


A REVIEW OF MENTAL HEALTH CARE IN CANADA: TOWARDS A SYSTEM-WIDE
CHANGE IN PERCEPTION AND TREATMENT

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A research paper submitted to the Graduate Program in Critical Disability Studies in partial
fulfillment of the requirements for the degree of

Master of Arts

Graduate Program in Critical Disability Studies

York University

Toronto, Ontario

M3J 1P3

(August 2016)

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Abstract

The main purpose of this critical research paper was to reflect on a few major issues that exist within the treatment of individuals within the mental health system in Canada today, and to provide recommendations for future research, policy and community development. The main themes that were generated during the literature review included issues related to diagnostic inflation, over-medicalization, the importance of good nutrition, socio-economic status and income inequality, and food insecurity. Through an exhaustive review and critical analysis of the literature using the feminist based standpoint theory, it was determined that mental health diagnosis is on the rise in Canada, and reliance upon the medical model as the primary treatment approach is also increasing. The concerns associated with this increase are exposed in the paper. The paper will discuss the importance of changing the focus to complementary and alternative treatment approaches to treating mental health, such as with nutrition, and the predicted outcome of this change. It was also determined that in order for such a change to occur, there would need to be a shift in the cultural perception of disability and mental health. As such, community providers may consider utilizing a critical approach in their practice and delivery of service, called critical community practice, derived from the field of social work and disability studies.

Introduction

Summary

Mental Illness and Public Health

According to the World Health Organization (WHO), by 2020 poor mental health will become the world's second highest problem of global disease (Watts, 2011). It is estimated that 1 in 4 Canadians will experience a mental health concern at some point in their lifetime (APA, 2000; Health Canada, 2002; Mental Health Commission of Canada, 2012). In Canada there are 6.7 million people or 19.8% of the population, living with a mental health problem or illness (Health Canada, 2002; Mental Health Commission of Canada, 2012). Mental health disorders are currently the leading cause of disability in Canada (Canadian Mental Health Association, 2007; Lakhan & Vieira, 2008) and account for 47% of all approved disability claims (Mental Health Commission of Canada, 2012). The most common reported mental disorders are major depression, bipolar disorder, schizophrenia, and obsessive compulsive disorder (OCD) (Lakhan & Vieira, 2008).

Mental health problems are conservatively estimated to cost the Canadian economy \$50 billion per year (Lim, Jacobs, Ohinmaa, Schopflocher, & Dewa, 2008), representing 2.8% of the country's gross-domestic product (GDP) (Mental Health Commission of Canada, 2012). The largest economic burden is from the use of direct government-funded health care services including medication coverage, the indirect cost of loss of productivity in the workforce, premature mortality, and non-government insured health care services (Health Canada, 1998). The Mental Health Commission of Canada (MHCC) (2012) reports that spending on providing treatment, care, and support services for people with poor mental health in 2011 was approximately \$42.3 billion. Over the next 30 years, it is estimated that the total costs will

exceed \$2.3 trillion (Smetanin et al., 2011). Mental illness in Canada is rapidly moving from a 'hidden disability,' to a not-so-silent public health concern.

Diagnostic Inflation

There has been a dramatic increase in the rate of diagnosed mental illness and use of psychotropic medication in the last 30 years (Barber, 2008; Batstra & Frances, 2012; Batstra & Frances, 2011; Healy, 1997; Whitaker, 2010). The advent of the Diagnostic and Statistical Manual (DSM) of Mental Disorders in the early 1950s, which provides a common language and standard criteria for the classification of mental disorders, has slowly transformed psychiatry, the interpretation of human behavior, and societal views of disorder. Although it brought greater consistency and dependability to psychiatric diagnosis, there are many limitations to the DSM (Batstra & Frances, 2012). The risk of false-positives remains high since the boundary between what is classified as mental illness and normal remain ambiguous (Batstra & Frances, 2012). In terms of normalcy, there is concern over whether western society is increasingly defining problems of living as disorders that are in need of treatment (Rose, 2006). Additionally, as diagnostic thresholds of illness are lowered to account for "early prevention" efforts, more individuals will receive unnecessary diagnosis and treatment that is less effective (Schwartz & Woloshin, 1999).

While the DSM continues to extend the borders of disorders, it also causes an extreme power differential. Psychiatrists are granted the authority to label individuals with an illness, recommend unnecessary treatment, and at times remove basic human rights, consent, and capacity through the Mental Health Act (Government of Ontario, 1990). The DSM does not appear to be losing popularity; it sold over 1.4 million copies between 2000 and 2008 (Barber, 2008). The fifth edition was released in 2013. At a cost of \$80 per copy, the American

Psychological Association (APA) generates substantial revenue from each edition of the DSM (Whitaker, 2010). Further, the APA has developed a monopoly over psychiatry, including development of the DSM, a division of publications related to the DSM, and protected earning power of psychiatrists (Whitaker, 2010).

The WHO reports that mental health will be a global health concern by 2020 - 2030 and suggests that mental ill health be immediately reframed as a public health priority (Vilhelmsson, Svensson, & Meeuwisse, 2011). However, a closer analysis of the reported data show that the information is collected primarily through epidemiological studies, which have a systematic bias to regularly report exaggerated rates of mental illness in the general population (Frances, 1998; Moffitt et al., 2009). They typically utilize analysts and interviewers who do not have the psychiatric or clinical training to understand whether the elicited symptoms represent clinically significant impairment (Batstra & Frances, 2011). Subsequently, the inflated rate of mental illness reported to the public leads to the opinion that mental disorders are being overlooked and are undertreated (Batstra & Frances, 2011; Moynihan, Heath & Henry, 2002). This phenomenon adds further pressure to psychiatrists, clinicians, mental health professionals, and general practitioners to make false-positive diagnoses and endorse unnecessarily aggressive treatment (Batstra & Frances, 2011).

Medicalization

The borders between normalcy and impairment continue to blur, and diagnostic inflation is increasing. As more people are receiving diagnoses, there is an extraordinary rise in the rate of prescribed psychotropic medication as the primary treatment approach (Barber, 2008; Barnett, 2012; Blech, 2006; Breggin, 2008; Leavitt, 2003; Strand, 2003). For example, in the United

States there were 227 million prescriptions for antidepressants in 2006, which accounts for a *30 million increase since 2000* (Barber, 2008).

The increasing rate of individuals in North America who now take medication for mental health-related issues on an ongoing basis is a concern for a number of reasons. The public is becoming increasingly over-reliant on medication to solve what may simply be the challenges of living. There is concern that people may be receiving prescription medication who do not require it. These individuals may experience iatrogenic effects, meaning that illness is actually created by taking medication when it is not needed (Barber, 2008; Breggins, 2008; Healy, 1997; Whitaker, 2008). The number of children now taking psychotropic medication is also increasing; in 2004, 11 million anti-depressants were prescribed for children (Barber, 2008). The long-term effects of psychotropic medication are still unknown, especially with younger populations (Blech, 2006; Leavitt, 2003; Strand, 2003). Subsequently, the literature suggests that overuse of psychotropic medication may become a threat to public health (Batstra & Frances, 2012).

As the growing number of concerns associated with increasing medicalization becomes more apparent, the social, environmental, and political factors receive even less attention. Many sociologists emphasize a “dark side” to the consequences of medicalization, reinforcing the notion of power and social control (Conrad, 1992). This becomes even more concerning as people are not provided with enough information, become more complacent, and less critical of the medical field and the various interconnections.

The Importance of Good Nutrition

Historically, research for the treatment of mental health has focused primarily on biochemistry and pharmaceutical interventions. Recently, there has been an increase in research

focused on the impact of nutrition and diet on mental health (Harbottle & Scholfelder, 2008). Specifically, it has been determined that following a nutritious diet, with access to whole foods that are rich in vitamins and minerals, have been shown to support an improvement in mental health and a decrease in symptoms across various diagnosis (Jacka et al., 2012; Harbottle & Scholfelder, 2008). Poor nutrition has been found to lead to mental illness, specifically depression, while good nutrition and in some cases, supplementation, has been found to support treatment outcomes. It is important to mention that during the research process, it was found that the majority of research conducted on nutrition, supplementation, and mental health has been focused on mood disorders and depression, which may be due to its prevalence in the general population and therefore the focus of research grants.

There has been extensive research on the efficacy of omega-3 (Parker et al., 2006). Epidemiological studies have suggested that diets lacking in omega-3 fatty acids may actually contribute to mood disorders, and therefore may increase the prevalence in the population (Parker et al., 2006). Treatment based studies have indicated that those living with mood disorders benefit from omega-3 supplementation (Parker et al., 2006). Research has also been focused on three micronutrients, which have been examined in depression: zinc, magnesium, and folate (Jacka et al., 2012). This area needs the attention of future research to support viable complementary treatment options for those living with mental health concerns.

Socio-Economic Status and Food Insecurity

In order for those living with mental health concerns to viably consider complementary and alternative approaches to treatment, such as good nutrition, they must have an adequate income first in order to afford a whole-foods based nutritious diet with supplementation as needed. This is especially true because there is no government funding to subsidize this form of

treatment focus, like there is with medical based treatment. Unfortunately, those individuals living with mental health concerns who are reliant upon the welfare state to subsidize their income, live with a low-socio economic status. To compound this issue, those living at a low socio-economic status are at higher risk of mental health concerns, which in turn creates a vicious cycle where poor mental health feeds a low socio-economic status, and a low socio-economic status feeds poor mental health. When individuals are living with poor mental health, and a low income, they are more likely to live with food insecurity, which further compounds the issue of access to good nutrition. Therefore, this becomes a multi-faceted issue that requires critical analysis to breakdown the barriers and understand the factors at play.

One of the major stressors for people living at a low socio-economic status is food insecurity. In fact, low income is the main predictor of food insecurity (Tarasuk, 2005). Food banks were utilized by 851,014 Canadians in 2011 and usage is up by 26% since 2008 (Hunger Count, 2011). Of those most likely to experience food insecurity, 59.7% were individuals who rely upon social assistance as their primary source of income (Health Canada, 2007; Hunger Count, 2011; Heflin et al., 2005). In 2006, of those receiving social assistance, there were 77,430 people receiving income support through ODSP, and 1 in 3 of those recipients had a mental health illness (Canadian Mental Health Association, 2007; Mental Health Commission of Canada, 2011).

A key social determinant of health is income-related food insecurity (Mirza, Fitzpatrick-Lewis, & Thomas, 2007). Healthy eating cannot be achieved without consistent and sufficient access to economic stability. Households with certain features, such as low-income, have a higher occurrence of food insecurity. There are additional populations of individuals who have greater needs and are at an even greater risk of experiencing food insecurity. Those with a low

socio-economic status are disproportionately affected by food insecurity; This population is also known to have a high prevalence of mental illness (Heflin, Siefert, & Williams, 2005; Mirza et al., 2007; Canadian Mental Health Association, 2007; Dubowitz, 2010; Nova Scotia Food Security Network, 2011). In previous research, the association between food insecurity and physical health problems is well documented (Mirza et al., 2007; Muldoon, Duff, Fielden, & Anema, 2012); however, literature linking food insecurity and mental illness, as well as any subsequent impact, is still largely undeveloped.

We must consider food insecurity as resulting from the political and economic structures of society that distribute economic resources unequally, and to highlight the challenges faced by a specific vulnerable population: those suffering from mental illness. Unequal distribution of economic resources leads to income inequality and a gap between the rich and poor. This has an even greater impact on particular vulnerable populations. Income inequality in Canada contributes to some individuals living with a low socio-economic status, producing various issues and negative impacts on health. Research has shown that low income is the strongest predictor of food insecurity (Tarasuk, 2005). Further, individuals living with mental illness are at a higher risk for having a lower SES, therefore are at a higher risk of food insecurity. This population also has their own unique challenges in accessing food resources that are a direct result of their mental illness. In addition, research has also shown that inadequate nutrition is a risk factor for increases in symptomatology, worse treatment outcomes, and poorer physical health (McCloughen & Foster, 2012). Therefore, it is essential to reduce income inequality, and develop and implement alternative methods for reducing food insecurity for this at-risk population.

The prevalence of mental illness among food insecure Canadians is alarming, as they are nearly 8 times more likely than the general population to experience issues with maintaining an acceptable supply of food (Goetz, 2008). A study completed by Muldoon et al. (2012) found that the prevalence of mental illness among participants with food insufficiency (hunger) was 35%, and 24% live with poor food quality. Therefore, food insecurity is an even larger issue for those living with mental illness than the general low SES population, specifically because they have additional financial obligations, such as additional healthcare costs, which result in less money for adequate nutrition (Carson, 2011; Heflin et al., 2005).

Those living with mental illness are also documented to have poorer health and lower life expectancy than the general population (McCloughen & Foster, 2012). People living with a serious mental illness have higher morbidity and mortality rates of cardiovascular disease than the general population, and also higher than expected rates of obesity, diabetes, infectious diseases, some forms of cancer, and HIV (Bottomley & McKeown, 2008; Robson & Gray, 2006). For example, individuals with schizophrenia have a two- to three- fold increase in risk of diabetes (Wilkinson, 2010). People living with a SMI are also nearly 8 times more likely than the general population to report concerns with maintaining an adequate food supply, 63% of which experience the most severe form of food insecurity (where quantity and quality of food are affected) (Goetz, 2008).

Research Questions

This critical theoretical essay will explore research, policy, practice, and politics, as it relates to mental health and its subsequent treatment, from a multidisciplinary lens. Specifically, this paper will begin by identifying the main challenges and concerns that this writer has observed and studied, within the field of mental health, as is related to diagnosis and

classification, the medical model, big pharma, over medicalization, social control, the importance of good nutrition and complementary treatment approaches to the medical model, political inequality among those living at a low socio-economic status, the relationship between low socio-economic status and mental health status, and the outcome it has on access to good nutrition and subsequent food insecurity. The intended goal with this paper is to identify that there are major concerns and public health risks regarding how mental health is currently being diagnosed and treated in Canada. Treatment occurs first and foremost with psychiatry, the medical model, and over medicalization, which is demonstrated in the literature by medication being known as the “gold standard.” This is also a common understanding in our society that mental health can be easily treated with a psychiatric pill, aka a “magic bullet” (Whitaker, 2010). However, if the goal is to shift towards utilization of complementary and alternative approaches, other structural macro-level changes need to occur, which will be explained in later sections of this paper.

The goal is to show evidence for why there needs to be a shift in the way mental illness is treated. Specifically, the argument is that treatment should move towards a more holistic multi-modal approach, also known in the literature as complementary and alternative medicine (CAM) (Freeman, 2012), that would utilize strategies that are proven to be helpful towards good mental health and lasting health outcomes, such as good nutrition. It will be shown that this is not easily said and done, because those living with mental health concerns and suffering from access to basic good nutrition, are in such a position because they have been effected by the large political inequities that disparage this population in North America, and are thus made reliant upon the welfare state to subsidize their state of low income. However, the literature has proven that even with the current welfare state and emergency food programming, it is not enough to provide

adequate nutrition for those living with mental health concerns at a low income. This paper will identify how mental health concerns are often exacerbated by the culmination of these factors and may contribute to a growing public health issue in North America, as well as add more pressure on our health care system and economy.

It should be noted that the data has been compiled largely from sources in the United States, Australia, and New Zealand, which is reflected in the references section. As this paper was being researched, it was observed that Canada lacks research regarding this subject, meanwhile the United States, Australia, and New Zealand have been focusing more heavily on these concerns. It should also be noted that the overarching themes will be extrapolated for the purpose of this paper to the Canadian population due to the similarity between cultures, health care, and political systems of these three countries, in order to attempt to stimulate further research in Canada, as well as to make suggestions for future direction based on the outcomes observed in the United States and New Zealand.

This paper and the body of its content is structured around 5 main themes, which are: diagnostic inflation, medicalization, nutrition and mental health, socio-economic status, and food insecurity. It will explore both micro (individual) and macro (population) level information, from the individuals who are experiencing mental health concerns, to the human services and community organizations facilitating programming, to the government and political systems that harness varying levels of power and change. This level of analysis was necessary in order to complete of full picture of the issue at hand and provide a comprehensive understanding of the issue. The types of questions that will be explored within these 5 main topics include, but are not limited to:

- ✓ Is the rate of diagnosed mental illness on the rise? If so, what is effecting this change?

- ✓ What is the primary treatment for mental illness? Why? Are there adverse health outcomes?
- ✓ Is there a more optimal and healthy way to treat individuals suffering from mental illness? Would the outcomes be better?
- ✓ Is there a higher prevalence of mental illness among those with a lower income?
- ✓ How does a lower income affect health, and specifically, mental health?
- ✓ Is there a discrepancy in income among the population, and do those with a lower income, suffer more? How do they suffer more?
- ✓ Does the political economy have an effect on income inequality?
- ✓ What is neoliberalism, and what does it have to do with mental health?
- ✓ What effect does neoliberalism have on the welfare state and ensuring basic needs are met, such as food insecurity?
- ✓ Are those with mental illness at greater risk of experiencing food insecurity?
- ✓ What implications does food insecurity have on those with mental illness?
- ✓ How are those with a lower income and therefore poor access to quality food supposed to maintain a treatment plan directed at better nutrition and decreased reliance on medication?
- ✓ What needs to be considered for mental health professionals, health policy makers, and psychiatrists if we are to move towards complementary and alternative methods of practice?

In the field of disability studies and health policy, it is important to approach information from a critical lens. This paper was written while utilizing a critical framework to conceptualize and reflect on the topics. The framework was chosen due to its use within the discourse on topics

of psychiatry, mental health, disability, and health policy. It has historically been utilized to expose issues affecting those living with mental health concerns in an effort to bring forth their experiences into the literature and hopefully influence future research and policy development within the field, as well as provide empowerment to this population. The critical framework is a feminist epistemology called standpoint theory and will be described in more detail in a later section.

The importance of using a critical framework and lens, such as feminist standpoint theory, is that it allowed the writer to consider and expose concerns as they have been highlighted by the consumer/survivor population. The consumer/survivor population are those individuals currently living, or having lived with, mental health concerns. An argument will be made for why standpoint theory is necessary within research and policy, especially in the future, precisely to foster empowerment within this population, as these individuals have historically been silenced through methods (direct and indirect) of social control by psychiatry, western medicine, and the industry of big pharma. It is time that these individuals were given back their voice after being silenced for so many years especially when influencing the programs and services that have a direct impact on their health.

While reflecting, writing, and discussing the literature from a critical standpoint about these issues is useful and arguably helpful, there still needs to be recommendations for future action that is both viable and concrete. It will be argued why it is vital that future development within mental health care incorporates a bottom-up approach, rather than top down. Bottom-up or grassroots movements are referred to in this way because the information is carried up from those who are living with and experiencing the issue at hand, and effecting the change and development in a way that is most helpful. It is referred to in the research and literature as

participatory action research (PAR), and will be highlighted again in a later section. What is the purpose of developing research, writing policy, and effecting change, that may not be as effective as possible because it does not actually support the concerns of those living with the issue? The literature and critical lens in this paper has been coupled effectively with a form of community practice that lends itself well to social change from a bottoms-up approach, which will also be explained in further detail later in this paper. This paper will highlight why it is an important practice that the community should embrace, in order to facilitate change that supports equality, solidarity, community, and social justice, from the level of human service organizations.

In order to move forward into the future, the writer will elaborate on the importance of critical and transformative community practice (CCP) within the field of mental health. Critical and transformative community practice promotes equality, solidarity, community, and social justice (Mullaly, 1997; Withorn, 1984). CCP is action based on critical theorizing, reflection, and a clear commitment to working for social justice through empowering and transformative practice (Henderson, 2007). Under CCP, human service organizations are in a role to become an agent or facilitator of change through community building, organizing, systems reform, policy advocacy, and structural change (Evans et al., 2014). Transformative practice and intervention such as CCP emphasizes larger systems that equally affect personal, interpersonal, and collective wellness (Evans et al., 2014). This paper will make an argument for why CCP should be applied within mental health policy and practice.

Methodology

Overview

This critical theoretical essay aimed to answer research questions regarding a specific topic on mental health in Canada, regarding the treatment of individuals within the mental health system in Canada. Generally speaking, the research questions were influenced over the course of 10 years, while the researcher worked within the field of community and institutional mental health in both paid and volunteer positions. The questions were generated by a general curiosity of the climate of mental health in Canada, on a micro and macro-level, and why things had progressed in the direction they did. The questions were influenced by many conversations over the years with individuals who utilize the mental health system in Canada, as well as professionals working within the system. These experiences sparked the direction of this research. The purpose of this paper was to reflect on the history of mental health in Canada, in order to understand the current situation, and the future direction, in regards to the specific research questions.

Data Collection

The data was collected by means of a literature review. The research paper was intended to answer the main research questions using reflective and interpretive methods to carefully examine the variables. As questions were answered, more had appeared; however, the process was not rigid and if new questions arose that were relevant, and within the scope of the research questions, they were explored. This approach fit the research paper because it allowed for leniency in terms of exploring the topic as more information was uncovered, which in turn allowed for a more meaningful interpretation of the phenomenon being questioned. There was no rock left unturned. If new issues arose, they were included because it was important to

include how the many factors contributed to the bigger picture. It was discovered during the research process that the topic required a comprehensive and flexible approach due to the many interconnections.

Data Analysis

The data was analyzed using a qualitative and interpretive method. Specifically, the literature was reflected upon using inductive analysis. If the literature was relevant to the specific question, it would be analyzed for its relation to the overall theme and its inter-relation to the question, as well as the depth and breadth of the articles. This was completed by analytical principles rather than by adhering to rules. York University's online library was primarily used to access databases which were then explored for literature, including indexes such as: ProQuest (PsychInfo, Social Services Abstracts, CBCA Complete, Sociological Abstracts) and Ovid (Social Work Abstracts). Key words that were used when searching for literature, included but was not limited to: mental health, mental illness, psychiatric disability, critical theory, disability theory, feminist theory, standpoint theory, critical community practice, psychiatry, medical model, medicalization, diagnostic inflation, income inequality, social inequities, political economy, neoliberalism, nutrition, diet. If articles that were found were relevant to the main themes, the references section of that article was snowballed for further resources of which contained the same theme. They were then judged interpretively based on the analysis explained above. Any relevant books that were found was through the Scott library.

Limitations

1. The depth of the problem got bigger as the subject was explored. It was challenging to keep the ideas contained in a way that did not snowball the information and stay within the page limit for the requirement of the paper.

2. The majority of the research was compiled from data sources originating in the United States or Australia and New Zealand. Therefore, the subject matter had to be judged whether or not it applied to the Canadian demographic or not. If appropriate, the information was generalized to also be relevant to the Canadian population. During the process, it was questioned whether the results from the literature used were confounded by extraneous variables that were unique to those specific countries.

Critical Framework

Overview

For this research study, the principal investigator will be utilizing a critical approach when exploring the literature and research questions, and also suggesting a critical practice for use within community practice for future development. A feminist framework will support the purpose of the research questions by supporting the researcher to critically examine and expose important issues as they relate to individuals living with mental illness, and as members of an oppressed group by specifically utilizing elements of standpoint theory. The main process of gathering information will be through a critical literature review. The basis of standpoint theory is grounded in collecting information from individuals of an oppressed or marginalized group in order to better understand their standpoint. Therefore, the three levels of critical analysis are: standpoint theory, participatory action research, and critical community practice, all of which complement one another due to their focus.

Based on the current literature, diagnostic inflation and over-medicalization of psychiatric disability in the Canada is an undeniable concern that requires further attention. However, since the issue is multifaceted, it is critical that the issue be analyzed from a variety of

discourses. As demonstrated in the formal and exhaustive critical literature review presented in this research paper, the growing body of literature has become quite comprehensive. It has been explored by many disciplines, all of which approach the subject from differing paradigms and utilize varying methodologies. This is advantageous for a researcher who is seeking a solid foundation for their own research and to develop their own methodology because it is possible to identify which one could be the most effective for their own research questions.

Critical Community Practice

Critical community practice (CCP) offers an all-encompassing transformative framework that integrates elements of critical theory into community practice. CCP creates a neutral and open space where ideas can be discussed and organized, and promotes fairness, unity, community, and social justice (Evans et al., 2014). CCP is values driven and derived from a combination of critical theory, disability theory, radical social work, counselling psychology, and philosophy. CCP incorporates philosophy from disability studies and the disability rights movements which is similar to the principles of social work (Hiranandani, 2005). Both movements strive for equal rights, equal opportunities, social justice, self-respect, and self-determination in their work (Hiranandani, 2005).

CCP is a model of community practice which employs a critical lens to organize ideas and therefore human service organizations can act as an agent for social change (Evans et al., 2014). According to Evans' paper 'Critical Community Practice' (2014), social action in CCP is initiated and fostered by: collecting and organizing thoughts, building community, advocating for policy development, structural level change, and reforming the system. CCP is rooted in anti-oppression and is focused on transforming the systemic roots of injustice from within the community (Evans et al., 2014). CCP is able to cross multiple disciplines to effect change and is

especially useful within the disability community because of the focus on social justice, empowerment, and transforming systems (Evans et al., 2014). CCP requires the expansion of professional roles to embrace both micro- and macro- levels of intervention (Evans et al., 2014) which is especially critical to the research questions highlighted in this paper. A CCP approach reflects a broader understanding of the factors that influence well-being and possible targets of intervention. For example, utilizing CCP can support shifting the discourse within mental health from a medical model framing of diagnosis and treatment, to a critical language of oppression and empowerment, and towards complementary and alternate treatment practices (CAP). In order to provide a helping model for marginalized members of society, we must target changes in the norms, policies, practices of institutions, social systems, and the broader political economy (Evans et al., 2014).

CCP has the ability to include members of the community within the process of transformative social change because it is closely aligned with participatory action research (PAR). PAR is a way of conducting research that includes those being affected by the change. It is a method which is empowering to the community because it utilizes the voices of those directly involved in the issue at hand, which is exactly what CCP's focus is. PAR shifts the standard practice of research from being conducted *on* people, to creating research *with* people (Evans et al., 2014). People are not viewed as the subjects, but are the participants in generating new knowledge and effecting change. This is at the heart of anti-oppressive practice and is a way to give voice to the experiences and concerns of individuals from marginalized groups (Evans et al., 2014). CCP engages the community because it creates conditions that enable community members to participate (Evans et al., 2014).

In her 2005 paper, *Towards a Critical Theory of Disability in Social Work*, Hiranandani explained that, “throughout history, individuals with disabilities have struggled to live full and productive lives as independently as possible in a society laden with stigma, discrimination, and attitudinal and environmental barriers, and are often regarded as functionally limited and unable to work. While historically, the dominant discourse on disability in social work has been that of an individual/medical model, which largely relegates the ‘problem’ of disability to a deficit within the individual, the field has attempted to move towards empowerment, strengths, and resiliency in recent years (Hiranandani, 2005). Therefore, in order to shift the focus of treatment modalities in psychiatry towards a multi-disciplinary, complementary and alternative approach, there also needs to be a cultural/societal shift in the way disability is defined and categorized. To date, no social work perspectives have incorporated the notion that disability must be redefined to sever its socially constructed link with functional impairment and subsequently, also severing the focus on treating individuals solely with a medical-model based approach (Hiranandani, 2005).

In light of CCP, it is important to be critical of all angles. Therefore, a shift in focus from medical model based treatment to a focus on complementary approaches could add different barriers to the disability population due to the low-income nature of this demographic. Suggesting that this marginalized population work on their nutrition without proper income may not be conducive to successful outcomes (which will be elaborated in a later section). Government subsidies for nutritional interventions may need to be considered, for example, using naturopathic doctors and dieticians, as well as coverage under OHIP.

There are already many examples of CCP in the community, as it relates to the main research themes discussed in this paper. One large-scale example is the Canadian Mental Health

Association Ontario's "Minding our Bodies (MOB): Eating Well for Mental Health" initiative, which ran from 2008 to 2013. The focus of this initiative was to "increase capacity within the community mental health system in Ontario to promote both physical activity and healthy eating for people with serious mental illness" (CMHA, 2015). MOB focused on province-wide initiation of various programs to local mental health providers to develop and deliver evidence-based physical health and healthy eating programs, improve access to local resources, and promote social inclusion (CMHA, 2015). One of these programs included the FRESH program, which focused on teaching individuals about the importance of good nutrition for mental health, as well as how to shop for and prepare healthy nutritious meals. This program was utilized across Ontario at various CMHA branches, as well as at the Gerstein Centre in downtown Toronto (it is still being utilized today). An evaluation of the CMHA FRESH program was completed by York University's Michaela Hynie at the York Institute for Health Research in 2011. The outcome of the evaluation found the program to be quite effective and well-received by the consumer/survivor population that was involved (Hynie & Steele-Gray, 2011).

Feminist Framework and Standpoint Theory

The main framework that will be utilized to address this research question is critical theory. Specifically, the researcher plans to critically examine the issues related to diagnostic inflation and over-medicalization of mental health, including the potential for alternatives, from a critical feminist lens. The inspiration for using this theory originated from the article written by Norah Martin in 2001 on *Feminist Bioethics and Psychiatry*. She provides a critical analysis of psychiatry from a feminist bioethics perspective. Feminist bioethics typically focuses on the experience of women within the medical system in traditional bioethics discussions. Martin's article expands the reach of this framework to criticize psychiatry because it has habitually been

left out of the discussion. This research paper will employ the main principles of feminist bioethics since they can be generalized beyond the experiences of just women. As guided by the main research questions, a feminist bioethics framework will be used to represent the experiences of other oppressed groups, in this case consumer/survivors, as a basis of exposing the issue of power and oppression practices within psychiatry.

Martin provides recommendations after first explaining epistemological issues in psychiatry. She incorporates the insights made by Mary Mahowald and Donna Haraway in the field regarding objectivity and standpoint theory. Standpoint theory remains a progressive technique to challenge the dominant way of thinking and Martin is a primary proponent of its utilization within psychiatry in the future. Martin's analysis of standpoint theory aligns well with the research questions in this paper, and will apply these techniques within the qualitative analysis process in order to attempt to better understand psychiatric practice and alternative programming through the lens of consumer/survivors by highlighting CCP in action in the community, such as the FRESH program initiative, and PAR used in research and program evaluations. Feminist bioethics theory is also useful in suggesting that progressive psychiatrists face challenges when trying to gain a balance between the needs of the individual and reducing oppressive practice, as well as incorporating CAP.

While there has been limited work within feminist bioethics since the early 2000s, the main arguments and concepts are drawn from the feminist discourse and can be applied to psychiatry and the medical model. Historically, psychiatry has been exposed to many forms of critical analyses, such as in the anti-psychiatry movement and critical psychiatry, such as through the work of Foucault and Szasz (Bracken and Thomas, 2010). However, these fields are limited in scope because they typically miss important information about how psychiatry effects

oppressed groups (Martin, 2001). Feminist discourse provides a unique opportunity to explore untouched factors due to their unique lens. Feminist theory is notoriously critical of any societal structure or norm that involves women, who as a group experience oppression and marginalization when patriarchal norms are the standard way of living. Therefore, feminists expose many concerns related to societal constructions, norms, and the subsequent effects on women as oppressed groups. This is useful for scholars engaged in a critical discourse, such as disability studies and health policy, who are interested in exploring the effects of an oppressive social institution and its effects on a marginalized group. For this reason, feminist theory is the main critical framework utilized in this research paper because the produced knowledge is interchangeable, flexible, and can be applied to a critical analysis of various topics.

Feminist standpoint *epistemology* is based on knowledge building that challenges individuals to see the world through the experiences of oppressed women and to apply this vision to activism and change. Feminist standpoint theory can be applied to any oppressed group, rather than only to women (Brooks, 2007). According to this epistemology, it is important to place the marginalized group or individual at the center of the research process and build knowledge outwards from there. This is highly aligned with both CCP and PAR. Feminist standpoint epistemology also challenges scholars to view society through the eyes of the experiences of the oppressed. Brooks (2007) explains that these experiences provide a powerful lens in which to evaluate society and provides a foundation from which we can begin to change it. This epistemology attempts to provide members of oppressed groups with a voice and to expose the knowledge that has remained hidden in their experiences of living life on the margins of society.

Main Themes

Diagnostic Inflation

Causes

It is estimated that 1 in 5 individuals will experience a mental health illness at some point in their life, based on DSM criteria (Canadian Mental Health Association, 2012). This represents a nearly 20% increase in prevalence rates over the last 20 years (Batstra & Frances, 2012). This may be due to the fact that increasingly, real-life stressors brought on by situational factors are being diagnosed as mental disorders (Barber, 2008). As public health shifts the focus from treating of mental illness to the prevention of illness, diagnostic criteria are widening. People who were once considered healthy or under situational stress are labeled as sick as practitioners continue to cast a wide diagnostic net (Batstra & Frances, 2012).

Psychiatry continues to medicalize general life functioning, and western society has become more tolerant and accepting of this phenomenon. This trend is exaggerated by the lowering of diagnostic thresholds and ease of criteria, making it easier for more people to receive a diagnosis. The DSM-V is prepared for release in 2013, which includes new diagnostic categories of disorders and lower threshold criteria for existing disorders. The new additions and changes are evidence of the further shift in psychiatry and public health towards illness prevention. In psychiatry, early prevention is premature and particularly problematic because there are no guaranteed methods of deciphering between those who will develop an illness and those who will not (Batstra & Frances, 2012). While lowering of diagnostic thresholds is effective at finding and treating illness of a small number of individuals very early on, it will vastly increase the risk of false-positives to an unacceptable rate (Batstra & Frances, 2012). For example, the current rate of false positives for the “psychosis risk syndrome” lies between 50%

to 84%, which is predicted to jump to 91% with use of the DSM-V as clinicians in community settings are enabled to apply criteria (Corcoran, 2010). Diagnostic proposals for generalized anxiety disorder (GAD) are expected to result in a 22% increase in prevalence rate (Andrews & Hobbs, 2010).

Excessively high rates of false-positives will be seen primarily with individuals who have milder cases of reported symptoms, which means these individuals will receive more aggressive forms of treatment than necessary and will lead to further exhaustion of the system (Batstra & Frances, 2012). Those who really need and benefit from services will either receive care that is not effective enough or will not receive services at all (Barber, 2008). Increasing the scope of diagnostic thresholds, as seen in the upcoming DSM-V, will increase the number of individuals who are labeled as unwell, who then receive treatment, which adds further pressure to the system and also to the economic social safety net.

Consequences

Diagnostic inflation of mental illness leads to increases in treatment with a primary focus on psychotropic medication. In the early 1900s, Freud introduced psychotherapy as a form of counseling that was revolutionary in the field of psychology and complemented the medical model focus of psychiatry. Psychotherapy gradually lost popularity in the mid 1900s and made way for the field of cognitive psychology; however, there has been a plethora of new and exciting types of evidence-based treatment come to the field in the early 2000s, such as Cognitive-Behavioural Therapy (CBT) and motivational interviewing (Barber, 2008). There are also holistic approaches to illness prevention and symptom management that employ a multi-modal approach to achieving good mental health, including paleolithic nutrition and functional

exercise (Cann, 2012). However, these treatments are all vastly underutilized and do not garner the same attention as pharmacology.

The primary method of treatment for mental illness is medication, which is researched and developed within the pharmaceutical industry and distributed by psychiatrists. Not only are the long-term side-effects of psychotropic medication unknown, but it is much more expensive than alternatives such as CBT, psychotherapy or motivational interviewing (Whitaker, 2010). The newer generations of psychotropic medication are ten times more expensive than older generations and are not proven to be more effective in clinical trials (Barber, 2008). Medication is an expensive treatment method that adds burden to the social system which has been exposed to more extensive cutbacks. For example, in 2009 the federal government of Canada announced \$60 billion in tax cuts (Langille, 2009). Extensive closure of community-based social service agencies and severely reduced care for those with mental health needs is additional evidence of the disintegration to social services and health care (Herd, 2002). Of the social assistance programs that remain, there are ongoing concerns about their adequacy to meet the needs of those who depend on them (Tarasuk & Davis, 1996).

Psychotropic medication is leading the pharmaceutical market and driving enormous revenue. In 2002, Prozac was the best-selling drug on the market with sales of \$2 billion annually (Barber, 2008). This is good news for the pharmaceutical industry since the mean age for the first bout of depression is now 14 years old, compared to 1990 when it was 35 (Barber, 2008). As rates of diagnoses reach new highs and easy to meet thresholds lower the age of onset, more people are receiving unnecessary medication. Nearly 1 in 5 visits to a psychiatrist result in a prescription for an antipsychotic (Barber, 2008). High levels of demand for treatment adds further pressure to the existing system and reduced care for those in need. Of individuals

actually diagnosed and living with a serious mental illness (SMI), only 40% receive treatment that is minimally adequate (Barber, 2008). There are some individuals who do not receive support or treatment at all (Barber, 2008). These various processes are intertwined with current circumstances: the expansion of diagnostic criteria, the view that public health problems are derived from undiagnosed mental health disorders, the push for disease identification, shifting towards screening, prevention and early intervention based on presymptomatic conditions, and the prevalent use of pharmacological remedies (Rose, 2006).

Medicalization

Background

Medicalization describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders (Conrad, 1992). The increasing rate of medicalization in western society is a concern as it presents a number of dangers, which include: iatrogenic causes of illness, unnecessary labeling and social stigma, diversion of resources away from those who are in genuine need of care, feeding unhealthy obsessions with health and illness, obscuring political and social causes of ill health, focus excessive attention on individualized pathology and pharmaceutical responses, threatening the viability of public health insurance systems, and economic waste (Moynihan et al., 2002).

Big Pharma

Worldwide pharmaceutical sales amount to nearly US\$700 billion annually; North America makes up approximately half of the revenue (Barber, 2008; Batstra & Frances, 2012). In the United States in 2006, there were 227 million prescriptions for antidepressants, which was up by 30 million in 6 years (Barber, 2008; Healy, 1997; Whitaker, 2010). This same year, the sale of anti-depressant medication generated \$13.5 billion dollars, while anti-psychotics

generated \$11.5 billion (Whitaker, 2010). Clearly there is a lot of money to be made on people with mental health concerns. In the pharmaceutical industry, psychotropic medication is the second most commonly prescribed after cardiac medication (Barber, 2008). Pharmaceutical companies generate more revenue than any other industry in the United States (Barber, 2008) and nearly twice as much is spent on marketing than on research and development (Batstra & Frances, 2012). Their marketing strategies are aggressive and in the United States this tactic accounts for the majority of patient requests for medication during psychiatric visits (Whitaker, 2010). These are powerful mechanisms employed with the purpose of turning non-patients into patients, then retaining these individuals within the medicated domain.

There is increasing concern of the relationship between psychiatrists, DSM panel members, and pharmaceutical companies (Cosgrove et al., 2006; Gagnon & Lexchin, 2008; Insel, 2011). Drug companies have an omnipresent influence over psychiatry, influencing thought leaders, monopolizing medical journals and knowledge exchange, consumer advocacy groups, providing extravagant incentives such as free trips, meals, and samples, and in the United States, performing direct-to-consumer promotional campaigns which can be seen in the media and on the Internet (Batstra & Frances, 2011). Medical journals are heavily influenced by the pharmaceutical industry because they provide the majority of funding (Batstra & Frances, 2012). This provides pharmaceutical companies with control over which articles are published and provides an incentive for the medical community to keep their interests aligned (Barber, 2008). The DSM is a tool that nearly guarantees that the listed disorders will require pharmacological intervention, which is why it is alarming that 56% of DSM panel members were found to have financial ties to companies in the pharmaceutical industry (Cosgrove et al., 2006). This also increases the probability that the drug industry could be wielding control over the DSM

(Cosgrove et al., 2006). The connections found between psychiatrists, the DSM, and the pharmaceutical industry is cause for concern due to the extreme profitability of the industry and the high potential for conflicts of interest (Cosgrove et al., 2006).

Social Control

Medicalization and the idea of social control stems from social analysis that assumes social and individual pathologies are expressed symptomatically and can be diagnosed and cured according to an organic conception of health and disease (Nye, 2003; Vilhelmsson et al., 2011). Throughout history, the idea of medicalization as a form of social control has been deeply explored. Durkheim wrote of the different forms of power that exist between societies (Conrad, 1992). Foucault incorporated the concept of “governmentality” into his theory of how the modern state ruled over the social body (Nye, 2003). And Parsons explored the notion of illness as deviant (Conrad, 1992). When illness is constructed as deviant, it is then socially accepted as something to be feared, isolated, and eradicated. There are many horrific examples in history of medical control in society over people that are classified as deviant to the human race (Nye, 2003), such as sterilization and eugenics of individuals living with disabilities. Like public health, the main goal of psychiatry is to cure its patients, which it accomplishes through legal measures of involuntary commitment and removal of certain rights and privileges (Zola, 1972). The goals of the medical community do not always align with the individual right to freedom, autonomy, respect, and independence which inherently develops an authoritative and controlling relationship (Barnett, 2012).

Some forms of medicalization are better described as “disease mongering,” which occurs as diagnostic boundaries are extended, forcing treatment of new illness and creating new markets for products (Moynihan et al., 2002). The medical model has taken dominance over a variety of

functions that exist within the ‘normal’ range of life, including childbirth, PMS, sexual preference, and disability (Conrad, 1992). For example, ordinary processes, such as male baldness, are deemed as ailments or medical problems (Moynihan et al., 2002). Common mild symptoms, such as irritable bowel, are defined as serious disease (Moynihan et al., 2002). Social or personal issues, such as social phobia, is promoted as a disorder (Moynihan et al., 2002). And risk, such as osteoporosis, is conceptualized as disease (Moynihan et al., 2002). These symptoms, processes, and issues are then medically reframed and advertised as illnesses that require medical attention and pharmaceutical relief.

Various social movements have attempted to develop and reinforce a separation between the individual and the medical model, a term known as demedicalization (Conrad, 1992). For example, homosexuality and the gay liberation movement of the 1960s added substantial pressure to the medical model and psychiatry; eventually homosexuality was removed from the DSM as an illness and redefined as a lifestyle choice. Although there was great importance to this liberation movement, the refocus on “lifestyle choice” removes responsibility of social constructionism of how homosexuality is defined away from a socio-environmental context. Another example is of the Independent Living Movement which asserted that individuals living with a disability found the medical presence unnecessary and counterproductive (Conrad, 1992). Medical matters would come secondary to the individual. They actively worked to demedicalize disability, including regaining independence from the system, restructuring the social construction of disability by placing more emphasis on the socio-environmental barriers, and were successful in establishing minimal contact with medical care (Conrad, 1992).

The way a society defines and classifies individuals, behavior, and health is important and can carry many implications. In contemporary public health there is a tendency to

individualize health. In doing this, the responsibility of ill health is removed from socio-political and environmental factors, and is placed entirely on individual genetics, behaviours, and lifestyle choice (Vilhelmsson et al., 2011). Problems are seen as individualistic rather than social.

Accordingly, the medical model effectively decontextualizes social problems by focusing on individual pathology (Conrad, 1992). Similar formulations can be found within the disability discourse and how disability is constructed within society. Rioux (2003) expanded on the social and scientific formulations found within theories of individual pathology put an emphasis on biomedical and functional approaches, thus leading to medical intervention. Individualized medical intervention is further reinforced by studies of public health that focus on a reductionist approach, which emphasizes an individual's value based on the optimal functioning of their organs (Vilhelmsson et al., 2011). Any variation (which occurs naturally within ecology and every species) is deemed "ill health," and subsequently medicalized. This becomes increasingly problematic when every aspect of life can then be diagnosed and treatable.

Having the authority to classify certain behaviours, persons, and things is the greatest form of social control (Conrad, 1992). Regardless of medical value, the social consequences of medicalization occur. Various consequences include the assumption of medical moral neutrality, domination by experts, individualization of social problems, depoliticization of behavior, dislocation of responsibility, the use of powerful medical technology, and the exclusion of deviance (Conrad, 1992).

Nutrition and Mental Health

Health Concerns & Vulnerable Populations

Health status is worse for those with lower incomes (Phipps, 2003; Humphries & Doorslaer, 2000; Marmot & Wilkinson, 2003). Socio-economically disadvantaged individuals

are at the greatest risk for poor health, especially poor nutrition. Cardiovascular risk factors and mortality rates are significantly higher among members of low income groups (Travers, 1996). In Canada, social welfare has been kept notoriously below the poverty line, so that those individuals who are reliant on social assistance as their primary income source, have very limited purchasing power in terms of accessing quality nutrition. Food insecurity is not only a violation of the basic human right to food, but it is also a public health concern (Vozoris & Tarasuk, 2003). In a multiple regression study by Vozoris and Tarasuk in 2003, they found that when compared with those in food-sufficient households, individuals in food-insufficient households report significantly higher rates of poor health, restricted activity, suffering from multiple chronic conditions, having a lower body weight, having major depression and distress, and having poor social support. They were also more likely to report having various serious health concerns, including diabetes, heart disease, high blood pressure, and food allergies (Vozoris & Tarasuk, 2003).

There are people who, due to their life circumstances, are more vulnerable and have a higher risk of experiencing income inequality and food insecurity than others. Out of each province in Canada, Nova Scotia has the highest rate of food insecurity (14.6% of households) (Williams et al., 2012). Aboriginal households suffer greater insecurity than non-Aboriginal households; 33% are food insecure (Health Canada, 2007). The incidence of mental illness is disturbingly high amongst food insecure Canadians (Muldoon et. al., 2012). The homeless population is predominantly vulnerable as they rely primarily on unsafe charitable food donations since their money for food after shelter and other expenses are extremely limited (Dachner & Tarasuk, 2002). Additionally, there has been a lack of information produced about the homeless population in particular. Even further negative outcomes are reported amongst

homeless youth, whose regular malnutrition is reported at a disturbingly high prevalence (Tarasuk, Dachner & Li, 2005).

Importance of Adequate Nutrition

Those living with mental illness have poorer health and lower life expectancy than the general population (McCloughen & Foster, 2012). Specifically, higher rates of obesity, diabetes, and cardiovascular disease have been observed among people with mental health needs and there are a number of contributing factors, which include: side-effects of psychotropic medication, impaired access to primary care and health promotion initiatives, apathy and reduced motivation to seek change, social isolation and diminished self-worth, and lack of regular exercise (Bottomley & McKeown, 2008; Dubowitz, 2010; Nova Scotia Food Security Network, 2011). Weight gain is one of the main reasons that individuals become non-compliant with treatment (Chung, 2011; McCloughen & Foster, 2012). Numerous studies have demonstrated the importance of proper nutrition within a holistic approach to the treatment of mental illness (Dubowitz, 2010; Harbottle & Schonfelder, 2008; Lakhan & Vieira, 2008; Perham & Accordino, 2007; Watts, 2011; Wilkinson, 2010; Young, 2002). It has been shown that proper nutrition can play a role in reducing symptomology, alleviating some of the side-effects of medication, such as weight gain, and increasing the rate of successful treatment outcomes (Bottomley & McKeown, 2008; Heflin et al., 2005; Lakhan & Vieira, 2008); however, further research in this area needs to be completed.

Although it has been identified that adequate nutrition is essential for those with mental health needs, the ability to afford a nutritious diet on various forms of social assistance remains the challenge. In Canada, it has been found that within low-income households there are systematic differences in food expenditure patterns when compared with other households

(Kirkpatrick & Tarasuk, 2003). Not only do households with a lower income spend less on food, but they purchase significantly less servings of fruit and vegetables (Kirkpatrick & Tarasuk, 2003). Specifically, those with mental illness and low income report that the cost of food is a major influence on which items they purchase at the grocery store, and typically have to compromise purchasing fresh produce (Carson, 2011).

Socio-Economic Status

Mental Health and Low Socio-Economic Status

People living with a mental illness are a unique at-risk population for experiencing even greater effects of lower socio-economic status (SES) as they have their own set of unique challenges due to their disability. Mental illness is defined in terms of severity and length of occurrence. It is either *acute* (short-term) and situational, or *chronic* (long-term) and pervasive (American Psychological Association, 2000). Those who are afflicted by acute mental illness would not meet qualifications for the Ontario Disability Support Program (ODSP) which is based on having a diagnosed disability for more than one year (Ontario Ministry of Community and Social Services, 2012). Therefore, they would be more pressured by the current welfare state to return to work, in the meantime being forced to subsist at an income from Ontario Works (OW) which is well below the poverty line, and continue to experience poor mental health (Canadian Mental Health Association, 2007). In 2011 the maximum OW income support entitlement for one person for basic needs and housing was \$552 per month (Ontario Ministry of Community and Social Services, 2012; Vozoris, Davis, & Tarasuk, 2002). Meanwhile, the average monthly rent in 2011 for a bachelor apartment in Toronto was \$822 (Canadian Mortgage and Housing Corporation, 2011). Therefore, a single person does not have sufficient income from OW to meet basic needs, when households are assumed to exist in the current market rental

accommodations (Vozoris et al., 2002). This raises serious concerns about whether a nutritious diet can be afforded while on OW. Additionally, in recent years entitlement in Canada for social programming has become increasingly conditional to reduce eligibility (Baker, 1997; Herd, 2002), adding further challenge to those living with mental illness who attempt to gain financial support through social assistance, and especially those who are currently unemployable.

Individuals whose mental illness is chronic and long-term are faced with increased challenges due to their disability and are dependent on long-term social assistance, such as the ODSP. Most individuals with a diagnosed mental illness are eligible for ODSP, which does provide greater economic stability than other forms of social assistance, such as OW. For example, the maximum ODSP entitlement per person in 2012 was \$1064 per month (Ontario Ministry of Community and Social Supports, 2012) compared to the previously mentioned \$552 for OW. People dependent on income support as their primary income live well below the subsistence level; those on ODSP are 34% below the poverty line, and those on OW are 63% below (Canadian Mental Health Association, 2007). Individuals living with a long-term disability have additional needs that require a higher income, and for those with mental illness that includes (but is not limited to), the need for specialized healthcare and supports (Bottomley & McKeown, 2008). To cover the cost of basic necessities such as food, clothing, and housing, ODSP remains significantly lower than needed (Canadian Mental Health Association, 2007). Additionally, many people living with a long-term mental illness are declined from ODSP on multiple occasions, causing them to remain on a lower source of social assistance (e.g. OW) while they continue to apply (OCAP, 2008; Canadian Mental Health Association, 2007). This adds to the stress and financial impact of living at a lower subsistence level for a longer period of time.

Welfare State

The Great Depression of the 1930's in Canada brought the arrival of the welfare state, with the goal of creating an equitable and cohesive society (Tarasuk & Davis, 1996). Collective and universal social programs focused on benefits which were primarily distributed as income. Programming that grew over the next 30 years focused on protecting people from various hardships such as disability or unemployment. Benefits require specific terms for eligibility and have become increasingly conditional and restrictive (Baker, 1997; Herd, 2002). It has been nearly a century since the advent of Canada's welfare state and the system has seen many changes. Between 2006 and 2015, the Conservative federal government in Canada was led by Stephen Harper, who made further cuts to the social programs as per their fiscal economic management plan to reduce the country's current deficit. These factors have a complex impact on the welfare state and the country has seen an erosion of social benefits and programs. The current federal leadership in 2016 is Justin Trudeau of the Liberal party, and it will be interesting to follow their policy regarding mental health and the welfare state in the years to come.

Poverty and rates of income inequality in Canada continue to rise; 9.4% of Canadians in 2008 were living below the poverty line (CIA, 2008). For those on social assistance, poverty is an unavoidable reality (Tarasuk & Davis, 1996). An invaluable component of Canada's social safety net is social assistance (Kneebone & White, 2009). Due to factors of 'gradual welfare retrenchment' in Canada resulting from neoliberalism over the past two decades (Baker, 1997; Langille, 2009), the country's welfare state can be classified as 'liberal' as social assistance programs remain modest and means-based (Esping-Andersen, 1990). The Canadian federal government continues to insist that restructuring of the welfare state is occurring due to fiscal economic policy, implemented to alleviate pressure on the tax system and reduce spending of the

revenue base, and reduce the country's debt (Wilson, 2000). This ideology is known as economic rationalism, with a predominant focus on market capitalism (Baker, 1997).

Socially, there appears to be an underlying shift in values from one of social rights to an emphasis on accountability to individual behavior, suggesting that those who are not employed are insufficient compared to those who are employable (Myles, 1996). Canada has moved away from guaranteed benefits such as 'social security,' 'citizenship rights,' and 'guaranteed annual income,' towards temporary supports based on need and designed to encourage 'self-sufficiency' and 'employability' (Baker, 1997). However, individual needs vary and it is not realistic, moral, or equitable to label every person with the same economic and social demands.

Neoliberalism

Neoliberalism is the current theory dominating the political and economic landscape in Canada and this has resulted in restructuring of the welfare state. Traditionally, neoliberalism is defined in terms of the economy, as being structured with a focus on free-markets by reducing barriers and restrictions in the marketplace, and being driven by a "laissez-faire" approach to development (Investopedia, 2012). The attention is on shifting power from the public to private sector, with a focus for governments to reduce the deficit, limit subsidies, broaden the tax base by reforming tax law, removing fixed exchange rates, opening up the market to trade by limiting protectionism, and privatizing state-run business (Brown, 2006; Investopedia, 2012).

Neoliberalism has come to dominate the politico-economic social system and discourse in Canada (Sachikonye, 2010). This ideology that was traditionally expressive of the economic marketplace, now defines social institutions through political drivers and governmental action. The privatization and outsourcing of various institutions such as welfare, education, jails, police, etc., entail policy that produces citizens as consumers whose moral autonomy is measured by

their capacity or ability for self-care or the ability to provide for one's own needs (Brown, 2006; Sachikonye, 2010). The effects of neoliberalism on the political and social landscape have resulted in a dismantling of the welfare state, wreak havoc on democratic sovereignty, and intensify income disparities (Borchert, 1996; Brown, 2006; Langille, 2009)

Many countries participating in the Organisation for Economic Co-operation and Development (OECD) with this politico-economic orientation, including Canada, began restructuring elements of their welfare state in the early 1990's in response to situational demands; mounting program costs, increasing numbers of applicants, structural transformations in the labour market and within families, and political agendas with an emphasis on the market and businesses (Baker, 1997; Herd, 2002; Kneebone & White, 2009). In terms of social benefits, this system implies that the market is a more reliable source for the welfare state than the government (Baker, 1997) and further contributes to a notion that people are valued based on their employable impact on the country, not leaving much room for those with disability. Further, the Canadian government has reformed the tax system, attempting to make the country more advantageous to business investment (Baker, 1997), which brings further fragmentation to the social safety net. In 2009, the federal government had announced \$60 billion in tax cuts (Langille, 2009). Extensive closure of community-based social service agencies and severely reduced care for those with mental health needs is additional evidence of the disintegration to the welfare state (Herd, 2002). Of the social assistance programs that remain, there are ongoing concerns about their adequacy to meet the needs of those who depend on them (Tarasuk & Davis, 1996).

Income Inequality

Income inequality has been increasing since the 1990's. This is demonstrated by the increasing Gini coefficient, which is designed to measure the extent to which the distribution of income among individuals or households within an economy deviates from a perfectly equal distribution. The Gini coefficient has risen from 0.305 in 1990, to 0.32- in 2009, putting Canada in 13th place among all of the countries participating in the OECD (Index Mundi, 2011). For those who depend on social welfare as their primary source of income, poverty is practically guaranteed (Tarasuk & Davis, 1996). Between 1990 and 2009, Canada has seen an increase in inflation by 45.9%, and most welfare incomes did not keep up (National Council of Welfare Reports, 2009). In some cases, actual welfare incomes have actually decreased by 20% or more. The gap between the poverty line and welfare incomes remains large and relatively unchanged in recent years, as some individuals attempt to survive at one-fifth of the poverty line (National Council of Welfare Reports, 2003). The government purposefully keeps the income of social welfare low enough so that it does not provide an incentive for individuals to remain on the benefit for a long period of time (Baker, 1997; Herd, 2002) and can resume positions of labour in the marketplace. Those that remain within such low socio-economic status are at risk of longstanding health inequalities and food insecurity (Health Canada, 2007; Hunger Count, 2011; Heflin et al., 2005; Tarasuk, 2005).

Food Insecurity

Background

Food insecurity results from the social conditions and policies that limit the resources available to a household to purchase adequate, nutritious food (McIntyre & Rondeau, 2009).

Food insecurity occurs when an individual is unable to, or uncertain of being able to, acquire a nutritious diet in quality and quantity that is socially acceptable and that meets their specific needs (Goetz, 2008; Heflin et al., 2005; Kirkpatrick, 2008; McIntyre & Rondeau, 2009; Mirza et al., 2007; Muldoon et al., 2012; Vozoris & Tarasuk, 2003). At the World Food Summit in 2009, the concept of *food security* was further defined as:

exist[ing] when all people, at all times, have physical, social and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for an active and healthy life. The four pillars of food security are availability, access, utilization and stability. The nutritional dimension is integral to the concept of food security. (p. 1)

Nutritional adequacy is critical and perhaps the most important determinants of health. To deny an individual secure access to food is a denial of their basic and fundamental human rights. The Canadian Charter of Rights and Freedoms was passed in 1984 and declared individuals the right to life, liberty, and security of their person, and not to be deprived thereof (Canadian Heritage, 1984). There has also been further global reference and legislation passed honoring people with the right to adequate nutritious food (United Nations, 1996).

Data on food insecurity is collected in a number of ways. The primary source of collection is through survey distribution, and the secondary source is accessed through frequencies of food banks utilization, levels of income, and rates of homelessness (Vozoris & Tarasuk, 2003). Until the end of the 1990's, Canada did not have a system of national data collection and relied merely on accessing information from local-level programming, such as food banks (Vozoris & Tarasuk, 2003). It was very challenging to understand the real extent, severity and implications of food insecurity in the country. Additionally, any surveys that were implemented were at the local level and were not standardized, with measures and terminology

varying widely between surveys and further complicating analysis (Vozoris & Tarasuk, 2003). The *National Population Health Survey* (NPHS) was developed in 1998 as part of the National Longitudinal Survey, in response to a need for a national system of data collection on food insecurity in Canada (Vozoris & Tarasuk, 2003). The NPHS was composed of population-based prevalence estimates for numerous indicators of household food insecurity (Vozoris & Tarasuk, 2003). Additionally, the *Household Food Security Survey Module* (HFSSM), and the *Canadian Community Health Survey* (CCHS) were developed and implemented in the early 2000's. These tools are also well-researched, standardized and contain multiple-indicator measures of food security (Health Canada, 2007). Most of these tools remain in circulation and are utilized by Statistics Canada for ongoing data collection.

As of 2004, more than 2.7 million Canadians (nearly 14% of the population) were found to be living in food-insecure households as a result of financial difficulty in accessing food (McIntyre & Rondeau, 2009; Ledrou & Gervais 2005). When polled in 2004, 71% of Canadians indicated that hunger was a serious problem in Canada (Heimann, 2004). There is convincing evidence of the relationship between household income, specifically those with low socio-economic status, and household food security (Health Canada, 2007; McIntyre & Rondeau, 2009). Of those most likely to experience food insecurity, individuals who rely on social assistance experience the highest incidence at 59.7% (Health Canada, 2007). The end of the month signals the most severe cases of hunger within food insecure households (McIntyre, Walsh & Connor, 2001). Results from the CCHS reported the experiences most commonly reported in food-insecure households in Canada as follows: 10% report worrying about running out of food, 7.7% report running out of food and not having enough money to buy more, and 8.4% report not being able to afford balanced meals (Tarasuk, 2009). Inequalities in nutrient

consumption may be associated with social inequities, including poverty-related inequities in access to food and other resources necessary for the achievement of optimal health (Travers, 1996).

Emergency Food-Response Programs

The most apparent expressions of persistently high levels of poverty in Canada has been the increased number of people seeking emergency food support and the concurrent proliferation of charitable food distribution and feeding programs which follow (Tarasuk & Davis, 1996). Charitable food distribution began in the early 1980's and initially developed as temporary, local, community-based participatory programs in response to emergency relief. They remain primarily charity-based, relying on donations, and at times programs will receive small government grants (Tarasuk & Davis, 1996). The fact that these programs have been in existence now for over 30 years, suggests that they have become institutionalized. Food support and local development initiatives that are established at the grassroots level are responsive to the needs of the community and are genuine responses to local need. However, food response initiatives are ad hoc responses to the underlying problem of poverty, income inequity, and the deteriorating social welfare system (Tarasuk & Davis, 1996). They are a band-aid solution and are not a viable long-term response to the reform needed. The situation is further complicated by the complex relationship with a changing national and global economy (Tarasuk & Davis, 1996).

Discussion

Policy Development and Data Collection

Canada needs to retain a national longitudinal data collection method and monitoring system that not only focuses on those afflicted with food insecurity, but also to show the patterns

of deprivation, any elements of change, as well as to determine and implement policy. Surveys should be far more comprehensive and include more measures such as the extent and severity of food insecurity. Additionally, surveys that rely on self-reported measures are important but inherently unreliable due to their subjectivity and vulnerability to bias. Therefore, it is important to also include objective measures within future methodology.

Policy should be developed in parallel, with a focus on alleviating broader social determinants of health such as poverty and income inequality, rather than just focusing on the outcome of this issue, such as food insecurity. Yeatman (2003) identifies many theories of processes within policy development, and various influences that can bear an impact on the success of food and nutrition policy at the local-level, including catalyzing events, individuals in positions of influence within the bureaucracy, use of information, gains and losses negotiated, identification of strategic actions including their success or failure.

A Critical Lens to Analyze Social Inequities

It is important to be aware that the way a problem is defined forms responses to it. For example, the belief that food banks are a source of charity can spawn a perpetuating cycle of judgment within the community, and stigma within those who access the program. The widespread public acceptance of food banks as a solution to the problem of food insecurity, creates a notion that individuals living at a lower socio-economic status require this charity to support their inadequacy (Baker, 1997). What is necessary is a way to construct the problem using a different lens. By applying a critical social science framework, one can begin to break down the barriers set in place by the larger societal structure, then move towards realization and acceptance of the true nature of this problem. As explained by Travers (1996),

‘Social relations are not “things” but processes. As such, people in their daily practices do not “produce” social relations, but enter into them. It is through these sets of social relations that the social world is organized. By displaying the social relations that people enter into through their practices, it becomes possible to explicate the social construction of a phenomenon such as the commercial organization of food, and perhaps critique how the social relations in the commercial sphere contribute to the organization of nutritional inequities. Such explication provides opportunities for changing the relations and constructing an alternative social world... nutritional inequities are socially constructed; people themselves are drawn into the relations organizing those relations. (p. 544)

A methodological procedure, called institutional ethnography, attempts to make the everyday world its problematic, by exposing social relations that arise from and are organized by everyday experience. It is explained by Smith (1987) that ‘institution’ refers to a set of complex social relations forming part of broader social constructs, and ‘ethnography’ as a commitment to an in-depth exploration that begins with people’s lived experiences. This is relevant and important to the study of food insecurity in Canada because of the potential significance for social change. The nature of this type of participatory research (one that includes the participant within the research, such as the emancipatory approach), provides an educative nature and empowers participants to begin structural change. This explicative approach further exposes the oppressive nature of social organization (eg. political, economic, structural), providing a necessary perspective for the economically disadvantage population. Moreover, time spent with individuals can be used twofold; one to collect data, but just as importantly, as a form of knowledge transfer and mobilization within communities. In 1996, Travers utilized institutional ethnography within her methodology in an attempt to elucidate the social organization of

nutritional inequities among socially/economically disadvantaged families. As predicted, she found that an oppressive nature exists within social organization; specifically, that welfare policies are based on assumptions that social problems, such as food insecurity, are caused by individual health behavior and inadequacies. Rather, it is largely the dominant discourse that guides policy, and the variety of oppressive policies that contribute to the perseverance of nutrition and health inequities (Travers, 1996; Yeatman, 2003; Coveney, 2003).

Conclusion

This critical research paper was written with the intention to highlight and reflect upon a variety of issues related to mental health in Canada. Generally, the issues were regarding the diagnosis and medical treatment of persons living with mental health concerns. It had been observed by the primary researcher through experience in community and institutional mental health practice, and also by collecting anecdotal evidence through work experience, that not only did there appear to be a growing issue related to an increase in diagnosis of mental health, but also that people were being prescribed *a lot* of psychotropic medication. It also appeared that individuals had become complacent with medical treatment, did not question their doctors, and placed a high level of trust in them. It also appeared that people were willing to take a pill in the hopes that this would help their mental health issue. With these issues in mind, this research paper exposed literature with data that supported these observations. Not only is diagnosis of mental illness on the rise in Canada, but people are being treated with a large amount of psychotropic medication which has negative consequences on the health of the population. The primary researcher observed that the basics we utilize to maintain good health (nutrition) were not being considered by health professionals, which probed further research. The data also

proved that good nutrition is essential for mental health, but that more research is needed.

However, the presence and influence of the pharmaceutical industry on psychiatrists and the DSM were shown to disrupt any successful movement of funding towards complementary and alternative treatment approaches (to the medical model) due to the financial influence and power of this group. The effect of social and political inequities on individual access to good nutrition for supporting mental health within our system needs to be the focus of future government action and health policy attention. If the community continues to support critical practices and uphold those affected members of marginalized groups, such as consumer/survivors, we may be able to affect the health of future lives, and the overall landscape of mental health treatment in Canada.

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