (Bezanson, 2006a; LeBaron 2010). Whereas critical political economy scholars have demonstrated the role of state in mediating tensions between labour and capital in different periods in history (e.g. the post-war compromise, interest rate adjustments such as the Volker shock, the restructuring of government powers under neoliberal globalization, neoliberal citizenship regimes and lowered tax rates), feminist political economists demonstrate the impact

of these types of shifts on the interrelated employment relations and practices of social reproduction (e.g. Vosko, 2000; McKeen & Porter, 2003; Porter, 2003; Vosko, 2006; Brodie, 2010). Both bodies of work demonstrate a trend towards privileging the interests of capital in the context of neoliberal globalization, but feminist political economy analyses include consideration of how shifts at the levels of the global economy, the nation-state, and the community are dependent on, and impact the organization of, social reproduction and associated gendered divisions of labour.

Today, with declining conditions of work and employment and the eradication and privatization of welfare-state services (Albo & Fast, 2003), responsibility for social reproduction is undergoing a restructuring. This restructuring is taking place through the state-enacted mechanisms of neoliberalism, such as the elimination of employer-provided supports, the privatization and downloading of social services, and the individualization of risk and responsibility.

Underpinning this restructuring is the notion that the state must reduce taxation to facilitate economic growth and/or free up public funds for investment in surplus producing spaces like private business (Phillips, 2002). Implicitly and explicitly, this free market logic positions decommodified supports for social reproduction as a hindrance to surplus production because they both reduce labour force dependency (and, therefore, exploitable labour time) and, through taxation, cost capitalists money in providing for the social reproduction of both workers and unemployed people. The result is greater demands on women to perform increasingly precarious paid work (often in the care sector) and more unpaid social reproduction (LeBaron, 2010). This trend has led some scholars studying social reproduction to identify a care deficit or crisis in social reproduction (Vosko, 2006; Brodie, 2010; Kunz 2010). With the intensification of un/underpaid social reproduction that accompanies social service restructuring and the

simultaneous intensification of precariousness in the labour force, the ability of individuals, families, and communities to reproduce themselves (and capitalism) is threatened.

1.2.1 Social Reproduction in Canada

In the Canadian context, the decline of government-provided and -supported services for social reproduction, such as childcare, employee benefits, pensions, employment insurance (EI), and welfare rates, as well as the decline of the standard employment relationship, the increase (and feminization and racialization) of precarious employment, and the rise of individualization have been linked by feminist political economists to larger trends in neoliberal globalization (Fudge & Vosko, 2003; Vosko, 2010). Scholars such as Bakker and Gill (2003 a & b) and Brodie (2010) have discussed generally the intensification in the amount of privatized work (often unpaid) required to reproduce daily and intergenerational life. Households (and therefore women) are taking on more and more of the risks associated with the capitalist mode of production, risks that were previously mitigated in the Canadian context (and to varying degrees in the larger network of advanced capitalist countries) by Keynesian social policies. Social reproduction is more than the free work done in households by women, it is “the political imaginaries, public policies, and material practices necessary to sustain and reproduce individuals, families, and communities on a daily and generational basis” (Brodie, 2010, p. 1561). And this work is being altered dramatically both within and outside of the home in the face of neoliberal globalization.

While those remaining state programs, community organizations, and informal arrangements between individuals provide some respite, the time and resources of these paid and unpaid service providers is not endlessly elastic. In light of these changes, and the associated responses with regard to social reproduction, feminist political economists are charting new theoretical terrain. “New” topics include mothering and immigration (see Arat-Koc, 2006 on transnational

mothering), prisons (Katz, 2001; LeBaron & Roberts, 2010), unfree labour (LeBaron, 2015), free trade agreements, and international investment (Bakker & Gill, 2003 b; Steans & Tepe, 2010). The expanding scope of scholarship on social reproduction demonstrates its changing dynamics, and provides new insights into the gender order and the roles of the household, the workplace, the state, and institutions of global governance in entrenching the economic and social order of this late phase of capitalism.

1.2.2 Feminist Political Economy and Questions of Mental Health and Illness

Feminist political economy scholars make visible the material conditions involved in the gendered nature of oppression and exploitation under capitalism. Yet there is very little, if any, analysis of mental health care and people with mental illness labels emanates from this domain. This lacuna is surprising given the commitment of feminist political economists to confronting marginalization. It is time to advance this analysis, especially as Mad Studies is coming of age in Canada as a field of scholarship that examines past and present experiences of people labelled mentally ill, and, like feminism itself, includes debates over ontology, methodology, and epistemology (LeFrancois et al., 2013). Mad Studies, however, has yet to include substantial work on social reproduction. These exciting new trends in social reproduction scholarship, and the advent of Mad Studies as its own field of scholarship, suggest an opportunity to develop a feminist political economy analysis of Mad issues, and to promote greater discussion of social reproduction within Mad Studies.

Transinstitutionalization is one neoliberal strategy of social reproduction. The room, board, and care services that form part of the mental health care system in Ontario are sites of social provisioning, specifically of daily maintenance. The privatization, downloading, and

individualization of these state services, together with new definitions of mental illness, have dramatically altered how people with mental illness labels secure and complete this daily maintenance, how they are treated and cared for, and how they acquire the daily necessities of life. In short, the organization of social services directed at people with mental illness labels is about how their daily maintenance is structured and restructured in the context of neoliberal policy reform to reduce demands for decommodified supports. This (re) organization involves moving mental health care programs out of government budgets, persuading people with mental illness labels to reduce their service use through independent participation in daily maintenance, encouraging people with mental illness labels to perform the activities of daily maintenance within sites of care for free, and, whenever possible, encouraging labour force attachment. The goal is not, as stated, only or even primarily to promote engagement by people with mental illness labels in production for surplus; service users are also encouraged to at least participate in the activities of daily maintenance in order to protect capital from high tax rates for social services (i.e., for social reproduction), thereby facilitating its accumulation (Phillips, 2002). To the extent that this neoliberal system of daily maintenance for people with mental illness labels who access social services encompasses, and relies upon, changing definitions of mental illness and recovery, transinstitutionalization can only be fully analyzed by supplementing a feminist political economy of social reproduction with Mad Studies insights as to the nature of mental illness and mental illness categories.

1.3 Mad Studies, Disability Studies, and Critical/Anti-Psychiatry Literature

This section outlines the aspects of Mad and Disability Studies, as well as critical/anti-psychiatry literature, which I draw upon to supplement my feminist political economy analysis, outlined

above. I focus in particular on works from Mad Studies scholars concerning language, identity, Mad peoples' history, and methodology. Critical/anti-psychiatry literature, which shares many of the same goals as Mad and Disability Studies, sometimes predated, or is deliberately positioned outside of the field of Mad Studies, so it is set apart here, although it could be argued that all of the literature reviewed below is, in fact, part of the field of Disability Studies.

Mad Studies is a unique field of scholarship that exists as a sub-discipline or sister discipline of Disability Studies. Mad scholars are concerned with the history, experiences, issues, and challenges associated with being labelled as mentally ill. As a field, Mad Studies does not advance one way of understanding mental illness or of analyzing life under psychiatric oppression, but is characterized by a shared commitment to placing peoples' voices and experiences at the center of the research (see Nabbali, 2009). A great deal has been written about people with mental illness labels, often without their input, and often in ways that fail to recognize agency and reproduce oppression. Mad Studies is about, by, and for people labelled mentally ill, seeking to contextualize Mad oppression within wider systems of domination and to situate people with lived experiences of Madness more firmly within the academy as teachers, researchers, and students (Reville, 2013).

I also draw on Disability Studies, as well as critical/anti-psychiatry literature (e.g. Szasz, 1961, 2007; Scull 1989; Chesler, 1972; Burstow et al., 2014), to discuss the biomedical and social models of disability and mental illness and the social determinants of health, because these models and discourses play an important role in transinstitutionalization. Disability Studies is also concerned with the oppression of people with health and impairment labels, but addresses a wider spectrum of disabling experiences and bodily difference. Disability Studies is a field dedicated to recording, analyzing, and struggling against the oppression(s) faced by those who

identify and/or are labelled as disabled, including people living with mental illness labels. Like Mad Studies, Disability Studies is interdisciplinary, and, like feminism, is not dominated by a single methodology, but rather features a rich tapestry of interpretations, approaches, and frameworks, including some political economy analyses.

There is much disagreement within and across Mad and Disability Studies literature about the nature of impairment and the root of ableism and saneism. Both Disability and Mad scholars, as well as activists and allies, have written about, theorized, and mounted numerous challenges (many successful) to involuntary and inadequate treatment, poor quality housing, low rates of income support, inaccessible workplaces, and unfair laws (Burstow & Wietz, 1988; Capponi, 1992, 2003; Su, 1997; Forchuck et al., 2004; Wilton, 2004a, 2004b; Fabris, 2006, 2011; Whitaker, 2002; Burstow, 2014).

1.3.1 Mad or Mentally Ill?

The term “Mad,” as it is used in the contemporary context, refers to anyone with mental diversity, psychiatric diagnoses, experiences, or identities that are constructed as “mental illness” (Reville, 2013; Shimrat, 2013). This re-appropriation of the term Mad comes from the consumer/survivor/ex-patient (c/s/x) movement, which seeks to promote pride, combat saneism, and eradicate forced “treatment” and other forms of psychiatric torture, abuse, and incarceration (LeFrancois et al., 2013). The move to re-appropriate oppressive language and develop new terminology is not unique to the Mad community. The positive use of the term “Mad” is similar to the re-appropriation of the term Queer (Corrigan & Matthews, 2003) by the LGTBQ community. The deployment of new or altered terminology, such as the use of “transinstitutionalization” in this dissertation, is not unlike the use of the term “women-of-colour” in the United States and Canada to unify women who experience racial oppression

(Silliman et al., 2004) in order to develop community-based resistance to state policies (Das Gupta & Iacovetta, 2000; Das Gupta, 2007) and to critically assess Canada's nation-building practice of labelling people who are not read as white (Bannerji, 2000). While I rarely use the term "Mad people" or "Madness" when talking about the group of people more generally labelled as mentally ill, this does not mean I agree with the mainstream categories of psychiatry – quite the opposite. I seldom use these terms in this dissertation because only one of the residents I interviewed had heard the term Mad used in a positive way. I instead use the terms people labelled mentally ill, people living with mental illness labels, "mentally ill", people with psychiatric diagnoses, experiences and behaviours defined as mental illness and atypical behaviours, experiences and identities. In using terms that have to do with labelling, I intend to convey that mental illness is socially constructed and imposed upon people through the processes of psychiatric, psychological, legal and political labelling. Though I would much prefer to use the terms Mad people and Madness, I am wary of imposing the political label on people who have yet to consider and comment on it. Clearly, Mad scholars, myself included, have much work to do if Reveille's (2013) goal of Mad Studies being articulated within the community is to be realized.

Clarifying how the term Mad is being used, and how experiences of Madness and Mad oppression are understood, is central to building a feminist political economy of transinstitutionalization. Although there are countless definitions and interpretations offered for Madness and experiences of Mad oppression, I take the position, similar to many Mad and critical/anti-psychiatry scholars (see Introductions in LeFrancois et al., 2013; Bustow et al, 2014), that Madness is the individual experience or identity, whereas mental illness is the social

construct and the source of Mad oppression. These understandings represent a radical departure from normative views of mental illness labels.

1.3.2 The Biomedical Model and its Critics

The mainstream understanding of mental illness is rooted firmly in the biomedical model of health/disability (also called the medical model and the individual model) (Priestly, 1998). The biomedical model of health/disability understands illness/impairment to occur exclusively within the body (Marks, 1997). Mental illness, which is treated synonymously with Madness in this model, is seen to result from biology, and is most often understood as a chemical imbalance in the brain. It is the model typically advanced by pharmaceutical companies, scientific researchers, and, in the case of Ontario, by social policy. Despite successful challenges to the biomedical model in the 1960s through the anti-psychiatry and ex-patient movements (Goffman, 1961, 1973; Szasz, 1961; Scull, 1989), we have witnessed its resurgence in the last thirty years with the growth of the “medical industrial complex” – the funding of research in universities by pharmaceutical companies and a focus on diagnosis within medical practice (Moncrieff, 2008).

1.3.3 The Social Model of Disability (and Madness)

Analyses of the limited parameters and use of the biomedical model of mental health/disability have given rise to the production of new models by disability scholars which attempt to challenge the oppressive thrust of the individual-focused view of disability. Most prominent among these is the social model of disability (Oliver, 1983), which advances an understanding of disability, including psychiatric disability, as a social construct or an oppressive social relation, while differentiating between impairment and disability (Marks, 1997; Gleeson, 1997; Everett, 2000; Gabel & Peters, 2004; Nabbali, 2009). Instead of looking to the individual body for the source of disability, scholars employing the social model recognize that some bodies are different, and

examine the “cultural, physical, and material environment” (Nabbali 2009, p. 1) for its disabling factors.

While the social model of disability has gained legitimacy on an international scale, there is no agreement within the literature about how to approach analysis (Gabel & Peters, 2004).

Consistent with the recognition/redistribution in feminism and idealism/materialism debates, there is much disagreement about the degree to which the material and socio-cultural operate in the oppression of people labelled disabled and/or mentally ill (Gleeson, 1997; Priestly, 1998); that is, in the creation of disabling environments.

The disagreement over the appropriateness of the social model of disability for unpacking experiences typically labelled as mental illness is succinctly captured in Nabbali’s (2009) piece on models and identities. She identifies shortcomings with the social model, including the focus on “embodied states,” which can result in the treatment of Madness as medical and as impairment, and posits society as disabling. Yet, as Nabbali demonstrates, not all people identify with their diagnosis or understand Madness as impairment. For some people it is a “dangerous gift,” while, for others, Madness invokes transgressive social behaviours, and for still others diagnoses are one of many techniques for managing groups of people and profiting from them in a manner compatible with prevailing economic ideologies (Szasz, 1961; Scull, 1989; Mitchell-Brody, 2007).

In addition, scholars such as Busfield (1996) and Fernando (1991) demonstrate that the processes of assessment and diagnosis within psychiatry and psychology vary based on one’s gender identity, race, sexuality, and class, and are grounded in broader economic and political realities. People labelled as disabled and/or mentally ill are differently located within hierarchies of class,

race, gender, sexuality, age, and citizenship status (Priestly, 1998), and have varying understandings of their experiences that the social model of disability does not fully consider.

Gabel and Peters (2004) are concerned with the potential of the social model of disability to assert oppressive categories by advancing one understanding of disability at the expense of others, and by closing off new spaces and forms of knowledge production – and, I would add, by re-inscribing biological understandings of Madness. This exclusion and delegitimization could have very real implications for people living with mental illness labels, and for those with disabilities more generally. For example, in order to access ODSP (which provides welfare payments to provincial residents with “impairments”), people with psychiatric diagnoses must provide medical documentation of their diagnosis and identify as “mentally ill.” These same people may experience Madness in their day-to-day lives in a manner inconsistent with the biomedical or social models. This dual existence, while not an ideal arrangement, may generate spaces where oppressive categories are resisted and/or appropriated. If scholars and activist communities critiquing medicine and public policy are asserting the dominant understanding of disability and Madness, this type of resistance may be foreclosed.

Understandings of impairment shift constantly, and are deeply situated in the specificities of time and place (Foucault 1967; Peterson 1982). Though interpretations of the roots of these definitions of impairment differ between scholars, the view that pathology is both historically- and geographically-contingent is a central insight for Disability and Mad Studies scholars. At different points in history, Madness was variously considered a gift, a possession, a sickness, and (as is the case now) a sickness/disability. Psychiatry and psychology have been, and are, involved in the oppression of the LGBTQ community (Chesler, 1972; Carr, 2005), women, Indigenous people (Menzies & Palys, 2006), People of Colour (Fernando, 1991), survivors of

violence, and those who experience addiction. The biomedical model of psychiatry – indeed, the very concept of impairment as applied to Mad people – is a tool of and/or embedded in the processes of colonialism, imperialism, and patriarchy, and the heterosexisms and transoppressions emergent from these processes (Fernando, 1991; Carr, 2005; Kirby, 2014). Its development, I contend, is inextricable from the development of Western capitalism, and it continues to be involved in its stabilization (see Moncrieff, 2008). In contemporary Ontario, the biomedical model is being used to legitimize the elimination of supports for daily maintenance – that is, it is central to transinstitutionalization.

The social model of disability does little to challenge the dominance of biopsychiatry, running the risk of reinforcing psychiatric categories as legitimate, and, perhaps more alarmingly, casting society's acceptance and entrenchment of these categories as progressive. Yet the acceptance of psychiatric categories and their ontological status as the location of the disabling features of society, whether through stigma, social and economic exclusion, and/or a lack of social services, erases their role in oppression. This acceptance and erasure produces a (re) legitimization of psychiatry, casting any other interpretation as regressive and even harmful to projects of accessibility and inclusion (Thornton, 2010).

In recognition of the challenges the social model poses to questions of Madness, scholars such as Peter Beresford (2005) consider how and if we might create a social model of Madness and distress that does not rely purely on individualized notions of mental illness. A. J. Withers' Radical Model of Disability (2014) proposes that the categories of impairment and disability are both oppressive social constructs, thus resolving the concern that the social model of disability, with its focus on impairment, legitimizes psychiatric interventions as always the most appropriate intervention for people with mental illness labels. In many ways, as this study demonstrates, the

social model is being co-opted, along with other progressive health models, to reproduce the status quo. I oppose this form of co-optation and oppression, and analyze its presence in my discussion of transinstitutionalization.

1.3.4 The Social Determinants of Health Model

Most recently, the biomedical model has been coded and advanced in health policy through the language of the social determinants of health. The social determinants of health model, which is close, methodologically, to the social constructionist/social model of disability (Kirby, 2004; Nabbali, 2009), has its roots in critiques of positivist understandings of health (Raphael & Curry-Stevens, 2008). This approach examines and draws links between health and social issues such as poverty, homelessness, inaccessibility, and income inequality, as well as issues of race and gender discrimination, among other forms of discrimination. The general argument is that population health is a direct reflection of the socio-economic arrangement of any given society. While scholars differ on methodology, issues of causation (i.e. does the social exacerbate or cause health problems?), levels of analysis, and recommendations, there is a common understanding that how and where people live, work, and reproduce has a direct impact on health, and that populations with high levels of poverty and discrimination experience corresponding levels of poor health (Hankivsky & Chrisoffersen, 2008; Marmot & Friel, 2008; Hawe, 2009; Raphael & Curry-Stevens, 2008; Siegrist, 2011).

As Raphael (2011) discusses in his analysis of social determinant of health discourses in Canadian policy documents and reports, there is a need for critical analysis of how the model is being deployed. While a social determinants of health framework can be used to mount a critical assessment of the role of power relations in (re)producing inequalities, the particular application of this model to mental health care in Ontario today sidesteps the framework's radical potential.

Rather than looking to the material roots of Mad oppression(s) and mental illness as a social construct, the social determinants of mental health are presented as something to be achieved in the pursuit of wellness through appropriate use of government and non-profit services, family support, and the harnessing of personal capacities. The presumption embedded in an uncritical social determinants framework is that health is a physical state to be achieved and preserved rather than a social construct. Scholars interested in the political economy of public policy and Madness, therefore, must expand the scope of critique beyond overt biomedicalization. While crucial to theorizing the emergence and articulation of psychiatry under capitalism, a critical political economy of biomedicalization that does not examine the place-specific and often subtle ways (such as the appropriation of the social determinants model) in which the biomedical model is being mobilized can no longer be accepted as sufficient.

1.3.5 The Political Economy Critique of Biomedicalization

Scholars interested in the political economy of mental health categorization (e.g. Busfield, 1986, 1996; U'ren, 1997; Morrow, 2004; Moncrieff, 2008; Tudor Hart, 2010; Cohen, 2013) have demonstrated how theorizing its history and changing relationship to capital can pose a challenge to its legitimacy. This tradition, while helping to disrupt the notion of a linear progression in our understanding of Madness, links the specific development of biopsychiatry in the West to the trajectory of capitalism. Beginning with a critique of early capitalist developments, Busfield's (1986) materialist history of psychiatric practices in England identifies the category of "mental illness" and the rise of institutionalization as mechanisms of social control. She links these practices with the establishment of the social and moral order that best suited the capitalist mode of regulation. U'ren (1997) argues that there is a "correspondence" between psychiatry and capitalist ideology. Under capitalism, to work and to be productive are good. The successes and

failures of an individual are a measure of work ethic, not social conditions. Similarly, psychiatry establishes the desire to work as a sign of wellness, sees individual bodies as the site of illness, and simultaneously treats the ills produced and/or exacerbated by capitalism.

Turning to the development of the global economy, Fernando (1991) demonstrates how psychiatry and psychology were mobilized to justify and reproduce racism and racial hierarchies, mobilizing notions of evolutionary superiority and slave-labour. This encoding of racialized bodies as biologically inferior was not limited to pre-capitalist economies, but continued with the spread of Western psychiatric understandings and practices across the globe through the establishment of centres of excellence, aid and training programs, and research regimes. This “psychiatric imperialism” was (and is) grounded in the understanding that assessment and treatment practices are applicable across time and space, making them “colour- and culture-blind,” and displaced alternative methods of addressing what the West has labelled “mental illness.” The spread of Western psychiatric practices can be understood, following Busfield (1986) and U’ren’s (1997) arguments, as part of the processes involved in the realization of neoliberal globalization.

More recent scholarship has examined the biomedical model under late capitalism. Marxist scholar Cohen (2013) explores the depopularization of social constructionist theories of Madness, arguing that psychiatry and psychiatric hegemony are part of capitalism’s superstructure.

Through the mobilization of biomedical knowledge, psychiatry is engaged in the reproduction of capitalism’s ideology by “normalizing patriarchal relations,” promoting the image of the “positive worker” and regulating youth behaviour (p. 8). While Cohen (2013) mentions neoliberalism briefly in his analysis of changes to work and family life, Moncrieff (2008) directly explores the relationship between the biomedical model of Madness and neoliberalism. She

argues that the consumerist-individualist culture of neoliberalism has paved the way for the commodification and expansion of the biomedical model of mental illness by the pharmaceutical industry. She establishes a mutually constitutive relationship between the culture of neoliberalism, the interests of “big pharma,” and the associated disciplinary mechanisms of psychiatric intervention. Tudor Hart (2010) documents the pathologization of problems such as depression and substance abuse that are caused or exacerbated by unemployment, increasing demands for flexibilization and growing inequality.

Within the population of people defined as mentally ill, Tudor Hart (2010) distinguishes between those who require social reform and the small minority with “psychotic illnesses” who “perceive and react to the world so differently from the rest of us that we can hardly communicate with them” (p. 315-316). It is unfortunate that Tudor Hart’s analysis relies on the saneist notion of the “uncommunicative psychotic” and the “rest of us.” This analysis creates two separate populations in order to advance an argument about the maddening nature of work under capitalism and the associated expansion of psychiatry. This method of categorization uncritically reproduces the biomedical model of mental illness, and legitimizes the reach of psychiatry into the lives of those people with “organic brain disorders.” Tudor Hart fails to engage with the material roots of the dichotomy between normalized and pathologized experiences of Madness that are historically- and geographically-contingent (see Fernando, 1991 on race and psychiatry). Still, his location of distress and “mental illness” within the intensification of capitalist accumulation fleshes out some of the concerns raised by Cohen (2013) and Moncrieff (2008) about the origins of psychiatric mobilization and expansion in this late phase of capitalism.

Insights into the relationship between biomedicalization and neoliberalism are not limited to Madness, but appear across disciplines in work by health care scholars who interrogate the ways

in which social and political determinants of health are erased through neoliberal policymaking and/or the mobilization of the biomedical model (Raphael & Curry-Stevens, 2008; Navarro, 2009). Whether the focus of scholars is on a “correspondence” between behaviours and health, psychiatry and capitalism, the role of psychiatric hegemony in capitalism’s superstructure, the culture of neoliberalism and “big pharma,” or the medicalization of unhappiness or alienation, the fundamental argument remains that the biomedical model of Madness (and health generally) is being mobilized to serve the needs of capital.

It is not enough, however, to simply describe how the biomedical model of mental health serves the interests of capital. It is also necessary to theorize why. Like Szasz (1961) and Scull (1989), I agree that psychiatry was and is mobilized as a form of social control and like Busfield (1986), I contend that the trajectory of mental health care treatment can be located in the development of the social order necessary to early capitalism, founded as it was, I argue, on a liberal ontology that wove rationality and participation in the processes of production together with being human, a logic which persists. Warner (2004), speaking specifically about alienation and schizophrenia, contends that people with this particular diagnosis become marginalized within the labour force due to a “limited ability to withstand stress, limited productive capacity and limited drive” (p. 205). While I would trouble the use of psychiatric labels put forward by Warner, his point about the labour force remains convincing; there is no question that those who, by virtue of expressed or perceived mental diversity, disability, and/or identity, are unwilling, unable, or seen as unable to keep up with the pace of production are marginalized within the labour force. This marginalization is explained away as a symptom of illness, hiding the raw nerve of capitalism and its exploitative relations, thus reinforcing its stability and legitimacy.

As such, the focus on the biochemistry of the individual, or even on mental diversity as impairment or ill health, precludes meaningful consideration of the social relations related to the construct of mental illness and the poverty faced by people with these labels. Furthermore, both the biomedical and social models, because they preserve the notion of Madness as sickness, are routinely involved in the legitimization of medical experimentation, incarceration, drugging, sterilization, exploitation, and warehousing of people seen as mentally ill.

In Ontario today, the government is co-opting the tendency of the social model of disability and the social determinants of health framework to legitimize the notion of mental illness as biological impairment. The provincial government, in doing so, calls for institutional reforms (such as more accessible workspaces and equity hiring practices) that remove barriers to economic and social participation. By stating that people with mental illness labels are able, and obligated, to manage their individual challenges and work just like everyone else, the provincial government appears to be advocating for progressive policies, when it is in fact justifying the elimination of supports for daily maintenance.

For example, people with mental illness labels, long understood to be the so-called deserving poor by virtue of their impairment, present a real challenge to the government of Ontario's commitment to enacting neoliberal welfare strategies. The government's most recent mental health care strategy, OMHM, uses the language of the social determinants of health in a way that redefines what it means to be mentally ill in order to be more compatible with the desire to reduce services. This new understanding of mental illness, far from a progressive approach, acts as a flanking strategy to the downloading and privatization of supports for the daily maintenance of people with mental illness labels.

The current use of the biomedical model of mental illness in Ontario involves the well-established practice of pathologizing Madness and Mad struggle, but is now being used to legitimize a retrenchment and reorganization of state-provided, -funded, and -directed supports for daily maintenance. Broadly, mental illness can be treated, stigma against people with mental illness labels can be addressed, and barriers to employment and social participation can be removed to allow greater participation in the labour force and greater independence in the activities of daily maintenance. Put another way, greater numbers of people with mental illness labels can be incorporated into the processes of production for surplus without threatening the legitimacy of psychiatric categories and the dominance of biopsychiatric treatment protocols.

Given the abuses suffered by people labelled mentally ill in the name of treatment, the high rates of precarious employment among people deemed to be disabled, and the ensuing crisis of social reproduction that places increased demands on individuals, and especially women, it is essential to remain critical of the understandings of mental illness being rolled out in government policy. It is also crucial to recognize that these definitions are not progressive, but are rather part of a strategy for solidifying a form of daily maintenance favorable to capitalist accumulation. I have called this phase in mental health care transinstitutionalization.

I commence this empirical analysis from the position that both mental diversity and Madness are real, but that mental illness is a social construct that changes across time and place, constituted as it is in relation to the prevailing arrangement of production.

1.4 Transinstitutionalization

The term transinstitutionalization is rooted in the critique of deinstitutionalization, specifically the lack of planning and the significant social problems that accompanied it.

Deinstitutionalization began in Ontario with the depopularization, if not the end, of long-term hospitalization for psychiatric patients, and the downloading and dispersal of services and responsibilities once concentrated within the institution – namely housing, income support, and treatment – to governmental and non-governmental service providers outside of the institution (Simmons, 1990).

Transinstitutionalization is often used to focus specifically on the criminalization and incarceration of people with mental illness labels caused by (unplanned and underfunded) deinstitutionalization (Slovenko, 2003; Jones, 2013). It is also more widely applied to the transfer of care for patients from psychiatric institutions to a dispersed network of governmental and extra-governmental institutions, policies, programs and practices associated with psychiatric hospitals, general hospitals, the prison system, shelters, and social housing (Simmons, 1990; Slovenko, 2003; Thakker et al., 2007) and suggesting in some ways a return to pre-asylum conditions (Morrissey & Goldman, 1986; Slovenko, 2003). However, there is missing a sustained consideration of the impact of the historically- and geographically-specific economic conditions that led to the reduction of long-term stays in psychiatric hospitals and the relocation of patients and care resources to the community or the prisons. Beyond simply providing a critique of the withdrawal of services and the ensuing incarceration, re-institutionalization, homelessness, and poverty experienced by ex-patients, it is necessary to consider how and why this occurred, the purpose of a diffuse mental health care system of services, and how it is legitimized. In short, the full potential of the concept of transinstitutionalization is not being realized due to a lack of attention to the broad shifts in dominant economic arrangements and psychiatric understandings that underpin various changes in government structure and public policy.

1.4.1 Moving Transinstitutionalization Beyond Prisons

The prison-centered definition of transinstitutionalization outlined above, while capturing an important effect of the often insufficient and diffuse operation of services, focuses narrowly on spaces of criminal incarceration (and on a human level, those people with mental illness labels who come into contact with the criminal justice system), and, consequently, fails to account for widespread governmental attempts to shed all, or a portion, of the historical responsibility for the daily maintenance of people with mental illness labels. The criminalization of Madness is, as such, only one aspect of transinstitutionalization. It is more accurate to state that the incarceration of people with mental illness labels is one of the effects of the continued neoliberalization of mental health care after the implementation of deinstitutionalization, with the correctional system comprising one of its constitutive institutions. For scholars interested in prisons, elevating these spaces as one site of transinstitutionalization that operates alongside shelters, boarding homes, community treatment centers, and nursing homes (Simmons, 1990), through policies such as community treatment orders (Fabris, 2006) and welfare regulations (Wilton, 2004a; Chouinard & Crook, 2005), allows for a more comprehensive understanding of how the current system of care understands and deals with Madness and poverty. Furthermore, it allows for a framing of the specific articulation of the criminal justice system in the context of privatization, de-funding, and deregulation and casualization of employment, allowing linkages to be traced between these patterns in the correctional system and the social policy restructuring implicated in transinstitutionalization more generally.

I am not the first to critique existing transinstitutionalization literature, to advocate for a new interpretation of the term, or to draw on housing sites as illustrations of the process of moving people from psychiatric hospitals to the community (see Simmons, 1990; Slovekno, 2003;

Thakker et al., 2007; Prins, 2011). Focusing on the Canadian context, specifically mental health policy in Ontario, Simmons (1990) uses the term transinstitutionalization to discuss the early movement of patients from psychiatric institutions to rehabilitation units, nursing homes, and supportive boarding homes. Thakker et al (2007) define transinstitutionalization as the movement of people from psychiatric institutions to jails, prisons, and homeless shelters. Slovenko (2003) argues it is the “shift from large institutions to nursing home care or other facilities” (pg. 654).

The problem with the current literature however, is that it does not develop a sustained analysis of the widespread changes to the institutions, programs, practices, and dominant understandings of mental illness. The result is that transinstitutionalization ends up looking like a disorganized mess or an accident. Yet transinstitutionalization is a much more deliberately developed set of government policies and government-directed institutions and practices, designed to reduce state responsibility for the daily needs of people marked as mentally ill and to redefine state understandings of mental illness. Prisons are part of the infrastructure of transinstitutionalization, but such a blunt instrument of social control is not always required to produce the desired patterns of everyday life in the age of psychiatric expansion and control. There is a symbiotic relationship – as some of the critical/anti-psychiatry literature points out – between psychiatric knowledge and neoliberalism that involves, but does not require, the prison system. Analyzing transinstitutionalization from the perspective of daily maintenance provides a window into the form and content of the oppression of people labelled mentally ill today, while naming some of the actors and processes responsible for its contemporary crystallization and observing some of the new institutional forms that are emerging as a result.

The insights of earlier transinstitutionalization scholars about the diffusion of services with deinstitutionalization are important for understanding the architecture of the mental health care system. What has yet to be discussed, however, is the logic behind the operation of such a diffuse system of care. Feminist political economy insights about the restructuring of daily maintenance under neoliberalism reveal how the downloading, privatization, and individualization of services that both produced and reproduce transinstitutionalization are intertwined with to the desire of the provincial government to reduce expenditures and create conditions in which greater numbers of the so-called mentally ill participate in production for surplus. Close attention to changing definitions of mental illness, exemplified in Mad and Disability Studies literature as well as critical anti-psychiatry scholars, shows how prevailing definitions work to encourage participation in the production of surplus and explain away the poverty, unemployment, and isolation that is endemic to the capitalist economy. Utilizing a feminist political economy lens, supplemented by insights from Mad and Disability scholarship, creates new opportunities for understanding the logic and articulation of a seemingly scattered and irrational mental health care system; that is, for understanding transinstitutionalization.

1.5 Conclusion

This chapter has reviewed the literature from critical political economists on public and social policy restructuring under neoliberalism, making the case that a feminist political economy intervention can reveal the ways in which the mental health care system is geared towards constructing a form of daily maintenance that supports the drive for unfettered accumulation. It has also reviewed literature from Mad and Disability scholars, as well as critical anti-psychiatry scholars, on dominant understandings of mental health, models of disability, and health. I argued that existing models either reproduce the social construct of mental illness as an individual,

biological problem and/or have been co-opted to retain space for continued control over the lives of people labelled mentally ill. I brought these two bodies of literature into conversation with the existing scholarly work on transinstitutionalization, arguing that the insight of a diffuse network of services is key to understanding the contemporary landscape of mental health care in Ontario, but that to understand the operation and implications of such a system, a feminist political economy approach that pays close attention to prevailing understandings of mental illness is needed. Drawn together, the insights in these three bodies of literature provide a useful framework for unpacking the current articulation of the mental health care system in Ontario under neoliberalism. Before doing so, however, it is important to consider, in some detail, the historical underpinnings of Ontario's transinstitutionalized mental health care system.

Chapter 2 A Critical History of Ontario's Transinstitutionalization

In this dissertation, as indicated above, transinstitutionalization refers to the phase or system of public mental health care constituted by the privatization of many of the services involved in the daily maintenance of people with mental illness labels, the mobilization of these services to condition the activities of daily maintenance and identities of service users to be more compatible with the neoliberal drive for unfettered capital accumulation, and the development of new understandings of what it means to be mentally ill. The history of transinstitutionalization, therefore, is the history of the relationship between social policy and the arrangement of the processes of capitalist production. As stated in the introductory chapter, focusing on mental health care as daily maintenance – one component of social reproduction – allows me to remain attuned to those shifts in the organization of production for surplus as well as social reproduction; these insights are provided handily by feminist political economists (e.g. Vosko 2000; Fudge & Vosko, 2003; McKeen & Porter, 2003; Porter, 2003; Vosko, 2006; Brodie, 2010). The struggle over mental health care, after all, is the struggle over the rates at which the economic elite, employers, and the state provide decommodified supports to people living in a particular period in the history of capitalism, and the dominant assumptions, identities, behaviours, and goals advanced within existing support services. Although there are scholars deconstructing the history of Ontario's mental health care system (e.g. Marshall, 1982; Simmons, 1990; Wiktorowicz, 2005), a historical account of transinstitutionalization in Ontario has yet to be advanced, despite the growing attention paid to mental health by governments (e.g. the At Home/Chez Soi program), business (e.g. Bell Canada Let's Talk), and the recent emergence of Mad Studies as a field of scholarship (see LeFrancois et al., 2013). Nor has there been any substantial critical political economy account of the history of mental health care in the province. To fill this gap, in

this chapter I trace the history of transinstitutionalization from the beginning of deinstitutionalization in the 1950s and 1960s to the present, from an examination of existing literature, archival documents, and government policies.

In developing a critical history of transinstitutionalization, this chapter pays attention to broad economic trends, the economic and political rationales behind specific policymaking decisions at the federal and provincial levels, and the relationship between these policies, the transmission of social norms, and the regulation of the daily lives and identities of people with mental illness labels. It pays close attention to changing arrangements of services for daily maintenance for people with mental illness labels from the beginning of deinstitutionalization to today, which has involved radical changes to the ways in which people acquire room, board, and treatment. In this critical history of transinstitutionalization and my analysis of its operation today, I understand policymaking as an “act of power” (Orsini & Smith, 2007, p. 35). This act of power includes, among other relations, gendered relations of production and prevailing attitudes about mental illness. This approach offers new insights into the articulation of the economic, social, and political developments that propelled Ontario towards the current system for meeting the daily needs of people with mental illness labels, and reinforces the need for a feminist analysis of the current arrangement of mental health care today.

It should be noted that people deemed to be mentally ill were not the only social group to be incarcerated in long-term “health care” facilities. People with different and/or multiple disabilities, as well as older persons without disabilities, experience(d) processes of deinstitutionalization and, likely, transinstitutionalization. Notably, the practice of institutionalizing people with intellectual disabilities was widespread in Canada, and the histories of people assigned the label of intellectual disability, like that of people labelled mentally ill, are

replete with accounts of violence, neglect, and silencing in institutions responsible for their daily maintenance. As with psychiatric institutionalization, there was no single moment in Canada in which the formal institutionalization of people with intellectual disabilities ended. The deinstitutionalization of people with intellectual disabilities was, rather, a long, drawn-out process that began with information gathering by the federal government in the 1960s, with each province proposing varying initiatives with similar goals (Radford & Park, 2003). In Ontario, this process of deinstitutionalizing people with intellectual disabilities began in the 1970s, and continued until 2009, when the last institutions were closed (Stainton, 1995; Radford & Park, 2003; Balogh et al., 2004; Lemay, 2009; Ontario Ministry of Community and Social Services [MCSS], History of Developmental Services, n.d.).

Today, people with intellectual disability labels experience poverty, homelessness, and limited access to government funds and social services (Radford & Park, 2003). Because of the parallels (both past and present) in the experiences of people labelled mentally ill and people with intellectual disability labels, much of my analysis of transinstitutionalization may have similarities with the experiences of the latter group. I also recognize that there is a degree of overlap between those people categorized as having an intellectual disability and those categorized as having a psychiatric disability, although I am dealing, in the analysis presented below, only with psychiatric transinstitutionalization. The similarities in experience and overlap in populations nevertheless require further research.

This chapter proceeds historically, charting what I argue are the five phases in the development of transinstitutionalization in Ontario. I begin with the earliest expressions of deinstitutionalization in Ontario in the 1950s, discuss the full expression of deinstitutionalization during the height of Keynesianism, move on to the crisis for ex-patients that emerged with the

decline of the Keynesianism, proceed through the various experiments with responses that developed to address this crisis, and conclude with a discussion of transinstitutionalization under neoliberalism today. Although focused on daily maintenance, this chapter does not provide an analysis of the day-to-day activities of service users or providers in the non-profit sector shaped by policy at each period in the history of transinstitutionalization; such an analysis would be beyond the scope of this project. Instead, this chapter provides a materialist history of the institutional and policy changes that structure mental health care. The analysis of the contemporary day-to-day work of service users and service providers, and the (sometimes gendered) underpinnings that, together with policies, programs, and practices, structure daily maintenance, will be provided in the chapters that follow. The materialist history of transinstitutionalization provided in this chapter traces the changes in the provisioning of room, board, and treatment services for people with mental illness labels in the last six decades. It serves to set the stage for an analysis of the logic and effects of the current system, while also denaturalizing poverty and pathologization and establishing these as social problems.

To date, Simmons' (1990) work, *Unbalanced*, provides the most comprehensive account of changes to Ontario's mental health care system from 1930-1989. In discussing some of the earliest changes to psychiatric institutions, Simmons employs the term transinstitutionalization to describe the movement of "chronically ill" and elderly "patients" to residential units within psychiatric hospitals. Although not a relocation to the community, according to Simmons, these attempts to change how mental illness is addressed and understood mark one of the first instances

of what he calls transinstitutionalization⁵ as a practice in Ontario. Marshall's work, *Madness* (1982), which analyzes the challenges faced by patients and service providers in the period of deinstitutionalization in Toronto, captures some of the effects of the downloaded approach. While Simmons (1990) and Marshall (1982) have done much of the work on the period leading up to the 1990s, their approaches often lack attention to the significant economic changes and crises of the last century, thereby offering a much-needed description rather than a political economy analysis of the history of mental health care in Ontario. These two very valuable historical accounts serve as my starting point for constructing the critical history of transinstitutionalization in Ontario. Other writings invaluable to this history are historical accounts of deinstitutionalization by Mad Studies and Disability Studies scholars and activists (e.g. Marshall, 1982; Capponi, 1992; Beresford, 2000; Everett, 2000; Voronka, 2008; Costa et al., 2012).

The history of transinstitutionalization is not straightforward. Contrary to what might be expected, the crisis of Fordism and the retrenchment of the Keynesian social programs was not the driving force behind the shift to deinstitutionalization, nor did transinstitutionalization emerge directly from neoliberal retrenchment and the privatization of social reproduction. Rather, I contend that the seeds of deinstitutionalization in Ontario were planted by increased federal investment in the social programs in the post-war era. A mapping of the development of transinstitutionalization onto the erosion of Canada's brand of Keynesianism and the introduction of more privatized social reproduction under neoliberalism is insufficient. While it is certainly true that the privatization of social services under the neoliberal agenda of the last three decades

⁵ As previously stated, processes of transinstitutionalization are not unique to those with mental illness labels, but also impact people with intellectual disabilities and other types of disabilities (see Radford & Park 2003; Balogh et al., 2004; Lemay, 2009).

has impacted the organization of social services accessed by people with mental illness labels, the complex process of neoliberal policy (re)making is indicative of something more multifaceted than simple privatization (Orsini, 2006; Graefe, 2005, 2016; Murray, 2011). It also involves a reconstitution of how people with mental illness labels are understood and expected to behave, as well as a “naturalization” of the ill-effects of neoliberal policymaking.

Each of these phases of transinstitutionalization is characterized by a particular arrangement of services and understandings of mental illness. The characteristics of each of these phases are informed by the prevailing arrangement of production, both for surplus and social reproduction, although often in surprising and seemingly contradictory ways. The first phase, the “Golden Age” which preceded wholesale deinstitutionalization, saw some downloading of provincial responsibility for room and board responsibilities, and resulted not from the decline of the post-war compromise, but precisely because of the existence of that compromise, and, particularly, the tensions it caused between the federal and Ontario governments. The second phase, deinstitutionalization, saw the intensification of deinstitutionalization, which involved further downloading of room and board as well as treatment services, and the solidification of Ontario’s preferred approach to mental health and social welfare generally. This occurred within the context of the eclipse of Keynesianism by monetarism in Canada, resulting in the intensification of crisis among deinstitutionalized populations. The third phase was a period of experimentation with services for room, board, and treatment, and rapid political upheaval (with the party in power changing three times over the course of a decade). While the crisis caused by deinstitutionalization could no longer be ignored, each party, upon forming government, advanced a slightly different strategy for solving the problem of deinstitutionalized persons. What each strategy had in common, however, was an unwillingness to accept full responsibility

for the daily maintenance of people with mental illness labels. The result was a further entrenchment of downloading, and privatization of room, board, and treatment services through third-way funding arrangements and the celebration of community-based mental health care as restorative of agency. The fourth phase is best characterized as the phase of the “common-sense revolution” and the beginnings of the blending of the biomedical model and wellness (fundamental to transinstitutionalization) under the guise of choice and progress. Under Premier Mike Harris, the Ontario Progressive Conservatives executed a widespread reorganization of social services, including mental health care. This reorganization included the introduction of a two-tiered welfare system, reduced funding for hospitals, and the privatization of paramedical services. The fifth phase – which we currently inhabit – is the full expression of transinstitutionalization. Room, board, and treatment services are provided through a loosely coordinated network largely comprised of non- and sometimes for-profit services. The government’s most recent mental health care strategy, OMHM, promises a renewed focus on efficiency and cost-savings as a way to improve mental health care and to address the substantial costs of the system. This involves a repositioning of the well-being of people with mental illness labels as symbiotic with social service retrenchment, and equates labour force attachment with wellness and recovery. It is within this fifth phase that I locate the chapters that follow the review below.

2.1 Phase One: Ontario in the “Golden Age”

Deinstitutionalization in Ontario, and the meagre community services that characterize it, emerged in the context of late Keynesianism. Deinstitutionalization in Ontario and Canada is often understood to have resulted from a number of factors, such as the rising cost of institutionalization, developments in psychopharmacology, the anti-psychiatry and patient rights

movements, and changes to understandings of mental illness and the role of psychiatry (Simmons, 1990). To this list we must add the shifts in prevailing economic ideology (Morrow, 2004) and the changing organization of social reproduction (Cameron, 2006). The challenges that people deemed to be mentally ill faced with the advent of deinstitutionalization were not, therefore, caused solely by the unravelling of the post-war consensus. Early forms of deinstitutionalization occurred under Keynesianism. The challenges facing people labelled as mentally ill became entrenched, and new challenges arose as the Keynesian welfare-state transitioned to a model of increasingly-privatized service provision and an ethos of individual responsibility.

To fully understand the impact of shifting economic conditions on de- and transinstitutionalization, it is necessary to start with a summary of Canada's "Golden Age" (from the mid-1940s until the late 1960s). At the dawn of the "Golden Age", institutionalization was the primary mechanism for providing the so-called mentally ill with their daily needs, and mental health was largely left to the provinces.⁶ In Ontario in the 1940s, there were twelve "mental hospitals" housing mental patients and people with intellectual disabilities, often for their entire lives. Most mental health care was organized in and around these institutions, and there was a significant need for additional psychiatric beds both in Ontario and in Canada as a whole (Simmons, 1990).

The post-war context saw the federal government openly involved in the market and promoting a strong welfare-state. While contested, the economic objectives underpinning many policy

⁶ According to the 1940 report by the Rowell-Sirois Commission on Dominion-Provincial Relations both "...Unemployment insurance and contributory Old Age pensions are inherently national in nature" (Taylor, 1978, p. 11) while asylums, according to the Constitution Act, 1867, fall under provincial jurisdiction. The exception was mental health care for military personnel (Taylor, 1978, pg. 10).

choices at this time were robust economic growth and high employment through “mass production for mass consumption,” strong welfare programs to address market failures, state support for a male breadwinner/female caregiver family model, and a focus on social inclusion and collective bargaining to regulate the class tensions and problems of overproduction that plagued Canada and other Western states in the 1930s and 1940s (Shields & Evans, 1998; Albo & Fast, 2003; Cameron, 2006; Workman, 2009). Growth during this period remained consistently high (15-20%) (Workman, 2009), and the federal government was actively involved in the expansion of social rights and decommodified services for social reproduction through direct spending (e.g. Unemployment Insurance [UI]) and the use of transfer payments (e.g. Family Allowance) (Cameron, 2006).

It was in the context of a burgeoning welfare state that deinstitutionalization began to take shape. William Lyon Mackenzie King, in a successful bid to win the 1945 election, promised to develop a planned economy and a comprehensive social security system (Finkel, 2006). Finkel (2006) argues that these plans were consistent with the stronger brand of Keynesianism⁷ demanded by then-powerful trade unions and the Canadian Labour Congress, but ran counter to King’s own preference for a more limited role for government in the marketplace. Despite some resistance to Keynesian ideology, the Dominion-Provincial Conference for Reconstruction and the Green Book Proposals emerged from King’s promises. These proposals focused on providing “high and stable employment and income and a greater sense of public responsibility for individual economic security and welfare” for post-Depression, post-war Canada (Taylor, 1978, p. 2). Included in these proposals were provisions for the development of more uniform health care

⁷ The more conservative brand of Keynesianism in Canada included little more than well-timed government spending during periods of economic crisis (Finkel, 2006).

services across the country through federal-provincial cooperation.⁸ While the Green Book Proposals failed as a result of disagreements with the Premiers of Quebec and Ontario over the proposed taxation schemes and grant payments (Taylor, 1978), and at least in part due to Mackenzie King's preference for a weaker welfare state (Finkel, 2006), the meetings did result in the federal government providing money to the provinces for the construction of hospitals, including mental health hospitals (Taylor, 1978). The provision of federal funding for mental health was an unprecedented decision on the part of the King government.

In 1951, the Canadian government, by then under the leadership of Louis St. Laurent, provided Ontario with grants of \$1,500 per bed in psychiatric units (PUs) in general hospitals, while the Ontario government promised an additional \$8,500 per bed (Dear & Wolch, 1987; Simmons, 1990). The federally subsidized PUs, which typically provided shorter terms of care, were cast as solutions to the shortage of beds in Provincial Psychiatric Hospitals (PPHs), as community-based care for prevention and early intervention into mental illness, and as a way to reduce the ever-growing size and cost of institutions (Simmons, 1990).

The expansion of the PU system was supported by psychiatrists, as it furthered their prestige by entrenching the alignment of "mental disease" with physical illness and placing their practice, at least in part, in the more reputable general hospitals (Simmons, 1990). In 1957, the *Hospital Insurance and Diagnostic Services Act* was passed, providing "for a contribution by the Federal Government of 50% of the cost...[of] insured hospital services, inpatient services, and outpatient

⁸ Also included in proposals were plans for unemployment insurance and pensions, as well as both private enterprise and public investment for employment.

services available...to all residents of the province” (Turner, 1958, p. 768).⁹ Initially, the Act excluded mental health hospitals and institutions which were already operating under provincial jurisdiction with aid from the federal government in the form of grants, but was later amended to include PUs in general hospitals, though psychiatric beds were limited to 10% -15% of the total number of beds provided (Roberts, 1964). Among other developments, these moves towards universal health care in Canada resulted in the *Medical Care Insurance Act* of 1966 and ultimately, the CHA (Mahon, 2008). PUs continued to be funded in connection with both of these statutes.

With the entrenchment of subsidized PUs in general hospitals in Ontario in the late 1950s, days of care provided in PUs climbed from 109,990 days in 1959 to 434,643 days in 1970. This increase was accompanied by a significant decline in days of care provided in PPHs (Simmons, 1990). The promise of cost-savings and a more community-based treatment approach appealed to the Ontario Conservatives, who were distrustful of “big government” and the trends in social spending under Keynesianism (Taylor, 1978; Finkel, 1993, 2006). At the same time, the early focus on community-based health, represented by the expansion of the PU system, was compatible with the mental hygiene movement popular at the time. In this context, the earliest move towards a more community-based approach to mental health care was overdetermined.

According to McBride (2001), while Keynesianism did inform many of the policy choices at the time, the Keynesian approach was not overwhelmingly hegemonic in Canada. While a strong welfare state did slowly emerge, countercyclical fiscal policy was absent, and there was much debate over the goals of policymaking (McBride, 2001). In Ontario specifically, the

⁹ Ontario was the first of six provinces to sign, and the program took effect on January 1, 1959 (Turner, 1958). Transfer payments never reached 50%, and have been on the decline more recently (Mahon, 2008).

Conservatives had a tradition of being more suspicious of the strong form of Keynesianism demanded by organized labour. As demonstrated in Finkel's (1993, 2006) discussions of Premier Drew, and Taylor's (1978) discussion of Premiers Drew and Frost, these leaders preferred private sector solutions, limiting state intervention in the market. As seen from their discussions, the uploading and offloading of costs, to the federal government and the private sector, respectively, and the early attempts to relocate some mental health services to the community, was consistent with Ontario's long history of economic conservatism and reluctant Keynesianism.

Furthermore, the mental hygiene movement, popular in North America during the first half of the 20th century (Dickinson, 1993), promoted prevention of mental illness through community-based responses to "incipient maladjustments" (Simmons, 1990, p. 50). It was, arguably, an extension of psychiatric control into the community, very much compatible with Fordist notions of mass production for mass consumption, a robust and healthy workforce, and full employment (see Workman, 2009 for greater discussion of Fordism).

The preoccupation with the reproduction of a healthy and productive workforce and the corresponding extension of psychiatric control was not limited to those who were employed. The 1950s in Canada was a period when "full-time mothering" – albeit it in a heavily racialized form shaped by socio-economic factors – in a nuclear family was seen as important to the development of children, who would then become adult citizens. In short, mothering was understood as important to the reproduction of the existing labour force as well as to the reproduction of a future labour force that would be socialized to behave in a manner compatible with the prevailing regime of accumulation. This male breadwinner/female caregiver model was supported by robust welfare state policies for the working family and wages sufficient for male workers to support dependents (Gazso, 2012).

Included in these services was “parent education.” Mental hygiene activists provided parent education for the purpose of ensuring a child development path that promoted “good mental health.” According to Dickinson (1993), “good mental health was defined in terms of personal capacities and interpersonal skills essential for individuals successfully to adjust to the ordered, but constantly changing nature of modern capitalist society” (p. 388). As stated above, the extension of psychiatry into the community under Keynesianism was compatible with the Fordist model of control over production for surplus and social reproduction, and helped plant the seeds of deinstitutionalization by further positioning (some) psychiatric services within the household and community through the provision of government services.

The mid-20th century was also a time of development for psychiatric chemotherapy (Gronfein, 1985; Simmons, 1990), as well as the entrenchment of the understanding of mental illness as a chemical imbalance in the brain, similar to a physical ailment (Simmons, 1990). These developments in psychopharmacology, and the corresponding alignment of madness with illness of the brain, had profound effects on the trajectory of deinstitutionalization, as “appropriate behaviour” could be obtained through the use of chemicals, and this form of “care” could be provided outside of the institution.

2.1.1 The Role of the Canada Assistance Plan

Further entrenching the move towards deinstitutionalization in the late 1950s was the attempt by the Ontario government to access additional federal subsidies through Unemployment Assistance. The precedent for this attempt had been set by the government of Prince Edward Island, which had received federal funding for elderly people transferred from institutions to other infirmaries (Simmons, 1990). Simmons (1990) discusses how Ontario, hesitant to build new institutions, established residential units (formerly called rehabilitation units) in PPHs, and

decertified and transferred primarily elderly people¹⁰ and “chronic” patients to these units.

Between 1961 and 1962, 3,244 residents had been reclassified and moved to residential units, but the provincial government was denied federal subsidies, as those units were still part of the PPHs. In response, the provincial government created the Homes for Special Care (HSC) program¹¹ in 1962, providing housing to people who would no longer “benefit” from active treatment. People in residential units were then moved into these HSC sites. The homes were indirectly eligible for federal funding through cost-sharing arrangements for welfare, which became further entrenched with the introduction of the CAP in 1965-66 (Simmons, 1990).

The importance of the CAP to the processes of deinstitutionalization in Ontario, and to the growth of private sector care services (e.g. psychiatric boarding and rooming homes) cannot be under estimated. The CAP provided federal funds at the rate of 50% for, among other programs, income assistance designed and administered by provincial governments (Dear & Wolch, 1987; Mahon, 2008). Prior to the CAP, welfare programs were largely the responsibility of the provinces and municipalities (Herd et al., 2005), and in Ontario, workfare programs had been installed as the preferred model (Torjman, 1996). The provisions of the CAP allowed income support programs to be means-tested, but neither workfare requirements nor residency requirements were permitted (Mahon, 2008). While the CAP certainly did not offer a fully decommodified and accessible social safety net (as provinces were able to impose welfare to work transitions on recipients), and there were no standard appeal processes or minimum welfare

¹⁰ Due to a lack of services for the geriatric community in Ontario, elderly people with no other options were often placed in psychiatric hospitals even if they were without a psychiatric diagnosis (Simmons, 1990).

¹¹ Homes for Special Care were boarding home-like residences placed primarily in rural or isolated communities, established using the language of community and home-like care. The provincial government then established what Simmons (1990) refers to as a “double transfer”, moving patients from psychiatric hospitals to residential units to Homes for Special Care. Approximately 11,500 people were transferred in the Homes for Special Care program between 1964 and 1973.

rates (Harles & Davies, 2005; Johnson & Mahon, 2006), this program did provide Canadians with a social safety net consistent with the moderate Keynesianism of the time (Finkel, 1993, 2006; Collier, 2007). With CAP, Ontario introduced a two-tier welfare system composed of the *Family Benefits Act*, which provided slightly higher rates of support for those people who qualified as long-term unemployable recipients, and General Welfare Assistance for short-term or “employable” recipients (Little, 1998a). This model contained, therefore, the precursor programs of the current ODSP and OW programs, respectively. The provision of these federal funds meant that the Ontario government could upload to the federal government some of the costs of patients living in PPHs by placing them in the community, where they would access federally-subsidized welfare, which could be used for food, and shelter. CAP, therefore, provided an avenue for the Ontario government to reduce provincial funding for room and board for mental patients, and to reduce and reorganize the delivery of mental health services.

Prior to CAP, Ontario’s rearrangement of services, such as the creation of residential units and early HSC, created the illusion of deinstitutionalization. As Simmons (1990) points out, however, this was little more than a relocation of patients from one form of custodial care to another. It was in the mid-1960s, aided arguably by the introduction of CAP, that deinstitutionalization truly began. According to Marshall (1982), in 1961 out-patient care accounted for only 20% of all mental health admissions, while admissions to PUs and PPHs accounted for 30% and almost 50%, respectively. If we look at Simmons’ (1990) discussion of the days of care provided in PPHs in Ontario between 1959 and 1970, there is a decline from over 6 million days of care provided to slightly less than 3 million over that period. This decline can be accounted for, in part, by the use of PUs, residential units, and the already-established HSC program, but it also represents a dramatic decline in the long-term population in PPHs, as

well as aggressive relocation of patients to the community. This relocation, however, was mobilized without the development of adequate systems of support or “aftercare” services, resulting in poverty, homelessness, and poor health by those affected by Ontario’s shift to deinstitutionalization (Marshall, 1982; Dear & Wolch, 1987; Simmons, 1990).

With deinstitutionalization came the reorganization of PPHs and PUs as the primary providers of community care, rather than custodial care. Community care, run by hospitals, was associated with out-patient and day treatment systems, as well as shorter-term in-patient treatment (Simmons, 1990). There was no network of services offering consistent support in terms of a transition to and participation in the extra-institutional community; patients were discharged without necessary support structures in place. The lack of sufficient services, according to scholars and activists, had devastating consequences ranging from crushing poverty to unsafe housing to death (Marshall, 1982; Capponi, 1992).

The development of deinstitutionalization and aftercare/community care in Ontario is often called unplanned, poorly planned or ad hoc (Marshall, 1982; Simmons, 1990; Lightman, 1997). This label gives the impression, however, that the struggles of the deinstitutionalized community were merely the result of an error on the part of government. Deinstitutionalization and the lack of corresponding community programs, however, emerged from considered decisions on the part of the provincial government to “reprivatize” many of the services for people with mental illness labels, such as room and board, associated with the psychiatric institution.

Although beginning in Ontario at the height of Keynesianism, this “reprivatization” of services became entrenched, and arguably intensified, by the “long downturn” in advanced capitalist countries in the late 1960s and 1970s. The long downturn was characterized by a decline in

accumulation, the internationalization of capital, growth in labour force insecurities, and state intervention in the form of retrenchment of social services (Albo & Fast, 2003; Saad Filho, 2008). The notion of the role of the state being one of managing the worst effects on the labour force, working towards high employment, and fostering social inclusion, was replaced with an understanding that the state should allow free market principles to guide the composition of the national economy, reduce social spending and market regulation, and maximize exports (Shields & Evans, 1998).

Looking specifically to Canada, Brodie and Trimble (2003) demonstrate how those social programs negotiated between the federal and provincial governments during the Keynesian era were coming under scrutiny, and indeed were directly blamed for the economic downturn. In the late 1960s, calls for public sector reductions and private sector deregulation were gaining popularity (Armstrong, 1997). It was in this moment, when the principles of privatization, downloading, and individualization began to guide social policy, that transinstitutionalization as it is expressed in contemporary Ontario has its roots.

2.2 Phase Two: The Crisis of Deinstitutionalization

In Canada, the 1970s was a period of early neoliberal-style preoccupation with deficits and some attempts to adjust state involvement in social reproduction (Braedley, 2006). During this period, wage controls were introduced (Sears, 1999) and programs such as UI were reduced (McBride, 2001). It is at this time that the “neoliberal policy bloc” began to develop in corporate and other policy circles (Sears, 1999; Carroll & Shaw, 2001).

In Ontario, specifically, in response to the economic downturn of the 1970s (Dear & Wolch, 1987), the provincial government focussed on restraint through the “rationalization” of social

services, the reluctance to increase public funding over time, and the transfer of funds for social services to the private sector to promote a market-based approach to welfare (Laws, 1988). In the context of the continued transfer of patients from institutions to private nursing and residential homes, the Department of Health, in submissions to Cabinet, argued that these measures would “reprivatiz[e] health care by 5.7 million in 1973/74 rising to 12.7 million in 1976/77” and would have a “marked employment effect” (Simmons, 1990, p. 117). At the same time, the Committee on Government Productivity was encouraging ministries to enter into contracts for “program delivery with agencies both inside and outside of government” for the purposes of flexibility and access to new avenues of care provision (Simmons, 1990, p. 117). The policy decisions of this committee represent the early privileging of the principle of privatization, as well as individualization and downloading, which shapes transinstitutionalization. The parameters of mental health care were no longer limited to PUs and PPHs, but rather involved governmental and non-governmental organizations associated with housing, income support, employment, and childcare, as well as a restructuring of the roles of families and the individual in care.

For people with mental illness labels, the crisis and retrenchment in social services meant cutbacks in funding for mental health treatment and income support, as well as diminished funding for extra-governmental groups providing care and support services. Indeed, this period constituted a “squeeze” on the entire loose network of room, board, and care services for the newly deinstitutionalized – and still “deinstitutionalizing” – community, as well as on the social safety net as a whole. This period marked a fundamental shift in the balance of power between labour and capital, which involved reduced wages, benefits, job security, and supports for social reproduction.

In 1976/77, the provincial government put \$36.3 million dollars into psychiatric hospitals and general hospitals, arguing that these institutions formed the backbone of community mental health (Simmons, 1990). The result was, according to Simmons (1990), an unbalanced mental health care system with much-needed community services, including quality housing, left neglected. Although some funds were directed towards psychiatric and general hospitals (Simmons, 1990), the conditions within these institutions were declining, while little was being done by government to improve community services. Marshall (1982) speaks specifically about the conditions within the Queen Street Mental Health Centre (QSMHC),¹² including an increased catchment area due to the 1979 closure of Lakeshore Psychiatric Hospital, a hiring freeze, and a subsequent intensification of work within the centre. These conditions resulted, predictably, in a decline in the quality of care, a return to a warehousing mentality, and increased strain on those working within the centre.

The closure of Lakeshore is an important example of the deliberate reduction in government services in an effort to reduce expenditures. According to the Ontario Ministry of Health of the day in a *Fact Sheet Concerning Closure of Lakeshore Psychiatric Hospital* (1979), it would require the movement of 146 patients to QSMHC and would result in \$2.6 million in savings. Yet only \$1.3 million would be used to expand services for communities in Lakeshore's catchment area. Services receiving funds were those identified as "top priority" by the communities, and would include aftercare in the community, services for rehabilitation and other supports. While the fact sheet is not explicit, it would appear that at least some of these services were provided by municipal governments, non-profits, and/or for-profit organizations.

¹² QSMHC is now the Centre for Addictions and Mental Health (CAMH).

Along with problems caused by cutbacks within the public sector, the offloading of care to the private and non-profit sectors did not improve conditions for people with mental illness labels as promised. Instead, social services became vulnerable to market forces. A 1979 report on Adult Residential Care Homes in Metro Toronto, discussing the issue of governmental responsibility, argued that the provincial government understood its responsibility for people with psychiatric disabilities to have ended once they were no longer benefitting from hospital care. The report further demonstrates the failure on the part of the provincial government to replace some 12,000 eliminated psychiatric beds with comparable community-based accommodation. Instead, accommodation was left to private voluntary organizations, and only 200 additional residential care beds had been established in Metro Toronto as of the time of the report's publication. Considering that, by 1980, the number of beds in PPHs had been reduced to 4,948 from 15,257 in 1965 (Hartford et al., 2003), there appears to have been a significant reliance on families, communities, and private sector provision of board and care for those deemed mentally ill. Furthermore, between 1971 and 1981, rates under the FBA decreased from 28.9% of average family income to 24.6% (Little, 1998b), resulting in decreased income for deinstitutionalized people at a time when demand for services and support was on the rise. What we see in this period is an attempt to render all services associated with mental health care compatible with an emergent citizenship regime demanding participation in the processes of production for surplus, and relying heavily on unpaid or underpaid social reproduction.

2.2.1 Understandings of Madness and the Rise of the Consumer-Patient Subject

Cutbacks to services, as previously mentioned, do not define the entirety of transinstitutionalization. With the retrenchment and privatization of services came the

downloading and offloading of responsibility for people with mental illness labels to the private sector (especially to non-profit service providers), and also the rise of disciplinary mechanisms that organized and defined people with mental illness labels in a manner consistent with the emerging neoliberal consensus. The changes to not only the scale of financial responsibility, but also to the responsibility for the quality and nature of services is emblematic of the amorphous nature of transinstitutionalization, and is a key source of its power.¹³

Marshall's (1982) discussion of comments in the *Globe and Mail* in 1980 by Ontario Minister of Health Dennis Timbrell captures the increased responsibility and decreased supports foisted upon people labelled mentally ill during this period. Timbrell stated that "[d]ischarged psychiatric patients are independent citizens... as private citizens, they can, and do live wherever they choose. Many of them choose to live in Parkdale because of the proximity of psychiatric services" (p. 97). These comments came on the heels of Timbrell's statement to the Ontario Legislature in 1979 that discharged psychiatric patients "are as free to come and go as you and I" (Marshall, 1982, p. 97).

While Marshall (1982) draws on these quotes to bring attention to the lack of choices facing deinstitutionalized people, these comments also highlight a shift in their relationship to the state and the market, as well as the emerging discourses of mental illness embedded in public policy. With deinstitutionalization came the idea of "choice" for people with mental illness labels, and the perception that they were ultimately responsible for the manner in which they "consume" social services, use their income support funds, and choose to live.

¹³ Also noteworthy is that, while the provincial government downloaded responsibility for the people labelled mentally ill, they retained their capacity to criminalize this group through "forming" and other types of involuntary institutionalization (see Chapter 3).

This focus on choice indicates the rise of what Isin (1998) terms “client and consumer control,” or what I refer to as the “consumer-patient subject.” Importantly, this is also consistent with the (re)emergence of the “gender-neutral,” self-sufficient, self-interested, rational subject of neoliberalism (Brodie & Trimbell, 2003). A difficult aspect of this discourse of freedom is that it intersects with, and legitimizes the demand for, the recognition of agency and autonomy among people with mental illness labels, while contributing to the reproduction and naturalization of the autonomous and rational subject on which neoliberalism depends. This discourse of freedom operates alongside programs, such as income assistance for people with disabilities and various psychiatric housing programs (including high-support and supportive homes) which require the service user to identify as “disabled” in order to obtain access. This requirement ensures that understandings of mental illness (and disability generally) are rooted in individual pathology, contributing to the naturalization of the widespread poverty and stigmatization experienced by people labelled mentally ill. Together, the operation of these discourses through the various policies, programs, practices, and institutions of emerging transinstitutionalization made people with mental illness labels “fit” into nascent expressions of neoliberalism in Ontario. While the operation of neoliberalism and understandings of mental illness have changed over time, the consumer-patient remains the central protagonist of transinstitutionalization.

Deinstitutionalization in Ontario reached its apogee as the post-war compromise came under attack and neoliberalism in Canada began to take shape. The trend toward the provision of services through for- and non-profit service providers that had characterized deinstitutionalization became entrenched as these same principles were broadly applied throughout the retooled set of social services. Ex-patients were deinstitutionalized into an increasingly privatized network of services, required to cobble together the necessities of daily living from various governmental

and extra-governmental institutions such as rooming and boarding homes. In turn, many of these governmental and extra-governmental institutions and networks reproduced individualism within the area of mental illness by ensuring the reproduction of certain definitions and parameters of disability, and by elevating a consumer-patient model of service provision. It is this downloaded, offloaded, and diffused amalgam of services involved in disciplining people with mental illness labels, coupled with the rise of the consumer-patient model, that characterizes Ontario's transinstitutionalization.

2.3 Phase Three: Political Upheaval and Policy Experimentation

Cost containment efforts during the process of deinstitutionalization produced social problems that could not be ignored. People, once hidden from public view with institutionalization, experienced visible poverty, homelessness, substandard housing, and incarceration during this process. One resident described the period of deinstitutionalization in the following way: "It was scary, people jumping off [a particular bridge]. It was almost a daily occurrence" (Interview with Resident).

On the heels of a number of high-profile deaths in Ontario's board and care homes (*Mayor's Action Task Force on Discharged Psychiatric Patients*, 1983 and 1984 – referred to as the *Gerstein Report*, 1983 and 1984) and increased media attention to the conditions facing ex-patients (Hartford et al., 2003), the municipal and provincial governments were forced into action, leading to what can be understood as a period of debate over the best strategies for "managing" the newly-deinstitutionalized population. It is important to underline that this debate over mental health strategies was occurring alongside debates about the correct path for welfare reform across all levels of government. No single level of government wanted to accept full responsibility for the deinstitutionalized population, but inaction was no longer an option. This

was a messy transitional period for mental health care in Ontario. The 1990s saw an increased role for government in encouraging private sector solutions, the elimination of well-paid jobs, and an increase in flexible employment and just-in-time production, with further reductions in income supports and other government and employer supports for social reproduction (Bezanson, 2006b). The debates, policy experiments, and responses to economic crises that took place in the arena of social provisioning at all levels of government at this time had a profound effect on the shape transinstitutionalization takes today.

In seeking to solve the problems caused by deinstitutionalization, provincial governments in power in Ontario between 1979 and 1993 commissioned and conducted numerous reports calling for better coordination of services and a clear mental health policy. A quick look at a few of these efforts demonstrates the complex and contested terrain of mental health policy in the transition from the earlier to later stages of neoliberalism in Ontario and Canada. With explicit concerns raised surrounding increases in mental health spending, PPHs and PUs were named as an inappropriate venue of complete service provision. The provincial government, in the 1983 *Heseltine Report* (cited in *Building Community Support for People*, 1988, itself commonly known as the *Graham Report*), was named responsible for ensuring that adequate funding was available, services were distributed equitably, and encouraging and assisting communities in mental health care service identification and planning, while communities (and the facilities and professionals within them) were responsible for delivery of local mental health care services. The *Graham Report* documented the lack of sufficient funding and the paucity of coordination and planning for mental health in Ontario in addressing the absence of a clear policy for mental health service delivery, and encouraged/supported the downloading of non-hospital mental health services to the level of the community, while simultaneously recognizing the need for a

wholesale increase in funding for mental health. While funding for mental health had, in fact, increased by the late 1980s, it had not increased at the same rate as other expenditures for health care (*Building Community Support for People*, 1988). What this transition period meant for PPHs, community services, and people with mental illness labels was a shift in responsibilities and organization, with broad experimentation by governments with public-private partnerships for mental health care reform.

As previously stated, psychiatric hospitals in the 1980s were undergoing major reorganization, including a reduction in days of care provided while assuming a new role as coordinators of community care, despite the fact that community-based services were themselves sorely lacking (Hartford et al., 2003). The *Gerstein Report* (1983 & 1984), as well as works by Dear and Wolch (1987) and Simmons (1990), reveals that a primary means of meeting the needs of people with mental illness labels at this time was the for-profit boarding and rooming home system. The conditions in many of these boarding and rooming homes, documented in the psychiatric survivor newspaper *The Cuckoo's Nest* by LaCroix (1986), Mallory (1986) and Capponi (1992) in *Upstairs in the Crazy House*, were less than ideal. The infrastructure was unsafe, the rooms unclean, and the food unacceptable. Furthermore, aftercare services at this time were ad-hoc (Marshall, 1982; Simmons, 1990). The *Gerstein Report* focussed on better housing regulations and improved after-care services through public-private partnerships, including increased funding by both the provincial and municipal governments. In searching for a solution to the problems in housing, the *Gerstein Report* advocated for the implementation of marketization strategies through public-private partnerships in order to improve the quality of housing stock available for those with mental illness labels.

Habitat Services, notably not one of the organizations wherein interviews were conducted, offers one example of the application of marketization principles to the social problems caused by deinstitutionalization and government withdrawal from social housing. Habitat Services, a non-profit organization established to oversee quality assurance in for-profit boarding homes, was to initially focus on pursuing commercial contracts with identified for-profit boarding home owners, who would agree to house people with psychiatric diagnoses and improve standards with the help of provincial and municipal government subsidies (Habitat Services, Habitat Model, n.d.). In exchange, owners agreed to house the people referred by Habitat Services, and to provide unrestricted access to inspectors for the purpose of monitoring standards. A core goal and justification for funding boarding homes through Habitat Services was to create competition among housing providers, necessitating a higher quality of care to attract tenants (Metropolitan Toronto Council Minutes, 1986, volumes 1 and 3). In a clear application of market principles, as well as the consumer-patient model, the proposal argued that, eventually, no one would choose to live in lower-quality housing, driving the more wretched boarding homes out of business. While improving standards in boarding homes was certainly important, given that the waiting list for housing in Ontario is reported to be anywhere from 290 days to six years (see Canadian Mental Health Association of Ontario [CMHAO], 2011; CAMH, 2012 b; ONPHA, 2015), it is difficult to assume that homeless and under-housed individuals had or have the “choice” to put certain housing providers out of business. Furthermore, the focus on individual responsibility for housing choices risks blaming housing problems on poor decision-making by those deemed to be mentally ill rather than a lack of options arising from a dramatic undersupply of housing (of any sort) for this population. The application of these principles of marketization to housing is not unique to the example of Habitat Services. Many of the housing programs for people with

mental illness labels in Ontario, according to the CAMH Housing Guide: 2004-2006 (n.d.) and Sylvestre et al. (2007), involve for-profit service owners and operators.

With the election of a New Democratic Party (NDP) government in 1990, new attention was turned to mental health. Released in 1993, the mental health strategy *Putting People First* announced that the multiple budgets for mental health services would be consolidated into one envelope, with the province acting as manager. This ten-year plan involved devolution of “administrative, fiscal and clinical responsibility for mental health care to regional authorities” and local communities (Hartford et al., 2003, p. 69). Using a graph to represent the new “consumer focussed framework for community support,” the report locates individual consumers as the central hub around which “families, generic community agencies/groups, formal mental health system and consumer/peer support/self-help” (p. 13) operate. The new system was to be three-tiered, with grassroots service delivery, local networks/authorities, and the provincial government each playing a defined role. The implementation plan involved combining existing mental health funding structures into one budget for mental health, and downloading responsibility for coordination and implementation of policy goals to the local and regional levels. The argument was that this local autonomy would reduce gaps and duplications in mental health services, further reducing the need for beds in PPHs. This plan, while still focussed on downloading and community-based care, was consistent with the more grassroots-style of public-private partnership favoured by the Ontario NDP, which focused on both economic growth and social goals. In 1995, with the election of the Progressive Conservative government, there was a return to a more market-based approach to social services that was decidedly top-down (Bradford, 2003), and which solidified transinstitutionalization in Ontario.

2.4 Phase Four: The “Common Sense Revolution”

With the election of Premier Mike Harris and the mandate of his “Common Sense Revolution,” Ontario experienced sudden, profound changes to the funding and design of social services. These changes contributed significantly to the solidification of transinstitutionalization. Hospital operational budgets experienced cuts of \$800 million, while the closure of forty hospitals was announced and the number of district health councils was cut in half (Gray, 1999). Included in these dramatic changes to the health care sector was the further elimination of psychiatric beds, the divestment and closure of six psychiatric hospitals without substantial community investment, and changes to the MHA that allowed greater policing of those deemed mentally ill, who were left without adequate access to services (Wiktorowicz, 2005). Focussing on the restructuring of the labour force and social services, Braedley (2012) demonstrates how health care services in Ontario were also retrenched by reducing base funding for hospitals, moving paramedical services (including some mental health care services) into the private sector, and relying on unpaid work in the home.

This period also witnessed a series of reforms to other social programs, including increased provincial control over public education, the move from welfare to workfare and cuts to social assistance rates, the legalization of the sixty-hour work week, the *Safe Streets Act* (criminalizing panhandlers and “squeegee kids”), and the downloading of responsibility for community housing (Keil, 2002). Bezanson (2006 a & b) documents the increased labour force insecurity and simultaneous intensification of labour of social reproduction within the household during this period. Families, especially women, experienced hardships associated with an increase in precarious employment and the amount of unpaid work required in light of the restructuring and de-funding of state supports for childcare, housing, health care, income support, and education

(Bakker & Gill, 2003 b; Bezanson, 2006 a & b). The policy changes in Ontario in the 1990s dramatically altered the landscape of citizenship in Ontario, and people with mental illness labels, now living in the community, were forced to contend with an approach to service provision that both demanded private market approaches to care and required independence in daily maintenance, ideally through production for surplus.

For people with mental illness labels, this focus on efficiency and independence meant prioritizing a decentralized network of care, with full responsibility no longer residing with the provincial government, but with a dispersed network of community-based service providers, families, and service users themselves. Arguably, what was needed was a primary focus on raising levels of income support, increasing funding for social housing, reducing wait times for psychiatric assessment (if desired), and access to treatment or alternatives. The trend is clear (although certainly it must be recognized that the desire to provide decommodified services and financial support differed depending on which party was in government) – the provincial government, in attempting to deal with the problems created by their unplanned deinstitutionalization, was focused on limiting the amount of responsibility the government would assume for the needs of people with mental illness labels. The desire to curtail the costs of mental health care was part of a large-scale reform to government involvement in social reproduction, which impacted all residents of Ontario, and solidified transinstitutionalization as the way to meet the needs of those deemed mentally ill.

2.5 Phase Five: Transinstitutionalization Comes of Age

Ontario's history of neoliberal restructuring cannot be considered without attention to similar trends at the federal level which impacted the structure of social policy at all other levels, and services for people with mental illness labels. At the same time as the provincial and municipal

governments were debating policy options to address the deinstitutionalized population, the federal government, as part of the austerity measures of the 1980s, reduced its role in social housing to a minimal level (Colderley, 1999). By the 1990s, the federal government had almost completely withdrawn from housing provisioning, in response, the Ontario government further downloaded responsibility to municipalities, who were ill-equipped financially to address housing needs. The goal of this downloading was to promote a private-sector approach at the community level (Hackworth & Moriah, 2006, Coulter, 2009) and to reduce the province's budgetary deficit, although federal funding for housing remained (Prince, 1998).

The 1990s also involved tightening eligibility for EI and the replacement of the CAP with the Canada Health and Social Transfer (CHST) in 1996, which removed the ban on workfare provisions (Bradford, 2007). In response to these changes, the newly-elected Conservative government in Ontario implemented a reorganization of Ontario's income assistance programs. During this period, Ontario witnessed the replacement of the income support provided through GWA, Vocational Rehabilitation Services, and the FBA with OW and ODSP (Chouinard & Crooks, 2005; Fraser et al., 2003), which resulted in cuts and freezes to rates of assistance received by those accessing provincial income support (Coulter, 2009). These cuts meant reduced funding for people with mental illness labels living in the community, coupled with increased individual responsibility to secure treatment, as well as a greater strain on housing providers reliant on the shelter portion of ODSP and OW to provide supportive housing services. In 2004, the CHST was split into the Canada Health Transfer (CHT) and the Canada Social Transfer (CST) for the purpose of ensuring greater transparency for health care spending. Although there is little research on whether or not this split between the CHT and the CST promotes the neoliberal agenda (Vosko, 2006), the rates of contribution from the federal

government to Ontario for social services do not appear to have kept pace with increases to health transfers since the 2007-2008 budget (Government of Canada, Department of Finance Canada, Federal Support to Provinces and Territories, n.d.). Perhaps this current trend in the CST is evidence of further retrenchment, as such a gap at least appears consistent with the ongoing withdrawal of the federal government from the funding of social programs. As provinces are not permitted to use the CHT for mental health care services provided outside of general hospitals (CHA), these changes may place additional pressure on the Ontario government to download service provision to communities and non- and for-profit agencies, which must continue to collaborate and/or compete to secure sufficient funding. Considering the high cost of health care, however, further research in this area would be required to confirm the nature of the dynamics at work between CHT and CST funding.

2.6 Transinstitutionalization Today

To understand the rise of transinstitutionalization and its central protagonist, the consumer-patient subject, it makes sense to start with the provincial government's most recent mental health care strategy and its impact on the LHINs. This strategy, OMHM, is arguably the most overt expression of the desire for privatization, independence in daily maintenance and labour force attachment, and the consumer-patient subject. At the same time, the local community and LHIN also reproduce these trends, often as a condition of funding.

2.6.1 *Open Minds, Healthy Minds* and the Social Determinants of Health

I contend that the Ontario government's most recent mental healthcare strategy posits a symbiotic relationship between the well-being of people with mental illness labels and increased labour force attachment, independence, reduced service use and cost-savings. This is not, however, to

suggest that the province is not spending money in the area of mental health care or funding non-profit service providers. According to Ontario's Mental Health and Addictions Leadership Advisory Council (OMHALAC) report (2015), in 2013-2014 the province spent nearly a billion dollars in community mental health and addictions support. The question we must ask, therefore, is how is this money being spent and towards what goals? The priorities of OMHM, initially focusing on children but now entering the second phase, include efficient service delivery, early intervention, the creation of resilient and inclusive communities, and integration and coordination. The strategy, and the Minister's Advisory Group report (2010) (entitled *Respect, Recovery, Reliance: Recommendations for Ontario's Mental Health and Addictions Strategy*) on which it was based, recognizes the struggles of people with mental illness labels with poverty, homelessness, unemployment, racism, sexism, homophobia, and social exclusion. These documents, however, do not provide much context for the material causes of these issues; instead, the government proposes that these oppressions are primarily grounded in a lack of understanding and acceptance of people labelled mentally ill and other marginalized groups. Instead of providing people with the material means to sustain daily life, the strategy sets out people's access to the social determinants of mental health (defined as education, employment, income, housing, and a sense of competence and connection) as fundamental to good mental health. These social determinants are presented as something the province is striving to provide people with the opportunity to access for the purposes of wellbeing and economic growth. Businesses are encouraged to promote good mental health in the workplace to combat absenteeism and to improve productivity, while communities and families are encouraged to improve their knowledge and strategies for addressing mental health to ensure appropriate service use and early intervention to minimize the cost and effects of mental health issues. While indeed

all of these factors are important to sustaining good health, little consideration is given to whether employment opportunities and social supports in Ontario at this time that would support good health.

The MOHLTC, rather than focusing on equalizing or increasing access to a variety of programs for people with mental illness labels (or all people), directs attention to anti-stigma/discrimination campaigns, the integration of mental health services, streamlined assessment and referral systems, and the promotion of inclusive communities. This model of service provision promotes efficiency, self-determination, and the creation of supports tailored to the needs of individuals and their communities while addressing problems of discrimination that impact those labelled mentally ill. By identifying social determinants as something to access as a society through individual efforts and appropriate program changes, like better coordination, government places responsibility directly on the shoulders of service users themselves, and gears their programs towards creating opportunities for “success.” The structure of mental health care establishes “normal” behaviour as engaging in the processes of capitalist production. This social determinants model guides funding arrangements, program design, and outcome measurement in those programs directed at people with mental illness labels that fall under the purview of the MOHLTC.

2.6.2 Local Health Integration Networks: Decentralized Control

Responsibility for the integration of the social determinants model and the OMHM framework more broadly rests with both the Ministry and its decentralized regional health care bodies. On the heels of the CHT and CST split, the MOHLTC in Ontario further entrenched downloading through the development of the LHINs. Ontario is now divided into fourteen of these LHINs (previously the smaller and more numerous District Health Councils), which are non-profit

organizations that have the “authority to manage their local health systems” (*Local Health System Integration Act* [LHSIA], 2006, see also Ontario’s Local Health Integration Networks, n.d.).

Under the LHSIA, LHINs are responsible for funding (or not) many health care providers, including community mental health and addiction agencies. Funding is provided to a LHIN “on the terms and conditions that the Minister considers appropriate,” but LHINs are permitted to “provide funding to a health service provider” within their geographical area (LHISA).

According to the LHIN Priority Setting & Decision Making Framework Toolkit (LHINCollaborative, 2010), there is now a common priority setting framework for the LHINs within which alignment with Ministry goals is a key criteria for funding. The Central LHIN Discretionary Funding Allocation Process for 2015-2016 document directly states that those proposals which do not align with LHIN priorities will not be evaluated or considered for funding. Given the close relationship between LHIN and the MOHTLC goals, elaborated on below in terms of mental health care specifically, it is clear that, to obtain funding, there must be an alignment between the goals of the service providers and those of the MOHTLC. In this way, the service providers, as a practical requirement of their funding conditions, are acting in the interest of the government and, as Brown (1992) would argue, are in many ways serving as an arm of the state. This is congruent with McGrath et al (2012), whose study pointed out that, in community agencies under neoliberalism, there is competition for funding among community services, and funding is often contingent on the ability of an organization to construct themselves in a manner that is compatible with government goals; in this particular study, in line with the promotion of partnerships among NPOs.

Martin and Hirdes (2009), reviewing mental health care in Ontario, refer to a 2008 report by Addictions Ontario, the CMHAO, CAMH, and the Ontario Federation of Community Mental

Health and Addictions Program, and demonstrate that only half of Ontario's LHINs prioritized mental health care. OMHM does refer to increased focus by LHINs on mental health and addictions and the need to streamline and invest in community services across the province, but, as is seen below, LHINs play an important role in perpetuating privatization and demands for independence as wellness.

The decentralized system of care and the focus on community partnerships evident in the LHINs' strategies is consistent with the triumph of the particular flavour of neoliberal redesign of community agencies, the consumer-patient subject, and the funding patterns favoured by the Harris government. It is not simply that responsibility has been relocated from the government to the community; indeed, how this responsibility is articulated remains overwhelmingly top-down. According to McGrath et al. (2012), the 1990s in Ontario saw market principles applied widely to the structure of non-governmental service providers. This approach has been further embedded with the development of the LHINs. Taking the form of contract funding opportunities, competition among agencies for funding and a focus on efficiency, non-profit organizations are now expected to collaborate with business and government for the delivery of services within a local area. The stated goal of the provincial government is increased efficiencies through the pooling of resources between and among "community partners".

The provincial government organizes the policy strategy, the parameters of LHINs' responsibilities, different assessment tools and accountability frameworks, and funding. LHINs, in turn, evaluate health needs in the appropriate catchment areas, provide funding to community services, and help in the implementation of the provincial health plans. While there are still some programs administered directly by the provincial government, such as some high-support housing programs, much of the responsibility for funding falls to the LHINs. Community-based services

may apply to receive funding through their LHINs; otherwise they may apply to other provincial, federal, and/or municipal programs, or they may not receive funding at all. The goal of the LHIN system is to promote efficient health care delivery through the coordination and integration of health care services. The province retains control over what constitutes appropriate (fundable) psychiatric treatment through these funding agreements, but it has distanced itself from full financial and administrative responsibility for the largely chaotic and uncoordinated treatment system (LHSIA). For example, LHINs provide funding from the MOHLTC to Health Service Providers (a LHIN term of art) who apply for financial support. The LHINs Integrated Health Services Plans (IHSPs) closely adhere to the priorities and understandings set out by the provincial government, and in particular, the most recent government strategy. The product of this mental health care system is an approach to treatment services that involves downloaded responsibility to communities, increased reliance on the non- and for-profit sector for service delivery, and greater responsibility for service providers, families, and those accessing services to navigate this network of services. A survey of the LHINs' IHSPs for 2013-2016¹⁴ reveals a commitment to the social determinants model as articulated in OMHM in the mental health and a social determinants framework of health care more generally. While the majority of the IHSPs do not expressly use the term social determinants, most recognize the role of employment, education, income, housing, and/or social inclusion in the quality of life of people with mental illness labels. There is, however, a persistent attribution of social problems facing this group to a lack of coordination and integration of existing services, as well as to individual attitudes. The focus of policy is on changing the design and operation of mental health care programs to promote independence, reduce stigma/discrimination, and streamline access. While all IHSPs

¹⁴ North Simcoe Muskoka LHIN was omitted as the IHSP was not retrieved.

focus on the need to improve mental health care services for communities, the plans are structured around the principles of fiscal restraint, the promotion of economic growth, and the corresponding need to change how services are provided and how service users and providers behave in the new framework.

According to the Toronto Central IHSP, health care costs in Ontario have grown at a rate of 6.1% annually from 2003/4-2011/12 and mental health and addictions are estimated to cost Ontario \$39 billion each year. This same IHSP states that people with complex health issues (which includes mental health issues and addictions - also called the “sickest”) make up 1% of the population, but account for one third of health care costs, while 5% of the population accounts for half of all health care costs in the Toronto Central LHIN. According to this thought trajectory, by changing how people access the mental health care system and reducing expressions of “mental illness” that result in unemployment, homelessness, and poverty, money can be saved.

In keeping with the mandate to build resilient and inclusive communities, LHINs are focused on developing self-management programs (IHSPs from South West, Central West, Central, Central East, Mississauga Halton), the promotion of healthy habits and coping mechanisms (IHSPs from South West, Mississauga Halton, Erie St. Clair, North West), supports for informal caregivers and families (IHSPs Erie St. Clair, Toronto Central), and the use of “appropriate” services through system integration (all IHSPs). Priorities include reducing the use of emergency departments/rooms as sites of care for people with mental illness labels, and implementing single points of access with standardized assessment and referral processes to improve “navigation” of mental health care resources.

The underlying message of the LHINs' strategies is clear, and consistent with that of the provincial government. Privatization of services will remain in place, and people with mental illness labels need better access to services to achieve the social determinants of health, and there is a need to build on the inherent resiliency of human beings to “manage the ups and downs of life” (OMHM, p. 7). Those who achieve these social determinants will be independent from the state to the greatest extent possible, and engaged in the promotion of economic growth both by reducing their use of state-funded services and through labour force attachment.

This focus on resilience, recovery, and the downloading of individual responsibility, along with the rise of the consumer-patient, is congruent with national and international trends. Ramon et al. (2009) conducted a comparative study of the notion of recovery in mental health approaches between Australia, Israel, and Canada, and found that recovery was indeed strongly promoted in Canada generally, and in Ontario specifically, through decentralized service provision, inclusion of consumers in policy design, implementation and evaluation, and the recognition of informal supports.

When analyzing the policy strategies of the MOHLTC and the LHINs, it becomes clear that their goal is to bring services (as well as service providers, largely in the non-profit sector) more fully into line with contemporary patterns of production both for surplus and social reproduction. It is important to question the form and content of this inclusion, and to trouble the notion that a greater incorporation of people deemed mentally ill into the contemporary labour force is a route to ending their oppression. Scholars have documented the declining employment standards and intensified demands placed upon those people – especially women and immigrants – performing both paid and unpaid social reproduction work in Ontario (Baines, 2004; Arat-Koc, 2006; Vosko, 2006; Braedley, 2012). Nevertheless, there has been no recognition of the barriers created by the

dynamics of deregulation and intensified paid and unpaid work demands in the lives of people with mental illness labels when seeking out the form of independence encouraged by the state. To be clear, the lack of secure, well-paying employment and substantive social supports directly contributes to the poverty of all Ontarians. For people with mental illness labels, who are routinely positioned as burdens on society, the economic hardships of the contemporary moment are reduced to individual sickness. The experiences of these individuals, while unique, are not separate from the wider struggles of Ontarians in the face of neoliberalism, and there is a need to trouble the notion that independence in any or all aspects of surplus production is an appropriate goal in the current context.

It would be erroneous to argue that the equation of work with recovery deepens the acuity of capitalist relations in the lives of people with mental illness labels, as certainly institutionalization served a particular goal of earlier phases of capitalist by dealing with those very people were marginalized by the organization of production (Busfield, 1986). However, it is accurate, I argue, to say that the continued privatization of mental health care services and the expansion of the demand to shape one's whole life to fit with the production of value into the lives of people with mental illness labels cannot be considered progress. Rather, it is indicative of a deepening of demands for productivity in every moment of life for all people, and is being mobilized not only by government but by those community-based organizations which emerged to address the problems of poverty created by the capitalist mode of production.

The emergence and entrenchment of the consumer-patient subject within social policy design, as well as the reproduction of this model at the level of (some) community service providers, operated alongside policy decisions made by the provincial government, and, to a lesser degree, by the federal and municipal governments, in responding to the crisis of deinstitutionalization.

The focus on private (i.e., market-based) solutions, such as for-profit care homes, the creation of a “disabled” category for welfare, the introduction of LHINs, and increased pressure on community partners, families, and individuals are all examples of policy strategies that create and stabilize transinstitutionalization in Ontario.

As I demonstrate in subsequent chapters, this increased emphasis on community-based service provisioning, especially without a significant increase in funding for room, board, and treatment, places increased expectations on service users, families, and non-governmental service providers under transinstitutionalization. Understanding transinstitutionalization as the result of poor planning, or as an accident caused by a misunderstanding of mental illness, overlooks the deliberate application of downloading, privatization, and individualization strategies in social and public policy. Furthermore, the logics and implications of these changes in how room, board, and treatment services are organized must be considered in light of declining labour standards and the privatization of social supports that occur under neoliberal globalization. As the intensification of un/under paid social reproduction work that accompanies the roll-back of social services proceeds, and the simultaneous intensification of precarity in the workforce continues, the ability of individuals, families, and communities to reproduce themselves (and capitalism itself) is threatened (Brodie, 2010; LeBaron & Roberts, 2010). While remaining state programs, community organizations, and informal arrangements between individuals provide some respite, the time and resources of these paid and unpaid service providers is not endlessly elastic. In the remainder of this work, I explore how this ensuing crisis is impacting both service users and service providers, and how the province is responding through the deepening of transinstitutionalization.

2.7 Conclusion

A history of transinstitutionalization demonstrates the complexity of, and common goals uniting, this loosely-coordinated network of services, namely continued privatization to the non-profit sector, the development of new understandings of mental illness aligned with resiliency and independence and, as will be seen in subsequent chapters, the use of privatized services to condition people to achieve independence (i.e. the social determinants of health). To state that transinstitutionalization is the unintended result of retrenchment erases the series of calculated policy decisions that prioritized individual responsibility, efficiency, austerity, and normalized patterns of behaviour and familialization. Although social policy directed towards mental health has changed significantly since deinstitutionalization, the goals of reducing, and ultimately eliminating, public responsibility for economic and social oppression are very much in progress.

As argued in this chapter, unplanned deinstitutionalization was not exclusively a result of neoliberal policies, but was initiated largely in response to the CAP during Canada's period of moderate Keynesianism (and Ontario's reluctant Keynesianism), and by focusing on creating normalized patterns of behaviour, including labouring for wage and mass production for mass consumption that relied on a male breadwinner/female caregiver form of social reproduction. Early expressions of transinstitutionalization developed in reaction to the crisis precipitated by unplanned deinstitutionalization in the late 1970s and early 1980s. Rather than provide fully-funded public mental health services to the deinstitutionalized population, the Ontario government, in keeping with broader trends in social policy and program restructuring at the provincial, national, and international levels at the time, introduced privatization measures, including contracting out services to private for-profit businesses, increased focus on family

performing the work of daily maintenance for people with mental illness labels, and a decreased focus on providing the necessary finances for mental health care.

When these marketization approaches to social problems failed to address the poverty, homelessness, and isolation of people with mental illness labels, a focus was placed on cultivating community networks at the regional level involving non- and for-profit organizations, businesses, service providers, consumers, families, and government. The focus on community network development is reflected in the *Gerstein Report*, the *Graham Report*, and *Putting People First*, which collectively demonstrate the unwillingness of the provincial and federal governments to commit to a publicly-funded and comprehensive mental health care system that would provide people with care services as well as supports for room and board.

The strategy of developing strong community-based responses was used, and continues to be used, to improve the coordination of the private provision of social work, and to encourage these providers to adhere to government mandates in order to secure funding. The strategies implemented to address the problems with the mental health system did little to address root causes, but instead further downloaded responsibility to communities, families and individuals, but with no sufficient increase in funding.

Today, people labelled mentally ill are defined as “disabled,” and are encouraged in social and public policy to be as independent as possible. This community is expected to select from the “market” of services that best suits their individual needs to manage their disability. Currently, the Ontario government is implementing a mental health strategy that posits compatibility between the autonomy of people with mental illness labels, economic growth, and cost-saving mechanisms associated with reduced state support (OMHM). This latest strategy creates a

picture of government, communities, businesses, non-profit organizations, service providers, families, and service users working together to achieve greater integration, to create opportunities for people with mental illness labels to access the social determinants of health and to promote cost-saving and economic growth. It is an attempt to further establish transinstitutionalization as a “best practices” approach.

What this chapter demonstrated, however, is how the prioritization of downloading and privatization of supports for daily maintenance was not only a key factor in the development of transinstitutionalization, but also failed to address the problems of poverty, homelessness, and isolation experienced by ex-patients. While the suffering caused by deinstitutionalization continues to attract a great deal of scholarly attention, what is often neglected is the political economy analysis of the mental health care system. As the Ontario government implements its latest strategy, there is an urgent need, given the failures of marketization strategies of the past, to critically assess the compatibility of this approach with the well-being of people with mental illness labels. I contend that the particular form of integration and independence being promoted in government policy is, in fact, incompatible with the goal of ending Mad oppression. Rather, this approach, and transinstitutionalization generally, seeks to “harmonize down” (Armstrong, 1996) the relation service users have with social services, and further integrates people with mental illness labels into exploitative relations of production, both in terms of production for surplus and in terms of social reproduction. The former is becoming increasingly precarious, and the latter increasingly demanding as a result. Yet, transinstitutionalization is more than just the privatization and restructuring of the services for people with mental illness labels; it also involves the development of demands for participation in surplus production or the mitigation of

its use in the reproduction of individuals with mental illness labels, which I address in the following chapters.

Related to the demands for increased participation in the labour force and independence in the activities of daily maintenance are the development of new understandings of mental illness labels that, together with decentralized and privatized approaches to service provisioning, stabilize this system of care. We have moved into a new phase in mental health care, transinstitutionalization, which involves new approaches to service provisioning, new pressures on service providers, service users, and their families, and new constructs of mental illness that render the diagnosed more compatible with surplus production (either by their participation or by pathologization and punishment, as will be seen in the chapters that follow). To understand transinstitutionalization, it is important to consider how its constituent policies around room, board and treatment are organized to serve an unfettered drive for capital accumulation, not only, or even primarily, by demanding labour force participation, but by reshaping the resources for and activities of the daily maintenance and dominant understandings of those deemed to be mentally ill.

Chapter 3 Treatment

This chapter starts from the position that treatment services in Ontario, although not bare necessities of daily living, are perceived and designed as necessary to the daily maintenance of people with mental illness labels, and should, therefore, be analyzed as such. Specifically, the biomedical model embedded in treatment services, namely diagnosing and medicating people, paints these services as necessary for daily maintenance and well-being. The dominance of the biomedical model can make it very difficult to discuss treatment policies, programs, practices, and institutions in their own right, but it is important to pull apart the different elements of the mental health care system in order to understand how each conditions the lives of service users to be more compatible with the neoliberal project and, by doing so, contributes to transinstitutionalization.

In this chapter, I consider the roles of both the privatization of treatment services and the biomedical model of mental illness in constituting a mental health care system that operates in the interest of cost reduction in the area of daily maintenance for the purpose of furthering the accumulation of capital. I argue that treatment services have been largely privatized at the level of NPOs in the interest of cost reduction. More than this, the work of providing treatment services, now downloaded to the level of NPOs, involves the reproduction of the biomedical model of mental illness, compatible with less expensive forms of treatment, as well as the promotion of independence in daily maintenance often defined as recovery by the provincial government. While it may appear that there are tensions between demands for independence and the biomedical model (which identifies people as irremediably sick), pathology and independence are brought together in the provincial government's recovery approach to treatment. The

recovery approach is the progenitor of the consumer-patient subject, and is central to the stability of transinstitutionalization.

The chapter is divided into two sections. First, I examine the privatization of treatment services to the level of NPOs and individual service users, paying close attention to the reproduction of the biomedical model of mental illness within the current network of treatment services. Second, I discuss how the biomedical model and demands for independence, largely reproduced through the work of non-profit service providers, have been brought together in the recovery approach to treatment presently promoted by the provincial government. I conclude with a discussion of the recovery approach and the consumer-patient subject.

3.1 Treatment as Distinct from Room and Board

All publically-funded services associated with daily maintenance for people with mental illness labels are conceptualized using medical language, and are often referred to as treatment or mental health care services (OMHALAC, 2015). These services include room and board, or housing and income supports directed at people with mental illness labels. Yet it is important to discuss medical treatment services apart from housing and income, as each area of social support has its own relationship with neoliberal social policy, contributes to the restructuring of daily maintenance in unique ways, and impacts service users differently. Treatment services, in particular, merit a separate analysis, as these services are primary sites where the biomedical model dominates.

I define treatment as those services associated with medical care, including psychopharmacology, psychiatric or psychological diagnosis, cognitive and/or dialectical behavioural therapy, and psychiatric nursing services. There is an admitted artificiality in any attempt to extract treatment

services from the broader pool of services provided to people with mental illness labels. I say such an abstraction is artificial because the inextricable links between treatment services and room and board (i.e. the medicalization of income support and housing services provided to people with mental illness labels), mean that all of these services are informed by dominant understandings of mental illness and prevailing best medical practices for managing “psychiatric disorders.” The psychiatric hospital may no longer be the primary site where room, board, and treatment are provided, but psychiatry and the biomedical model of mental illness continue to inform all aspects of government-funded, -directed, and -provided programs contributing to daily maintenance.

3.2 Treatment as a Service for Daily Maintenance

Treatment services are not always essential to the well-being of people with mental illness labels; they therefore do not always constitute a need. Yet some people with psychiatric diagnoses identify treatment services as necessary to their well-being (see Nabbali, 2009), making access to these services an important consideration in an analysis of a system of mental health care.

Indeed, people with mental illness labels have a complex and varied relationship with treatment services (Nabbali, 2009), as we will see in residents’ perceptions described in this chapter.

On the one hand, treatment services provide some people with sought-after access to the resources that support acceptable behaviours/identities, support participation in the labour market, and offer some insulation from more invasive forms of psychiatric intervention such as forced hospitalization and criminalization. On the other hand, treatment has often taken the shape of experimenting on and abusing people with mental illness labels (Simmons, 1990), and many scholars, activists and consumer/survivor/ex-patient (c/s/x) movement-identified people question the often coercive administration of medication as the primary means for dealing with

diagnoses of mental illness, emotional differences, and/or pain (see edited volumes Ben-Moshe et al., 2014; Burstow et al., 2014). Despite resistance to the biomedical treatment model, it remains dominant in the West (Moncrieff, 2008; Cohen, 2013). In Ontario, biomedical treatment services are perceived and clearly articulated by the provincial government as necessary to the daily well-being of people with mental illness labels. Indeed, this chapter shows that governments, non- and for-profit organizations, community members, service providers, and some individual service users generally proceed from such an understanding.

Whether one views biomedical treatment services as required, oppressive, or somewhere in between, these services undeniably comprise a central component of the mental health care system in Ontario. Moreover, as illustrated in Chapter 2, treatment services have been mobilized in various ways in Ontario's social policy over the course of the last two centuries to structure patterns of service use by people labelled mentally ill, as well as where and how people live and reproduce themselves. Treatment has become part of the infrastructure of the daily maintenance of people with mental illness labels living in the community; as a result, it is one of the core areas through which transinstitutionalization is constituted.

3.3 The Privatization of Treatment Services in Ontario

In considering the organization of treatment services under neoliberalism, I first map the privatization of these services to the level of NPOs, charitable organizations, and occasionally to private business owners. I then examine, through the case study of the housing sites, the immense amount of daily work required to make this treatment system function, and demonstrate how the biomedical model of mental illness is reproduced. I show how the treatment system relies on service providers as workers who experience intensified demands on their time and energies, as champions of a biomedical system of treatment, and as enforcers of the consumer-

patient subject, all of which work together to reduce the “burden” of the reproduction of the mentally ill on public resources.

3.3.1 Government Policymaking

Some scholarly and activist work has centred on the experiences and challenges faced by people labelled mentally ill in light of neoliberal restructuring in Canada and Ontario. The main focus of critical scholars in this area is often on the gaps in housing and income programs (Prince, 1998; Wilton, 2004; Chouinard & Crooks; 2005), on the problems associated with the anti-stigma and recovery campaigns, and on cultivating individual resiliency (Costa et al., 2012; Harper & Speed, 2012; Howell & Veronka, 2012). Very little contemporary academic work has reflected on the reorganization of medical treatment services in Ontario in the context of neoliberalism, what is considered appropriate medical treatment, what treatment is publically funded, how treatment is provided, and how treatment has become integral to the processes of reproducing people with mental illness labels.

During institutionalization, room and board were positioned as components of treatment, bringing together the services for the patients’ material needs and treatment services. The few community mental health services that existed under institutionalization and continued with deinstitutionalization were insufficiently resourced (Simmons, 1990). With the transition to deinstitutionalization, especially the ad hoc and unplanned form of deinstitutionalization implemented in Ontario (Simmons, 1990; Finkler, 2013), the provincial government continued to provide services directly associated with hospitals and/or physician care, while substantial portions of the work involved in treatment services were dispersed across multiple levels of government, the community, the private sector, and individual families; alternatively, these supports were simply not provided. In essence, deinstitutionalization removed the PPH as the

primary access point for treatment services, replacing it with the community (Marshall, 1982; Simmons, 1990). Non-profit and for-profit organizations, regional and municipal governments, and even provincial pilot projects were established and stretched to try to fill the gaps in treatment and other services (Marshall, 1982; *Gerstein Report*, 1983 & 1984; Metropolitan Toronto Council Minutes, 1986; Dear & Wolch, 1987; Simmons, 1990).

Although deinstitutionalization was, at least in part, about cost reduction, today, the provincial government maintains a significant financial and administrative commitment to the provisioning of medical treatment services, that is, physician services, including medication, diagnosis, and therapy and services provided in hospitals and clinics (e.g. out-patient mental health clinics or therapy). Specifically, the Ontario government funds psychiatric treatment in general hospitals (with the help of federal transfers), services within PPHs (without federal transfers), and some community-based clinic work (Canada Health Act [CHA] 1985, Health Insurance Act Ontario [HIA], 1990; Government of Ontario, Ontario Health Insurance Plan [OHIP], Health Force, n.d.). The provincial government also funds, in whole or in part, many of the services involved in the administration and implementation of treatment at the community level, typically through the LHINs (Ontario Non-Profit Housing Association [ONPHA], 2013) or through special program funding (Interview with Service Provider).

It would be erroneous to suggest that the government of Ontario has moved out of treatment services altogether. Rather, treatment services have been privatized, largely within NPOs, which receive varying rates of government funding, and which are shaped to reduce service use and associated costs to the public purse. In the area of mental health care, the LHINs' IHSPs closely adhere to priorities and understandings set by the provincial government, particularly the most recent provincial mental health care strategy, OMHM, which focuses intently on cost reduction.

While it is relatively simple to explain which services the province must fund pursuant to the CHA (hospital- and physician-provided services) and those services which receive funding outside of that framework (community mental health care services) (CAMH, About Therapy, n.d.; Government of Ontario, OHIP, Health Force, n.d.), it is beyond the scope of this dissertation to map the various funding arrangements that allow Ontario's many community mental health services to operate. A search within the provincially funded Mental Health Helpline, a database and initial access point for public, private, and public-private mental health supports, revealed almost six hundred counselling and treatment services in the province. Those provided for free outside of hospitals would have varying funding arrangements with the province, other levels of government and/or charitable donors.

Not only are funding arrangements diverse, but the work involved in contemporary treatment services is spread across an array of governmental and non-profit supports involving everything from occasional case-management to daily medication administration and supervision within high-support housing environments (Interviews with Service Providers). Broadly, drawing on the descriptions of funding arrangements provided by the government, CAMH and by service providers, this uncoordinated public treatment system is constituted by three overlapping modes of service provisioning (see Figure 1.0): hospital medical services (mode one), non-hospital medical services (mode two), and auxiliary services (mode three). The latter two modes together constitute the community-based treatment system that, while present during institutionalization to a small extent (Simmons, 1990), flourished with the transition to deinstitutionalization and the long period of policy experimentation that has followed.

In-patient hospital services and day-patient or out-patient hospital medical services (clinics) comprise the first mode, and are funded by the federal and provincial governments (although

hospitals do raise charitable funds, and some, such as CAMH, are run as non-profit organizations). Services comprising the second mode, non-hospital medical services, involve psychiatric, psychological, nursing, and counselling services paid for by the government but offered outside of the hospital environment, in clinics, housing sites, in-street health services, or through some other non-hospital outreach like drop-ins (Government of Ontario, OHIP Insurance Plan, Health Force, n.d.). The third mode, auxiliary mental health care treatment, includes everything from clinical case management to occupational therapy. Auxiliary service providers are typically social workers, mental health support workers, nurses, and occupational and recreational therapists often paid for by non-profit organizations (including those running high-support sites)), which cobble together funding from a variety of governmental sources, including grants from the MOHLTC, LHIN funding, municipal governments, and charitable sources (ONPHA, 2013).

Figure 1.0: Treatment Services in Ontario

Types of Care	Hospital Medical Services (mode 1)	Non-Hospital Medical Services (mode 2)	Auxiliary Services (mode 3)
Primary Funding Source(s)	federal government, MOHLTC, LHINs	MOHTLC, LHINs	non-profit organizations, government grants (all levels), LHINs, MOHLTC, charitable donations
Care Providers	hospital staff (medical and non-medical)	psychiatrists, psychologists, nurses, counsellors	social workers, mental health support workers, nurses, occupational and recreational therapists
Site of Service Provisioning	hospitals	community	community

The parameters of work for auxiliary care providers are not straightforward. The interview data demonstrate that some service providers working at the auxiliary level have “clinical” credentials (e.g. as nurses, registered social workers, and/or mental health support workers/clinicians), and provide associated clinical services such as cognitive or dialectical behavioural therapy or medication administration. The data also demonstrate that those who identify as clinicians do the daily work involved in the coordination of treatment, such as medication delivery, administration and supervision, finding available medical practitioners, blood work, communication between service providers and community treatment order teams, family supports, and filling in gaps in treatment. Service providers who are not clinically trained provide these same services (Interviews with Service Providers). There are no defined roles for people working at the auxiliary level, with workers doing everything that is necessary (Interviews with Service Providers). These unclear parameters of work reflect, in many ways, the substantial demand placed on service providers to simply make the system work.

While this downloading of day-to-day treatment may appear innocuous, or even as a progressive form of grassroots service provisioning, it is, as a system, critically underfunded. Not only do the majority of public funds go to hospital services (Auditor General Reports, 2008, 2010), but Ontario is below the national per-capita spending average on both mental health care and community mental health care (CMHA-Toronto, 2014). Moreover, because psychiatrists and other highly medicalized services receive the most secure funding (although there are often long wait times for these services [CAMH, Getting an Assessment, n.d.]), the current treatment system, which is presumed to facilitate freedom and agency, reinforces the biomedical model.

The biomedical model in these sites reflects, in part, the numerous medical and legal mechanisms made available through provincial legislation to encourage medication compliance (e.g.

involuntary hospitalization and community treatment orders (see Mental Health Act [MHA], 1990 [Ontario]). The province is clearly reproducing the view that medical treatment is necessary for people with mental illness labels, and has an interest in treatment enforcement. Yet the provincial government offloads much of the cost associated with administering and enforcing treatment compliance to service providers in the community. In essence, the majority of mental health care funds in Ontario are directed to services provided in hospitals, while people deemed to be mentally ill are encouraged, often through coercive mechanisms embedded in income support policies (see Chapter 4 below), to access services in the community. Either the majority of funds are directed to the hospitals because community mental health care services are so ineffectual that large numbers of people have to access hospital services, or the provincial government contains costs by allocating the majority of funding to hospital services, the usage of which it then actively discourages. In all likelihood, both explanations are, to some extent, true.

Indeed, the immense amount of work being performed by service providers and residents is not a dysfunction of the system, but a key design feature of Ontario's mental health care system. The work of service users in the private sector is essential to the functioning of a treatment system that operates to download and privatize, to the greatest extent possible, the costs associated with mental health care treatment. This relieves, or at least diminishes, the tax "burden" posed by people with mental illness labels, and ostensibly frees some of these funds to reduce budgetary deficits, lower taxes, or invest in programs that more directly contribute to capital accumulation (e.g. investing in businesses). The implications of these economic goals loom large in the lives of service providers and residents.

3.4 The Daily Work of Privatizing and Privatized Treatment

While the housing sites are spaces that reveal the worst effects of downloading and privatization, as well as the reproduction of the biomedical model of mental illness, they are also sites of care and personal fulfillment. Many residents spoke positively about their housemates and service providers, their satisfaction with their housing, the improvement in their housing situation or health since moving into a high support environment, and the contributions the residents themselves make to the house or to the wider community (Interviews with Residents). They also offered strident criticisms of the state of housing services in Ontario, the frustrating house rules, the (side) effects of medication, and their isolation (Interviews with Residents). The housing sites are, clearly, neither entirely liberating nor entirely oppressive. These somewhat contradictory spaces provide a useful window into how the dual thrusts of neoliberal pressures to download, privatize, and individualize treatment services and changing understandings of mental illness operate together to structure treatment services in a manner compatible with the pursuit of cost-savings in the area of the daily maintenance of people with mental illness labels, as well as in social reproduction more broadly.

All of the residents interviewed had been hospitalized at some point due to a psychiatric diagnosis, with in-patient tenures ranging from a couple of months to eight years. All were prescribed a regime of psychiatric medication, and saw a psychiatrist and/or general practitioner regularly for medication monitoring. Some were attached to ACT teams or external case management programs. No one had a therapist, but many received intermittent cognitive or dialectical behavioural therapy from case managers or staff, while many residents sought informal therapeutic relationships with staff. The staff performing the everyday work involved in treatment included nurses, mental health support workers, general support workers, and

occupational therapists, while members of ACT teams, probation and parole officers, care coordinators supervising community treatment orders, and case workers from outside services also provided supports to specific residents (Interviews with Service Providers and Residents).

Medication is still the primary mechanism of medical treatment within these housing sites, and all residents have been prescribed psychopharmaceuticals by a psychiatrist or a general practitioner (Interviews with Service Providers). According to the non-profit service providers, the coordination and administration of medication is a primary, if not their only, day-to-day task, and forms a major component of the work they do in the daily maintenance of residents (Interviews with Service Providers). The pharmaceuticals are paid for, with only a few exceptions, using drug cards provided to recipients of OW and ODSP support. The service providers working in a day-to-day capacity with residents were frank about the substantial amount of their workday spent coordinating access to biomedical treatment services and filling in the gaps around these services (Interviews with Service Providers).

Medication compliance involves maintaining contact with the psychiatrists and general practitioners prescribing medication, attending medical appointments, coordinating appointments with blood labs and injection services, and finding and securing funding for any non-biomedical therapies a resident might desire, although no one had a therapist at the time of my interviews. Staff members provide supports for or complete all of these tasks with residents, and also administer injections (nurses only), distribute medications daily to most residents, set up medication administration schedules that mirror those of a hospital, track symptoms, manage symptoms and (side) effects, explain consequences of non-compliance, note behavioural changes, and try to intervene in behaviours associated with crisis. The service providers see themselves as the arbiters of mental health care, keeping residents well through hard work. They expressed

frustration about the diffuse and underfunded treatment system that allows people with mental illness labels to slip through the cracks, about the absence of supports for personal goals and recovery (Interviews with Service Providers), and the problems with service providers from other NPOs who do not seem to care about their “clients” (Interviews with Service Providers).

This treatment model creates a dynamic in which service providers, who are active participants in the organization of daily maintenance of residents, are also workers who face challenges in their places of employment due to an increasingly lean set of social supports. They struggle to provide access to and coordinate services for their clients, and their designated role is to reproduce dominant views of mental illness and wellness, key to the retrenchment of services.

As stated, while control over what it means to be mentally ill, and what services should be accessed, remains with the province and the provincially-funded psychiatrists (who are in some cases formally attached to these housing sites), service providers do the work of communicating, coordinating, and enforcing psychiatric treatment, and with it, the biomedical model of mental illness. As one service provider stated, “we know [the residents] so well that when [they get] sick, we call the doctor to take them for assessment, and we can avoid sending them to the hospital long term” (Interview with Service Provider). The day-to-day work of reproducing the biomedical model of mental illness and treatment has been so successfully downloaded to the third level of care (a process facilitated in large part, I suspect, through conditional funding arrangements with the MOHLTC and LHINs that require adherence to provincial priorities), that the constant physical presence of the physician is no longer necessary for managing the behaviours and movements of people labelled mentally ill.

3.4.1 Treatment as Necessary

Service providers, while aware of the need for more funding (Interviews with Service Providers), are not as concerned with the articulation of the biomedical model of mental illness that governs their day-to-day work. In operating from the perspective that psychopharmaceutical medication is a primary, if not the only, mechanism for addressing mental illness, the service providers are reproducing the biomedical model, which defines mental illness as an individual pathology that can be treated (but, notably, not cured) with medication. In keeping with the biomedical model, medication compliance is mandatory at some sites and encouraged in others (Interviews with Service Providers), with service providers explaining the potential consequences of non-compliance, such as hospitalization or loss of housing, as follows:

We have clients who politely decline to take their medication sometimes, and we respect that. [The staff ensures that residents] have information about what may happen if they do refuse their medication. If they decompensate and they go into hospital and it becomes a long hospitalization, it may put their housing at risk. [We just make] sure that they are aware of symptoms [indicating] that they are becoming a little bit unwell, [and ask]: What is the crisis plan? What do they want us to do if we recognize signs and symptoms (if they mention [them] to [service providers])? What would they like us to do to help them out? (Interview with Service Provider)

Service providers all use the language of mental illness, and see medication as necessary to resident well-being. Those residents who are compliant with medication regimes are seen as doing well, while those who are not are often referred to as not doing well or “decompensating” (as in experiencing a decline in their capacity), or as at risk of decompensating (Interviews with Service Providers). Moreover, independence in medication compliance is viewed as an indicator of wellness. For example, when I asked about mandatory medication compliance, two service providers explained its centrality to well-being, and how it is a measure of independence:

As far as medication goes, if someone [can] prove they can be compliant on their own, and we do have them, they do it. [There are] those who have proven the opposite, not willfully but by forgetting... they need a structure... It is case by case, but [medication support] is necessary and 75% need help. This is why they succeed where they are and might fail where the worker just comes by and throws them a blister pack [of medication] and leaves. (Interview with Service Provider)

Some people do it on their own, [maybe] two or three people. [Others], they still need a little push. We give them the meds because they cannot [take medication] themselves. They don't remember their medication and sometimes say they don't need their medication. We say, "Yes you do. That is why you are doing very well, [because you are] taking the medication." (Interview with Service Provider)

While some residents identified with a biomedical label, others rejected the idea of mental illness completely (Interviews with Residents). Many expressed uneasiness with the label of mental illness, and were unwilling to identify themselves in a particular way (Interviews with Residents). One interview participant refused to address the question of mental illness, but spoke of what seemed to be medical (side) effects and a reluctance to take additional medication to address these issues (Interview with Resident). Despite the diversity of resident identities, the biomedical model of mental illness remains dominant and forms – with a few nods to the dialectic between brain chemistry and circumstance – the only lens through which resident experiences and behaviours are understood.

It is clear that treatment services, in addition to being generally organized around the biomedical model of mental illness, also promote psychiatric treatment as an integral step towards recovery (although, as noted, recovery is not understood as meaning cured). Residents who access the most support around treatment are understood as the most disabled by service providers, who routinely discuss step-down programs for people who are able to perform the activities of daily maintenance with fewer supports (Interviews with Service Providers). Those who are able to

manage their own medication, tolerate (side) effects, who can be successfully stepped down from intensive supports such as ACT, and attend appointments on their own are seen as closer to recovery; that is, better able to manage their mental illnesses. As one service provider put it when discussing the reduction of service for residents still living in the housing sites:

[Within the high support program] they are given the opportunity to live independently. [They have their] own apartment and space and they [also] have the consistency of staff support with medication and looking after the home and develop[ing] their skills so they are able to take on a little more independence and some of these roles. We have clients who, when they first came in, couldn't cook. But, after two years, are cooking and grocery shopping independently.... It took two years to consistently work on those skills and get them to that point. And now we are able to transition [to] where they don't need the support anymore, and maybe [a case manager] will see them a couple of times a week. (Interview with Service Provider)

Wellness, in this way, is not only aligned with treatment compliance, but also with a reduction in service use (e.g. medication monitoring, coordination, money management, cooking), and, as the province would put it, with “resilient” individuals. This directly reduces demands upon public funding, as well as other decommodified supports.

The work involved in managing people with mental illness labels is not only downloaded to non-profit service providers, but also to residents of high-support housing sites themselves. While it is unquestionable that having greater autonomy over one's own daily life through independent money management, for example, is important and desirable for many people, dependence and independence are being read through a medical lens – the former is equated with being less well and a “burden” on the system, while the latter is viewed as evidence of doing well and reducing the use of publically funded services. To be clear, it is not the provisioning of skills for independent living that is problematic; rather, it is the narrow view of wellness defined solely in relation to capacity to comply with a medication regime which is troubling.

Indeed, the biomedical model's conception of wellness and recovery, reflected in government policy and the language of service providers, aligns compliance and independence with wellness. This critique should not be read as a call to resist medication (as everyone labeled mentally ill should act in whatever way they judge best), or to indicate that people with mental illness labels should not work towards independence. Rather, it highlights the fact that medication compliance, and especially independent medication compliance, reproduces and further downloads to the individual an understanding of mental illness (and wellness) grounded in the biomedical model, an indispensable component of a transinstitutionalized mental health care system. Without a model of mental illness that simultaneously validates an understanding of mental illness as individual pathology, and wellness as independence in the activities of daily living, it would be far more difficult to maintain transinstitutionalization as something other than a naked example of neoliberal public policy attempts to reduce the public cost of social services.

3.4.2 Compliance as Wellness

The focus on a consumer-patient who is accessing the “appropriate” services, compliant with their individualized treatment regimes, socially integrated, and, most importantly, independent, is presented as the “happy,” “healthy,” and “resilient” success story. Examples of successful consumer-patients who have achieved the social determinants of mental health are often included in government reports and strategy papers. The use of the stories of individual people, as Costa et al. (2012) point out, legitimizes existing models of service provision and enforces a model of behaviour. This model of the ideal consumer-patient minimizes the negative experiences some people have with the treatment system, such as involuntary institutionalization and the effects of medication, or tense relationships with service providers and family.

Independence in medication compliance as “success” was a narrative readily put forward by staff and residents interviewed. The ability to self-administer medication was rare but could result in reduced supervision or even a change of housing (Interviews with Residents and Service Providers). According to staff, those who self-administer medication are fairly few:

We monitor about 90%+ of meds for our clients. [Many clients have had] such lengthy hospitalizations, and things are so structured in a hospital environment, you don't have to worry about remembering to take your medication because someone does it for you. And it works well, everyone has agreed to it. As we see it, people are becoming more and more independent in other areas, [and] we do encourage [and support this independence]. If [what is required is a reminder to take] the medications in your [unit], then we will do that as well. (Interview with Service Provider)

We found that holding all their medication and continuing what it was like in the hospital has worked really well because it is something they are in routine for. But we have down-stepped [some] people. (Interview with Service Provider)

[Some residents] have achieved a level of ability where they could move into a reduced level of care, manage their own meds and have someone check in... they could manage. (Interview with Service Provider)

These quotes indicate that those who have greater independence in medication compliance are seen as doing better, and do achieve some measure of freedom from the gaze of service providers. The idea that taking medication is necessary due to impairment, and that independence, despite this impairment, is achievable for some through adherence to psychiatric treatment, represents a blending of the biomedical model of mental illness and the individual responsibility fundamental to the neoliberal project. The seemingly contradictory notions that a person with a mental illness label must take their medication in order to function, and the drive to promote their independence in everyday life, are not only present in the housing sites, but are communicated by the provincial government, as well as by organizations such as the Mental Health Commission of Canada (MHCC) as discussed in the final section of this chapter.

3.4.3 Gendered Work?

The feminization of work is often apparent in social service provisioning, but this gendered division of work was not present in the coordination and supervision of treatment in the housing sites. The interpretation of symptoms, construction of diagnoses, and the design of treatment plans are impacted by the prevailing gender order (see Busfield, 1996), but the work of service providers involved in everyday treatment was not obviously organized along gender lines. It was surprising that service providers in the housing sites were not primarily female, when women are “disproportionally represented” in health and social service sectors (Armstrong et al., 2008, pg. 90).

The fact that equal numbers of male- and female- identified support workers were employed at the sites raises the need for further inquiry. Why do these housing sites seem to be an exception to the rule of the feminization of work in the social service sector? It is possible that a life course study, focussed on the experiences of service providers and with family members and friends of residents, would demonstrate the expected gender patterns in the area of treatment, but such a course of inquiry was beyond the scope of this study. I suspect that the largely male population of residents in the housing sites, coupled with the pervasive myth that people deemed to be mentally ill, especially men, are dangerous, has created a demand for a type of social service provisioning that is distinctly masculine. In other words, there is a need in the high-support housing environment for the presence of supervising bodies viewed as less likely to be assaulted, and perceived as having the physical strength required to intervene in circumstances in which residents behave violently.

3.4.4 The Complex Position of the Service Provider

It would be inaccurate to paint all service providers in this study as exploited or as lacking agency in the face of oppressive neoliberal reforms. Rather, the organization of the services and the experiences of providers and residents reveals how the pressures of neoliberalism create policies and spaces where service providers are doing the work of reproducing the biomedical model, coordinating treatment, while in the same moment, as with other service providers in NPOs (see Baines, 2004; Baines et al., 2009), their time and energies are being exploited in the process. Specifically, service providers are called upon to frame their clients both as sick and as capable of independence, and this work takes considerable energy which, as discussed above, is often unpaid and framed as doing a job well. Again, part of the structure of treatment services that facilitates reduced public expenditures and promotes a view of mental illness compatible with downloading and privatization is the exploitation of service providers in terms of their labour time, but this structure also includes the direction of the energies of service providers towards reproducing the biomedical model of mental illness and wellness, which plays a crucial role in maintaining transinstitutionalization. The work of treatment (although socially constructed as necessary in relation to the biomedical model of mental illness) is, clearly, socially reproductive work. This work is part of the reproduction of people with mental illness labels in the day-to-day, and is also involved in reproducing norms (like the biomedical model, and independence-as-wellness) and behaviours (those embodied in the consumer patient subject) that stabilize transinstitutionalization, and neoliberalism more broadly. The work of service providers and, as will be seen in Chapter 5 below, of residents, sits at the intersection of the competing interests of labour and capital over the amount of public funds to be spent on social reproduction. While often a response would be to provide additional funding, in the case of treatment services, where

biomedicalized definitions of experience are imposed, it is important to be cautious that a call for more support is not co-opted into a further reproduction of the biomedical model or legitimization of practices such as forced treatment.

3.5 The Recovery Model and the Consumer-Patient Subject

Transinstitutionalization involves the development of an understanding of mental illness compatible with the demand for independence in daily maintenance and, ideally, in employment. The question remains, however, how do demands for independence and the understanding of people with mental illness labels as sick co-exist? And how do these forces function in the solidification of transinstitutionalization? The apparent contradiction between sickness and independence finds its resolution in the recovery model of mental illness.

The recovery approach is a cornerstone of Ontario's current mental health care policy.

According to the federally-appointed MHCC, recovery is not “equate[d] with ‘cure’, but refers to living a satisfying, hopeful and contributing life, even when there are ongoing limitations caused by mental health problems and illnesses” (2015, pg. 11). The Ontario government, in OMHM, appears to endorse a recovery approach, as evidenced in its professed goal of supporting the “training of family health care providers on early identification and the recovery approach” (pg. 14), but is also focussed on creating resilient people, who can cope with the ups and downs of life and, thereby, achieve greater success in “school, work and life” (pg. 7) as well as early intervention for the purpose of reducing the “health, social and economic costs” (pg. 12) associated with their mental illnesses. While both the MHCC and Ontario can be critiqued for reproducing a biomedical model of mental illness, it is clear that the province has harnessed the idea of a “contributing” life in the creation of a mental health care system that operates to reduce its own cost.

The recovery approach serves two distinct functions in transinstitutionalization. First, it retains the ideas that people with mental illness labels are sick, that treatment is necessary, and that medication compliance is a primary indicator of recovery. It legitimizes an easily-downloaded treatment system wherein most of the work can be completed by non-profit service providers rather than physicians, and, ideally, by patients themselves. At the same time, in maintaining the view that people with mental illness labels are sick, the province retains legal and medical control over the lives of this group. This has the added benefit of maintaining the prestige of psychiatrists and the interests of pharmaceutical companies, although these are not the system's primary considerations. In a system where medication is the primary treatment, the recovering mental patient takes medication willingly in pursuit of normative behavioural patterns that facilitate access to the social determinants of health, independence, and autonomy over daily life. This understanding is the foundation of the consumer-patient subject. Put another way, the ideal mental patient, the consumer-patient subject, takes medication in order to reduce the use of other services, and as part of achieving independence in daily life, thus contributing to cost reduction in the area of mental health care and, ideally, contributing to surplus production by engaging in the labour force.

Second, the recovery approach, in preserving the idea that people with mental illness labels are sick, stabilizes transinstitutionalization – it explains the inability of people with mental illness labels to achieve independence in daily life or through labour force participation at a time when wages are low, employee benefits and other supports for social reproduction are being eliminated, and workplaces are inaccessible. The argument here is simple: when people with mental illness labels experience poverty, homelessness, unemployment, incarceration, and hospitalization, the most popular explanation is that they are mentally unwell. One service provider spoke about

problems with income support programs, the lack of opportunities for employment, and the low wages and lack of benefits their clients experience when seeking employment, and questioned whether criminalized activities can really be attributed to mental illness (Interview with Service Provider). But others who spoke about work, housing loss, or hospitalization pointed to symptoms of mental illness or the diagnosis itself as the root cause (Interviews with Service Providers). While these service providers are well aware of the economic and social marginalization faced by residents, and their attitudes can be understood as compassionate, they also explain away the poverty, incarceration, and isolation perpetuated by a mental health care system guided by the goals of cost-reduction coded as liberation.

Some government and community organizations also work overtly or subtly to suggest that mental illness is the root of social problems like homelessness, incarceration, and unemployment (e.g. MHA, the Homelessness Hub on Mental Health, n.d.; The Mental Health Strategy for Corrections in Canada, 2012). Such understandings of marginalization conceal how the very policies and programs that are supposed to address these hardships are actually implicated in their reproduction. Moreover, in defining people with mental illness labels as sick, the reach of the provincial legal and medical system into the lives of those whose behaviours are non-normative is preserved and justified. That is, the biomedical model maintains the threat of further psychiatric control and intervention, which can result in a loss of housing or, as one service user pointed out, more medication (Interview with Resident) – making it a significant deterrent to resistance to treatment, as well as a disincentive for seeking out treatment services.

3.6 Conclusion

Transinstitutionalization involves privatization of services for daily maintenance, shaping the activities of daily maintenance themselves to further both this privatization itself and

participation in all processes of capitalist production, as well as the promotion of an understanding of mental illness compatible with a system geared towards cost reduction.

Treatment, I have argued, is perceived as necessary to the daily maintenance of people with mental illness labels, and is organized to shape the use of treatment, and other services, in a way that reduces the cost of these treatments, thereby contributing to transinstitutionalization.

In this chapter I have demonstrated how treatment services are extensively privatized, downloaded and individualized. This privatization of the administrative duties and day-to-day tasks involved in the delivery of treatment services takes the shape of private sector providers, in particular non-profit organizations, doing most of the work of communicating government mandates on mental health, while also filling in gaps in service provisioning, all with the aim of striking a balance between preserving the individual biomedical model of mental illness and keeping residents out of the hospital. This privatization serves to reduce the amount of public funds expended by the MOHLTC in psychiatric treatment, while allowing the provincial government to maintain control over who is defined as mentally ill, and what mental illness means in the public and social policy arenas.

I also examined how the biomedical model is reproduced through, and shapes, the activities of daily maintenance of residents. Taking medication is viewed as both a necessary activity of daily maintenance (due to illness) and as central to achieving independence in all aspects of daily maintenance for someone living with a mental illness label, such that those who achieve medication compliance or who independently take medication are seen as doing well. The private sector and individuals do much of the work involved in coordinating a treatment system that reproduces the biomedical model of mental illness.

Finally, I considered how the biomedical model of mental illness and demands for independence coalesce under neoliberalism, largely through the recovery approach that forms the backbone of Ontario's current mental health care policy framework. The recovery approach, which combines a biomedical understanding of mental illness with an emphasis on independence in medication compliance as indicative of wellness, further legitimizes a treatment system downloaded to the individual, and contributes significantly to the development of the consumer-patient, the person who mitigates their cost to society by achieving independence in the activities of daily living.

In sum, this chapter demonstrates how, under neoliberalism, treatment services operate in numerous ways to reduce their own draw on public funds, thereby serving the interest of capital accumulation. The downloading and privatization of the work involved in coordinating, overseeing, and enforcing treatment allows the provincial government to avoid some financial, and much administrative, responsibility for these services. The daily work of treatment itself is structured in a way that reproduces the biomedical model of mental illness, while also blending it with demands for independence, culminating in the recovery approach and the promotion of the consumer-patient subject. In short, treatment services are being reorganized to reduce the tax "burden" of the mental health care system in the interest of economic growth. The persistent dominance of categories of mental illness and biomedical interpretations of emotional and mental experiences and diversity within government, MHCC, and the housing sites themselves raise questions about the efficacy of the Mad movement and other critical engagements with psychiatry outside of the academy. I suspect that a major barrier to alternative interpretations / therapies is the fact that state-provided services for people with mental illness labels are largely medical, and access is, perhaps predictably, dependent upon a medical / psychiatric diagnosis. How do people outside academic and activist circles obtain access to alternative interpretations

and treatments/supports? Further research, and much work, are necessary in order to answer that question satisfactorily.

Chapter 4 Income Supports

Prevailing scholarship on the shape of Canada's income assistance programs under neoliberalism focuses on issues of access, low social assistance rates, mandatory work for welfare or workfare requirements, and the challenges facing recipients who are struggling to acquire sufficient resources to maintain themselves (e.g., Chouinard & Crooks, 2005; Wilton & Schuer, 2006; Bako, 2011). While scholars such as McKeen and Porter (2003) discuss welfare payments as part of the infrastructure of social reproduction, there has been little inquiry into the operation of these programs as supports for daily maintenance for people with mental illness labels, or how they shape the activities of daily maintenance in their lives. This gap in the literature is significant, given the high rates of poverty and the consequent dependence upon income assistance programs among people with mental illness labels.

The Canadian Survey on Disability (CSD) 2012 points to the significant role played by income support programs in the lives of people with mental illness labels. The data, collected between September 24, 2012 and January 13, 2013,¹⁵ indicate that the median personal income in Canada for people with a "mental health related disability" is \$14,700 (before tax). It is not surprising, therefore, that 57.8% of respondents with a mental health-related disability rely on some kind of income assistance program (e.g. provincial welfare, Old Age Security, Employment Insurance, Guaranteed Income Supplement) to meet their basic needs. It is likely that the median income in Canada among people with mental illness labels is even lower than the CSD data would suggest, and that their use of assistance programs is higher, because the CSD did not take into account

¹⁵ According to the Data Sources section of the Concepts and Methods Guide for the CSD, 2012, all data were "collected directly from survey respondents and derived from other Statistics Canada surveys" (para 3).

members of the Canadian Forces, anyone under the age of 15, anyone living in institutions¹⁶ or collective dwellings,¹⁷ or anyone living on First Nations reserves¹⁸ (Bizier et al., 2014).

Given the role of assistance programs in the lives of the so-called mentally ill, it is important to consider the unique ways in which they impact the daily lives of this group of people. In Ontario, according to *Brighter Prospects: Transforming Social Assistance in Ontario* (2012), a report commissioned by the provincial government, there were 299,003 cases (which includes both primary applicants and families), or 415,338 people, accessing the Ontario Disability Support Program (ODSP) in 2010. In this group of recipients, 39% of primary applicants (over 116,000) had a “mental disability.”¹⁹ In the same year, there were 251,757 cases, or 456,882 people, accessing Ontario Works (OW). While comparable data was not available about the health status of those on OW, *Brighter Prospects* reports that 70% of ODSP applicants were receiving OW prior to successfully transitioning to ODSP, meaning that there are likely a significant number of

¹⁶ “Institutional collective dwellings are general and speciality hospitals, chronic care and long-term care hospitals, nursing homes, group homes or institutions for the physically disabled and treatment centres, group homes for children and youth, group homes or institutions for people with psychiatric disorders or developmental disabilities, federal correctional institutions, provincial and territorial custodial facilities, young offenders’ facilities, jails and police lock-up facilities, shelters for persons lacking a fixed address, shelters for abused women and their children and other shelters and lodging with assistance services.” (Statistics Canada, Census Dictionary, 2011a) For full list of collective dwellings please see Census Directory, (2011 b).

¹⁷ The exclusion of people living in institutions and collective dwellings as defined above is significant when analyzing the mental health of Canadians. In the area of supportive housing alone there are 25,000 units in the country (to say nothing of shelters, other forms of housing for people with mental illness labels like Homes for Special Care and homeless people with mental illness labels) (MHCC, 2013). Those who experience the mental health care system most acutely were left out of this study.

¹⁸ Although I address the labour force experiences of the interview participants who live in collective dwellings, no interviewee identified as being a member of an Indigenous group in Canada or as living on a First Nations reserve. There is a need for future research on the specific experiences of Indigenous Canadians with mental illness labels under transinstitutionalization both on and off First Nations reserves.

¹⁹ This terminology can be confusing as the authors define “mental disorder” using the *Diagnostic and Statistical Manual of Mental Disorders*, which they state includes “psychoses, neuroses, addiction, autism and developmental delay” (pg. 44). The report, however, later differentiates between mental disability (39%) and developmental disability (18%) thus seemingly distinguishing between mental illness and intellectual disability. It is clear, therefore, that the authors initially lump developmental disability and mental disability together under the category of mental disorder, but later differentiate between the two when discussing rates of usage among people from different disability groups. It can be reasonably assumed, therefore, that this 39% is made up of people mental disabilities refers to people with mental illness labels.

people currently accessing OW who will qualify for ODSP on the basis of a diagnosis of mental illness. These numbers indicate how important income support programs are for people with mental illness labels. It is through income support that many people are able to pay rent in high-support and supportive housing programs, access medications, childcare programs, employment supports, education funds, and purchase food and clothing. That is, income support programs provide access to some of the resources required for daily maintenance.

Given the importance of OW and ODSP in the lives of people with mental illness labels, this chapter considers how Ontario's two income support programs contribute directly to transinstitutionalization. I provide an analysis of the OW and ODSP programs and associated policies, and draw on the experiences of residents and service providers to show the real-life implications of these programs for people dependent on them for some of the basic necessities of survival. I argue that OW and ODSP, like treatment and housing, are mechanisms through which the mental health care system and the daily activities and identities of people with mental illness labels themselves are shaped by the drive to foster accumulation in late capitalism.

I also demonstrate how, since the turn of the century, the government of Ontario has focussed on cultivating employment among people deemed to be mentally ill as a means of addressing poverty and the high cost of the mental health care system, including the cost of income supports. Against the backdrop of this governmental focus on employment, I consider the past and present labour force experiences of the residents, and contextualize these experiences within the literature on employment and disability. I argue that the focus on employment is not progressive because there is little consideration of the quality of employment available. Rather, the employment focus is a means of further reducing the cost of the mental health care system by encouraging

people to participate in wage work, thereby diminishing their need and eligibility for social services.

A feminist political economy lens, precisely because it pays attention to the often unpaid work involved in reproducing the self and others, provides new insights into how OW and ODSP encourage independence in daily maintenance *as well as* labour force attachment (in the case of OW specifically), whenever possible. In addition, the Mad Studies lens, which remains attuned to dominant understandings of mental illness, reveals where and how OW and ODSP reproduce the image of the consumer-patient subject, that ideal mental patient who contributes to cost-savings in the area of mental health care by mitigating service use (and, therefore, their own “burden” on public finances), and who participates in surplus production both in the labour force and at home.

4.1 Income Support as a Mechanism of Daily Maintenance

At first glance, income support programs appear to be only indirectly involved in the processes involved in reproducing the population, by replacing wages typically earned in the labour force. I argue, however, that Ontario’s two income support programs should be considered an integral part of social reproduction for two reasons. First, income support programs are not limited to providing financial support alone; they also provide services such as prescription drug coverage (see ODSP Directive 9.7 & 9.8 and OW Directive 7.2 & 7.3), which are clearly supports for social reproduction. Second, OW and ODSP not only provide the income necessary for the most basic means of survival (as defined by the provincial government), but also guide where and how the work involved in this survival takes place. In the same way that McKeen and Porter (2003) do in discussing welfare in Canada, I treat income support as part of, and central to, the

organization of social reproduction under neoliberalism and, specifically, consider how it shapes the daily maintenance of people with mental illness labels.

4.2 Ontario's Income Support System

Three elements of OW and ODSP reveal how income support programs shape the mental health care system, and service users themselves, to align more closely with the unfettered accumulation of capital: the privatization of responsibility for access and coordination to the private sector and onto individuals; discouragement of accessing more expensive services, such as hospitals, through punitive income support directives; and, the use of these same directives to promote normalized behaviours and identities that support reduced service use and, more generally, promote adherence to the model of the consumer-patient subject. I include, in my consideration of each aspect of income support programs, the experiences of residents and service providers who come into contact with these programs every day.

The distinction between ODSP and OW reflects the categories of the deserving and undeserving poor – a distinction revived with neoliberalism to distinguish between those who are seriously “sick” and those who are temporarily experiencing hardships (Teepie, 1995). OW is general welfare assistance, and is designed to promote labour force attachment through workfare provisions and low levels of income replacement. ODSP provides slightly higher rates of income for “impaired” persons, with optional participation in workfare programs. OW is available to all Ontarians, while ODSP is only available to those with a “substantial physical or mental impairment that is continuous or recurrent and expected to last one year or more.” The impairment experienced by ODSP recipients must also have a “direct and cumulative effect... on the person’s ability to attend to his or her personal care, function in the community and function in a workplace, result[ing] in a substantial restriction in one or more of these activities of daily

living”²⁰ (ODSP Act, 1997). Included in each form of income support are policies and interventions tailored to the “needs” of each group. In the case of OW, those accessing the program receive lower rates of income replacement, mandatory job training, and other workfare-related programming, such as job searches and counselling. As they are not sufficiently “sick,” those accessing OW must obtain any type of labour force attachment they can as soon as possible. For those accessing ODSP, the goal is to provide supports to maximize the independence of these individuals for long-term success.

This income support model was created in 1997, following the 1995 election of the Progressive Conservatives under Premier Mike Harris on their “Common Sense Revolution” platform. Among the many changes made by the Harris government was the replacement of income support provided through General Welfare Assistance, Vocational Rehabilitation Services, and the *Family Benefit Act*, with OW and ODSP (Chouinard & Crooks, 2005; Fraser et al., 2003), along with massive reductions in the rates of assistance. Administration of OW was downloaded to municipalities, which pay just under 20% of the costs of the benefit and half of the administrative costs, with the provincial government paying the balance. According to Lightman et al. (2006), this restructuring of income support is similar to the federal restructuring of welfare payments that occurred with the introduction of the CHST, which included a reduction in rates as well as the removal of the federal ban on workfare provisions. Under the 2015 regulations, those who access OW receive a monthly means-tested amount that depends on family size and structure. The base rate in 2015 was \$626 per month for a single person, as well as a card

²⁰ The impairment and its projected duration must be verified by a member of the College of Physicians and Surgeons of Ontario, a member of the College of Psychologists of Ontario, a member of the College of Optometrists of Ontario and/or a registered nurse with an extended certificate of registration (Ontario Disability Support Program Act, 1997. Regulation 222/98, 46 (1)).

covering pharmaceuticals and transit support if the individual is able to prove they have permanent employment and/or are attending school. To access financial support, recipients are required to participate in workfare activities.²¹ Individuals accessing ODSP receive close to \$1000 per month, and may also receive coverage for dental and vision care, prescription drugs, disability support items, and childcare.²² To gain access to ODSP, applicants must provide substantial medical information.

4.2.1 Privatized and Individualized Access

Although access to income support, especially the slightly higher rates and medical supports offered through ODSP, is important to many people deemed to be mentally ill, there are significant barriers to accessing these disability payments. An analysis of the ODSP application process demonstrates that the complexity of the application process itself, and the reduction in administrative support for those seeking to apply, serve to download responsibility to service providers and individuals in financial need. These two elements operate together to reward individuals who are able to complete this process independently of support from ODSP staff and/or who are able to seek application support in the community or the private sector through family, friends, and/or non-profit organizations (Fraser et al., 2003).

²¹ Assets for a single person cannot exceed \$2500. Some assets, such as a vehicle, pre-paid funerals, RESPs and business assets, are exempt from the calculation of asset limits (Ontario Works Act, 1997, Regulation 134/98, 38 & 39).

²² Typically a single person's assets must not exceed \$5000. Examples of exemptions provided by the Ontario government include homeownership, furnishings, and other "necessary personal items" such as clothing, a primary vehicle, pre-paid funerals, some amount of trust funds, RESPs, RDSPs and or "the cash surrender value of life insurance policies up to available limits"(Income support, Treatment of Assets, (n.d).). This group may work if they successfully complete an employability determination assessment to ensure their ability to pursue and maintain "competitive employment," defined as employment that pays at least minimum wage or equivalent, and create a job plan with their ODSP worker.

The application process for ODSP, according to the Ontario government, can take anywhere “from a few weeks to a few months” (MCSS, Income Support, n.d.). Governments and advocacy groups (e.g. Ontario Women’s Justice Network, ODSP, n.d.) alike suggest that those applying to ODSP who need money right away apply first to OW for immediate financial aid, and then access OW support to complete the more onerous ODSP application process.

There are two components to an ODSP application. First, there is an initial screening for financial eligibility, and second, once applicants have qualified financially (a process similar to that required to qualify for OW), provision of a disability determination package is required. Gathering the necessary information for the disability determination package can be a daunting task. Applicants must have proper identification documents, knowledge of and access to records pertaining to their financial situation, contact with the necessary medical professionals (who, ideally, are knowledgeable about the ODSP application process), as well as access to transportation, the internet, and/or a telephone for the purpose of acquiring and submitting forms and attending medical examinations. For those living in poverty, the financial outlay required to gather the necessary records and assessments is a significant barrier. Furthermore, according to a study by the Dis/Abled Women’s Network (DAWN), ODSP provides insufficient accommodations for those with literacy barriers due to disabilities (e.g. sensory disability, intellectual disability, learning disability), or those for whom English or French is not their primary language (Fraser et al., 2003). While some non-profit and community-based organizations provide assistance for the application process, individuals must have some knowledge of these services, and must feel comfortable disclosing their personal details in order to avail themselves of this kind of community-based support. For those who experience anxiety, depression, and delusions, the application process can be harmful (Fraser et al., 2003), because

gathering and disclosing personal information, visiting medical professionals, and waiting for approval can exacerbate stress. As a result, many individuals who would likely qualify for, and benefit from, ODSP are unable to apply, or are unable to complete the application process. These barriers have not always been in place.

Prior to 2000, case workers were assigned to all recipients of OW and ODSP to assist with the transition from the former to the latter and to address any problems with their ODSP payments and services. Today, applications to OW are done through a centralized call centre-based service (Fraser et al., 2003), and applications to ODSP involve an in-person assessment for financial eligibility, followed by an electronic referral to the Disability Adjudication Unit. No single person is responsible for an entire application.

In a study of the experiences of female recipients of ODSP, Chouinard and Crooks (2005) note the recipients' frustration with changes to the delivery of supports for those accessing ODSP. Recipients under the system that predated ODSP were assigned a single case worker, whom they identified as more accessible, having greater knowledge about individual recipients' situations, and being more aware of support services available in the non-profit sector and through other government programs.

Under the current system, recipients are expected to speak with any available worker about their problems or concerns, workers whom they may not know, who have large caseloads, and who are perceived to be less accessible. This sentiment was also expressed among my interviewees. One resident stated in relation to ODSP, "I'd like to meet them personally sometimes, you know? Who is taking care of me...?" (Interview with Resident).

A lack of accessible information further downloads the responsibility to individual recipients, and the decentralized non-profit and community organizations are involved in the ground-level

coordination of benefits and services. Indeed, the service providers I interviewed spoke of the effort involved in ensuring clients had access to ODSP and OW in order to pay rent (which is revenue on which these housing sites are dependent) (Interviews with Service Providers), and the difficulties coordinating with other case managers (Interviews with Service Providers).

While support for the application process has been retrenched and downgraded, the current application process also rewards displays of independence, such as applying without support or seeking out application support from non-profit and/or community organizations or friends and family. Those who are unable to apply “correctly” are either denied ODSP, or experience a much longer application time, and by extension, experience delays in accessing pharmaceuticals, acceptable housing, nutrition, and therapy. The arduous application process, and lack of social supports for those undertaking it, reflects the privatization of supports through discourses of independence and through increased responsibility placed on primarily non-governmental service providers, who, in the case of housing providers, rely on the shelter portion of income support to continue operations in light of low levels of state supports. The application process serves, therefore, the dual purpose of offloading some of the responsibility for support services to private sector service providers, as well as individuals, both of whom are dependent on the money, as well as the promotion and rewarding of displays of independence that comprise a fundamental characteristic of the consumer-patient subject.

4.2.2 Containing Service Use: Hospitalization

While the process of accessing income support indirectly promotes independence and reduced service use, the potential for the removal of supports for those who experience long-term psychiatric hospitalization directly promotes adherence to normative behavioural patterns and reduced service use. According to both ODSP and OW directives, if a person is admitted –

voluntarily or involuntarily – to a hospital, they are permitted to keep the full amount of their income support payments for three months. This allows them to maintain a residence and pay bills while receiving in-patient treatment. However, if after three months the individual remains in the institution or hospital, their shelter allowance can be reduced, depending on their family status. If the shelter allowance is reduced, the amount provided is equivalent to the personal needs assessment (OW directive 6.9.; ODSP directive 8.2). Hospitalization in a correctional psychiatric facility is treated as incarceration, and ODSP is not provided (ODSP directive 2.6), nor is OW provided to incarcerated persons (OW directive 6.12).

The potential loss of income, housing, and belongings is a powerful disincentive to seeking mental health care in institutions. Participants in a focus group study of the housing experiences of psychiatric survivors accessing ODSP spoke directly to this problem – namely, the fear of losing their homes, furniture, pets, and clothes as a consequence of long-term hospitalization (Forchuck et al., 2004). If an individual loses their housing while hospitalized, the search for affordable and safe housing must begin anew.

This policy effect was confirmed in the interviews I conducted. One service provider discussed the shelter gaps that arise when someone has to leave the housing site for medical reasons and ends up looking for housing again (Interview with Service Provider). Another discussed residents' hospitalization and loss of housing as potential consequences of failure to comply with medication regimes (Interview with Service Provider). One participant discussed the efforts involved in making individualized plans to permit a small amount of rental arrears (Interview with service provider), and another service provider explained that, in many cases, families pay the rent if ODSP shelter allowances are reduced as a result of long-term hospitalization (Interview with Service Provider).

Depending on the type of community-provided housing available, especially for individuals who require a high-support living environment, regaining access to housing can be a particularly difficult process, given the long wait lists for supportive housing. As one service provider stated, waiting for someone to die was often how people gained access to housing due to a long wait list (Interview with Service Provider). The difficulty of accessing ODSP or other programs without a fixed address compounds the difficulty of this situation. These directives, by financially penalizing those who access long-term hospital care, encourage people to access (often compulsory) treatment within the community rather than through sites such as psychiatric, rehabilitation, or general hospitals, which, as demonstrated in Chapter 3, receive the majority of provincial funding for mental health care. This element of ODSP and OW arguably promotes the use of services provided within the community, while buttressing the status of the “good” consumer-patient, who accesses the “right” services, thereby fulfilling one of the primary objectives of Ontario’s current mental health policy.

The OW and ODSP directives also encourage the downloading of the costs of institutionalization and the reduction of support payments to service providers, families, and residents. When I questioned non-profit supportive housing providers about these policy directives, I was informed that, for the most part, the residents did not experience long-term institutionalization precisely because the staff and residents’ families kept a close eye on them. When they did experience long-term institutionalization, mechanisms were in place (such as family support or individualized plans) to allow housing to be maintained (Interviews with Service Providers) even if ODSP payments were reduced. However, service providers are acutely aware of this directive, work hard to avoid loss of housing, and, as discussed above in Chapter 3, will sometimes communicate the risks of hospitalization to residents (Interviews with Service Providers). A

conversation I had with a service provider is instructive of the challenges posed by the OW and ODSP regulations for staff, families, and residents. These difficulties are especially important considering that the shelter portion of income support is part of the operating budget for all high-support housing sites.

Service Provider (SP): We never kick anyone out because they are in hospital.

We go visit and make sure [they are] getting better.

Researcher (R): And ODSP has no problem with that?

SP: If you are [hospitalized] longer [ODSP] cut you off. *The rent has to be paid* [my emphasis]. You never know how long [a resident will be hospitalized]. If they [are hospitalized] longer, the social worker will contact ODSP and ODSP is [put] on hold.

R: What happens to the room?

SP: [Our organization will] still hold it.

R: Even if they are not paying rent?

SP: Family [members] will pay.

R: So most people [who are hospitalized] keep ODSP?

SP: The check goes directly to the house.

R: And when it runs out you contact the family?

SP: Family keeps a close eye. [Nothing like this has ever] happened. We never kick out anyone because they [are hospitalized].

This conversation demonstrates a clear tension between the need for rent to be paid, the unwillingness of ODSP to pay in situations of long-term hospitalization, and the reluctance on the part of service providers to evict anyone. In these situations, the resident's family pays the rent, the organization absorbs the cost short term, or the person is evicted. In every possible instance, however, responsibility for the cost of housing in the event of long-term institutionalization falls somewhere other than upon the government. Not reporting hospitalization to the government was not mentioned as a strategy for maintaining housing for residents in any of the sites. Inasmuch as the decision to reduce income support is explicitly within the discretion of the Minister, there are undoubtedly instances wherein the administrators of income support are aware of a hospitalization, but decide not to reduce support payments.

There is an obvious need for ongoing housing support for those who experience voluntary or involuntary hospitalization, but fulfilling this need this would require the government to pay both the shelter portion of ODSP and OW and the costs of housing the hospitalized patient in the hospital environment.

Given the high rate of poverty and unemployment among this population in Ontario, and the large numbers of people who qualify for ODSP due to mental illness labels, such policies can only be understood as an attempt to limit public expenditures on the daily maintenance of these people. Specifically, the costs of mental illness are mitigated by encouraging service users to meet their daily needs through the loose network of services (provided primarily by non-profit organizations) and by pressuring service providers to implement measures to keep their clients out of the hospital. These financially punitive policies reveal that the province, as in the case of deinstitutionalization, prioritizes cost saving over the freedoms and well-being of people with mental illness labels. Voluntary and involuntary hospitalization means risking homelessness due to the dramatic undersupply of affordable housing, the prohibitions on maintaining personal savings while receiving income support, and the low rates actually paid to service users pursuant to Ontario's income support programs. This reality, coupled with directives that reduce income support services, is a powerful tool for reducing the use of hospital treatment by those with mental illness labels, and for enforcing normalized patterns of behaviour.

4.2.3 Controlling Behaviours and Identities

The previous two sections show that the language around impairment and access promote the biomedical model of mental illness, where directives related to hospital stays promote the use of primarily privatized services for daily maintenance. Ontario's laws concerning the voluntary and involuntary admission of individuals to a hospital for psychiatric assessment further promote the

reduced use of hospital services and behaviours and identities that escape the gaze of professionals who wield some or all of the legal and medical authority of the psychiatric system.

The only requirement for involuntary admission is the opinion of a medical doctor that an individual may cause serious bodily harm to themselves or others, or that the person's condition is deteriorating such that hospitalization is required. If a physician makes the decision that a patient is in need of psychiatric evaluation in accordance with these guidelines, the law allows for that patient to be held in a hospital for three days on a non-consensual basis. The doctor ordering the assessment must sign what is commonly known as Form 1, an Application for Psychiatric Assessment (APA) form, and the individual must be seen by a psychiatrist within three days of her/his hospitalization. In situations where an individual is unwilling to participate in an assessment, police are permitted to forcibly detain that person within, or to forcibly escort the individual to, a psychiatric facility (MHA, 1990; Psychiatric Patient Advocate Office [PPAO], n.d.).

Upon assessment, the psychiatrist can recommend admission. If the patient refuses to be admitted voluntarily, the psychiatrist can complete a Certificate of Involuntary Admission (known as a Form 3). This form changes the legal status of the patient, and allows the hospital to detain the patient within the treatment facility. A Form 3 lasts for two weeks, but the person can be further detained upon completion of a Certificate of Renewal (Form 4), which permits detention for another month. Upon expiry of the first Form 4, completion of a second Form 4 extends involuntary admission by two months, after which completion of a third Form 4 extends admission by another three months – such that one Form 1, one Form 3, and three Form 4 certifications can produce an involuntary admission of six months, two weeks, and three days. At

the end of this period, Certificates of Continuation (Form 4a) can further extend involuntary admission indefinitely, but by no more than three months at a time.

The patient has the right to challenge their involuntary admission status each time a new form is completed, with the exception of Form 1, which cannot be challenged. The Consent and Capacity Board automatically reviews involuntary status at the completion of the first Form 4a, and at the completion of every fourth Form 4a thereafter. Any voluntary psychiatric patient who decides to leave treatment can be “formed” and detained in the facility (see PPAO, n.d. and CAMH, Common Legal Forms Appendix C). What is more, judges can order a peace bond for psychiatric evaluation, and police officers can take a person into custody for evaluation if an officer believes that person to be a threat to cause serious bodily harm or serious physical impairment to themselves or others due to a mental disorder (MHA, 1990).

Although no substantial research has been undertaken on instances of income support reduction as a result of hospitalization, the fact that a person can be sent for evaluation upon the judgment of police officers, held against their will should they be “formed” and, as a result, potentially lose the shelter portion of their income support, housing and belongings, acts as a powerful incentive to avoid any public displays of behaviour that might bring them to the attention of authorities. Moreover, in those places where community treatment is not available, accessible, or desirable, an ODSP or OW recipient with a diagnosis of mental illness might opt not to pursue provincially funded treatment in hospitals or psychiatric institutions for fear of being held past the three-month mark identified in OW and ODSP directives. Community-based treatment, private treatment (if the individual can afford it), or no treatment at all may be seen to be “safer”, or at least more controllable, options, further solidifying the loosely coordinated network of services as the primary provider.

In addition to shaping the activities of daily maintenance and limiting the use of these services through income support programs, OW targets the other side of production, production for surplus, through its workfare provisions and low rates of support. As a condition of receiving OW, recipients must be engaged in employment assistance activities, and must look for employment (OW Directive 8.1). ODSP, however, only directly targets one aspect of surplus production, social reproduction, by shaping the activities of daily maintenance to reduce its tax “burden,” although recipients can apply to access employment supports and employment programs similar to those provided under OW. The arrangement of ODSP gives the impression that those receiving it are the deserving poor, are in need of income support due to impairment that is no fault of their own, and are therefore exempt from pressures to obtain employment. The presence of such exemptions from workfare and the slightly higher rates of support offered by ODSP appear to indicate that the provincial government acknowledges that some people cannot be employed at a rate that would allow them to maintain themselves.

The notion that people with mental illness labels who are not employed constitute the deserving poor is at odds with the province’s attempt to reduce the cost of the mental health care system. Yet the provincial government has not eliminated the workfare exemption under ODSP. Instead, the pressure for labour market attachment is coming from a governmental focus on improving employment rates among people with mental illness labels, the alignment of employment with recovery and wellness, and the identification of employment as a social determinant of (mental) health. Rather than compelling ODSP recipients to obtain employment the provincial government encourages employment among all people with mental illness labels. The next section examines the promotion of employment, and raises questions about what kind of

employment people with mental illness labels can expect to obtain, as well as whether such employment is likely to improve a person's health.

4.3 Promoting Employment

There is no question that unemployment is a significant problem among people with mental illness labels. According to the CSD, the employment and unemployment rates in Canada among people with "mental health related disabilities" at the time of the survey, were 35.9 % and 19.6%, respectively, compared to 73.6% and 7.3% among people without a disability. When disaggregated by province, the numbers among people with mental illness labels in Ontario are comparable to the Canadian average, with a 35.6% employment rate and a 22.6% unemployment rate (Statistics Canada, Table 115-0006). Again it should be noted that these numbers do not provide a full picture due to the exclusion of numerous groups from the survey. It is not likely, however, that the picture in Canada as a whole would be substantially improved by including the labour force experiences of people living in institutions, collective dwellings, or on First Nations reserves, or even the portion of the 68,000 regular members of the Canadian Forces with mental illness labels who are, by definition, employed (National Defense and the Canadian Armed Forces, Government of Canada, n.d).

The Canadian Mental Health Association Fact Sheet (n.d.) reports that 70% to 90% of people with serious mental illness face unemployment. While there is no citation for this statistic, and it is unclear how unemployment is measured,²³ there is no question that unemployment rates among people with mental illness labels in Ontario and Canada are extremely high. We know very little about the precise contours of labour force participation of people deemed to be mentally ill in

²³ It may be that non-participation in the labour force was equated with unemployment.

Ontario, but, despite this lack of knowledge, the province is attempting to deal with the problem of poverty and mental illness by promoting labour force attachment whenever possible, rather than providing non-poverty rates of assistance. Employment has been named by the province as a social determinant of (mental) health, thereby wedding labour force participation to recovery (OMHM). The current government strategy (OMHM) is overt about this aim, positing a sort of win-win-win situation for people with mental illness labels, taxpayers, and the economy when people with mental illness labels. Yet, neoliberal social policymaking (Raphael et al., 2008) and precarious employment (Benach et al., 2014) have been linked to health inequality, raising serious questions about the province's aims. If wellness and recovery are to be defined in relation to participation in all areas of capitalist production (production for surplus and social reproduction), then it is essential to consider precisely what type of employment and rates of remuneration are available for people with mental illness labels.

4.3.1 Targeting the Employment of People with Mental Illness Labels

After deinstitutionalization, mental health strategies like *Building Community Support* (1988) and *Putting People First* (1993) promoted community, family, and individual responsibility for the poverty and homelessness caused by deinstitutionalization, and further developed and coordinated the network of services for mental health care we know today. While inaccessible workplaces were understood to frustrate access to employment among people with mental illness labels and there was some attention to the need for vocational and social supports, it was with the turn of the 21st century that the province became focused on the employment status of the “mentally ill.” As part of the “Common Sense Revolution” platform, the Harris government developed *Making it Work*, a plan for bolstering labour force attachment among people with “serious mental illnesses” that was part of the broader mental health reform plan, *Making it*

Happen (1999). *Making it Work* identified employment as an important determinant of mental and physical health. It also identified the amount of services being accessed by this community as key to understanding both the duration and “the severity and chronic nature of the problem” of mental illness (p. 5). *Making it Work* marked the first concerted attempt both to download responsibility for the resources for daily maintenance to the private sector and families (in line with previous strategies) and to reposition the so-called seriously mentally ill as potentially productive members of the labour force, thereby justifying reduced access to publically funded supports for daily maintenance. This policy arguably marked the first attempt since institutionalization to sever the connection between mental illness and the category of the deserving poor.

Although it would be over a decade before the next mental health care strategy came into effect, the focus on labour force attachment has remained in place. OMHM promotes employment as well as reduced absenteeism among people with mental illness labels as part of the “recovery approach” to care. The provincial government’s current focus is on providing opportunities to “access the social determinants of mental health” (p. 12) and on service users acquiring the “resiliency” to deal with the ups and downs of everyday life (pp.7, 9). In this strategy, obtaining and performing well in employment is viewed as an important element in reducing “the personal, social and financial burdens of mental health and addictions” (p. 4), as well as in achieving the goal of lowering the per person cost of mental health and addiction services.

In short, as previously stated, the responsibility for mitigating the economic “burden” of mental illness lies with the individual, and mental health care policies and programs should be constructed in such a way as to promote (greater) independence from the state, both through employment and in performing activities of daily maintenance with reduced supports. Conduct

which results in the mitigation of the public “burden” is understood as recovery. Those people with psychiatric diagnoses who obtain independence from state services are perceived and celebrated as recovered/recovering, and are the protagonists of anti-stigma public education campaigns (e.g. Bell Canada Let’s Talk) that seek to eliminate discrimination and to provide greater opportunities for achieving the social determinants of mental health. Those who remain on income support and/or who use high-cost mental health care services (like hospitalization or ACT) are, by implication and in practice, seen as unwell, and cast as burdensome and sick.

The “sickness” label has significant consequences in terms of freedom from institutionalization and involuntary medication, and impacts how people with mental illness labels feel about themselves and conduct their daily activities. One resident captured the impact of the OMHM’s equation of the use of government services with sickness and being burdensome perfectly when discussing the volunteer work performed in exchange for \$100/month:

[Volunteering] is sort of working for taxpayers dollars anyhow. If you are working in the hospital [or] you are out delivering flyers or any job, it is like working for your own tax-paying money. It is not the same as living on [taxpayers] money but you are working for [that money]. That would be a good thing don’t you think so? Someday I will pass away and I want to leave something to someone as everyone who is proper in life should do. Like the normal and proper [thing] is to have something to leave behind. Not just sit there because I [have a psychiatric diagnosis] and think that I would have to blame [the fact that] I couldn’t perform... like [everyone else]. (Interview with Resident)

Encapsulated in this resident’s reflection is both the notion of being a “burden” on public finances and the need to mitigate this burden as much as possible; this is the basis of the consumer-patient subject, who, ideally, is employed, but who at least conducts their daily activities in a way that reduces their economic impact on the rest of society.

This is not to argue that people with mental illness labels should not be employed, or that the government should not aid in the pursuit of employment or take measures to end employment discrimination. Employment can be an antidote to the more repressive aspects of the mental health care system, such as the invasive medicalizing assessment required to access ODSP, or housing that enforces medication compliance. Moreover, employment can certainly offer people a sense of personal fulfillment, access to benefits (such as health insurance), and social connections. Indeed, residents valued employment, and wanted to return to the labour force if they were not employed. Many saw employment as an opportunity to be engaged in their communities, and some also aligned the ability to obtain employment with wellness.

If I was healthy enough [for employment] yeah... but even volunteer work is great. Being with different people, giving back to the community. There are a lot of things I like to do giving back to the community. (Interview with Resident)

I would like to work when I get better. (Interview with Resident)

I would love to work, but not right now [due to on-going legal issues]. (Interview with Resident)

I can't work because I'm too sick, but I wouldn't mind having a job if one day I can just stabilize my moods. (Interview with Resident)

The problem, evidently, is not the activities related to employment; people with mental illness labels certainly have the capacity to work, as evidenced in their use as sources of labour in care facilities in the past (see Reaume, 2009) and present (see Chapter 5 below). Residents also volunteered outside of the homes and received a \$100/month work-related benefit for this work (Interviews with Residents), indicating it is considered an employment activity under the ODSP employment supports program (ODSP Directive 9.1). There is no reason to suspect people with

mental illness labels cannot do the work involved in employment. The problem is the types of employment available for people with disabilities, and mental illness labels more specifically.

According to Wilton and Schuer (2006), “workplaces and labour processes in contemporary capitalist economies remain, at their very core, geared toward an able-body/mind norm” (p. 187).

As such, people with disabilities contend with barriers to employment such as inaccessible workplaces and hiring discrimination (Wilton, 2004b; Vick & Lightman, 2010; Hall & Wilton, 2011). This is especially true for women (Edwards & Imrie, 2003; O’Hara, 2004). Beyond barriers to employment itself, research indicates that there are greater rates of precarious employment among those with disabilities, and again, especially women with disabilities (Tompa et al., 2006).

Among the residents, use of ODSP was high (all but one was receiving ODSP), and participation in employment was low, with only two interview participants employed in a part-time capacity (Interviews with Residents). Two other residents, earned money by selling contraband goods and homemade crafts (Interviews with Residents), while, as stated, three other residents volunteered and received a small stipend from the province (\$100/month, ostensibly to be used for transit costs) (Interviews with Residents). While nearly all residents had been employed at one time in their lives, only four currently had access to active employment benefits and one had received “unemployment” insurance in the past (Interview with Residents).²⁴ Specifically, four participants, at the time of interviews, were receiving the Disability Benefit offered through the Canada Pension Plan (CPP) for people under 65 (Interviews with Residents).

²⁴ The interview participant differentiated between ODSP and unemployment payments, and indicated previously accessing Unemployment Insurance (UI), the predecessor of Employment Insurance, established in 1996, the federal program that replaces the income of people who are laid off (Lin, 1998).

The type of benefits available to residents, of lack thereof, speaks to the kinds of employment residents were engaged in. The capacity to access Disability Benefits through CPP means that the recipient contributed to the pension plan in four of the last six years prior to applying, or three of the last six years prior to applying if the applicant contributed for twenty-five years (Government of Canada, CPP, Disability Benefits Overview, n.d.). That none of the other residents interviewed had access to this benefit indicates that the jobs they reported having were either not formal employment, or that the time spent in employment was insufficient to allow them to qualify for the Disability Benefit under CPP. Given the research discussed above on the barriers to employment and high rates of precarious employment among people with disabilities, the low rates of access to benefits (such as the Disability Benefit under CPP) are not surprising. Service providers often attributed unemployment and poverty to the presence of a mental illness label, and sometimes to the stigma attached to residents as a result (Interviews with Service Providers). Only one provided an analysis of the kinds of employment available and the problems associated with moving off income support:

They go from having a cheque of \$1200 and no taxes to working at Wal-Mart for \$1200. Rent was \$109 and now it is \$360, and they are now paying taxes. And the formula [for rental subsidy] is on gross [income], not net. And you lose your health card/drug card. (Interview with Service Provider)

This service provider was pointing to the prevalence of low-wage employment faced by people with disabilities, and the unwillingness of the government to account for this reality when designing welfare programs or, I would contend, employment strategies.

If the type of employment available to people with disabilities does not provide a living wage, access to benefits like medical insurance, and/or sufficient hours to qualify for benefits like Employment Insurance or Disability Benefits under CPP, then it is unlikely to be the type of

employment that will support good health. If someone is employed, even part-time, and receiving ODSP, the government claws back 50% of everything over \$200/month up to the point where the individual no longer qualifies financially for the program. This means that, after 17.5 hours of work at minimum wage a month, every hour of work saves the province almost \$6 dollars in ODSP funding up to the point where the person is no longer eligible financially for ODSP payments (Ministry of Community and Social Services, Treatment of Income, n.d.)²⁵. There is little consideration of the types of employment available; in fact it appears that any job is considered a good job, indicating that the provincial government is less concerned with the well-being of people with mental illness labels, and more concerned with reducing the costs of income support programs.

4.4 Conclusion

In this chapter, I have argued that it is necessary to consider income support programs both in terms of how they encourage labour force participation in the interest of including more people in the production for surplus and reducing the use of state services, and in terms of how they operate to reduce the amount of public funds spent on recipients' daily reproduction within the mental health care system. As such, OW and ODSP should be treated as part of the mental health care system and the network of services directed at the daily maintenance of people with mental illness labels. I have provided an exegesis of OW and ODSP programs and associated policies, and considered how they operate to condition the usage of services for daily maintenance among people with mental illness labels.

²⁵ There are instances when all or a portion of the income earned over \$200 is exempt from the claw back. For example, childcare costs can be used to offset deductions and full-time students are permitted to keep all income earned.

In particular, I have explored how OW and ODSP directives around hospitalization condition recipients to access community treatment services rather than hospital treatment services, and to adhere to normative behavioural patterns. Those who are able to successfully navigate the ODSP application system, which provides insufficient application supports, are rewarded with higher rates of income support than those accessing OW, while those who avoid hospitalization are seen as doing well and adhering to the consumer-patient subject model. I have argued that, while OW is the only income support program that targets both daily maintenance and production for surplus, those people with mental illness labels accessing ODSP, as well as those also accessing OW, are subject to a mental health care strategy which focuses on labour force attachment, draws a direct link between employment and wellness, and operates to save money in the area of income support. I considered the past experiences of residents with paid work or employment, and raised questions about the kinds of jobs available to this group and whether those sorts of jobs would truly support good health, or simply reduce residents' use of public services.

The recognition – in both income support policies and in mental health strategies – that people with mental illness labels are not pathologically unproductive, and that many can participate in the capitalist economy, is a welcome change. Yet this positioning should not be read as singularly progressive; considered alongside OW and ODSP programs, the locating of people with mental illness labels as potentially productive participants in a capitalist labour market plays a key part in transinstitutionalization, a mental health care system that operates primarily in the interest of cost reduction.

Chapter 5 Housing

This chapter considers how housing services for people with mental illness labels contribute to transinstitutionalization. In discussing the role of housing services in transinstitutionalization, it is essential to first recognize that the housing services for people deemed to be mentally ill provide more than shelter; they also provide supports for the activities of daily living. Aside from treatment services, which was discussed in Chapter 3 above and will not be treated in depth here, housing sites provide varying degrees of support for cooking, cleaning and laundry, supports for coordinating access to the resources required for these activities, and supports for maintaining emotional wellbeing and family relationships. The particular kind of supportive housing that a person accesses depends largely on what is available to them.

In considering the role of housing for people with mental illness labels in transinstitutionalization, I first examine how shelter and supports that make up this type of housing have been downloaded, in large part, to the private sector – largely in the form of NPOs. I argue that the privatization of mental health housing was not part of the withdrawal of federal and provincial responsibility for social and subsidized housing at the turn of the 21st century, but rather was created pursuant to deinstitutionalization. In many ways, mental health housing was ahead of the curve for privatization. Where downloading and privatization took place with many other forms of housing subsidies in the 1990s and 2000s, this had already happened in the area of mental health housing during deinstitutionalization. Ontario, I contend, remains in the midst of the housing crisis for people with mental illness labels that was caused by deinstitutionalization, and which has been exacerbated or continued, but not caused, by neoliberalism. The provincial government, as with deinstitutionalization itself, is unwilling to take full responsibility for the costs of the housing services necessary for the daily maintenance of people with mental illness

labels. As such, the province keeps the economic costs of the mental health care system, which was raised as a concern most recently in 2011 in OMHM, at arm's length.

Second, drawing on data from the case studies, I examine the work involved in running high-support housing sites, highlighting the high level of demands placed on service providers under this model, and focusing in particular on the amount of work involved in daily maintenance being performed by residents. I argue that this resident involvement in operating the housing sites contributes to the functioning of the downloaded housing sites, and, therefore, to the government's goal of realizing cost savings in services provided to people with mental illness labels. I also consider how this work, which is encouraged by both service providers and government policy, reproduces the consumer-patient subject.

Third, and slightly differently from previous chapters, I examine how these housing sites, as well as the broader policy context in which these homes operate, limit the romantic, sexual and reproductive lives of residents. This social regulation reveals another dimension of the consumer-patient subject not readily exposed by the examinations of income support and treatment services undertaken in previous chapters. Specifically, I suggest that the consumer-patient subject, that ideal mentally ill person that transinstitutionalization seeks to produce, is not expected to have a spouse or children, suggesting that the consumer-patient model is, in some ways, eugenic. I also explore how these controls over reproduction relate directly to the goals of cost saving in the area of mental health care, and, specifically, in the daily maintenance of people with mental illness labels.

This chapter, therefore, considers three ways in which housing for people with mental illness labels in Ontario contribute to a transinstitutionalized mental health care system; through

privatization and downloading, through offloading of work involved in the operation of housing facilities to residents, and through the limitations placed on romantic, sexual and family life by housing policies as a condition of residence. Before doing so, I outline how housing fits into the broader scheme of services required for daily maintenance amongst people with mental illness labels.

5.1 Housing as Daily Maintenance

Shelter is a necessity, for the most part, for survival, especially in a place like Canada with its harsh winters. Beyond providing shelter, housing is also a place where much of the coordination and completion of the socially-necessary labour required for the reproduction of the population takes place. Mental health housing is not exceptional in this respect; these spaces offer shelter, but they are also spaces where the resources expended in reproducing residents in the day-to-day are coordinated, and where the work of daily maintenance is completed. In this sense, these housing sites are households, all of which expand and contract the amount of social reproduction they do in relation to access to necessary resources and supports (Luxton, 2006b). Daily maintenance in these homes is directly impacted by the prevailing arrangements of production for surplus and social reproduction.

5.2 Arm's Length Responsibility for Mental Health Housing

The federal and provincial governments have, since the 1980s, embarked on a long march towards the total defunding of social housing and subsidized housing. Indeed, a trend of restructuring, defunding, downloading, and privatization of social and subsidized housing in Ontario and Canada in the last thirty years has been well documented by scholars such as Prince (1998), Colderly (1999), Hackworth and Moriah (2006), and Hackworth (2008). In the mid-

1990s, the federal government withdrew its support for social housing programs, downloading administrative responsibility to the provinces while gradually reducing funding transfers. Today, according to ONPHA (2015), the federal government provides approximately \$500 million per year “through IAH and the Homelessness Partnering Strategy” with the intention of eliminating funding entirely by 2033 (p. 3).

After the election of the Progressive Conservative Harris government in 1995, Ontario’s provincial housing program was substantially diminished, and with the turn of the century responsibility for the coordination of social and subsidized housing was transferred to municipal governments, such that local governments, non-profits, and for-profits assumed most of the work involved in providing publically funded and publically subsidized housing services (Hackworth & Moriah, 2006; ONPHA, 2015). Today, despite the provincial government’s investment of four billion dollars in the housing system, more than 40,000 people were added to the growing waitlist in 2015 alone. This waitlist now comprises more than 168,000 households, and average wait times are just under four years (ONPHA, 2015). In addition to overt privatization strategies, aggressive gentrification policies in urban settings such as, but not limited to, Toronto’s Parkdale neighbourhood (Slater, 2004) have had the effect of financially squeezing out working class, unemployed and/or poor people. These gentrification policies also fail to take into account what current residents might want for their neighbourhood, and create spaces where poverty is both naturalized and policed (Murray, 2015). Without question, the landscape of social and subsidized housing in Ontario is at a crisis point, brought on at least in part by the offloading of provincial and federal responsibility for this necessary service.

While it would be easy to draw a straight line between downloading and privatization of social and subsidized housing and the paucity of supportive housing for people labelled mentally ill,

such an account would not be adequate to the complexity of Ontario's experience in this area. Of course, there are people with mental illness labels who live in, or are seeking to access to, unsupported social and subsidized housing (that is, public housing without supports for daily living). However, the network of supported housing was not directly impacted by the downloading and privatization of administrative and financial responsibility for Ontario's social and subsidized housing system. Throughout the radical changes implemented by the Harris government, some funding for supportive housing – which encompasses some, but not all housing for people with mental illness labels – remained, and today is provided to housing operators by the province directly from MOHLTC and the Ministry of Communities and Social Services, through the LHINs, or through both (CAMH, 2012 a; ONPHA, 2013).

It is puzzling that the Harris government, which was otherwise dedicated to the neoliberal project of reducing government expenditures in social services, did not engage in a wholesale downloading of responsibility for mental health housing (or all supportive housing) to the municipalities and the private sector. It is also puzzling that the province, despite privatization in many other areas of mental health, continues to fund these housing sites today. The reasoning behind these puzzles may lie in the fact that the province never really resumed administrative or financial responsibility for the room and board of the mentally ill after deinstitutionalization, nor for the coordination of the resources and activities of daily living that took place within institutions. This downloading occurred with deinstitutionalization, preceding by several decades the withdrawal of the federal and provincial governments from housing at the end of the last century. With deinstitutionalization, its crisis (Marshall, 1982; *Gerstein Report*, 1983& 1984; LaCroix, 1986; Mallory, 1986; Dear & Wolch, 1987; Capponi, 1992), and the subsequent period of policy experimentation, housing and other services for people with mental illness labels

developed in the late 20th century, and continues to develop today, in a rather ad hoc fashion, with operators cobbling together funding from various governmental and non-governmental sources (ONPHA, 2013). According to Sylvestre et al. (2007), the housing system for mental health care is comprised of custodial, supportive, and supported housing. Custodial housing offers low supports, and is often provided by for-profit operators. Supportive housing, which includes the sites used as case studies in this dissertation, are “typically available in the form of congregate settings (converted houses, clustered apartments), and [offer] rehabilitation-oriented support aimed at enabling consumers to improve their community living skills”. Supported housing operated from a “strengths-based approach to housing”, which works to ensure residents stay in apartments in the community and residents “have access to individualized and flexible professional support that they choose and control” (p. 82). The network of housing in Ontario, for which there is no overarching framework (Sylvestre et al., 2007) is complex to say the least. The province promises a framework for supportive housing in the coming years which will hopefully involve more funding (Ministry of Municipal Affairs and Housing, Ontario’s Long-term Affordable Housing Strategy-Update, 2016).

In many ways, mental health housing in Ontario was ahead of its time in terms of operating within a loose network of non-profit and governmental services and funding arrangements. Despite a commitment from the government to continue funding, and even expanding supportive housing units for people with mental illness labels,²⁶ the network of housing with supports is woefully underfunded, and, as a result, the crisis of housing caused by deinstitutionalization

²⁶ The second phase of *Open Minds, Healthy Minds* includes “investing \$16 million over three years, starting in 2014–15, to create 1,000 new housing spaces for people with mental health and addictions issues, including \$4 million for 248 supportive housing units in 2016–17” (Ministry of Finance, Transforming Health Care, Ontario Budget, 2016, p. 2).

persists in many ways. The provincial government does not want to resume full responsibility for providing this resource necessary to daily maintenance, which was so deftly shed with deinstitutionalization. In the context of Harris' common sense revolution, the logic of a lean social network likely informed the decision to preserve supported housing as it was in 1995, and I would argue that today, despite the documented hardships faced by people who do not have access to housing, this logic persists.

It is important to provide a brief overview of the landscape of housing with mental health supports to both demonstrate the extent of the present crisis and to set the stage for an analysis of life in the homes. This overview is necessary because the pressures placed on service providers and residents under the present system can only be fully comprehended in the context of the broader state of mental health housing in the province. There are different types of housing provided to people with mental illness labels, but they can be broadly conceptualized as either custodial (which is focussed on maintenance only) or supportive (which is focussed on recovery) (CAMH, 2012 a). Although precise definitions and numbers differ (see for e.g., CAMH, 2012 b; Suttor, 2016), the supportive category includes, but is not limited to, high support housing of the type implemented at the sites considered as case studies for this project. Beyond that, the definition of supportive housing varies widely from region to region, but MOHLTC identifies the availability of 24 hour support as that category's defining feature (Central East LHIN, Supportive Housing Review Report, 2009). The matter is somewhat confused by the fact that supports are sometimes attached to individuals (e.g. ACT services) rather than to the housing environment in which the individual resides (Interview with Resident). When services are attached to the individual and not the housing site, however, they are properly understood as part of the treatment system rather than the housing system. As such, this chapter focuses exclusively on

housing sites which are dedicated to providing services on-site for people with mental illness labels.

As of 2012, there were 10,000²⁷ supportive housing units for mental health in Ontario and 6,000 custodial units (CAMH, 2012 a), while the waitlist in Toronto alone has more than 5,000 names on it, with most seeking “low or medium levels of support and 300 [applicants]... in need of high support housing” (CAMH, 2012 b, p. 3). While the CAMH document lists wait-times for one of these units as one to six years, a news release about the Ontario Mental Health and Addictions Alliance stated that the provincial average wait-times for one of these units is 290 days, but can be up to 1097 days depending on the region in question (CMHAO, 2011). At the same time, according to a study by Sylvestre et al. (2007), many of the people accessing this type of housing do not need the high level of service and supervision provided in these spaces, but it is the only service available which weds housing subsidy with supports for the activities of daily living.

Available funding sources for housing include, in addition to funding from the Ministries and the LHINS, regional / municipal governments, charitable donations, and, occasionally, federal aid (e.g. the At Home/Chez Soi pilot project and research program). Typically, funding for capital expenditures comes from one source, while funding for service programs comes from another, while residents are charged the shelter portion available through OW or ODSP in order to fund operating costs. No single level of government, ministry, or non-profit agency is entirely responsible for housing services, and the funding arrangements are complex, involving funding from the MOHLTC, LHINS, and/or other non-profit organizations (Interviews with Service Providers).

²⁷ CAMH (2012 a) reports that 8,500 of these are for mental health and 1,500 are for addictions.

What this overview of housing with supports demonstrates is that, unlike social housing, responsibility was never devolved to the municipalities and the non-profit sector by the provincial government. Rather, the responsibility for the funding of housing with supports for mental health care was devolved with the advent of deinstitutionalization, and has arguably been somewhat further downloaded with the introduction of LHINs, but MOHLTC still directly funds some housing service providers (CAMH, 2012 a; Interview with Service Provider).

Additionally, in seeking out new opportunities for funding for supportive housing, the province is exploring the social impact bond model of funding. Under this model, “bonds leverage investments from people and organizations outside of government to pilot programs aimed at improving social outcomes. Funding for the service is provided upfront, with investors getting paid financial returns if the agreed-upon social outcomes are achieved” (OMHALAC, 2015, p. 13). This is a more direct way to privatize the cost of housing and to wed normalized behaviours and identities to the production of profit, but there is no evidence that this has yet been implemented. Rather, Ontario continues to provide funding, either directly or indirectly through the LHINs, in a manner that, considering wait-times, does not address the housing crisis among people with mental illness labels. The province protects public funds from the full demands for shelter and support services arising from the housing crisis, and assumes little to no administrative responsibility for the operation of these homes.

The story of mental health housing in Ontario is not, as stated, the typical account of neoliberal downloading and privatization during the late 1990s and early 2000s, as was the case with social housing. Rather, it is a story of a continued crisis of housing that dates back to the beginning of deinstitutionalization and the province’s divestment at that time of much of the responsibility for shelter and the resources for everyday life. This privatization of housing services in the interest

of cost-savings and a consequent reduction, or at least the appearance of a reduction, in the amount of tax dollars expended for the reproduction of people with mental illness labels, is a central organizing feature of transinstitutionalization.

5.3 Privatization of Housing at the Level of the Individual

In this section, I first consider the experiences of service providers as overworked in an underfunded housing system. Building on the discussion of how service providers are filling in the gaps in service provisioning in this decentralized and underfunded housing system, I then map the contributions that residents are, as a result, making to the provision of housing services. I argue that the work residents are doing is integral to the functioning of these defunded and underfunded housing sites, and to the enactment of the consumer-patient subject. At the same time, I argue, this work is invisibilized through the long-standing pathologization of people accessing psychiatric housing, the organization of the work of people with mental illness labels within sites of care historically (Reaume, 2004; Reaume, 2009), as well as its association with therapy given its placement in a medicalized housing site. Just as the work of social reproduction is concealed by its naturalization as gendered work and its location in the so called private realm, so too is the work of daily maintenance performed by residents in the area of housing erased by virtue of the view that, because they reside where they do, they are ill, and that, in performing many of the essential functions required for the operation of the housing sites, they are only receiving care.

5.3.1 The Paid Work, Unpaid Work and Overwork of Service Providers

In the housing sites where I conducted interviews, staff members were very much involved and provided a high level of support to residents, though the staff stated that this level of involvement

was not always the case for service providers involved in mental health care (Interview with Service Providers). When asked to describe their jobs, service providers reported that, while their titles differ, they all do tasks related to cleaning, light maintenance (e.g. plunging toilets and changing light bulbs), shopping and banking with or for residents, providing formal and informal talk therapy, organizing and attending appointments (with doctors, blood labs, case managers, income support workers, and probation officers), offering support for and coordinating supports with family members, helping to organize and sometimes accompanying residents on travel, finding appropriate services within the community, tutoring, helping with money management, laundry, and/or cooking and administering medications. While some service providers, such as nurses and trained mental health care support workers, also provide ‘clinical supports’ (e.g. cognitive or dialectical behavioural therapy and injections of medication), all service providers, regardless of title, provide and support the activities of daily living among residents, and this work is shaped by the pressures of neoliberalism.

Insufficient funding for mental health housing looms large in the sites where I conducted my interviews. Across the board, service providers reported that a primary concern was with funding, either for better funding arrangements,) for more units, for increased welfare rates, for more staff, or for more specialized staff, and for staff training (Interviews with Service Providers). Service providers are closely attuned to the struggles residents, and people with mental illness labels generally, face within the existing loosely coordinated network of governmental and non-governmental services, as well as the toll this arrangement takes on service providers. One service provider, who highlighted the need for more housing units and more staff, described the job as moving from crisis to crisis: “you field everything that comes

through the door, there is not much room for [significant] personal interaction.” (Interview with Service Provider).

Within the context of piecemeal funding and an absence of sufficient community-based mental health care services, service providers in these sites work more hours than they are paid for, and are overworked, performing tasks outside of the parameters of their positions with people who are not technically their clients, such as family members or other residents. They view this as the secret to program success, but are well aware of the fact that they are being stretched due to a lack of funding. While the social location of service providers is not the subject of this dissertation, there is a need for research into the positioning of these workers given that the organization of socially reproductive work is deeply gendered, raced and classed (e.g. Duffy, 2005, 2007; Luxton, 2006; Ferguson, 2008), and stretches across national boundaries (Arat-Koc, 2006; Rioux, 2015). Service providers described their overwork, unpaid work, and how they fill in gaps in services in the following ways:

There are not enough hours in the day and week to get it all done. You do go beyond...you don't go 9:00 to 5:00 and say, “well, it's 5:05 pm I am not going to pick up this call.” (Interview with Service Provider)

[Doing everything] is the secret. [That is] why we look askance at some of these agencies who come in with a list they need to check off and [then leave]. (Interview with Service Provider)

Similar struggles are expressed by mental health service providers in the Ontario Auditor General's 2010 report. Yet these challenges are not new or limited to psychiatric housing or the mental health care sector generally. In Canada, and in Ontario specifically, the work of social service providers has been restructured to reflect the lean workplace of neoliberalism, resulting in an increase in unpaid work by employees in the highly feminized social service sector as well as

heightened workplace demands (Baines, 2004; Baines et al., 2009). This unpaid work is often understood as a normal part of having a professional job or as a means of maintaining integrity in work and offering sustained care in a time of, and in spite of, a move towards a lean social service system (Baines, 2004). The last three decades in Ontario and Canada have seen the retrenchment and reorganization of supports for housing (Colderly, 1999) and health care (Armstrong & Armstrong, 2010), as well as income support (Chouniard & Crooks, 2005; Little, 1998a) and childcare (Vosko, 2006; Mahon & Brennan, 2013), to name a few. The organization of work in the homes examined here, in particular the unpaid work and/or overwork of service providers (although not feminized, as discussed in Chapter 3 above), reflects both the specific funding arrangements for mental health housing, and the larger restructuring of supports for daily maintenance and social reproduction more broadly. While articles by Baines (2004) and Baines et al. (2009) demonstrate the impacts of restructuring and subsequent exploitation of service providers resulting in burnout and stress, impacts which were present in the housing sites, there is less attention paid to the largely unpaid work of service users. However, as I demonstrate below, service users are stepping in and completing some of the tasks required of service providers, just as service providers are being overworked and performing unpaid work. The contributions of residents must be framed in the context of neoliberal restructuring of social supports and in relation to the interrelated changes in understandings of mental illness and wellness.

5.3.2 The Paid and Unpaid Work of Residents in the Homes

Of the residents I interviewed, ten reported that they were engaged in work within the homes. In some sites, small amounts of money or goods, such as coffee or cigarettes, were occasionally offered as compensation for work, and in other sites no compensation was offered. Not

surprisingly, eight of the ten residents who reported involvement in work in the homes were living in sites where compensation was offered and where there was more space in need of cleaning.

Tasks reported by residents included sweeping, mopping, taking out garbage, and running errands for staff and housemates (Interviews with Residents). Residents defined this work variably as helping out, doing mandatory chores, and a way to get cigarettes and small amounts of money.

I sometimes go [run errands] for [another resident in exchange for] coffee. Also, the [staff] give me [errands related to running the home] and I get five dollars for that. (Interview with Resident)

I help out as much as I can. [The staff] have got me doing a couple of chores. They've got a couple things around the house certain people do, certain people do. (Interview with Resident)

I sweep. I help out, no pay. (Interview with Resident)

When asked about the work being done by residents, staff repeated resident descriptions and added to the list the tasks performed by residents – watching more “vulnerable” housemates and cleaning the kitchen (Interview with Service Providers). The unpaid work was described by staff as the residents ‘volunteering’, leisure activities or occupational therapy, and tasks done for pay were described as work.²⁸

There is a lot of that [volunteering]. Cleaning, taking out the garbage.... (Interview with Service Provider)

Some clean the kitchen, dishwasher, and dust, and some sweep. Some get paid right away, some save. It is not a lot, sometimes they want a cigarette or

²⁸ There were several other resident-performed tasks reported by residents and service providers, but they cannot be disclosed as they indicate physical aspects of the sites and may reveal their location and compromise anonymity.

a coffee the same day. It is whatever they prefer. We trained [a resident] to [do a specific task]. It is like their little job. (Interview with Service Provider)

The activities being performed by residents appear banal and, of course, are regular parts of everyday life. Indeed, these activities are everyday aspects of living in a community and feeling a sense of connection, but they are undoubtedly also productive. They contribute to the daily functioning of the housing sites, and are, therefore, necessary to the reproduction of the residents.

Participation in this work is not, however, required. While residents in some of the sites are sometimes asked to do chores, they are not punished if they do not do the work requested.

Residents largely report satisfaction with the level of care, support, and housing quality provided within the homes. Those who do work in the sites do not object to participating in the work, and see it as a way to contribute to their community; much like service providers, their unpaid work is a way of shielding clients from the effects of an underfunded mental health care system. What must not be ignored, however, is that the work residents do for free or for little pay is the same work that service providers reported themselves as performing as part of their career, albeit often involving overwork and/or unpaid work. More than this, the work of residents contributes directly to the work required to reproduce both the population in the day-to-day as well as a mental health care system that operates with insufficient government funding. Figure 2.0 offers a means of visualizing precisely how many of the tasks being done by service providers are also done by residents, as reported by residents and staff.

Figure 2.0: Work Performed in the Homes by Staff and Residents

Tasks Performed at the Sites	By Staff	By Residents
Medication Administration / Supervision	✓	
Cleaning / Looking After Building	✓	✓
Cooking	✓	✓
Coordinating / Finding Services	✓	
Emotional Support	✓	✓
Errands	✓	✓
Money Management	✓	
Formal and Informal Talk Therapy	✓	

The work residents perform is undertaken in a context in which service providers, as described above, feel that they require more resources to do their jobs properly. When a resident runs an errand related directly to the functioning of a high-support housing site, offers support, or watches another resident, that resident is doing the same tasks assigned to staff members, and is alleviating some of the substantial workplace demands, including demands for unpaid work, placed upon them. Residents are also completing some of the daily work involved in the reproduction of people with mental illness labels for free, for barter or for very little pay. It is certainly less costly for a non-profit housing provider with limited and insecure funding to offer either small or no compensation to a resident willing to perform some of the tasks associated with the operation of the housing site than it would be to hire another service provider. Residents, like service providers, are simultaneously struggling against, and trying to fill the gaps in, a system of daily maintenance where need far outstrips available resources.

Luxton (2006) argues that neoliberal policies assume that women, in light of cuts to pay, jobs and social programs like education and health care, would increase the amount of socially reproductive work done in the homes (or hire someone to do it for them), resulting in increased inequality among women and (what others have termed) a crisis in social reproduction. While there is no overt statement within the homes that the work of residents discussed above is informed by this logic, it is nonetheless present.

Moreover, the acceptability, and promotion, of the resident-worker role is also part of the constitution of the consumer-patient subject. Given the high rates of unemployment or non-participation in the labour force among residents (as discussed in Chapter 4 above), the unpaid work in the homes is not only a means of reducing the “burden” of people who are labelled mentally ill, but also constitutes a key mechanism through which residents demonstrate wellness. For the ideal consumer-patient, participation in production for surplus and daily maintenance as an aspect of social reproduction is a key element of recovery.

Residents are indeed encouraged to engage in the activities of daily maintenance for their whole household. The work of residents is not organized primarily around gender norms and naturalized as “women’s work”, as is the case with substantial portions of socially reproductive labour, nor in terms of being good at their jobs, as is often the case with social service providers. Rather, I argue that, in light of consistently inadequate levels of government funding and overloaded service providers, resident participation in activities vital to the operation of the housing sites can be understood as protecting public funds from the cost of mental illness, thereby reducing the “burden” placed by the mental health care system on public finances, and protecting the rest of society from the daily reproductive needs of the unproductive “mentally ill”. Services that shape the daily lives of residents to take on activities of their own reproduction in

the interest of mitigating the economic “burden” they impose upon society play a key role in the constitution of transinstitutionalization.

5.4 Limitations on Family Life

In addition to residents being encouraged to engage in some of the work involved in maintaining the sites in an unpaid or underpaid capacity, serving both to mitigate costs and to promote the consumer-patient subject, little support is provided for the work involved in residents’ participation in social reproduction beyond daily maintenance. Indeed, the housing sites where I conducted interviews are structured in such a way as to deny residents the opportunity to create or maintain family units; neither partners nor children can live within these sites. The prohibition on family life within these housing sites is underpinned by the idea that people with mental illness labels, certainly while accessing such a high level of support, are unfit to be parents. This understanding is not dissimilar from ideas that people, especially women, accessing welfare should not have children (Smith, 2010), and the broader assumption that social reproduction is an individual activity that one must not participate in until doing so can be supported entirely through participation in production for surplus. These interventions into / barriers to social reproduction are often presented as being in the best interest of residents, in light of their diagnoses. In the next section, I offer an overview of the experiences of residents, and attitudes of service providers, in relation to the restrictions on family life imposed as a condition of residence in the sites considered by this study.

5.4.1 Single-Person Occupancy and Childcare

As stated, high-support housing is based on a model of a single-person resident; as a result, neither partners nor children live in these units. When I asked interview participants about this

rule, it was confirmed that children and partners, while permitted to visit, were not permitted to live in the homes. The explanation was that the units were not equipped for other people.

During the interviews with service providers, it was suggested that perhaps there were no children because no resident had ever asked for this accommodation. It was further suggested that it would be very difficult to sort out shelter subsidies if a child were to live in one of these homes. One interview participant commented that the staff would likely do their best to accommodate a child, but that additional funding for associated support services would likely be difficult to secure (Interviews with Service Providers). Residents who do not live in a high-support home can obtain support to apply for new housing to accommodate parenting, but high-support housing is simply not set up for this. Even so, children are very often apprehended by the Children's Aid Society (CAS) (Interview with Service Provider). As one service provider stated:

We support families where maybe the head of the household has a mental illness. [Yet], 99% of the time the baby is taken away. [New housing will not be secured] until we can be assured that they are going to keep [the baby]. Because CAS comes in and takes [the child] away. (Interview with Service Provider)

The statistic of 99% is likely hyperbole used to demonstrate the high frequency at which clients are losing their children. Statistics about the rate at which children are removed from the custody of parents labelled mentally ill are not available for Ontario. What I did find when looking for statistics on CAS and parents with psychiatric diagnoses was the assessment tool used by CAS workers when evaluating future risk of neglect. According to the *Ontario Family Risk Assessment Descriptors Neglect Index* assessment tool, if the primary parent or caregiver has a current or past "mental health problem," the "risk score" increases. The risk score also increases when indicators of poverty are present, such as infestations, inadequate plumbing or heating, and inadequate winter clothing. Given the high rates of poverty among people with psychiatric

diagnoses, especially those accessing support services, and the fact that the mere presence of a psychiatric diagnosis increases the “risk score,” the frequency of removal cited by the worker is not surprising. It is, however, deeply troubling that parents with psychiatric labels appear to be unfairly targeted and scrutinized by CAS, and the approach taken by CAS to people with mental illness labels speaks loudly about who is and is not valued as a reproductive member of society.

Considering the role of eugenics in the lives of people with mental illness labels and dis/Abled people’s history generally (Hubbard, 2006), and the specific eugenic attitudes in Ontario represented, for example, by the mental hygiene movement discussed in Chapter 2 above, it is difficult to see the scrutiny and consequent limitation of residents’ capacity to reproduce and raise their children as anything other than a continuation of eugenic practices.

Given the devastating effects for both parents and children of forced separation by the government, more research needs to be done on when, and why, people with mental illness labels with children lose custody of them. Such research would be an especially timely contribution to scholarship exploring how public policies, especially those targeting children and women, is being designed to produce political subjectivities compatible with the current processes of capitalist accumulation (Smith, 2010; Murray, 2015).

Children who are not removed by CAS could theoretically live with their parents if the assigned tenant-relations worker could find suitable housing with appropriate supports. No residents interviewed had children living with them, despite the fact that the units are covered by the Residential Tenancies Act (RTA) and residents “have every right as everyone else under the RTA” to make such use of their space as they see fit (Interview with Service Provider). To date, none of the sites where I conducted interviews has provisions for residents with children, but it

appears that at least some service providers are willing to consider doing so should circumstances require it.

Interested in exploring the impact of a lack of provisions for children in these homes, and in the seemingly contradictory arrangements between the desire to offload costs to individuals and the apparently constant presence of (more costly) CAS services in lives of people with mental illness labels, I asked each participant who was willing to discuss parenting if they had children. Seven of the residents who participated in interviews reported having children and one person reported being told not to have children (although they did not say by whom) (Interviews with Residents).

Of the residents with children, two women were much more willing to speak about their parenting experiences. They spoke of the difficulties in maintaining relationships with their children while living in the high-support program. One female resident has multiple children (now young adults). She lived in a psychiatric hospital for more than five years, and sees her eldest regularly, but spoke of her frustrations when trying to contact her youngest.

I keep asking [worker] to contact me so I can go and visit [the child and] see how [they are doing] in school.... [The worker] tells me [the child] is [doing well and] doing well in school. And that is all I get. I miss my [children].

This particular resident credits her children for her ability to avoid self-harm, and ended our interview by stating, “I just want to be happy and I hope... my kids are happy without me” (Interview with Resident).

Another woman spent over seven years in a psychiatric hospital. Following her hospitalization, she lived with her children and spouse. When I asked her if they visited her, she indicated that they are not allowed to do so at the moment (Interview with Resident).

Certainly, for a woman struggling to find access to housing and appropriate support, pregnancy and mothering adds another layer of complication. Yet, should a woman become pregnant, decide to continue the pregnancy, and want to act as the primary caregiver for the child, she would, given the current structure of high-support programs, likely have to either change housing environments or act as the test case for her home. When I asked if residents, particularly women, could have children or have children live with them, I was told that many of the women were not well enough to have children with them, and that in some sites, women were provided with a prescription for birth control if they were of childbearing age (Interview with Service Provider). This issue did not come up at all sites.

When I inquired with service providers what would happen if a resident became pregnant, one stated, “[residents] are too old and we are tight on this. We [wouldn’t let that happen]” (Interview with Service Provider). It could be argued that this particular service provider understands being “tight on [biological reproduction]” as protecting the residents from the economic and legal hardships imposed on poor, primarily female, individuals with mental illness labels, which are complicated by the lack of available high-support family housing and the seemingly inevitable CAS intervention. The idea of protection was echoed by another service provider who informed me that any “vulnerable” person has been prescribed birth control which they receive with their other medications (Interview with Service Provider). What these comments draw attention to, however, is how the mental health care and legal systems in Ontario passively (through a lack of housing options with supports) and actively (through the removal of children by CAS) deny reproductive freedom, similar to eugenic practices of the past. These practices merit a further discussion of eugenics.

While the Ontario government did not officially sterilize people, the contemporary denial of supports, removal of children by CAS, and outright discouragement of biological reproduction by residents (either by limiting overnight guests, not allowing partners to live in the sites, and/or the prescription of birth control), brings to mind eugenic practices historically aimed at people with mental illness labels, and disabled people generally, such as sterilization in Alberta (see New/Eugenics Archives Project of Alberta) and the mental hygiene movement (see Simmons, 1990; Dickinson, 1993), and also speaks to current social attitudes about who should and should not reproduce. Moreover, the overt expression of limitations imposed on resident biological reproduction raises important questions about the power relations between service providers and residents, the discretionary authority exercised by service providers over the sexual activities of residents, and the social context in which the exertion of control over the reproductive life of another person as a form of protection manifests as an example of common sense.

Some service providers did not feel that the denial of parenting was always necessary, or passed on this question altogether (Interviews with Service Providers). Others pointed out that the residents had already lost custody of children due to hospitalization or other experiences associated with their diagnoses (Interview with Service Provider). The ability to parent when diagnosed as mentally ill is complicated by the fact that, to access services, one must construct oneself as sick.

Indeed, to obtain access to care offered by high-support housing programs, and, if required, long-term income support, people must construct themselves as sick. As discussed above in Chapter 4, to access ODSP, the highest level of income support in Ontario, applicants must be assessed by a psychiatrist and must submit medical documentation. To access high-support housing, applicants must agree to be identified as a person with a “mental illness.” That is, they must

construct themselves as mentally ill, whether they agree with that label or not. There remains a persistent threat that this self-identification could be used as a basis to remove a child from the resident's custody or to deny the opportunity to regain custody. The high-support housing model based on a single person status may, therefore, act as a barrier for those who become parents while in a high-support unit, or who must demonstrate occupation of acceptable housing in order to maintain or regain custody of their children. The issue of access is further complicated by long waitlists in supportive, social and subsidized housing, as discussed above, and a persistent lack of supportive housing programs suitable for families.

While it was primarily women who discussed their parenting experiences, and it is exclusively women who are prescribed birth control, men with psychiatric diagnoses face many of the same challenges when seeking a relationship with their children or the right to parent, and this is, of course, complicated by the fact that men with mental illness labels, as pointed out by one service provider, are more often understood as violent as compared to women (Interview with Service Provider). The fact remains, however, that, as with other forms of social reproduction, it is women more than men who are responsible for the labour involved in parenting children.

Women are more likely to be the lone or primary caregivers for their children and, therefore, the implications of the single-person model on which high-support housing seems to be largely based may have a greater impact on women and their access to care.

A psychiatric diagnosis and residence in psychiatric housing does not mean that women escape the gendered nature of the impacts on their role as caregivers of the privatization of services for social reproduction. Rather, they experience what is referred to as the ensuing crisis of social reproduction in a very real way. Specifically, they experience the erosion of state supports for daily maintenance as they access social supports for mental health care, as well as when they

engage or seek to engage in the work involved in parenting. At the same time, they are subject to a labour force that is not only inaccessible, but also increasingly precarious, for women. When women with mental illness labels search for housing, the unequal distribution of responsibilities for care under neoliberalism (De Wolfe, 2006) and the feminization of poverty and precarious labour must be taken into account if women are to have equal access while managing care responsibilities and contending with notions of recovery and success that are not only saneist, but also male-centric.

5.4.2 The Consumer-Patient Subject and the Unfit Parent

Stemming directly from the denial of a capacity to parent, and especially of women's capacity to mother, is the individualized gender-neutral consumer-patient model. Indeed, consideration of the specific limitations on the reproductive lives of residents, as well as the wider policies implemented by CAS, reveal that the consumer-patient is sexless, genderless, and childless as well as, ideally, engaged in production for surplus and achieving independence in daily maintenance. Any difficulties, such as a loss of custody, are attributed to the unfitness of people with mental illness labels as parents, and not to the systematic denial of access to the freedoms and services needed to parent. While no service provider used the term unfit, notions of vulnerability and protecting residents were plentiful, and there was a complete lack of critique of the prescription of birth control or the removal of children by CAS. This silence speaks loudly to the fact that such measures were seen as common sense outcomes for people with mental illness labels. What is more, the CAS policies clearly indicate that those who are poor and who have mental illness labels will come under greater scrutiny should they parent, clearly assuming that oversight of the reproductive lives of people with mental illness labels is necessary, as they are at a higher risk of being unfit parents.

It is almost certainly cheaper to limit the reproductive and romantic lives of residents than it is to reorganize existing, or provide new, services that would allow residents greater autonomy over how they construct their lives. Moreover, it is certainly seen as less of a “burden” on social services to limit reproduction than it would be to provide services for a person accessing the mental health care system as well as their children. Rather than offering (potentially more costly) supports for parenting, children are simply removed from the custody of people with mental illness labels, and both subtle and overt understandings that such people should not parent are deployed to legitimize these actions.

The lack of supports for parenting likely impact women predominantly, especially those who, as women, are expected to perform higher rates of unpaid domestic work with less access to income, and to assume a primary role in biological reproduction, childrearing, and caregiving. A woman with a mental illness label who is unable to support her child or maintain custody can be seen as pathological, both in terms of psychiatric wellness and resiliency, and in her failure to fulfill the mother role thrust on her by the continued biological essentialization of the female body. While child welfare is an important issue, the idea that a person with a mental illness label, and especially one accessing public supports, is, by default, too unwell to care for their child while in high-support housing is based on ideas that mental illness is sickness, and that they alone will have to engage in parenting work, rather than being provided with supports. Changing this pathologization of and limitation over the reproductive lives of people with mental illness labels would require not only thinking about mental health care services beyond daily maintenance, but also rethinking how social reproduction as a whole is organized.

Such changes, however, would require a greater share of public funds to be directed towards social reproduction through the establishment of more robust social services that do not operate

solely on the basis of the biomedical model. Yet, I contend, the limitations on the reproduction of people with mental illness labels, and especially those living in mental health housing, operate in the interest of reducing the amount public funds allocated to social reproduction. In the case of the sites considered in this project, residents are dissuaded from having children through single occupancy housing models that do not permit partners or children to live there, and the lack of alternatives due to the housing crisis in mental health housing and affordable housing more broadly. They are also actively policed by the administration of birth control and the removal of children by CAS.

These limitations on the romantic, sexual and family life of residents do three things to reduce the cost of mental health care. Firstly, they contain the use of housing supports, as well as income supports, provided to service users to meet only their own daily needs and not the needs of a child or partner and child. Second, building on Smith's (2010) argument that the sexual regulation of people accessing welfare produces a flexible childless worker, these programs ensure that the energies of service users are directed not at reproducing new life, but rather at the work of acquiring independence in daily maintenance, ideally through employment. Third, and less overt, the limitation quells the social anxiety, visible in the rise of prenatal testing and human genome mapping, that people with mental illness labels will pass these traits on to a child, who will then, in turn, be dependent on social services. These eugenic, or perhaps, in keeping with Smith's (2010) language and the emerging terminology, neo-eugenic policies and practices directly protect public funds from the mentally ill, and are, regrettably, a predictable feature of transinstitutionalization.

5.5 Mirroring the Institution

In the areas of treatment, income, and housing policies and programs, there are many instances where the mental health care services intersecting in the lives of residents create effects similar to institutions. Here, I briefly list these effects, and provide a discussion of how there are legacies of institutionalization in the mental health care system of today. I argue that, despite these similarities, transinstitutionalization is not tantamount to re-institutionalization, for a single, but very important, reason.

In terms of treatment services, the medication regimes and punishments for non-compliance mirror the rigorous and often forced administration of treatment within psychiatric institutions. Moreover, the reproduction of the biomedical model of mental illness entrenches the legitimacy and dominance of psychiatry, and maintains the prestige of psychiatrists. This is not dissimilar from the introduction in institutions of medical treatments (such as lobotomy, insulin coma therapy, metrazol, electroconvulsive therapy and, later, anti-psychotics such as Haldol) which further aligned psychiatry with the practice of medicine, and enhanced the prestige of psychiatrists (Simmons 1990). Additionally, the equation of paid labour with recovery and wellness (though not cure, given the dominance of the biomedical model) mirrors the goals of the earliest days of the psychiatric institution. Ben-Moshe et al. (2014) argue that, in the mid to late 1800s, it was believed that anyone could be brought up to normative standards, and “cure” was defined as a capacity to participate in paid labour. While ideas of a common capacity for cure and normalcy may have penetrated the institutions, and especially therapeutic communities such as those established by William Tuke (the father of moral treatment), under Ontario’s form of institutionalization, the degree of emphasis in provincial psychiatric institutions on rehabilitation

and capacity for paid work paled in comparison to the focus on the exploitation of patients as sources of free labour via work therapy (Reaume, 2009).

While work in the institutions was much more regimented and regular than it is in the housing sites considered in this project, there is no question that using residents to offload demands caused by an underfunded network of services bears some resemblance to historic practices of mental health care. Furthermore, while there were no sterilization policies in Ontario, the limitations placed on the sexual and family life of residents by the design of the housing sites mirrors the denial of family relationships resulting from long-term institutionalization in years past. Finally, Goffman's (1961, 1973) work on psychiatric institutions demonstrates these places to be "total institutions"; all-encompassing, with every aspect of life tightly scheduled, conducted in the same place with large "batches" of others, under the same authority and with the goal of fulfilling the plan of the institution.

There are undoubtedly elements of life in the housing site that resemble the institution. Many phases of daily activity are carried out in the company of a large group of others (e.g. meals, outings), and the day-to-day is often tightly scheduled (medication, visits, etc.), both of which are features of the rational plan designed to fulfill the aim of the institution (reduce costs, promote independence, produce a particular subjectivity, etc.). Although I would argue that the stripping away or mortifying processes that Goffman (1961, 1973) suggests are central to becoming a mental patient are not practiced in these spaces, such processes (if they indeed occur) would likely be found to have happened long before a person becomes a resident in a high-support housing site. If anything, life in high-support housing and the requirement that people identify as mentally ill to obtain access to services maintain the psychiatric identity of the residents, but do not represent the first moment of becoming a mental patient. It is obviously undeniable that, in

many ways, the contemporary mental health care system described in this project has, effectively, replaced the institution.

However, I would argue that we are not witnessing wholesale re-institutionalization, as Goffman might, but rather a collection of open practices of psychiatrization and psychiatric oppression in the everyday. Mental patients are no longer hidden away; on the contrary, they have been placed in the community, where society actively participates in their pathologization. No longer do we need to conceal people with mental illness labels or their often horrifying treatment behind the walls of the institution, releasing only those who are “cured”. Instead, the province has, in downloading these services to the community, rendered the presence of people with mental illness labels, and the poverty they often experience, a commonplace and natural (side) effect of mental illness.

What is more, by ending institutionalization without sufficient transitional or community-based supports in place, the province has altered the relationship between the so-called mentally ill and the processes of production, extending into our lives the pressures of neoliberalism and calling it freedom. Transinstitutionalization is not freedom, not for people labelled mentally ill, any more than participation in the processes of production for surplus and social reproduction is freedom for people who escape the processes of psychiatric pathologization. Through different means, both systems impose the same pressures, requiring their participants to align their lives with surplus production under threat of marginalization and poverty.

5.6 Conclusion

This chapter considered how mental health housing services contribute to the constitution of transinstitutionalization, a system of mental health care which operates in the interest of limiting

the cost of the daily maintenance of people with mental illness labels. I first considered the development of the network of mental health housing, explaining how it is unique in its form and history from social and subsidized housing. I locate the downloading of shelter and supports for everyday living for people with mental illness labels in deinstitutionalization and in the withdrawal of federal and provincial responsibility for social and subsidized housing at the turn of the 21st century. I argued that, despite the housing crisis for people with mental illness labels, the province remains unwilling to take full responsibility for the costs of the housing services necessary for the daily maintenance of people with mental illness labels, continuing to fend off the costs of the mental health care system that would require public revenue to be used for social reproduction.

Second, I examined the work involved in operating high-support housing sites. I demonstrated how some residents do some of the work involved in running the home for free, for barter or for very little money. I contended that their work, often coded in terms of therapeutic tasks or leisure activities, alleviates demands placed on service providers who are stretched thin, and, by extension, on the government to more fully fund these sites. In this way, the work of residents contributing to their own daily maintenance, work that is done by service providers for a wage, directly protects surplus by shielding public funds, as well as charitable donations, from the cost of housing and the services viewed as necessary for this group in light of its poverty and mental illness labels. Work performed by residents, therefore, contributes directly to the government's goal of realizing cost savings in services for people with mental illness labels. I also considered how the encouragement of work in the homes reproduces the consumer-patient subject.

In the final section, I examined the limitations imposed on the romantic, sexual and family lives of the residents through the housing model, practices in the homes and CAS policies. I suggested

that these limitations reveal the consumer-patient subject, the ideal mental patient, to be childless as well as productive. I also argued that these limitations contain the cost of housing support as well as income support, ensure that the energies of service users are directed towards better fulfilling the consumer-patient subject ideal, and reduce the perceived possibility that the genetic underpinning of mental illness will be passed on to the children of those deemed to be mentally ill. Separately and together, these aspects of housing for people with mental illness labels reduce the costs to the government associated with their daily survival, and reproduce an understanding of mental illness and people with mental illness labels, the childless consumer-patient subject, compatible with this goal. Housing services for people with mental illness labels, therefore, is a lynchpin in the constitution of transinstitutionalization.

Conclusion

Mental illness is still readily accepted as a biological fact, rather than as a condition that is socially constructed in whole or in part. This acceptance has had the effect of closing off the avenues of analysis that consider the relationship between the experiences of people with mental illness labels and systems of mental health care on the one hand, and the prevailing arrangements of capitalist production, on the other hand. Closing off the possibility that mental illness is socially constructed can lead to the assumption that people with mental illness labels are impoverished and oppressed due to individual pathology, its associated unproductivity, past government mistakes, or simply as a result that the mental health care system that needs more funding. These assumptions erase the connection between the imperative of capitalist accumulation, the organization of the mental health care system, and the everyday experiences and identities of people deemed mentally ill.

This dissertation sought to chart new territory, to use a feminist political economy approach to draw the connections between the drive for unfettered accumulation under neoliberalism and the organization of the public mental health care system in Ontario *as well* as the implications for dominant understandings of mental illness and for the daily lives of people with mental illness labels living in the province. I began with the assertion that a feminist political economy analysis, supplemented by insights from Mad Studies about changing understandings of mental illness, wellness and recovery, has the potential to offer an improved understanding of mental health care under neoliberalism. There has been little conversation between feminist political economy and Mad Studies and the dissertation aimed to help fill this gap.

I argued that in order to understand the connections between neoliberalism, the mental health care system, and the lives of people with mental illness labels, mental health care must first be

recognized as comprised of support services for daily maintenance, a central aspect of social reproduction. Operating from the perspective that mental health care services are a system of daily maintenance, I conceptualized Ontario's public mental health care system under neoliberalism as comprised of treatment, income support, and housing services. I argued that this system operates to reduce public costs and the associated tax burden in the interest of the further accumulation of capital in three distinct but interrelated ways by: 1) the continued privatization and downloading, primarily to NPOs, of the services of treatment, income support, and housing; 2) the promotion of independence in the activities of daily maintenance and labour force attachment whenever possible; 3) the development of new definitions of mental illness, wellness, and recovery that promote and encourage economic independence in policy and practice. The entwinement of well-being and productivity culminates in a model mental patient who accepts the "reality" of a psychiatric diagnosis, and manages it in a way that permits independent participation in both daily maintenance and the labour force. I refer to this figure as the consumer-patient subject, and I have demonstrated how it haunts the diffuse network of services that make up the mental health care system in Ontario today.

I argued that these developments in mental health care constitute a new phase in Ontario's history of mental health care that is as distinct as institutionalization and deinstitutionalization. Drawing on the existing literature on the downloading, privatization, and diffusion of support services following deinstitutionalization and expanding on an existing term, I contended that this new phase of mental health care can be most accurately described as transinstitutionalization.

Transinstitutionalization is a system of mental health care that operates to reduce costs in the interest of reducing the tax burden of people with mental illness labels, thus furthering economic growth and the accumulation of capital. Under transinstitutionalization, the objective of cost

reduction is pursued by targeting the daily maintenance of people with mental illness labels who access public services.

While the cost of the public mental health care system in Ontario has long been the concern of the provincial government, prompting in many ways the unplanned and ad hoc deinstitutionalization, under neoliberalism the techniques for achieving cost savings in this area of daily maintenance have changed. As Chapter 2 shows, prior to the 1990s in Ontario, the focus was largely on reducing the cost of the daily reproduction of people with mental illness labels through privatization and downloading of social services to lower levels of government and to the non-profit and for-profit sectors. Today, as demonstrated in Chapters 3, 4, and 5, privatization and downloading are still key organizational principles within the mental health care system, but there is also an emphasis on independence in daily maintenance, and whenever possible, labour force attachment among service users. The focus on independence includes the development of understandings of mental illness, wellness, and recovery that are compatible with reducing the public funds spent on reproducing people deemed mentally ill. These understandings of mental illness, wellness, and recovery are advanced in government strategies and reports as well as the service provisioning of treatment, income support, and housing, now done in large part by non-profit organizations.

Because the dynamics and their implications of neoliberalism for people with mental illness labels are not visible solely through an analysis of social policy, I investigated high-support housing sites as case studies for this dissertation. The fieldwork was also critical in ensuring that the voices of people labelled mentally ill were included in the dissertation.

In the first chapter, *Towards a (Mad) Feminist Political Economy of Transinstitutionalization*, I argued that a feminist political economy analysis of mental health care policy in Ontario that draws on existing insights into social reproduction, and is supplemented by insights from Mad Studies, uncovers the existence of a new form of mental health care system, transinstitutionalization. I defined transinstitutionalization as a neoliberalized mental health care system governed by the objectives of increasingly privatized services for the daily maintenance of people with mental illness labels, mobilization of these services to promote participation in daily maintenance and labour force participation by those with mental illness labels, and the articulation of definitions of mental illness and recovery compatible with demands for independence, crystalizing in the consumer-patient subject model as the ideal mental patient. I suggested that, despite the attention feminist political economy scholars pay to marginality, little work has been done on issues of mental health and Madness.

In explaining the framework used in this study, I offered a review of critical political economy literature addressing social policy, defined neoliberalism, and explained how I understand the state to operate within capitalism. I discussed feminist political economists' insights on social reproduction and their usefulness in examining the mental health care system as a set of programs and policies conditioning the daily maintenance of people with mental illness labels. I reviewed literature from Mad and Disability Studies on questions of mental illness, health and recovery, the biomedical and social models of disability, and the social determinants of health framework. I argued that, despite the radical underpinnings of Mad Studies, that field had paid little attention to its potential links with feminist political economy. I reviewed existing transinstitutionalization literature, and proposed enhancing the concept to capture the impact of neoliberalism on public mental health care. The contribution this chapter made, in addition to laying out the framework

for the rest of the dissertation, was to show how feminist political economy and Mad Studies must be brought together if we are to achieve an improved understanding of mental health care systems.

The second chapter, *A Critical History of Ontario's Transinstitutionalization*, provided the history – in many ways a retelling of the history – of Ontario's mental health care system from deinstitutionalization to today. By paying close attention to the interplay between dominant understandings of mental illness, the relationship between the federal and provincial governments, and the prevailing economic ideology, I was able to divide the history of transinstitutionalization into five distinct historical phases. Each phase corresponds to changing economic conditions, decisions made by the provincial government, and understandings of mental illness. Each phase, I suggested, represents a distinct step in the development of transinstitutionalization and its central protagonist – the consumer-patient subject, the ideal mental patient. This chapter offered the unique insight that deinstitutionalization in Ontario, although it may appear at first glance to be a neoliberal policy strategy, was rooted in earlier provincial policy-making processes, indicating the need for more comparative work on deinstitutionalization between provinces which may have taken a different path.

The third chapter, *Treatment*, opened the second part of the dissertation, examining the state of mental health care in Ontario today through archival research, policy analysis, and case studies. In *Treatment*, I argued that medical services should be analyzed as contributing to daily maintenance and that the structure of treatment services in contemporary Ontario contributes to transinstitutionalization in the following ways. It downloads much of the responsibility for treatment services (both administering and coordinating treatment) to the non-profit sector, often with insufficient funding, producing intensified demands on service providers, as well as

positioning service providers as those who reproduce the biomedical model, dominant understandings of recovery, and the consumer-patient subject. I argued that each of these elements of treatment operate in favour of reducing the public “burden” of the reproduction of people labelled mentally ill.

I then explored in depth the content of treatment work done in the housing sites, showing the primacy placed on medication compliance and its alignment with wellness and recovery. I argued that this focus on compliance as wellness further individualizes responsibility for treatment at the level of service users, and further entrenches the consumer-patient subject as the ideal. I closed with the argument that the biomedical model of mental illness and demands for independence come together under neoliberalism in the recovery approach employed by the province in OMHM that contributes to the legitimacy and stability of transinstitutionalization. This chapter, as a whole, offered the first feminist political economy analysis of mental health treatment in Ontario, although more work needs to be done in this area.

In the fourth chapter, *Income Supports*, I argued that Ontario’s income support programs condition the activities of daily maintenance among recipients with mental illness labels to reduce their service use and to more closely align themselves with the consumer-patient subject model. I provided an in-depth analysis of the application processes for OW and ODSP, their directives, and their interaction with mental health law, demonstrating the ways in which they operate to reduce usage and, by extension, existing or potential costs. I then examined how, in addition to the workfare provisions in OW, people with mental illness labels are being encouraged to obtain employment, which is seen as a sign of wellness and is framed as a social determinant of health. I reviewed resident experiences with employment to help fill a gap in our knowledge about this population’s participation in the labour force. I raised questions about the province’s positioning

of employment as a social determinant of health in light of the high rates of precarious employment, unemployment, and low-wage employment among people with disabilities, both in the existing literature and in the experiences of my interviewees. I contended that the government's focus on employment is more concerned with cost reduction in the area of residents' daily maintenance than it is with their health. This chapter contributed an improved understanding of how ODSP and OW operate in the lives of people with mental illness labels and how they interact with legislation like the MHA, 1990. It also drew attention to the need for more research into the employment experiences of people with mental illness labels in Ontario and Canada, especially given the exclusion of large numbers of this group from the CSD, 2012, and the move on the part of the province to remove many people with mental illness labels out of the category of the deserving poor.

In the fifth chapter, *Housing*, I examined the downloading of mental health housing (shelter and supports) to the non-profit (and occasionally, for-profit) sector. Distinct from the downloading of social and subsidized housing in the late 20th and early 21st centuries in Ontario, the divestment of much of the responsibility for the shelter and supports for daily living occurred with deinstitutionalization and was motivated by the cost-saving goals that produced a deinstitutionalized mental health care system. I examined daily life within the housing sites and recorded how residents' work contributes to the functioning of the sites and to the government's goal of realizing cost savings in the services for people with mental illness labels. Finally, I examined how rules and policies within and outside the housing sites limit the romantic, sexual, and family life of residents and people with mental illness labels generally. The consumer-patient subject is not only self-sufficient but childless. I concluded with a discussion of how these eugenic policies contain the cost of housing supports and of income and treatment supports,

ensuring that service users' energies are directed toward work in the homes, toward reducing the possibility that the genetic underpinnings of mental illness will be passed on, and ultimately toward becoming the ideal consumer-patient subject. These housing policies contribute to the development of a population that is as independent as possible from social services, and reduces the share of social services for those with mental illness labels. I ended this chapter with an assessment of the similarities and differences between the housing sites and the institution. This chapter highlighted the similar pressures on service providers and service users to do paid work and the differences in how these pressures are manifested. It also raised the issue of neo-eugenics in Ontario's mental health care system as well as the legacies of institutionalization such as forced medication that persist in many corners of the mental health care system in the province.

Together, these chapters demonstrate the distinct and overlapping ways in which the mental health care system privatizes services for daily maintenance within the non-profit sector, shapes these services to demand independence in daily maintenance as well as production for surplus among services users, and promotes compatible understandings of mental illness and recovery. These three elements operate in the interest of producing a leaner mental health care system and a mental patient who is both sick and economically independent. A feminist political economy lens, in paying close attention to the relationship between production for surplus and social reproduction, reveals the extent to which the mental health care system attempts to align the whole life of service users with the interest of surplus production. This system is transinstitutionalization.

I raised questions about why these developments have been unanalyzed, coming to the conclusion that it is the direct result of the lack of communication between feminist political economy and Mad Studies. Despite critiques from Mad Studies scholars on mental health care

systems and psychiatry generally (e.g. edited volume by LeFrancois et al., 2013 and Burstow et al., 2014), and the recovery model in particular (Costa et al., 2012, Howell & Voronka, 2012), there has yet to emerge a sustained critique of this new form of penetration of the capitalist imperative for accumulation into the lives of people accessing mental health care services. At the same time, while feminist political economists have dedicated significant energy towards understanding the implications of the privatization of social reproduction under neoliberalism and its impact on people who are oppressed by hierarchies of gender, “race,” class, citizenship, and disability (edited volume by Bakker & Gill, 2003; Luxton & Bezanson, 2006; LeBaron & Roberts, 2010; Steans & Tepe, 2010; edited volume by Vosko, 2006; Vosko 2010), little attention has been paid to people labelled mentally ill or the mental health care system. Nonetheless, I contended that it is precisely the tools of feminist political economy that are needed in order to understand and challenge transinstitutionalization as a system which seeks to render people more compatible with the drive for accumulation and which is too often mistaken as progressive.

Specifically, analyses of social reproduction produced by feminist political economists recognize the interrelationship between production for surplus (wage labour) and social reproduction in the production of surplus, the tensions that emerge over wages used in the reproduction of the population, the role of the state in mediating these tensions, and the associated arrangement of decommodified supports for social reproduction (Bezanson, 2006 a & b; Cameron, 2006; Vosko 2000). Feminist political economists demonstrate how, under neoliberalism, it is not only that wages and employer-provided benefits are declining, but state supports for social reproduction are being recognized in the interest of capital accumulation (edited volume by Luxton & Bezanson, 2006). This reorganization of supports is directly informed by the logic of neoliberalism, namely that the use of public funds in support of social reproduction is a deterrent

to economic growth, both in terms of softening the need for labour force dependency and in siphoning off surplus through taxation to be used in activities perceived as non-productive (Phillips, 2002). It is precisely these tensions and developments, I have argued, that inform the organization of mental health care under neoliberalism.

In making this argument, my dissertation contributes to feminist political economy a much-needed focus on issues of Madness and mental health care, and to Mad Studies the hitherto-absent critical political economy lens. I offer a new framework for analyzing mental health care that identifies it as a system of daily maintenance, and therefore as part of the processes of production, while challenging dominant understandings of mental illness and recovery. This dissertation has provided a detailed application of this framework to Ontario's mental health care system, demonstrating that, although the path between preserving and advancing Mad agency and autonomy on the one hand and recognizing the exploitative conditions resulting from demands for productivity on the other is a narrow one, it can indeed be walked.

This study of transinstitutionalization is a contribution to the fields of feminist political economy and Mad Studies, and sheds light on the effects of the neoliberalized mental health care system on a small group of people in one Canadian province. It does not address how transinstitutionalization is experienced differently across social locations, focussing instead on sketching the terrain of the system itself. It is clear, however, from the few examples of gendered implications of transinstitutionalization that Ontario's contemporary mental health care system is experienced differently depending on one's social location. There is a need for more research to allow for an expanded gender analysis of transinstitutionalization, as well as analysis related to race, citizenship, and gender identity.

In particular, it is necessary to consider how transinstitutionalization impacts Black and Indigenous People and People of Colour, as well as Transgender and Gender Variant/Non-Binary identified people who have incurred psychiatric labels. There is also an urgent need to consider if and how transinstitutionalization operates in the lives of people with other types of disability labels, such as people with intellectual and physical disabilities and the Deaf community, as well as people with multiple and intersecting disabilities labels. Although limited, this study opens up space for further inquiry that stretches across social and geographical location and interrogates how neoliberalism is dramatically altering where and how the daily maintenance of people with all disability labels takes place. When applied to the area of disability it is not only people with mental illness labels who will benefit from a feminist political economy analysis.

Through this dissertation I am extending the benefits of a feminist political economy analysis, which draws attention to the exploitation and inequality experienced by diverse groups in late capitalism, to people with mental illness labels. Transinstitutionalization is not liberation but rather the greater inclusion of people with mental illness labels into the exploitative processes of capitalist production, processes that often do not provide a decent standard of living to people marked as disabled. This is not to argue that we should return to institutionalization or that people deemed mentally ill should not or cannot participate in all aspects of production. Nor is it to argue that people with mental illness labels should wait for a more equitable economic system before demanding full inclusion in the processes of production. Rather, I have contended that this kind of inclusion is not enough nor is it “good enough” for people labelled mentally ill.

Moreover, I have contended that the mental health care system, while it may look progressive and is in many ways an improvement on wholesale institutionalization, remains oppressive, operating in the interest of capital over well-being. Our understanding of the operation of the mental health

care system, precisely because it is a system of daily maintenance and therefore often hidden from the public eye, is enriched the application of a feminist political economy lens.

Bibliography

Archival Resources

Centre for Addiction and Mental Health Archives (CAMHA)

LaCroix, Marie. (1986). About a Boarding Home. Cuckoo's Nest. Sept & Oct. CAMHA. Centre for Addition and Mental Health, Queen Street Site Fonds. Box 24-05, Series J-3.

Mallory, John. (1986). Rocket Launcher. Cuckoo's Nest. Sept & Oct. CAMHA. Centre for Addition and Mental Health, Queen Street Site Fonds. Box 24-05, Series J-3.

Ontario Ministry of Health. (1979). Fact Sheet Concerning Closure of Lakeshore Psychiatric Hospital. CAMHA. Centre for Addition and Mental Health, Queen Street Site Fonds. Box 25-04, Series J-3.

Provincial Community Mental Health Committee. (1988). Building Community Support for People: A Plan for Mental Health in Ontario. Toronto, ON, Canada: Ontario Ministry of Health. CAMHA. Centre for Addition and Mental Health, Queen Street Site Fonds. Box 23-01, Series J-3.

Psychiatric Aftercare in Metropolitan Toronto Summary (1981). Community Resources Consultants of Toronto and the Clark Institute with grant from Ontario Ministry of Health. CAMHA.

City of Toronto Archives (CTA)

Department of Social Services (1979). Adult Residential Facilities: Boarding homes and Lodging Houses. First Report to the Metropolitan Social Services and Housing Subcommittee on Boarding homes and Lodging Houses. CTA. Fonds 200, Series 1618, File 3220- General - 03335 Problems Associated with Boarding & Lodging Houses with Crisis, Residential & Similar Care Facilities.

City Of Toronto Minutes. Executive Committee Report Number 11.22 (1983). Mayor's Action Task Force on Discharged Psychiatric Patients. 1782-1785.

City Of Toronto Minutes. Executive Committee Report Number 11.1 (1984). Final Report of the Mayor's Action Task Force on Discharged Psychiatric Patients. 3479-3586.

Metropolitan Toronto Council Minutes. Report Number 7 of the Community Services and Housing Committee (1986) Volume 1, 1332-1338.

Metropolitan Toronto Council Minutes. Report Number 22 of the Management Committee (1990) Volume 3, 2692-2702.

Government Resources

Canada Health Act, 1985. Retrieved from <http://laws-lois.justice.gc.ca/eng/acts/C-6/>. Last accessed December 8th, 2016.

Department of Finance Canada. (n.d.). *Federal support to provinces and territories*. Retrieved from <https://www.fin.gc.ca/fedprov/mtp-eng.asp#>. Last accessed December 8th, 2016.

Government of Ontario. (n.d.). Health Force: Ontario Health Insurance Plan. Retrieved from http://www.healthforceontario.ca/en/Home/Nurses/Training_%7C_Practising_Outside_Ontario/Ontario's_Health_Care_System/Ontario_Health_Insurance_Plan. Last accessed December 16, 2016.

Government of Canada. (n.d.). Canada Pension Plan disability benefit. Retrieved from <https://www.canada.ca/en/services/benefits/publicpensions/cpp/cpp-disability-benefit.html>. Last accessed December 14, 2016.

Government of Canada. (2012). The mental health strategy for corrections Canada. Retrieved from <http://publications.gc.ca/site/eng/427753/publication.html>. Last accessed December 13, 2016.

Health Insurance Act, 1990 (Ontario). Retrieved from <https://www.ontario.ca/laws/statute/90h06>. Last accessed December 15th, 2016.

Local Health Integration Networks. (n.d.). *Ontario Ministry of Health and Long-Term Care*. Retrieved from http://www.health.gov.on.ca/transformation/lhin/lhin_mn.html.

Local Health System Integration Act (2006, c-4). Retrieved from http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06l04_e.htm. Last accessed December 16, 2016.

Mental Health Act, 1990. (Ontario). Retrieved from <https://www.ontario.ca/laws/statute/90m07>. Last accessed December 14th, 2016.

National Defense and Canadian Armed Forces. (n.d.). About the Department of National Defence and the Canadian Armed Forces. Retrieved from <http://www.forces.gc.ca/en/about-us.page>. Last accessed December 14, 2016.

Office of the Auditor General. (2008). *Ministry of Health and Long-Term Care, Community Mental Health (Chapter 3, Section 3,06)*. Retrieved from

http://www.auditor.on.ca/en/content/annualreports/reportsbytopic/bytopic_health.html. Last accessed December 13, 2008.

Office of the Auditor General. (2010). *Ministry of Health and Long-Term Care, Community Mental Health. (Follow-up on VFM Section 3.06, 2008 Annual Report)*. Retrieved from http://www.auditor.on.ca/en/content/annualreports/reportsbytopic/bytopic_health.html. Last accessed December 13, 2008.

Ontario Disability Support Program Act (1997, c-25, sch. B). Retrieved from <https://www.ontario.ca/laws/statute/97o25>. Last accessed December 16, 2016.

Ontario Ministry of Children and Youth Services. (2016). Ontario Family Risk Assessment Descriptors Neglect Index. *Ontario Child protection tools manual (2016)* (pp. 33-37). Retrieved from <http://www.children.gov.on.ca/htdocs/English/documents/childrensaidd/Child-Protection-Tools-Manual-2016.pdf>. Last accessed December 14, 2016.

Ontario Ministry of Community and Social Services. (n.d.) Social Assistance Directives. Retrieved from <http://www.mcsc.gov.on.ca/en/MCSS/programs/social/directives/index.aspx>. Last accessed December 13, 2016.

Ontario Ministry of Community and Social Services. (n.d.). *History of Developmental Services*. Retrieved from <http://www.mcsc.gov.on.ca/en/dshistory/index.aspx>. Last Accessed December 8, 2016.

Ontario Ministry of Community and Social Services. (n.d.). Income support: How to apply. Retrieved from http://www.mcsc.gov.on.ca/en/mcsc/programs/social/odsp/income_support/apply_income.aspx. Last accessed December 13, 2016.

Ontario Ministry of Community and Social Services. (n.d.). *Social assistance policy directives*. Retrieved from www.mcsc.gov.on.ca/en/MCSS/programs/social/directives/index.aspx#ow. Last accessed December 16, 2016.

Ontario Ministry of Community and Social Services. (n.d.). *Social assistance: Treatment of Income: When you Work and Earn Money*. Retrieved from http://www.mcsc.gov.on.ca/en/mcsc/programs/social/odsp/income_support/odsp_workearn.aspx. Last accessed December 14, 2016.

Ontario Ministry of Community and Social Services. (n.d.). *Income support: Treatment of Assets (ODSP)*. Retrieved from http://www.mcsc.gov.on.ca/en/mcsc/programs/social/odsp/income_support/assets.aspx. Last accessed December 16, 2016.

Ontario Ministry of Community and Social Services. (2012). *Brighter prospects: Transforming social assistance in Ontario*. Retrieved from http://www.mcscs.gov.on.ca/documents/en/mcscs/social/publications/social_assistance_review_final_report.pdf. Last accessed December 16, 2016.

Ontario Ministry of Finance. (n.d.). Transforming Health Care. *Jobs for Today and Tomorrow: 2016 Ontario Budget*. Retrieved from <http://www.fin.gov.on.ca/en/budget/ontariobudgets/2016/bk8.html>. Last accessed December 16, 2016.

Ontario Ministry of Municipal Affairs, Ministry of Housing. (2016). *Ontario's Long-Term Affordable Housing Strategy-Update*. Retrieved from <http://www.mah.gov.on.ca/Page9181.aspx>. Last accessed December 14, 2016.

Ontario's Mental Health & Addictions Leadership Advisory Council (OMHALAC). (2015). *Better mental health means better health: Annual report of Ontario's Mental Health and Addictions Leadership & Advisory Council*. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/bmhmbh/mental_health_adv_council.pdf. Last accessed, December 8, 2016.

Ontario Ministry of Health. (1993). *Putting people first: The reform of mental health services in Ontario*. Retrieved from <http://ontario.cmha.ca/files/2011/06/puttingpeoplefirst.pdf>. Last Accessed December 8, 2016.

Ontario Ministry of Health. (1999). *Making it Happen: Implementation Plan for Mental Health Reform*. Retrieved from <http://ontario.cmha.ca/files/2011/06/makingithappen1999.pdf>. Last accessed December 14, 2016.

Ontario Ministry of Health. (n.d.) *Making it work: Policy framework for employment supports for people with serious mental illness*. Retrieved from <http://ontario.cmha.ca/files/2011/06/makingitwork.pdf>. Last accessed December 14, 2016.

Ontario Ministry of Health and Long-Term Care. (2010). *Respect, recovery, resilience: Recommendations for Ontario's Mental Health and Addictions Strategy*. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health/mentalhealth_rep.pdf. Last Accessed, December 8, 2016.

Ontario Ministry of Health and Long-Term Care. (2011). *Open minds, healthy minds: Ontario's comprehensive mental health and addictions strategy*. Retrieved from http://www.health.gov.on.ca/en/common/ministry/publications/reports/mental_health2011/mental_health_rep2011.pdf. Last Accessed December 13, 2016.

Ontario Ministry of Health and Long-Term Care. (n.d.). *Ontario's Local Health Integration Networks*. Retrieved from <http://www.lhins.on.ca/>. Last accessed December 16, 2016.

Ontario Works Act, 1997. Available at <https://www.ontario.ca/laws/statute/97o25a>. Last accessed December 16, 2016.

Provincial Community Mental Health Committee. (1988). *Building community support for people: A plan for mental health in Ontario*. Retrieved from <http://ontario.cmha.ca/files/2011/06/grahamreport.pdf>. Last accessed December 16, 2016.

Statistics Canada. (n.d.) *Canadian Survey on Disability, 2012*. Retrieved from <http://www23.statcan.gc.ca/imdb/p2SV.pl?Function=getSurvey&SDDS=3251>. Last accessed December 14, 2016.

Statistics Canada. (n.d) Table 115-006. Labour force status for adults with disabilities, by disability type and global severity, sex and age group, Canada, provinces and territories. Retrieved from <http://www5.statcan.gc.ca/cansim/pick-choisir?lang=eng&p2=33&id=1150006>. Last accessed December 14, 2016.

Statistics Canada. (2011a). Institutional Resident. *Census Directory*. Available at <https://www12.statcan.gc.ca/census-recensement/2011/ref/dict/pop053-eng.cfm>. Last accessed December 16, 2016.

Statistics Canada. (2011b). Collective Dwelling. *Census Directory*. Available at <https://www12.statcan.gc.ca/census-recensement/2011/ref/dict/dwelling-logements002-eng.cfm>. Last accessed December 16, 2016.

Resources from Private Organizations

Canadian Mental Health Association. (n.d). *Mental Health for All Fact Sheet Mental Health is Everyone's Concern*. Retrieved from http://mentalhealthweek.cmha.ca/files/2013/03/CMHA_MHW2012_Everyones_Concern_ENG_Final.pdf. Last accessed December 14, 2016.

Canadian Mental Health Association, Ontario. (2011). Ontario Mental Health and Addictions Alliance launches election campaign. Retrieved from <http://ontario.cmha.ca/news/ontario-mental-health-and-addictions-alliance-launches-election-campaign/#.UorcD8SsiSp.Last> Accessed, December 8, 2016

Canadian Mental Health Association, Toronto. (2014). *Why can't Canada spend more on mental health? Executive summary*. Toronto, ON. Retrieved from <http://toronto.cmha.ca/files/2014/04/Executive-Summary-1.pdf>. Last accessed December 13, 2016.

Central LHIN. (2012). *Discretionary Funding Allocation Process*. Retrieved from <http://www.centrallhin.on.ca/forhsp/policiesdirectivesresources.aspx>. Last accessed December 8, 2016.

Central LHIN. (n.d.). *Integrated Health Service Plan (2013-2016): Creating Caring Communities*. Retrieved from <http://www.centrallhin.on.ca/goalsandachievements/ihsp.aspx>. Accessed December 8, 2016.

Central East LHIN. (2012). *Integrated Health Service Plan (2013-2016): Community First*. Retrieved from <http://www.centraleasthin.on.ca/goalsandachievements/ihsp.aspx>. Accessed December 8, 2016.

Central East LHIN. (2009). *Supportive Housing Review Report*. Retrieved from <http://www.centraleasthin.on.ca/Page.aspx?id=13476>. Last accessed December 14, 2016.

Central South LHIN. (n.d.). *Integrated Health Service Plan (2013-2016): Better Integration, Better Health Care*. Retrieved from <http://www.southeasthin.on.ca/GoalsandAchievements/Planning/IHSP.aspx>. Last accessed December 8, 2016.

Central West LHIN. (n.d.). *Integrated Health Service Plan (2013-2016): Healthy Change*. Retrieved from <http://www.centralwesthin.on.ca/Page.aspx?id=5894>. Last Accessed December 8, 2016

Centre for Addiction and Mental Health. (n.d.). About therapy. Retrieved from http://www.camh.ca/en/hospital/visiting_camh/rights_and_policies/Pages/challenges_choices_abouttherapy.aspx. Last accessed December 13th, 2016.

Centre for Addiction and Mental Health. (n.d.). Getting an assessment. Retrieved from http://www.camh.ca/en/hospital/visiting_camh/rights_and_policies/Pages/challenges_choices_get_assess.aspx. Last accessed December 13, 2016.

Centre for Addiction and Mental Health. (n.d.). Common Legal Forms. Retrieved from http://www.camh.ca/en/hospital/visiting_camh/rights_and_policies/Pages/challenges_choices_appelegalform.aspx. Last accessed December 13, 2016.

Centre for Addiction and Mental Health. (n.d.). *Appendix C: Common legal forms*. Retrieved from http://www.camh.ca/en/hospital/visiting_camh/rights_and_policies/Pages/challenges_choices_appelegalform.aspx. Last accessed December 14, 2016.

Centre for Addiction and Mental Health. (2004-2006). *The housing guide: A comprehensive guide for people with mental health and substance abuse concerns*. Toronto, ON: Centre for Addictions and Mental Health.

Centre for Addiction and Mental Health. (2012a). *From this point forward: Ending custodial housing for people with mental illness in Canada*. Toronto, ON. Retrieved from: <http://eenet.ca/wp-content/uploads/2014/12/Community-Support-and-Research-Unit-2012-From-This-Point-Forward.pdf>. Last accessed December 12, 2016.

Centre for Addiction and Mental Health. (2012b). *Road to recovery: Client experiences in supportive housing*. Toronto, ON. Retrieved from https://www.camh.ca/en/hospital/about_camh/influencing_public_policy/Documents/Road_to_Recovery-Client_Experiences_in_Supportive_Housing.pdf. Last Accessed, December 8th, 2016.

Champlain LHIN. (n.d.). *Integrated Health Service Plan (2013-2016)-Towards a Person-Centred Health Care System*. On file with author.

Erie St. Clair LHIN. (2012). Integrated Health Services Plan (IHSP 3). Retrieved from <http://www.eriestclairrhin.on.ca/Accountability/IHSP/IHSP3-2013-2016/IHSP%203%20-%202013-2016.aspx>. Last Accessed December 8, 2016.

Fraser, J., Wilkey, C., & Frenschkowski, J. (2003). *Denial by design... the Ontario Disability Support Program*. Toronto, ON: Income Security Advocacy Centre. Retrieved from <http://www.odspaction.ca/sites/odspaction.ca/files/denialbydesign.pdf>. Last Accessed, December 8, 2016.

Gaetz, S., O'Grady, B., & Buccieri, K. (2010). *Surviving crime and violence: Street youth and victimization in Toronto*. Toronto, ON: JFCY & Homelessness Hub. Retrieved from <http://www.homelesshub.ca/survivingthestreets>. Last accessed December 16, 2016.

Habitat Model. (n.d.). *Habitat Services*. Retrieved from <http://www.habitatservices.org/the-habitat-model/>. Last accessed December 16, 2016.

Hamilton Niagara Haldimand Brant LHIN. (2012). *Integrated Health Service Plan (2013-2016)-Working Together for Better Health Care: Integrated Health Service Plan*. Retrieved from <http://www.hnhblhin.on.ca/goalsandachievements/strategicdocuments/integratedhealthserviceplan.aspx>. Last Accessed December 8, 2016.

Homelessness Hub. (n.d.) Mental Health. Retrieved from <http://homelesshub.ca/about-homelessness/topics/mental-health>. Last accessed December 13, 2016.

Psychiatric Patient Advocate Office. (n.d.). *InfoGuides*. Retrieved from http://www.sse.gov.on.ca/mohltc/ppao/en/Pages/InfoGuides/2016_Form1.aspx?openMenu=smenu_InfoGuides. Last accessed December 13, 2016.

Local Health Integration Network Collaborative (LHINCollaborative). (2010). *LHIN Priority Setting & Decision Making Framework Toolkit*. Retrieved from: <http://www.lhincollaborative.ca/resources.aspx>. Last Accessed December 8, 2016.

Mental Health Commission of Canada. (2013). *Turning the Key: Assessing Housing and Related Supports for Persons Living with Mental Health Problems and Illness* Retrieved from http://www.mentalhealthcommission.ca/sites/default/files/PrimaryCare_Turning_the_Key_Full_ENG_0_1.pdf. Last accessed December 16, 2016.

Mental Health Commission of Canada. (2015). *Guidelines for Recovery-Oriented Practice* Retrieved from <http://www.mentalhealthcommission.ca/English/document/72756/guidelines-recovery-oriented-practice>. Last accessed December 13, 2016.

Mississauga Halton LHIN. (n.d.). *Integrated Health Service Plan (2013-2016): Partnering for a Healthier Tomorrow*. Retrieved from <http://www.mississaugahaltonlhin.on.ca/goalsandachievements/ihsp.aspx>. Last Accessed December 8, 2016.

North East LHIN. (2013). *Integrated Health Service Plan (2013-2016): Quality Health Care When NORTHERNERS Need It*. On file with author.

North West LHIN. (n.d.). *Integrated Health Services Plan (2013-2016)*. Retrieved from <http://www.northwestlhin.on.ca/goalsandachievements/IntegratedHealthServicesPlan.aspx>. Last Accessed December 8, 2016.

Ontario Non-Profit Housing Association. (2015). 2015 waiting lists survey: ONPHA's report on waiting lists statistics for Ontario. Toronto, ON. Retrieved from https://www.onpha.on.ca/onpha/web/Policyandresearch/2016_Waiting_List_Survey/Content/PolicyAndResearch/Waiting_Lists_2016/2016_Waiting_Lists_Survey.aspx?hkey=08cff4ce-7f97-4af4-910c-c64954d28a4a. Last Accessed December 8, 2016.

Ontario Non-Profit Housing Association. (2013). LHINs and the Housing System. Retrieved from https://www.onpha.on.ca/onpha/Content/PolicyAndResearch/focusONs/LHINs_and_the_housing_system.aspx. Last accessed December 13th, 2016.

Ontario Women's Justice Network. (n.d.) *Ontario Disability Support Program*. Retrieved from http://owjn.org/owjn_2009/women-like-me/women-homelessness-and-poverty/346-odsp-income-support-program. Last accessed December 16, 2016.

South West LHIN. (2012). *Integrated Health Services Plan (2013-2016): Living Healthy, Independently and Softly at Home*. Retrieved from <http://www.southwestlhin.on.ca/goalsandachievements/ihsp.aspx>. Last Accessed December 8, 2016.

Suttor, G. (2016). *Taking Stock of Supportive Housing for Mental Health and Addictions in Ontario*. Wellesley Institute. Retrieved from <http://www.wellesleyinstitute.com/publications/taking-stock-of-supportive-housing-for-mental-health-and-addictions-in-ontario/>. Last Accessed December 8, 2016.

Toronto Central LHIN. (2013). *Integrated Health Service Plan (2013-2016): A Plan to Transform Local Health Care for All*. On file with author.

Torjman, S. (1996). *Workfare: A poor law*. Ottawa, ON: The Caledon Institute of Social Policy. Retrieved from <http://www.caledoninst.org/publications/pdf/10eng.pdf>. Last accessed December 16, 2016.

Waterloo Wellington LHIN. (2012) *Integrated Health Services Plan (2013-2016): Better Health, Better Futures*. Retrieved from http://www.waterloowellingtonlhin.on.ca/goalsandachievements/ihsp_archives.aspx. Last accessed December 8, 2016.

Academic Sources

Albo, G. (2002). Neoliberalism, the state, and the left: A Canadian perspective. *Monthly Review*, 54(1), 46–55.

Albo, G. (2009). The crisis of neoliberalism and the impasse of the union movement. *Development Dialogue*, 51, 119-132.

Albo, G., & Fast, T. (2003, May). *Varieties of neoliberalism: Trajectories of workfare in advanced capitalist countries*. Paper presented at the Annual Meetings of the Canadian Political Science Association, Congress of the Humanities and Social Sciences at Dalhousie University. Retrieved from: http://www.uibk.ac.at/wuv/pdf/ehem/albo_workfare.pdf

Arat-Koc, S. (2006). Whose social reproduction? Transnational motherhood and challenges to feminist political economy. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neoliberalism* (pp. 75-92). Kingston & Montreal: McGill-Queen's University Press.

Armstrong, P. (1996). The Feminization of the Labour Force: Harmonizing Down in a Global Economy. In I. Bakker (Ed.), *Rethinking Restructuring: Gender and Change in Canada* (pp. 29-54). Toronto: University of Toronto Press.

Armstrong, P. (1997). Restructuring public and private: Women's paid and unpaid work. In S. Boyd (Ed.), *Challenging the public/private divide: Feminism, law and public policy* (pp. 37-61). Toronto: University of Toronto Press Inc.

Armstrong, P., Armstrong, H., & Scott-Dixon, K. (2008). Making Gender Matters Visible. *Critical to care: The invisible women in health services* (pp. 88-120). Toronto: University of Toronto Press.

Armstrong, P., & Armstrong, H. (2010). Who Pays? *Wasting away: The undermining of Canadian health care* (2nd ed.) (pp. 145-178). Don Mills, ON: Oxford University Press.

- Baines, D. (2004). Caring for Nothing: Work Organization and Unwaged Labour in Social Services. *Work, Employment and Society, Volume 18(2)*, 267–295.
- Baines, D., Davis, J., Saini, M. (2009). Wages, working conditions, and restructuring in Ontario's social work profession. *Canadian Social Work Review, 26(1)*, 59-72
- Bakker, I. (2003). Neo-liberal Governance and the Reprivatisation of Social Reproduction: Social Provisioning and Shifting Gender Orders. In I. Bakker & S. Gill (Eds.), *Power, production, and social reproduction: Human insecurity in the global political economy* (pp. 66-82). Basingstoke: Palgrave Macmillan.
- Bakker, I., & Gill, S. (2003a). Global political economy and social reproduction. In I. Bakker & S. Gill (Eds.), *Power, production, and social reproduction: Human insecurity in the global political economy* (pp. 3-16). Basingstoke: Palgrave Macmillan.
- Bakker, I., & Gill, S. (2003b). Ontology, method and hypotheses. In I. Bakker & S. Gill (Eds.), *Power, production, and social reproduction: Human insecurity in the global political economy* (pp. 17-41). Basingstoke: Palgrave Macmillan.
- Bako, O. (2011). Neoliberalism and Its Effects on Canadian Women in Poverty. *The Lyceum. 1 (1)*, 32-40.
- Balogh, R., Ouelette-Kuntz, H., & Hunter, D.J. (2004). Regional variation in dental procedures among people with an intellectual disability, Ontario, 1995-2001. *Journal of the Canadian Dental Association, 70(1)*, 680-681.
- Bannerji, H. (2000). *The dark side of the nation: Essays on multiculturalism, nationalism, and gender*. Toronto: Canadian Scholars' Press.
- Benach, J., Vives, A., Amable, M., Vanroelen, C., Tarafa, G., & Muntane, C. (2014). Precarious Employment: Understanding an Emerging Social Determinant of Health. *Annual Review of Public Health. 35*, 229-253
- Beresford, P. (2000). What have madness and psychiatric system survivors got to do with disability and disability studies? *Disability & Society, 15(1)*, 167-172.
- Beresford, P. (2005). Social work and a social model of madness and distress: Developing a viable role for the future. *Social Work & Social Sciences Review, 12(2)*, 59-73.
- Bezanson, K. (2006a). *Gender, the state and social reproduction: Household insecurity in neo-liberal times*. Toronto: University of Toronto Press.
- Bezanson, K. (2006b). The neo-liberal state and social reproduction: Gender and household insecurity in the late 1990s. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist*

political economy challenges neoliberalism (pp. 173-214). Kingston & Montreal: McGill-Queen's University Press.

Bezanson, K. & Luxton, M. (2006). Social Reproduction and Feminist Political Economy. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neoliberalism* (pp. 3-11). Montreal: McGill-Queen's University Press.

Bizier, C., Marshall, C., & Fawcett, G. (2014). Mental health-related disabilities among Canadians aged 15 years and older, 2012. (89-654-X2014002) Ottawa, ON. Statistics Canada. Canadian Survey on Disability, 2012. Retrieved from <http://www.statcan.gc.ca/pub/89-654-x/89-654-x2014002-eng.pdf>. Last accessed December 14, 2016.

Bradford, N. (2003). Public private partnership? Shifting paradigms of economic governance in Ontario. *Canadian Journal of Political Science / Revue canadienne de science politique*, 36(5), 1005-1033.

Bradford, N. (2007). Placing social policy? Reflections on Canada's New Deal for cities and communities. *Canadian Journal of Urban Research*, 16(2), 1-26.

Braedley, S. (2006). Someone to watch over you: Gender, class, and social reproduction. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neoliberalism* (pp. 215-230). Kingston & Montreal: McGill-Queen's University Press.

Braedley, S. (2012). The masculinization effect: neoliberalism, the medical paradigm and Ontario's health care policy. *Canadian Women's Studies*, 29(3), 71-83.

Brenner, N., Peck, J., & Theodore, N. (2009). Variegated neoliberalization: Geographies, modalities, pathways. *Global Networks*, 10(2), 182-222.

Brodie, J. (2010). Globalization, Canadian family policy and the omissions of neoliberalism. *North Carolina Law Review*, 88(5), 1559-1592.

Brodie, J., & Trimble, L. (2003). Reinventing Canada. In J. Brodie and L. Trimble (Eds.), *Reinventing Canada* (1-16). Toronto: Prentice Hall.

Brown, W. (1992). Finding the Man in the State. *Feminist Studies*, 18(1), 7-34.

Burstow, B. (2014). Withering away of Psychiatry: An Attrition Model for Antipsychiatry. In B. Burstow, B. LeFrançois, & S. Diamond (Eds.), *Psychiatry disrupted: Theorizing resistance and crafting the (r)evolution* (pp. 34-51). London: McGill-Queens University Press.

Burstow, B., & Weitz, D. (1988). *Shrink resistant: The struggle against psychiatry in Canada*. Vancouver: New Star Books.

- Burstow, B., LeFrançois, B. A., & Diamond, S. (Eds.) (2014). *Psychiatry disrupted: Theorizing resistance and crafting the (r)evolution*. Montreal; Ithaca: McGill-Queen's University Press.
- Busfield, J. (1986). *Managing madness: Changing ideas and practice*. London: Hutchinson.
- Busfield, J. (1996). *Men, women and madness*. London: Hutchinson.
- Cameron, B. (2006). Social reproduction and Canadian federalism. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neoliberalism* (pp. 45-74). Kingston & Montreal: McGill-Queen's University Press.
- Campbell, M. (1998). Institutional ethnography and experience as data. *Qualitative Sociology*, 21(1), 55-73.
- Campbell, M., & Gregor, F. (2002). *Mapping social relations: A primer in doing institutional ethnography*. Aurora, ON: Garamond Press.
- Capponi, P. (1992). *Upstairs in the crazy house: The life of a psychiatric survivor*. Toronto: Viking Press.
- Capponi, P. (2003). *Beyond the crazy house: Changing the future of madness*. Toronto: Penguin Books LTD.
- Carr, S. (2005). "The sickness label infected everything we said": Lesbian and gay perspectives on mental disorder. In J. Tew (Ed.), *Social perspectives in mental health: Developing social models to understand work and mental distress* (pp. 168-183). London: Jessica Kingsley Publishers.
- Carroll, W., & Shaw, M. (2001). Consolidating the neoliberal policy bloc in Canada, 1976-1996. *Canadian Public Policy*, 27(2), 195-217.
- Chapman, C, Carey, A. C. & Ben-Moshe, L. (2014). Reconsidering Confinement: Interlocking Locations and Logics of Incarceration. In L. Ben-Moshe, C. Chapman & A.C. Carey (Eds.), *Disability incarcerated: Imprisonment and disability in the United States and Canada* (pp. 3-24). Palgrave Macmillan.
- Chesler, P. (1972). *Women and madness*. New York: Avon Books.
- Chouinard, V. (2006). On the dialectics of differencing: Disabled women, the state and housing issues. *Gender, Politics & Culture: A Journal of Feminist Geography*, 13(4), 401-417.
- Chouinard, V., & Crooks, V. (2005). "Because they have all the power and I have none": State restructuring of income and employment supports and disabled women's lives in Ontario, Canada. *Disability & Society*, 20(1), 19-32.

- Clark, D. (2002). Neoliberalism and public service reform: Canada in comparative perspective. *Canadian Journal of Political Science / Revue Canadienne De Science Politique*, 35(4), 771-793.
- Clarke, J. (2008). Living with/in and without neo-liberalism. *Focaal*, 51(Summer), 135-147.
- Clarkson, S., & Lewis, T. (1999). The contested state: Canada in the post-cold war, post-Keynesian, post-Fordist, post-national era. In L. Pal (Ed.), *How Ottawa spends, 1999-2000: Shape shifting: Canadian governance toward the 21st century* (pp. 293-340). Oxford: Oxford University Press.
- Cohen, B.M.Z. (2013). The power of madness: A Marxist critique of social constructionism. In H. Goodman, B. Russo, & J. Zóximo (Eds.), *Beyond these walls: Confronting madness in society, literature and art* (pp. 67-79). Retrieved from: www.interdisciplinarypress.net/online-store/ebooks/diversity-and-recognition/beyond-these-walls.
- Colderley, C. (1999). Welfare state retrenchment and the nonprofit sector: The problems, policies and politics of Canadian housing. *Journal of Policy History*, 11(3), 283-312.
- Collier, C. (2007, May-June). *Is Canada ready for a new universal social program? Comparing the cases of universal Medicare in the 1960s and "universal" child care in the new millennium*. Paper presented at the Annual Meeting of the Canadian Political Science Association, University of Saskatchewan.
- Corrigan, P., & Matthews, A. (2003). Stigma and disclosure: Implications for coming out of the closet. *Journal of Mental Health*, 12(3), 235-248.
- Costa, L., Voronka, J., Landry, D., Reid, J., McFarlane, B., Reville, D., & Church, K. (2012). Recovering our stories: A small act of resistance. *Studies in Social Justice*, 6(1), 85-101.
- Coulter, K. (2009). Deep neoliberal integration: The production of third way politics in Ontario. *Studies in Political Economy*, 83, 191-208.
- Das Gupta, T. (2007). Immigrant women's activism: The last thirty years. In G. Fuji Johnson & R. Enomoto (Eds.), *Race, racialization and antiracism in Canada and beyond* (pp. 105-116). Toronto: University of Toronto Press.
- Das Gupta, T., & Iacovetta, F. (2000). Introduction: Whose Canada is it? Immigrant women, women of colour and feminist critiques of multiculturalism. *Atlantis: Critical Studies in Gender, Culture & Social Justice*, 24(2), 1-4.
- Dear, M.J., & Wolch, J.R. (1987). *Landscapes of despair: From deinstitutionalization to homelessness*. Cambridge, UK: Polity Press.

- De Wolfe, A. (2006). Bargaining and collective responsibility for social reproduction. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neoliberalism* (pp. 93-116). Kingston & Montreal: McGill-Queen's University Press.
- Dickinson, H. (1993). Scientific parenthood: The mental hygiene movement and the reform of Canadian families, 1925-1950. *Scientific Journal of Comparative Family Studies*, 24(3), 387-402.
- Duffy, M. (2005). Reproducing Labour Inequalities: Challenges for Feminists Conceptualizing Care at the Intersections of Gender, Race, and Class. *Gender & Society*, 19 (1), 66-82.
- Duffy, M. (2007). Doing the Dirty Work. Gender, Race, and Reproductive Labor in Historical Perspective. *Gender & Society*, 21 (3), 313-336.
- Duffy, Mignon. 2011. *Making Care Count: A Century of Gender, Race, and Paid Care Work*. Piscataway, NJ: Rutgers University Press.
- Edwards, C., & Imrie, R. (2003). Disability and bodies as bearers of value. *Sociology*, 37(2), 239-256.
- Evans, B., & Shields, J. (2002). The third sector, neo-liberal restructuring and 'partnerships': Governance and the re-making of state-civil society relationships. In C. Dunn (Ed.), *Oxford handbook of Canadian public administration* (pp. 139-158). Toronto: Oxford University Press.
- Evans, B. M., & Smith, C. W. (Eds.). (2015). *Transforming provincial politics: The political economy of Canada's provinces and territories in the neoliberal era*. University of Toronto Press
- Everett, B. (2000). *A fragile revolution: Consumers and psychiatric survivors confront the power of the mental health system*. Waterloo, ON: Wilfrid Laurier University Press.
- Fabris, E. (2006). *Identity, inmates, capacity, consent, coercion: Chemical incarceration in psychiatric survivor experiences of community treatment orders*. Unpublished Master's thesis. Ontario Institute for Studies in Education, Toronto, ON.
- Fabris, E. (2011). *Tranquil prisons: Chemical incarceration under community treatment orders*. Toronto: University of Toronto Press.
- Ferguson, J. (2010). The uses of neoliberalism. *Antipode*, 41(Supplement), 166-184.
- Ferguson, S. (2008). Canadian Contributions to Social Reproduction Feminism, Race and Embodied Labor. *Race, Gender & Class*, 15 (1-2), 42-57
- Fernando, S. (1991). *Mental health, race, and culture*. New York: St. Martin's Press.
- Finkel, A. (1993). Paradise postponed: A re-examination of the Green Book proposals of 1945. *Journal of the Canadian Historical Association*, 4(1), 120-142.

- Finkel, A. (2006). *Social policy and practice in Canada: A history*. Waterloo, ON: Wilfrid Laurier Press.
- Finkler, L. (2013). "They should not be allowed to do this to the homeless and mentally ill": Minimum separation distance bylaws reconsidered. In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 221-238). Toronto: Canadian Scholars Inc. Press.
- Forchuck, C. (2004). Surviving the tornado of mental illness: Psychiatric survivors' experiences of getting, losing, and keeping housing. *Psychiatric Services: Psychiatry Online*, 57, 558-562.
- Foucault, M. (1967). *Madness and civilization: A history of insanity in the age of reason*. London: Tavistock Publications.
- Fudge, J. & Cossman, B. (2002). Introduction. In B. Cossman and J. Fudge (Eds.), *Privatization, Law and the Challenge to Feminism* (pp. 3-37). Toronto: University of Toronto Press, 2002.
- Fudge, J., & Vosko, L. (2003). Gendered Paradoxes and the Rise of Contingent Work: Towards a Transformative Feminist Political Economy of the Labour Market." In Wallace Clement and Leah Vosko (Eds.), *Changing Canada: Political Economy as Transformation* (pp. 183-209). Montreal and Kingston: McGill-Queen's University Press.
- Gabel, S., & Peters, S. (2004). Presage of a paradigm shift? Beyond the social model of disability toward resistance theories of disability. *Disability & Society*, 19(6), 585-600.
- Gazso, A. (2012). Moral codes of mothering and the introduction of welfare-to-work in Ontario. *Canadian Review of Sociology*, 49(1), 26-49.
- Gleeson, B.J. (1997). Disability studies: A historical materialist view. *Disability & Society*, 12(2), 179-202
- Goffman, E. (1961) *Asylums*. London: Penguin Books.
- Goffman, E. (1973). The Characteristics of Total Institutions. In W.V. Heydebrand (Ed.), *Comparative organizations: The results of empirical research* (pp. 312-338). Englewood Cliffs, N.J.: Prentice-Hall.
- Graefe, P. (2005). *Roll out neoliberalism and the social economy*. Paper presented at the *Annual Meetings of the Canadian Political Science Association, Congress of the Humanities and Social Sciences*. London, ON: University of Western Ontario.
- Graefe, P. (2007). Political economy and Canadian public policy. In M. C. Smith & M. Orsini (Eds.), *Critical policy studies* (pp. 19-40). Vancouver: UBC Press.

- Graefe, P. (2016). Retooling Social Reproduction for Neoliberal Times: The Example of the Social Economy. In S. Springer, K. Birch, and J. MacLeavy (Eds.), *The Handbook of Neoliberalism* (pp. 284-294). London & New York: Routledge.
- Gray, C. (1999). Will voters' response to health care reforms determine the fate of Mike Harris? *Canadian Medical Association Journal*, *160*(11), 1623-1624.
- Gronfein, W. (1985). Psychotropic drugs and the origins of deinstitutionalization. *Social Problems*, *32*(5), 437-454.
- Hackworth, J. (2008). The durability of roll-out neoliberalism under centre-left governance: The case of Ontario's social housing sector. *Studies in Political Economy*, *81*, 7-26.
- Hackworth, J., & Moriah, A. (2006). Neoliberalism, contingency and urban policy: The case of social housing in Ontario. *International Journal of Urban and Regional Research*, *30*(3), 510-527.
- Hall, E., & Wilton, R. (2011). Alternative spaces of 'work' and inclusion for disabled people". *Disability & Society*, *26*(7), 867-880.
- Hankivsky, O., & Christoffersen, A. (2008). Intersectionality and the determinants of health: A Canadian perspective. *Critical Public Health*, *18*(3), 271-283.
- Harles, J., & Davies, J. (2005). *Federalism matters: Welfare reform and the intergovernmental balance of power in Canada and the United States*. Orono, ME : Canadian-American Center, University of Maine.
- Harper, D., & Speed, E. (2012). Uncovering recovery: The resistible rise of recovery and resilience. *Studies in Social Justice*, *6*(1), 9-25.
- Hartford, K., Schrecker, T., Wiktorowicz, M., Hoch, J.S., & Sharp, C. (2003). Four decades of mental health policy in Ontario, Canada. *Administration and Policy in Mental Health*, *31*, 65-73.
- Harvey, D. (2005). *A brief history of neoliberalism*. New York: Oxford University Press.
- Harvey, D. (2007). Neoliberalism as Creative Destruction. *The ANNALS of the American Academy of Political and Social Science*, *601*, 22-44.
- Hawe, P., & Potvin, L. (2009). What is population health intervention research? *Canadian Journal of Public Health*, *100*(1), I-8-I-14.
- Herd, D., Mitchell, A., & Lightman, E. (2005). Rituals of degradation: Administration as policy in the Ontario Works programme. *Social Policy & Administration*, *39*(1), 65-79.
- Howell, A., & Voronka, J. (2012). Introduction: The politics of resilience and recovery in mental health care. *Studies in Social Justice*, *6*(1), 1-7.

- Hubbard, R. (2006). Abortion and disability: Who should and should not inhabit the world? In L.J. Davis (Ed.), *The disability studies reader* (pp. 93-103). New York: Routledge.
- Isin, I.F. (1998). Governing Toronto without government: Liberalism and neoliberalism. *Studies in Political Economy*, 56(Summer), 169-191.
- Jenson, J. & Albo, G. (1989). A Contested Concept: The Relative Autonomy of the State. In W. Clement & G. Williams (Eds.). *The New Canadian political economy* (pp. 180-211). Kingston, Ont.: McGill-Queen's University Press.
- Johnson, R., & Mahon, R. (2006). NAFTA, the redesign and rescaling of Canada's welfare state. *Studies in Political Economy*, 76, 53-78.
- Jones, J. (2013). Forensic issues and psychiatric syndromes. In K. Tusaie & J. Fitzpatrick (Eds.), *Advanced practice psychiatric nursing: Integrating psychotherapy, psychopharmacology and alternative/complementary approaches* (pp. 524-531). New York: Springer Publishing Company.
- Katz, C. (2001). Vagabond capitalism and the necessity of social reproduction. *Antipode*, 33(4), 709-728.
- Keil, R. (2002). 'Common-sense' neoliberalism: Progressive conservative urbanism in Toronto, Canada. *Antipode*, 34(3), 578-601.
- Kirby, A. (2014). Trans-jeopardy/trans-resistance: Shaindl Diamond interviews Ambrose Kirby. In B. Burstow, B. LeFrançois, & S. Diamond (Eds.). *Psychiatry disrupted: Theorizing resistance and crafting the (r)evolution* (pp. 163-174). London: McGill-Queens University Press.
- Kirby, J. (2004). Disability and justice: A pluralistic account. *Social Theory and Practice*, 30(2), 229-246.
- Kirby, S., & McKenna, K. (1989). *Experience, research, social change: Methods from the margins*. Toronto: Garamond Press.
- Kunz, R. (2010). The crisis of social reproduction in rural Mexico: Challenging the 're-privatization of social reproduction' thesis. *Review of International Political Economy*, 17(5), 913-945.
- Larner, W. (2000). Neoliberalism: Policy, ideology, governmentality. *Studies in Political Economy*, 63, 5-25.
- Laslett, B., & Brenner, J. (1989). Gender and social reproduction: Historical perspectives. *Annual Review of Sociology*, 15, 381-404.

- Laws, G. (1988). Privatization and the local welfare state: The case of Toronto's social services. *Transactions of the Institute of British Geographers*, 13(4), 433-448.
- LeBaron, G. (2010). The political economy of the household: Neoliberal restructuring, enclosures, and daily life. *Review of International Political Economy*, 17(5), 889-912.
- LeBaron, G. (2015). Unfree labor beyond binaries: Social hierarchy, insecurity, and labor market restructuring. *International Feminist Journal of Politics*, 17(1), 1-19.
- LeBaron, G., & Roberts, A. (2010). Toward a feminist political economy of capitalism and carcerality. *Signs*, 36(1), 19-44.
- LeFrancois, B., Menzies, R., & Reaume, G. (Eds.). (2013). *Mad matters: A critical reader in Canadian mad studies*. Toronto: Canadian Scholars Inc. Press.
- Lemay, R. (2009). Deinstitutionalization of people with developmental disabilities: A review of literature. *Canadian Journal of Community Mental Health*, 28(1), 181-194.
- Leyes, C. (2010). Health, healthcare and capitalism. In L. Panitch & C. Leyes (Eds.), *Socialist Register 2010: Morbid symptoms: Health under capitalism* (pp. 1-28). Halifax: Fernwood Press.
- Lightman, E. (1997). Discharge planning and community housing in Ontario. *Social Work in Health Care*, 25(3), 63-75.
- Lightman, E., Herd, D., & Mitchell, A. (2006). Exploring the local implementation of Ontario Works. *Studies in Political Economy*, 78, 119-143.
- Lin, Z. (1998). Employment Insurance in Canada: Policy changes. *Perspectives: Statistics Canada*, 47 (Catalogue no. 75-001-XPE), 42-47.
- Little, M.J.H. (1998a). A closer look at the neo-liberal petri dish: Welfare reform in British Columbia and Ontario. *Canadian Review of Social Policy*, 57, 16-45.
- Little, M.J.H. (1998b). *'No car, no radio, no liquor permit': The moral regulation of single mothers in Ontario, 1920-1997*. Toronto: Oxford University Press
- Loeppky, R. (2004). International restructuring, health and the advanced industrial state. *New Political Economy*, 9(4), 493-513.
- Luxton, M., & Braedley, S. (2010). *Neoliberalism and everyday life*. Montreal: McGill-Queen's University Press.
- Luxton, M. (2006). Feminist Political Economy in Canada and the Politics of Social Reproduction. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neoliberalism* (pp. 11-44). Kingston & Montreal: McGill-Queen's University Press.

- Mahon, R. (2008). Varieties of neoliberalism: Canadian social policy from the 'golden age' to present. *Social Policy & Administration*, 42(2), 342-361.
- Mahon, R., & Brennan, D. (2013). Federalism and the 'new politics' of welfare development: Childcare and parental leave in Australia and Canada. *Publius: The Journal of Federalism*, 43(1), 90-108.
- Marks, D. (1997). Models of disability. *Disability Rehabilitation*, 19(3), 85-91.
- Marmot, M., & Friel, S. (2008). Global health equity: Evidence for action on the social determinants of health. *Journal of Epidemiology & Community Health*, 62(12), 1095-1097.
- Marshall, J. (1982). *Madness: An indictment of the mental health care system in Ontario*. Toronto: Brownstone Press.
- Martin, L., & Hirdes, J.P. (2009). Mental health needs and service use in Ontario. *Healthcare Management Forum*, 22(1), 40-46.
- Maynes, M.J., Pierce, J., & Laslett, B. (2008). *Telling stories: The use of personal narratives in the social sciences and history*. Ithaca: Cornell University Press.
- McBride, S. (2001). *Paradigm shift: Globalization and the Canadian state*. Halifax, N.S.: Fernwood Publishing.
- McBride, S., & McNutt, K. (2007). Devolution and neoliberalism in the Canadian welfare state: Ideology, national and international conditioning frameworks, and policy change in British Columbia. *Global Social Policy*, 7(2), 177-201.
- McGrath, S., Moffatt, K., George, U., Lee, B., & Lagios, A. (2012). Disciplining community agencies: The pressure to partner. *Canadian Social Work Review*, 29(1), 5-23.
- McKeen, W., & Porter, A. (2003). Politics and transformations: Welfare state restructuring in Canada. In W. Clement & L. F. Vosko (Eds.), *Changing Canada: Political economy as transformation* (pp. 109-134). Montreal: McGill-Queen's University Press.
- Menzies, R., & Palys, T. (2006). Turbulent spirits: Aboriginal patients in the British Columbia psychiatric system, 1879-1950. In J. Moran & D. Wright (Eds.), *Mental health and Canadian society: Historical perspectives*. Montreal and Kingston: McGill-Queen's University Press, 149-175.
- Mitchell-Brody, M. (2007). The Icarus Project: Dangerous gifts, iridescent visions, and mad community. In P. Stastny & P. Lehman (Eds.), *Alternatives beyond psychiatry* (pp. 137-145). Berlin: Peter Lehmann Pub.

- Moncrieff, J. (2008). Neoliberalism and biopsychiatry: A marriage of convenience. In C.I. Cohen & S. Timimi (Eds.), *Liberatory psychiatry: Philosophy, politics, and mental health* (pp. 235-255). Cambridge: Cambridge University Press.
- Morrissey, J., & Goldman, H. (1986). Care and treatment of the mentally ill in the United States: Historical developments and reforms. *The Annals of the American Academy of Political and Social Science*, 484(1), 12-27.
- Morrow, M. (2004). Mental health reform, economic globalization and the practice of citizenship. *Canadian Journal of Community Mental Health*, 23(2), 39-50.
- Murray, K.B. (2011). Making space in Vancouver's east end: From Leonard Marsh to the Vancouver agreement. *BC Studies*, 169, 7-49.
- Murray, K.B. (2015) Bio-gentrification: Vulnerability biovalue chains in gentrifying neighbourhoods. *Urban Geography*, 36(2), 277-299.
- Nabbali, E. M. (2009). A 'mad' critique of the social model of disability. *International Journal of Diversity in Organisations, Communities and Nations*, 9(4), 1-12.
- Navarro, V. (2009). What we mean by social determinants of health. *International Journal of Health Services*, 39(3), 423-441.
- O'Hara, B. (2004). Twice penalized: Employment discrimination against women with disabilities. *Journal of Disability Policy Studies*, 15(1), 27-34.
- Oliver, M.(1983). *Social Work with Disabled People*. Basingstoke: Macmillan.
- Orsini, M. (2006). From 'community run' to 'community based'? Exploring the dynamics of civil-state transformation in urban Montreal. *Canadian Journal of Urban Research*, 15(1), 22-40.
- Orsini, M., & Smith, M. (2007). Critical policy studies. In M. Orsini & M. Smith (Eds.), *Critical policy studies* (pp. 19-40). Toronto: UBC Press.
- Panitch, L. (1981). Dependency and Class in Canadian Political Economy. *Studies in Political Economy*, 6 (Autumn), 7-33.
- Parenti, D. (2000). The micropolitics of identity in adverse circumstances: a study of identity making in a total institution. *Journal of Contemporary Ethnography*, 29 (1), 93-119.
- Patten, S. (2006). The undemocratic deficit: Neoliberal governance and the undermining of policy: The case of social housing in Ontario. *International Journal of Urban and Regional Research*, 30, 510-527.
- Peck, J. (2013). Explaining (with) neoliberalism. *Territory, Politics and Governance*, 1(2), 132-157.

- Peck, J., & Tickell, A. (1994) Searching for a new institutional fix: The after-Fordist crisis and the global-local disorder. In A. Amin (Ed.), *Post-Fordism: A reader* (pp. 280-315). Oxford: Blackwell Publishers LTD.
- Peck, J., & Tickell, A. (2002). Neoliberalizing space. *Antipode*, 34(3), 380-404.
- Peterson, D.E. (Ed.). (1982). *Mad people's history of madness*. Pittsburgh: University of Pittsburgh Press.
- Phillips, L. (2002). Tax Law and Social Reproduction: The Gender of Fiscal Policy in an Age of Privatization. In B. Cossman and J. Fudge (Eds.), *Privatization, Law and the Challenge to Feminism* (pp. 41-85). Toronto: University of Toronto Press, 2002
- Porter, A. (2003). *Gendered states: Women, unemployment insurance, and the political economy of the welfare state in Canada, 1945-1997*. Toronto, ON: University of Toronto Press.
- Portes, A. (1983). The informal sector: Definition, controversy, and relation to national development. *Review*, 7(1), 151–174.
- Priestly, M. (1998). Constructions and creations: Idealism, materialism and disability theory. *Disability & Society*, 13(1), 75-94.
- Prince, M. (1998). Holes in the safety net, leaks in the roof: Changes in Canadian welfare policy and their implications for social housing programs. *Housing Policy Debate*, 9(4), 825-848.
- Prince, M. (2010). What about a disability rights act for Canada? Practices and lessons from America, Australia, and the United Kingdom. *Canadian Public Policy*, 36(2), 199-214.
- Prins, S. (2011). Does transinstitutionalization explain the overrepresentation of people with serious mental illnesses in the criminal justice system? *Community Mental Health Journal*, 47(6), 716-722.
- Radford, J.P., & Park, D.C. (2003). Historical overview of developmental disabilities in Ontario. In I. Brown & M. Percy (Eds.), *Developmental disabilities in Ontario* (pp. 3–18). Toronto: Ontario Association on Developmental Disabilities.
- Ramon, S., Shera, W., Healy, B., Lachman, M., & Renouf, N. (2009). The rediscovered concept of recovery in mental illness: A multicountry comparison of policy and practice. *International Journal of Mental Health*, 38(2), 106-126.
- Raphael, D. (2011) A discourse analysis of the social determinants of health. *Critical Public Health*, 2(2), 221-236.

Raphael, D., & Curry-Stevens, A. (2008). Surmounting the barriers: Making action on the social determinants of health a public policy priority. In D. Raphael (Ed.), *Social determinants of health: Canadian perspectives (2nd ed)*, (pp. 362-377). Toronto: Canadian Scholars' Press.

Raphael, D., Curry-Stevens, A., & Bryant, T. (2008). Barriers to addressing the social determinants of health: Insights from the Canadian experience. *Health Policy*, 88 (2-3), 222-235.

Reaume, G. (2004). No profits, just a pittance: Work, compensation, and people defined as mentally disabled in Ontario, 1964-1990. In S. Noll & J.W. Trent (Eds.), *Mental retardation in America: A historical reader* (pp. 466-493). New York: New York University Press.

Reaume, G. (2009). *Remembrance of patients past: Patient life at the Toronto Hospital for the Insane, 1870-1940*. Toronto: University of Toronto Press.

Redden, C.J. (2002). *Health care, entitlement, and citizenship*. Toronto: University of Toronto Press.

Reville, D. (2013). Is Mad Studies emerging as a new field of inquiry? In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian mad studies* (pp. 170-180). Toronto: Canadian Scholars Press.

Rioux, S. (2015). Embodied contradictions: capitalism, social reproduction and body formation. *Women's Studies International Forum*, 48, 194-202.

Roberts, C.A. (1964). Psychiatric treatment and the future of mental hospitals in Canada. *Canadian Medical Association Journal*, 90, 731-735.

Saad Filho, A. (2008). Marxian and Keynesian Critiques of Neoliberalism. In L. Panitch, C. Leys, G. Albo, V. Chibber, & A. Saad Filho (Eds.), *Socialist Register*. London: Merlin Press, pp. 337-345

Sandall, J., Benoit, C., Wrede, S., Murray, S.F., van Tejlingen, E.R., & Westfall, R. (2009). Social service professional or market expert? Maternity care relations under neoliberal healthcare reform. *Current Sociology*, 57(4), 529-553.

Schmidt, I. (2011). There were alternatives: Lessons from efforts to advance beyond Keynesian and neoliberal economic policies in the 1970s. *Working USA*, 14(4), 473-498.

Scott, S. (2010). Revisiting the Total Institution: Performative Regulation in the Reinventive Institution. *Sociology*, 44 (2), 213-231.

Scull, A. (1989). *Social order/mental disorder: Anglo-american psychiatry in historical perspective*. Berkeley: University of California Press

- Sears, A. (1999). The 'lean' state and capitalist restructuring: Towards a theoretical account. *Studies in Political Economy*, 59, 91-114.
- Shields, J., & Evans, B.M. (1998). *Shrinking the state: Globalization and public administration 'reform'*. Halifax, NS: Fernwood Publishing.
- Shimart, I. (2013). The tragic farce of community mental health care. In B. LeFrancois, R. Menzies, & G. Reaume (Eds.), *Mad matters: A critical reader in Canadian Mad Studies* (pp. 144-157). Toronto: Canadian Scholars Inc. Press.
- Siegrist, J. (2011). Social determinants of health – contributions from European health and medical sociology. *Política y Sociedad*, 48(2), 249-258.
- Silliman, J., Gerber Fried, M., Ross, L., & Gutiérrez, E.R. (2004). *Undivided rights: Women of color organize for reproductive justice*. Cambridge, MA: South End Press.
- Simmons, H. (1990). *Unbalanced: Mental health policy in Ontario, 1930-1989*. Toronto: Wall & Thompson.
- Slater, T. (2004). Municipally managed gentrification in South Parkdale, Toronto. *The Canadian Geographer/Le Géographe canadien*, 48(3), 303–325.
- Slovenko, R. (2003). The transinstitutionalization of the mentally ill. *Ohio North University Law Review*, 29(3), 641-60.
- Smith, A.M. (2010) Neo-eugenics: A feminist critique of Agamben. *Occasions: Interdisciplinary Studies in the Humanities*, 1(2), 1-12.
- Smith, D. (1996). Contradiction for feminist social scientists. In H. Gottfried (Ed.), *Feminism and social change: Bridging theory and practice* (pp. 46-59). Chicago: University Illinois Press.
- Spitzer, D.L. (2004). In visible bodies: Minority women, nurses, time, and the new economy of care. *Medical Anthropology Quarterly*, 18(4), 490–508.
- Stainton, T. (1995). Bureaucracy and ideology: A case study of the rise of the community living movement in Ontario in the 1970's. *Ontario Journal on Developmental Disabilities*, 4(1), 75-87.
- Steans, J., & Tepe, D. (2010). Introduction: Social reproduction in international political economy: Theoretical insights and international, transnational and local sitings. *Review of International Political Economy*, 17(5), 807-815.
- Su, F. (1997). *I once was lost: The immigrant experience and the recovering schizophrenic*. Waterloo, ON: Parkminister Publishing.

- Sylvestre, J., George, L., Aubry, T., Durbin, J., Nelson, G., & Trainor, J. (2007). Strengthening Ontario's system of housing for people with serious mental illness. *Canadian Journal of Community Mental Health*, 26, 79-95.
- Szasz, T.S. (1961). *The myth of mental illness: Foundations of a theory of personal conduct*. New York: Dell Publishing Co.
- Szasz, T.S. (2007). *Coercion as cure: A critical history of psychiatry*. New Brunswick, N.J.: Transaction Publishers.
- Taylor, M.G. (1978). *Health insurance and Canadian public policy: The seven decisions that created the Canadian health insurance system*. Montreal: McGill-Queen's University Press.
- Teeple, G. (1995). *Globalization and the decline of social reform*. Toronto: Garamond Press.
- Thakker, Y., Gandhi, Z., Sheth, H., Vankar, G.K., & Shroff, S.. (2007). Psychiatry morbidity among inmates of the 'beggar home'. *International Journal of Psychosocial Rehabilitation*, 11(2), 31-36.
- Thornton, D.J. (2010). Race, risk, and pathology in psychiatric culture: Disease awareness campaigns as governmental rhetoric. *Critical Studies in Media Communication*, 27(4), 211-335.
- Tompa, E., Scott, H., Trevithick, S., & Battacharya, S. (2006). Precarious employment and people with disabilities. In L. Vosko (Eds.). *Precarious employment understanding labour market insecurity in Canada* (pp. 90-114). Montreal: McGill-Queen's University Press, 2006.
- Tronto, J. C. (1993). Care. In *Moral boundaries: A political argument for an ethic of care* (pp. 101-124). New York, NY: Routledge.
- Tudor Hart, J. (2010). Health, healthcare and capitalism. In L. Panitch & C. Leyes (Eds.), *Socialist Register 2010: Morbid symptoms: Health under capitalism* (pp. 315-325). Halifax: Fernwood Press.
- Turner, J.G (1958). The hospital insurance and diagnostic services act: Its impact on hospital administration. *Canadian Medical Association Journal*, 78, 768-770.
- U'Ren, R. (1997). Psychiatry and capitalism. *Journal of Mind and Behavior*, 18(1), 1-12.
- Vick, A., & Lightman, E. (2010) Barriers to employment among women with complex episodic disabilities. *Journal of Disability Policy Studies*, 21(2), 70-8.
- Voronka, J. (2008). Re/moving forward? Spacing mad degeneracy at the Queen Street site. *Resources for Feminist Research*, 33 (1/2), 45-61.
- Vosko, L.F. (2000). *Temporary work the gendered rise of a precarious employment relationship*. Toronto: University of Toronto Press.

- Vosko, L.F. (2002). The past, present (and futures) of feminist political economy in Canada: Reviving the debate. *Studies in Political Economy*, 68(Summer), 55-83.
- Vosko, L.F. (2006). Crisis tendencies in social reproduction: The case of Ontario's early years plan. In K. Bezanson & M. Luxton (Eds.), *Social reproduction: Feminist political economy challenges neoliberalism* (pp. 145-172). Kingston & Montreal: McGill-Queen's University Press.
- Vosko, L.F. (2010). *Managing the margins: Gender, citizenship, and the international regulation of precarious employment*. Oxford: Oxford University Press.
- Wacquant, L. (2010). Crafting the neoliberal state: Workfare, prisonfare and social insecurity. *Sociological Forum*, 25(2), 197-220.
- Warner, R. (2004). *Recovery from schizophrenia: Psychiatry and political economy* (3rd ed.). Hove ; New York: Brunner-Routledge.
- Whitaker, R. (2002). *Mad in America: Bad science, bad medicine, and the enduring mistreatment of the mentally ill*. Cambridge, MA: Perseus Publishing.
- Whiteside, H. (2009). Canada's healthcare crisis: Accumulation by dispossession. *Studies in Political Economy*, 84, 79-100.
- Wiktorowicz, M.E. (2005). Restructuring mental health policy in Ontario: Deconstructing the evolving welfare state. *Canadian Public Administration*, 48(3), 386-412.
- Wilton, R. (2004a). More responsibility, less control: Psychiatric survivors and welfare state restructuring. *Disability & Society*, 19(4), 371-385.
- Wilton, R. (2004b). Putting policy into practice: Poverty and people with serious mental illnesses. *Social Science & Medicine*, 58, 25-39.
- Wilton, R. & Schuer, S. (2006). Towards socio-spatial inclusion? Disabled people, neoliberalism and the contemporary labour market. *Area*, 38(2), 186-195.
- Withers, A.J. (2014). Disability, divisions, definitions and disablism: When resisting psychiatry is oppressive. In B. Burstow, B. LeFrançois, & S. Diamond (Eds.), *Psychiatry disrupted: Theorizing resistance and crafting the (r)evolution* (pp. 114-129). London: McGill-Queens University Press.
- Workman, T. (2009). *If you're in my way, I'm walking: The assault on working people since 1970*. Halifax & Winnipeg: Fernwood Publishing.

Appendix A

Consent Forms

Elizabeth Tobin LeBlanc Haley (researcher)
PhD Candidate in Political Science
York University, Toronto, ON

Informed Consent Form for Residents in Supportive Housing

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

I am requesting your participation in my dissertation research. I am a PhD Candidate in Political Science at York University in Toronto, ON. My research maps the current arrangement of services directed at people with psychiatric diagnoses in Ontario with a specific focus on the issue of gender. I am using supportive housing as a case study. My goal is to build on the experiences and knowledges of people living in supportive housing to analyze the current policies, programs, practices and institutions, both governmental and non-governmental, that impact people with psychiatric diagnoses. Below is an informed consent form that gives me your permission to use the contents of our conversation as part of my research findings.

Study Name: Gendering Psychiatric Supportive housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing.

Researchers: Tobin LeBlanc Haley, PhD Candidate, Political Science York University Toronto ON

What is this form for?

This form asks if I can interview you for my research. I want to learn about your experiences living in supportive housing and accessing social services. I will provide you with any transit costs and a small honorarium of \$35.00. Below is a written informed consent form that gives me permission to interview you and use the information you share with me in my research project. Your identity will remain anonymous.

Purpose of the Research: This research explores the arrangement of services for people with psychiatric diagnoses in Ontario with a specific focus on the issue of gender. I am using supportive housing models as a case study. My goal is to build on the experiences and knowledge you have as a person living in supportive housing to analyze the current policies, programs, practices and institutions, both governmental and non-governmental, that impact people with psychiatric diagnoses. I seek to understand how and why these policies, programs, practices and institutions seek to organize people with psychiatric diagnoses. I hope to draw links between your experiences and the current trends in government organization, economic organization, and mainstream understandings of mental health, disability, men and women.

I am studying records, regulations and policies and conducting interviews with supportive housing residents, supportive housing owners, government officials and people who come into contact with supportive housing on a regular basis (e.g. personal support workers, social workers, street health workers and community/non-profit organization workers). I aim for 16-17 of the interviews to be with supportive housing residents. I will present findings in conference papers, journal articles and in a final dissertation that is a requirement for the completion of a Doctorate of Philosophy (PhD).

What You Will Be Asked to Do in the Research: You, as residents in supportive housing, have the experiences and knowledges that are essential to this research project. You will be asked to take part in a semi-structured interview that will last up to 60 minutes (although time will be left for a longer interview should you wish for more time). During the interview you will be asked a series of questions regarding your experiences as a resident in supportive housing and about your experiences with services. Some of the questions you might be asked include: How long have you lived in this home? What has been your overall experience residing in this home? What aspects of living in the home do you like or dislike?

Other topics will include, but are not limited to, income support, quality of housing, access to paid work, access to transit, access to childcare, activities of daily living, access to treatment, opportunity for hosting visitors and participate in social activities, changes you would like to see and interaction with other residents.

Risks and Discomforts: While I do not expect any risks or discomforts to arise from this research process, I acknowledge that asking you to discuss your current and past experiences with social services may result in feelings of anxiety, insecurity, sadness, distress and anger. I know as well that you may be concerned that any criticisms of your home, fellow residents, landlord or support staff might be shared with staff and/or put your housing or relationships in your home in jeopardy. That is why there is, included in the confidentiality section of this letter, an assurance that your identity will be kept confidential during the interview process, during any follow up interactions as well as the final written product. Only your gender identity, age, parenting status, a general description of the home and the fact that you live in supportive housing in Ontario will be disclosed in the findings.

Benefits of the Research and Benefits to You: The benefit of this project is that it draws attention to the specific history and current experiences of people within supportive housing. This is a topic that received some attention in the 1980s and 1990s but has faded into the background in more recent years. This research project also looks at how supportive housings is part of the larger mental health and social care system and how the income support, treatment and housing policies that compose this system may produce or reduce effects such as, but not limited to, isolation, poverty, lack of access to treatment, stigma and marginalization of those persons accessing this system.

In terms of benefitting you, one of my research goals is to place the knowledge of supportive housing residents at the centre of this project. Often mental health policy research does not recognize the knowledge and expertise of people with psychiatric diagnoses. By drawing on your expertise as people with first-hand knowledge of supportive housing life, my aim is to build an analysis that confronts the oppressions of people with psychiatric diagnoses and offers new ways

thinking and talking about “mental health” policy and structures of social care. An important part of meeting these goals will be by sharing research results with the people that I have interviewed and by making my research publically available in written and spoken forms.

Voluntary Participation: Although I am approaching you to participate in this study, you do not have to say yes. Your participation in the study is completely voluntary, it is up to you if you want to participate in this research project or not. Should you decide to volunteer you may also refuse to answer particular questions without telling me why. I will respect your choice not to answer certain questions and it will have NO negative consequences for you or impact the way you, or other residents, are portrayed in this research project.

If you decide not to volunteer, this will have no negative consequences for you or other supportive housing residents. Your decision not to volunteer will NOT influence how you, or other residents, will be portrayed in my research, the nature of your relationship with York University, either now or in the future, nor will it affect any future interactions you may have with me.

Withdrawal from the Study: You may stop participating in the study at any time, for any reason, and you do not have to say why. If you decide to stop participating, the confidentiality agreement will be upheld. I will not tell anyone your name or any of the information you shared with me, nor will I use this information in my research. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with me, York University, or any other group (s) associated with this project. You are sharing your experiences and knowledges with me. The extent to which you choose to share, how long you choose to be interviewed and the questions you choose to answer or not answer is completely up to you. In the event you withdraw from the study, all associated data collected will be immediately destroyed. Should you withdraw from the study you will still be provided with the non-alcoholic drink, snack and transit costs.

Confidentiality: I will make an audio recording of the interview as well as handwritten notes. If a recording device is a barrier to your participation, I will rely on handwritten notes. All information you supply during the research will be held in confidence and your name will not appear in any report or publication resulting from the research. Your comments, however, may be quoted anonymously if you consent. Also, a general description of the type of supportive housing you live in may be included.

While I am recording the interview, I will use a small tape recorder that will be visible to you throughout the interview and you will be clearly informed as to when it is turned on and off. Your data will be safely stored in a locked filing cabinet in my home or on a password protected computer. Only I will have access to the filing cabinet and computer. All data will be stored for 5 years after the publications resulting from my thesis are first released. At the end of this time period all data will be destroyed through shredding and deleting. Confidentiality will be provided to the fullest extent possible by law.

Questions About the Research? If you have questions about the research in general or about your role in the study, please feel free to contact me at (email removed for publication) or my Graduate Supervisor - Dr. Leah Vosko - either by telephone or email at (phone number and email removed for publication). You may also contact the Graduate Program in Political Science, S672 Ross Building, Room S634, York University, 4700 Keele St. Toronto, ON. Phone #: 416-736-5265.

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I, _____, consent to participate in Gendering Psychiatric supportive housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing conducted by Elizabeth Tobin LeBlanc Haley. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

<u>Signature</u>	<u>Date</u>
Participant	
<u>Signature</u>	<u>Date</u>
Elizabeth Tobin LeBlanc Haley	

Additional Consent:

Recording Interview

I, _____, consent to having my interview for the research project Gendering Psychiatric supportive housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing recorded by Elizabeth Tobin LeBlanc Haley. My signature below indicates my consent to the recording of my participation in interview form.

<u>Signature</u>	<u>Date</u>
Participant	
<u>Signature</u>	<u>Date</u>
Elizabeth Tobin LeBlanc Haley	

Quoting Comments:

I, _____, consent to my comments being quoted anonymously for the research project Gendering Psychiatric supportive housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing conducted by Elizabeth Tobin LeBlanc Haley. My signature below indicates my consent to having my comments quoted anonymously.

<u>Signature</u>	<u>Date</u>
Participant	
<u>Signature</u>	<u>Date</u>
Elizabeth Tobin LeBlanc Haley	

Elizabeth Tobin LeBlanc Haley (researcher)
PhD Candidate in Political Science
York University, Toronto, ON

Informed Consent Form for People Working and/or in Contact with Supportive Housing

Project Title: Gendering Psychiatric Supportive Housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing

This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines.

What is this form for?

This form asks if I can interview you for my research. My research maps the current arrangement of services directed at people with psychiatric diagnoses in Ontario with a specific focus on the issue of gender. I cannot pay you, but I will provide you with any transit costs, non-alcoholic drink and snack. I am using housing as a case study. Below is a written informed consent form that gives me permission to interview you and use the information you share with me in my research project. Your identity will remain anonymous.

What is my research about?

This research explores the organization of services for people with psychiatric diagnoses in Ontario today with a specific focus on the issue of gender. I am using supportive housing as a case study. My goal is to build on the experiences and knowledge of government officials, boarding home residents and owners, and professionals, such as yourself, to help me analyze the current policies, programs, practices and institutions, both governmental and non-governmental, that impact people with psychiatric diagnoses. I want understand how and why these policies, programs, practices and institutions affect people with psychiatric diagnoses. I hope to draw links between residents' experiences and government organization, economic organization, and mainstream understandings of mental health, disability, men and women.

I am conducting interviews. I am also doing policy analysis and archival research. I will present my research in conference papers, journal articles, talks, and in a final dissertation which I must complete in order to receive my degree (PhD in Political Science).

What will I ask you to do?

You, as a professional working in or in contact with supportive housing, have knowledge that is important to this research. You will be asked to take part in a semi-structured interview that will last up to 60 minutes (although it can be shorter or longer based on your preference). You will be asked a series of questions regarding your experiences as someone working in or in contact with supportive housing. Topics will include, but are not limited to, questions about your knowledge of the policies governing quality of housing, access to transit, access to childcare, activities of

daily living (cooking, cleaning etc), structure of supports for daily living and paid work, access to treatment, opportunity for hosting visitors, regulations regarding hosting visitors, interactions with staff and residents and changes you would like to see.

What are possible risks/discomforts for you?

I do not expect any risks or discomforts to arise for you from this research process. I acknowledge, however, that asking you to discuss your place of employment may cause some concern. You may be concerned that any critiques or suggestions you have might put your employment in jeopardy. Included in the confidentiality section is the promise that your identity will be kept confidential to the full extent provided by the law in both the interview process, any follow up as well as the final written product. Only your gender identity and either your job title or a general description of your job (should you consent to this) will be disclosed in the final product. I have a list of resources for you should you require or want support for any emotion you experience during or after the request for interview and/or interview process. You may ask for this at any time.

What are the benefits of this research?

The benefit of this project is that it draws attention to the history and current experiences of people within supportive housing. This research project also looks at how supportive housing is part of the larger mental health and social care system and examines how the mental health and social care system seeks to provide care and/or might produce effects like isolation, poverty, lack of access to treatment, stigma and other oppressions for people with psychiatric diagnoses. I will suggest new ways of thinking about mental health and social care and propose alternative models of service provision guided by the observations and insights I get from interview participants.

What are the benefits for you?

As professionals working to provide support within the mental health care system generally, I hope to tap into your expertise and incorporate it into my research. This is a chance for you to share your views, experiences, ideas, suggestions and for the incorporating of this information into my research whenever possible.

Your participation is completely voluntary. What does that mean?

It is up to you if you want to participate in this research project or not. Should you decide to volunteer you may also refuse to answer particular questions without telling me why or withdraw from the study at any time. In the event you withdraw from the study, all associated data that I have collected will be immediately destroyed. Your decision not to volunteer, not to answer certain questions or to withdraw from the study will not influence how you, or other professionals, will be portrayed in my research, nor will it affect your relationship with me, York University, or any other group (s) associated with this project either now or in the future.

Confidentiality: Read how I will protect your identity.

I will ask you if I can record our interview. If a recording device is not something you are comfortable with I will rely on handwritten notes. If I am recording the interview, I will use a small tape recorder that will be visible to you throughout the interview and you will be clearly informed as to when it is turned on and off. I will also ask you if I can quote you anonymously.

All information you supply during the research process will be held in confidence and your name will not appear in any report or publication resulting from the research. Your data (information

about you) will be safely stored in a locked filing cabinet in my home or office on a password protected computer. Only I will have access to the filing cabinet and computer. All data will be stored in the manner outlined above until all written works resulting from this project have been published. After this, all data will be destroyed through shredding and deleting. Confidentiality will be provided to the fullest extent possible by law.

Questions or concerns?

Any questions about this research and/or your role in this study can be directed to me at (email removed for publication) or to my Graduate Supervisor, Dr. Leah Vosko (email and phone number removed for publication) may also contact the Graduate Program in Political Science, S672 Ross Building, Room S634, York University, 4700 Keele St. Toronto, ON. Phone #: 416-736-5265. This research has been reviewed and approved by the Human Participants Review Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, York Research Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures

May I interview you?

I, _____, consent to participate in *Gendering Psychiatric supportive housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing* conducted by Elizabeth Tobin LeBlanc Haley. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____ Date _____

Participant

Signature _____ Date _____

Elizabeth Tobin LeBlanc Haley

Additional consent:

May I record our interview?

I, _____, consent to having my interview for the research project *Gendering Psychiatric supportive housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing* recorded by Elizabeth Tobin LeBlanc Haley. My signature below indicates my consent to the recording of my participation in interview form.

Signature _____ Date _____

Participant

Signature _____ Date _____

Elizabeth Tobin LeBlanc Haley

May I quote you anonymously?

I, _____, consent to my comments being quoted anonymously for the research project *Gendering Psychiatric supportive housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing* conducted by Elizabeth Tobin LeBlanc Haley. My signature below indicates my consent to having my comments quoted anonymously.

Signature _____ Date _____

Participant

Signature _____ Date _____

Elizabeth Tobin LeBlanc Haley

May I include your job title?

I, _____, consent to a description of my title being included in *Gendering Psychiatric supportive housing: An analysis of the gender order operating through the institutions, policies, programs and practices of supportive housing* conducted by Elizabeth Tobin LeBlanc Haley. My signature below indicates my consent to a description of my job and job title being included in this project.

Signature _____ Date _____

Participant

Signature _____ Date _____

Elizabeth Tobin LeBlanc Haley