From Containment to Resilience:

A Genealogy of the Governance of Mental Abnormality in Canada

by

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A thesis submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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ABSTRACT

This dissertation uses a governmentality lens to map shifts in the categorization, problematization, and governance of mental abnormality in Canada, from pre-Confederation times until the present. Focusing in particular on several recent consultations and reports issued by the federal government and the province of Ontario, the dissertation asks: *What is novel about how those categorized as mentally abnormal (TCAMA) are framed in recent public transcripts? Are these documents indicative of a paradigm shift in how mental abnormality is understood? If so, what does this mean for the future governance of TCAMA*? This dissertation surveys, primarily through a discursive lens, past approaches to the governance of mental abnormality in Canada. Three overarching governing mentalities – containment, medicalization, and deinstitutionalization – are examined. For much of Canadian history the governance of TCAMA was informed by the idea of containment, which relied on technologies such as work therapy, mental testing, and sterilization to isolate lunacy, insanity, and feeblemindedness from broader society. By the mid-twentieth century, mental abnormality was reframed as mental illness, which like other illnesses, was thought to be treatable with surgery and pharmaceuticals. Later, deinstitutionalization emptied out psychiatric hospitals and hospital wards, prescribing community-based treatment programmes in their place. However, these services were never fully installed, resulting in criminalization, poverty, homelessness, and by the early 2000s, a crisis in a deinstitutionalization mentality.

The dissertation next deploys a Foucauldian discourse analysis to examine testimonies collected during the Standing Senate Committee on Social Affairs, Science and Technology (SSCSST) (2003-2006) and Legislative Assembly of Ontario (LAO) (2009-2010) investigations into mental illness and mental health. It maps the problems and solutions with Canada's mental health system, as identified by seven different groups. Four final reports are then juxtaposed with the preceding testimonies: the LAO’s *Navigating the Journey to Wellness* (2010); the Ontario Ministry of Health and Long-Term Care’s *Open Minds, Healthy Minds* (2011); the SSCSST’s *Out of the Shadows at Last* (also known as the Kirby Report) (2006); and, the Mental Health Commission of Canada’s (MHCC) *Changing Directions, Changing Lives* (2012). The final reports contained dominant prevention and recovery discourses, which the dissertation locates within a proposed fourth mentality: resilience. Resilience is an experimental mentality that centres mental health while deemphasizing mental illness. It informs prevention and recovery, programmes which individualize and responsibilize TCAMA for their own fates. Resilience moves away from either/or categorizations of mental illness to locate everyone on the same mental health continuum. This continuum draws a new line between normal/abnormal, not on the basis of diagnosed mental illness, but on one’s ability to adapt to, or bounce back, from life’s challenges, regardless of social inequities.

PREFACE

This project was partially funded by the Social Sciences and Humanities Research Council of Canada.

DEDICATION

To everyone on board the ship of fools.

ACKNOWLEDGEMENTS

To begin, I extend my deepest thanks and heartfelt appreciation to my supervisor and mentor, Dr. Janine Brodie. In addition to her boundless generosity of knowledge, time, and feedback, Dr. Brodie provided me with two critical elements to envision this project: a curiosity to play with ideas, and encouragement of my desire to push the boundaries of the field by studying the irrational. Dr. Brodie motivated me to exceed the limits of what I thought myself capable as a scholar. As her research assistant, Dr. Brodie entrusted me with projects and roles that helped me to develop the confidence and leadership skills needed to succeed. I continue to cherish and draw upon the formative advice she offered me as a first-year PhD student: “don’t defer.”

Thank you to my internal examiners, Dr. Lois Harder and Dr. Catherine Kellogg. In addition to serving on my committee, their mentorship throughout the program equipped me with the confidence and ability to express and defend my ideas. Thank you to my external examiners, Dr. Judy Davidson and Dr. Marina Morrow, for their generous and thoughtful engagement with my work. Special thanks are also due to Dr. Malinda Smith, Dr. Judy Garber, and Dr. Robert Nichols, for their support and encouragement throughout my time in the program. Thank you to the University of Alberta’s Department of Political Science administrative team, some of whom no longer reside in the department, but whose various forms of support enabled me to complete this project – Cindy Anderson, Donna Coombs-Montrose, Caroline Kinyua, Tara Mish, Sharina Prasad, and Lihong Yang. I would also like to thank Carleton University’s Political Science Department, which in addition to providing me with a space to work during the final year of this project, offered a welcoming environment within which to complete it.

This project would not have been possible without the endless support of my family and friends, whom I love and cherish dearly. Thank you to my parents, Karen and John Phillips, for

encouraging my education, pushing me to succeed, understanding when I did not call home, and offering words of love and reassurance when I did. The devoted care they provided during my ill health inspired me to write a dissertation about the topic years later. Thank you to Stephen and Laura Phillips for their belief in me, and to their children, Ethan and Owen, whose laughter was the ultimate anecdote to my dissertation stress. I would also like to thank my family in Ottawa, Sheila Wadden and Robert Talbot, and their children, Eileen and Everitt, for welcoming and helping us navigate everything Ottawa. Thank you to the Normandeau family for their support and generosity, as well as to the wider Phillips and Wadden families for their encouragement.

I am grateful to have been surrounded by a group of friends who provided the solidarity, thoughtful discussion, and most importantly, the laughter needed to grow into a scholar, and ultimately, into myself – in alphabetical order, Alysha Anderson, Monty Bal, Drew Brown, Kit Carole, JD Crookshanks, Alexa DeGagné, Matt Dow, Brent Epperson, Keegan Gibson, Justin Leifso, Dougal MacDonald, Jatinder Mann, Sarah Murphy Brown, Randi Nixon, Josh Paley, Daisy Raphael, Lena Saleh, Leigh Spanner, Holly Stover, and Alex Wilson. I would especially like to thank Charlie, Daisy, and Josh for generously hosting me during my defense, and for their nourishing food and company. I would be remiss if I did not also thank my non-human animal friends for their comforting companionship throughout – Brutus, Charlie, Chico, Fraidy, Ginger, Iris, Santos, Sassy, Satchmo, Sophie, and Ted.

Finally, thank you to my partner, Danielle Normandeau, for accompanying me on this journey, playing with ideas, sharing my ups, consoling my lows, all the while treating me – and ensuring I treat myself – with kindness. Danielle's commitment to care, collaboration, and critical inquiry in the face of individualization is truly radical. It is with great pride that I get to witness Danielle's academic journey unfold. I am thrilled for our next life chapter with Iris.

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LIST OF ABBREVIATIONS

CAMH	Centre for Addiction and Mental Health
CMHA	Canadian Mental Health Association
CNCMH	Canadian National Committee on Mental Hygiene
ESC	Eugenics Society of Canada
LAO	Legislative Assembly of Ontario
MHCC	Mental Health Commission of Canada
OMHLC	Ontario Ministry of Health and Long-Term Care
PPH	Provincial Psychiatric Hospital
SSCSST	Standing Senate Committee on Social Affairs, Science and Technology

CHAPTER 1: INTRODUCTION

1. Introduction and Statement of Research Problem

This dissertation employs a governmentality lens to examine ongoing shifts in the categorization, problematization, and governance of mental abnormality in Canada from pre-Confederation times to present. It is particularly focused on the present moment when there has been a flurry of activity at both provincial and federal levels of government, wherein mental health has newly been taken up as a national issue. This moment marks two shifts: first, the framing of mental abnormality as a national problem, whereas in the past it has been left up to provincial jurisdictions; and, second, a shift towards the individualization and responsibilization of mental health as solutions to recent problematizations of mental abnormality. This dissertation locates ongoing and recent shifts in the governance of mental abnormality within a broader resilience mentality. I then situate these shifts in relation to previous moments in the governance of mental abnormality at the provincial level (Ontario), which I in turn locate within mentalities of containment, medicalization, and deinstitutionalization. This project is not concerned with mental abnormality as a problem, but rather, with the ways it has been problematized at various points in time. It aims to demonstrate that categorizations and problematizations of mental abnormality have shifted through time, while highlighting the shifting line between normal and abnormal, and subsequently, inclusion and exclusion.

This project relies on a Foucauldian conception of abnormality (1965; 2003). It uses the term “mental abnormality” to refer to what at different times has been called lunacy, insanity, feeblemindedness, mental illness, and now, mental health problems. Consequently, it refers to those who have been labeled as lunatics, insane, feebleminded, and mentally ill as “those categorized as mentally abnormal” (TCAMA). The use of “mental abnormality” and “TCAMA” is consistent with this project's aim of unsettling essentialist categories by pointing to their many different meanings over time. Categorizations such as lunacy and mental illness are informed by broader mentalities[1], and are part of a wider power/knowledge nexus that relies on various sites of expertise to arrive at solutions. For example, the category mental illness presupposes that mental abnormality is a medical problem, and calls for medical solutions. One of the goals of this project is to undertake a genealogy of mental abnormality – and of the many shifts in expertise, categorizations, problematizations, and solutions that have marked its governance over time.

Canada is at a critical juncture in the governance of mental abnormality. Over the past 15 years there has been a flurry of activity at both national and provincial levels. This activity has included public reports that focus on the overall mental health of Canadians and a failing mental health system. These documents have also provided recommendations directed at improving the mental health of all, rather than treating the mental illness of the few. This degree of activity was indicative of a crisis point in mental health policy, marked by widespread agreement that deinstitutionalization programmes – the emptying out of provincial psychiatric hospitals (PPHs) and psychiatric wards under the assumption that TCAMA would fare better in the community – adopted by provincial governments between the 1960s and 1990s, were not working. This opened up a space for discussions on future mental health policy directions. These discussions were marked by competing discourses articulating distinctive ideas of what future mental health policy directions should look like.

As Neil Bradford argues, public commissions are created at critical policy junctures to achieve consensus on future policy directions (1998, 12). This project examines two interview series: first, the Government of Canada's Standing Senate Committee on Social Affairs, Science

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[1] Governmentality, as well as the relationship between problems and problematization, are explained more fully in the theoretical framework, commencing page 8.

and Technology's (SSCSST) hearings on mental illness and mental health services in Canada, conducted from 2003 to 2006; and, second, the Legislative Assembly of Ontario's (LAO) Select Committee on Mental Health's hearings on mental illness and mental health services in Ontario, conducted from 2009 to 2010. Both commissions brought together a diverse group of witnesses with competing discourses, among them psychiatrists, medical service providers, community service providers, government organizations, Indigenous representatives, anti-psychiatry activists, and personal testimonies. Each group of stakeholders identified what they perceived to be problems with and solutions for Canada's mental health system.

This project also analyzes four public transcripts that followed these interview series. The SSCSST recommendations were summarized in *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (2006), commonly known as the Kirby Report. The Kirby Report recommended the creation of a national mental health commission, realized in 2007 with the creation of the Mental Health Commission of Canada (MHCC). In 2012, the MHCC released its own national mental health plan, *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. At the provincial level, the LAO recommendations were summarized in *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians* (2010). In 2011, the Ontario Ministry of Health and Long-Term Care released the provincial plan: *Open Minds Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (2011). This dissertation argues that the final reports and plans contained unified policy approaches that authorized some stakeholder perspectives – and some discourses – over others. These new policy approaches are part of an experimentation with a new mentality – resilience. This dissertation seeks to understand this activity by answering these research questions: *What is novel about how* *those categorized as mentally abnormal (TCAMA) are problematized in recent public transcripts? Are these documents indicative of a paradigm shift in how mental abnormality is understood? If so, what does this mean for the governance of TCAMA*?

A great deal of work has been undertaken within disability and mad studies with respect to the social dimensions of mental abnormality (Battersby and Morrow 2012; Church 2008; 2013; Morrow 2013; Poole 2011; Poole and Ward 2013; Reville 2008; 2013; Voronka 2013). Historical studies have examined various dimensions in the history of mental abnormality, from how it was understood, to how it was treated, to the rise of psychiatric survivor activism (Burstow 2013; Diamond 2013; Moran 2000; Reaume 2000; 2002; 2006; Shortt 1986; Starkman 2013). However, mental abnormality has been largely overlooked within political science and thus, stands as an understudied dimension of governance. This project is novel because it introduces a governmentality lens to the study of mental health policy in political science, which it then uses to capture how shifting mentalities surrounding mental abnormality inform subsequent shifts in its categorizations, problematizations, and solutions. While past approaches to mental health policy focused on monumental shifts at the level of the state, a governmentality lens extends beyond the state to capture the various ways through which mental abnormality is governed through every day, micro practices and locales. It does so through attention to discourse as a productive force, which captures broader power/knowledge relationships at play in governance (Foucault 1980, 93).[2] As such, while this dissertation is concerned with policy shifts and public transcripts circulating at provincial and federal government levels, these documents are only particular moments grasped within broader shifts in the way mental abnormality is dominantly categorized, problematized, and governed.

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[2] I elaborate more fully on Foucault's approach to discourse in the theoretical framework to follow.

A governmentality lens is an appropriate theoretical approach because it extends beyond state institutions to demonstrate that public transcripts are bound up with broader discursive shifts in society. Most recently, these shifts include major changes in the way we talk about mental abnormality – including the fact that after centuries of silence, it is being talked about publicly. From Clara Hughes (Ansari 2015) to Bob Rae (Taber 2011), more and more public figures are coming out about their experiences with mental illness, and major organizations are undertaking public mental health campaigns, such as Bell's *Let's Talk* campaign to end stigma (Bell 2016). Universities are paying attention to mental health on their campuses by implementing a broad range of initiatives put in place to help students cope with stress, including the University of Alberta's *Unwind Your Mind* program (Healthy Campus Unit 2016), supplementing the limited mental health services on campus with workshops offered through Counselling and Clinical Services, such as *Creating a Resilient Mindset* (Counselling and Clinical Services 2016).

These narratives contain the same threads that run throughout the above-listed documents – a shift away from an overreliance on mental health services towards the cultivation of personal resiliency. In effect, a focus on the mental illness of the few has been supplanted by a focus on the mental health of all. This focus erases and further abnormalizes those living with chronic mental illnesses, who often have little access to resources required for personal resiliency. It is also assumed that TCAMA desire normalization in the first place. This dissertation argues that the shift away from mental illness and towards mental health draws a new line between normal and abnormal, and upon new grounds: mental illness is no longer the basis of mental abnormality; rather, mental abnormality is the inability or refusal to exercise resiliency and recovery – a personal, moral failure to exercise responsibility over one's own well-being.

This dissertation converses with two key concepts in political science. The first is reason. Canonical texts in political theory frame man (white, property-owning man) as first and foremost, a reasoning being. Social contract theory isolates reason as that which allows the perceived reasoning subject to transition from a hypothetical state of nature to civil society (Hobbes 1651; Locke 1689; Rawls 1971). Canonical social contract theorists juxtapose the reasoning subject with the "savage," the figure residing in a state of nature. In this dissertation I shift this gaze away from the subject/savage to consider reason/unreason. Little attention is paid within political science to the irrational subject, the mirror of reason and its rational subject. If reason is what facilitates the original and all subsequent contracts, then those categorized as irrational, or mentally abnormal, fall outside the requirements for full membership in civil society. Of course, this exclusion has not been limited to TCAMA, but has also included Indigenous peoples, people of colour, women, gender and sexual minorities, children, those living in poverty, and many more. Like these other groups, the state identifies TCAMA as a problem to be managed and thus as people not entitled to full social citizenship. This dissertation picks up with this point to consider the different ways TCAMA have been categorized, problematized, and governed at various points and places in Canadian history.

The second entry point into political science for this project is power. Political science is fundamentally concerned with the study of power. However, while power is most often studied as the "power to" do something or the "power over" someone (Brodie 2014, 4-5), less attention is given to the relationship between power and knowledge and the micro operations of power through which we are governed, and govern ourselves, on a day to day basis (Brodie 2014, 9). Hence, one of Foucault's key arguments regarding power is that "political theory has never ceased to be obsessed with the person of the sovereign" and that what is needed is "to cut off the

King's head" (1980, 121). Foucault suggests that power exists beyond the law, which necessitates that I examine instances of power beyond formal policy documents, for example, the implementation of work therapy in asylums, the sterilization of TCAMA, and the use of psychopharmaceuticals. This dissertation demonstrates further that the operation of power in the exclusion, governance, and management of TCAMA does not solely operate from the top down, for instance, in the figure of the psychiatrist during the incarceration of TCAMA during lunacy reform, or in the performance of lobotomies during the medicalization of mental abnormality. While these moments are undoubtedly important, there is a great deal to examine in the more nuanced ways through which mental abnormality is governed.

The way we think about mental abnormality is informed by what Foucault identifies as a power/knowledge nexus (1980, 119). While there are multiple discourses circulating at any one time, our understanding of mental abnormality is informed by dominant discourses, which embed themselves as truth. Dominant discourses demarcate what normalcy and abnormality look like, excluding the latter from full political membership. The nuances of these exclusions are best captured through a governmentality lens, which accounts for power dynamics beyond the level of the state. Solutions to the problems posed by mental abnormality have typically been informed by psychiatric knowledges – knowledges contained, for instance, in the many editions of the *Diagnostic and Statistical Manual of Mental Disorders* (2013). Emergent discourses – produced through different sites of power/knowledge – are gaining influence because, as this dissertation will show, there has been a decline in psychiatric power. This dissertation contributes to political science by drawing attention to the play between these discourses, and of the power/knowledge nexi through which they are produced. It also contributes to the discipline by capturing and analyzing the individualized ways through which mental normalcy is disciplined on a day to day basis, and through which mental abnormality continues to be overlooked and excluded, granted in new ways. A governmentality approach allows me to argue that, although the days of work therapy and lobotomy are gone, TCAMA are still excluded from society and subject to violence, but on new grounds and in new ways.

2. Theoretical Framework

This section outlines the theoretical framework guiding this project. It begins by expanding upon governmentality as a unique approach to isolating and understanding the micro processes involved in governance. Four mentalities are introduced that, between the early nineteenth century and the present, have informed the many programmes and technologies involved in the governance of mental abnormality in Canada: containment, medicalization, deinstitutionalization, and now, resilience. Mental abnormality is discussed and situated in relation to an ever-shifting line between normal and abnormal. Following this, the relationship between power and expertise is explored with a particular focus on the role of the psychiatrist. I argue that while the psychiatrist was once at the apex of the containment and medicalization of mental abnormality, this expertise has shifted to other sites. This discussion also flags particular programmes and technologies as instances of disciplinary power (including psychiatry) and biopower. Individualization and responsibilization are later introduced as two key technologies deployed to operationalize resilience, the fourth mentality explored in this project. The last section is dedicated to the shifting role of community.

2.1 Governmentality and Govern-mentalities

This project uses a governmentality lens to examine various moments in the governance of mental abnormality in Canada. Governmentality provides an approach to studying mental health policy that, while deemphasizing the state, considers the multiple levels and ways through which mentally abnormal subjectivities are categorized, problematized, and governed. A governmentality approach broadens our conception of power beyond the sovereign to consider more nuanced ways through which power operates, for instance, in the ways we are disciplined, or discipline ourselves, to appear and behave "normally." The channels through which these capillaries of power operate are informed by expert discourses, which authorize the psychiatrist or community mental health worker, and simultaneously install multiple sites of power while also fulfilling the promise of the liberal state – to govern, or interfere, to the least extent possible (Miller and Rose 2008, 26).

"Governmentality" was coined by Michel Foucault to designate a form of governance unique to the modern liberal state, an analytical grid upon which we can understand various relations of power and conduct that extend beyond its sovereign forms (Foucault 2008, 186). Since Foucault's untimely death in 1984, governmentality has been taken up by contemporary scholars to uncover the myriad ways through which power is exercised beyond the state (Brown 2015; Dean, 2010; Miller and Rose 2008; Walters 2012). Governmentality is significant because it "represents a shift away from the power of command and punishment targeting particular subjects and toward the power of conducting and compelling populations 'at a distance'" (Brown 2015, 117). Hence, in order to get at the complexities behind the governance of mental abnormality we must seek out and critically examine the multiple, nuanced ways through which it is problematized and managed, not the least, through the very language that we use.

A governmentality approach suggests that governance is comprised of an ensemble of rationalities (govern-mentalities), programmes, and technologies. Political rationalities are "ways of rendering reality thinkable in such a way that it [is] amenable to calculation and programming" (Miller and Rose 2008, 16). In other words, rationalities are mentalities, ways of identifying social problems that render them amenable to intervention, while at the same time informing what those interventions should look like. These ways of thinking about problems always assume relations and goals about the means and ends of governance:

> For Foucault, political rationalities posit ontological qualities and relations of citizens, laws, rights, economy, society, and states – qualities and relations inhering in orders of reason such as liberalism, Christianity, Roman law, and so on, which may combine awkwardly, but nonetheless all become salient parts of that by which worlds are ordered, humans act, and governments rule (Brown 2015, 116).

Taken together, these presumed qualities and relations comprise "the fabric of our ways of thinking about and acting upon one another and ourselves" (Barry, Osbourne and Rose 1996, 7). Simply put, political rationalities inform the nature, means, and end goals of what is up for grabs in governance.

Rationalities identify and open social problems up for intervention through discourse. It is therefore possible to trace rationalities through an attention to language. Discourse marks the difference between the field of possibilities that could be stated at any given moment, and what is stated (Foucault 1991, 63). It is productive, informing the range of possible solutions. As Miller and Rose highlight, it makes "reality amenable to certain kinds of action" (2008, 31). The difference between what could be said and what is said at any given time informs the terrain of possibilities for intervention. For instance, at different points in time, mental abnormality has been discursively coded as lunacy and as mental illness. Lunacy is rooted in the latin *luna*, which means "moon" (Reaume 2002, 407-408), suggesting it is linked to lunar cycles and therefore ebbs and flows. These ebbs and flows can be contained but not cured. Conversely, mental illness suggests that mental abnormality is a sickness, which opens up the possibility of "treating" the brain in the pursuit of a cure, for example, through lobotomy or psychopharmaceuticals. These discursive shifts point to the need to closely examine categorizations of mental abnormality, as they have significant bearing on the solutions put forth to govern it.

There are multiple, competing discourses at play surrounding mental abnormality at any one time. This dissertation borrows from Raymond Williams' (1977) typology of cultural elements to situate these discourses in relation to one another. At any one time there is a dominant discourse: for example, a medicalization mentality framed mental abnormality as a physical illness, and therefore as something that was amenable to a cure. However, Williams argues that the dominant cannot be fully captured without reference to the "residual" and the "emergent" (1977, 121). Williams defines the "residual" as that which "has been effectively formed in the past" yet still remains "as an effective element of the present" (1977, 122). For example, medicalization discourses supplanted containment discourses, but the latter did not disappear altogether. Elements of these discourses remain to this day, although they are not dominant. Williams understands the "emergent" as "new meanings and values, new practices, new relationships and kinds of relationships" that are always being created (1977, 123). Some emergent discourses may embed themselves in dominant discourses. However, when this embedding takes place the emergent becomes a mere replica of the "genuinely emergent cultural practice" (126). For example, the dominant deinstitutionalization discourse that took hold in the 1970s did not emerge in pure form out of thin air, but was a result of the incorporation of genuinely emergent psychiatric survivor discourses into what had until then been dominant medicalization discourses.

Currently, we are at a moment of great instability in the governance of mental abnormality in Canada. Multiple discourses are at play. This dissertation argues that recent policy approaches reflect an engagement with resiliency discourses. However, whether or not resilience will take hold as a dominant mentality is indeterminable. Williams suggests that it is not possible to fully understand dominant cultural systems without understanding their residual and emergent counterparts (1977, 121). In order to more fully understand each of the key mentalities taken up within this project, I trace not only their dominant discourses, but also their residual and emergent elements.

Problematizations of mental abnormality are entwined with the ways it is categorized, both of which are bound up with the broader mentalities that shape them. This project borrows from Miller and Rose's usage of problematization. They explain "that 'problems' are not pre-given, lying there waiting to be revealed. They have to be constructed and made visible […]" (2008, 14). The problem of mental abnormality, in other words, does not exist separately from its production through various ways of thinking. Furthermore, its problematizations shift across time and within different contexts. Miller and Rose state that "problems did not merely represent themselves in thought – they had to be rendered thinkable in such a way as to be predictable or operable" (2008, 15-16). Hence, the problem posed by mental abnormality in the 1830s is not the same problem that it posed in the 2012 MHCC national strategy. In the 1830s, lunacy was problematized as a threat to society, whereas in the 2012 national strategy, mental illness was problematized for the demand it placed on an overburdened service system.

The ways in which mental abnormality are categorized and problematized opens it up for, and informs, particular interventions and solutions. These solutions, or programmes, are intertwined with rationalities. The relationship between rationalities and programmes is one "of *translation* – both a movement from one space to another, and an expression of a particular concern in another modality" (Miller and Rose 2008, 61, italics in original). Governmentality involves an *ethos* and a *techne* (Barry, Osbourne and Rose 1996, 8) – that is, a sense of what the end goal of governance should be – a reason for being – and a sense of the mechanisms possible to achieve that end. Programmes represent the translation of this *ethos* into proposed solutions. Therefore, programmes necessarily "lay claim to a certain knowledge of the sphere or problem to be addressed […]" (Miller and Rose 2008, 62). In other words, programmes put forth for the management of mental abnormality are bound up with its categorizations and problematizations.

While programmes are informed by rationalities, they are put into effect by technologies, a third component of governmentality (Miller and Rose 2008, 63). This is not to say that rationalities and programmes translate perfectly into technologies, or that there is a director orchestrating this translation of rationality into action. As Miller and Rose explain, the technologies through which we come to be governed are a "complex assemblage of diverse forces" (Miller and Rose 2008, 63). And, rationalities, programmes, and technologies are constantly shifting and responding to each other, for "government is a congenitally failing operation […]" and is made up of a variety of "heterogeneous, and rivalrous" programmes (Miller and Rose 2008, 71). As Miller and Rose explain, "solutions for one programme tend to be problems for another," and "technologies produce unexpected problems" or result in "unplanned outcomes" (2008, 71). Moreover, "techniques invented for one purpose may find their governmental role for another […]" (Miller and Rose 2008, 71). For example, the call for patient rights advanced by psychiatric survivor groups in the 1980s was taken up by the Ontario Ministry of Health in a different way than initially construed – in effect, to support a programme of deinstitutionalization and to legitimate the rolling back of services. Miller and Rose summarize the ideal schemes and actual outcomes of rationalities, programmes, and technologies perfectly when they state that "whilst we inhabit a world of programmes, the world is not itself programmed" (Miller and Rose 2008, 71). While rationalities, programmes, and technologies attempt to actualize visions of what should be, this process is complicated, messy, and unpredictable. It also means that the outcomes of one programme, whether anticipated or not, often inspire the next.

At any one time there are numerous mentalities informing the means and ends of governance (Miller and Rose 2008, 17). Hence, it is challenging to use a governmentality lens in a way that systematizes all sites and means of governance. Although governmentalities are multiple and varied, Miller and Rose stress that many bear certain "family resemblances" in the ways they conceptualize problems and render them amenable to certain solutions (2008, 17). In particular, Rose and Miller point to resemblances within classical liberalism, social liberalism, and neoliberalism (2008, 17). Brodie (2007) has argued that the history of Canadian social policy can be organized around these three broader mentalities. This dissertation identifies four distinct mentalities – containment, medicalization, deinstitutionalization, and resilience – that have structured the governance of mental abnormality in Canada. These four mentalities roughly correspond to the shifting mentalities of liberal governance that have been noted by Brodie (2007), and Miller and Rose (2008).

As further explained in Chapter 3, a containment mentality structured programmes of lunacy reform between the early nineteenth and early twentieth centuries. The motivation underpinning containment was the segregation of TCAMA away from society. It translated into programmes of lunacy reform, largely through the construction of large-scale asylums across Ontario commencing in the mid-1800s, and moral treatment, which was operationalized through technologies such as work therapy. This containment mentality was commensurate with a classical liberal "world of walls" (Walzer 1984, 315), which segregated the public from the private, and politics from economy. Chapter 4 introduces the second and third mentalities, medicalization and deinstitutionalization. Medicalization was the dominant way of thinking about mental abnormality from the 1930s to 1960s, and framed mental abnormality as a physiological problem that could be treated or indeed cured through medical interventions on the body. This translated into programmes of medical treatment, including technologies such as lobotomy and electroshock. It was also during this period that psychopharmaceuticals were invented. The rationale guiding this mentality was that mental illness could be cured, and patients could be returned to the community. This mentality corresponded with social liberalism's commitment to scientific and social progress. The third mentality that this dissertation takes up is deinstitutionalization, which was the dominant way of thinking about mental abnormality from the 1960s to 1990s. After treatment programmes failed to cure mental patients and psychiatric hospitals were overcrowded and underfunded, the rationale guiding deinstitutionalization was that mental patients could be released into, and would fare better, in the community. This mentality was imbricated with the rights-based consumer/survivor movement, as well as neoliberal efficiency measures. This translated into programmes and technologies of trans-institutionalization, the transfer of patients to other institutions, and deinstitutionalization, the emptying out of psychiatric hospitals onto the streets (Simmons 1990, 109, 157).

Chapter 7 focuses on resilience, the fourth mentality explored in this dissertation. The rationale guiding resilience is that anyone can acquire the skills necessary to cope with stress, thereby preventing mental illness in the first place. It reflects a shift in focus away from mental illness and towards the mental health of all. Resilience informs programmes – such as mental health literacy – designed to prevent mental illness by promoting good mental health to the general population, and recovery, whereby those already experiencing mental illness are responsibilized for finding their way back to normalcy. Popularized in the 2000s, mental health resilience is part of a growing resilience trend that has pervaded many ways of thinking about today's social problems. It is commensurable (Kuhn 1982, 670) with neoliberalism, individualizing and responsibilizing TCAMA for their own well-being.

2.2 Mental Abnormality: Lunacy, Insanity, Feeblemindedness, Illness, and Health

This dissertation engages with mental abnormality, a constantly shifting category that at various periods has been categorized as lunacy, insanity, feeblemindedness, or the illness of a few to, more recently, the mental health of all. This project frames mental abnormality as opposite to reason, itself a constantly shifting category. Social contract theory foregrounded the capacity to reason as the singular attribute of humans, distinguishing us from other animals. However, this discourse drew a dangerous line between reason and unreason. If the normal, ideal political subject is a reasoning being, what do we do with those who do not reason, or more appropriately, those who reason differently from the "rational," natural, rights-bearing subject? Early liberal theorists responded to this question by excluding TCAMA from full political membership. According to Hobbes, "Likewise, Children, Fooles, and Mad-men that have no use of Reason, may be Personated by Guardians, or Curators […]" (Chapter 16, 219). Locke adds, "But if, through defects that may happen out of the ordinary course of nature, anyone comes not to such a degree of reason wherein he might be supposed capable of knowing the law and so living within the rules of it, he is never capable of being a free man […] And so lunatics and idiots are never set free from the government of their parents" (Chapter 6, paragraph 60, 34). Rousseau keeps it simple: "Madness does not bring about right" (Chapter 4, 144). In these discourses we can observe that those categorized as without reason – TCAMA – are located outside of the social contract, permanent wards of their families and/or the state. This is not to say that mental abnormality was an invention of social contract theory. Rather, social contract theory represents one variant, albeit an influential abnormalization of some behaviour. Universal and essentialist categories such as reason and unreason are anything but absolute, and are socially constructed.

This dissertation builds upon Foucault's distinction between normal and abnormal to conceptualize mental abnormality as a constantly shifting category. The concept abnormal also recognizes that mental abnormality has been open to various forms of interventions, with the aim of achieving normalcy. Itself a shifting category, normalcy necessarily conjures up the abnormal – that is, behaviours that conflict with prevailing norms. Foucault coined the term normalization to refer to the processes whereby individual bodies are brought into alignment with the norm (2007, 57). In the governance of mental abnormality in Canada, these processes have taken many forms, from work therapy, sterilization, and medical treatment, to more recently, recovery and resilience.

The dichotomization of reason and unreason is explored in Foucault's text *Madness and Civilization* (1965) (as well as the longer monograph, *History of Madness* [2006a]). Here, Foucault traces the categorization and problematization of unreason from the Middle Ages through to the beginning of the nineteenth century. He introduces the ship of fools as a segregation device that embodied the exclusion of TCAMA from society.[3] Specifically, it is here that Foucault identifies the dichotomization of reason and unreason that underlies subsequent shifts in the governance of mental abnormality:

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[3] The historical accuracy of Foucault's account has been called into question: it is unclear, for example, whether there ever really was a ship of fools in the Middle Ages, or whether this was simply a moral trope invoked in literature. However, whether or not this ship of fools existed historically, Foucault's work still carries much theoretical weight.

> The madman's voyage is at once a rigorous division and an absolute Passage. In one sense, it simply develops, across a half-real, half-imaginary geography, the madman's *liminal* position on the horizon of medieval concern – a position symbolized and made real at the same time by the madman's privilege of being *confined* within the city *gates*: his exclusion must enclose him; if he cannot and must not have another *prison* than the *threshold* itself, he is kept at the point of passage. He is put in the interior of the exterior, and inversely. A highly symbolic position, which will doubtless remain his until our own day, if we are willing to admit that what was formerly a visible fortress of order has now become the castle of our conscience (Foucault 1965, 11, italics in original).

As demonstrated in this passage, the categorization of unreason functioned to position TCAMA to a liminal position in the polis. At the same time, the construction of unreason was critical to the social construction of reason as its opposite. In this sense, TCAMA were always included, theoretically, in governing rationalities, while their physical exclusion manifested in a variety of strategies. Furthermore, Foucault's analysis suggests that even though TCAMA are no longer physically confined away at the limits of society, programmes and technologies installed to manage mental abnormality are still organized around this reason/unreason binary, and still function to exclude TCAMA in other ways. Thus, while the physical exclusion of unreason has and continues to take a variety of forms, it has been made permanent in our minds, and continues to inform the governance of mental abnormality in present day strategies.

In the 1930s, medicalization discursively coded mental abnormality as mental illness, or as Foucault put it, "unreason joins illness" (1965, 205). Before this coding was possible, however, there was another fundamental shift in the way mental abnormality was understood and studied. Prior to the late 1800s, questions about human nature were the domain of philosophy. Towards the late 1800s, however, there was an ontological shift in the study of mental abnormality, towards positivism and science. Rose explains,

> […] there is a common acceptance that something significant occurred in a period from about 1875 to about 1925 […] This event appears to consist of the translation or extension of certain recurrent questions about the nature of humans from the closed space of philosophy to a domain of positive knowledge (Rose 1985, 3).

The permeation of mental abnormality by positivism concealed that the divide between unreason and reason was social. Foucault argues that "a certain technical control of illness conceals rather than points to the movement that closes the experience of madness upon itself" (1965, 293). Taylor explains that "What Foucault is showing is that despite the apparent progress which the birth of psychiatric science represented – for instance, it means that we now 'treat' prisoners and the mad instead of torturing or simply confining them – it was not benign" (Taylor 2009, 135). Purportedly objective medical categorizations of mental illness are rooted in socially constructed divisions between reason and unreason.

Positivist thinking about mental abnormality laid the ontological groundwork for its discursive construction as a medical, and later on, a biochemical problem. Chapters 3 and 4 highlight a significant shift in thinking about mental abnormality, away from lunacy and towards mental illness. Shifts in the categorization of mental abnormality occurred alongside shifts in authority, from psychoanalysis, to psychiatry, to the psychopharmaceutical industry and construction of the neurochemical self. In our present understanding of mental abnormality, "Mind is simply what the brain does" (Rose 2007, 192). Rose explains, "While our desires, moods, and discontents might previously have been mapped onto a psychological space, they are now mapped upon the body itself, or one particular organ of the body – the brain" (2007, 188). Rose coins the term "neurochemical citizenship" to denote our understanding of ourselves as neurochemical beings (2007, 217-218). Alongside this neurochemical shift is the emergence of new forms of knowledge via neuroimaging, such as CT, PET, and MRI scans (2007, 190).

2.3 Psychiatry, Power, and the Role of Expertise

Liberal projects of governance rely on expertise, which informs and guides the self-regulation of citizens while upholding their freedom from undue interference (Miller and Rose 2008, 69). This dissertation engages with many sites of expertise, especially psychiatry. What we now call psychiatry began as alienism. Alienism took hold within a containment mentality – during lunacy reform – where general physicians with an interest in lunacy took up positions as superintendents of asylums. At the same time that lunacy reform fostered the development of alienism, alienism greatly informed the development of lunacy reform with a firm belief in moral treatment. Although alienists began as medical physicians, the solutions they advanced – such as work therapy – were not rooted in a medical, physiological understanding of mental abnormality. As such, there was little prestige accorded to alienism within the broader medical field. This lack of credibility was reinforced by low discharge rates, one measure of their effectiveness. Legitimacy within the medical field was obtained when those previously known as alienists began looking at what had until then been known as lunacy or insanity through a medical lens, which called for medical solutions. Alienism became psychiatry – a distinct site of expertise within the medical field with a scientific claim on mental abnormality. Chapters 3 and 4 map out in greater detail the development of psychiatry as a medical specialization.

Expertise is central to liberal governance. It is defined as “the social authority ascribed to particular agents and forms of judgment on the basis of their specialized claims to possess truths and rare powers” (Miller and Rose 2008, 26). Expertise is key to liberal governance because it serves as a relay between political authorities and the individuals to be governed, and upholds the liberal promise of state non-interference in the private lives of individuals (Miller and Rose 2008, 68). Expertise functions as a relay by translating political problems such as “economic productivity, innovation, industrial unrest, social stability, law and order, normality and social pathology, and so forth” into issues “of management, accounting, medicine, social science and psychology" (Miller and Rose 2008, 68). Expertise transforms social issues into political problems (Miller and Rose 2008, 68). The relay of expertise completes itself by informing people of techniques that can help them to "manage better," legitimated by a claim to "the power of truth" (Miller and Rose 2008, 68). This relay function translates "problems of regulation" within "disputed terrains of politics" into "the tranquil yet seductive territory of truth" (Miller and Rose, 69). In other words, expertise functions by depoliticizing issues of political rule, thereby obscuring and supplanting political force with scientific truth. This dissertation emphasizes the role of psychiatric expertise in the arrival at solutions to mental abnormality, which as Foucault shows, emerged as a professional power to lay a claim to truth on abnormal behaviour (2003a).

Psychiatry developed and made truth claims to specialized knowledges around mental abnormality. It was productive, shaping an understanding of mentally abnormal subjectivities as well as the official discourses surrounding them. By shaping these knowledges, psychiatry could "lay claim to a certain knowledge of the sphere or problem to be addressed […]" (Miller and Rose 2008, 62). This expertise points to the productive relationship between knowledge and power. Foucault explains that truth "is linked in a circular relation with systems of power which produce and sustain it, and to effects of power which it induces and which extend it" (1980, 132-133). Power is productive, yielding "truth-effects" (Foucault 2003b, 179). Expertise operates by making these truth claims available to "the 'self-steering' mechanisms of individuals" (Miller and Rose 2008, 42). Subjects of governance internalize expert advice, using it to guide their everyday activities. For example, within our present emergent mentality – resilience – expertise functions by translating the political problem of the management and regulation of mental abnormality into a series of life tips and techniques for acquiring resilience. These tips are made available in resources such as Alberta Health Services' *Bounce Back Book: Building Resiliency Skills in Your Preschooler* (2010), and in the University of Alberta's Counselling and Clinical Service's workshop on *Creating a Resilient Mindset* (Counselling and Clinical Services 2016). Within a broader neoliberal rationality operationalized through responsibilization and individualization, it is up to the individual to use this information to make oneself resilient.

Containment, medicalization, deinstitutionalization, and resilience differently position psychiatric expertise. Under a containment mentality, alienists disciplined mentally abnormal bodies using a regimen of moral treatment. Under a medicalization mentality, psychiatrists deployed medical procedures such as electroshock and lobotomy. Under a resilience mentality, however, there has been a sharp decline in psychiatric power, supplanted by individualized TCAMA as "experts of themselves" (Miller and Rose 2008, 215) who must make use of information obtained from community mental health organizations to best manage "the enterprise of [their lives]" (Miller and Rose 2008, 171; Cruikshank 2006). Within containment and medicalization mentalities, psychiatrists developed what Miller and Rose refer to as "enclosures," or "relatively bounded locales or fields of judgement within which their authority is concentrated, intensified and rendered difficult to countermand" (2008, 209). The rights-based consumer/survivor movement challenged this authority. At the same time, neoliberal metrics such as budgets and audits have curtailed psychiatric power, whereby psychiatrists must also function as administrators to calculate the risk involved in making a diagnosis (Miller and Rose 2008, 108). Psychiatric knowledges based in human conduct have shifted into "calculative regimes of accounting and financial management" (Miller and Rose 2008, 212). A plethora of professional associations and organizations made this scrutiny possible (Miller and Rose 2008, 108). Ultimately, the discipliners became the disciplined. Chapters 3 to 7 trace the decline in psychiatric power more fully.

This dissertation flags instances of disciplinary power and biopower in the various programmes and technologies informed by psychiatry, as well as by other sites of expertise involved in the governance of mental abnormality at a distance. These understandings of disciplinary power and biopower are borrowed from Foucault. The body is disciplined through a series of dividing practices, such as normal and abnormal, to conform with the norm. Foucault coined this process "normalization" (2007, 57). As Foucault explains,

> Disciplinary normalization consists first of all in positing a model, an optimal model that is constructed in terms of a certain result, and the operation of disciplinary normalization consists in trying to get people, movements, and actions to conform to this model, the normal being precisely that which can conform to this norm, and the abnormal that which is incapable of conforming to the norm (2007, 57).

The object of disciplinary power is the body, as a component of the broader population. Disciplinary power breaks the body down into its constituent parts and mechanisms, altering these components to bring them into alignment with a norm: "discipline, of course, analyzes and breaks down; it breaks down individuals, places, time, movements, actions, and operations. It breaks them down into components such that they can be seen, on the one hand, and modified on the other" (Foucault 2007, 56). In doing so, disciplinary power authorizes and produces various knowledges surrounding the body.

Whereas the object of disciplinary power is the individual body, the object of biopower is population: "Biopolitics deals with the population, with the population as political problem, as a problem that is at once scientific and political, as a biological problem and as power's problem" (Foucault 2003b, 245). Biopolitics suggests knowledges apply to population as a living organism, as "man-as-species" – with similar biological and social characteristics, including birth, death, and disease (Foucault 2003b, 239, 242-243). Populations are conceived on the basis of these knowledges – that is, "processes such as the ratio of births to deaths, the rate of reproduction, the fertility of a population, and so on" (2003b, 243). These processes are the very targets that biopolitics controls, which is accomplished through the optimization of the conditions needed for some populations to thrive, to the exclusion and death of others (2003b, 243). These conditions are informed by experts.

Sovereign power is epitomized in the sovereign "right to take life or let live" (Foucault 2003b, 241). It is exhibited in the public display and ritual of death of the individual, outlined at the beginning of *Discipline and Punish* with the 1757 hanging and quartering of Damiens for attempted regicide (Foucault 1975, 3-5). In contrast, biopower is characterized by "the power to 'make' live and 'let' die" (Foucault 2003b, 241). It is detached from the sovereign figure, operating at a distance by "making live and letting die" populations (Foucault 2003b, 247). "The power to 'make' live and 'let' die" can be observed in interventions taken to improve and sustain the lives of some, while failing to do so for others (2003b, 241). Biopolitics is accompanied by a new understanding of death: "Death was now something permanent, something that slips into life, perpetually gnaws at it, diminishes it and weakens it" (2003b, 244). Here, death introduces risk – that is, "internal dangers" (Foucault 2003b, 249). The role of the biopolitical state is to intervene to protect some populations against these risks.

The state's public hygiene function is a central mechanism through which it protects a population. As a branch of knowledge, public hygiene is a concern for the cleanliness and purity of a population. In turn, it categorizes "unhygienic" as a social problem (2003b, 244). In the early twentieth century, psychiatry grew out of and elaborated Canada's public hygiene function, extending it to the mind. As explained by Foucault, "Roughly, on the one hand, psychiatry made an entire part of public hygiene function as medicine and, on the other, it made the knowledge, prevention, and possible cure of mental illness function as an absolutely necessary form of social precaution against a number of fundamental dangers linked to the very existence of madness" (Foucault 2003a, 119). Chapters 3 and 4 draw linkages between psychiatry's public hygiene role, degeneracy theory, and racism in Canada. Degeneracy theory is imbricated in the idea of mental fitness and feeblemindedness, discourses that have informed (and still inform) eugenicist solutions to mental abnormality.

It is important to note that disciplinary power, sovereign power, and biopower are not static, nor are they contained within separate epochs of history. Their operations transform over time. One did not surpass the other, although sometimes one tempered, but did not completely silence, the other. Disciplinary power, sovereign power, and biopower operate on different sites through different authorizations, but come together to work on shared problems, such as mental abnormality. For example, resilience-based mental health literacy programmes disseminate recommendations to the general public on how to optimize their mental health, such as undertaking regular exercise and maintaining a healthy diet. This is a contemporary example of biopower. These recommendations are delivered to the population based on expert-identified biological characteristics such as stress, endorphins, and hormones. However, disciplinary power coexists with biopower, where individuals discipline their bodies through exercise and eating certain foods, to conform to mentally healthy norms. Under a resilience mentality, these examples of self-discipline are also instances of two neoliberal technologies, responsibilization (Brown 2015, 131-132) and individualization (Beck and Beck-Gernsheim 2002, 2). Meanwhile, sovereign power operates on those who, lacking mental health services, may end up homeless or in prisons and therefore in contact with police.

2.4 Resilient Technologies: Responsibilization and Individualization

This dissertation demonstrates that the line between mental normalcy and abnormality has been redrawn under a resilience mentality. Resilience corresponds with neoliberal logics. One of neoliberalisms's most striking features has been a shift away from what, under social liberalism, had been the governance of the collective – that is, "relations of dependency and obligation to one another" – and towards the construction and governance of the responsible individual – "the actively responsible self" (Rose 1996, 57). The remaking of the neoliberal subject is done according to market logics. Here, behaviour and responsibility are framed in terms of rational action, defined solely in terms of self-interest. Brown argues that a neoliberal mentality "configures human beings exhaustively as market actors, always, only, and everywhere as *homo oeconomicus*" (Brown 2015, 31, italics in original). In other words, the rational actor is a self-seeking market actor.

> In making the individual fully responsible for her- or himself, neoliberalism equates moral responsibility with rational action; it erases the discrepancy between economic and moral behaviour by configuring morality entirely as a matter of rational deliberation about costs, benefits, and consequences. But in doing so, it carries responsibility for the self to new heights: the rationally calculating individual bears full responsibility for the consequences of his or her action no matter how severe the constraints on this action. […] The model neoliberal citizen is one who strategizes for her- or himself among various social, political, and economic options, not one who strives with others to alter or organize these options. A fully realized neoliberal citizenry would be the opposite of public-minded; indeed, it would barely exist as a public" (Brown 2005, 42-43).

As Brown explains, neoliberalism redefines the rational actor. Under neoliberalism there is a conflation of acting morally and acting rationally as the self-seeking subject. Here, the line between mental normalcy and abnormality has been redrawn – being categorized as mentally ill does not constitute abnormality. Rather, abnormality is exhibited in the failure to take personal responsibility for one's own well-being.

As will be explored further in Chapter 6, prevention and recovery are currently being experimented with as programmes that have been put forward to manage mental abnormality. These programmes are operationalized via individualization and responsibilization. Individualization is defined as "a compulsion, albeit a paradoxical one, to create, to stage manage, not only one's own biography but the bonds and networks surrounding it and to do this amid changing preferences and at successive stages of life, while constantly adapting to the conditions of the labour market, the education system, the welfare state and so on" (Beck and Beck-Gernsheim 2002, 4). What were once considered to be social problems are being downloaded onto the shoulders of individual subjects (Beck and Beck-Gernsheim 2002, 2).

Individualization reframes the social. Beck and Beck-Gernsheim explain that "individualization means the disintegration of previously existing social forms – for example, the increasing fragility of such categories as class and social status, gender roles, family, neighbourhood etc." (2002, 2). Individuals still physically inhabit these social spaces but they must devise their own regulations and guidelines, and "import them into their biographies through their own actions" (2002, 2). Zygmunt Bauman explains, "ours is, as a result, an individualized, privatized version of modernity, with the burdens of pattern-weaving and the responsibility for failure falling primarily on the individual's shoulders" (Bauman 2000, 8). The paradox, as Bauman further highlights, is that we are "a society of individuals" (2005, 16). He states that "in this respect, at least, members of such a society are anything but individual, different or unique. They are, on the contrary, strikingly *like* each other in that they must follow the same life strategy and use shared – commonly recognized and legible – tokens to convince others that they are doing so" (2005, 16, italics in original). Ultimately, we are all struggling to deal with the same set of problems, but as individuals and through individualizing processes.

Responsibilization is another technology through which a resilience mentality is operationalized. Responsibilization operates in tandem with devolution, a process whereby "large-scale problems, such as recessions, finance-capital crises, unemployment, or environmental problems, as well as fiscal crises of the state, are sent down the pipeline to small and weak units unable to cope with them technically, politically, or financially" (Brown 2015, 132). Responsibilization itself is a process that "forc[es] the subject to become a responsible self-investor and self-provider […]" (2015, 84). Absent of state supports that have been eroded by neoliberal policies of privatization, these smaller units are responsible for finding ways to cope with the insecurities that were at one point provided for by a social liberal state. Furthermore, responsibilization is informed by market logics – that is, responsibilization is not an unfortunate side effect of cutbacks, but an opportunity. As Brown explains, "Responsibilization tasks the worker, student, consumer, or indigent person with discerning and undertaking the correct strategies of self-investment and entrepreneurship for thriving and surviving […]" (2015, 131-132). In this sense, responsibilization shapes the subjectivities of these smaller units, "remaking and reorienting them for a neoliberal order" (Brown 2015, 133).

This dissertation argues that not all TCAMA as smaller units are equally equipped to cope. Responsibilization occludes one of the founding tenets of social liberalism – the recognition that many inequalities are structural, and therefore beyond the reach of the individual (Brodie 2003, 64). Responsibilization conceals over these inequalities while further perpetuating them. The devolution of care work, from what was once provided via state social security programs to smaller units, responsibilizes women in particular. As Brown argues, "'responsibilization' in the context of privatizing public goods uniquely penalizes women to the extent that they remain disproportionately responsible for those who cannot be responsible for themselves" (Brown 2015, 105). She further explains,

> As provisioners of care for others in households, neighbourhoods, schools, and workplaces, women disproportionately remain the invisible infrastructure for all developing, mature, and worn-out human capital – children, adults, disabled, and elderly. Generally uncoerced, yet essential, this provision and responsibility get theoretically and ideologically tucked into what are assumed as preferences issuing naturally from sexual difference, especially from women's distinct contribution to biological reproduction (Brown 2015, 105).

As demonstrated in this passage, responsibilization is dangerous because it veils and intensifies structural inequalities. This is not the first time that the governance of mental abnormality has been unequally downloaded onto women; for example, mental hygiene programmes of the early 1900s emphasized the role of the mother in the production of mentally hygienic citizens. However, contemporary formulations of responsibilization manifest in new ways and are authorized by new sites of expertise.

Responsibilization is a moralizing process. As Brown explains, *homo oeconomicus* is not just a rational actor, but a moral actor (2015, 42-43). Responsibilization ascribes moral significance to market behaviour. The good, mentally healthy citizen is one who optimizes their mental health and personal resiliency to cope with insecurity. The danger with responsibilization, however, is that it moralizes those at the end of the devolution pipeline without the resources needed to cope with this insecurity. Moreover, responsibilization conceals that insecurity is structural in the first place, and reframes it as an individual short-coming. The failure to eat right, exercise, and efficiently cope with stress is reframed as a moral failing, within the context of an unequal distribution of the very resources required to achieve these goals. This is not the first time that morality has been invoked in the way we view mental abnormality. Chapter 3 links a containment mentality to the moralization of cleanliness. Rather, a resilience mentality shifts the basis for moralization in line with neoliberal market logics. In other words, we conduct ourselves in relation to a system of risks, costs, and benefits not only because it is the rational thing to do, but also because it is the moral thing to do.

Responsibilization is embedded in “choice” discourses. As will be seen in Chapter 6, one of the guiding principles of recovery models is the autonomy of TCAMA to choose the path that best fits their personal recovery journey. However, as Kershaw explains, “the language of choice facilitates the articulation of neoliberal principles within a rhetorical framework that conveys a sense of political neutrality and individualizes responsibility for social inequalities” (2004, 928). Choice conceals social and political inequalities. The market provides TCAMA with several services that they are being told will improve their mental health: healthy foods, yoga, and counselling. However, not everyone can afford organic groceries, yoga memberships, and $150 private counselling sessions. Not everyone has a choice. This dissertation argues that the structural inequalities barring many TCAMA from accessing these resources are veiled by the idea that they have a choice, and are reframed as personal, moral failings.

Technologies of individualization and responsibilization are reflected in prevention and recovery mental health programmes. Recovery has been identified as “the cornerstone of the [MHCC] strategy” (Morrow and Weiser 2012, 30). Broadly, it refers to a process whereby TCAMA live relatively normal lives despite living with mental illnesses. As highlighted by Davidson and Roe’s “recovery in” and “recovery from” distinction:

> Recovery from serious mental illnesses involves the amelioration of symptoms and the person’s returning to a healthy state following the onset of the illness. This definition is based on explicit criteria of levels of signs, symptoms, and deficits associated with the illness and identifies a point at which remission may be said to have occurred (Davidson and Roe 2007, 463).

In this sense, “recovery from” is no different than the recovery model used when someone recovers from a flu or broken arm. In contrast, a “recovery in” paradigm “refers to the process of living one’s life, pursuing one’s personal hopes and aspirations, with dignity and autonomy, in the face of the on-going presence of an illness and/or vulnerability to relapse” (Davidson and Roe 2007, 464). They add that recovery also refers “to overcoming the effects of being a mental patient – including poverty, substandard housing, unemployment, loss of valued social roles and identity, isolation, loss of sense of self and purpose in life, and the iatrogenic effects of involuntary treatment and hospitalization – in order to retain, or resume, some degree of control over their own lives” (2007, 461-462). This model of recovery frames mental illness not as curable, but as a lifelong condition with which one copes. As discussed in Chapter 6, the MHCC national strategy embraced this recovery model.

Prevention is another instance of the responsibilization and individualization technologies embraced by the final MHCC national strategy, and is reflected more broadly in campus and workplace wellness initiatives. Prevention is the first of six strategic directions guiding the MHCC’s 2012 national strategy. Prevention suggests that mental illness can be prevented through the promotion of good mental health practices. Like recovery, this way of thinking is embedded within a resilience mentality. The idea of resilience is not limited to mental health discourses, and has become omnipresent in Canada’s twenty-first century policy landscape. As Brassett, Croft, and Vaughn-Williams highlight, “resilience is fast becoming *the* organising principle in contemporary political life” (2013, 222, italics in original). While resiliency discourses are ubiquitous, they occupy a particularly important role in the ongoing discussions surrounding mental healthcare reform. As highlighted by Brodie and Phillips, “Resilience is unquestionably a primary motif in the robust self-help and self-care genre of popular culture in the early 21st century" (2014, 3). It requires certain skills, "such as courage, will-power, fortitude and character […] reconfigured as 'coping strategies' or 'skills' that can be learned by anyone" (O'Malley 2010, 489). Chapters 6 and 7 of this dissertation locate resilience discourses in contemporary mental health reform discussions.

2.5 Community: From Exclusion to Inclusion

This dissertation examines the ways in which shifting conceptualizations of community have been invoked in various strategies for the governance of mental abnormality. Under a containment mentality, TCAMA were segregated away from the community to prevent their contamination of it. Some TCAMA were sterilized to prevent the spread of what was perceived as their immoral, unclean ways of life to the broader community. Partially enabled by the development of psychopharmaceutical technologies, a deinstitutionalization mentality invoked community as something that TCAMA could be released into. Whereas a containment mentality excluded TCAMA from community, a deinstitutionalization mentality newly included TCAMA as potentially full members – that is, if they adhered to their treatment plans within the physical geography of the community. Here, community was also intended to serve as a provider of services. However, as Chapter 4 outlines, these services were never fully put in place, and those who were newly included in community on the basis of mental abnormality were newly excluded on other grounds, such as homelessness and criminalization. Furthermore, the consumer/survivor movement invoked community as a network of care and solidarity towards self-determination. Multiple community discourses have, and continue, to circulate. Chapter 6 considers the ways through which community is currently being invoked to responsibilize and individualize TCAMA, and to produce responsible, mentally healthy subjectivities. Rose identifies in community the construction of a new ethic – a “community-based ethic” that “is accomplished through building a new relation between ethical citizenship and responsible community fostered, but not administered, by the state” (2000, 1398). Miller and Rose argue that neoliberal governance is done through community via “the instrumentalization of personal allegiances and active responsibilities” (2008, 90). Those included in community are those “who have the financial, educational and moral means to ‘pass’ in their role as active citizens in responsible communities” whereas others are excluded “by virtue of their incapacity to manage themselves as subjects” (Miller and Rose 2008, 98). This dissertation argues that the line between mental normalcy and mental abnormality in contemporary times is being redrawn on the basis of personal responsibility. TCAMA are expected to draw on community for their own well-being, shifting responsibility away from the state to provide for them. If they cannot provide for themselves in this way, they are reframed as irresponsible, and there is no safety net left to catch them when they fall.

3. Chapter Breakdown

This dissertation has eight chapters. This chapter has introduced my research problem and outlined the theoretical perspectives that go on to inform my analysis in later chapters. Chapter 2 outlines the context leading up to our present moment of mental health policy reform in Canada, and elaborates on the recent flurry of activity that has transformed mental abnormality into a national issue. It then goes on to outline the research methods employed in this project, especially a genealogical approach and Foucauldian discourse analysis. This dissertation argues that four mentalities have dominated the history of the categorization, problematization, and governance of mental abnormality in Canada. Chapter 3 introduces the first of these mentalities, containment, which shaped the governance of mental abnormality in Ontario from the early nineteenth to the early twentieth centuries. Chapter 4 explores two further mentalities, medicalization and deinstitutionalization, which dominated the governance of mental abnormality in Ontario from the early to the late twentieth century. Chapters 3 and 4 map the role of expertise in this history, with particular attention to the professionalization and subsequent demise of psychiatry. These chapters also demarcate the constantly shifting line between mental normalcy and abnormality across these periods, as well as the implications of the categorization "abnormality" for exclusion from political membership.

Chapter 5 introduces a crisis point in the governance of mental abnormality in the early 2000s: deinstitutionalization did not work. This meant a shift away from a deinstitutionalization mentality towards a search for new solutions. I analyze testimonies collected throughout the SSCSST investigation into the state of mental health and mental health services in Canada between 2003 and 2006, as well as those collected by the LAO's Select Committee on Mental Health and Addictions between 2009 and 2010. Relying on a close analysis of these documents, I outline the problems and solutions with Canada's mental health system as identified by seven different groups, structured around a series of key themes. Chapter 6 analyzes contemporary reports and strategy documents to determine which perspectives were authorized, and which were overlooked, during this process. It highlights prevention and recovery as key themes contained within the final Ontario and MHCC strategies. Chapter 7 argues that this consultative process reflects a new mentality at play in mental health policy in Canada – resilience. I locate resilience within broader neoliberal logics and consider the implications of a resilience mentality for mental health services in Canada, the latter which came to be a major point of contention in the 2016-17 Health Accord talks. Chapter 8 offers a conclusion and final remarks.

CHAPTER 2: CONTEXT AND METHODOLOGIES

1. Context

The governance of mental abnormality in Canada is at a transformative juncture: there is an apparent growing demand for public services, yet fewer and fewer are available. Deinstitutionalization programmes did not work the way they had been envisioned. The idea offered by a deinstitutionalization mentality was simple: TCAMA were better served by being released into the community, where they would have access to the mental health and social services required for their well-being, and at the same time be included as citizens of the broader community. That was not the case, however. TCAMA were released into the community, but few services were made available to them upon their arrival. Consequently, throughout the 1980s and 1990s the Ontario Government struggled to complete the transition towards a comprehensive system of community services. Public transcripts during that period illustrated recurrent attempts to complete the deinstitutionalization process: the "Heseltine Report," or *Towards a Blueprint for Change: A Mental Health Policy and Program Perspective* (1983); the "Graham Report," or *Building Community Support for People: A Plan for Mental Health in Ontario* (1988); and, *Making It Happen: Implementation Plan for Mental Health Reform* (1999). Yet, by the early 2000s, and despite recurrent attempts at reform, governments were confronted by the same problem: there were simply not enough services available to meet a growing demand, while other social problems associated with unsupported deinstitutionalization multiplied. This introduced a major problem at both provincial and federal levels: what do we do now about mental abnormality?

The failure of a community-centred mental health system pointed, not only to a crisis in mental health service provision, but more broadly, to a crisis in what had been, up until that point, the dominant mentality informing the governance of mental abnormality: deinstitutionalization. Deinstitutionalization prescribed that TCAMA could be assimilated into society with the proper regimen of medications and out-patient community services. But with insufficient services, TCAMA were only relocated onto the streets and into prisons. This crisis opened up space for new approaches, and ultimately, for new ways of thinking about mental abnormality.

Neil Bradford suggests that at times of critical policy junctures governments institute commissions where diverse stakeholder groups can offer up their perspectives on an issue, with the guiding goal of establishing consensus on future policy directions (1998, 12). Two such commissions were undertaken in the early 2000s with regards to mental abnormality: first, the Standing Senate Committee on Social Affairs, Science and Technology's (SSCSST) investigation into mental health and mental illness, from February 2003 to May 2006; second, a similar investigation undertaken by the Legislative Assembly of Ontario's (LAO) Select Committee on Mental Health and Addictions between March 2009 and May 2010. The seeds of the SSCSST's investigation were sown during a prior commission, from February 2000 to October 2002, on the "state of the health care system in Canada" (2003, No. 9, 1). At that time, the committee took note of "a handful of health care issues that [they] felt … clearly needed greater in-depth study" (2003, No. 9, 1). One of those issues was "mental illness and mental health," which they identified as "an orphan child of the health care system," and "a peripheral issue" (2003, No. 9, 1). The impetus for the LAO's commission was a Private Member's motion delivered by Christine Elliott on December 4, 2008. The motion proposed that a Select Committee be mandated to craft a new strategy on mental health and addictions for Ontario. On

February 24, 2009, the LAO voted unanimously in favour of this commission (LAO 2010, 23-24).

The federal and provincial committees summarized the findings of their investigations into final reports. The SSCSST released *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada*, commonly known as the Kirby Report, in 2006. The Kirby Report provided an overview of Canada's mental health system, highlighting its many problems and inadequacies, and proposed several recommendations to shape a recovery-centred mental health system in Canada. A key recommendation proposed by the Kirby Report was the creation of an arms-length organization charged with developing a national mental health strategy. This recommendation was realized in 2007 with the launch of the Mental Health Commission of Canada (MHCC), which, in 2012, released *Changing Directions, Changing Lives: The Mental Health Strategy for Canada*. The LAO released its final report, *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians*, in 2010. Like the Kirby Report, *Navigating the Journey to Wellness* provided an overview of the many problems impacting Ontario's mental health system, with a focus on lack of services. In 2011, the Ontario Ministry of Health released *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy*.[4]

The management (medical or otherwise) of mental abnormality falls under provincial jurisdiction. Section 92(7) of the BNA Act delegates to provinces "the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in

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[4] *Open Minds, Healthy Minds* (2011) was released by the Ontario Ministry of Health and Long-Term Care (OMHLC), and was separate from the LAO's *Navigating the Journey to Wellness* (2010). This project does not assume that the SSCSST and LAO reports fed directly into the MHCC and OMHLC documents, which also included external research by those bodies. Rather, it proposes that the SSCSST and LAO hearings provided a sample of a wide range of discourses circulating the issue of mental health reform at the time, which were also available to the MHCC and OMHLC.

and for the province, other than marine hospitals" (BNA Act, 1867). It is beyond the scope of this project to explore the governance of mental abnormality in every province and territory. As such, in this project I focus on one province in particular – Ontario (Upper Canada), both because of its size and its extensive history of mental health policy reform.

Federal and provincial reports do not stand alone, but are situated within broader ongoing shifts in the ways that society categorizes, problematizes, and governs mental abnormality. Unique to contemporary times, mental illness has "come out of the closet," with public figures coming forward to speak publicly about their own struggles with mental illness. Once a taboo topic, mental illness is now a generalized problem, with estimates that one in five Canadians will experience some form of mental illness in their lifetime (CMHA 2017). After years of oppression experienced by TCAMA, suddenly everyone is united in their fight against stigma. Indeed, this shift has influenced a broad range of institutions, including University campuses such as the University of Alberta, with its "Exam Season Mental Health Check-In" and "Unwind Your Mind" program, featuring a "Furry Friends" initiative through which therapy animals are made available to students across campus with the aim of reducing stress by interacting with non-judgemental, affectionate pets (University of Alberta 2016). It is no secret that everyone is talking about mental health. However, it is being talked about in particular ways. And, while everyone is talking about mental health, there is little discussion of who is excluded from these new discourses.

2. Methodologies

This project employs a governmentality lens to critically examine the mental health discourses at play in the aforementioned public transcripts. It compares strategies for the governance of mental abnormality in the present moment with past approaches. This dissertation writes a genealogy of the present moment to demonstrate that prevention and recovery discourses reflect a new way of thinking about mental abnormality – resilience, which it compares with past mentalities such as containment, medicalization, and deinstitutionalization. In doing so, this project has five goals: 1) to uncover subjugated voices and sites of resistance by probing the history of the governance of mental abnormality in Ontario; 2) to destabilize mental abnormality as a constantly shifting category that draws lines between inclusion and exclusion; 3) to connect prevention and recovery programmes with new ways of thinking about mental abnormality; 4) to consider the shifting role of community as it relates to mental abnormality; 5) and, to trace residual discourses from problematic policies of the past, such as mental hygiene, through to the present moment. In doing so, this dissertation argues that much like past approaches to the governance of mental abnormality, ongoing and recent prevention and recovery discourses exclude those who, for whatever reason, are not resilient in the face of life's challenges. This exclusion is dangerous given the present lack of mental health services available to provide support to this group.

This project employs a Foucauldian discourse analysis and genealogy to accomplish these goals. My research was conducted in three stages: in Chapters 3 and 4, I undertake a genealogy of the governance of mental abnormality in Ontario (Upper Canada) between 1830 and 2000, and locate key moments within broader mentalities of mental abnormality; in Chapter 5, I conduct a Foucauldian discourse analysis of key debates heard during the SSCSST and LAO hearings; finally, in Chapter 6, I undertake a Foucauldian discourse analysis of the reports released following these commissions, including the Kirby Report (2006), *Navigating the Journey to Wellness* (2010), *Open Minds, Healthy Minds* (2011), and *Changing Directions, Changing Lives* (2012). In this discourse analysis I identify key themes, which I demonstrate, are part of a new experimental mentality currently emerging within mental health policy discussions – resilience, which is explored further in Chapter 7. This chapter elaborates on the methodological perspectives that guided my research.

2.1 Foucauldian Discourse Analysis

This project employs a Foucauldian discourse analysis, a variant of critical discourse analysis (CDA). CDA is a method that analyzes the role of discourse in shaping "socially shared knowledge, attitudes and ideologies" (Van Dijk 1993, 258-259). It is concerned with "the role of text and talk in creating, maintaining, and legitimating inequality, injustice, and oppression in society" (Van Leeuwen 2015, 1). Unlike other methods, CDA does not prescribe a particular set of steps needed to conduct an analysis. Rather, "there are many ways to do 'critical' discourse analysis" (Van Dijk 1993, 279). As Wodak points out, it is not a singular method, but one that can be pursued via a plethora of approaches (1999, 186).

There are many varieties of CDA in the social sciences, such as quantitative and emancipatory. This project deploys a Foucauldian CDA, which views discourse as a productive force. Foucault defined discourse as a set of concepts and statements that are informed by a broader way of thinking – or mentality. Hence, by analyzing discourses, it is possible to identify and interrogate the mentalities informing them. For Foucault, discourse and power go hand in hand – they are interconnected in a power/knowledge nexus. He argues that "There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association" (1980, 93). Discourse is produced by power, but it is also productive: it prescribes what should be, authorizes certain sites, and produces subjectivities while delimiting normal and abnormal behavior. It "[renders] reality amenable to certain kinds of action" (Miller and Rose 2008, 31). Discourse is informed by expert knowledges, and, in turn, gives authority to some over others. Through an attention to discourse we can discern its power effects, such as the production of unequal subjectivities and the prescription of particular solutions.

There are multiple discourses circulating around a problem at any one time, which are in turn informed by various mentalities. As discussed in Chapter 1, Williams coined the terms dominant, residual, and emergent to describe always shifting dynamics between cultural elements (1977). Over time, dominant discourses weaken, living on as residual or disappearing altogether (Williams 1977, 122). New discourses – emergent discourses – are constantly produced, and may be crushed, modified, or absorbed by the dominant (Williams 1977, 126). Foucault argues that "Each discourse undergoes constant change as new utterances (*énoncés*) are added to it" (1991, 54, italics in original). Discourses always compete with each other for dominance, especially in times of crisis, when space is opened up for new approaches to old problems. The 2000s was one such crisis period for the governance of mental abnormality. The SSCSST and LAO commissions created a space for the airing of competing discourses by different groups involved in Canada's mental health system. Each of those discourses prescribed different solutions towards future mental health policy directions in Canada. However, as Bradford explains, the consensus reached by commissions privilege some voices – and discourses – over others. Commissions privilege the ideas that best fit current national priorities and institutions (Bradford 1998, 3, 12). In other words, some discourses are commensurable (Kuhn 1982, 670) with broader logics and policy directions. Chapter 5 maps the competing discourses that swelled around the SSCSST and LAO commissions. Chapter 6 identifies which of those discourses took hold, and which were relegated to the margins.

Foucauldian discourse analysis lends itself well to a governmentality approach because through analyzing and mapping discourses, we can identify the broader mentalities informing them. It is challenging to isolate mentalities because they lack a "systematic and closed character" (Miller and Rose 2008, 58). With an attention to discourse, however, we can identify their regularities, such as how a problem is framed and categorized, why it is a problem in the first place, and its feasible solutions. Moreover, different mentalities authorize some knowledges over others. Foucauldian discourse analysis is a way of identifying those knowledges, as well as the expertise informing them. Finally, discourses prescribe norms, and therefore, draw lines between normalcy and abnormality, and consequently, social inclusion and exclusion.

Foucauldian discourse analysis is particularly beneficial for a public policy-based project because discourse is the foundation upon which policy is based. More specifically, discourse prescribes the means, end goals, and limits of policy. Through Foucauldian discourse analysis this project demonstrates that mental health policy developments are contingent on shifting ways of thinking about mental abnormality. As Hewitt argues, "The key strength of discourse analysis inspired by Foucault in fields of public policy research is to open up ways of understanding policy activity which are based neither on rational nor political frameworks, but which emphasize the contingent nature of rationality and seek to uncover the power relations of policy making" (2009, 14). This project dismantles the progress narrative surrounding mental health policy developments, especially claims that successive approaches are necessarily more humane or scientific than their predecessors. Instead, this project demonstrates that successive mental health policy directions are contingent on shifting power relations and ways of thinking about mental abnormality. Foucault explains, "My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do" (Foucault 1983, 231-232). In other words, it is not that current approaches to mental abnormality are better or worse than asylums, mental hygiene, or lobotomy, but that they are equally contingent and just as dangerous.

2.2 Genealogy

In addition to Foucauldian discourse analysis and governmentality, this project undertakes a genealogy of the governance of mental abnormality from pre-Confederation Canada until the present. Like CDA, there are many varieties of genealogy. This project employs a Foucauldian genealogy. Foucault deployed genealogy to argue that what are perceived to be universal categories are actually unstable and constantly shifting discursive constructs that are continually reformed by the power/knowledge nexus (1984, 76-77). Dreyfus and Rabinow explain that a Foucauldian genealogy "seeks the surfaces of events, small details, minor shifts and subtle contours" (1983, 105). Smaller, more nuanced discursive shifts are often overlooked by historical analyses focused on a "search for 'origins'" (Foucault 1984, 77). In contrast, Foucault suggested that smaller shifts reveal a great deal about competing narratives that are excluded by dominant histories. He explains that

> genealogy retrieves an indispensable restraint: it must record the singularity of events outside of any monotonous finality; it must seek them in the most unpromising places, in what we tend to feel is without history – in sentiments, love, conscience, instincts; it must be sensitive to their recurrence, not in order to trace the gradual curve of their evolution, but to isolate the different scenes where they engaged in different roles. Finally, genealogy must define even those instances when they are absent, the moment when they remained unrealized (Plato, at Syracuse, did not become Mohammed) (1984, 76).

For Foucault, genealogy demands the destabilization of grand narratives – that is, stories that have become so natural and universal that we have forgotten that they are just stories.

Even though Foucault undertook several genealogical projects throughout his career, he did not lay down a singular methodological framework. This is in large part because by its very definition, genealogy defies a standardized methodological template. However, William Walters' recent work (2012) on governmentality provides a helpful breakdown of three, often overlapping, styles of genealogy at play in Foucault's work. Walters explains that "whatever its style, emphasis or source, genealogy uses historical knowledge to reveal that who and what we are is not fixed or eternal, not a matter of destiny or grand design, but a series of contingent becomings" (2012, 115). Walters refers to this process as "dis-inevitable-izing" (2012, 115). While Foucauldian genealogies are undertaken in a variety of ways, they are united in their common goal to "[denaturalize] objects and subjects, identities and practices that otherwise appear given to us, lessening the strangehold they exert on our political imagination" (Walters 2012, 118). The overarching purpose is to unveil "that other identities and existences are possible" (Walters 2012, 118).

Walters outlines that genealogy can be categorized according to three different styles: GI: "genealogy as descent"; GII: "genealogy as re-serialization and counter-memory"; and, GIII: "genealogy as the retrieval of forgotten struggles and subjugated knowledges" (2012, 112). Walters emphasizes that these styles are overlapping – neither "watertight compartments" (112) nor "mutually exclusive" (116). GI: "genealogy as descent" (2012, 112) bears the closest resemblance to what might first come to mind when we hear the term "genealogy" – that is, genealogy as a family tree (Walters 2012, 117). It involves tracing the various pathways through which something in our present has acquired universal meaning:

> With GI it is usually a matter of tracing the pathways by which something significant and valued in the present came to take the form that it has. These pathways are multiple. To follow lines of descent is to decompose what otherwise appears integral and complete; to identify seams and stitches that were initially hidden from view; to reveal that a final

> product is actually a hodge podge of bits and pieces, each of which has its own history (Walters 2012, 118).

This dissertation undertakes a GI: "genealogy as descent" by destabilizing, or "dis-inevitable-izing" (Walters 2012, 112-115) the concept mental illness. This necessitates, first, letting go of the progress narrative surrounding mental illness, and in particular, that it can be objectively located in our brains, synapses, and neurotransmitters. Instead, this dissertation tracks the conditions through which mental illness became the dominant discursive coding of what is perceived to be mental abnormality, a constantly shifting categorization.

GII: "genealogy as re-serialization and counter-memory" works to push forward alternative perspectives by dislodging and shuffling the contents of settled "discursive objects" (Walters 2012, 112, 125). This style is characterized by "a double move of disconnection and reconnection" (Walters 2012, 131). It destabilizes seemingly self-evident objects and relocates them in a new sequence. Chapter 5 engages with this style by destabilizing the finality of official mental health reform reports, such as the Kirby Report (2006), by analyzing the testimonies that supposedly informed it, thereby contrasting what was said from what was transcribed. By doing so, this project destabilizes the authority of these reports. At the same time, it reorganizes the reports' contents by uncovering which knowledges were authorized in the final reports, and which were silenced, subjugated, or re-inscribed.

GIII: "genealogy as the retrieval of forgotten struggles and subjugated knowledges" has the goal of uncovering forgotten struggles and knowledges (Walters 2012, 112, 132). Walters explains that "GIII reminds us of the forgotten contests, the contingencies, the good fortune … the fact that things could have turned out very differently. It refuses to read the fact of the victory of the ultimate winners backwards into history" (2012, 134). GIII uncovers and accounts for marginalized perspectives and knowledges that are erased by the inevitability and universality of dominant, authorized knowledges. GIII is particularly useful for destabilizing dominant public health and psychiatric approaches to mental abnormality, while taking into account TCAMA's activism and counter knowledges throughout various periods of governance. This includes, for example, consumer/survivor narratives in the 1960s-1990s. Having outlined Foucauldian discourse analysis, governmentality, and genealogy, with an emphasis on diverse genealogical styles, this chapter will now proceed to outline this project's three stages of research.

3. Stages of Research

3.1 Stage One: Genealogy of the Governance of Mental Abnormality in Ontario (Upper Canada), 1830-1990

Mental abnormality has been a constant problem in Canadian governance. In Chapters 3 and 4 I undertake a genealogy of the governance of mental abnormality in Ontario (Upper Canada) from 1830 to the 1990s. The purpose of this genealogy is to uncover key moments in the governance of mental abnormality throughout this period, including forgotten struggles, and to identify and locate them within broader ways of thinking about mental abnormality – or, mentalities. It was beyond the capacity of this project to identify, locate, and analyze the infinite number of primary sources spanning this 160-year period of time.[5] As such, with a few exceptions, this stage of research relied upon secondary sources, such as Harvey Simmons' *Unbalanced: Mental Health Policy in Ontario, 1930-1989* (1990), and Thomas E. Brown's "The Origins of the Asylum in

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[5] Foucault's genealogical method was marked by non-decidability. Due to time and length requirements it was not possible to conduct a genealogy of Foucault's breadth. I had to actively choose what to emphasize based on secondary sources, thus rendering my genealogy partial. This does not make my genealogy less persuasive. Future genealogies of the governance of mental abnormality in Canada may indeed emphasize different moments. Keeping with a governmentality approach, however, I estimate that those moments, much like the ones I emphasize here, would also fall under the four mentalities examined in this project – containment, medicalization, deinstitutionalization, and resilience.

Upper Canada, 1830-1839" (1984). After conducting this secondary research, I was able to divide this 160-year period into three distinct mentalities surrounding mental abnormality. Each of these mentalities informed different solutions and strategies for intervention: first, containment, and the institutionalization of lunacy and insanity; second, medicalization, and the treatment of mental illness; and third, deinstitutionalization, and the release of TCAMA into the community. Chapters 6 and 7 explore ongoing experimentation with a fourth mentality, resilience, which is redefining mental abnormality in the present moment.

Guided by Walters' typology of genealogies, three questions were asked of each of the mentalities explored in Chapters 3 and 4:

1. What language was used to categorize mental abnormality?
2. Why was mental abnormality considered a problem?
3. Who, and with what solutions and knowledges, were authorized by the policy directions taken?

These questions were informed by Miller and Rose's breakdown of governmentalities as rationalities, programmes, and technologies (2008, 61-63). The identification and examination of various moments in the governance of mental abnormality reveals a great deal about the grounds upon which mental abnormality was categorized and problematized at various points in Canada's history. Examination of the strategies deployed to manage TCAMA yields key insights into shifting sites of expertise, power, and knowledge. While answering these guiding questions, I paid particular attention to counter-narratives and shifting residual discourses throughout each of these periods. I traced the metamorphosis of what were at one point considered dominant knowledges, such as mental hygiene, from dominance to entropy. These discourses are still at play, some of which have mutated, such as prevention, and some of which remain subjugated.

By tracing this instability, this project sheds light on and destabilizes the present moment to uncover the voices that have been relegated to the margins.

3.2 Stage Two: Foucauldian Discourse Analysis of SSCSST and LAO Committee Hearings

Stage two (Chapter 5) of this research builds on the previous stage by conducting a Foucauldian discourse analysis of the SSCSST and LAO hearings on mental illness and mental health. These hearings were conducted 2003 to 2006 (federal) and 2009 to 2010 (provincial). In this stage I conducted a Foucauldian discourse analysis of a sample of testimonies collected at both the federal and provincial levels. In doing so, I identified and examined a series of competing debates between multiple groups involved in Canada's mental health system. By closely examining these competing discourses, I identified which voices and knowledges were reflected in the consensus reached in the MHCC and Ontario Strategy documents, and which were excluded. This is of particular importance given that the current climate of mental health reform claims to prioritize input from all designated stakeholder groups.

The testimonies collected at the federal level were expansive. While it was conceivable to read all of the testimonies, it was beyond the scope of this project to conduct a complete analysis of all the proceedings. This necessitated a purposive, typical case selection (Seawright and Gerring 2008). To proceed with this process, this stage began by first reading all of the federal SSCSST proceedings on "Mental Health and Mental Illness," accessible on their parliamentary webpage. Testimonies were extensive, collected throughout the period spanning February 2003 to May 2006. By conducting a preliminary reading of all testimonies, I was able to categorize the "stakeholders" into seven different groups: psychiatry; medical service providers; community service providers; government; Indigenous representatives; anti-psychiatry activists; and, personal testimony. For each group, I analyzed four hearings sessions. In most cases I analyzed two hearings sessions held prior, and two hearings sessions following, the release of interim reports. There were two exceptions to this split: for Indigenous representatives, and those with personal testimonies, it was only possible to capture one hearings session received prior to the Committee's interim reports, and three received after. This was because only one hearing session was held for each group prior to the release of the interim reports.

Analysis of the LAO Select Committee on Mental Health and Addictions hearings followed a similar process. I began by reading all of the transcripts collected throughout the LAO proceedings, conducted between March 2009 and May 2010. Provincial proceedings differed from federal proceedings in structure. Each federal session began with testimonies from a panel of witnesses, followed by a question and answer period from committee members. In contrast, provincial proceedings were structured around one witness at a time, whose testimony was immediately followed by questions and answers from committee members. As was the case for the federal hearings, I organized witnesses into seven distinct groups: psychiatry; medical service providers; community service providers; government; Indigenous representatives; anti-psychiatry activists; and, personal testimony. To maintain consistency with analyses carried out on federal testimonies, four sets of testimonies were collected from each of these seven groups according to a purposive case selection (Seawright and Gerring 2008).

I conducted a Foucauldian discourse analysis of the testimonies selected at the federal and provincial levels. I analyzed the testimonies around the same three questions introduced in the first stage of my research. These questions were asked of each of the seven groups identified above:

1. What language was used to categorize mental abnormality?

2. Why was mental abnormality considered a problem?
3. Who, and with what solutions and knowledges, did the testimonies authorize?

After compiling and analyzing my data, I organized my findings into a series of themes, which are explored further in Chapter 5. These themes were organized around issues such as the role of psychiatry, medical and community service provision, and self-determination for Indigenous and consumer/survivor communities. By structuring my data into a series of themes, I was able to trace the outcomes of competing discourses in the final reports and strategies, which I analyzed in the following research stage.

3.3 Stage Three: Foucauldian Discourse Analysis of Contemporary Public Transcripts

Stage three of my research was a Foucauldian discourse analysis of four documents described above: *Navigating the Journey to Wellness* (2010); *Open Minds Healthy Minds* (2011); *Out of the Shadows at Last* (the Kirby Report, 2006); and, *Changing Directions, Changing Lives* (2012). Documents were selected at two levels of government because while mental health services fall under provincial jurisdiction, mental health has been drawn into federal policy discourses, especially since the creation of the MHCC in 2012. Furthermore, the taking up of mental health at the federal level in itself represents an interesting moment in the governance of mental abnormality, which this project aims to capture and understand. I organized the Foucauldian discourse analysis of these four documents around three key questions, described above. The purpose of this research stage was two-fold: first, to identify the dominant discourses surrounding the present crisis in the governance of mental abnormality; and, second, to analyze these discourses as a way to uncover new ways of thinking about mental abnormality, which as I argue, are rooted in an experimental resilience mentality.

3.4 Summary of Research Stages

A combination of Foucauldian discourse analysis, genealogy, and governmentality approaches allowed me to map both subtle and major shifts in the governance of mental abnormality in Canada, from pre-Confederation times to the present. In stage one of my research I uncovered shifting approaches to the categorization, problematization, and management of mental abnormality across three periods: containment, medicalization, and deinstitutionalization. The genealogical approach undertaken in this stage helped me to locate dominant approaches within a set of competing discourses, and to map dominant, residual, and emergent discourses throughout each of these periods. The Foucauldian discourse analysis conducted of the SSCSST and LAO hearings in stage two allowed me to capture competing discourses that arose around the ongoing crisis in the governance of mental abnormality. Through the Foucauldian discourse analysis conducted of four contemporary public transcripts in stage three, I traced the outcomes of the competing discourses isolated in stage two to reveal which discourses were authorized by the final reports and strategies, and therefore, which were relegated to the margins. Furthermore, the Foucauldian discourse analysis undertaken in stage three offered a glimpse into an experimental mentality informing prevention and recovery strategies – resilience. Resilience will be explored more fully in Chapter 7.

CHAPTER 3: CONTAINMENT: THE GOVERNANCE OF MENTAL ABNORMALITY IN ONTARIO (UPPER CANADA), 1830 – 1920s

1. Introduction

Containment was the dominant mentality informing the categorization, problematization, and governance of mental abnormality in Ontario (Upper Canada) from 1830 to the 1920s. Containment suggested that the confinement and isolation of TCAMA away from society was for their own good, as well as for the good of society. Containment informed three broader programmes: first, lunacy reform, and the confinement of lunacy and insanity behind institutional walls commencing the 1840s; second, mental hygiene, and the prevention of insanity beginning the early 1900s; and, third, eugenics, and the sterilization of the feebleminded to prevent its spread commencing the early 1900s. In the early 1900s, mental hygiene was the dominant approach to mental abnormality, however, this chapter introduces eugenics as a competing programme that struggled to take hold. Each of these three programmes sought to contain mental abnormality, viewing it as a threat to the rest of society.

Throughout this period, mental abnormality was differently understood as lunacy, insanity, and feeblemindedness. While there was a broader shift away from lunacy and towards insanity throughout the mid-1800s, these categories were not exclusive and often overlapped until the late 1870s, when insanity became the dominant term. Feeblemindedness was introduced as a separate category alongside insanity in the early 1900s. Different ways of thinking about mental abnormality opened it up for diverse interventions, ranging from moral treatment to sterilization. Programmes were informed by, and, in turn, authorized alienism and psychiatry as new sites of expertise. The outcome of one programme often informed the next; for example, lunacy reform resulted in overcrowding, which opened up space for mental hygiene initiatives designed to prevent insanity in the first place.

This chapter maps these many shifts. It is organized around three broader containment programmes: lunacy reform, mental hygiene, and eugenics. The first section begins by outlining the social and political context in which lunacy became a problem. I then explore the category lunacy and the problem it presented for early Upper Canada. Next, I outline lunacy reform and moral treatment. I introduce alienism as a site of expertise that grew around the idea of lunacy. Lastly, this section traces a shift away from the governance of lunacy and towards insanity, as well as the transformation of alienism into psychiatry. The second section, on mental hygiene, focuses on the 1870s when containment programmes were in crisis. Lunacy reform did not deliver on its promise to reform TCAMA. Rather, broader definitions of abnormality, as well as high admissions of incurable cases, contributed to overcrowded asylums. These problems contributed to a decline in psychiatric power, which led to its professional reorganization and the further medicalization of insanity. I introduce mental hygiene as a programme designed to contain insanity by preventing it in the first place through the proper socialization of children. In the third section, I introduce feeblemindedness as a less severe form of mental abnormality, and discuss eugenics as a programme deployed to prevent its spread through interventions on the reproduction of the feebleminded.

2. Lunacy Reform

2.1 Context

In the 1830s, Upper Canada was an agrarian society undergoing early stages of urbanization. The ideal subject was self-reliant and hard-working (Dear and Wolch 1987, 72; Brown 1984, 43-44), as well as male, property-owning, and of British descent. In addition to TCAMA, it was assumed that women, Indigenous, and racialized groups lacked the reasoning capacities of their white, male counterparts, who were situated as heads of household. Those who did not conform to this model were often a problem for Upper Canada's social order. The term "social problem," coined in early nineteenth century Europe, authorized interventions on problem groups, primarily for two reasons: first, for "the salvation of wayward or broken people"; and, second, for the "strengthening [of] the collective" (Brodie 2008, 26). In other words, interventions were carried out for the good of both those deemed to be a "problem" and for broader society. For Upper Canada in the 1830s, lunacy was one such problem.

Lunacy reform was a containment programme designed to confine lunatics behind the walls of specialized institutions, or asylums. Lunacy reform was consistent with a classical liberal "world of walls" that socially differentiated and separated out social problems into specialized institutions with different hierarchies of authority (Walzer 1984, 315). Lunatic asylums sprung up alongside other institutions for problem groups, such as reformatories, reserves, orphanages, and prisons. As Scull explains, "there was an "enthusiasm for the institution as the solution to the problem of deviancy" (1984, 21). There were great differences in the management of different problem groups, with different knowledges, programmes, technologies, and expertise. However, the strategy was the same: to solve social problems by segregating "problem" groups away from society because of the threat of moral contamination.

Keeping with classical liberal values of self-sufficiency, lunatics were cared for by their families up until the 1840s (Brown 1984, 27). Often, however, both non-threatening and violent lunatics were sheltered in district jails at the expense of the district (Brown 1984, 28-29). Although they shared a facility, lunatics were segregated away from other prisoners. For instance, when William Lyon Mackenzie visited the Home District Gaol in 1830, he discovered three women lunatics locked up in cribs in its basement (Brown 1984, 29). Hence, containment did not start with the opening of the doors of the first asylum. Rather, lunacy had already been separated out from other forms of deviancy in peoples' minds. This way of thinking in turn informed the construction of separate institutions.

The large-scale building of institutions for the containment of mental abnormality facilitated the growth of specialized knowledges, technologies, and expertise within them. Scull explains that the specialization of apparatuses for the control of deviant groups occurred alongside the professionalization of those designated to manage them: "Gaolers were transformed into prison wardens; madhouse keepers into alienists or psychiatrists; the local militia were replaced by a bureaucratically organized police force; the parish vestrymen by paid Poor Law Guardians" (1984, 22). Asylums were headed by alienists, or physicians with an interest in lunacy who believed in moral treatment, such as work therapy, as opposed to physical restraints. Alienists were also known as superintendents of asylums. The transformation of alienism into psychiatry would come later when mental abnormality was reframed using a medical lens.

2.2 Lunacy and the Lunatic Problem

In nineteenth-century Upper Canada, mental abnormality was dominantly understood and categorized as lunacy. The terms lunacy and lunatic were deployed to describe mental abnormality as early as the thirteenth century in Europe, but their etymological origins date back to Roman mythology (Reaume 2002, 407-408). Lunatic is derived from the Latin *lunaticus*, which means "moon-struck," from the root *luna*, which means "moon" (*Online Etymology Dictionary*, *s.v.* "lunatic"). The term lunacy suggests a link between mental abnormality and lunar cycles, a regular, but uncontrollable and unknown force outside of the body. This connection locates lunacy beyond human control. Lunacy, then, was embedded with a degree of fatalism that was at odds with the progressive impulses of modernity.

In the mid-nineteenth century, lunacy was subdivided into three categories: 1) Manic personality, which included violence, swearing, paranoia, and drinking; 2) Melancholia, which included depression, and the refusal to eat, sleep, and/or work; 3) Dementia, which described incoherence, the refusal to take part in activities, wandering, and "being dirty" (Mitchinson 1988, 95). These behaviours fell outside of the norm, and in particular, conflicted with values such as self-reliance and productivity in the public sphere, as well as social reproduction in the private sphere. Lunacy was often attributed to "'moral' or psychological events" (Shortt 1986, 95). Causes included loss, grief, love, business, religious excitement, political excitement, or an improper upbringing (Shortt 1986, 95). Emergent discourses later established a connection between physical events and mental trauma. For example, a fall from a horse could physically damage the brain, which, in turn, caused lunacy (Shortt 1986, 95). The *Third Annual Report* by the Directors of the Provincial Lunatic Asylum, at Toronto (1853) distinguished between moral and physical causes. Moral causes included religious excitement, grief, family quarrels, or reverses in life. Physical causes included ill health, injury of the head, intemperance, and uterine disturbance (1853, 44). Notably, the terms lunacy and insanity are used interchangeably throughout this report, pointing to instability in these discourses.

2.3 Lunacy Reform and Moral Treatment

Upper Canada entered a period of "lunacy reform" in the 1830s, when official legislative discussions began (Brown 1984, 30-34; Dear and Wolch 1987, 74-75; Moran 2000, 49). The upkeep of lunatics had become too demanding on local jails and charities. In jails, lunatics had become a nuisance and a financial burden. In an 1830 prisoners' petition, inmates of the Home District Gaol protested both an insufficient dietary allowance and their being housed with lunatics (Brown 1984, 35). District authorities complained to legislators that lunatics were "an unwanted drain on district funds," as well as "a dangerous moral contagion that might infect others, even criminals and debtors" (Brown 1984, 35-36). At the same time, private charities established to meet the needs of Upper Canada's poor were pressuring the government for more public aid (Dear and Wolch 1987, 74). At the same time that representatives from district jails and private charities expressed their concerns to the government, a broader "rising tide of protest (especially from judicial quarters) focused attention on the plight of the insane" (Dear and Wolch 1987, 81). The government was under pressure to provide for lunatics in new ways, not just for the good of jails, charities, and society, but also for lunatics themselves. Locking up lunatics in jails was increasingly viewed as inhumane.

In 1830, Upper Canada's legislative assembly passed an act to authorize the transfer of government funds to shelter lunatics in Toronto's district jail. In 1833, this act was extended to include all district jails (Brown 1984, 29; Moran 2000, 49). As Brown explains, "The 1830 Act was the first formal legislative acknowledgement of public responsibility for the insane in the province of Upper Canada" (1984, 30). Not long after, in 1835, Upper Canada's Legislative Assembly dispatched a special committee to the United States to research and report on the possibility of a provincial lunatic asylum (Brown 1984, 30; Dear and Wolch 1987, 81). Lunatic asylums were already in use throughout the United States and United Kingdom, and were understood as a sign of political maturity. The committee produced its report in 1836. However, by the time a bill for the construction of a lunatic asylum could be read, Upper Canada's

Assembly was dissolved by Sir Francis Bond Head (Brown 1984, 31). Once the Assembly was back in session, and following further petitions presented by various districts, "An Act to authorize the erection of an Asylum within this Province for the reception of Insane and Lunatic persons" (The "May 1839 Act") was passed on May 11, 1839 (Brown 1984, 32; Dear and Wolch 1987, 81; Frankenburg 1982, 172).

After the May 1839 Act received assent, construction was delayed due to problems with site selection. Out of a sense of urgency, Toronto's abandoned York jail was converted into a temporary asylum in 1841 (Dear and Wolch 1987, 81; Frankenburg 1982, 172). However, the York jail could only accommodate 100 persons, and quickly became overcrowded (Dear and Wolch 1987, 82). Overcrowding would be a persistent problem throughout the institutionalization and hospitalization of TCAMA in Upper Canada and Ontario. Finally, on August 22, 1846, work began on Upper Canada's first Provincial Lunatic Asylum, following a ceremonial procession and recital of "Rule Britannia" (Brown 1984, 27). The asylum, located at 999 Queen Street West, Toronto, opened on January 26, 1850 (Reaume 2000, 6). Upper Canada had entered the "era of the asylum" (Brown 1984, 27).

Reform was comprised not only of the establishment of separate institutions, but also of the authorization of new knowledges. In contrast to jails, asylums were designed to contain lunatics, and to reform them. The transfer of lunatics out of jails and into their own separate institutions was made possible by the idea that cure was possible – that they could be reformed and returned to society. Fatalism was replaced by optimism that lunatics could return to normalcy. As Brown suggests, "What was sought was no longer simply the containment of the unproductive – but their reclamation and reformation, the unproductive rendered productive once again" (Brown 1984, 45). The end goal of reform was to normalize lunatics to Upper Canada's dominant values, making them self-reliant and productive actors (Scull 1984, 26).

Asylums were a dedicated space for moral treatment. Moral treatment was pioneered in Europe by alienists such as Philippe Pinel and William Tuke, who "argued that corporal punishment and medicine's customary somatic remedies were largely useless in the treatment of insanity" (Dowbiggin 2003, 6). Moral treatment was so-called because its interventions offered a humane alternative to physical restraints and ill-informed violent remedies, such as bleeding and cupping. In contrast, alienists suggested that lunacy was best addressed using "kindness, reason, and discipline to enable the patient to mobilize his or her intelligence and emotions in the struggle against obsessional and delusional thinking" (Dowbiggin 2003, 6). Moral treatment framed lunacy as something curable – that is, as a temporary condition. The mind was not permanently broken, but alienated, and therefore recoverable, through proper nutrition, activity, and a pleasant environment (Mitchinson 1988, 89; Shortt 1986, 129).

As Dowbiggin argues, the "asylum was considered to be the institutional expression of moral treatment and thus was essential to successful therapy" (2000, 84). Asylum surroundings were considered to be especially important. For example, Upper Canada's Provincial Lunatic Asylum (Toronto) was constructed in what was then open countryside, with views and fresh water that were thought to promote patient well-being (Moran 2000, 84). Paternalism was another key component of moral treatment made possible by asylums. Moral treatment demanded that superintendents have control over their patients' lives. The confinement of lunatics away from their families and friends was key to their therapy (Dowbiggin 2003, 6). The asylum authorized the superintendent as the embodiment of reason. Superintendents drew lines between normal and abnormal behaviour. Foucault referred to this as psychiatric power

(Foucault 2006b, 132-133).[6] The asylum facilitated superintendent control while also legitimating the segregation of lunatics away from the rest of society on the basis that it was for their own good.

Moral treatment did not employ external restraints such as chains and cribs. However, it was internally restraining. Shortt argues that “beneath its rhetoric it sought to replace external restraint with the force of internalized values” (1986, 129). Moral treatment was largely comprised of religion, patient recreation, and most importantly, work therapy (Moran 2000, 92-96; Reaume 2000, 14; 2006, 69-70; Shortt 1986, 128-129). Work therapy “was a repetitive, steady, and orderly activity, that, [when supervised], could re-instill the regular and sober habits that medical superintendents considered essential to patient recovery” (Moran 2000, 92). It diverted the mind away from one’s symptoms and helped “regulate the digestive and respiratory systems” (Moran 2000, 92). Alienists argued that through work therapy, “the will […] would regain control of the disordered mind” (Shortt 1986, 133). They also suggested that the “physical exercise brought about by certain types of work, such as agricultural labour or working in a laundry, was viewed as an essential way of redirecting a person’s ‘alienated mind’ from their troubles onto the task at hand” (Reaume 2006, 70). Of course, this work was gendered and classed. At 999 Queen Street West, men farmed and gardened while women sewed, dusted, and served as domestic servants for superintendents (Reaume 2000, 144-146). Work therapy helped finance asylums, for “the extent to which patient work was therapeutic, profitable, or exploitative was subject to debate” (Moran 2000, 93).

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[6] In *Psychiatric Power* (2006b), Foucault does not distinguish between alienism and psychiatry. Although my discussion in this section focuses on alienism, the concept psychiatric power is equally applicable because it denotes the same seat of authority.

By the 1880s, a whole system of asylums had sprung up across Ontario, with at least 70 per cent of patients working without any kind of wage (Reaume 2006, 80). It was thought that by working throughout their stay at an asylum, that non-paying lunatics could earn their way "as privileged inmates of one of society's most benevolent institutions" (Moran 2000, 92). However, patient labour was also convenient. At 999 Queen Street West, Superintendent Workman suspected a problem with the building when two bouts of cholera swept the asylum between 1850 and 1852. Upon investigation, he made a troubling discovery that the asylum's contractors had forgotten to connect the basement drains to the main sewer line, and the basement was filled with two years of waste. Patients were assigned to clean it up (Moran 2000, 86-87). In 1860, these patients were also conscripted to a poignant construction project: "What more poignant example of patient labour can there be than that of insane asylum inmates building the very walls behind which they were confined?" (Reaume 2006, 74). A containment mentality informed work therapy as a moral treatment programme. In turn, work therapy produced the very walls – technologies – that contained lunacy away from society.

Prior to lunacy reform there were some medical – as opposed to moral – attempts at cure. In the early 1800s, general physicians experimented with "bleeding, blistering, purging, sweating, and vomiting" – otherwise known as "heroic therapy" (Dowbiggin 2003, 5). Heroic therapy was an attempt to expel the moral contaminant. It was gradually abandoned because it caused physical suffering and was ineffective (Dowbiggin 2003, 5; Scull 1984, 133). The failure of mainstream medicine to cure lunacy in the early 1800s opened up space for alienism to establish itself as a new authority with new approaches.

Alienism, and later psychiatry, occupied a unique position within the medical field. Alienists argued that the heroic therapies carried out by general physicians "reflected both a prejudice against and an insensitiveness toward the mentally ill" (Dowbiggin 2003, 6). While alienists rejected traditional medical approaches as "worse than useless," "the initial response of most of the medical profession to the claims of moral treatment was one of hostility" (Scull 1979, 134-135, 141). Many physicians responded to moral treatment by reasserting the importance of traditional medical therapies (Scull 1979, 135). They believed that alienists lacked the "expertise and special skills" demanded of a legitimate medical profession (Scull 1979, 141).

Alienism transformed into psychiatry in the 1860s-1870s at the same time that insanity took hold as the dominant framing of mental abnormality. These shifts were fueled by the application of Cartesian dualism to the mind and body (Scull 1979, 159). The mind may have been "an immortal, immaterial substance," but it "was forced in this world to operate through the medium of a material instrument, the brain" (Scull 1979, 159). As a specialized body part, the brain was susceptible to somatic irritation, which in turn produced insanity (Scull 1979, 160). Unlike lunacy, insanity had medical connotations. By attributing insanity to physical causes, psychiatry gained medical legitimacy and established a monopoly of expertise on the brain (Scull 1979, 129, 161). Psychiatry grew in popularity: "Asylums dotted the countryside, proof of psychiatry's institutional power and social status" (Dowbiggin 2003, 8). By the 1860s, psychiatry established its own professional organization and started publishing its own journal (Dowbiggin 2003, 9). It is important to note, however, that even though mental abnormality became a bodily problem, the brain was not well understood or physically tampered with. Medical interventions such as lobotomy did not come into use until the early to mid-1900s. Until then, insanity may have been attributed to the brain, but psychiatrists still focused their efforts on reforming and containing abnormal behaviours, rather than probing their physical causes.

3. Mental Hygiene

3.1 Context

By the 1870s, the term lunacy was outdated and insanity had taken hold as the dominant categorization of mental abnormality. This shift was reflected in the 1871 name change of 999 Queen Street West, from the “Provincial Lunatic Asylum, at Toronto” to “Asylum for the Insane, Toronto” (Reaume 2002, 409). This name change was one moment in a broader shift happening across North America: “By the 1870s in North America, officials who ran lunatic asylums renamed them Insane Asylums” (Reaume 2002, 409). Insane was derived from the Latin *insanus*, meaning unsound (Reaume 2002, 409). The term insanity reframed mental abnormality as “unsoundness of mind” (*Online Etymology Dictionary*, s.v. “insanity”). Unsoundness implied multiple degrees and types of affliction, in contrast to either/or categorizations of lunacy. At the same time that the term insanity took hold, mental abnormality began to be divided into lesser and more severe forms of disturbance.

Incurability and overcrowding in asylums were major problems. Lunacy reform created a physical space for TCAMA, at the same time that the grounds for institutionalization expanded to include, among other things, aging, alcoholism, syphilis, and infirmity (Dowbiggin 2003, 9). Critics argue, however, that asylums functioned less as a curative environment than as “a dumping ground where patients were left to ‘rot’ year in and year out, warehoused in abysmal conditions” (Reaume 2000, 159). The mass warehousing of various conditions contributed to a perceived division between curable and incurable cases. Curable cases were those who would recover from their symptoms and regain normalcy. However, incurable cases were more common. In the 1876 annual report of the Asylum for the Insane, Toronto, it was observed that 87.5 per cent of the year’s admissions had been chronic (Reaume 2000, 7). Towards the end of the nineteenth century, it was estimated that 81.5 per cent of admissions "were not considered fit for discharge" (Reaume 2000, 7).

As admission levels grew and discharge rates slumped, several asylums sprung up across Ontario. In 1856, only six years after opening its doors, Toronto's asylum was so overcrowded that part of King's College was converted into a branch asylum, as were military barracks in Fort Malden (1859) and Orillia (1861) (Mitchinson 1988, 92). Asylums opened in London (1870), Hamilton (1876), Mimico (1890), Brockville (1894), Cobourg (1902), and Penetanguishene (1904) (Mitchinson 1988, 92). Some argued that "the system [was] based on moral treatment, but its curative effect offset by continuing overcrowded conditions" (Mitchinson 1988, 92). Incurability and overcrowding were mutually reinforcing: low discharge rates led to overcrowding, which in turn, was thought to diminish the curative capacities of moral treatment (Shortt 1986, 128).

Overcrowding and incurability challenged the legitimacy of alienism, and its knowledges and programmes. The public, and the broader medical establishment, cast doubt upon moral treatment. However, superintendents maintained that moral treatment was effective, and that overcrowding was caused by high levels of incurable admissions, such as those admitted too late for treatment to be effective. Cure was thought to be most effective when TCAMA were admitted at the first onset of their symptoms. In the 1868 annual report of the Asylum for the Insane, Toronto, Superintendent Workman explained that

> Among the various adverse facts to be considered in forming a prudent anticipation of the issue of any case, that of its duration is certainly in the first rank. How can we expect that a condition of mind which has long since become the settled mental constitution of the patient will be changed speedily, if, indeed, at all, by submitting it to treatment at this late period? The time of recuperative activities, both physical and psychical, has passed away, and we now have but the crumbling ruin which their ill-directed operation has left behind (Provincial Lunatic Asylum 1868, 11).

The timing of admissions was not the only factor, however. Superintendents felt that some cases were incurable from their onset. Workman argued that “there are cases, and the number is considerable, in which recovery is impossible, or at least up to the present time has not been found to occur, at whatever period they may be subjected to treatment” (1868, 11). Such cases included *general paresis*, a degenerative condition caused by syphilis (*Dictionary.com*, s.v. “general paresis”), which also accounted for many asylum deaths (1868, 11).

Desperate to substantiate their curative powers, superintendents tried to limit the number of incurable admissions (Mitchinson 1988, 91). It was relatively easy to limit the admission of those committed under a Form K (after 1882, known as a Form A), which outlined evidence of insanity provided by local physicians and relatives (Reaume 2000, 24-25; Shortt 1986, 50-51). However, while superintendents could limit entry to those referred under a Form K/A, it was far more challenging to turn away cases committed under a Schedule 2, a shorter document transferring patients from prisons by authority of the Lieutenant Governor (Reaume 2000, 25; Shortt 1986, 50-51). In addition to Schedule 2 admissions, superintendents would often admit patients under a Form K/A despite their incurability for humanitarian reasons. For many, an asylum was their only refuge (Mitchinson 1988, 91).

3.2 Neurology vs. Psychiatry

Incurability and overcrowding led to a decline in psychiatric power, which made room for new discourses. Towards the end of the nineteenth century, overcrowded asylums and incurability contributed to mounting criticism against psychiatry as a legitimate medical profession. One source of this criticism was neurology. Neurology was a specialization that took physiological approaches to what it understood to be nervous disorders. It took hold in 1875 with the creation of the American Neurological Association, and *The Journal of Nervous and Mental Disease* (Shortt 1986, 138-139). Neurology was made possible by two moments: first, 1880s European developments in medical science that sought somatic sources of mental abnormality; and, second, experiences treating nerve injuries in soldiers during and after the American Civil War (Dowbiggin 2003, 10-11; Shortt 1986, 139). Neurologists acquired prestige "as physicians familiar with the most recent scientific medicine of Europe" (Dowbiggin 2002, 11).

The advancement of neurology perpetuated the division between curable and incurable cases, and contributed to the idea that there were multiple levels of insanity. The field introduced a new clientele, those with borderline states who could be treated out of outpatient clinics (Shortt 1986, 139). Such conditions included "dyspepsia, anxiety, insomnia, mild depression, and general malaise" (Dowbiggin 2003, 11). This new category of TCAMA were not completely insane, but rather, "emotionally disturbed patients" who "fell short of the criteria necessary for the only other form of psychiatric care – asylum admission" (Shortt 1986, 139). There was also a class-based division between those committed to asylums and those receiving outpatient neurology services. Typically, the latter were more affluent than asylum inmates (Dowbiggin 2003, 10-11; Shortt 1986, 139). The prestige of neurology was reinforced by a focus on affluent clients: "It was chiefly their success in recruiting patients with [borderline] symptoms that sustained neurology's rise; for it often meant that neurologists treated patients with money and social rank" (Dowbiggin 2003, 10-11). Divisions based on income and access to private care persist today. Not everyone can afford private counselling, at $150 and often more per session.

Neurology challenged psychiatry's monopoly over mental abnormality. Even though psychiatry had acquired some medical legitimacy by acknowledging a physical connection between insanity and the brain, it still largely dealt with insane behaviours as opposed to their physical causes. It lacked neurology's research and scientific legitimacy. Neurologists lamented the metamorphosis of psychiatrists into asylum administrators (Shortt 1986, 35). They were "disdainful of psychiatrists' seeming obsession with asylum management, administration, and treatment," and argued that if psychiatry was to continue to lay claim to mental abnormality, it should be under the supervision of neurology (Dowbiggin 2003, 11).

Towards the end of the 1800s, psychiatrists were still answerable to the Inspector of Prisons and Public Charities (Dowbiggin 2003, 25; Shortt 1986, 36). As asylums became increasingly overcrowded, public officials put a limit on their increasing budgets (Dowbiggin 2003, 16, 25; Shortt 1986, 40). Psychiatrists were thought of as "public-salaried civil servant[s] locked into a hierarchical network dominated by elected politicians" (Dowbiggin 2003, 25). By the end of the 1800s, salaries and benefits "were no longer terribly generous" and the profession had lost its glamour and appeal (Dowbiggin 2003, 24).

3.3 Professional Reorganization

A series of competing discourses surrounding the future of psychiatry merged into its professional reorganization. Neurology's critique of psychiatry dwindled in the early 1880s, but psychiatry had absorbed its criticisms. Psychiatry began reorganizing itself as a medical profession in response to disillusionment from within the profession (Dowbiggin 2003, 26). In so doing, it endeavoured to "prove professional 'relevance'" (Reaume 2000, 18). At the 1881 annual meeting of the Association of Medical Superintendents of American Institutions for the Insane, a call was made "for a more vigorous and scientific approach to institutional treatment" (Shortt 1986, 139). A new generation of psychiatrists with an interest in cutting edge treatments replaced retiring alienists (Shortt 1986, 139). At the 1890 annual meeting, the organization's president "[felt] secure in calling for a reorganization of the group" that would both incorporate the latest neurological developments and reflect the career aspirations of the next generation (Shortt 1986, 139). In 1891, the Association of Medical Superintendents of American Institutions for the Insane changed its name to the American Medico-Psychological Association (*Scholarly Societies Project* 2015). In 1894, the organization even invited a neurologist, S. Weir Mitchell, to give a keynote address, where he critiqued psychiatry for its distance from general medicine (Dowbiggin 2003, 27).

Professional reorganization was directed towards scientific and medical legitimacy, and the power that came with it. Simmons explains,

> Only if the mental health professionals could convince the government and elite decision-makers that mental illness was in fact an illness, if the ordinary general practitioner could be convinced that he should take mental illness seriously and be trained to identify and even treat certain forms of mental illness, and if the public could be convinced that mental health professionals were engaged in approximately the same kind of endeavour as medical doctors, then the gap between psychological and physical medicine might be bridged, with the mental health system reaping the benefits of enhanced status, improved finances and public standing (1990, 37).

This gap was partially bridged through discursive shifts. Reaume explains that

> For an emerging mental health profession, being able to "reform" the language pertaining to asylum inmates and mental institutions was part of an effort to enhance their professional status. This effort to try to rename and redirect popular language that was used to describe mental hospitals and those who lived in them was therefore tied in with wider professional aims of promoting a supposedly more scientific model towards mental disorders (2002, 410).

Asylums were renamed hospitals in the early twentieth century, for instance, in 1907 when 999 Queen Street West changed from Asylum for the Insane, Toronto, to Hospital for the Insane, Toronto (Reaume 2000, 6). Superintendent Daniel Clark advocated for this name change because the term asylum was custodial sounding, whereas the term hospital implied treatment and cure and was therapeutically optimistic (Reaume 2002, 410-411). TCAMA became patients, and insanity became a medical condition. Not only was lunatic an outdated term, but it was also "adopted as a derisive way of describing anyone who had that label attached to them" (Reaume 2002, 409).

3.4 Mental Hygiene

Mental hygiene and eugenics were two competing programmes adopted in the early twentieth century as solutions to insanity and feeblemindedness respectively. Both approaches offered an opportunity for psychiatrists to obtain legitimacy. Eugenics is explored further in the next section. Mental hygiene initiatives supposed that insanity could be prevented in the first place. More generally, hygiene refers to "the degree to which people keep themselves or their environment clean, especially to prevent disease" (Cambridge Dictionaries Online, s.v. "hygiene"). It took hold as a branch of knowledge and a science of mental health that focused on the prevention of disease (Richardson 1989, 1). By preventing insanity in the first place, mental hygiene appeared as a viable solution to issues of overcrowding and incurability. Mental hygiene fueled psychiatric power, which presented itself as the only profession with the required knowledge to identify and protect society from insanity. Many psychiatrists became members of the Canadian National Committee on Mental Hygiene (CNCMH), an organization established in 1918 that was committed to the prevention of insanity (Dowbiggin 2003, 19; McLaren 1990, 59).[7]

The child was a special focus of mental hygiene practices. This focus corresponded with an early twentieth century movement focused on the proper socialization of children. The twentieth century was even dubbed "the century of the child" (Richardson 1989, 2). Up until this

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[7] In 1950 the CNCMH became the Canadian Mental Health Association (CMHA) (CMHA 2015).

point, insanity was considered an adult affliction. Richardson points out that “the application of the concept of mental illness to children is surprisingly recent” (Richardson 1989, 9, 14). The introduction of childhood into dominant ways of thinking about mental abnormality opened up more possibilities for intervention. It was thought that “society could be protected through the socialization of children” (Richardson 1989, 2). Because interventions were directed at the child, public schools were an ideal site to deliver mental hygiene programmes (Richardson 1989, 2). As Richardson explains, schools “offered an unprecedented opportunity for large scale public intervention into child life” (Richardson 1989, 14). Psychiatrists stressed that schools should play a role in socialization. At a 1928 conference, Dr. C. Campbell suggested that

> If the school is an apparatus through which the community hopes to train the child for future citizenship it will be interested not only in pedagogic problems, but in the formation of character; it will pay attention to the emotional as well as to the intellectual life; it will be interested in the social adaptation of the child as well as in the scholastic progress (Campbell 1928, 14).

School-based mental hygiene programmes included moral and physical training, and mental testing, which were largely delivered by teachers (Richardson 1989, 14). These programmes also drew a new link between physical health and mental well-being (Richardson 1989, 15).

Parenting was another site of intervention opened up by mental hygiene discourses, as psychiatrists often blamed childhood insanity on improper parenting (Martin 1928, 6). At his 1928 presentation to the CNCMH, Dr. Charles Martin asked, “How often does the hand that rocks the cradle plant unwittingly the seeds of permanent ill-health?” (1928, 6). Parenting discourses were, of course, gendered, as mothers performed the bulk of the work of child-rearing. As a solution to improper parenting, psychiatrists designed classes to equip parents with the skills and knowledge needed to properly socialize their children. Dr. Charles Martin explained that

> Not least among our activities have been the classes on parent education instituted throughout the country, projecting a flood of light on the problems of the home, on the relations of parents to children, on the role in the family life of the educational training of the child. […] The parent is taught his duty in the supervision of the child – his idiosyncrasies and behaviour, his daily hygiene of sleep and food and play, his vocational adjustments and his emotional conflicts (Martin 1928, 6).

Through mental hygiene programmes, psychiatrists established themselves not only as medical experts, but also as social experts with a hand in pedagogical and child-rearing theories.

4. Eugenics

4.1 Hereditarianism and Feeblemindedness

As psychiatry reorganized itself as a medical profession and asylums became hospitals, the causes of mental abnormality were reframed with scientific and medical discourses. One such discourse was hereditarianism, which took hold in the late nineteenth century. Hereditarianism suggested that some people had a genetic predisposition to mental abnormality that was passed on through reproduction. Mental abnormality was reframed from a moral to a genetic contaminant that endangered the wider population – a biopolitical construct (Foucault 2003b, 245). Simply put, it was thought that mentally abnormal genes dirtied the gene pool. As such, what had been a moral division in society was solidified as scientific fact. Hereditarianism was intertwined with degeneracy theory, the belief that mental abnormality was "an earlier and primitive state of being" (Shortt 1986, 98). As Foucault discusses in *Society Must Be Defended* (2003b), the discursive construction of population as a target for intervention was bound up with race and racialization (254). As Danielle Peers argues, the relationship between degeneracy, or the idea that some groups are lesser humans, was simultaneously ascribed to racialized and disabled bodies in Canada (2015).

Hereditarianism made room for the discursive construction of feeblemindedness as a new category of mental abnormality in the early twentieth century. Feeble means “weak and without energy, strength, or power,” or “not effective or good” (Cambridge Dictionaries Online, s.v. “feeble”). It included “those individuals who were considered in terms that are now seen as offensive: ‘half-wits,’ ‘idiots,’ people believed to be of below-average intelligence for their age and thus devalued members of society” (Reaume 2000, 31-32). Feeblemindedness was harder to detect than insanity:

> In 1914, however, [C.K. Clarke] and his staff had encountered a category of men, women, and children whose mental and behavioural symptoms were often less conspicuous than those of insane asylum patients. He claimed to have become aware of these so-called feebleminded defectives because the Toronto schools, Juvenile Court, Public Health Department, and various social agencies referred cases to him at the TGH for psychiatric examination. In his own words, these persons were “not easily detected except by those who are familiar and experienced in psychiatric and psychological methods.” This, he asserted, made them dangerous; for they often roamed the streets and provided the material out of which criminals, prostitutes, juvenile delinquents, and dependent single mothers were created (Dowbiggin 2003, 161).

Even though feeblemindedness was harder to detect than insanity, it was still perceived as a major threat to Canadian society. It was thought that the feebleminded were more likely to spread contagious diseases: “When I tell you that communicable diseases are more rapidly spread through their agencies than through any others, you will realize the menace there is to this country” (Martin 1928, 4). Feeblemindedness also was blamed for the degeneration of Anglo-Saxon morals:

> Individualism, materialism, feminism, and socialism were said to be rampant. The purported surges in venereal disease, tuberculosis, alcoholism, divorce, and labour unrest were pointed to by the nervous as evidence of the erosion of traditional values (McLaren 1990, 27).

Feeblemindedness “threaten[ed] the moral integrity of all normal people” (Scull 1984, 128). Fear of it “swept the country” (McLaren 1990, 41). Reaume refers to this fear as “the myth of the menace of the feebleminded" (2000, 31-32). Those in lower social positions were blamed for behaviours that led to wider social problems. Their behaviour was attributed to feeblemindedness, which stemmed from poor genes that could be spread to the wider population (Reaume 2000, 31-32). In other words, causes for social inequalities were given scientific legitimacy through feeblemindedness.

Fear of feeblemindedness overlapped with fear of racialized others. It was problematized alongside with immigration and diversity. This was nothing new. As early as the 1850s, Superintendent Workman blamed Irish immigrants for overcrowding, arguing that "their tendency to inter-marry […] left them with a hereditary taint resulting in an incurable form of insanity" (Mitchinson 1988, 93). In the early twentieth century, the degeneration of Canadian society was blamed not only on its "mentally ill and feebleminded elements" who were "uncommonly promiscuous," but also on an "influx of immigrants beginning in the late 1890s" (Dowbiggin 2003, 133). Degeneracy theory advanced that racialized groups were lesser humans and posed a threat to Canada's Anglo-Saxon norms (McLaren 1990, 46). Ultimately, degeneracy theory provided "objective scientific justifications for old, deep-seated racial and class assumptions" (McLaren 1990, 49).

4.2 Segregation and Sterilization

By the 1930s, the dominant solution to insanity was mental hygiene. Mental hygiene was thought to contain insanity by preventing its development in the first place. Eugenics was a competing, radical approach that struggled to take hold around feeblemindedness. It was a radical biopolitics that, like mental hygiene, was directed towards the prevention of mental abnormality. Unlike mental hygiene, however, which prevented insanity through socialization, eugenics prevented mental abnormality by intervening on the reproductive capacities of the feebleminded. The term eugenics was coined in 1883 by Francis Galton, the cousin of Charles Darwin, who took an interest in the relationship between genetics and society (McLaren 1990, 15; Dowbiggin 2006, 179). It was thought that society could be shaped by adding or subtracting different genetic factors. While positive eugenics "[encouraged] the fertility of the fit," negative eugenics "[restricted] the breeding of the unfit" (McLaren 1990, 16). In 1930, eugenicists organized into the Eugenics Society of Canada (ESC), arguing for state controls over the reproduction of the unfit (Dowbiggin 2003, 184; McLaren 1990, 18, 107).

Eugenicists advocated for the segregation and sterilization of the feebleminded. It was a popular discourse. Even Tommy Douglas, in his 1933 Master's thesis, argued that the reproduction of the "subnormal" should be limited because they were responsible for the Great Depression (McLaren 1990, 8). In 1919, a report issued by the Royal Commission on the Care and Control of the Mentally Defective and Feebleminded in Ontario recommended the construction of custodial institutions for the feebleminded (Dowbiggin 2003, 166-167). These differed from hospitals for the insane, which were gradually reframed as places of treatment and potential cure. However, there was no optimism that feeblemindedness could be cured – it was a permanent, often inherited, state. Hence, the logic underlying the report's recommendation was that the segregation of the feebleminded away from society would prevent them from reproducing, and thereby prevent the mixing of their genes with the "healthy 'race'" (Reaume 2000, 32). A depressed economy prevented the construction of these institutions (Dowbiggin 2003, 166-167). Eugenicists continued their fight against feeblemindedness with a new argument: if it was not possible for the feebleminded to be segregated away from society, then their reproduction should be prevented through sterilization, a more direct measure (Dowbiggin

2003, 167). Sterilization laws were passed in Alberta in 1928, and in British Columbia in 1933, and were not repealed until 1972 (Dowbiggin 2003, 133-134; 2006, 179; McLaren 1990, 107). Legislation for sterilization never passed in Ontario, perhaps due to higher proportions of Catholic voters compared to Canada's Western provinces, but was still carried out unofficially (Dowbiggin 2003, 187-188; McLaren 1990, 25).

Eugenics was a popular way of thinking that took its most extreme form in Nazi Germany's policies. In 1934, the Nazi government passed a sterilization law targeting feeblemindedness, schizophrenia, and epilepsy (United States Holocaust Memorial Museum 2017). In 1939, it instituted the T4 programme, designed to euthanize the "incurably ill, physically or mentally disabled, emotionally distraught, and elderly" (Encyclopaedia Brittanica Online 2017, s.v. "T4 Program"). Eugenics lost popularity in Canada during World War Two, as part of a broader effort by the West to distance itself from Nazi policies (Dowbiggin 2003, 187-188; McLaren 1990, 147). By 1940, the Eugenics Society of Canada (ESC) had collapsed (Dowbiggin 2003, 187; McLaren 1990, 148).

The distinction between mental hygiene and eugenics discourses was not neat. For example, even though the focus of the CNCMH was on the prevention of insanity through mental hygiene, the organization still campaigned against unemployment, sex work, and crime, social ills attributed to feeblemindedness (McLaren 1990, 5). Both mental hygiene and eugenics were strategies directed at the containment of mental abnormality via prevention, however, eugenics took on a radical biopolitical form. Although their approaches were carried out using different technologies, proponents of mental hygiene and eugenics converged on various issues, such as immigration. Canada experienced an explosion in immigration during the first decade of the twentieth century. Public health officials argued that immigration posed a hazard to Canadian society, believing many immigrants to be “carriers of hereditary weaknesses that made them prone to crime, dependence, and physical and mental disabilities” (Dowbiggin 2003, 136-137). Proponents of mental hygiene and eugenics pushed for restrictions (Dowbiggin 2003, 138). Canada’s 1869 Immigration Act had already prohibited entry to those with afflictions anticipated to become a burden on Canadian society, such as insanity (Dowbiggin 2003, 141; McLaren 1990, 55). However, in 1902 the act was broadened to include even more afflictions, and “by 1906 the feeble-minded, idiots, epileptics, insane, deaf, dumb, blind, infirm, and those afflicted with a loathsome, contagious, or infectious disease were specified as belonging to the prohibited groups” (McLaren 1990, 56). Immigrants were deported who, within two years of their arrival to Canada, were admitted to charitable institutions such as asylums. Immigration also opened up another professional opportunity for psychiatrists through the CNCMH, which was involved in the mental testing of immigrants (Dowbiggin 2003, 167; CMHA 2015). Alarm over immigration subsided in 1928 when medical officers began inspecting immigrants in Europe, before they arrived in Canada, and in the 1930s when the federal government suspended immigration due to the Great Depression (Dowbiggin 2003, 178).

5. Conclusion

Containment took many forms, from lunacy reform, to mental hygiene, to sterilization. Lunacy became a public policy issue in the 1830s when previous strategies, such as familial and community care, were no longer feasible solutions. District jails were an inappropriate place for lunatics, and also proved to be financially draining on largely municipal governments. This opened up space for new ways of thinking about mental abnormality. Lunacy reform was an alternative approach informed by a containment mentality that authorized the confinement of lunatics in their own special institutions, and away from society. Alienists, however, fell through on their promise to reform lunatics through moral treatment, and by the 1870s, incurability and overcrowding were major problems. These problems reflected a crisis in a containment mentality. This crisis was addressed with new containment programmes, such as mental hygiene and eugenics, which sought to contain insanity through prevention, while at the same time introducing feeblemindedness as a new category for governance. However, by the 1930s, hospitals for the insane remained overcrowded and by the 1940s, eugenics discourses had dissipated.[8] Containment had not worked. The next chapter picks up at this moment to examine the emergence of medicalization and deinstitutionalization mentalities.

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[8] Although eugenics discourses had subsided by the 1940s, sterilizations were still performed well into the 1970s, especially on Indigenous women. See Erika Dyck and Maureen Lux, "Population Control in the 'Global North'?: Canada's Response to Indigenous Reproductive Rights and Neo-Eugenics," *The Canadian Historical Review* 97, no. 4 (2016). Additionally, there was an external review report released Thursday, August 27, 2017, on the involuntary tubal ligation of Indigenous women at the Royal University Hospital, Saskatoon, into the 2000s. See Holly Moore, "Long Awaited Review into Forced Sterilization of Indigenous Women at Saskatoon Hospital Finds 'Covert and Overt' Racism Among Staff," *APTN National News*, August 27, 2017, http://aptnnews.ca/2017/07/27/long-awaited-review-into-forced-sterilization-of-indigenous-women-at-saskatoon-hospital-finds-covert-and-overt-racism-among-staff/.

CHAPTER 4: MEDICALIZATION AND DEINSTITUTIONALIZATION: THE GOVERNANCE OF MENTAL ABNORMALITY IN ONTARIO, 1930s – 1990s

1. Introduction

Despite persistent attempts at containment throughout the nineteenth century, mental abnormality remained a key policy problem throughout the twentieth century. Mental hygiene programmes were ineffective, and with no known cure, hospitals for the insane were more overcrowded than ever. Sterilization laws were never passed in Ontario, and eugenics approaches gradually lost favour in a broader attempt by the West to distance itself from Nazi policies (Dowbiggin 2003, 187-188; McLaren 1990, 147).[9] This made room for emergent mentalities, and by the 1930s, a medicalization mentality had supplanted containment. Whereas the purpose of previous programmes was to contain, the purpose of medicalization strategies was to treat. As an illness, it was thought that cure, although yet undiscovered, was possible. Feeblemindedness, however, understood to be a permanent state, lacked any therapeutic optimism. Psychiatry focused its efforts on mental illness, while other sites of expertise, specialized knowledges, and welfare discourses grew up around feeblemindedness. As such, it is beyond the scope of this project to trace the governance of feeblemindedness to the present moment: it merits an entire dissertation of its own.

The discursive coding of mental abnormality as mental illness made room for a new set of programmes and technologies. What were once asylums, and later custodial hospitals for the insane, became medical facilities where mental illness was treated with shock therapy, lobotomy, and eventually, with psychopharmaceuticals. Later, however, a consumer/survivor movement, informed by social liberal citizenship discourses, protested perceived psychiatric abuses and

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[9] As previously noted, however, involuntary sterilizations were still carried out well beyond the 1940s, in particular on Indigenous women, even though eugenics discourses were no longer dominant. See Dyck and Lux (2016).

involuntary confinement. In addition to psychopharmaceutical technologies, this movement informed deinstitutionalization as a new mentality surrounding mental abnormality. A deinstitutionalization mentality suggested that the mentally ill would fare better in the community, provided that a full range of outpatient and community services were made available to them. It was thought that as long as the mentally ill took their medications and accessed services, that they could assimilate into society to become active citizens and community members. This marked an important shift away from their confinement behind asylum walls. However, these services were never made available and absent the appropriate supports, many of those released between the 1960s and 1990s ended up in rundown boarding homes, homeless, or in prison.

This chapter begins by examining medicalization, and in particular, a shift away from insanity and incurability, towards mental illness and curability. Next, it maps the development of medical technologies, with a focus on shock treatment, lobotomy, and Thorazine. Despite the drastic pursuit of a cure, psychiatric hospitals remained overcrowded into the 1950s, and medicalization also fell into crisis. Hence, in the next section, this chapter introduces another mentality – deinstitutionalization – which informed our way of thinking about mental abnormality into the 1990s. Both medicalization and deinstitutionalization were progressive. Medicalization suggested that if patients could be cured, they could be discharged. Faced with the reality that cure was not possible, deinstitutionalization suggested they could still be discharged provided their symptoms were managed. Under deinstitutionalization, consumer/survivor activism was a competing discourse to psychiatry, a discourse that ultimately, challenged psychiatric power. Next, I discuss the motives underlying deinstitutionalization and community care, and map the outcomes of the large-scale emptying out of psychiatric hospitals between the 1960s and 1990s.

2. Medicalization

Medicalization supplanted containment in the 1930s as the dominant mentality informing the governance of mental abnormality. Medicalization suggested that mental abnormality was caused by physical problems in the brain, which if physically treated, could be cured. It offered a solution to incurability and overcrowding. Under this mentality, mental abnormality was no longer something to be contained away from society as a threat, but could be treated. Treatment allowed for the reintegration of TCAMA into society as rights bearing social citizens. And, like any other medical problem, it was a legitimate illness. TCAMA were not threats or degenerates, but ill. The reframing of mental abnormality as an illness opened it up for a whole new set of interventions to try and cure it, and hospitals were no longer designed to be sites of containment, but sites of cure.

2.1 From Incurable Insanity to Curable Mental Illness

By the 1930s, mental hygiene strategies had proved ineffective. However, mental hygiene discourses did contribute to the further medicalization of insanity, which played a role in its recoding as mental illness. Additionally, mental hygiene carved out a specialized role for the psychiatrist, thereby fueling psychiatric power. In order to maintain this legitimacy, psychiatry had to continue on its path towards medical legitimacy by demonstrating that mental abnormality was the same as any other illness. By the 1930s, those “who formerly were described as ‘insane and dangerous to be at large’ … were now described as ‘mentally ill’…” (Frankenburg 1982, 173). Frankenburg highlights that “the overall trend was to recognize insanity as mental illness, and commitment as a medical procedure” (1982, 173). These discursive shifts were also reflected in legislation, for example, in Ontario’s 1935 *Mental Hospital Act*, which relied on medical terminology. The act stated that the purpose of mental hospitals was to treat, an idea that differed greatly from their earlier custodial function (Frankenburg 1982, 173).

By the 1950s, what were once known as asylums were referred to as Provincial Psychiatric Hospitals (PPHs), and they were still “the primary locus of care for Ontarians suffering from mental illness” (Hartford et al. 2003, 66). The federal government’s 1948 National Health Grants initiative included a Mental Health Grant, expanding the number of beds in PPHs (Dear and Wolch 1987, 96). In addition to dedicated hospitals, however, general hospitals also offered a space for treatment in their own psychiatric wards. Psychiatrists preferred working in psychiatric wards because “it suited their professional aspirations to link themselves as closely as possible to general medicine” (Simmons 1990, 44). However, general hospitals were only eligible for federal cost-sharing initiatives if less than 10 per cent of their beds were psychiatric patients (Hartford et al. 2003, 66). Typically, there was more therapeutic optimism for those admitted to psychiatric wards, whereas chronic cases were committed to mental hospitals (Simmons 1990, 73). Effectively, there was a “two-tier pattern,” where general hospital psychiatric wards were “the preferred alternative of the psychiatric profession,” and PPHs remained underfunded and overcrowded ([Simmons 1990, 78] in Hartford et al. 2003, 66).

2.2 Treating Mental Illness

The reframing of mental abnormality as a medical problem opened it up for new interventions. These interventions were largely experimental, directed towards a potential cure. The discovery of a cure was important to psychiatry because it would “prove professional ‘relevance’” (Reaume 2000, 18). Experimental treatments were termed heroic, since the “‘dramatic’ attempt to relieve a person of his or her affliction was in itself a sign of the ‘valour’ of this approach” (Reaume 2000, 18). Treatments included insulin shock, first administered at Mimico PPH in 1937 (Reaume 2000, 19). Between 1938 and 1939, Metrazol, another form of shock treatment, began at Toronto, London, Whitby, Brockville, and Kingston PPHs (Reaume 2000, 19). In 1941, Ontario’s first lobotomy was performed at Toronto PPH (Reaume 2000, 20). This period was the peak of psychiatric power, what Simmons refers to as “the heyday of paternalism in psychiatry” (1990, 218-219). Even though treatment was delivered in “the best interests of … mentally ill people,” it did not require patient consent, and was sometimes carried out involuntarily (Simmons 1990, 218-219). Furthermore, none of these treatments were found to cure mental illness.

By the 1970s, lobotomies fell into disuse due to legal hoops established in response to a growing patients’ rights movement. Electroshock treatments were used far less frequently than the 1940s to 1960s, however, are still delivered today in the form of Electroconvulsive Therapy (ECT) (Reaume 2000, 20). Heroic treatments were supplanted by the discovery of psychopharmaceuticals in the 1950s. Rhône Poulenc, a French pharmaceutical company, first introduced the antipsychotic chlorpromazine in 1950. Not long after, Smith, Kline, and French marketed the drug in North America as Thorazine (Scull 1984, 80). Thorazine reduced symptoms in people with mental illnesses such as schizophrenia, which until its introduction, seemed impossible to treat. Hence, it was greeted by psychiatrists as “an instance of scientific serendipity” (Scull 1984, 80). However, Thorazine came with a host of side effects including dyskinesia, an involuntary movement disorder, and the Thorazine shuffle, a stiff walk (Goode

2003). At the time, Thorazine was the only drug available to treat mental illness, and within one year of its release it had increased Smith, Kline, and French's sales by a third (Scull 1984, 80). Over the next several decades, drugs multiplied to treat a variety of mental illnesses.

Although Thorazine helped manage patient symptoms, the overcrowding of PPHs was still a major problem. Psychiatry had given up on the idea that invasive medical procedures could permanently cure mental illness. The public grew concerned over the conditions faced by TCAMA in overcrowded PPHs, especially given a growing patients' rights movement. As Dear and Wolch explain, "overcrowded and essentially custodial institutions had increasingly come under attack for failing to provide adequate care and treatment and for the deplorable physical conditions that inmates were forced to endure" (1987, 16). Since mental illness could not be cured, but at best managed, people began wondering if PPHs were appropriate places for TCAMA. There was a "growing disenchantment during the 1950s and 1960s with the adequacy of such institutions as a response to mental illness" (Scull 1984, 95). Furthermore, in light of inflation, hospital employee unions, and the phasing out of unpaid patient labour, PPHs called for increasing financial support from provincial governments (Scull 1984, 138-139). These factors reflected a broader crisis in a medicalization mentality.

3. Deinstitutionalization

Deinstitutionalization appeared as a solution to a number of problems increasingly associated with medicalization, including public distrust, financial unsustainability, rights discourses, and the realization that many mental illnesses could only be managed and not cured. Deinstitutionalization proposed that patients were better off in the community, both for their own good, as well as for the good of the public purse. Mental abnormality was an illness, not a moral contagion, and TCAMA were rights bearing citizens, and therefore, should not be incarcerated. With the right combination of medications and community services, TCAMA no longer posed a threat, and could even assimilate into society.

Deinstitutionalization was foreshadowed and accompanied by trans-institutionalization, which was instituted starting the 1950s to cut PPH costs. Trans-institutionalization referred to "the transfer of large numbers of mentally ill people, most of them elderly, from psychiatric hospitals to private nursing or residential homes" (Simmons 1990, 109). Effectively, it took those with no hope of recovery out of PPHs, and transferred them to long-term care facilities (Simmons 1990, 109). It dealt with a very old problem, incurability, by relocating it outside of the psychiatric system. The deinstitutionalization of patients from PPHs and psychiatric wards between the 1960s and 1990s was also accompanied by a slowing stream of new patients. In 1970, more mentally ill were admitted to psychiatric wards in general hospitals than to PPHs (Simmons 1990, 65).

3.1 The Consumer/Survivor Movement

Fiscal pressures were compounded by the consumer/survivor movement, another source of critique leveled against PPHs. In the 1960s and 1970s, within a broader civil rights movement and social citizenship discourses, ex-patients organized to protest their involuntary committal and invasive medical treatments (Reaume 2002, 412). Organizations included Toronto's On Our Own (1977) and Vancouver's Mental Patients' Association (1978) (Nelson 2012, 234; Reaume 2002, 412-420). There was tension within this movement. Some group members were anti-psychiatry, rejecting treatment altogether, calling themselves survivors for having survived an oppressive system (Reaume 2002, 419). Other group members, calling themselves consumers because it connoted choice, believed that treatment was acceptable provided it was consensual. Together, these various perspectives became broadly known as the consumer/survivor movement (Reaume 2002, 405-406). As the consumer/survivor movement took hold, it was even joined by voices from within psychiatry itself, such as Thomas Szasz, who published *The Myth of Mental Illness* (1961), *The Manufacture of Madness* (1970), and *The Myth of Psychotherapy* (1978) (Reaume 2002, 413-414).

The consumer/survivor movement contributed to the legal curtailment of psychiatric power. By the 1980s, invasive treatments were heavily restricted, marking "the thin edge of the wedge in the movement to reduce psychiatric paternalism and to grant mental patients the right to refuse treatment unconditionally" (Simmons 1990, 221). In 1982, the Psychiatric Patient Advocate Office was opened in Ontario to advise on patients' rights (Hartford et al. 2003, 68). Subsequent Ontario Mental Health Acts (MHAs) reflected these shifts (Frankenburg 1982, 174; Hartford et al. 2003, 67-68). Ontario's 1960 MHA authorized physicians to involuntarily admit patients if it was in their best interests, otherwise known as the welfare standard (Frankenburg 1982, 174). In 1967, however, the MHA was amended so that patients could only be admitted if they were dangerous to others, otherwise known as the safety standard (Frankenburg 1982, 174). Thus, even if treatment was deemed to be in their best interests, patients could only be involuntarily admitted if they posed a threat to society. Psychiatric power was further curtailed by the 1978 MHA, which demanded a 120-hour assessment period prior to involuntary admission (Frankenburg 1982, 174). The 1978 MHA also instituted psychiatric review boards, giving patients the opportunity to contest involuntary treatments and admissions (Hartford et al. 2003, 67-68).

3.2 Deinstitutionalization and Community Care

The logic underlying deinstitutionalization was that services could be relocated to the community, where patients could access them as community members. Although the idea was not fully embraced until a deinstitutionalization mentality had taken hold, community care was not a new concept. Since the 1940s, multiple government proposals, such as the 1944 McGhie Report and the 1959 Dymond Report, recommended that Ontario's mental health system shift its focus towards community-based service provision (Dear and Wolch 1987, 96-97; Hartford et al. 2003, 66; Simmons 1990, 39, 96). Despite multiple documents recommending the shift, however, PPHs remained the primary locus of care (Hartford et al. 2003, 66). Simmons described Ontario's mental health system as a slanted tripod: it had three legs, PPHs, psychiatric wards, and community care. However, PPHs and psychiatric wards received far more funding than community services, which were an afterthought (Simmons 1990, 256).

As deinstitutionalization supplanted medicalization as the dominant way of thinking about governing mental abnormality, community-based service provision became a central programme focus. Academics have identified a variety of factors that propelled this shift. Simmons, for example, attributes the transfer of patients into the community to four factors: financial pressure, anti-psychiatry sentiments, citizen rights discourses, and an "almost inexorable decline in psychiatric authority" (Simmons 1990, 235-236). Scull argues that there had been a push towards deinstitutionalization since the 1860s, but it remained marginal until structural forces in the 1970s "allowed governments to save money while simultaneously giving their policy a humanitarian gloss" (1984, 139). Morrow borrows from Lesage to attribute deinstitutionalization to "a number of interconnected forces including developments in psychopharmacology, new psychosocial rehabilitation practices, studies about the negative impact of institutional life, concern about the civil rights of people with mental illness, and cost-containment" ([Lesage 2000] in Morrow 2004, 42). Each of these factors undoubtedly played a role in the decision to release mass numbers of patients into the community. In the end, however, it was a deinstitutionalization mentality that finally translated these factors into action. Specifically, the mentally ill were released into the community because they were no longer perceived as a threat. This solution also was responsive to consumer/survivor demands. It was thought that TCAMA could assimilate into society, which from a humanitarian perspective, seemed to be in their best interests.

3.3 From Hospitals to Homelessness

Over four decades, thousands of patients were discharged from PPHs and psychiatric hospital wards. Some psychiatric hospitals were permanently closed, including Lakeshore in 1979, formerly the Mimico Branch Asylum (Lakeshore Grounds Interpretive Centre 2017). Others were transformed into smaller mental healthcare centres, such as the former London PPH, which became the Regional Mental Health Care Centre in 2001, and permanently closed in 2014 (Sher 2014). Between the 1960s and 1976, Ontario's total PPH bed capacity dropped by two thirds (Dear and Wolch 1987, 97). There was also a gradual decline in the number of beds available in psychiatric wards, from 219 per 100,000 people in Ontario in 1965, to 81 per 100,000 in 1980 (Hartford et al. 2003, 67). This trend continued into the 1990s and 2000s. In 1992 there were 58 beds per 100,000, and in 2003, only 30 (Hartford et al. 2003, 70).

Deinstitutionalization was cast as a progressive approach to the governance of mental abnormality. Unfortunately, however, this "solution" to the crises in medicalization also created a plethora of new problems. Scull argued, at the time, that it was "built on a foundation of sand" because “the contention that treatment in the community [was] more effective than institutionalization [was] an empty one” (1984, 1). Ultimately, a key component of deinstitutionalization was the transfer of services into the community. However, this transfer did not take place. Very little of the PPH operating budgets were invested into community services. As Dear and Wolch explain “When Lakeshore Psychiatric Hospital was closed, only $1.15 million of its $13 million annual operating budget was transferred directly to community health care in the area” (1987, 108). Thousands of patients were emptied onto the streets without the appropriate supports. As Simmons explains,

> Ill-prepared, entered into from generous, or sometimes cynical motives, deinstitutionalization led to the release of thousands of ex-psychiatric patients from provincial institutions. Protected by laws which limited the ability of authorities to commit them involuntarily to a mental hospital, many mentally ill people wandered the streets dressed in rags, living in doorways and barely able to fend for themselves (1990, 256).

Ill-equipped to cope with the mass release of patients, communities struggled to reintegrate them, and for those who did not end up homeless or in prisons, care work was downloaded onto women caregivers: “The movement to deinstitutionalize people with mental illness has led to a myriad of reintegration issues that include increased stresses on community-based organizations and increased voluntary care-giving labour, often provided by female family members” (Morrow 2004, 43).

Discharged patients were “isolated from communities of support,” and relegated to “psychiatric ghettos” made up of boarding homes (Nelson 2012, 234). Many were placed in privately operated, “poor quality and unregulated housing” (Hartford et al. 2003, 67). Down the road from 999 Queen Street West, the neighbourhood of South Parkdale, Toronto, contained over 80 boarding houses (Dear and Wolch 1987, 108). In 1982, most discharged patients received a welfare allowance of $258/month, which after paying the cost of room and board, left them with $28/month for clothes, personal items, and transportation. As Dear and Wolch state, “In such abject poverty, medication is frequently sold, prostitution flourishes and morale is low” (Dear and Wolch 1987, 109). This fueled the criminalization of mental illness. Chaimowitz observes that as PPHs and wards emptied out, prisons lacking sufficient mental health services quickly filled up with mentally ill inmates (2012, 3). Deinstitutionalization may have offered an alternative to PPHs, but it was certainly not a more humane one.

4. Conclusion

Medicalization and deinstitutionalization mentalities informed very different, and competing, programmes and technologies. Medicalization informed treatment programmes, which suggested that mental abnormality was an illness, and that like any other illness, it could be cured with medical technologies. Medical technologies included invasive, and sometimes non-consensual psychosurgeries, such as lobotomy. In the end, psychiatry gave up on this pursuit and conceded that mental illness could not be cured, but with technologies such as psychopharmaceuticals, could be managed. This crisis in medicalization made room for a new approach. Deinstitutionalization, fueled by consumer/survivor activism, overcrowding, and financial pressure, advanced release programmes, which suggested that patients were better off in the community where their symptoms could be managed with technologies such as psychopharmaceuticals and outpatient services. However, thousands of patients were released from PPHs before these services were put into place. Indeed, these services have yet to be put in place.

Deinstitutionalization failed. Starting from the 1960s, it resulted in the mass release of patients into communities that had little to offer them. Hence, from the late 1980s to the early

2000s, there was a crisis in a deinstitutionalization mentality. A flurry of reports offered multiple recommendations towards finally establishing a community-based service system, with the ultimate goal of completing the deinstitutionalization process: the *Graham Report* (1987), the *Epp Report* (1988), *Putting People First* (1993), and *Making It Happen* (1999). By the 2000s, Canada's entire mental health system was in a state of disrepair. It was at this point in time that the SSCSST and LAO committee began their work. The next chapter analyzes the testimonies collected during their investigations.

CHAPTER 5: COMPETING DISCOURSES SURROUNDING MENTAL HEALTH REFORM IN TWENTY-FIRST CENTURY CANADA

1. Introduction

This chapter conducts a Foucauldian discourse analysis of competing mental health reform discourses at the provincial (Ontario) and federal levels, between 2003 and 2010. These competing discourses were reflected in the testimonies collected during two separate investigations: first, at the federal level, the Standing Senate Committee on Social Affairs, Science and Technology's (SSCSST) investigation into "mental health and mental illness," which took place between February 2003 and May 2006; and, second, at the provincial level, the Legislative Assembly of Ontario's (LAO) Select Committee on Mental Health and Addiction's investigation, which took place between March 2009 and May 2010. A major component of both investigations was the collection of testimonies from individuals who, in different ways, were involved with Ontario and Canada's mental health systems. This experience uniquely enabled these individuals to offer their perspectives on what they perceived to be problems with, and solutions to, an inadequate mental health system.

The SSCSST and LAO investigations opened a space for rival voices and knowledges at a time when a deinstitutionalization mentality was in crisis. As Neil Bradford explains, commissions are undertaken at crisis points in Canadian policy to reach a consensus on future approaches (2008, 12). The purpose of the SSCSST and LAO investigations was to collect the opinions of those with first-hand knowledge of Canada's mental health system, and to inform new approaches. However, the opinions collected were diverse, informed by different knowledges and sites of expertise. Effectively, the hearings opened a space for multiple and competing discourses, each seeking to shape Canada's future mental health policy directions.

In this chapter I situate those who testified within seven distinct groups: psychiatrists; medical service providers (outside of psychiatry); community service providers; government; Indigenous representatives; anti-psychiatry activists; and, personal testimonies. I included psychiatrists from universities, hospitals, and private practices. I separated psychiatrists out as a distinct group from other medical service providers because historically, they have been authorized as experts in mental abnormality. However, as discussed in previous chapters, this influence has waxed and waned. Government representatives came from various departments and ministries at the federal, provincial, and municipal levels, ranging from Health Canada's Population and Public Health division, to the City of Toronto's Shelter, Support and Housing Administration. Government representatives could be further divided into two subgroups: those from areas such as corrections and housing working with populations who already succumbed to mental illness, and those focused on promotion initiatives directed at the general population. Medical service providers included psychologists, nurses, physicians, and hospital administrators. I included psychologists and counsellors within this group because even though they do not exist within a traditional medical model, they are authorized as professionally certified mental health practitioners. Community service providers refers to those offering medical and/or social services to TCAMA. This group was diverse, ranging from crisis centres to advocacy organizations. Unlike psychiatrists and medical service providers, community service providers did not claim medical expertise but instead, focused on the social determinants of mental health. Indigenous representatives included those speaking directly to the unique mental health concerns of Indigenous peoples and communities. In this group I included representatives from different First Nations, Inuit, and Métis bands and organizations, as well as larger organizations that spoke to the collective needs of Indigenous communities, such as the Native

Mental Health Association. Anti-psychiatry activists focused on the rights of TCAMA, and included original members of consumer/survivor activist groups from the 1980s, as well as those in the present protesting ongoing abuses, ranging from the effects of deinstitutionalization to forced treatment. Finally, those offering personal testimonies included service users and/or their family members. This group conveyed their experiences with existing programs. Some members of this group gave their first names only, whereas others' first and last names were provided. In this analysis I refer to individuals using the names they provided to the SSCSST and LAO committees at their discretion, whether partial or full.

This chapter begins by outlining the events and context leading up to the SSCSST and LAO commissions. At the federal level, the SSCSST investigation was motivated by the findings of a previous SSCSST report on health care. At the provincial level, the LAO investigation was sparked by a private member's bill. In the next two sections, I conduct a discourse analysis of the problems and solutions identified by the seven groups described above. I analyze the hearings using the following three questions:

1. What language was used to categorize mental abnormality?
2. Why was mental abnormality considered a problem?
3. Who, and with what solutions and knowledges, did the testimonies authorize?

I organize these testimonies around key themes to pull out their competing discourses and solutions. The competing problems identified by different voices within these groups included a lack of mental health services, a lack of community services, a limited focus on treatment instead of prevention, the prioritization of physical over mental illness in healthcare and society, disproportionate levels of mental illness, addictions and suicide in Indigenous communities, and rights violations. The competing solutions identified by voices from within these seven groups included an integrated mental health system, prevention and promotion programmes, recovery programmes, and self-determination.

2. Background

The SSCSST and LAO commissions picked up where the deinstitutionalization discussed in the last chapter left off – the early 2000s, in the face of the many failures of this approach. The SSCSST investigation was inspired by a previous investigation it had undertaken between February 2000 and October 2002, on the "state of the health care system in Canada" (2003, No. 9, 1). Throughout its previous investigation, the SSCSST observed "a handful of health care issues that [they] felt […] clearly needed greater in-depth study" (SSCSST 2003, No. 9, 1). One of these issues was identified as "mental illness and mental health," which they found to be "a peripheral issue" in their earlier study, and "an orphan child of the health care system" (2003, No. 9, 1). In February 2003, the SSCSST officially received its mandate from the Senate, "to study the state of mental health services and addiction treatment in Canada and to examine the role of the Federal government in this area" (SSCSST 2004, 1).

The SSCSST defined its approach as "broad," examining many different areas of mental health, mental illness, and addiction in Canada, including the prevalence of disorders, their economic impact, policy approaches at different levels of government, research and surveillance, and service delivery (SSCSST 2004, 1). A major component of its investigation was the input of in-person testimonies from those with firsthand experience of Canada's mental health system, collected during hearings at various cities across the country. The majority of testimonies were from witnesses who were either invited by the committee to appear before them or who, after learning of the committee's mandate, reached out to share their stories. Public sessions also provided the opportunity for walk-ons – those from the general public who could view a session, and following the testimonies given by pre-arranged speakers, step forward to share their stories.

Prior to publishing its final Kirby Report, the SSCSST released its findings in four interim reports: the first, released November 2004, was entitled *Overview of Policies and Programs in Canada*; the second, released November 2004, was an examination of *Mental Health Policies and Programs in Selected Countries*; the third, released November 2004, was *Issues and Options for Canada*; and, the fourth, released October 2005, was *a Proposal to Establish a Canadian Mental Health Commission*. At the end of the SSCSST's mandate, these interim reports were compiled as a final document, popularly referred to as the Kirby Report (2006).

The LAO voted unanimously for the creation of the non-partisan Select Committee on Mental Health and Addictions on February 24, 2009 (LAO 2010, 23). This followed the reading of a Private Member's motion by MLA Christine Elliott on December 4, 2008, for the creation of a Select Committee that would be mandated "to develop a comprehensive Ontario mental health and addictions strategy" (LAO 2010, 24). In the motion, Elliott proposed the following issues as the committee's focus:

> The urgent need for a comprehensive mental health strategy in Ontario to work in cooperation with the Mental Health Commission of Canada and to coordinate the delivery of mental health programs and services in Ontario;
>
> The lack of coordination in Ontario for the delivery of mental health programs and services across many provincial ministries;
>
> The mental health issues of children;
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> The increase in suicide among young people;
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> The mental health and/or addiction problems of homeless people;
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> The mental health needs of residents of long term care facilities;

> The lack of access to even basic health services for aboriginal Canadians in many parts of Ontario; and
>
> The issues facing courts and police across Ontario in dealing with increasing numbers of alleged offenders with significant mental health and/or addiction problems (LAO, 4 December 2008, 1st Session, 39th Parliament, 5 and 6).

Between April 2009 and May 2010, the LAO Select Committee held public hearings in several cities across Ontario. In the first round of hearings, the Committee heard from government organizations involved "in the delivery of mental health and addictions services," and from "invited guests," including Senator Michael Kirby, then Chair of the MHCC and former Chair of the SSCSST's own investigation into Canada's mental health system (LAO 2010, 25). In the next round of hearings, the Committee received testimonies from health and social service providers, community organizations, individuals with personal testimonies, and their family members. The Committee also met with the Minister of Health and Long-Term Care (MOHLTC), as well as the Minister's Advisory Group on Mental Health and Addictions (LAO 2010, 25). In total, the LAO Committee heard from over 230 organizations and individuals over 30 days of hearings (LAO 2010, 25). In addition, the Committee conducted site visits to facilities for the treatment of mental illness and addiction, such as the Centre for Addiction and Mental Health (CAMH), the former site of Toronto's 999 Queen Street West. The Committee also visited the following First Nations communities "to discuss their mental health and addictions issues": Alderville First Nation, Curve Lake First Nation, Hiawatha First Nation, Oneida Nation of the Thames, Sandy Lake First Nation, and Six Nations of the Grand River (LAO 2010, 26). Based on its findings, the Committee tabled an interim report in March 2010, and released its final report in August 2010.

3. Problems

3.1 Lack of Mental Health Services

Psychiatrists, medical service providers, and those offering personal testimonies problematized the lack of mental health services in Canada. Both psychiatrists and medical service providers attributed this inadequacy to a disorganized mental health service system, underfunding, and a shortage of professionals. While medical service providers and individuals seeking care identified a shortage in multiple types of mental health professionals, psychiatrists focused almost exclusively on a lack of psychiatric services. This contrast reflected an underlying contest between the psychiatric profession and multiple sites of authority in the system.

The lack of mental health services was central to the accounts offered by psychiatrists, medical service providers, and personal testimony. They argued that it was hard to access mental health services in the first place. Psychiatrist Dr. Pierre Lalonde stated that “We have quality of care. The problem is accessibility” (2003, No. 14, 105). Murray, whose son had been diagnosed with schizophrenia and later killed by a bus in an attempt to run away from the Royal Ottawa Hospital, testified that “Invariably, when things really went wrong it was because we could not access the health care system in a timely fashion for reasons of lack of beds, emphasis on community treatment, a missed opportunity for him to go in voluntarily, or shortage of staff and insecure facilities” (2003, No. 9, 15). Similarly, Richard Casey said that “in a sense we have a blanket or a patchwork quilt for a twin bed but the country is the size of the king-size-plus, and it is stretched to the limit” (2005, No. 5, 156). Susan Kilbride-Roper “[spoke] about the need for more readily available psychotherapy” (2005, No. 15, 12). Roy Muise explained that “in Halifax, there is a waiting list of 500 people considered non-urgent for appointments at our psychiatric hospital. That means 500 people know they need help and cannot get it” (2005, No. 15, 17).

Notably, these testimonies reflected a desire for, and faith in, mental health services. The problem was not that mental health services were ineffective, but rather, that they could not be accessed in the first place.

Psychiatrists and medical service providers attributed the lack of mental health services to a disorganized system, underfunding, and a shortage of professionals. Psychiatrist Dr. Mimi Israël testified that “The current system of mental health care delivery is poorly organized, inconsistent and inefficient. The result is decreased accessibility to appropriate care, with the expected potentially preventable consequences […]” (2003, No. 14, 69). Many psychiatrists used the word “silos” to describe the mental health system as a series of isolated, fragmented services that do not speak to each other (2003, No. 14, 69). Similarly, medical service provider Dr. Albert Schumacher, past President of the Canadian Medical Association, testified that accessibility “is the number one concern of patients and their families” (2005, No. 13, 25).

The problem of accessibility was tied to underfunding. Dr. Schumacher continued that, “it must be recognized that it is not only an issue of accessibility but also one of availability. Many important mental health and addiction services cannot be accessed by patients because the services are simply not available” (2005, No. 13, 25). Psychiatrist Dr. Patrick J. McGrath explained that “we recently had a very large increase in the health budget in this province [Nova Scotia]: $212 million, $220 million, and less than 1 per cent of that went to mental health” (2005, No. 15, 197). Another psychiatrist, Dr. Rayudu Koka, pointed out “that the minister stated somewhere in the document that we can do it without any further increase of resources. I don’t know how we can do it. We are already lean meat projects in the mental health system, at least in my place” (2009, MH-16, MH-440). Patty Rout, Vice-President of the Ontario Public Service Employees Union – many members of which provide mental health services – shared this concern, stating that “The main issue is sufficient funding for each public sector caring for those people with mental illness or an addiction” (2009, MH-27, MH-669). Dr. Paul Garfinkel, President and CEO of the Centre for Addiction and Mental Health (CAMH) testified that “Within Canada, Ontario’s spending for mental health trails the national average: On total per capita spending across the provinces, we are ninth. Clearly, we’re confronted in this country and this province with an enormous gap between the size of the problem and the health care response” (2009, MH-9, MH-107).

Unlike psychiatrists, medical service providers drew attention to the financial barriers that kept many from accessing psychological and counselling services in particular. Dr. Robert McIlwraith, a professor in psychology at the University of Manitoba, testified that “The mental health system – squeezed as it is – seems to be abandoning the idea that treatment includes therapy” (2003, No. 16, 53-54). The problem with this approach, he continued, is that when psychological and counselling services are not publicly funded, those in need must pay for them out of pocket. Many do not have the resources to do so. He explained that

> There has been much spirited discussion about the dangers of Canada falling into a two-tier health care system. Such a system already exists, unfortunately, in quite an extreme form in the case of access to psychological services. Psychologists’ services are not covered under medicare, as insured services, in any province. If people have the money or private insurance coverage, they have access to high quality psychological services, often within days or weeks. If they are dependent upon the public health care system, however, they will encounter long waits for the available psychological services in hospital out-patient departments or services based in schools, if they can even find them embedded in those institutions (2003, No. 16, 54).

Dr. Diane Sacks, past President of the Canadian Pediatric Society, echoed this concern, stating that “We have to recognize that many of the experts and known successful treatments are currently available only to those who can pay” (2005, No. 13, 23). Marie Adèle Davis, Executive Director of the Canadian Pediatric Society, explained that “Cost […] becomes a huge barrier for families without insurance to get access to timely care" (2009, MH-15, MH-339-40). Psychiatrists concentrated on the lack of psychiatric services, whereas medical service providers broadened this to include other sites, including psychology. This reflects an underlying competition between psychiatric and multiple sites of authority.

Psychiatrists and medical service providers linked system disorganization and underfunding to a shortage of mental health service providers. However, the grounds upon which they problematized the shortage were informed by competing logics. Psychiatrists were concerned with a shortage of psychiatrists in particular, whereas medical service providers were concerned with a general shortage of mental health service professionals. Psychiatrist Dr. Pierre Lalonde highlighted "a shortage of psychiatrists" (2003, No. 14, 2003), and Psychiatrist Dr. Cameron Stevenson testified that "Physicians throughout this city continually remind me that they cannot get psychiatric assistance" (2009, MH-13, MH-247-48). In contrast, medical service providers drew attention to a broader shortage of mental health service providers:

> Mental health and illness depend upon integrated and interdisciplinary care from a variety of health care providers. The shortage of family physicians, specialists, nurses, psychologists and other professionals in the public health system impacts our ability to deliver the care and the services (2005, No. 13, 25-26).

Psychiatrists and medical service providers problematized underfunding and the shortage of mental health service providers on different grounds. For medical service providers, underfunding and a shortage of professionals resulted in decreased access to mental health services at all levels of the health care system, ranging from nurses to counsellors. In contrast, psychiatrists problematized a lack of psychiatric services in particular, carving out a hyper-specialized role for themselves. For example, psychiatrists suggested that the problem with a disorganized mental health system was that cases that could be dealt with by less specialized providers were ending up in their caseloads. Dr. Mimi Israël testified that "The existing model is sustained by a lack of continuity between primary and specialized services," and that "The result is ultra-rapid referral to psychiatry, thereby taxing scarce resources and decreasing accessibility to all […]" (2003, No. 14, 70). Dr. James Farquhar stated "that the doctor has to be a case manager and handle every little thing, which creates the illusion that we need many psychiatrists, who are highly paid compared to case managers, about three or four times as much" (2003, No. 14, 73). Dr. Pierre Lalonde testified that "Skills must be put to good use. Of course, psychiatrists have done all kinds of things, including tasks that could be delegated, but as there is no one else to do them, they have to do them" (2003, No. 14, 89). Dr. Blake Woodside echoed this concern, stating that "Psychiatrists are sufficiently short in number in this country that we mainly see very ill people; we do not have the time to see the worried well" (2004, No. 5, 17). The logic guiding these testimonies was that because psychiatrists were a specialized and precious resource, their services must be reserved for complex cases.

3.2 Lack of Community Services and Supports

Community service providers, government justice and housing departments, and anti-psychiatry activists problematized the lack of community services and supports. This lack was attributed to the broken promise of deinstitutionalization to implement sufficient community services, and insufficient funding. They also suggested that Canada's mental health system did not pay enough attention to the social determinants of mental health, and therefore, that the funding of community services and supports was not prioritized by the government. Community service providers and government justice and housing departments discussed intersections of homelessness and criminalization with insufficient community supports. The logic informing these discourses was that mental illness had social, not just medical, causes. This logic competed with the problematization of the lack of medical services by psychiatrists, medical service providers, and those offering personal testimonies explored above, who attributed mental illness to physical causes.

Community service providers and anti-psychiatry activists linked inadequate funding to the legacies of deinstitutionalization programmes. Phil Upshall, President of the Mood Disorder Society of Canada, testified that

> With de-institutionalization, the great mantra was that we would close these thousands and thousands of provincial psychiatric hospital beds and move people into a continuum of care that is community-centred. It was a beautiful philosophy, one that I do not think anyone around this table would disagree with. However, the reality is that thousands of hospital beds were closed and the provinces diverted the money, I suspect deliberately, to more well-advocated activities (2004, No. 9, 12).

For Upshall, the problem was not a deinstitutionalization mentality itself, or the idea of community care. Rather, the problem was one of programme implementation. Deinstitutionalization, as it was originally envisioned, did not happen. Likewise, Terry McCullum, of Loft Community Services, explained that “For over 20 years, the province [Ontario] has been committed to switching from an institutionalized-based kind of funding for mental health and addictions to a community-based. […] Everyone says the community is the answer, right? Hey, people need services in their local community, person-to-person and on their streets, and yet the funding doesn’t support that” (2009, MH-14, MH-288).

Because social supports were not put in place prior to deinstitutionalization, communities were ill-equipped to provide for TCAMA. This resulted in an ongoing funding problem for community service providers. John Gray, President-Elect of the Schizophrenia Society of Canada, stated that “The biggest barriers to NGOs in terms of providing these services is the lack of resources, which are used for developmental costs and training costs, and also the lack of awareness of some clinicians and providers of their programs” (2004, No. 9, 6). Similarly, Nancy

Beck, Director of Connections Clubhouse, stated that “The mental health budget is eroding. We do not have the resources to overcome the challenges before us, whether they relate to service or infrastructure” (2005, No. 15, 75). For community service providers, the community could provide the services needed by TCAMA, the problem was that they did not have the funding to do so.

Some community service providers testified that the shortage of funding resulted in competition amongst themselves. Nancy Beck, Director of Connections Clubhouse, explained that “there is fierce competition among small community organizations and they are fighting against each other for very few dollars. That political scene does not allow them to work together closely because there are just not enough funds to do it” (2005, No. 15, 85). Lorne Zon, CEO of CMHA Ontario, stated that “there are major inequities in the funding of community mental health services across the LHINs [Local Health Integration Networks], a difference of more than 600% in some cases” (2009, MH-8, MH-79). Competition between service providers, they argued, prevented cooperation across various community organizations that could otherwise have collaborated in the delivery of community services.

Anti-psychiatry activists also linked the lack of community services and supports to inadequate funding. This group critiqued the deinstitutionalization process on the grounds that it left them with few social supports. It forced ex-patients to live in substandard conditions. Diana Capponi, activist and founder of the Ontario Council of Alternative Businesses (OCAB), explained that “There has been a complete lack of attention to the social determinants of health as they relate to people with mental health or addiction issues” (2005, No. 5, 18). Eugène LeBlanc, publisher and editor of *Our Voice/Notre Voix*, testified that “I am as sure as I am sitting here that many of the people out there who are diagnosed are just bored to death; they live in excruciating poverty, they are homeless, and we do not bother to treat that" (2005, No. 15, 257). Pat Capponi, author and long-time activist in Toronto, explained that "Few of the dollars saved from the closure of beds followed them into the community" (2004, No. 7, 47). For Pat Capponi, the lack of social supports not only infringed upon ex-patients' rights, but having been institutionalized for so long, many ex-patients were uninformed about their rights in the first place. She stated that, "They were broken, hugely vulnerable, unaware of their rights or obligations, often illiterate with no job skills, no friends and few remaining contacts with families" (2004, No. 7, 47). Because they were discharged without social supports, institutionalization continued outside of the hospital. Pat Capponi explained that "We saw as the older patients faded away, newly labelled men and women from the same social strata took their places and quickly learned many of the same lessons of the powerlessness and defeat. Institutionalization was continuing in the community, defined by the lack of care and indifference to our plight" (2004, No. 7, 47). She explained further that ex-patients did not feel miserable because of mental illness, but because they were living in poverty: "We realized we were miserable because we were thigh-deep in miserable circumstances" (2004, No. 7, 48). Likewise, Vahe Kehyayan, with the Psychiatric Patient Advocate Office, stated that "living in poverty, joblessness, homelessness, substandard housing and the absence of equitable access to resources and opportunities […] can directly and negatively impact physical and mental health" (2009, MH-14, MH-331). The logic underlying these testimonies was that mental illness was a social, not physical, problem.

Community service providers and government justice and housing departments drew connections between homelessness, and inadequate community services and supports. They pointed to a cyclical relationship between the two: mental illness led to homelessness, but homelessness, in turn, exacerbated mental illness. Paul Quinn, Director of the Gerstein Centre, explained that “About 30 per cent of the people who call us are homeless and housing is an issue. A large number are in substandard housing, and financial issues and a variety of other things are causing them to go into crisis” (2005, No. 5, 147). Nancy Beck stated that “Opportunities for housing, employment, and education supports are too rare” (2005, No. 15, 75). Michelle Gold, Senior Director of Policy and Programs with CMHA Ontario, articulated “that there are just not enough employment support programs, period” (2009, MH-8, MH-82). Finally, Michael Creek, with the Gerstein Centre, testified that “These opportunities and chances for people are too far between – people just don’t get those opportunities” (2009, MH-5, MH-35). Government housing departments echoed these concerns. Bill Cameron, Director General of the National Secretariat on Homelessness, with Human Resources and Skills Development Canada, explained that “Approximately 30 to 35 per cent of homeless people in general have a mental illness, and that approximately 20 to 25 per cent of homeless people suffer from concurrent disorders, meaning a combination of severe mental illness and addictions” (2004, No. 7, 60). Cameron further explained that homelessness and mental illness reinforced each other, stating that “We know that mental health problems can lead to homelessness, but they can also result from homelessness, given the traumatic impact of being destitute and living on the street” (2004, No. 7, 61). Phil Brown, with the City of Toronto’s Shelter, Support and Housing Administration, pointed to the increased prevalence of mental illness and addictions amongst homeless people, referencing a survey that “revealed this: 33% of long-term shelter users have a diagnosed mental illness; 35% have an alcohol addiction, and 50% have an addiction to other drugs; 18% have a diagnosed concurrent disorder; and a mere 17% were identified as able to maintain a home of their own without some level of support” (2009, MH-22, MH-586). These testimonies suggested that homelessness, and mental illness and addiction, were mutually reinforcing, and therefore that mental illness was exacerbated by social causes.

Community service providers and government justice departments also discussed the relationship between mental illness and criminalization. Community service providers testified that ex-inmates were not provided with sufficient mental health community supports upon release, and that often, the justice system was treated as an access point to mental health services by those with mental illness. Paula Osmok, Executive Director of the John Howard Society of Ontario, testified that “the rates of mental health concerns and addiction within prison populations are disproportionately high […]” (2010, MH-3, MH-36). She added that upon release, “When behaviour that has often led to incarceration isn’t adequately managed in the community, the road back to prison is the one they likely follow” (2010, MH-3, MH-36). Susan Davis, with the Gerstein Centre, explained that “it is certainly not an access point that is positive for people, whether or not it’s effective, which, many times, it isn’t. But on top of that, there is the added stigma, and even just a criminal record that can come with that, when there should have been an access point that didn’t involve any of that” (2009, MH-5, MH-37). Liisa Leskowski, Executive Director of the John Howard Society of Thunder Bay, lamented that “As a society I think we’ve failed, and I think as systems we’ve failed if someone with a mental illness ends up incarcerated” (2010, MH-3, MH-37). She added that “We are funded to address the criminal behaviours, but we often find ourselves scrambling to deliver the human and social services which address the underlying causes, sometimes, of a person’s involvement with the law” (2010, MH-3, MH-37).

Government justice departments testified to high levels of mental illness and addiction amongst offender populations. This pointed to another legacy of deinstitutionalization – the criminalization and reinstitutionalization of TCAMA into corrections facilities. Government justice departments testified that there are high rates of mental illness and addiction amongst offender populations. Larry Motiuk, Director General of Research with Correctional Service of Canada, stated that "the majority of our offender population have significant issues with substance abuse and addiction," and that "there is also a lifetime prevalence rate of mental disorder in about 84 per cent of our population, which is more than twice that of the general population" (2004, No. 7, 52). Witnesses explained that this higher prevalence rate is further compounded by corrections systems' lack of capacity to meet the needs of this population. Hence, even though those with mental illness were treating the justice system as an access point for mental health services, as testified to by community service providers, this access point did not necessarily result in sufficient services. Françoise Bouchard, Director General of Health Services with Corrections Canada, explained that "We do have some capacity issues. While our five treatment centres are directed to provide specialized intensive care, they are lacking capacity in respect of resources" (2004, No. 7, 54). Bouchard also expressed concern that "We do not have the staffing ratio we would like to achieve, and which is needed to manage those cases" (2004, No. 7, 54). The high prevalence of mental illness and addiction amongst the offender population was therefore compounded by inadequate services within corrections facilities.

Community service providers, government justice and housing departments, and anti-psychiatry activists discussed the lack of community services and supports. The logic informing these discourses was that mental illness was a social, not medical, problem. This logic competed with the lack of medical services, spoken to by psychiatrists, medical service providers, and those with personal testimonies, who viewed mental illness as a physical problem. Community service providers and anti-psychiatry activists linked the lack of community services to the legacies of deinstitutionalization, which resulted in an ongoing lack of funding being funneled into the community. Community service providers and government housing departments demonstrated a mutually reinforcing relationship between mental illness and homelessness. Community service providers testified to the relationship between mental illness and criminalization, where some treated the justice system as an access point for mental health services. Government justice departments identified disproportionate levels of mental illness and addiction amongst the offender population, which was further compounded by the lack of mental health services within corrections facilities.

3.3 Lack of Prevention

Medical service providers and government health representatives argued that Canada's mental health system was too reactive and did not pay enough attention to prevention. Medical service providers testified that there was a lack of intervention in the early presentation of symptoms, which would prevent further deterioration. Government health departments suggested that the mental health system is too focused on mental illness, as opposed to mental health, which could prevent mental illness in the first place. This was indicative of the broader struggle for resources within medicine, between advocates of acute care and advocates of preventative medicine. However, it also signaled the reemergence of prevention discourses similar to those that surrounded mental hygiene programmes in the early twentieth century.

Medical service providers drew attention to the lack of intervention in early signs of mental illness, especially in children. In response to the Senate Committee's interim reports, Dr. Diane Sacks of the Canadian Pediatric Society testified that

> The greatest omission in the work that I see is that it fails to stress the reality that most of the mental health disorders affecting Canadians today begin in childhood and

> adolescence. Failure to recognize this fact leads us to dealing with a stage-four cancer, often with major secondary effects, instead of a stage-one or stage-two disease (2005, No. 13, 21-22).

She continued to explain,

> […] that failure to address problems of mental health disorders at the beginning, before years of isolation, failure and social dysfunction, leads to self-medication with drugs and alcohol, bullying behaviours, low self-esteem, other antisocial behaviour and, all too often, unfortunately, suicide (2005, No. 13, 24).

Concern over early intervention was also expressed by Dr. Beth Mitchell, from London Health Sciences Centre, who stated that "It's very difficult, I think, in a system that's geared to look after people who have already been diagnosed and have already developed problems, sometimes of a long-term nature, to think about it in the same way we think about health promotion: think about early intervention, look for early signs" (2009, MH-11, MH-165). Notably, these testimonies did not frame mental illness as something that could be prevented in its entirety, but rather, as something that could be intervened upon to prevent further deterioration.

Government health departments problematized the lack of focus on prevention in mental health policy discussions. For them, however, the problem was a lack of focus on mental health rather than mental illness. Tom Lips, Senior Adviser with Population and Public Health, Health Canada, stated that

> Because the pain and burden of mental illness is so great, most public and policy discussions that are normally about mental health actually focus on the treatment of mental illness. It may be difficult to retain a positive understanding of mental health as the ultimate goal of all services, programs and policies in this area. Mental illness undermines mental health, but mental health is more than simply the absence of mental illness. It is a fundamental resource of all human beings and an essential component of all health (2003, No. 11, 7).

Lips further defined "poor mental health" as "the inability to recognize, understand and cope with stress, emotions and personal needs or boundaries," all of which can manifest "in hopelessness, anxiety, school failure, lack of self-care, excessive risk-taking, lack of productivity, family breakdown, substance abuse, antisocial behaviour and, in the extreme, self-injury, suicide and violence" (2003, No. 11, 68). Similarly, Elvy Robichaud, New Brunswick's Minister of Health and Wellness, stressed the need to "do more at the national level in terms of education and promoting healthy mental hygiene" (2005, No. 15, 234). These testimonies reflected a broader shift in focus, away from the chronic mental illness of the few, and towards the good mental health of all.

Both medical service providers and government health departments discussed the lack of emphasis on prevention. Medical service providers suggested that mental illnesses could have been prevented from worsening if caught early. This is similar to 19th century superintendents' claims that the potential for curability was directly related to the timing of admissions. However, medical service providers did not claim that a complete cure was possible, an idea informed by the failure of medicalization programmes to cure mental illness throughout the early to mid-twentieth century. Government health departments agreed that mental health policy discussions lacked focus on prevention. However, they linked this to a broader lack of focus on mental health as opposed to mental illness. Ultimately, medical service providers talked about prevention in regards to the individual body, whereas government health departments talked about it in relation to the general population.

3.4 Stigma and Discrimination

Those offering personal testimonies emphasized stigma and discrimination against those with mental illness. Richard Casey testified that "I have come to realize first-hand through our daughter's illness and certainly through her death that the stigma is profound" (2005, No. 5, 156). Graham Cushing talked about the impact of stigma and discrimination on employment, suggesting that "The real reason that people may not want to hire is stigma and discrimination" (2005, No. 5, 158). Helen Forristall testified that "There are severe consequences to admitting that you are mentally ill" (2005, No. 22, 62).

Those offering personal testimonies attributed stigma to the prioritization of physical over mental illnesses. Murray stated that "Canadians who are directly affected by the disease are immeasurably impacted by the failure of the health system to put them on at least an equal footing with other patients" (2003, No. 9, 17). Sheila Hayes Wallace stated that "Faced with this knowledge of my difficulties, how dare anyone question the validity of a respectful response to my accommodation needs? Well, I do not have an X-ray to wave about or scars to display" (2005, No. 15, 21). David asserted that "There is no difference between someone who has a mental illness and someone who has a physical illness" (2003, No. 9, 37). Alistair Deighton said "I broke my brain. If you break a leg, you get a cast. I broke my brain, you have to get medication" (2010, MH-3, MH-48). Helen Forristall even stated that "I would do anything to have breast cancer over mental illness. I would do anything because I do not have to put up with the stigma" (2005, No. 22, 63). Stigma was problematized because it was a barrier, limiting employment opportunities, as well as access to mental health services. The logic underlying these testimonies was that mental illness was an illness like any other, and therefore, that those with mental illness were, and deserved to be treated, the same as everybody else.

3.5 Colonization

Indigenous representatives indicated that Indigenous communities experienced higher rates of mental illness, addiction, and suicide than the general Canadian population. Witnesses attributed this phenomenon to the ongoing effects of colonization, and in particular, to residential schools and community relocation. Brenda M. Restoule, Psychologist and Ontario Board Representative with the Native Mental Health Association of Canada, stated “It is my opinion that the significant cultural loss of Aboriginal people, which may be linked to the residential school experience, has been a contributing factor to the poor mental health status of Aboriginal people, which seems to be widespread in our communities across this country” (2004, No. 9, 47). Dr. Cornelia Wieman, a Psychiatrist with Six Nations Mental Health Services, stated that “there is an inextricable link back to the historical experiences of Aboriginal people in this country that include colonization, residential schools and racism” (2004, No. 9, 52-53). Chief Ron Evans of Norway House Cree Nation, with the Assembly of Manitoba Chiefs, said

> Today, we ask you to consider the connection between mental illness and addiction that our peoples experience and the dramatic upheaval in our lives due to the imposition of new ways and laws by newcomers, including the imposition of the crown. This devastating effect [has been] most directly felt since the late 19th century through successive Indian Acts that control all aspects of our lives from the cradle to the grave and through residential schools. These two weapons tore apart our families, denied us their love and nurturing, and undermined our traditional livelihood and any inroads our entrepreneurs made in the newer economies (2005, No. 16, 73-74).

This passage identified mental illness, addiction, and suicide as effects of the structural violence of settler colonialism and racism.

Chief Norman Bone, Chief of Keeseekoowenin First Nation with the Assembly of Manitoba Chiefs, also drew attention to the impact of colonization on mental health, stating that “In 100 years we have had all kinds of things happen to us, aside from the strategy here, the residential schools, the children’s aid society system, how it did not serve us very well in the early part of the last century” (2005, No. 16, 78). Chief Shawn Atleo, Chief A-in-chut, B.C. Regional Chief with the Assembly of First Nations, stated that “We are encountering a modern phenomenon that has to do with the legacy of the residential schools” (2005, No. 27, 12). Jennifer Dickson, Executive Director of Pauktuutit Inuit Women’s Association explained that

> However, lest we become complacent, let us remember that past and ongoing societal transition, including forced settlement, relocation and residential schooling, have placed social and economic conditions in many remote communities in the Arctic at the extremes of many of Statistics Canada's indicators. They include the highest rates of unemployment, the lowest income, the highest cost of living, the worst housing conditions, the highest rates of communicable diseases and the shortest life expectancy of all Canadians (2005, No. 27, 25-26).

Lori Sterling, Ontario's Deputy Minister of Aboriginal Affairs, testified that "you can't leave the question of current challenges without for a second mentioning the residential school experience" (2009, MH-6, MH-49). And, Deborah Chansonneuve, Research and Development Consultant with Minwaashin Lodge Aboriginal Women's Support Centre, stated that "No other population group in Canada's history has endured such a deliberate, comprehensive and prolonged assault on the family and on their human rights" (2009, MH-15, MH-379).

Additionally, witnesses explained that it is not just colonization programmes that negatively impact the mental well-being of Indigenous people, but also their effects on the socio-economic conditions of some communities. Hence, like community service providers and anti-psychiatry activists, Indigenous representatives attributed mental illness and addiction to social, not physical, causes. Brenda Restoule explained that

> Social conditions in First Nation communities complicate our mental health status. Statistics identify that First Nation people often live below the poverty line. The economic depravity in First Nation communities is highlighted by the high unemployment rates, low-income levels, and significant financial hardships experienced by many individuals and families. Poor housing conditions are also evident. Aboriginal people report overcrowding, substandard housing, poor sewage, and lack of running water as common complaints of the daily stressors they must face (2004, No. 9, 48).

Similarly, Dr. Valérie Gideon, Director of Health and Social Development with Assembly of First Nations, stated that "Some mental health experts have diagnosed First Nations as suffering from low-grade levels of post-traumatic stress disorder as a result of living in poverty and despair" (2005, No.23, 82). Jules Picard, Social Services Coordinator with First Nations of

Quebec and Labrador Health and Social Services Commission, stated that "Social conditions within these communities are deteriorating in a way that can only be described as extremely alarming" (2005, No. 23, 92).

Many witnesses pointed to an alarmingly high rate of suicide within some Indigenous communities, especially amongst Indigenous children and youth. Jason Whitford, Coordinator with the Assembly of Manitoba Chiefs' Youth Council, stated "that of the close to 300 people we have met with and talked to about suicide prevention, probably 95 per cent had suicide directly impact their family or close friend" (2005, No. 16, 57). Dr. Gideon testified that "this past March, an eight-year-old boy from the Gods Lake First Nation in Manitoba committed suicide by hanging himself, and his eleven-year-old brother had committed suicide 3 years earlier. I am sure you would agree with me that children this young should not know what suicide is, let alone contemplate it" (2005, No. 23, 82). Chief Atleo also expressed concerns over the prevalence of suicide in some Indigenous communities, explaining that "I will turn 39 years old soon, and I must be honest and say that I did not expect to make it to this age. […] Of the kids I used to go fishing with, and play with on the beaches of my village, most are gone. Tragically, most have died through suicides and other forms of violent deaths" (2005, No. 27, 10).

Indigenous representatives linked alarmingly high rates of mental illness, addiction, and suicide to the effects of colonization, and especially to the impacts of programmes such as forced relocation and the residential school system. The logic underlying their testimonies was that mental illness, addiction, and suicide were the result of previous interventions by the state into Indigenous ways of life. Like community service providers and anti-psychiatry activists, Indigenous representatives looked at mental illness as a social problem with social causes. This conflicted with the idea that mental illness was a physical illness with physical causes, as suggested by psychiatrists, medical service providers, and those offering personal testimonies.

3.6 Rights Violations

Anti-psychiatry activists drew attention to the past and ongoing rights violations of TCAMA. This reflected an ongoing engagement with the rights and citizenship discourses that shaped the consumer/survivor movement in the mid to late-twentieth century. Pat Capponi, author and long-time activist in Toronto, explained that "Our civil rights are affected as laws are passed to 'protect society' from the mentally ill" (2004, No. 7, 49). Diana Capponi, survivor and founder of the Ontario Council of Alternative Businesses (OCAB), stated that "Full citizenship rights are enshrined in our nation's Charter of Rights and Freedoms. However, many of those rights that others take for granted are not afforded to us" (2005, No. 5, 17). These testimonies suggested that although patients were deinstitutionalized and returned to the community, that they were still located outside of full political membership.

Anti-psychiatry activists were especially concerned with psychiatric treatments. They suggested that even though they were physically discharged from hospitals during deinstitutionalization, that their institutionalization continued through out-patient treatments, sometimes involuntarily. Pat Capponi testified that "we have assertive community treatment teams, ACT teams that primarily ensure that the client takes the medication" (2004, No. 7, 49). She further explained that

> […] funding has increasingly gone to keep discharged patients in chemical straitjackets for the comfort of the mainstream community. If the client is depressed and upset that his life is so narrowly constricted, if he is fearful of an abusive landlord, if poverty leaves him hungry and restless, his medication is increased. If he has the remaining life inside his body to be angry, the dosages will ensure that anger is forgotten (2004, No. 7, 49).

Eugène LeBlanc stated that "Clients of mental health services are also concerned about the true side effects of ECT and over-medication by psychiatrists. I have people in their twenties taking over 15 pills per day" (2005, No. 15, 246). Don Weitz argued that electroconvulsive therapy (ECT), formerly known as shock treatment, "has caused a virtual epidemic of brain damage, including permanent memory loss […]" (2005, No. 6, 139) as well as "the effect of psychological trauma" (2009, MH-19, MH-520). Anti-psychiatry activists argued that psychiatric treatments were used in the place of social supports. For example, Pat Capponi explained that "The only resources we have in any abundance yet again are expensive psychiatrists, occupational therapists, nurses, and social workers who are reduced to delivering pills and needles, organizing 'outings' and maintaining the client in the community" (2004, No. 7, 49).

The logic underlying anti-psychiatry activist discourses was that even though patients had been deinstitutionalized, their social segregation was continuing in the community through other means. They suggested that even though they were physically free, they were not given the same rights as other members of society. Furthermore, they argued that their social segregation continued through psychiatric treatments, sometimes involuntarily, on an out-patient basis. These testimonies deployed the same rights and citizenship discourses that informed the consumer/survivor movement in the mid to late-twentieth century. Their problematization of medical services conflicted with the problematization of the lack thereof by psychiatrists, medical service providers, and those offering personal testimonies.

4. Solutions

4.1 An Integrated System of Mental Health Services

Psychiatrists and medical service providers suggested that an integrated system of mental health and community services would solve the lack of mental health services. An integrated system would involve cooperation between psychiatrists and other service providers so that those with mental illness could access services at several points throughout the healthcare system and in the community. Even though psychiatrists and medical service providers recommended the same solution, however, their logics differed. Specifically, psychiatrists suggested that system integration would filter out mild cases of mental illness that could be treated by other service providers, funneling the more specialized cases onto them. This logic situated psychiatrists, and psychiatric knowledges, at the hub of an integrated system. In contrast, medical service providers authorized multiple sites of authority, and did not indicate that more specialized cases should be funneled to psychiatrists. These different logics reflected an underlying debate between psychiatric and multiple sites of authority.

Psychiatrists and medical service providers scrutinized a disorganized, underfunded mental health service system. In response, they recommended that available services be reorganized into an integrated system. Not only would an integrated system increase access to services, but it would also maximize efficiency despite sufficient funding. Psychiatrist Dr. Mimi Israël suggested that "A potential solution would be to create a circular flow model for mental health care delivery, a system whereby primary and specialized services would collaborate to provide a continuum of care and where the flow of information and expertise between sectors would be optimized" (2003, No. 14, 70). Similarly, Dr. James Farquhar suggested that "If somebody has a psychiatric consultation and there could be some mechanism whereby the person can authorize another doctor or health professional to see the text of that, it might reduce a lot of waste in the system" (2003, No. 14, 89). Dr. Rayudu Koka stated that "Also, I think that integration and collaboration are the most important things in this day and age. We have to collaborate, co-operate and work together with different programs and primary care" (2009, MH-16, MH-440).

Notably, psychiatrists did not limit their recommendations to medical services, but also included community services. Dr. Ellen Lipman stated that "we need to consider moving services into the community," because "that would allow you to use multiple types of personnel to deliver services and allow those services perhaps to be more seamless than they can be in these medical silos or education versus medicine silos" (2005, No. 14, 56). Dr. Herbert Orlik explained that "In a multi-systemic approach you would look at aspects of the system. You would look at the school, the community services, at community-based facilities, at parenting skills, at the child learning temper management, temper control, and things of that kind. Put it together into a package and away you go. Those are effective therapies" (2005, No. 15, 210). These testimonies discursively produced a division between specialized and primary or community care, and therefore, between psychiatrists and other service providers. As a precious resource, psychiatrists suggested that their services would be used more efficiently if they were reserved for specialized cases that were untreatable by other service providers. Their knowledges would be best utilized if disseminated to medical and community service providers. These testimonies reasserted psychiatric authority as the hub of the mental health system.

Like psychiatrists, medical service providers recommended the reorganization of mental health services into an integrated system. Margaret Synyshyn, President of the Registered Psychiatric Nurses of Canada, argued that mental health services should be embedded "as a component in a primary health care model for service delivery," one principle of which is "intersectoral collaboration – having all services necessary for a reasonable quality of life available, not supporting the traditional stovepipe models that serve to fragment and compartmentalize services […]" (2003, No. 16, 58). Marie Adèle Davis, Executive Director of the Canadian Pediatric Society, suggested that "It's important that mental health care is delivered in a multidisciplinary team atmosphere. It's no one health professional who's going to be able to totally support a family" (2009, MH-15, MH-340). Maggie Gibson, a psychologist with St. Joseph's Health Care, argued that

> […] there is an urgent need for a concerted effort by the psychology community and other professions with a stake in mental health for the elderly, to strategize with partners in governments, universities, colleges and other training programs, professional regulatory bodies, advocacy groups and members of the lay public to figure out how we will meet the present and emerging mental health needs in the aging segment of the population (2003, No. 17, 15).

Margaret Flower, a Clinical Counsellor with CAMH, suggested that "There needs to be training that combines the models for mental health and substance misuse, to remove them from the silos" (2005, No. 20, 24).

Medical service providers, in agreement with psychiatrists, argued that community services should be included into an integrated mental health service system. Dr. Beth Mitchell, from London Health Sciences Centre, explained that "We're looking to partner more strongly with community agencies. We have a number of pilot projects with the Canadian Mental Health Association [CMHA] in London, as well as others, to look at how we partner and provide services through them or with them so that it doesn't mean a trip to the hospital always; there are other ways of providing those kinds of services" (2009, MH-11, MH-166). Senator Cordy asked Dr. Diane Sacks, "As a teacher within the school system, very often you felt that you were outside the loop. How do we engage the school system to help these children?" (2005, No. 13, 38) The doctor replied

> What we need is coordination. We need to include teachers because, as far as I am concerned, they are the vital ones, not parents. First of all, they spend more time with the child than the parents, and interaction is when kids' illnesses often are displayed.

> Therefore, it is more likely that illness in children and adolescents will be picked up in the school society. We need to teach the teachers how to identify that this child needs some screening. It could be put on a report card (2005, No. 13, 38-39).

These testimonies introduced new sites of authority into the treatment of mental illness, especially the teacher as a member of the diagnostic team.

Psychiatrists and medical service providers agreed that the solution to a disorganized, underfunded mental health service system was its reorganization into an integrated system. They also agreed that this network should include community services. However, their recommendations were informed by competing logics. Whereas medical service providers authorized multiple sites of authority and knowledges, psychiatrists carved out a specialized role for themselves at the hub of an integrated system. Both groups agreed that community services should be integrated alongside medical services in a seamless system. However, medical service providers carved out new sites of authority in the community, such as the teacher, whereas psychiatrists framed community services as one more spoke connected to the hub of their expertise.

4.2 Prevention and Promotion

Medical service providers and government health representatives argued that there should be a greater focus on mental illness prevention in Canada’s mental health system. This was a response to their earlier concerns that many cases of mental illness could have been prevented in the first place, or at least prevented from further deteriorating. Prevention programmes would decrease the number of cases of chronic mental illness, thereby decreasing the strain on an underfunded mental health service system. Although both groups argued in favour of prevention, however, they recommended different programmes. Medical service providers recommended early intervention in individual cases via mental health treatments, with the goal of preventing mental illness, or at least diminishing it. In contrast, government health representatives recommended the promotion of good mental health principles to the entire population, with the goal of preventing mental illness. Whereas medical service providers focused their discussions on mental illness, government health representatives focused on mental health.

Medical service providers argued that mental illness could be prevented, or limited, by intervening in individual cases at the first presentation of symptoms. Dr. Paul Garfinkel, President and CEO of CAMH, argued that "Early recognition is important; identification of emerging problems is important […]" (2009, MH-9, MH-108). Margaret Synyshyn explained that "We know that many physical illnesses are preventable or more easily treated if identified early. This is also true in the areas of mental health and mental illness" (2003, No. 16, 57-58). Synyshyn went on to explain that "It is most effective – from both a human perspective and a financial perspective – for individuals and families to access services before their symptoms interfere with the quality of their family life, their social life, educational preparation or employment" (2003, No. 16, 58).

Most medical service providers focused their discussions about early intervention on children and youth. For example, Dr. Diane Sacks suggested that

> Recognizing that the majority of adolescent mental health disorders – depression, anxiety, ADD, LD – being scientifically genetic in origin, begin in our young and do not go away, it is vital to take the next step. We should target youth identification and treatment. Child and adolescent disease should be understood as the precursor of adult disorders, and not stand alone as an orphan. It should in fact be a priority (2005, No. 13, 22).

However, a minority of medical service providers discussed intervention in old age. Speaking specifically to seniors' mental health, Psychologist Venera Bruto stated that "The early detection and prevention message is an important one to get out there to both clinicians and the population" (2003, No. 17, 26). Bruto explained that intervention should be directed towards the improvement of quality of life, since some mental illnesses in seniors – such as dementia – are not preventable: "Every time that we work with a patient, our goals must make sense within the context of improving quality of life, not merely fixing it. We can fix some things and by all means, we should. However, for some things, we need to adapt and look at different ways of improving quality of life" (2003, No. 17, 41). This suggests that while it may not be possible to prevent mental illnesses in an aging population, it is important to provide as enjoyable a life as possible.

Government health representatives recommended that mental health policies and services be directed at the promotion of good mental health in the general population. Unlike medical service providers, they spoke about mental health, as opposed to mental illness. They identified mental health as a component of overall physical health, rather than its own area of specialization. Tom Lips, Senior Advisor with Population and Public Health, Health Canada, argued that "Because physical health and mental health are interdependent, promoting mental health contributes to physical health and vice versa. We believe that an integrated approach to both physical and mental health is appropriate" (2003, No. 11, 6). Here, Lips defined mental health promotion as

> […] the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Promoting mental health at the population level includes providing information, resources and opportunities that help people to establish a positive self-image and a sense of autonomy; to improve their ability to offer and receive mutual support; to understand, express and cope with their emotions; to develop skills for parenting, partnering and problem solving; to recognize and deal with stress and its effects; to recognize the symptoms of mental disorders; to seek informal or formal health, when appropriate; and to overcome prejudices, stigma and discrimination about mental illnesses, as well as other differences (2003, No. 11, 10).

Similarly, Elvy Robichaud, New Brunswick's Minister of Health and Wellness, stated that he was "favourable to health promotion and education" (2005, No. 15, 235). When asked by Senator Pépin to clarify whether he was referring to mental health promotion, or to overall health promotion, Robichaud replied "For health in general," to which Senator Pépin asserted, "Yes, but there should be a little something for mental health" (2005, No. 15, 235). In response to this, Robichaud reinforced that "Yes, but mental health is part of an individual's general state of health" (2005, No. 15, 235). After Senator Pépin once again asserted that "it should be specified," Robichaud clarified that "Yes, but I do not like to compartmentalize one or the other health problem […] When we have a campaign to promote and develop community strategies for the population's health, not only will it affect our hospital system in general, but also the quality of life of our people in New Brunswick" (2005, No. 15, 235). These testimonies suggested that mental health was a component of overall physical health, and not its own area of specialization. In other words, this group did not think about the mind and brain as a unique area of specialization, but rather, as components of general health. This idea negated a specialized role for psychiatry.

Government health representatives also identified personal resilience as an important component of prevention and promotion. Tom Lips explained,

> Research indicates that there is a continual and often powerful interaction between physical and mental health. Personal resiliency, optimism, a sense of social support, a sense of autonomy or mastery, a positive self-image, and even basic happiness contribute significantly to health promoting behaviours, to resistance to illness, to help seeking, to the perceived severity of symptoms, the speed of recovery and the degree of excess disability from an injury or illness (2003, No. 11, 8).

This testimony suggested that mental health could not be understood outside of physical health, and that like physical health, it could be strengthened. Promotion and resilience programmes are not designed to meet the needs of those already in distress. Rather, they are designed to provide the information needed by individuals to develop resiliency skills within themselves. Government health representatives located the mind and brain in the rest of the body, but unlike community service providers and anti-psychiatry activists, did not situate that body within a broader social context. They did not offer a solution to the structural causes of stress, such as unemployment, discrimination, and racism. The solution was to strengthen one's capacity to bounce back from those stressors.

Both medical service providers and government health representatives recommended a shift in focus towards prevention in Canada's mental health system. However, there were differences in the programmes recommended to carry this out. Medical service providers recommended intervention, a programme whereby mental health service providers would intervene at the early presentation of symptoms in individual cases. In contrast, government health representatives recommended promotion, a programme designed to prevent mental illness through the development of personal resilience. These competing recommendations reflected an underlying debate in categorizations of mental abnormality. Medical service providers spoke to mental illness, whereas government health representatives spoke to mental health. Mental illness and mental health differ in two respects: first, mental illness is particular to the mind and brain, whereas mental health is one more component of physical health; second, mental illness opens up space for medical interventions, whereas mental health does not authorize a particular site of expertise. Rather, the latter responsibilizes members of the general population for their ability to bounce back, rather than succumb, to life's stressors.

4.3 Recovery and the Community

Community service providers and those with personal testimonies recommended that there be a greater focus on recovery within Canada's mental health system. However, their notion of recovery differed widely from its medical understanding. For community service providers and those with personal testimonies, recovery was not the curing of mental illness, but rather, the ability to live a normal life despite it. This understanding of recovery was social, not medical. Community service providers argued that with the appropriate services, the community could facilitate recovery. In their vision, the community would offer a series of services and supports from which individuals could pick and choose, depending upon their recovery goals. These testimonies framed the community as a provider of services and supports.

Community service providers and those with personal testimonies defined recovery as the ability to live a normal life despite symptoms. Lorne Zon, CEO of CMHA Ontario, defined recovery as "maximizing the opportunities for each individual experiencing a mental illness to live as full and productive a life as possible," where there were "three cornerstones of recovery: a home, a friend and a job" (2009, MH-8, MH-79). Terry McCullum, with Loft Community Services, identified a "widespread acceptance of recovery thinking, which is broader than a medical model of thinking in mental health" (2009, MH-14, MH-287). Nancy Beck, Director of Connections Clubhouse, stated "I would like the system to focus on recovery and to offer alternative health choices […]" (2005, No. 15, 76). Carole Tooton, Executive Director of the CMHA, Nova Scotia division, expressed "I believe the resilience of individuals has helped them to survive and move on despite the system. There is hope, and if we did not think there was hope, we would not be here. There is recovery" (2005, No. 15, 83). Those with personal testimonies shared this understanding of recovery. Roy Muise explained that recovery was "not necessarily the absence of symptoms, but learning to live with, through and beyond those symptoms and achieving the life that we want" (2005, No. 15, 18). George MacDonald identified key components of recovery, such as "food, shelter, transportation, financial assistance, medicine, various appointments, recreation and grocery runs" (2005, No. 15, 24). Susan Kilbride-Roper observed that

> […] there is getting to be more and more focus on recovery rather than just dealing with mental illness. […] I think we have to look at that, not just treating the illness, but looking beyond the illness to things that will make our lives richer and that will support us other than psychotherapy and medication. We need to focus on recovery and to educate people to see beyond the illness (2005, No. 15, 40).

The notion of recovery put forth by community service providers and those with personal testimonies was individualized and demedicalized. They situated the individual at the centre of one's own recovery journey, a social, rather than medical, process.

Community service providers outlined a special role for the community in recovery discourses, as a provider of services and supports. As such, it was important that community services providers be equipped with sufficient resources, something lacking following deinstitutionalization. Carole Tooton, Executive Director of the CMHA, Nova Scotia Division, suggested "we need to have a variety of resources available to allow individuals to have the opportunities to choose what they need to help them move on in their road to recovery. I do not think we can expect there to be one fix for everybody" (2005, No. 15, 85). Terry McCullum stated that "even though you have mental health and addiction challenges, you can live a successful life in the community with the proper supports and orientation" (2009, MH-14, MH-288). These testimonies were grounded in a social determinants approach. For instance, Carole Tooton stated that "We need to include that people require after care, not just with medication, but also with employment, proper housing and adequate incomes" (2005, No. 15, 82). Paul Quinn, Director of the Gerstein Centre, explained that

> For us in downtown Toronto, one of the things that we really think needs to be focused on is the determinants of health and wellness. I'll just read off what we've done, because

> several people put the work in on this: Investment in the wider social and economic base will contribute to lifelong health and wellness. For example, an increase in income support programs, investment in safe and affordable housing, primary health care, education supports and job creation are critical in an economically sustainable health system and to individual mental health recovery (2009, MH-5, MH-35).

These testimonies demedicalized mental illness. Even though community service providers acknowledged medical treatment as an important support, it was situated alongside social factors such as housing and employment.

Community service providers and those with personal testimonies recommended that Canada's mental health system should be organized around recovery. A system organized around recovery would make available the services and supports necessary for someone with mental illness to live a normal life, despite mental illness. These recommendations stemmed from a social, rather than medical, understanding of mental illness, which competed with medical discourses. It is important to note the way in which community was taken up by these testimonies. The community was framed as a provider of services and supports, which individuals could choose from to support their individual recovery plans. It did not convey solidarity or collectivity.

4.4 Self-Determination

Indigenous representatives, as well as anti-psychiatry activists, identified self-determination as the solution to the concerns they brought before the committees. As discussed above, Indigenous representatives connected the ongoing impacts of colonization to disproportionately high levels of mental illness, addiction, and suicide amongst Indigenous communities. In response, this group identified the recognition of treaty rights and Indigenous approaches to holism as solutions to this problem. Anti-psychiatry activists problematized the legacies of deinstitutionalization on their social determinants, as well as the violation of their rights through ongoing psychiatric treatments. The solutions advanced by this group were peer support and survivor-led employment opportunities. Importantly, both groups identified an important role for community in their self-determination. However, this notion of community differed from the one put forth by community service providers. Indigenous representatives, and anti-psychiatry activists, defined community as a sense of collectivity and solidarity within their groups. In contrast, community service providers spoke of community as a network of services that facilitated individualized recovery plans.

Indigenous representatives articulated that disproportionately high levels of mental illness, addiction, and suicide amongst Indigenous communities could only be addressed by recognizing Indigenous treaty rights and knowledges. This was a rejection of ongoing colonial interventions and knowledges. Chief Ron Evans stated that “We put our treaties front and centre today because that is where we believe the change must come to improve the health of our peoples. The recognition and the affirmation of our treaty rights and inherent rights that the Constitution speaks to must include implementation of our treaty rights and respect for our inherent right to self-determination” (2005, No. 16, 73). He explained further that “These underlying causes of mental illness can only be addressed through acting on our treaty and inherent rights to self-determination and establishing a new relationship with the Crown” (2005, No. 16, 73). Dr. Gideon stated that “health research has demonstrated a clear link between self-determination and cultural continuity and improved health outcomes […]” (2005, No. 23, 84).

Indigenous representatives argued that solutions to mental illness, addiction, and suicide must be grounded in the community. Dr. Kirmayer explained that “We need theories – which, I think, are available within psychiatry and psychology in the form of family therapy, family systems theory, network theory, community psychology – that pay attention to the larger webs of relatedness that people have" (2004, No. 9, 45). Chief Atleo explained that "It would take community-designed and community-driven solutions," and that "The communities need to have their jurisdiction properly recognized" (2005, No. 27, 11). Amanda Meawasige, with the Assembly of Manitoba Chiefs' Youth Council, explained that "all of the work that we engage in starts with the belief that the strengths are found in communities and we have to work with existing resources to further build capacity at that level for them to be self-sustaining" (2005, No. 16, 58). Dr. Gideon explained that "Unless First Nations have a sense of ownership and control over a comprehensive mental wellness program, any new investment or initiative would be working against itself" (2005, No. 23, 84).

Anti-psychiatry activists deployed a similar notion of community, favouring community solidarity and support in lieu of psychiatric treatment. This solidarity developed in the aftermath of deinstitutionalization. Pat Capponi explained, "We began to have role models and leaders. We were achieving, breaking myths and assumptions about who and what we were, and we were forming community" (2004, No. 7, 48). Upon release, the necessary services and supports were not put in place. So, consumers/survivors developed community amongst themselves to give, and receive, support. Sonja Cronkhite, Program Coordinator with Psychiatric Survivors of Ottawa, suggested that "This focus on creating healthy community through genuine and mutual relationships is what makes the practice of peer support different from the other services" (2009, MH-15, MH-375). Pat Capponi argued that consumer/survivor communities need to be supported in their future development, likening them to Indigenous communities. She argued that

> One thing we need is human development such that we would be allowed ways to develop as a community, much like Aboriginal community development, with recognition of the wrong that has been done and an effort by the federal government to

> put that right with seed money for that development within the chronic psychiatric patient community – and not through professional auspices (2004, No. 7, 70).

An important component of community amongst anti-psychiatry activists was the development of their own, survivor-run businesses. Diana Capponi explained that "Alternative businesses are managed and controlled entirely by people with mental health and addiction histories" (2005, No. 5, 17). She pointed out that "The businesses work so well because they are designed to meet the particular needs of groups wanting economic opportunity" (2005, No. 5, 18). Pat Capponi explained that "We have shown that those labelled seriously mentally ill who work within survivor-run businesses require less medication and spend less time in hospital" (2004, No. 7, 49). These testimonies reflected a competing notion of community to that put forth by community service providers. Community was not a provider of services and supports, but a shared identity. For Indigenous representatives, it was a shared way of thinking and being, and a rejection of further colonial interventions. For anti-psychiatry activists, it was solidarity and mutual support.

In addition to community, Indigenous representatives identified Indigenous knowledges and approaches to wellness as a key component of successful mental health solutions. Special attention was given to holism and interconnectedness. Dr. Laurence Kirmayer explained that "In developing a mental health plan, the Assembly of First Nations and the Inuit Tapirisat talk about 'mental wellness' in a broader sense because it goes beyond affliction to include positive aspirations for health" (2004, No. 9, 41). Brenda Restoule, with the Native Mental Health Association of Canada, testified that

> Aboriginal people tend to be concerned about holism – the concept that we find in the medicine wheel where there is interconnectedness between the mental, emotional, physical and spiritual domains. This requires that we look at relationships – be they between social conditions, economic conditions, cultural conditions, and health

> conditions, to relationships between people and within the community and within programs (2004, No. 9, 51).

Indigenous representatives also stressed interconnectedness. Christina Keeper, with the Assembly of Manitoba Chiefs' Suicide Prevention Envisioning Team, explained that "the concepts must address the concepts of our traditional worldview, which affirms the interconnectedness of all life […]" (2005, No. 16, 54). Chief Evans added that "All life is interconnected, and this is the way health services and programs need to be, from prevention, education and treatment to healing to palliative care" (2005, No. 16, 76). It is important to note that holism and interconnectedness differed from the social determinants model put forth by community service providers. Holism and interconnectedness were rooted in Indigenous knowledges and ways of being, whereas a social determinants model was grounded in settler knowledges.

Indigenous representatives carved out a special role for Indigenous youth in community-led solutions. Their testimonies authorized Indigenous youth to create and lead their own mental health strategies. Amanda Meawasige, with the Assembly of Manitoba Chiefs' Youth Council, stressed the importance of "youth leadership development," expressing that "We want to train young people to be helpers to other young people" (2005, No. 16, 59). She explained further that youth leadership "has to do with the revitalization of culture and reclaiming our cultural identities as young people" (2005, No. 16, 59). Deborah Chansonneuve, with Minwaashin Lodge Aboriginal Women's Support Centre, indicated that "Another urgent need is for youth engagement and peer-led prevention services by and for Inuit" (2009, MH-15, MH-380). Onalee Randell, Director of Health of Inuit Tapiriit Kanatami, pointed out that "Youth have clearly indicated that they want to be involved and engaged in the planning and delivery of programs" (2005, No. 27, 15). Likewise, Jennifer Dickson stated that "This is key: Let us follow the Inuit youth" (2005, No. 27, 27). Like medical service providers, Indigenous representatives focused on youth. However, they looked at youth in different ways. For medical service providers, youth were a target for intervention, to prevent the worsening of mental illness via medical treatments. For Indigenous representatives, youth were leaders, not a target for intervention, but authors of their own solutions.

Indigenous representatives and anti-psychiatry activists argued for their self-determination in opposition to, or as a claim to justice in light of, the colonial and psychiatric knowledges and interventions to which they had been subjected. Indigenous representatives located the solution to disproportionately high levels of mental illness, addiction, and suicide in the state recognition of their treaty rights. They expressed that any solution must be community-driven, youth-led, and based on Indigenous knowledges and ways of being, such as holism and interconnectedness. This group carved out a unique role for Indigenous youth, which differed from the emphasis placed on youth by medical service providers. Anti-psychiatry activists emphasized the importance of mutual support and survivor-run businesses, which rejected both psychiatric treatment models and traditional employment opportunities. Both groups stressed the importance of community, which differed greatly from the notion of community put forth by community service providers. The latter group framed community as a provider of services and supports, and its role was to provide those with mental illness with a choice of options to facilitate their individualized recovery journeys. The individual was located at the heart of community service provider notions of community. In contrast, the collectivity was located at the heart of Indigenous and anti-psychiatry activist notions of community.

5. Conclusion

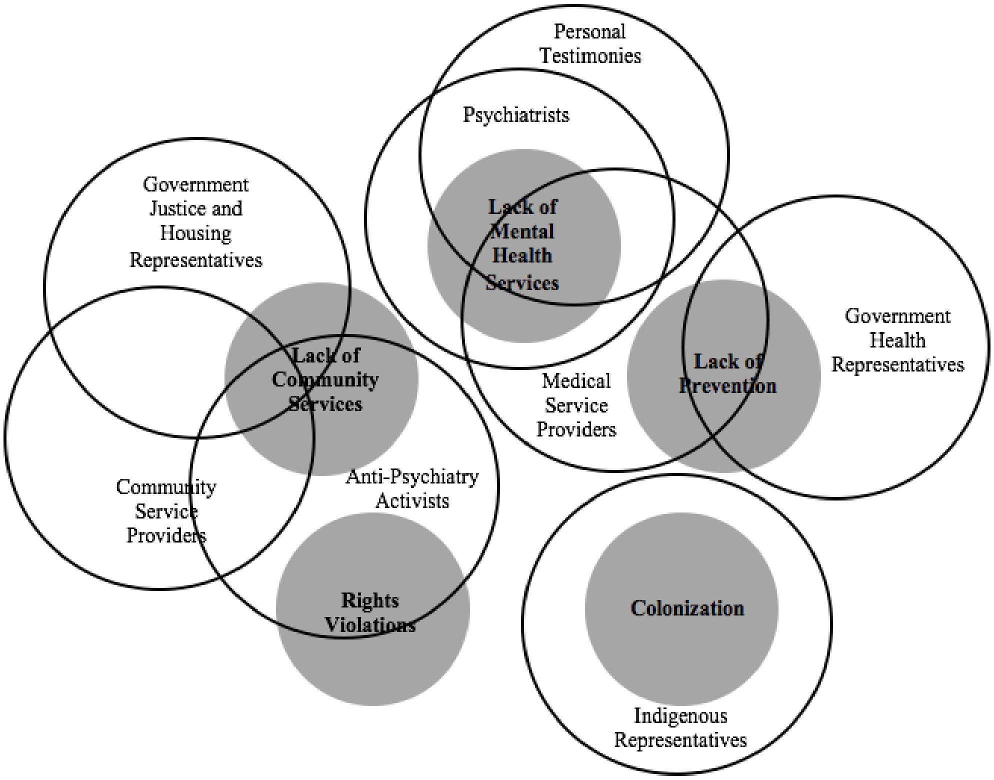
The SSCSST and LAO hearings provided a space for the airing of competing discourses, at a time when governments were planning future mental health policy directions following the failures of deinstitutionalization programmes. This was emblematic of Bradford's claim that governments implement commissions at critical policy junctures to seek consensus on future directions (1998, 12). This chapter analyzed these discourses around three guiding questions:

1. What language was used to categorize mental abnormality?
2. Why was mental abnormality considered a problem?
3. Who, and with what solutions and knowledges, did the testimonies authorize?

I divided witnesses into seven "stakeholder" groups: psychiatrists, medical service providers, community service providers, government, Indigenous representatives, anti-psychiatry activists, and personal testimonies. There were coalitions between groups based on shared discourses. For example, psychiatrists, medical service providers, and those offering personal testimonies categorized mental abnormality as a medical illness, whereas community service providers, Indigenous representatives, and anti-psychiatry activists emphasized its social and political causes. Government health representatives deemphasized mental illness, and introduced mental health, a category that extends beyond the mentally ill few to include the entire population.

Mental abnormality was problematized on various grounds, informed by multiple sites of expertise. Figure 1 maps the problems identified across the seven different groups, and illustrates overlaps between them. The five core problems identified across seven groups of witnesses were: lack of mental health services; lack of community services; lack of prevention; colonization; and, rights violations.

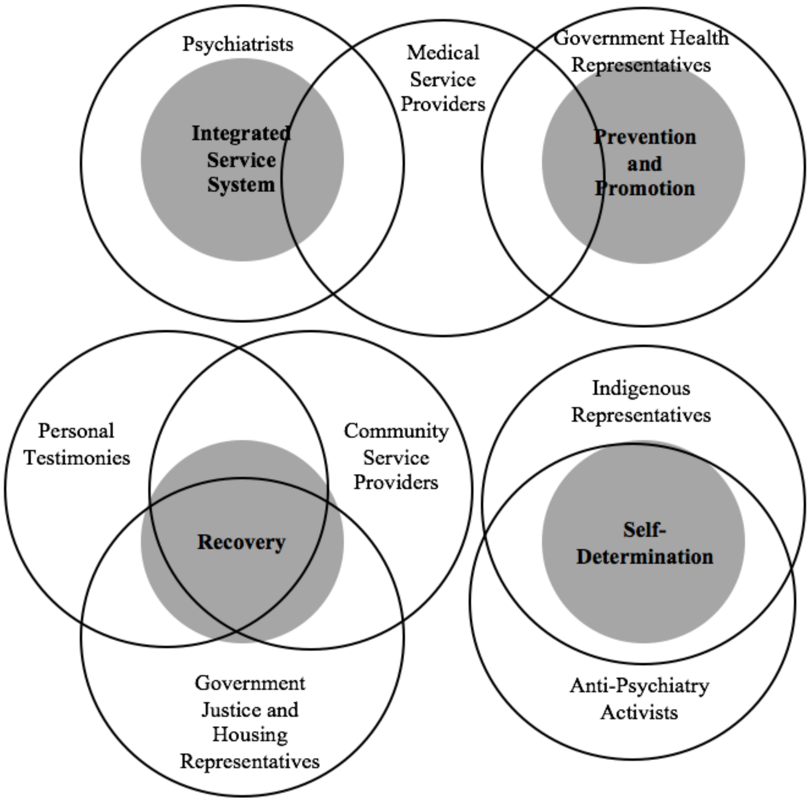
Figure 1: Problems with Canada's Mental Health System, as Identified by Seven Groups



Psychiatrists, medical service providers, and those with personal testimonies problematized the lack of access to mental health services. Psychiatrists and medical service providers linked the lack of access to a disorganized, underfunded mental health system. Community service providers, government justice and housing representatives, and anti-psychiatry activists problematized the lack of community services and supports, which they linked to the legacies of deinstitutionalization. The underfunding of community services was compounded by the lack of importance that Canada's mental health system placed on social, as opposed to medical, determinants. In turn, medical service providers and government health representatives argued that Canada's mental health system does not place enough importance on prevention, as opposed to treatment. Indigenous representatives linked disproportionate levels of mental illness, addiction, and suicide to colonization, and especially to the residential school system, relocation, and cultural loss. Anti-psychiatry activists problematized the legacies of deinstitutionalization and ongoing rights violations, and drew attention to ongoing, and sometimes forced, psychiatric treatments. They suggested that social segregation was still going on outside of hospital walls.

As outlined in the theoretical framework, discourse contains an *ethos*, or an end goal for governance (Barry, Osbourne and Rose 1996, 8). Hence, the competing discourses used to problematize mental abnormality were embedded with an idea of what should be, and therefore, informed competing solutions. Figure 2 maps the recommendations made by the seven groups, including overlap between them. This chapter identified four main solutions cutting across the SSCSST and LAO testimonies: an integrated mental health service system; prevention and promotion; recovery; and, self-determination.

Figure 2: Solutions to Canada's Mental Health System, as Identified by Seven Groups



Psychiatrists and medical service providers argued that the solution to underfunded mental health services was their reorganization into an integrated system. However, psychiatrists put themselves at the hub of that system, whereas medical service providers authorized multiple sites of authority. Medical service providers and government health representatives suggested that a mental health system organized around prevention would reduce the strain on an already overburdened service system. However, medical service providers recommended intervention programmes, with a particular focus on youth, whereas government health representatives recommended promotion models that linked mental to physical health. Community service providers and those with personal testimonies argued that Canada's mental health system should be recovery-oriented, where recovery was presented as the ability to live one's life despite mental illness. This notion of recovery competed with medical definitions, and reflected a fatalistic attitude that mental illness could never be prevented or cured, but at best, managed. Their testimonies carved out a special role for community, as a hub of services and supports within which one can navigate one's individual recovery journey. This competed with the notion of community put forth by Indigenous representatives and anti-psychiatry activists who argued for self-determination. These groups treated community as a shared identity, and as a sense of solidarity, which conflicted with the individualized notion of community contained within recovery discourses. Indigenous representatives maintained that solutions to high rates of Indigenous mental illness, addiction, and suicide must start with the recognition of their treaty rights, and must be community-based, youth-led, and based on Indigenous knowledges. Anti-psychiatry activists argued for greater recognition of consumer/survivor communities and survivor-led businesses.

The SSCSST and LAO commissions brought together multiple actors with diverse perspectives, each seeking to inform future mental health policy directions. The various categories, problems, and solutions identified were grounded in competing logics, for instance, competing sites of authority, competing notions of community, and competing understandings of mental abnormality – medical, social, and political. These debates reflected different mentalities, or ways of thinking about mental abnormality. The next chapter examines four contemporary documents at the provincial and federal levels to map the outcomes of these debates.

CHAPTER 6: DISCOURSE ANALYSIS OF LAO AND SSCSST COMMITTEE REPORTS, AND MINISTRY OF HEALTH AND MHCC STRATEGY DOCUMENTS

1. Introduction

This chapter identifies and analyzes key discourses and recommendations across four public transcripts on mental health reform: the Legislative Assembly of Ontario's (LAO) Select Committee on Mental Health and Addictions' final report, *Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians* (2010); the Ontario Ministry of Health and Long-Term Care's *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* (2011); the Standing Senate Committee on Social Affairs, Science and Technology's (SSCSST) final report, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (also known as the Kirby Report) (2006); and, the Mental Health Commission of Canada's (MHCC) *Changing Directions, Changing Lives: The Mental Health Strategy for Canada* (2012). It analyzes these documents using three guiding questions:

1. What language was used to categorize mental abnormality?
2. Why was mental abnormality considered a problem?
3. Who, and with what solutions and knowledges, were authorized by the documents' recommendations?

These documents followed the LAO and SSCSST consultation processes examined in the previous chapter. This chapter has two goals: first, to compare and contrast key themes in the categorization, problematization, and solutions to mental abnormality across official reports; and, second, to identify which perspectives were included in the final reports, and which were left out. Ultimately, these public transcripts reflected a consensus for future mental health policy directions. Although there are differences across the documents, they reflect broader shifts towards recovery, prevention, and the de-medicalization of mental abnormality.

This chapter is organized into three sections. In the first section, I briefly outline each of the four documents. In the second section, I compare and contrast the documents across nine key discourses, which together constitute the reports' programmatic recommendations, and variously cover the categorization, problematization, and solutions to mental abnormality: mental illness, mental health, and addiction; the (dis)organization of service systems; prevention; stigma; rights; the justice system; colonization; peer support; and, the authorization of personal testimonies. While the documents addressed all of these themes, they emphasized and gave more attention to the disorganization – and reorganization – of service systems, recovery, prevention, and anti-stigma programmes. I link these discourses to the testimonies outlined in Chapter 5. In the third section, I identify issues from the consultation process that the reports deemphasized, or failed to address entirely. These include the role of psychiatry, Indigenous youth leadership, and, anti-psychiatry activism.

2. Introduction to Reports and Strategies

2.1 Navigating the Journey to Wellness: The Comprehensive Mental Health and Addictions Action Plan for Ontarians (2010), LAO Select Committee – Provincial

Navigating the Journey to Wellness was the final report issued by the LAO Select Committee on Mental Health and Addictions following its 18-month investigation into "the mental health and addictions needs of the entire province" (2010, i). The report made 23 recommendations to the LAO, the main recommendation being the creation of a centralized provincial body that would oversee all mental health and addictions services and programmes – Mental Health and

Addictions Ontario (3). The remainder of the recommendations were organized under two headings: 1) "Essential Services and Supports," including a "Core Basket of Coordinated Services," "Treatment," and "Community Services and Supports"; 2) "Justice Issues," including "Courts and Corrections," and "Legislation" (v). Throughout this chapter I refer to this document as the "LAO Report."

2.2 Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy (2011), Ontario Ministry of Health and Long-Term Care – Provincial

Open Minds, Healthy Minds was released by the Ontario Ministry of Health and Long-Term Care in 2011 as a "long-term" strategy geared towards the optimization of mental health for all Ontarians, and integration of services for those experiencing mental illness and addiction. The context surrounding its release was a funding commitment by the Ontario government for community mental health, addictions programs, and children's mental health (2011, 5). The Ontario strategy was designed to work in tandem with the provincial budget commitment to transform the mental health sector (5). It identified as its goal a "plan to support mental health throughout life, from childhood to old age, and to provide the integrated services and supports that Ontarians need if they experience a mental illness or addictions" (5). The strategy was organized around four goals: first, improving mental health; second, creating communities within which TCAMA can thrive; third, early intervention into mental illness and addictions problems; and, fourth, service delivery. The strategy focused the first three years of its commitment on children and youth. Throughout this chapter I refer to this document as the "Ontario Strategy."

2.3 Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada (Kirby Report) (2006), Standing Senate Committee on Social Affairs, Science and Technology – Federal

The Kirby Report was the final report tabled by the SSCSST following its two-year investigation into the state of mental illness and mental health in Canada. The 484-page report was organized into six parts: "The Human Face of Mental Illness and Addiction" documented the lived experiences of TCAMA; "Overview" outlined the report's recovery vision; "Service Organization and Delivery" focused on mental health services; "Research, Ethics and Privacy" discussed the importance of mental health research; "Federal Leadership" outlined the role of the federal government in the reorganization of Canada's mental health system; and, "Strategic Planning and Inter-Governmental Coordination," which presented two key principles for a transformed mental health system: promotion and prevention. In sum, the report identified the shortcomings of Canada's fragmented mental health system, and made 118 recommendations towards its reorganization into a recovery-oriented system "that rests firmly on the three pillars of choice, community and integration" (56). A key recommendation made by the report was the creation of the Mental Health Commission of Canada (MHCC), which it charged with writing a national strategy. Throughout this chapter I refer to this document as the "Kirby Report."

2.4 Changing Directions, Changing Lives: The Mental Health Strategy for Canada (2012), Mental Health Commission of Canada – National

Changing Directions, Changing Lives was a national mental health strategy released by the MHCC in 2012 in partial fulfillment of its mandate by the federal government (2012, 2). The 152-page strategy was organized around six strategic directions: "Promotion and prevention";

“Recovery and rights”; “Access to services”; “Disparities and diversity”; “First Nations, Inuit and Métis”; and, “Leadership and collaboration.” This national report’s recommendations were geared towards the reorganization of existing resources into a recovery and prevention-oriented mental health system. Like the Ontario Strategy, the MHCC strategy centred much of its promotion and prevention programmes on children. It concluded with a “call to action” that encouraged all Canadians to take part in transforming its programme recommendations into practice (124). Throughout this chapter I refer to this document as the “National Strategy.”

3. Key Themes in Mental Health Reform Documents

This section identifies and analyzes key discourses in the categorization, problematization, and solutions to mental abnormality, across the LAO Report, Kirby Report, Ontario Strategy, and National Strategy. These discourses include: mental illness, mental health, and addiction; the (dis)organization of service systems; prevention; stigma; rights; the justice system; colonization; peer support; and, the authorization of personal testimonies. This section compares and contrasts the ways in which the documents engaged with each of these themes. There were subtle differences across the documents, however, all were informed by similar logics. For example, the Ontario documents collapsed addiction and mental illness into one category, whereas the Kirby Report bracketed addiction off as a separate problem meriting its own study. However, in its short section on addiction, the Kirby Report did craft recommendations towards including addiction under the mental health funding envelope, as well as the integration of mental health and addictions service systems. Conversely, the federal documents discussed the impact of colonization on disproportionate levels of mental illness and suicide in Indigenous communities, whereas this issue was deemphasized by the Ontario documents. Despite these differences, the overarching themes that cut across each of the documents were a shift away from mental illness and towards mental health, the need to integrate medical and social services into a recovery-oriented system, and a shift in focus from treatment to prevention.

3.1 Mental Illness, Mental Health, and Addiction

The LAO Report, Ontario Strategy, Kirby Report, and National Strategy shifted focus away from mental illness and towards mental health. This shift extended the target of their recommended programmes from those with mental illness to the broader population. Unlike mental illness, the documents suggested that mental health, much like physical health, was an aspect of everyone's life. Despite this shift, there were subtle differences across the documents. For example, the Kirby Report indicated great difficulty arriving at terms with which to categorize mental abnormality, whereas the National Strategy deployed broad terms, including mental illness and mental health. One of the most striking trends was the likening of mental health to physical health in the Ontario Strategy and National Strategy.

The LAO Report and Ontario Strategy coupled addiction with mental illness and mental health. In its introduction, the LAO Report categorized mental abnormality as "mental health and addictions issues" (1). It referred to "mental health and addictions services" (3). It described those in need as "people with mental illnesses and addictions" (9). Similarly, the Ontario Strategy referred to "people with mental illness or addictions" (4). Unlike the LAO Report, the Ontario Strategy offered a logic behind the coupling of mental illness, mental health, and addiction. It stated that there is a "strong link between mental illness and addictions" even though "mental health and addictions services have traditionally been provided separately" (16).

The Ontario Strategy likened mental illness and addiction to physical illness, arguing that they should be treated together rather than across separate service systems:

> A person with high blood pressure does not go to a series of different providers to address their needs, nor do they change providers based on their age – they go to their family doctor. By the same token, a person with a mental illness and an addiction should not have to go to one program or service provider for their mental health needs and another to help with their addiction (16).

The coupling of addiction with mental illness and mental health provided a rationale for the incorporation of addictions services under mental health services, which would allow the addictions service system to draw from mental health funds.

In contrast to the LAO Report and Ontario Strategy, the Kirby Report bracketed addictions off as a separate problem. However, it did craft recommendations that suggested the future incorporation of mental health and addictions services, reflecting a similar logic to that underlying the provincial documents. The Kirby Report was open about its minimization of addiction:

> The Committee believes it is necessary at the outset to acknowledge something that will become quickly evident to the reader of this report. The Committee has not been able to devote as much attention to substance use issues as it intended when it embarked on its study of “mental health, mental illness and addiction.” This report therefore focuses primarily on mental health issues (37).

The Kirby Report made it clear that its recommendations pertaining to mental illness and mental health were not equally applicable to addictions: “It would clearly not be appropriate for the Committee to assume that conclusions it has reached after carefully considering the mental health evidence necessarily apply with respect to substance use issues” (38). The Kirby Report argued that addiction was a separate problem meriting fuller attention outside of what it could provide: “This report only scratches the surface of many substance use issues that deserve a much fuller treatment” (38). Addictions took up only a short chapter in a large report that prioritized mental illness and mental health. However, the few recommendations that the report did make regarding addictions were informed by a similar logic to that employed in the LAO Report and Ontario Strategy. For example, the Kirby Report recommended “That the Government of Canada include as part of the Mental Health Transition Fund … $50 million per year to be provided to the provinces and territories for outreach, treatment, prevention programs and services to people living with concurrent disorders” (219). Concurrent disorders referred to those with both mental illness and addiction. It further recommended “That the Canadian Mental Health Commission … actively partner with national addiction organizations, and work toward the eventual goal of integration of the addiction and mental health sectors” (225). Unlike the LAO Report and Ontario Strategy, the Kirby Report did not couple mental illness and addiction throughout. However, its brief treatment of addiction reflected a similar logic – that is, that mental illness and addiction are related and collapsible into one broad category.

The Kirby Report reflected difficulty in arriving at terms to categorize mental abnormality. This differed from the other documents, which deployed consistent usage throughout. The Kirby Report variously referred to TCAMA as “people living with mental illness,” “patient/client,” and “people with direct experience of mental illness” (39). It was reflexive about the difficulty experienced in arriving at terms: “How, then, should the report refer to the people most directly affected by mental illnesses and addictions? As the Committee noted in its interim report, there is no single, easy choice” (39). Conversely, the LAO Report and Ontario Strategy consistently referred to TCAMA as “people with mental illnesses and addictions” (LAO 9; OMHLC 4), and the National Strategy consistently referred to TCAMA as having “mental health problems and illnesses” (14). Although the Kirby Report did not display the same consistency in terms as the other documents, all four documents shared a similar logic.

This logic was that mental abnormality was a broad, imprecise category, that included everything from diagnosed mental illness, to addiction, to more minor and unspecified problems. The broadening of this category was significant because it widened the target of mental health programmes from a specified few to a larger segment of the population, disrupting the link between categories, problems, and solutions. The widening of mental health to include the broader population also makes programmatic recommendations more general.

In addition to the broadening of the category mental abnormality, the documents relied on a relatively new concept – mental health, understood as a state of mental well-being. For example, the Ontario Strategy stated that "We will create an Ontario where all people have the opportunity to thrive, enjoying good mental health and well-being throughout their lifetime" (4). It expressed the need to "identify standards and best practices that improve mental health and reduce addictions – and help everyone in the province reach their full potential" (5). It defined mental health as follows:

> Good mental health is a resource for living. It enhances physical health and helps people succeed in school, at work and in their relationships and to contribute to our communities. People who feel good about themselves and their lives are more productive and less likely to take sick days. To improve their mental health, Ontarians must know how to manage stress and enjoy work-life balance. They need constructive ways to deal with negative emotions such as anger, sadness, fear and grief. They also need activities and interests that help them feel more self-confident and form supportive friendships (10).

Similarly, the National Strategy defined "positive mental health" as "feeling well, functioning well, and being resilient in the face of life's challenges" (20). Like the broad definitions used to categorize mental abnormality throughout the reports and strategies, the category mental health broadened the grounds for intervention to include the entire population. The idea that everyone has a degree of mental health made promotion and prevention programmes possible.

The provincial and national strategies likened mental health to physical health. This discourse was deployed by government health departments throughout the hearings. The Ontario Strategy suggested that

> Ontarians do many things to maintain their physical health – like eating healthy foods, staying active, and not smoking. When people do become physically ill, our health system is there to provide treatment and support. It's time to take the same approach to mental health and addictions, from prevention, to identification, to treatment (5).

The discourse used by the National Strategy to discuss mental health was similar to that used in discussions surrounding physical health, such as the optimization of "protective factors," and the minimization of "risk factors" (20). The National Strategy identified physical health as a protective factor for mental health (20). The likening of mental health to physical health in the provincial and national strategies was significant because it suggested that the head was not a separate area of expertise, but rather, was part of the overall body. And, if the head could be treated in the same way as the rest of the body, there was no need for psychiatric expertise. This idea conflicted with the testimonies offered by psychiatrists, who carved out a hyperspecialized role for themselves.

3.2 The (Dis)Organization of Service Systems

The biggest problem identified across the reports and strategies was the disorganization of Canada's mental health system. This was identified as a problem on the grounds that it kept many of those in need from accessing mental health services, which, as the reports also identified, were few and far between due to funding issues. In response to this problem, the documents argued for the integration of mental health services into a coordinated system. This was a recommendation put forward by psychiatrists and medical service providers. A key component of this recommendation was the integration of medical and community services into one system to be located in the community. This system would be person-centred, empowering individuals to choose the services that best fit their needs and recovery plan. Community service providers put this idea forward during the consultation process. The documents framed the community as a marketplace of services, rather than a shared identity or collectivity. The integration of medical and community services into one system reflected a broader shift towards the de-medicalization of mental abnormality.

The documents were especially focused on a disorganized service system, picking up on the testimonies of psychiatrists, medical service providers, community service providers, and those with personal testimonies. The LAO Report stated that

> One of the main problems in Ontario's mental health and addictions system is that there is, in fact, no coherent system. Mental health and addictions services are funded or provided by at least 10 different ministries. Community care is delivered by 440 children's mental health agencies, 330 community mental health agencies, 150 substance abuse treatment agencies, and approximately 50 problem gambling centres. Many people simply fall through the cracks, or give up in frustration because of the complexity of the system (3).

Similarly, the Ontario strategy stated that "One of the biggest challenges is that mental health and addictions services are fragmented, spread across several ministries and offered in a variety of care settings" (6). It attributed this fragmentation to a "silo" approach:

> Mental health and addictions services have historically been delivered separately from other health services, such as family health care, acute care, emergency care and long-term care. This "silo" approach makes it hard for people to navigate the health system and access all the services they need. It can also lead to gaps, unnecessary duplication or the inappropriate use of services (18).

Notably, this passage linked service silos to attempts at broadening mental health services beyond psychiatry, to include multiple sites of authority. The Kirby Report expressed similar problems with disorganization, stating that "The separation between services and supports that are delivered through the health care system and those that fall largely under other spheres of responsibility … points to the fact that many institutional and structural roadblocks stand in the way of realizing a ‘seamless’ delivery of mental health supports and services” (51). Similarly, the National Strategy explained that “fragmented and underfunded mental health systems across the country are far from able to meet the mental health needs of Canadians,” and that “For those needing assistance, the current system can feel like a maze, as it can to the thousands of dedicated people who provide the services, treatments and supports that people need” (52). Each of the documents examined system disorganization as a key problem. System disorganization presented a problem because it kept those in need of services from accessing them. This was a persistent critique offered by psychiatrists and medical service providers throughout the SSCSST and LAO hearings. However, the documents offered more insight into the causes of this fragmentation. As hinted at above in the Ontario Strategy, services were disorganized because historically, mental health services were limited to psychiatric services. Disorganization stemmed from the broadening of mental health services to include other sites of authority, such as the family doctor.

The documents recommended system integration and coordination as a solution to disorganization, a recommendation made by psychiatrists, medical service providers, and community service providers during the hearings. This recommendation suggested that the services were there, but that they needed to be reorganized into a coherent system. The integrated service system recommended by the documents included medical and non-medical services provided across multiple sites of authority. Moreover, the documents located the individual at the centre of this service system, an idea grounded in recovery, which was advanced by community service providers.

The documents identified the need to integrate services into a coherent system. In other words, bureaucrats emphasized a bureaucratic solution, rather than investing more funding into existing systems. The LAO Report recommended the creation of a central bureaucratic structure, Mental Health and Addictions Ontario (MHAO), which would be charged with this reorganization. It stated that "Mental Health and Addictions Ontario should ensure that a basket of core institutional, residential and community services is available in every region of the province for clients of all ages, identify gaps, and eliminate duplication" (7). While the LAO Report addressed the need for medical services, it emphasized community services:

> The Select Committee has premised its choice of essential community services and supports on the frequently used phrase, "a home, a friend and a job." While recreational, social, and cultural activities help to create environments that foster companionship and social support, we feel that housing, peer support, employment, and support for family caregivers are particularly crucial to the creation of a strong basis of community services (10-11).

The Ontario Strategy similarly suggested that medical and non-medical "services should be integrated so people have easy access to the right mix of supports. Better coordination across health and other human services – such as housing, income support, employment and the justice system – will lead to better mental health" (8). The Kirby Report identified the integration of "all types of services and supports across the many levels of government and across both the public/private divide and the professional/non-professional dichotomy" as one of the three main components of a recovery-oriented system (46). Like the provincial documents, it emphasized that mental health services are social as well as medical:

> On the other hand, the variety of mental health treatments and services funded by ministries of health must also be integrated with the broader range of services required by people living with mental illness that are the responsibility of the various governmental departments and agencies that deal with income support, housing, employment, etc. Moreover, it is essential that services and supports for people living with both mental illness and addiction be better integrated (51).

The National Strategy recommended the integration of services into "tiers" based on severity, so that "every door is the right door to meeting people's mental health needs in the least intensive, most appropriate, and cost-effective manner possible" (54). Like the LAO Report, Ontario Strategy, and Kirby Report, the National Strategy emphasized that a reorganized service system should include non-medical services:

> A more integrated mental health system must also be linked to, rather than isolated from, all parts of the community and other service systems. Family doctors, teachers, police personnel, and long-term care workers are among those who should work with each other and with mental health service providers to address people's mental health needs. A more coordinated and integrated system will make available multiple resources to help facilitate recovery: timely access to medications and to adequate and affordable housing; professional counselling, as well as readily available peer support; and help in setting and meeting educational and employment goals (55).

The recommendation that an integrated service system should include non-medical as well as medical services, a solution shared across all four reports, was significant for several reasons. It authorized multiple sites of authority, as opposed to a single psychiatric authority, recognizing that the governance of TCAMA has extended beyond the walls of the asylum. The fusion of medical and non-medical services also demedicalized mental abnormality, suggesting that it had social as well as physical causes. Furthermore, when mental health is applicable to everybody, then all institutions are responsible for its governance.

The integration of services was a key component of recovery, one of the biggest programme recommendations made throughout the documents. A recovery-oriented system was the guiding vision of the Kirby Report's recommendations, and was one of the National Strategy's six strategic directions. The National Strategy defined recovery as follows:

> The concept of recovery is built on the principles of hope, empowerment, self-determination and responsibility. In a recovery-oriented system, people who experience mental health problems and illnesses are treated with dignity and respect. To the greatest extent possible, they control and maintain responsibility for their mental health and well-being, and they make their own choices about which services, treatments and supports may be best for them, informed by the advice of professionals, as well as family and peers (16).

During consultations, community service providers recommended that mental health services be reorganized around recovery. Like community service providers, the National Strategy defined recovery, not as the amelioration of symptoms, but rather, as the ability to live the best life possible despite symptoms. Specifically, the National Strategy defined recovery as "living a satisfying, hopeful, and contributing life, even when there are ongoing limitations caused by mental health problems and illnesses" (15). The Kirby Report was broader in its conceptualization of recovery, suggesting that it could refer both to living life despite symptoms, or the amelioration of those symptoms, but should be defined by the individual undergoing it: "*Recovery* is not the same thing as being cured. For many individuals, it is a way of living a satisfying, hopeful, and productive life even with limitations caused by the illness; for others, recovery means the reduction or complete remission of symptoms related to mental illness" (42, italics in original). However, even when defined as the amelioration of symptoms, the Kirby Report used the descriptors "reduction" and "remission," suggesting that mental abnormality was incurable. The recommendation towards a recovery-oriented system, offered by both the Kirby Report and National Strategy, was significant because it was informed by a fatalistic logic that suggested that mental abnormality was incurable, and therefore, that TCAMA had to make do and live the best life possible despite ongoing problems.

The documents located the individual at the centre of an integrated service system. A person-centred system was important, the documents suggested, because it empowered TCAMA to make their own choices in accordance with their self-determined recovery plans. The idea that TCAMA should be able to exercise choice in services was informed by consumer/survivor activism, which protested involuntary and violent treatments during the hearings. The Ontario Strategy argued that "mental health and addictions services must be centred around the person and better integrated with each other and with other health care services to provide supports that are necessary" (16). Similarly, the Kirby Report recommended a "system that puts people living with mental illness at its centre, with a clear focus on their ability to recover" (37). It further suggested "that the goal of mental health policy should be to enable people to live the most satisfying, hopeful, and productive life consistent with the limitations caused by their illness" (45). The National Strategy likewise explained that

> In a recovery-oriented system, people who experience mental health problems and illnesses are treated with dignity and respect. To the greatest extent possible, they control and maintain responsibility for their mental health and well-being, and they make their own choices about which services, treatments and supports may be best for them, informed by the advice of professionals, as well as family and peers (16).

Because the documents put the individual at the centre of their proposals for service integration, the community was framed as a market of services, as opposed to a shared identity or collectivity, where individual TCAMA could take responsibility for their recovery plans and pick and choose from multiple services.

3.3 Prevention Two Ways

Prevention was another key recommendation offered by the four documents. However, prevention was taken up in two different ways, as intervention and promotion, often within the same document. In fact, the Kirby Report described intervention and promotion as "part of the same set of interventions" (415). The reports and strategies acknowledged that it was not possible to prevent more serious forms of mental illness through promotion, but that these cases could at least be prevented from further deteriorating if intervention occurred early. By receiving mental health services at the first signs of symptoms, TCAMA would reduce their burden on an underfunded mental health system later in life. Similar to the testimonies, the documents focused prevention efforts on children. This was a recommendation made by medical service providers during the LAO and SSCSST hearings. The documents typically discussed prevention in relation to children. For example, the LAO Report suggested that

> Presenters identified prevention, early identification and early intervention as critical components of a more effective and efficient children's mental health system. We concur and firmly believe that these are essential components at all stages of an individual's life. We acknowledge that there are assessment and screening tools in use but feel that provincially-applied, evidence-based, age-appropriate assessment and screening tools are necessary to ensure consistency (8).

Similarly, the Ontario Strategy explained that "Acting early – at the first signs of mental illness or problematic substance use and gambling – can have a profound effect. It can help prevent addictions from taking over, and for those with a mental illness, it can shorten the journey to recovery" (8). Like the LAO Report, the Ontario Strategy also focused its prevention discourses on children, stating that it was "particularly important for children and youth as symptoms of mental illness often first occur during childhood and adolescence" (8). The Kirby Report emphasized that "The importance of early intervention cannot be overstated. When symptoms of distress or illness first appear in a child or young person, regardless of age, family caregivers, health professionals and educators should intervene immediately" (136). The National Strategy similarly explained that the majority of adults with mental illness first started experiencing symptoms in childhood, and that by intervening in symptoms at a young age, it was possible to reduce the burden placed on mental health services later in life (24).

The second usage of prevention was promotion. This idea was emphasized by government health departments during the hearings. The idea of promotion suggested that good mental health, including personal resiliency, could prevent mental illness later in life. The Ontario Strategy suggested that "Ontarians are happier, more resilient and more likely to succeed in school, work and life when they are able to cope with stress and manage the ups and downs in life. Programs will be available for all ages to help Ontarians develop the skills they need early in life to improve their mental well-being and to lead healthier lives" (7). The Kirby Report explained that

> Mental health promotion focuses on the foundations of good mental health. Broadly speaking, it emphasizes positive mental health, as opposed to mental illness. It addresses the determinants of mental health – the many personal, social, economic and environmental factors that are thought to contribute to mental health, and to the overall health and well-being of the population. Such factors include healthy childhood development, income and social status, and education (411).

Similarly, the National Strategy suggested that although "it is not possible to know in advance which individuals will experience the symptoms of a mental health problem or illness," that "we can enhance factors that are known to help protect people" (20). It identified such "protective factors" as "having a sense of belonging, enjoying good relationships and good physical health, feeling in control of one's life, and possessing good problem-solving skills" (20). The documents treated intervention and promotion as complementary programmes. For example, the National Strategy explained that:

> The goal of promoting mental health and preventing mental illness is straightforward: to increase the number of people who enjoy good mental health and reduce, to the greatest extent possible, the number of people whose mental health is poor, who experience the symptoms of mental health problems or illnesses, or who die by suicide (20).

Functioning as complementary programmes, promotion would decrease the likelihood of developing mental illness in the first place, but if unsuccessful, intervention would catch early signs of mental illness before they became acute.

The idea of prevention simultaneously opened up new sites of authority while denying specialized sites for mental illness. Intervention introduced a role for the primary physician and teacher to identify and diagnose mental abnormality at its first signs. For example, the LAO Report recommended that "Mental Health and Addictions Ontario should ensure that primary care providers and relevant staff in all levels of the education and long-term care systems have access to common, age-appropriate, evidence-based assessment and screening tools" (8). The Ontario Strategy explained that

> Many people who experience a mental health or addictions problem will turn first to their family doctor. Family health providers must be able to identify people at risk (e.g., people with chronic diseases, people who have recently experienced a loss, people being treated for pain), screen patients, help them manage their own care, find ways to engage and support their families, and monitor their health over time (14).

Similarly, it recommended that schools be equipped with "mental health resources" because "For children and youth, the first signs that they are struggling with mental health issues may be at school – in the form of changes in behavior, an inability to focus, or a drop in their marks" (14). The Kirby Report indicated that "There was agreement also regarding the importance of teachers having the training necessary to recognize better mental health issues in their students and to help them find effective treatment, rather than, as now, referring students to already overburdened emergency rooms or relegating them to long waiting lists" (138). These recommendations carved out new sites of authority for the primary physician and teacher as members of diagnostic teams and providers of services. The idea that primary care providers and teachers should play a role in identification and mental health service delivery was borrowed from psychiatrists' and medical service providers' testimonies. Unlike psychiatrists' testimonies, however, the recommendations presented by the reports and strategies did not authorize psychiatry at the hub of these services. Rather, it authorized multiple sites of authority.

Promotion discourses authorized teachers and employers above and beyond intervention. The reports and strategies recommended not only that primary physicians and teachers intervene in mental illness, but also, that teachers and employers deliver mental health promotion programmes to students and employees in the classroom and workplace. For example, the

National Strategy suggested that "Infants, children, and youth are best reached at home, school or post-secondary institutions through broad programs that promote mental health for all, complemented by targeted prevention programs for those at highest risk due to factors such as poverty, having a parent with a mental health or substance use problem, or family violence" (24). It recommended "[Increasing] comprehensive school health and post-secondary mental health initiatives that promote mental health for all students and include targeted prevention efforts for those at risk" (2012, 27). In the workplace, the LAO Report suggested that "much more needs to be done to increase awareness of the importance of a healthy workplace in the creation of a positive and successful work environment" (2010, 12). The Ontario Strategy suggested that:

> Research has shown that mental health disability claims have overtaken cardiovascular disease as the fastest growing category of disability costs in Canada. Workplaces should be key partners in our mental wellness strategy, adopting policies and programs that help employees enhance their mental health. Happier workers, higher productivity and less absenteeism – we all gain from improvements in mental health (2011, 11).

The Kirby Report similarly stated that "there is a range of secondary intervention strategies designed principally to reduce the effects of stressful work situations by improving the ability of individuals to adapt to and to manage stress" (2006, 180). The National Strategy went beyond the other documents to identify the home as another site for promotion, stating that "Comprehensive, home-based approaches can support parents to have healthy pregnancies and to foster social and emotional development in early childhood, which are the first steps toward mentally healthy lives for infants and young children" (2012, 25). This suggestion broadened the age of prevention to pregnancy and infancy. These recommendations authorized multiple sites of authority in the promotion of mental health, ranging from the teacher, to the workplace, to the parent. The logic underlying these recommendations was that the incorporation of promotion programmes into existing institutions outside of the medical sphere would reduce the need for new medical services, thereby reducing the strain on an overburdened mental health service system. These recommendations were geared towards keeping the employee in the workplace, as well as engineering a resilient generation of children who could bounce back from life's stressors. By bouncing back rather than succumbing to mental illness, they would reduce their strain on the mental health service system later in life. Resilience precludes the need to fund medical services.

3.4 (Anti-)Stigma

Stigma was a shared theme across the documents. Those offering personal testimonies throughout the hearings identified it as a major problem. The Ontario Strategy explained that "Whether experienced through family, friends, media, housing, health services or the justice system, stigma isolates people, and eats at the health of individuals, families and our communities" (12). The Kirby Report indicated that "Perhaps the most damaging effect attributed by witnesses to stigma and discrimination was that originating in the belittling, denigrating attitudes towards mental illness and those who suffer it that seem to pervade all levels of society" (14). Similarly, the National Strategy explained that "People living with mental health problems and illnesses often report that the experience of stigma – from members of the public, from friends, family and co-workers, and even at times from the very service systems that they turn to for help – has a more devastating impact on them than the illness itself" (22).

In response to these concerns, the Ontario Strategy and National Strategy recommended the implementation of anti-stigma and mental health promotion campaigns to enhance society's awareness of mental illness. For example, the Ontario Strategy stated that it would "Implement more mental health and promotion and anti-stigma practices for children and youth, educators, health providers, workplaces, seniors' service providers, municipal service providers, justice providers and the public" (12). Similarly, the National Strategy recommended "[Fighting] stigma by including opportunities in promotion, prevention and early intervention initiatives to meet and talk with people living with mental health problems and illnesses" (23). If, as the documents suggested, mental health is everywhere, then everyone is vulnerable to stigma. The logic underlying these recommendations was that society would gain a greater understanding of mental illness if it was talked about publicly, thereby removing barriers to the full participation of TCAMA in society. Effectively, anti-stigma initiatives were designed to put mental health everywhere.

3.5 Rights

The reports and transcripts highlighted the importance of putting the individual at the centre of an integrated service system, thereby facilitating their right to choose their own personal recovery plan. Unlike the Ontario Strategy, Kirby Report, and National Strategy, however, the LAO Report problematized rights-based legislation that disallowed involuntary treatments, even if they were perceived to be in the best interests of TCAMA. The LAO Report stated that "we are troubled that so many witnesses have experienced difficulty in obtaining care for family members who are clearly very ill, yet refuse treatment or are too quickly discharged from hospital" (15). On the other hand, it acknowledged that "Rights advocates cautioned the Select Committee that involuntary admission and treatment are such grave violations of autonomy that society has to accept these risks and dangers. They also warned that psychiatric drugs can have serious side effects to which many people are reluctant to expose themselves" (15). Despite this caution, the LAO Report conceded "that the right to autonomy must be balanced with the right to be well" (15). It therefore recommended that

> The Ministry of Health and Long-Term Care should create a task force, incorporating adequate representation from, among others, mental health clients and their caregivers as well as mental health law experts, to investigate and propose changes to Ontario's mental health legislation and policy pertaining to involuntary admission and treatment (16).

This recommendation reasserted coercion over the mentally ill, and conflicted with rights-based anti-psychiatry activist testimonies. The logic underlying this recommendation was that involuntary treatment was actually in keeping with the rights of TCAMA, because they had a right to treatment. In contrast, the remainder of the documents emphasized the importance of choice and self-determination. The Kirby Report and National Strategy identified choice and self-determination as key components of recovery programmes. The LAO Report argued that involuntary treatment best upheld the rights of TCAMA. Conversely, the remainder of the documents argued that choice and self-determination upheld the rights of TCAMA. Despite these differences, the logic underlying their recommendations was the same: to uphold the rights of TCAMA.

3.6 The Justice System

The documents problematized the criminalization of mental illness and the lack of mental health services across the justice system. This idea was taken from government justice department testimonies. The LAO Report stated "that far too many Ontarians experience their first contact with the mental health system through the justice system" (13). The Kirby Report indicated that "A comparison between admissions to federal institutions in 1967 and then again in March 2004 indicates that there has been a 60% increase in the number of offenders with mental disorders" (301). The National Strategy attributed higher rates of criminalization to deinstitutionalization, observing that there is a much higher proportion of people living with mental health problems and illnesses in the criminal justice system than in the general population" (46). Another problem identified was inadequate services in the justice system. The LAO Report stated that "individuals who are incarcerated need access to the full basket of mental health and addictions services" (14). The Ontario Strategy recommended that the Ministry of Health "Better understand the mental health and addictions services that should be available within the justice system, including incarcerated populations" (18). The National Strategy recommended the provision of "appropriate mental health services in the youth and adult criminal justice system" (49). A key component of recommendations regarding the justice system were geared towards the reintroduction of offenders with mental illness and/or addiction back into the community, where they could access the same integrated service system as everyone else. For example, the LAO Report stated "that prison discharge plans for individuals with a mental illness or addiction should include connection to a system navigator, and from there to appropriate community services, particularly housing" (14). Likewise, the National Strategy argued that "At a minimum, correctional and forensic facilities need to make sure that everyone has a comprehensive plan to address continuity of mental health services following discharge, and to ensure that the basic requirements, such as social support, housing, medication, and proper identification documents, are in place" (47-48). The documents established a causative relationship between the lack of community mental health supports and the incarceration of TCAMA. Hence, the solution put forth to the overrepresentation of TCAMA in the justice system was the same as that offered by recovery discourses: a community-based integrated service system.

3.7 Colonization

The Kirby Report and National Strategy borrowed from the testimonies provided by Indigenous representatives to link disproportionately higher rates of mental illness, addiction, and suicide within Indigenous communities to colonization. The Kirby Report explained that

> The Committee struggled with the knowledge that, despite multiple reports and substantial allocations of human and financial resources, the overall mental health of Aboriginal peoples continues to be at serious risk. Taking the rates of suicide and of addiction as measures, their mental health is located at the extreme negative end of the continuum (361).

Similarly, the National Strategy stated that "Many First Nations communities also experience high rates of poverty, shortages of adequate housing, unsafe drinking water, and a lack of educational, employment and economic opportunities, all of which undermine health and well-being" (98). Both of these documents attributed higher levels of mental illness, addiction, and suicide to colonization. Specifically, the Kirby Report argued that "Canada's record of treatment of its Aboriginal citizens is a national disgrace" (361). Similarly, the National Strategy suggested that "A broad range of legislation and policies aimed at assimilation have undermined mental health and well-being for more than 200 years" (96).

The Kirby Report and National Strategy recommended that Indigenous communities be granted control over their own mental health service delivery systems. This was a solution offered by Indigenous representatives during the hearings. The Kirby Report stated that "We heard also that if Aboriginal peoples could take ownership and control of their personal and community health, much of their present ill-health would be prevented" (362), and therefore recommended

> That the Canadian Mental Health Commission … establish an Aboriginal Advisory Committee comprised of representatives of Aboriginal communities, whose membership shall be determined by the Commission in consultation with Aboriginal organizations, and shall provide representation from First Nations, Inuit and Métis and broadly reflect the geographic distribution of Aboriginal communities across the country (363).

One of the National Strategy's recommendations was to "Support and recognize the community as its own best resource by acknowledging local knowledge and by developing community capacity to improve mental wellness" (99).

In addition to self-determination, the Kirby Report and National Strategy recommended that solutions to mental illness, addiction, and suicide within Indigenous communities be grounded in Indigenous approaches to wellness, rather than illness. This was a recommendation made by Indigenous representatives throughout the hearings. The Kirby Report pointed out that "Witnesses representative of all Aboriginal peoples emphasized that the focus must be changed from mental illness to mental wellness. They called for a holistic and comprehensive approach addressing all determinants of health" (363). Similarly, the National Strategy recommended "a coordinated continuum of mental wellness services (mental health and substance use services) for and by First Nations, which includes traditional, cultural, and mainstream approaches" (98). The National Strategy also introduced the idea of "cultural safety," which was "grounded in [I]ndigenous knowledge and experience, and is based on the recognition of cultural diversity and the influence that social inequalities and imbalances of power have on relationships between the service provider and service user" (97).

Although the Kirby Report and National Strategy made recommendations towards self-determination and wellness, they located these principles within their broader prevention model. For instance, the Kirby Report recommended "the development of a strategy oriented to the promotion of wellness, to restoration of positive mental health and to prevention of worsening mental health outcomes for Aboriginal peoples" (369). Similarly, the National Strategy argued that "More focus is also required on mental health promotion and mental illness prevention programs for youth to help foster resiliency and healing…" (106). The Kirby Report and National Strategy did attribute mental illness, addiction, and suicide within Indigenous communities to colonization, and in response, recommended that communities be granted control over their service systems. This discourse held the Canadian state accountable for the negative effects of colonization. However, the Kirby Report and National Strategy did not hold the state accountable for compensating these injustices. Rather, they suggested that colonization was a thing of the past, and that Indigenous peoples should develop their resiliency to adapt to their social circumstances. This downloaded responsibility for the well-being of Indigenous communities onto their own shoulders.

The LAO Report observed that Indigenous peoples face higher rates of mental illness, addiction, and youth suicide, and the Ontario Strategy observed that Indigenous children face greater challenges to accessing mental health services. However, these documents did not place as much emphasis on these problems as the Kirby Report and National Strategy, perhaps because legally, Indigenous relations and responsibilities fall under federal jurisdiction. The LAO Report indicated that "First Nations people struggle with above-average rates of mental illness, addictions, and youth suicide owing in part to a history of poverty and the consequences of residential schooling" (1). It recommended that Ontario establish even more silos, or "centres of expertise" for First Nations mental health, which is located alongside similar centres for Francophones, seniors, and employment issues" (5). The Ontario Strategy explained that

> Currently, there are some groups of children that have even greater challenges accessing the care they need. To address this, we need to increase the availability of culturally-appropriate services to better serve more children and families who are Aboriginal, or in high needs, or in underserved communities, who have complex mental health needs requiring specialized care, and/or who must navigate across key transition points (23).

In response to this problem the LAO Report recommended "Hiring new Aboriginal Mental Health and Addictions Workers in Aboriginal communities, and developing and implementing an Aboriginal Mental Health and Addictions Worker Training Program to increase the supply of trained workers in these communities" (24). Neither the LAO Report nor the Ontario Strategy prioritized self-determination. Rather, their solutions were located within a broader integrated service system programme.

3.8 Peer Support

The documents acknowledged the role that unpaid peer support plays in Canada's mental health system. Peer support is rooted in Canada's consumer/survivor movement. Throughout the testimonies, anti-psychiatry activists explained how absent of state supports following deinstitutionalization, they established community amongst themselves to support each other. The LAO Report stated that "Much was said and written about the immense value of involving people with lived experience in the delivery of services. Presenters told us that the lens of experience, provided by consumer/survivor initiatives and more specifically peer support, can contribute to reductions in hospitalizations, and improve well-being and access to treatment" (11). Similarly, the National Strategy explained that "Peer support works because people who have experience with mental health problems and illnesses can offer support, encouragement, and hope to each other when facing similar situations" (72).

The reports and strategies recommended the professionalization, and therefore the regulation, of peer support. The LAO Report recommended that community-based services include peer support workers, who should be accredited through peer support organizations (11). Similarly, the National Strategy recommended "[Increasing] appropriately resourced peer support initiatives in both independent, peer-run agencies and mainstream settings" and "[Developing] nationally recognized guidelines for peer support, in collaboration with peer support organizations" (71). The Kirby Report recommended that peer support workers be paid for their services, suggesting that "Once self-help and peer support work is recognized as a paid profession, the door opens on all sorts of possibilities that offer the potential for considerable benefit …" (243). It also pointed out that peer support was cheaper than medical services: "Self-help and peer support groups (and the research that focuses on them) point out that the solutions they offer to people and families suffering from mental illness and addiction are more cost-effective than professional help" (246). This recommendation was borrowed from anti-psychiatry testimonies, which emphasized the importance of consumer/survivor community.

3.9 The Authorization of Personal Testimonies

A consistent theme across the documents was the authorization of personal testimonies. The documents frequently made reference to the testimonies received by those with mental illness and their families, reiterating over and over that the committees heard and understood what this group was saying. For example, the introduction to the LAO Report stated that

> From the parents sleeping by their front door to prevent their son from slipping out to buy drugs, to the daughter who dealt with more than 20 health care providers and social service agencies on her mother's behalf, to the husband who was in the room when his wife committed suicide, *we have listened to your stories* (1, emphasis added).

Similarly, the Kirby Report explained that "Through two online consultation processes, as well as hearings in every province and territory, the Committee heard from those who are most directly affected by Canada's mental health system, people who live or lived in the past with a mental illness or addiction" (2). The National Strategy stated that "The Commission has drawn on the experience, knowledge and advice of thousands of people across the country in the course of drafting this *Strategy*" (2). It referred to those with mental illness and their families as "experts by experience" (40).

The documents stressed that future mental health directions should be informed by those with personal testimonies and/or their families, because they are the ones with the most experience of Canada’s mental health system. For instance, the Ontario Strategy argued that “People with lived experience of a mental illness or addictions, and their families, bring their strengths, wisdom, and resilience to their care. They must have a voice as essential partners in system design, policy development, and program and service provision, and the opportunity to make informed decisions about their personal care and support” (9). The Kirby Report defined “The informed perspective of persons living with mental illness, as well as that of their family” as “invaluable” (247). The National Strategy stressed that “People living with mental health problems and illnesses must be actively involved in all aspects of planning, delivery, evaluating, monitoring, and researching programs and policies that affect their lives, including government policy that relates to mental health” (120).

As shown, the documents made frequent reference to the testimonies received from those living with mental illness and their families. These testimonies served two purposes: first, the process of testifying before the commissions quelled the frustrations of those whose needs were not being met by Canada’s broken service system; and, second, the reports and strategies legitimated various recommendations by grounding them in the testimonies of those most affected by them. It was undoubtedly important that this group of witnesses have their experiences reflected in the reports and strategies. However, the documents’ discursive representation of this reflection process served an additional, and more dangerous function: it concealed the erasure of other discourses from the final reports and strategies. The erasure of these discourses will be explored in the next section.

4. What was Left Out?

This section compares what was said during the hearings with what was represented in the final documents. In the first section I link the discourses contained in the final documents to their origins in the testimonies of the seven groups explored in Chapter 5: psychiatrists; medical service providers; community service providers; government; Indigenous representatives; anti-psychiatry activists; and, those offering personal testimonies. In the second section I identify issues that arose during the hearings and were contained, but deemphasized, in the documents, including psychiatric authority, and access to private counselling services. In the third section I explore a recommendation made by Indigenous representatives that was left out entirely from the final documents – Indigenous youth leadership. In the last section I identify recommendations contained in the final documents that were informed by a different logic than their original testimonies, specifically, peer support, and Indigenous wellness.

4.1 What was Heard?

Many of the problems and solutions communicated to the committees during the hearings were reflected in the final documents. Psychiatrists, medical service providers, and those with personal testimonies identified a disorganized mental health service system, and psychiatrists, medical service providers, and community service providers recommended the reorganization of services into an integrated system, including non-medical services. The final documents echoed these recommendations, prescribing the reorganization of existent services, rather than increased funding for new services. Effectively, the documents advanced bureaucratic solutions rather than recommending greater resources. Medical service providers and government health representatives identified a lack of focus on prevention in Canada's mental health service system.

Specifically, medical service providers indicated that many cases of chronic mental illness in adults could have been prevented if intervened on at their first signs. They recommended a shift towards intervention, a key recommendation contained within the final documents. Government health representatives problematized a lack of focus on prevention, and recommended a greater focus on population mental health via promotion programmes. These ideas were central to the recommendations made by the final documents.

Community service providers, anti-psychiatry activists, and government justice and housing representatives identified an underfunded and inadequate community service system. They emphasized the social, rather than medical, causes of mental illness. Community service providers recommended the reorganization of services around a non-medical recovery model, a concept also taken up by those with personal testimonies. They located the individual at the centre of an integrated mental health service system, recommending that the community function as a provider of services from which TCAMA should pick and choose. Alongside prevention and an integrated service system, recovery was at the crux of the final documents. Government justice and housing representatives recommended greater social supports for TCAMA, who they pointed out, often ended up homeless or in the criminal justice system. The final documents included housing in their recommended service system. They also recommended more mental health services for offenders, and that they be provided with greater mental health services and supports upon their release.

The reports and strategies echoed the concerns expressed by Indigenous representatives over disproportionate levels of mental illness, addictions, and suicide amongst Indigenous communities. The provincial documents paid less attention to this issue than the federal documents, perhaps owing to the federal government's jurisdiction over treaties. Like Indigenous representatives, the LAO Report, Kirby Report, and National Strategy attributed this problem to colonization. The federal documents echoed the recommendation that Indigenous communities be granted control over their own mental health service systems, to be grounded in Indigenous wellness knowledges. Finally, the documents borrowed from those with personal testimonies to problematize stigma and discrimination, recommending anti-stigma programmes.

4.2 What was Deemphasized?

Two issues were deemphasized by the final reports and strategies: psychiatric expertise, and access to private mental health services. The documents echoed psychiatrists' concerns about disorganized mental health services, as well as their recommendation for an integrated mental health service system. However, the reports and strategies did not pick up on psychiatric expertise, a key logic informing psychiatrists' testimonies. Psychiatrists problematized a disorganized service system because mild cases that could have been dealt with by primary physicians ended up on their caseloads, which were already overburdened. The logic underlying their testimonies was that they alone possessed the expertise to treat complex cases of mental illness. Similarly, the logic underlying their recommendation for an integrated service system was that less specialized service providers could treat mild cases of mental illness using psychiatric knowledges, funneling more severe cases up to them, at the hub of an integrated service system. In other words, the problems and solutions identified by psychiatrists carved out a hyperspecialized role for themselves. In contrast, the final documents did not recognize a unique role for psychiatry, but instead authorized multiple sites of authority. This reflected an ongoing decline in psychiatric power.

The final documents did not adequately address financial inaccessibility to some mental health services, especially private counselling services. This was a smaller point raised during the hearings, yet it points to new and ongoing class-based exclusions. During the hearings, some medical service providers suggested that Canada was falling into a two-tier system of mental healthcare provision. Dr. Robert McIlwraith, a psychology professor at the University of Manitoba, testified that

> There has been much spirited discussion about the dangers of Canada falling into a two-tier health care system. Such a system already exists, unfortunately, in quite an extreme form in the case of access to psychological services. Psychologists' services are not covered under medicare, as insured services, in any province. If people have the money or private insurance coverage, they have access to high quality psychological services, often within days or weeks. If they are dependent upon the public health care system, however, they will encounter long waits for the available psychological services in hospital out-patient departments or services based in schools, if they can even find them embedded in those institutions (2003, No. 16, 54).

The final documents located the individual at the centre of an integrated service system, from which they could pick and choose services. However, they overlooked that some face more limited options. For example, not everyone has the resources or private insurance coverage to access private counselling services. Here, the reports and strategies failed to address underfunding as an underlying problem. Instead, they recommended the reorganization of services that were already available, a bureaucratic solution.

4.3 What was Left Out Entirely?

The documents left out Indigenous youth leadership, a recommendation made by Indigenous representatives. Throughout their testimonies, Indigenous representatives recommended that future Indigenous mental health policy directions be informed by Indigenous youth. For example, Jennifer Dickson emphasized that "This is key: Let us follow the Inuit youth" (2005, No. 27, 27). Amanda Meawasige stressed the importance of “youth leadership development,” explaining that “it has to do with the revitalization of culture and reclaiming our cultural identities as young people” (2005, No. 16, 59). Since high levels of mental illness, addiction, and suicide were attributed to colonization, the logic underlying this recommendation was that Indigenous youth could regain wellness by reclaiming their cultures. Indigenous representatives also pointed to the role played by Indigenous youth in peer support programmes, to prevent Indigenous youth suicides. The exclusion of Indigenous youth leadership from the reports was curious, especially given the prioritization of community control and wellness. Instead, the final documents centred prevention discourses on children and youth more generally, and identified them as targets for intervention and promotion programmes, ultimately, to engineer a resilient next generation. The implications of the exclusion of this recommendation from the final documents will be discussed in the next chapter.

4.4 What was the Logic?

The final documents acknowledged the importance of peer support in consumer/survivor communities, an idea introduced during the hearings by anti-psychiatry activists. Additionally, they recommended Indigenous community control over Indigenous mental wellness initiatives. However, the logics that informed these recommendations during the testimonies differed from those deployed in the final documents. In the hearings, recommendations for peer support, and Indigenous community control over wellness, were informed by a broader demand for self-determination. In contrast, the final documents incorporated peer support, and Indigenous community control and wellness into its broader prevention and recovery mandate, without any additional funding to support personal recovery plans or community building.

Similarly, the final documents depoliticized recommendations made by Indigenous representatives, who recommended Indigenous community control over mental wellness. The final documents echoed this recommendation, stating that Indigenous communities should be granted control over their own mental wellness programmes. However, the testimonies offered by Indigenous representatives were informed by a broader demand for self-determination, which the final documents did not reflect. For example, Chief Evans indicated that "These underlying causes of mental illness can only be addressed through acting on our treaty and inherent rights to self-determination and establishing a new relationship with the Crown" (2005, No. 16, 73). Even though the Kirby Report and National Strategy identified colonization as the cause of disproportionate levels of mental illness, addiction, and suicide amongst Indigenous communities, they did not get at the bigger picture: self-governance and the recognition of treaty rights. In contrast, the documents located community controlled wellness initiatives within a broader settler prevention and recovery framework. Specifically, the National Strategy argued that

> Just as for the population as a whole, mental health and suicide need to be addressed together through the promotion of good mental health for all; the prevention of mental health problems for those at risk; early identification and timely access to services, treatments and supports for mental health problems and illnesses; and the reduction of the stigma of mental health problems and illnesses (2012, 97).

As demonstrated by this passage, the documents may have recommended community controlled solutions, but they located Indigenous peoples within the broader population, undermining their self-determination. In this sense, the reports and strategies were one more imposition of settler programmes on Indigenous communities.

The reports and strategies recommended the professionalization of peer support. In the process of doing so, however, they depoliticized it. They removed it from its political origins, which was activism and resistance against the mental health system, especially psychiatry. For example, the Kirby Report pointed out that "In Canada, the first alternative mental health service based on people's living with mental illness helping one another, called the Vancouver Mental Patients' Association (MPA), was established in 1971" (227). The MPA was one of a series of consumer/survivor organizations that offered mutual support to its members. However, the report failed to acknowledge that the MPA was not only a peer support organization, but as described in Chapter 4, was one of a series of political organizations that emerged in the 1970s to protest Canada's mental health system, particularly psychiatry, as well as the conditions that ex-patients were forced to live in following deinstitutionalization. In one sense, the reports and strategies accorded self-determination to anti-psychiatry activists by recommending that they be paid for their labour. On the other hand, however, they recommended the professionalization, regulation, and standardization of consumers and survivors into the very system that they organized to protest in the first place, thereby displacing their self-determination with bureaucratization.

5. Conclusion

This chapter analyzed the LAO Report, Ontario Strategy, Kirby Report, and National Strategy along three guiding questions:

1. What language was used to categorize mental abnormality?
2. Why was mental abnormality considered a problem?
3. Who, and with what solutions and knowledges, were authorized by the documents' recommendations?

I identified nine themes across the documents in response to these questions: mental illness, mental health, and addiction; the (dis)organization of service systems; prevention; stigma; rights;

the justice system; colonization; peer support; and, the authorization of personal testimonies. My discourse analysis revealed a shift in the categorization of mental abnormality, away from mental illness and towards mental health. This extended the target for intervention from the mentally ill few to the entire population, and removed the head from the purview of psychiatry. Ultimately, the documents deemphasized the mentally ill few, and focused on the mental health of the general population. The documents also indicated the collapse of mental illness and addiction into one category. I argued that even though the Kirby Report was open about its limitations with regards to addiction, whereas the Ontario documents coupled it alongside mental illness, that all documents recommended that addictions services be integrated into the mental health service system.

The documents identified several problems, but paid the most attention to both the disorganization of service systems, and stigma. The criminalization of mental illness, and colonization, were also discussed, but received far less attention. The documents problematized a disorganized service system on the grounds that existing service systems could not meet seemingly increasing cases of mental illness. They identified stigma as an additional barrier, not only to accessing services, but also to employment and housing opportunities – that is, to a normal life. The normalization of employment and housing draws a new line between normal/abnormal, not between those with mental illness and those without, but rather, between those who regardless of mental illness, go to work and provide shelter for themselves. The documents discussed the over-representation of those with mental illness and addiction in the criminal justice system, which they linked to the failure of deinstitutionalization programmes. They drew attention to higher rates of mental illness, addiction, and suicide within Indigenous communities, which they attributed to the effects of colonization.

The documents recommended many programmes as solutions to Canada’s mental health system, including the bureaucratization of existing services into an integrated, recovery-based service system, the implementation of prevention programmes, anti-stigma campaigns, recovery plans for offenders, Indigenous control over wellness initiatives, and the professionalization of peer support. However, they paid the most attention to an integrated service system, and prevention. The documents recommended the reorganization and bureaucratization of existing services into a person-centred, integrated service system grounded in recovery. They recommended that this service system should include non-medical services, demedicalizing mental abnormality. The logic underlying this recommendation was that rather than increase funding for new services, that it was possible to centralize existing services into an integrated system from which individuals could pick and choose according to their individual recovery plans. This solution framed inaccessibility to services as a bureaucratic issue, rather than as a funding problem, while downloading responsibility for recovery onto individual shoulders.

Alongside the bureaucratization of existing services, the documents emphasized prevention programmes, including intervention and promotion. The logic underlying this solution was that the prevention of mental illness would decrease demand on a limited mental health service system in the long run. This would circumvent the need for future increases to mental health service funding, while simultaneously authorizing new sites of authority in the governance of mental abnormality, including the primary physician, teacher, and employer. The documents recommended anti-stigma practices through education and promotion, which would locate mental health everywhere, and mental illness nowhere, thereby removing the barriers faced by TCAMA to living a normal life. They also suggested that justice facilities be equipped with appropriate mental health services, and that offenders be provided with individual recovery plans and supports upon their release into the community. The reports and strategies grounded their logics in the testimonies of those with mental illness, legitimating their recommendations.

This chapter compared testimonies alongside the final documents to determine what was left out. The documents picked up on one of the programme recommendations offered by psychiatrists, which was the reorganization of services into an integrated system. However, they did not recognize psychiatry as a singular site of expertise, but authorized multiple sites. The documents failed to pick up on one of the problems introduced by medical service providers, which was that private counselling services were financially inaccessible for many. Although the documents picked up on the programme recommendations made by Indigenous representatives, for community control and Indigenous wellness knowledges, they failed to carve out a special role for youth leadership. Furthermore, although they reflected most of the programme recommendations made by anti-psychiatry activists, and Indigenous representatives, they did so using a logic that undermined their self-determination. The undermining of their self-determination illuminates the productive power of discourse. Specifically, the documents recommended the professionalization of peer-support and its incorporation into a mental health system that consumers/survivors organized to protest in the first place. Moreover, they located Indigenous community control over wellness initiatives within a broader prevention logic, imposing one more settler program rather than recommending Indigenous communities' rights to self-governance.

As previously discussed, Neil Bradford argues that commissions are created at critical policy junctures to air out grievances and reach a consensus on future policy directions (1998, 12). The LAO and SSCSST hearings were two such opportunities. The hearings were flooded by a series of competing discourses, for example, psychiatric versus multiple sites of authority, medical versus social causes, and treatment versus prevention. This chapter demonstrated that the final documents took up many, if not most, of the problems and solutions contained within a range of testimonies. However, these problems and solutions were captured by discourses that recommended a shared end goal, or consensus, for the governance of mental abnormality: a shift from mental illness to mental health; a recovery-oriented system; and, prevention. As explained in the theoretical framework, discourses provide hints to broader mentalities. These discourses signaled experimentation with the idea of resilience, a new mentality informing prevention and recovery programmes. Resilience, prevention, and recovery are explored in the next chapter.

CHAPTER 7: EMERGENT MENTALITIES: RESILIENCE

1. Introduction

This chapter introduces the concept of resilience as an experimental fourth mentality in the governance of mental abnormality. A resilience mentality categorizes mental abnormality as mental health, and prescribes recovery and prevention programmes. Resilience suggests that in most cases, mental illness can be prevented by learning to bounce back in the face of life's stressors. It also suggests that those who do not bounce back can at least recover to a "normal" life, despite living with mental illness. From unemployment to natural disasters, we are told that we can overcome anything that life throws our way provided we work hard enough. Bookstore shelves are lined with a seemingly infinite supply of self-help guides designed to help us do so, and resilience training is now being written into public school curriculum and university wellness initiatives.

The SSCSST and LAO hearings revealed multiple, competing discourses surrounding mental abnormality. These discourses informed various programme recommendations. Ultimately, however, the final documents settled on prevention and recovery solutions, which promote good mental health while locating the individual at the centre of a newly integrated, recovery-oriented system. The final documents arrived at these solutions because recovery and prevention, and the broader resilience mentality within which they are located, are commensurable (Kuhn 1982, 670) with neoliberalism. In other words, resilience corresponds with broader neoliberal logics (Brodie and Phillips 2014).

This chapter begins by introducing resilience as a ubiquitous strategy that has permeated every aspect of governance in the twenty-first century (Brodie and Phillips 2014, 3). Derived from systems ecology and engineering, resilience refers to the capacity to adapt to change, and/or to return to equilibrium following disruption. Although it is not a new concept, it has been coopted by neoliberalism to individualize and responsibilize subjects for their own fate (Brodie and Phillips 2014, 12). It eschews political activism by teaching individuals to withstand life's stressors. Here, resilience potentially draws a new line between normal and abnormal. Mental illness does not equal mental abnormality. One can be mentally ill but successfully adapt to society by leading a normal life. Mental abnormality refers, instead, to one's inability to bounce back or adapt. Resilience reframes this inability as a personal choice, that is, unwillingness. Next, I discuss two examples of prevention programmes, Alberta Health Services' *Bounce Back Book Series*, and the University of Alberta's mental wellness initiatives. The chapter ends by pointing to early signs of cracks in resiliency logics, including Attawapiskat First Nation's youth suicide crisis in 2016, and contention over the targeted mental health funding piece in recent Health Accord talks.

2. Resilience and Neoliberalism

Contemporary mental healthcare reform discussions are increasingly informed by a resilience mentality. However, this mentality extends beyond mental health policy discussions to inform everything from parenting tips, to university mental wellness campaigns, to self-help manuals. Indeed, resilience is a "primary motif in the robust self-help and self-care genre of popular culture in the early 21st century" (Brodie and Phillips 2014, 3). However, resilience is not limited to mental health. It has been taken up within various sectors to inform a wide array of policy issues. Neocleous identifies it as "one of the key political categories of our time" (2013, 3). However, whether it is applied to mental health reform or to international security, the underlying logic remains the same: we cannot predict change, but we can learn to adapt to it.

Likewise, we do not know what challenges the future will bring, but we can learn to withstand them.

Parul Sehgal argues that humans have always been attracted to resilience stories, for example, the image of the Phoenix rising from the ashes (Sehgal 2015). However, he points out that the term has only recently achieved everyday popularity (Sehgal 2015). Andrew Munro similarly identifies resilience as a "keyword" in academic fields ranging from psychology to political science, and a "buzzword" in corporate and governmental spheres (2013, 1). Brodie and Phillips point out that the concept has infused governing agendas on everything from security threats to environmental catastrophes (2014, 3). Mark Neocleous observes that it "falls easily from the mouths of politicians, a variety of state departments are funding research into it, urban planners are now obliged to take it into consideration, and academics are falling over themselves to conduct research into it" (2013, 3). Resilience is everywhere. And, once this is apparent, it is impossible not to notice the countless ways in which the term is deployed in our everyday lives. So, what is resilience?

The term resilience is rooted in the latin *resilire*, meaning to jump back (Bourbeau 2013, 6; Sehgal 2015). It refers to the ability to adjust to, or recover from, adversity, misfortune, and change (Bourbeau 2013, 6). The resilient individual is one who "suffers some insult or disturbance, but whose integrity is held to have been maintained, or even enhanced, by its resistive or adaptive response" (Munro 2013, 1). In short, resilience refers to the capacity to bounce back from, rather than succumb to, life's unpredictable challenges. Conceptually, resilience has long been a key theme in ecology and engineering (Bourbeau 2013, 8). In ecology, resilience refers to the capacity of an ecological system to maintain its functions amidst disturbance, and therefore to transform itself to adjust to change (Bourbeau 2013, 8). It is a way of coping with global environmental change (Joseph 2013, 39). In engineering, resilience measures the capacity of an object or system to return to equilibrium following displacement, and therefore to return to its original form despite physical stressors (Bourbeau 2013, 8; Neocleous 2013, 3).

Resilience, thus, is not a new concept, but its contemporary popularity is a reflection of its suitability for neoliberal logics of governing. Walker and Cooper identify "proximity between the emergent discourse of 'resilience' and contemporary neoliberal doctrines" (2011, 145). Joseph posits that resilience fits well with neoliberal logics because its insistence on individual preparedness corresponds with neoliberal notions of individual responsibility (Joseph 2013, 41). Resilience encourages active citizenship, that is, the responsibilization of individualized subjects for one's own well-being (Joseph 2013, 42). It has been identified as a new neoliberal technology of the self (Larner 2011, 13; Neocleous 2013, 5), a training "to withstand whatever crisis capital undergoes and whatever political measures the state carries out to save it" (Neocleous 2013, 5). Resilience represents "an anxious political psyche" within "a politics of anticipation," wherein we must constantly prepare ourselves for the next attack (Neocleous 2012, 191-92).

Resilience is a way of coping with neoliberalism's crises. Rather than changing the system, one must change oneself (Brodie and Phillips 2014, 5; Larner 2011, 13). It is grounded in uncertainty (Larner 2011, 13). One of neoliberalism's key tendencies has been what Brenner, Peck, and Theodore refer to as "regulatory failure," that is, the capacity to reinvent itself in times of crisis (2010, 218). Resilience is one more neoliberal experiment, an attempt to shore up its credibility by diverting attention from its internal incoherencies by shifting the attention to the failings of individuals. Resilience conveys a new message: hard work does not guarantee success, so prepare yourself for failure.

Resilience downloads collective problems onto the individual (Beck and Beck-Gernsheim 2002, 3; Welsh 2013, 8). It responsibilizes the individual for one's failures, which it reframes as a reflection of individual character (Sehgal 2015). Resilience displaces the victim, instead attributing misfortune to individual will (Schott 2013, 211). This logic lets the state off the hook for the provision of the supports necessary for our survival. Instead, those who are not self-sufficient are told to take responsibility for their own bad choices (Brodie 2007, 159-60). Hence, rather than offer any concrete supports, the state targets interventions in the form of resiliency training to those deemed to be at risk, offering them "a 'hand-up' to the labour force and to entrepreneurialism rather than a 'hand out' to a certain life of dependency" (Brodie and Phillips 2014, 7). The neoliberal state is not held accountable for its lack of social supports when it is up to the individual to ensure one's own well-being: "'Resilient' peoples do not look to states to secure their wellbeing because they have been disciplined into believing in the necessity to secure it for themselves" (Reid 2012, 69). At the same time, the resilient subject knows that one's well-being will never be secured, and that one must continually adapt to new threats and dangers (Evans and Reid 2013, 85).

As noted above, the idea of resilience also avoids the potential of political resistance (Reid 2012, 76). Resiliency training teaches us to bounce back from, rather than protest, resist, or counter the sources of life's challenges. We must adapt to ongoing change, but we must not incite it. Welsh argues that

> Resilience holds out the promise of knowing "when" change enters a system, in turn holding out the promise of managing change, of ameliorating its unacceptable effects. However, paradoxically through that technology it also holds the promise of avoiding fundamental change. Certainly it introduces flexibility and adaptability but framed in

> terms of maintaining system function as the priority, with responsibility for maintaining function something distributed throughout the system. As such, it could be said to produce active citizens and active institutions whose act is to maintain the status quo rather than conceive of challenging it (2013, 7).

Neocleous similarly argues that "resilience is by definition *against resistance*" (2013, 7, italics in original). Resilience insists that we use our energies to secure ourselves, rather than resisting the neoliberal state that demands this from us in the first place (Neocleous 2013, 7). We can bounce back from systemic failures, but we cannot challenge them. Hence, Neocleous argues that resilience is no more than "an aptitude for little other than keeping things exactly as they are" (2012, 196). As such, resilience represents "nothing less than the attempted colonization of the political imagination by the state" (Neocleous 2013, 4). The next section examines resilience as a new, and experimental, mentality informing contemporary mental health reform discussions.

3. Re-thinking Mental Abnormality

Recent and ongoing mental health policy approaches in Canada are increasingly informed by resilience. Resilience suggests that most members of the general population can withstand life's calamities through various coping mechanisms, thereby preventing mental illness. It also suggests that the few with non-preventable forms of mental illness can at least adapt to life despite symptoms, go to school, get a job, and have a family. Resilience responds to an old problem – incurability – with defeat. We do not know what causes mental illness. We do not know who it will affect. We do not know what lies on the horizon. All we know is that we can bolster our mental health through certain coping mechanisms, which, we are told, will help us to keep going despite life's blows.

Resilience also informs *mental health*, the preferred *mot-de-jour*. The new mentally abnormal are those who do not work to improve their mental health. The final documents demonstrated a shift in focus away from the mental illness of the few, and towards the mental health of all. Mental illness has always been something that affected the few, whereas mental health is something that affects us all. Unlike past approaches, mental illness and mental health are not binary categories. There is no longer a neat dichotomy between those who are lunatics, insane, and mentally ill, and those who are not. Rather, as the MHCC argued, "there is no 'us' and 'them' when it comes to mental health and well-being" (2012, 12). Resilience locates us all on the same "mental health continuum" (Brodie and Phillips 2014, 18). As Brodie and Phillips argue, "There is no longer anything special or unique about the experiences of the chronically mentally ill" (2014, 18). Instead, those with mental illness are at the extreme negative end of a continuum, where they can return to equilibrium if they so choose. The problem with this approach, however, is that it invisibilizes the unique needs of those with chronic mental illness, for whom returning to equilibrium presents far more barriers than for others. The shift towards mental health draws a new line between normal and abnormal. Mental illness does not make you abnormal, but the inability to keep going despite of it, does make one abnormal.

A resilience mentality identifies new problems pertaining to mental abnormality – newly defined as the inability to bounce back – on new grounds. As the category mental health expands, there are increasing numbers of people who may not have a chronic mental illness, but who experience what the National Strategy referred to as "mental health problems" (2012, 14). More and more people are coming forward with needs that Canada's mental health system, including its medical and non-medical spheres, cannot meet. The problem posed by mental abnormality is that there are few state supports left to provide for those who, according to resiliency discourses, choose not to rebound from life's challenges. The limited supports left, or put in place, following deinstitutionalization, were further compounded by subsequent decades of neoliberal cutbacks that contributed to the underfunding of an already fragmented system. However, under a resilience mentality an inadequate mental health service system is not the problem, and furthermore, as the hearings revealed, there was no consensus amongst competing discourses as to what the problem, and its solutions, were. That said, the reports did concur on the identification of suspect individuals as the problem - people who place demands on an already overburdened system. The inability to bounce back and to make it on one's own is fundamentally a personal, moral failing.

The final documents put forward a variety of solutions, which I loosely grouped under prevention and recovery. Prevention includes both intervention and promotion. The logic underlying these solutions is that the state cannot support those who, due to mental illness or any other reason, are unemployed or homeless. Over the past few decades, many of these individuals have been incorporated into the justice system. But as demonstrated by the testimonies of government justice departments, and by recent high profile cases involving inmate suicides, even this solution is failing. The justice system, much like the mental health system, lacks adequate services. The logic underlying the final documents was that the state cannot provide for those in need. However, it can remove certain barriers, enabling those with mental illness to provide for themselves. In the case of prevention, this involves providing members of the general population with tips on strengthening their personal resilience, making them able to survive precarity. In the case of recovery, this involves putting the individual at the centre of an integrated system, making it easier for them to access the limited services that are available. It involves anti-stigma campaigns that put mental health into the public lexicon, making it easier for those with mental illness to re-enter sectors such as the workforce and housing, facilitating their recovery. When the state removes barriers to our mental health and recovery, the rest is up to us. From there it is a short step to the easy refusal to respond to those who, we are told, have chosen their fates.

Recovery

The final documents were clear that prevention and recovery were the solution. However, they were less clear about what concrete prevention and recovery programmes looked like. A person-centred approach justified the ambiguity surrounding recovery – that is, that there was no "one-size-fits-all" recovery plan. The documents could not define what recovery looked like, because every recovery journey is different. It cannot be defined for someone, because that would undermine one's self-determination. Ambiguity is not only written into recovery, but is at its very core.

Recovery is an old concept that has been co-opted by neoliberalism to individualize and responsibilize TCAMA for their own well-being (Harper and Speed 2012; Howell and Voronka 2012; Morrow 2013). This project agrees with Morrow and Weisser that recovery formed a "cornerstone" of the new national strategy (2012, 30). This was consistent with recovery trends in mental health reform discussions. Piat and Sabetti argue that recovery "represents a radically new paradigm in mental health that has emerged over the past two decades, transforming systems of care throughout the world" (2009, 17). Pilgrim argues that recovery is "the harbinger of successful mental health service reform" (Pilgrim 2008, 299).

Scholars locate the origins of mental health recovery discourses in the consumer/survivor movement (Morrow and Weisser 2012, 28; Morrow 2013; Poole 2011, 9). The logic guiding consumer/survivor notions of recovery was "that people with serious mental illnesses can, and should be entitled to, have a life beyond that of a 'mental patient'" (2007, 461). Jennifer Poole points out that “At that time, it was a bold move away from the often-hopeless prognoses given to those diagnosed with schizophrenia, severe depression or other serious mental health issues” (2011, 9). Piat and Sabetti identify “considerable tension between consumer definitions of recovery and those of clinicians” (Piat and Sabetti 2009, 19). Poole goes on to identify multiple recovery discourses, and suggests that “Fuelled by neo-liberalism and therapeutism, some recovery talk may be serving interests that do not include those it proclaims to help and heal” (100). Morrow and Weisser state that its meaning has shifted (2012, 28). This dissertation is consistent with Poole’s and Morrow and Weisser’s observations, demonstrating that recovery is being taken up, not as a form of resistance, but as a way of propping up those in need of services to deal with their own problems. This is consistent with what John Clarke identifies as neoliberalism’s tendency “to bend these words (and the political and cultural imaginaries they carry) to new purposes” (2008, 140).

Scholars point out that recovery has been deployed to responsibilize TCAMA for their own well-being, while simultaneously covering over the social inequities that contribute to mental illness in the first place (Battersby and Morrow 2012; Morrow 2013). Battersby and Morrow argue that

> Although recovery models encompass social supports (like housing and income) for people with mental illness, our findings demonstrate that, in practice, an individualistic view of mental illness persists that works against recognizing the contribution of systemic social and structural inequities to people’s experiences of mental illness and to their recovery journey (Battersby and Morrow 2012, 104).

Similarly, Morrow and Weisser argue that dominant notions of recovery overlook additional structural barriers along the lines of race, gender, sexuality, and age (2012, 28). Morrow and Weisser further point out that dominant recovery discourses overlook neoliberal cuts to social supports, arguing that “recovery without a full recognition of the current social and political context which has eroded social welfare supports will be impotent to foster real systemic change" (2012, 40). The individualization and responsibilization of TCAMA for their own recovery overlooks collective social problems, such as structural oppression and inadequate state-funded supports. As Morrow argues, "For people experiencing mental distress, who in the course of 'treatment' may lose certain citizenship rights and who may rely on and off on the social service system for most of their lives, the emphasis on private solutions to social problems is particularly reprehensible" (2013, 328). Recovery situates every TCAMA at the same starting line, and overlooks that some face additional hurdles. When those hurdles interfere with their ability to recover, this is perceived as a personal, moral failing – that is, they did not recover because they did not work hard enough.

Prevention

The final documents fell short on prescriptive prevention programmes. This silence was indicative of a broader problem with resiliency discourses, which as Brodie and Phillips point out, are "[silent] about the role of social programs…" (2014, 8). However, within a wider context, a plethora of promotion programmes have sprung up in multiple sites over the past ten years, ranging from the home, to the public school, to the university, to the workplace. These programmes offer tips on building personal resiliency.

Alberta Health Services' *Bounce Back Book* series is one such programme. One of its workbooks, *The Bounce Back Book: Building Resiliency Skills in Your Preschooler* (2010), recommends a variety of activities to parents to help develop resiliency in their children. The introduction claims that "Helping children develop self-confidence, problem solving skills, emotional regulation and empathy skills will equip them to be successful in life" (3). It encourages parents to “Get silly with your kids! Build resiliency in your children that will last a lifetime” (3). The activity book is sub-divided into four resiliency skills, including self-confidence, problem solving, emotional regulation, and empathy, each with multiple activities (5). To build self-confidence, the book recommends building a wall of fame for one’s two-year old, because “Children thrive on adult attention and approval” (8). The “Little Shopper activity” builds problem solving skills by having three-year olds find and fetch grocery store items. Parents can instill emotional regulation in their three-year old through the “Double bubble the fun” activity that teaches relaxing breathing techniques (26). Empathy can be instilled in four-year olds by having them act out different scenarios with puppets (36). This programme authorizes the parent, who is in turn charged with the responsibilization of their preschooler for their well-being. It is unclear how these skills will help children cope with life’s challenges, or how they will shape them into resilient adults. Ultimately, we will not know the answers to these questions for several more years, when today’s children grow into adults.

The *Bounce Back Book* series is part of a broader psychological literature that emerged in the early 2000s with the goal of building resiliency in children, including *Raising Resilient Children: Fostering Strength, Hope, and Optimism in Your Child* (Brooks and Goldstein 2002), *Building Resilience in Children and Teens: Giving Kids Roots and Wings* (Ginsburg 2011), and *9 Ways to a Resilient Child: Raising Kids Who’ll Bounce Back From Adversity and Challenging Times* (Coulson 2017). This dissertation does not claim that childhood resiliency will not prevent mental illness. It does claim that by training children – tomorrow’s adults – to bounce back in the face of life’s stressors, that we are teaching the next generation to bear, rather than question and resist, the structural causes of the challenges they will face. Furthermore, this project argues that it is dangerous to bank on resilience as a mental health strategy. A recent area of study, it cannot yet be known whether children currently receiving resilience training will grow into resilient adults. What is clear, however, is that if resilience training does not offset mental illness in the future, there are insufficient medical and social supports available to meet future demand.

In addition to child rearing, resilience-building initiatives are fast becoming the guiding principle of university mental health programming (Aubrecht 2012). One example is the University of Alberta, which has instituted several programs designed to foster resilience and help students withstand the seemingly inevitable stress of university life. “PositiveU” is an initiative undertake by the University of Alberta Clinical and Counselling Services to “build resilience within the student body in order to enhance individual ability to cope with post-secondary life, improve overall campus mental health and wellbeing, and over time, reduce the number of mental health crises seen on campus” (Clinical and Counselling Services 2017). The Healthy Campus Unit oversees the “Unwind Your Mind” programme “to create environments for students to destress” (2016). Its “Furry Friends” programme offers puppy therapy (2016), and Clinical and Counselling Services now hosts a “Yoga for Mental Hygiene” workshop (2017). This year, the University of Alberta’s “Giving Day” sought donations for student care packages designed to “help students get through difficult times,” which included a sleeping mask, ear plugs, herbal tea, hand sanitizer, bubble wrap, a stress ball, and crayons (2017). These solutions de-medicalized mental abnormality, suggesting that by getting a good night’s sleep, drinking a hot beverage, and drawing some pictures, students can withstand and bounce back from university stressors, including exams, part-time jobs, and mounting student debt.

It has been made clear that resilience is the solution to increasing rates of mental illness amongst students. The problem, however, is that resilience depoliticizes structural sources of mental illness. Aubrecht points out that resiliency programs suggest “that mental illness in students is not only ‘normal,’ but a fact of life” (2012, 67). The suggestion that students can be taught to withstand university stressors permits the university to turn its back on underlying structural causes, such as racism and high rates of campus sexual assaults (Normandeau and Phillips 2016, 6). Harper and Speed suggest that like recovery, resilience conceals over social inequity to frame mental illness as an individual problem (2012, 9-13). Similarly, Howell and Voronka argue that resilience is a cheap solution, supplanting public health care with “self-help and positive thinking” (2012, 4-5). They further argue that mental health resilience works “to create a resilient citizenry, able to cope with uncertainty” (2012, 4-5). This citizen is encouraged to find personal solutions to, rather than challenge, social problems: “rather than confronting austerity measures or other matters of social justice through political action, citizens are enjoined to look inward, gather their strengths, and be resilient” (Howell and Voronka 2012, 4-5). Ultimately, a resilience solution creates a new problem: what about those who do not, or cannot, bounce back?

4. Cracks in the Logic

Resilience is a new mentality surrounding mental abnormality, albeit in experimental stages. However, it is already showing cracks. Despite widespread promotion programmes designed to produce a resilient next generation, not everyone is bouncing back. In April 2016, a crisis unfolded at Attawapiskat First Nation where eleven children, aged nine to fourteen, attempted suicide within a 24-hour period (Spurr 2016). Thirteen years earlier, in 2003, Indigenous representatives testified to the SSCSST regarding the importance of Indigenous youth leadership in community mental health solutions. This dissertation pointed out that this recommendation was overlooked in both the Kirby Report (2006) and National Strategy (2012), which recommended promotion programmes for all youth. By directing mental health promotion programmes at Canada's broader settler population without addressing the particular needs of Indigenous youth, the settler colonial Canadian state is effectively "[letting] die" (Foucault 2003, 241) the next generation of Indigenous communities.

Canada's recent Health Accord talks were another indication of the flaws contained within a resilience mentality. After several attempts at negotiations, federal and provincial governments failed to renew the Accord, as intended by December 2016.[10] The source of their disagreement was targeted funding, including mental health services. The federal government offered up $11.5 billion over a ten-year period, but these were targeted funds for home care, prescription coverage, and mental health services (Tasker 2016). The provinces preferred a 5.2 per cent increase in annual health transfers, to be used at their discretion (Tasker 2016). The need for large-scale investment in mental health services demonstrates that prevention is not working – people need services, more than ever. Health Minister Jane Philpott pointed out that 500,000 Canadians cannot work because of mental illness (Tasker 2016). When the provinces and federal government failed to reach an agreement, she expressed her disappointment that Canadian children would not get the mental health services they desperately needed: "I woke up this morning feeling very hopeful, thinking about half a million kids that are waiting for care for mental health services and hoping to be able to give them good news today" (Tasker 2016). These examples demonstrate that only five years after the release of the National Strategy, children are not bouncing back, and adults are not recovering. These early signs of cracks in resiliency logics raise serious questions concerning the future of mental health care in Canada,

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[10] By March 2017, the federal government had finally reached individual agreements with each of the provinces and territories (Galloway 2017).

and especially, where that care will come from. With current state resources already at capacity, what will happen to those who do not bounce back?

5. Conclusion

This chapter introduced resilience as a fourth mentality in the governance of mental abnormality. Resilience logics have informed a discursive shift away from mental illness, and towards mental health, and in short, a subsequent shift away from the treatment of the few, and towards the mental health of all. Resilience is not a new concept, having long served as a popular area of study in ecology and engineering. However, it is now being taken up in new ways, co-opted by neoliberal logics and inserted into multiple policy domains. One such domain is mental health. This chapter located two overarching mental health policy directions – recovery and prevention – within a broader resilience mentality. Both of these directions individualize and responsibilize TCAMA for their own fates. None of the reports and strategies analyzed in this dissertation provided concrete recovery recommendations. Rather, recovery is first and foremost a subjective concept, meaning that recovery journeys should be individually planned and defined, rather than imposed. In contrast, promotion programmes, such as Alberta Health Services' *Bounce Back Book Series* (2010) and the University of Alberta's mental wellness initiatives, are targeted at entire student bodies. The purpose of these programmes is to teach students the skills needed to cope with life's challenges. This chapter concluded by identifying early signs of cracks in resiliency logics, including the Attawapiskat First Nation youth suicide crisis, and contention over mental health funding in recent Health Accord talks. It concluded by questioning the fate of those for whom prevention and recovery programmes are ineffective, but who due to responsibilizing and individualizing resiliency discourses, have no claim on the state.

CHAPTER 8: CONCLUSION

1. Summary

This dissertation employed a governmentality lens to identify four mentalities surrounding mental abnormality in Canada, between the 1830s to the present. These mentalities include containment, medicalization, deinstitutionalization, and most recently, resilience. I demonstrated that categorizations and problematizations of mental abnormality have changed through time, differently informed by shifting logics. I highlighted the shifting line between normal and abnormal, and subsequently, inclusion and exclusion. Each of the programmes explored in this project represented a progressive shift, at the time, in mental health policy. However, many of them tested the limits of what was considered humane, and they each generated new problems, which went on to inform subsequent solutions.

This dissertation showed that crisis periods in the governance of mental abnormality are marked by a flurry of competing discourses, as evidenced, for example, by the SSCSST and LAO hearings. Ultimately, however, some discourses – and programme recommendations – are authorized over others because they are commensurable (Kuhn 1982, 670) with broader mentalities. In what follows, I summarize each of these four mentalities, and demonstrate their alignment with various programmes and technologies involved in the governance of mental abnormality, from the 1830s to the present. Table 1 presents a summary of my findings, and demonstrates the relationship between containment, medicalization, deinstitutionalization, and resilience mentalities, and their corresponding time periods, programmes, and technologies.

Containment was the dominant mentality informing the governance of mental abnormality in Upper Canada/Ontario, from the 1830s to the 1920s. It suggested that mental abnormality could be segregated away from society, for both the good of society as well as

Table 1: Mentalities, Programmes, and Technologies in the Governance of Mental Abnormality in Canada, 1830s to Present

Dominant Mentality	Time Period	Programmes	Technologies
Containment	1830s to 1890s	Lunacy reform 1) Confinement 2) Moral treatment a) Work therapy b) Recreation c) Religion	Asylum walls Gardening, sewing, cooking, laundry Exercise Praying
	1900s to 1920s	Mental hygiene	Good parenting Moral training Physical exercise Mental testing Inspection of immigrants
		Eugenics	Sterilization Inspection of immigrants
Medicalization	1930s to 1950s	Treatment	Lobotomy Electroshock Psychopharmaceuticals
Deinstitutionalization	1960s to 1990s	Community services	Psychopharmaceuticals Boarding houses
Resilience	2000s to Present	Recovery Prevention	Employment Exercise Deep breathing Proper sleep Good parenting

TCAMA. Different ways of thinking about mental abnormality during this period, including lunacy, insanity, and feeblemindedness, opened it up for various interventions. Containment informed three subsequent programmes: lunacy reform, including confinement and moral treatment, mental hygiene, and eugenics.

Lunacy reform was a programme designed to contain lunatics behind the walls of large-scale, specially designed lunatic asylums, commencing the mid-1800s. It was commensurable (Kuhn 1982, 670) with a broader classical liberal “world of walls” (Walzer 1984, 315). Lunacy reform was a way of providing for lunatics while simultaneously separating them away from society, using technologies such as asylum walls and straitjackets. In addition to confinement, it included moral treatment programmes designed to reform the lunatic, primarily through work therapy, including technologies such as gardening, sewing, cooking, laundry, and prayer. It was considered a humane alternative to physical restraints, and re-instilled morals such as self-reliance, hard work, and gender norms into lunatics.

Lunacy reform authorized alienists, harbingers of moral treatment, who occupied the role of superintendents over asylums. However, towards the end of the nineteenth century, neurologists critiqued alienists for low cure and discharge rates (Dowbiggin 2003, 10-11; Shortt 1986, 139). Their critique was grounded in an emergent discourse surrounding the causes of mental abnormality, specifically, that it was the result of neurological, and therefore, somatic, causes (Dowbiggin 2003, 10-11; Shortt 1986, 138-39). Alienists incorporated emergent neurological discourses into their dominant understanding of mental abnormality, while also undergoing professional reorganization into psychiatry, a medical profession that dealt with insanity, as opposed to lunacy. An example of this reorganization was the renaming of asylums as hospitals (Reaume 2000, 6).

Lunacy reform resulted in new problems, primarily, overcrowding and incurability. There was not enough room or resources to contain TCAMA away from society. However, in the early twentieth century they were still viewed as a threat. Overcrowding and incurability contributed to a crisis in a containment mentality, which informed new containment programmes – mental hygiene and eugenics. Mental hygiene and eugenics were programmes designed to contain mental abnormality, not be confining TCAMA away from society using walls, but by confining mental abnormality away from society by preventing it in the first place, albeit using different technologies. Mental hygiene, specifically, was a programme designed to prevent mental abnormality through the proper socialization of the child, both at home and in the classroom (Richardson 1989, 2). Dominant discourses surrounding insanity combined with emergent pedagogical discourses anticipating the "century of the child" (Richardson 1989, 2) to focus the child as the object of intervention for technologies such as moral training, physical exercise, and mental testing. Mental hygiene transformed psychiatrists into social experts, who through organizations such as the CNCMH, were involved in the inspection of immigrants for mental fitness, and contributed to mental hygiene curriculum for schools and parenting classes (Dowbiggin 2003, 9; McLaren 1990, 59).

In the early twentieth-century, dominant discourses suggesting a somatic link to mental abnormality merged with hereditarian discourses to construct feeblemindedness, a less severe category of insanity. Containment still categorized mental abnormality as a threat to society, but this time, that threat was grounded in genetic discourses. Genetic discourses suggested that social problems were the result of the reproduction of the feebleminded (McLaren 1990, 27-32). This way of thinking informed eugenics, a radical biopolitical programme that contained mental abnormality using sterilization technologies. Eugenics programmes lost popularity by the end of the 1930s, in Canada's broader effort to distance itself from Nazi Germany policies (Dowbiggin 2003, 187; McLaren 1990, 147). However, residual hereditarian discourses that attribute mental illness to genetic causes persist today, in neurochemical understandings of mental abnormality.

By the 1930s, medicalization supplanted containment as the dominant mentality surrounding mental abnormality. Mental hygiene and eugenics programmes failed to contain mental abnormality. That failure perpetuated incurability and overcrowding in hospitals. Although mental hygiene was ineffective, its discourses contributed to the further medicalization of mental abnormality, newly categorized as mental illness. Medical discourses merged with social progressive discourses to suggest that like any other illness, mental illness could be cured, and patients could be released from hospitals. Treatment programmes employed experimental technologies, such as lobotomy and electroshock (Reaume 2000, 19-20), but neither resulted in a cure. Furthermore, a growing consumer/survivor movement, informed by citizen rights discourses, contributed to the legal curtailment of lobotomy (Simmons 1990, 20).

Treatment programmes failed to cure mental illness. However, the invention of psychopharmaceuticals in the 1950s suggested that it could be managed. This technology, in addition to growing public concern about the conditions faced by rights-bearing TCAMA in PPHs, aligned with social progressive discourses to inform deinstitutionalization (Dear and Wolch 1987, 16; [Lesage 2000] in Morrow 2004, 42). Deinstitutionalization supplanted medicalization in the 1960s as the dominant mentality surrounding the governance of mental abnormality. It proposed that with technologies such as psychopharmaceuticals and community services, that patients – newly categorized as rights-bearing citizens – would fare better in the community. Over a 30-year period, deinstitutionalization programmes released thousands of TCAMA onto the streets. Unfortunately, however, few services were transferred into the community (Dear and Wolch 1987, 108). Consequently, many ex-patients ended up in boarding houses, homeless, or in prison. By the late 1980s, deinstitutionalization fell into crisis, evidenced by successive public reports aimed at the completion of a community-based service system.

The failures of deinstitutionalization programmes made room for new ways of thinking about the governance of mental abnormality. The SSCSST (2003 to 2006) and LAO (2009 to 2010) hearings provided a space for the airing of competing discourses. The final documents, however, were informed by an emergent resilience mentality. Resilience borrows from residual mental hygiene discourses, this time merged with neoliberal discourses, to suggest that mental illness is preventable. It prescribes recovery and prevention programmes that individualize and responsibilize TCAMA for their own fates. Through technologies such as employment, sleep, exercise, drinking tea, and psychopharmaceuticals, TCAMA are expected to bounce back from, or adapt to, life's challenges. Under a resilience mentality, a mental illness diagnosis does not mean one is mentally abnormal. However, the inability – perceived as the refusal – to bounce back, or adapt to it, does. This dissertation identified early signs of cracks in resiliency logics, including the Attawapiskat First Nation suicide crisis in April 2016, and contention over targeted mental health funding during recent Health Accord talks. These early cracks indicated that, like the dominant mentalities preceding it, resilience is generating new exclusions with dangerous consequences.

2. Significance of Findings and Areas for Future Study

This dissertation demonstrated that mental abnormality – the irrational – *is* political, and merits greater attention within political science. Mental abnormality is an object of governance, and the ways through which it is governed extend far beyond finished policy documents – to the doctor's office, public school curriculum, workplace “wellness” initiatives, and even to the everyday language that we use, such as “that’s crazy” or “that’s insane.” My research results illustrated that a governmentality approach is valuable to political science as a tool that helps to reveal multiple sites and relations of power that often go unnoticed, and consequently, unchallenged.

The conclusions drawn by this project bear much significance for the future of mental health policy in Canada. Specifically, this project demonstrated that negative outcomes have the most impact on those inhabiting already marginalized positions. It highlighted that even when mental healthcare reform discussions appear to be consultative in nature, and make every concerted effort to include those who have experienced the mental health system firsthand, that negative outcomes still risk further burdening those least equipped to cope. This dissertation suggested that prevention and recovery directions should be rethought to ensure that the cost of mental health for those with the resources to access it is not placed on the backs of those without the resources to bounce back.

This dissertation made various references to intersections of mental abnormality with race, Indigeneity, gender, sexuality, class, and ability. For example, it suggested that early-1900s mental hygiene programmes could not be considered apart from immigration restrictions. A potential area for future study would be a fuller investigation into these overlaps using an intersectionality lens (Collins 2000; Dhamoon 2009; Smith and Jaffer 2012). An intersectionality lens would situate ableism alongside racism, colonization, sexism, and homophobia within the same broader white settler, able-bodied, hetero-patriarchal system of governance. This approach would uncover potential sites of resistance and ways to challenge and dismantle this system.

Another potential area for future research would be a comparative/international analysis of Canadian mental health policy. The federal and national reports and strategies borrowed from approaches undertaken in other countries, as seen in the SSCSST's second interim report, *Mental Health Policies and Programs in Selected Countries* (2004). It was outside of the scope of this project to add an additional, comparative/international dimension to its analysis. However, it would be interesting to locate Canadian mental health policy directions globally and to examine how the governmentality approach employed in this project might apply to past and present approaches undertaken in other countries.

3. Moving Forward

In Spring 2015 I visited the old grounds of the London Lunatic Asylum during a stay with my parents in London, Ontario. The grounds had last been used as the site of London's Regional Mental Health Centre, a series of buildings separate from the original Asylum, accessed via Highbury Avenue. The Centre had recently been closed and its services relocated to larger, newer hospitals throughout the city. During my visit, my aunt told me of another access point to the grounds, via a small road off Dundas Street. Intrigued, I borrowed my parents' car and went in search of the alternate entrance. When I turned my car into the entrance, I found myself at the end of a long, tree-lined roadway, which led to the grounds of the original Asylum. The wings of the Asylum had long been demolished, but its main building was still standing, albeit with boarded up windows and doors. I was struck by the emptiness of the property, which was once populated well beyond the capacity of the institution. There was no one to be found.

On my way home from the grounds I suddenly stopped the car when a woman erratically ran off a bus and stood screaming in the middle of the street. It was not long until a police cruiser pulled out of a nearby station to investigate. As I drove home I was struck by the juxtaposition, and it occurred to me that within a five-minute drive, I had traveled from a containment to a resilience mentality. I was struck by the stretch of farmland that had once been the site of "work therapy," but was now completely empty. On the other hand, the woman on Dundas Street stood out as an example of what happens when one does not "bounce back." It occurred to me that it was unlikely that she served as a witness before the SSCSST and LAO committees, although she would bear the brunt of their subsequent recommendations.

Throughout this study I was reminded of other figures, including Marilyn – nicknamed Trixie – from my hometown, St. John's, Newfoundland. Marilyn could often be seen walking the streets of St. John's with a beautiful fur coat on in July, and depending on the day would wish a random passersby a "good day" or yell at them to "fuck off." I was reminded of Ashley Smith, who after six years of being transferred amongst different correctional facilities, killed herself in her segregation cell at 19 years of age while prison guards watched. Her original "crime" was throwing crab apples at a postal worker when she was 13 (National Post, 19 December 2013). I was reminded of Edward Snowshoe who committed suicide after 162 days in a segregation cell. Corrections officers were "unaware" of his previous suicide attempts (CBC, 11 July 2014).

These stories, amongst others, demonstrate the effects of mental health policy shifts on the very lives that those shifts overlook. Yet these are not the lives at the centre of prevention and recovery discourses. They are not the spokespeople for the *Bell Let's Talk* campaign, nor are they the targets of university mental wellness initiatives. Prevention and recovery are appealing ideas – it is easy to fall into the trap of thinking that after hundreds of years, we have found the solution to mental abnormality. However, more so than anything else, this dissertation demonstrated that captivating and convincing discourses can translate into dangerous technologies, and that new inclusions result in new exclusions. This dissertation demands that we ask: if prevention and recovery centre the individual, who do they marginalize? Who is silenced when we talk about our mental health? If promotion campaigns bolster the mental health of all, what about the mental illness of the few? Who will catch those who do not bounce back and recover when they fall? We cannot predict the future of mental health policy in Canada, but we can trace its past. This past suggests that resilience is not enough.

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