

## **MENTAL HEALTH REFORM, ECONOMIC GLOBALIZATION AND THE PRACTICE OF CITIZENSHIP**

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### **ABSTRACT**

Drawing on research conducted in British Columbia, Ontario, and Quebec it is argued that tension exists between mental health reforms born out of concern for the well-being and care of people and those that are being driven by cost-containment and efficiency. Contributing to this tension are competing discourses about mental health and mental illness. It is argued that progressive change requires the meaningful engagement of mental health care recipients in policy decision-making processes and ongoing analysis about the interconnections between economic globalization, social welfare state restructuring and mental health reform.

### **INTRODUCTION**

According to the literature on health reform, the trend away from hospital care toward community-based services is the result of several interconnected processes that include both domestic political developments and international pressures (Armstrong et al., 2002). Researchers have documented radical reforms to the health care sector in Canada that followed the post-war era, the rise of the welfare state, and its subsequent decline as the state increasingly focused on debt and deficit reduction (Armstrong et al., 2002; Aronson & Neysmith, 1996; Aronson & Neysmith, 1997; Mimoto & Cross, 1991). Although similar trends in the delivery of mental health services have been documented, over a longer period of time, mental health is still virtually absent from public debates about health care reform in Canada.<sup>1</sup>

Mental health reform in Canada can be seen as part of two concurrent processes. The first is a shift in the understanding and treatment of mental illness, which has led to changes in care (e.g., a shift from institutional to community-based care and more involvement of mental health recipients and their families in care decisions). The second is the re-arrangement of the fiscal and service-delivery structures of health care leading to a decentralized mental health care delivery structure in Canada. The tension between these two processes is evident especially in Canada, as governments align themselves with neo-liberal ideologies that promote reduced expenditures on social programs and increased competitiveness in the global marketplace through privatization. Further, competing discourses about the meanings, causes, and treatments of mental illness complicate responses to people with mental health problems and policy decision-making processes.

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The author would like to acknowledge the Canadian Institutes of Health Research who supported the original research on which this article is based.

Drawing on research conducted in British Columbia, Ontario, and Quebec, the interconnections between economic globalization and social welfare state restructuring are used as a jumping-off point for examining key mental health reforms. In this context, competing discourses about mental health and mental illness are explored for how they inform policy and service responses. The role of key stakeholders in the policy-making process, with an emphasis on the “practice of citizenship” and the political engagement of mental health care recipients will be discussed as avenues for change. Rather than making definitive claims, the emergent analysis points to the importance of understanding mental health reform in the current global economic context.

### THE STUDY

The following is a discussion that draws on an analysis emerging from ongoing research conducted over the period of 2001-2004 in Quebec, Ontario, and British Columbia. In each of these provinces 15-20 interviews were conducted with mental health providers, administrators and advocates.<sup>2</sup> Interview participants were asked to reflect on key reforms in mental health over the past ten years, the philosophy that guides the mental health care system, the mechanisms for the involvement of mental health care recipients in policy and service delivery decision making, the particular needs and issues as they pertain to women and other “vulnerable” groups, and the role of fiscal constraints/cost containment in federal and provincial mental health care policy decision making.

Policy statements and mental health plans in each of these provinces were examined to reveal governments’ positions on equity, organizational structures, mechanisms for the involvement of people diagnosed with mental illness, recognition of diversity, and changes in resource allocation.

#### **Economic Globalization, Social Welfare Restructuring and Mental Health Reform**

In Canada, mental health has been referred to as one of the “orphan children” of medicare (Romanow, 2002, p.178) in part because it has historically received a smaller share of federal health dollars. Although this disparity has been recognized and attempts to ameliorate it have ensued (e.g., the practice of some provinces “protecting” mental health dollars) the fact remains that mental health services are under-resourced particularly at the community level. The reasons for this are complex and reflect in part the ways in which mental illness has been understood and the attendant stigma attached to people with mental illness and to some extent their providers (Prince & Prince, 2002; Sartorius, 2004; Wahl, 1999). Historically, this stigma translated into discrimination and the belief that people with mental illness were somehow less “worthy” of care. Further, because the locus of care was the asylum, much of what was done to people with mental illness was beyond public scrutiny. Vestiges of this discrimination remain today and are reflected in inadequate and/or punitive social policies that especially marginalize people with mental illness. Despite calls for a wider range of mental health support and treatment options the dominance of bio-psychiatry has meant that most resources have been channelled towards biomedical interventions (Morrow, 2002; Morrow & Chappell, 1999). Policy is not only driven by the ways in which mental health/mental illness is understood but is also intimately connected to economic decision making.

Over the past decade mental health reform has been driven primarily by fiscal constraints and government concerns for cost containment in the health and social service sectors, which in turn is influenced by economic globalization and the increased use of “market mechanisms” in the delivery of health and mental health services (Shera, Aviram, Healy, & Ramon, 2002; Swenson, 2002). In the process, there has been an ideological shift from viewing social supports as an entitlement of citizenship, toward policies that emphasize the economic independence of individuals regardless of their status in society (Bashevkin, 2002; Cohen, 1997; McQuaig, 1995; Mishra, 1999). For people with mental illness—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 troubling.

Economic globalization affects policy decision making at the federal and provincial levels. Governments are increasingly being pressured at the international level to open up new markets for economic growth, including those pertaining to services such as health. Indeed, over the past ten years the Canadian health care system has undergone a series of reforms and changes, which have included increased experimentation with privatization, and critics have noted that the Canadian health care system with its unique public/private mix cannot be adequately protected under the terms of trade agreements (e.g., NAFTA and the GATS; Canadian Centre for Policy Alternatives, 2002; Hankivsky & Morrow, 2004). Consequently, concerns have been raised about the implications of economic globalization for the Canadian health care system especially with respect to how it might adversely impact health equity and health status (Coburn, 2000).

In a climate of global economic competitiveness governments are further entreated to reduce taxes and social expenditures. A key feature of economic globalization has thus been welfare state restructuring and the retrenchment of social programs like social assistance, health, education, public housing, legal aid, and employment supports (Bashevkin, 2002). In Canada, where the welfare state has had a strong and enduring presence, these shifts are dramatically changing the social support system for people with mental illness, many of whom rely not only on mental health services but also on social assistance, public housing, and a whole range of community-based supports. Further, economic globalization has been said to undermine democracy because it ties decision making by governments to the needs of transnational corporations (Brodie, 1995). In this climate, the implications for the democratic participation of mental health care recipients in health care decision making at national, provincial, and regional levels (a right only newly gained and still tenuous at best) has not yet been fully explored.

Two features of mental health reform are critical with respect to shifting the way people with mental illness are treated. The first is deinstitutionalization, and the attendant downsizing/closure of psychiatric hospitals; the second is the move, on behalf of governments, to create mechanisms for the participation of mental health care recipients in policy and treatment decision making. The former is significant because it illustrates most directly the implications of care shifts in times of fiscal constraints. The latter is a barometer of the degree to which mental health systems are able and willing to incorporate divergent viewpoints.

### Deinstitutionalization and the Downsizing of Psychiatric Hospitals

In the Canadian context, deinstitutionalization is a process that began in the 1950s with the shift of care from public mental hospitals to community mental health services (Shera et al., 2002). Deinstitutionalization was, and continues to be, driven by 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).

Although the term “deinstitutionalization” suggests that people were primarily released into independent living situations, the reality is that individuals leaving large psychiatric hospitals were placed in a number of different situations. For example, some were transferred to nursing homes or other residential facilities while others ended up in a variety of marginalized situations including living in rented rooms or on the street (Lurie, 1984). Early appraisals of deinstitutionalization pointed to the lack of sufficient support services to maintain individuals in the community and to the subsequent “urban drift” and “revolving door syndrome” which saw people returning to large cities in order to gain access to support services and public transportation corridors (Dear & Wolch, 1987; Minkhoff, 1987). The “ghettoization” of people with mental illness in inner cities, and the coinciding of deinstitutionalization with welfare state restructuring, has prompted an enduring skepticism as to whether deinstitutionalization is fueled less by concerns about care and more by concerns about cutting costs (Chambers, 1993; Dear & Wolch, 1987; Rose, 1979; Skull, 1984).

Supporters of deinstitutionalization argue that community-based care is a more humane, less restrictive, and an appropriate form of care. Indeed, many contemporary studies show that individuals fare well on standardized measures related to assessing symptoms, daily living skills, and residential status once they leave institutionalized care (Lesage, Morissette, Fortier, Reinhartz, & Contandriopoulos, 2000; Reinhartz, Contandriopoulos, & Lesage, 2000; Reinhartz, Lesage, & Contandriopoulos, 2000; Rothbard & Kuno, 2000).

Although a substantial body of literature on psychiatric deinstitutionalization exists (e.g., Bachrach, 1992, 1996; Dear & Wolch, 1987; Lesage et al., 2000; Reinhartz, Contandriopoulos et al., 2000; Reinhartz, Lesage et al., 2000; Rothbard & Kuno, 2000), with some exceptions (McGrew, 1999) studies have generally focused on individual clinical outcomes and/or on the effects of reforms on the mental health professions, rather than on the roles of multiple stakeholders as the process of deinstitutionalization unfolds (Lesage, 2000). What is missing from these examinations is an exploration of the diverse concerns and needs of recipients of mental health services, family members, mental health administrators, providers, and advocates; and what these mean for individuals being transferred from psychiatric hospitals.

Studies suggest that the role of “community” is critical in the deinstitutionalization process (e.g., BC Ministry of Health Services, 2002). That is, the involvement of a wide range of key stakeholders is necessary to ensure the successful integration of individuals arriving to new communities. Divergent viewpoints about the causes and treatment of mental illness, combined with stigmatizing misperceptions about mental illness, threaten the ability of newly arriving members to integrate into towns where populations are small and traditions of acceptable social behaviour are entrenched (Halseth, 1998). This disjuncture is also often visible in clashes between

the professional system of care and consumer advocacy organizations directed by people who have been or are currently in the psychiatric system.

Further, 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. Consumer advocacy organizations also feel the stress when care is transferred to communities, as mental health service recipients often require more complex forms of advocacy under these conditions. Reintegration can be especially difficult during restructuring which may include cutbacks to community supports. A brief examination of the current phase of deinstitutionalization in British Columbia is illustrative.

In BC, Riverview Hospital has been the sole tertiary mental health care facility since it was established in 1913. Proposals aimed at phasing out Riverview Hospital have been made periodically since the late 1960s; however, the current phase of deinstitutionalization began with recommendations arising from the 1998 BC Mental Health Plan. The plan called for regional self-sufficiency for mental health services—that is, the devolution of tertiary resources from Riverview to the regional health authorities (BC Ministry of Health, 1998). The most recent iteration of deinstitutionalization (the “Riverview Redevelopment Project”) began in 2000 and is focused on relocating approximately 400 of Riverview’s remaining occupants to cities and towns throughout BC. Many of these residents are being moved to new and/or existing tertiary care facilities in the regions.

These changes are being implemented in the context of a health system that has recently undergone considerable restructuring. This restructuring includes new fiscal pressures, the rapid amalgamation of 52 regional health authorities into six, and changes to the mechanisms designed to involve mental health care recipients in decision making. The result is that regions are in competition for resources and for jobs that come with the establishment of new care facilities. Further, the BC provincial government has recently implemented the deepest cuts to social services in Canadian history (Klein & Long, 2003; Long & Goldberg, 2002). These cuts and policy changes, especially changes related to disability benefits and social assistance, have already had an impact on many of BC’s most marginalized people with mental illness.

Although initial research suggests that this phase of “redevelopment” has had successful results for the individuals being transferred (BC Ministry of Health, 2002) this may in part be because many individuals are simply being relocated to new tertiary care facilities where they are not dependent on the wider social welfare system for support. What is not known is what supports are necessary for individuals displaced by the Riverview transfers who may now be living in more independent situations. It is arguable that in the current climate of welfare state restructuring it is necessary to understand how the reorganization of services and cutbacks to community mental health supports (including cutbacks to welfare, legal aid, supportive housing, etc.,) are affecting people diagnosed with mental illness. Indeed, some have called for a “systems” approach that is better able to assess the multi-dimensional nature of restructuring by combining sociological, clinical, and epidemiological approaches (Lesage, 2000; Tansella & Thornicroft, 1998).

Most significantly, perhaps, there is a difference between “being” in the community and having an active role in the community and it is this dimension of deinstitutionalization that has been largely ignored (Ramon, 1991). Arguably, the

degree to which individuals are actively accepted into communities and are able to play useful roles is an important determinant of mental health.

### **The Practice of Citizenship**

Barnes and Bowl assert that “. . . ideology, power and practice have contributed to the disempowerment of people who have been diagnosed with mental illness” (2001, p. x). In particular, the tension in psychiatry between social control and care and treatment of people is an ongoing controversy with concrete implications for the civil rights of people with mental illness diagnoses and therefore for their full participation in the community (Barnes & Bowl, 2001). The politicization of people who have been diagnosed with mental illness has resulted in demands for their more active involvement in treatment and in policy making. The success of the movement to mobilize a certain sector of the psychiatrized population in certain urban areas in Canada has been well documented (Everett, 2000) and yet little is known about the degree to which this movement has fostered the capacity for broader-based citizen-engagement with respect to the reform process outside of urban centres.

If mental health reforms are to be successful, avenues for the engagement of key stakeholders and particularly people diagnosed with mental illness, who are most directly affected, are needed. Although public participation is an important goal of health promotion (World Health Organization, 1986), mechanisms for soliciting and maintaining public participation vary with respect to the degree of decision-making power granted to people using the system and have often not included the requisite support and training required for effective and meaningful participation (McCubbin & David, 1996; Wharf Higgins, 1999). People who have experienced long-term psychiatric care often lack the requisite skills and training required for active citizen-engagement and have often been involuntarily committed; they have thus in some cases been divested of certain citizenship rights.

Citizenship is not just about having citizenship rights (e.g., legal, civil, political, social and economic rights) it is also about the capacity to “practice as citizens.” As Barnes and Bowl point out, “in terms of the relationship between the individual and the state this can mean, in practice, the extent to which people are able to contribute to the creation of public services which are often the form through which this relationship is mediated” (2001, p. 15). That is, citizenship is integrally tied to political participation.

Citizenship is not just a legal status but also confers membership in a particular community, which is bounded and can be exclusionary. The struggle of people with mental illness to be accepted as full citizens in their communities and as being able to make valuable contributions to social and cultural life has been hampered by stigma and discriminatory practices, which keep these individuals from being able to gain and maintain employment and other active community roles. Thus, citizenship must be seen as a combination of having individual rights and the ability to participate meaningfully in society and its political decision-making processes (Lister, 2003).

Mechanisms for the participation of mental health recipients in decision making in the mental health domain vary from province to province and are dependent, in part, on how vibrant the psychiatric survivor movements are in each locale and the degree to which mechanisms for participation have been formally built into mental health structures.

Historically, Ontario has had a strong and radical movement of psychiatric survivors that have had a direct impact on the direction of policy. This, combined with

sympathetic support from some politicians, bureaucrats, and academics, has resulted in the development of some important user-directed initiatives; for example, the Ontario Consumer Development Initiatives which supported mental health care recipients in peer-directed projects (Trainor, Shepherd, Boydell, Leff, & Crawford, 1997), and economic development models that have acted outside of the mental health system (Church, 1997; Church & Reville, 2001). However, despite the success of such initiatives (e.g., participants in the Consumer Development Initiatives reported that they used significantly fewer mental health services and found peer support significantly more helpful than any professional group) they have not received a level of support that this impact would justify (Trainor et al., 1997).

In Quebec a different model has prevailed, whereby user-driven advocacy groups have officially become part of the mental health system. L'Association des groupes d'intervention en défense de droits en santé mentale du Québec (l'AGIDD-SMQ), established in 1990, is an umbrella organization that oversees consumer advocacy groups throughout the province. The commitment to these groups was built into the 1989 Mental Health Policy. White (1996) refers to the relationship between these groups and the government as "conflictual collaboration" or "contradictory participation" to describe the ways in which their autonomy is constrained through the demands arising from government funding. Indeed, although these groups have been able to lobby for the rights of individual mental health care recipients, their ability to affect systemic change has been limited.

In BC formal mechanisms for the participation of mental health recipients have been largely dismantled under the current liberal government. Indeed, one of the government's first actions with respect to the mental health system was to dismantle the office of the mental health advocate<sup>3</sup> which was the first position of its kind in Canada dedicated to the role of systemic advocacy. This suggests a reticence on behalf of the government to document and make change based on people's experiences with mental health care.

Unfortunately, user participation, mutual aid, and self-help models are often compromised during restructuring processes and budget restraint. The examples from BC, Ontario, and Quebec suggest that these models will be tolerated only to the degree that they do not challenge the dominance of the "service paradigm" and biopsychiatry (Trainor et al., 1997).

### Discourses about Mental Illness

If, as Warner says, "psychiatric ideology is influenced by economic conditions" (1994, p. xi), then how we understand mental illness is intimately tied to economic restructuring. Indeed, Deena White describes mental health as a "notoriously trying policy domain" in part because the "uncertainty and controversy about the causes and the very nature of mental disorders makes the most appropriate means for their social management a puzzle" (1996, p. 289). Certainly, in a climate of cutbacks and retrenchment, challenges to predominant discourses about mental illness and the power invested in these will be less welcomed.

In Foucault's (1965) historical study of the experience of madness, he illustrates how one of the key surviving discourses about mental illness emerges during the Renaissance—that is, that "madness" is to be juxtaposed against reason. As Barnes and Bowl (2001, p. 9) argue "In a society in which the scientific rationality of enlightenment thinking provides the key point of reference, the irrationality of the insane presents a profound threat to social order as well as to personal integrity." The

rise of medical science solidified this notion; where rational scientific knowledge, in the form of psychiatry and psychology, and the moral authority of the doctor came to supplant other ways of understanding and dealing with “madness.”

A well developed critique of the “psychiatric paradigm” can be found in the work of early anti-psychiatry activists and feminists who were concerned with both the abuses of psychiatry and its claims to objective knowledge (e.g., Chesler, 1972; Laing, 1960; Leifer, 1990; Penfold & Walker, 1983; Szasz, 1974). For example, early anti-psychiatry activists struggled to highlight the civil rights of people with mental illness and wrestle control from powerful professionals in order to put support and treatment into the hands of people struggling with mental health problems (e.g., Chamberlin, 1978). Feminists pointed to the ways in which women had historically been pathologized by psychiatry and argued that women’s subordinate social positioning and disproportionate poverty led to mental health problems (Penfold & Walker, 1983). Still others have exposed western psychiatry as based on racist assumptions (Fernando, 2003). Increasingly, mental health service users—who are often subject both to mental health and disability policies—are looking to progressive discourses about disability to develop their approaches (Beresford, Harrison, & Wilson, 2002).

Despite this critique, the mental health system has been slow to take account of the differing needs and social experiences of people in the mental health system; that is, a social analysis of gender, class, sexuality, and, especially, race is still absent from even the progressive work of alternative groups.

Competing discourses in the mental health domain are tied intimately to structures of power in which bio-psychiatry has the most resources. Consequently, people are limited with respect to choice of treatment in a health care system that covers only certain kinds of care. The rigidity of a system that gives primacy to bio-medical explanations for mental illness is illustrated in the service gaps for women who are concurrently experiencing mental health problems, substance use problems, and violence and trauma in their lives. Currently, the mental health system requires that a primary problem be identified (i.e., mental illness) before services can be engaged and stresses on other support systems (e.g., women’s shelters and women’s addictions services) mean that many women with the most complex problems are unable to get support and treatment (Morrow, 2002).

## CONCLUSIONS

A review of policy in British Columbia, Ontario, and Quebec demonstrates that there is broad philosophical consistency across provinces. All jurisdictions have committed to improving access to mental health services, improving coordination of the mental health system, decentralizing administration and service delivery, promoting opportunities for “self-help,” preventing unnecessary hospitalization, and increasing community (consumer and family) participation in the decision-making process (McNaughton, 1992). As the foregoing analysis suggests, the progressive intent of these reforms can be stymied by a focus on economic concerns.

Indeed, Shera et al. (2002), in their comparison of mental health reforms in four countries (Canada, Australia, Britain, and Israel), conclude that reforms were primarily driven by concerns regarding cost containment and cost reduction. In each case market mechanisms have been introduced within the delivery of mental health services even though the evidence as to their efficacy is not yet clear. They also con-



clude that despite progressive policy statements about a community-based philosophy of care, in reality there has been very little reallocation of resources to community care.

Although, there is evidence that mental health care recipients have historically had an impact on the development and design of services in Canada, meaningful participation has been limited in most jurisdictions and is being actively dismantled in others. The degree to which people who have been psychiatricized can “practice citizenship” is dependent in part on the willingness of society and the mental health system to incorporate a range of understandings about mental health and mental illness. White and Mercier (1991) observe that:

... a hospital-centred, medicalized system is typically governed by professional/client relations, characterized by treatment and care on the one side, and passivity and dependence on the other. In contrast, a community-centred and participative system is ideally characterized by democratic and egalitarian relations in an environment that is ostensibly experienced as natural and supportive. Its governing principle is to empower resource users: helpers are seen to be at the service of users, and the latter define their own needs. (p. 21)

In Canada there is an active tension between these two approaches—the strength of the community movement, which includes a robust critique of the psychiatric paradigm, has kept this tension at the forefront of mental health policy and practice. However, elements of the larger context of health reform (i.e., global economic competitiveness, cost containment, efficiency, and government cutbacks) and the fact that mental health is still (relatively speaking) a low priority for governments threaten to stymie progressive social change in this arena.

## NOTES

1. A discussion of mental health has been included in two recent federal reports on health care (i.e., the Report from the Commission on the Future of Health Care in Canada headed by Roy Romanow and the report from The Standing Committee on Social Affairs, Science and Technology headed by Senator Michael Kirby). In the “Romanow Report” mental health is discussed in a brief two pages with a focus on recommendations related to home care (see *Building on Values: The Future of Health Care in Canada*, 2002: 178–179). Senator Kirby gives mental health more attention in his 2001 report on health care and his launch in February 2003 of a Senate Committee study on mental health care suggests that mental health is an ongoing concern for the Committee. Kirby, however, supports the commercialization and privatization of the health care and his role as director of Extencicare Inc has led to claims that his report is biased (see The Canadian Health Coalition *A Recipe for Commercialization and Privatization* Media Release October 25, 2002 <http://www.healthcoalition.ca/kirby-release.html>).
2. Many of the advocates interviewed were individuals who had been “psychiatricized” and were now working in the system to make change.
3. Under the Liberal government a Minister of State for Mental Health has been appointed. In response to concerns about the loss of the advocacy office the government has indicated that the Minister of State has now taken on this role. Critics argue that for advocacy to be effective it has to be “arms-length” from the state.

## RÉSUMÉ

Sur la base de recherches effectuées en Colombie-Britannique, en Ontario et au Québec, on pose ici l’hypothèse qu’il existe certaines tensions entre les différents types de réformes en santé mentale, opposant les approches inspirées du bien-être et des soins des patients, et celles issues de préoccupations liées aux

coûts et à l'efficacité. S'ajoutent à ces tensions les discours divergents sur la santé et la maladie mentale. Les auteurs avancent que tout changement productif nécessite un engagement significatif de la part des bénéficiaires des soins de santé mentale, que ce soit dans le processus de prise de décisions sur les politiques qui les concernent ou dans le processus d'analyse en cours sur les relations entre la mondialisation économique, la restructuration de l'État providence et la réforme de la santé mentale.

## REFERENCES

- Armstrong, P., Amaratunga, C., Bernier, J., Grant, K., Pederson, A., & Wilson, K. (2002). *Exposing privatization: Women and health care reform in Canada*. Aurora, ON: Garamond Press.
- Aronson, J., & Neysmith, S. (1996). The work of visiting homemakers in the context of cost cutting in long term care. *Canadian Journal of Public Health*, 87(6), 422-425.
- Aronson, J., & Neysmith, S.M. (1997). The retreat of the state and long-term provision: Implications for frail elderly people, unpaid family carers and paid home care workers. *Studies in Political Economy*, 53(Summer), 37-66.
- Bachrach, L. (1992). Psychosocial rehabilitation and psychiatry in the care of long-term patients. *American Journal of Psychiatry*, 149(11), 455-463.
- Bachrach, L. (1996). The state of the state mental hospital. *Psychiatric Services*, 47, 1071-1078.
- Barnes, M., & Bowl, R. (2001). *Taking over the asylum: Empowerment and mental health*. Basingstoke, Hampshire: Palgrave.
- Bashevkin, S. (2002). *Welfare hot buttons: Women, work and social policy reform*. Toronto: University of Toronto Press.
- BC Ministry of Health. (1998). Revitalizing and rebalancing British Columbia's mental health system: The 1998 mental health plan. Victoria, BC: Ministry of Health and Minister Responsible for Seniors, Adult Mental Health Division.
- BC Ministry of Health Services. (2002). *The Seven Oaks project*. Victoria, BC.
- Beresford, P., Harrison, C., & Wilson, A. (2002). Mental health service users and disability: Implications for future strategies. *Policy and Politics*, 30(3), 387-396.
- Brodie, J. (1995). *Politics on the margins: Restructuring and the Canadian women's movement*. Halifax, NS: Fernwood.
- Canadian Centre for Policy Alternatives. (2002). *Putting health first: Canadian health care reform, trade treaties and foreign policy (summary report for the Commission on the Future of Health Care in Canada)*. Ottawa: Consortium on Globalization and Health, Canadian Centre for Policy Alternatives.
- Chamberlin, J. (1978). *On our own: Patient controlled alternatives to the mental health system*. New York: Hawthorne Books.
- Chambers, S. (1993). *Implementing the 1987 draft plan to downsize Riverview Hospital: Expanding the social control network*. Simon Fraser University, Vancouver.
- Chesler, P. (1972). *Women and madness*. New York: Avon Books.
- Church, K. (1997). Business (not quite) as usual: Psychiatric survivors and community economic development in Ontario. In E. Shragg (Ed.), *Community economic development: In search of empowerment* (2nd ed.). Montreal: Black Rose.
- Church, K., & Reville, D. (2001). *"First we take Manhattan" evaluation report on a community connections grant OCAB regional council development*. Toronto: Ontario Council of Alternative Businesses.
- Coburn, D. (2000). Income inequality, social cohesion and the health status of populations: The role of neo-liberalism. *Social Science and Medicine*, 51, 135-146.
- Cohen, M.G. (1997). From the welfare state to vampire capitalism. In P.M.W. Evans & R. Gerda (Eds.), *Women and the Canadian welfare state: Challenges and change* (pp. 28-65). Toronto: University of Toronto Press.
- Dear, M.J., & Wolch, J.R. (1987). *Landscapes of despair: From deinstitutionalization to homelessness*. Princeton: Princeton University Press.

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- Everett, B. (2000). *A fragile revolution: Consumers and psychiatric survivors confront the power of the mental health system*. Waterloo, ON: Wilfrid Laurier University Press.
- Fernando, S. (2003). *Cultural diversity, mental health and psychiatry: The struggle against racism*. New York: Brunner-Routledge.
- Foucault, M. (1965). *Madness and civilization: A history of insanity in the age of reason*. New York: Random House.
- Halseth, G. (1998). *Cottage country in transition: A social geography of change and contention in the rural-recreational countryside*. Montreal: McGill-Queens University Press.
- Hankivsky, O., & Morrow, M. (2004). *Trade agreements, homecare and women's health*. Ottawa: Status of Women Canada.
- Klein, S., & Long, A. (2003). *A bad time to be poor: An analysis of British Columbia's new welfare policies*. Vancouver: Canadian Centre for Policy Alternatives and Social Planning and Research Council of BC.
- Laing, R.D. (1960). *The divided self*. London, UK: Tavistock Publications.
- Leifer, R. (1990). Introduction: The medical model as ideology of the therapeutic state. *The Journal of Mind and Behaviour*, 11(3-4), 247-258.
- Lesage, A. (2000). Evaluating the closure or downsizing of psychiatric hospitals: Social or clinical event? *Epidemiologia e Psichiatria Sociale*, 9(3), 163-170.
- Lesage, A., Morissette, R., Fortier, L., Reinhartz, D., & Contandriopoulos, A. (2000). Downsizing psychiatric hospitals: I. Needs for care and services of current and discharged long-stay patients. *Canadian Journal of Psychiatry*, 45(6), 526-531.
- Lister, R. (2003). *Feminist theory and practice of citizenship*. Paper presented at the German Political Science Association, Mainz, Germany.
- Long, A., & Goldberg, M. (2002). *Falling further behind: A comparison of living costs and employment and assistance rates in British Columbia*. Vancouver: Social Planning and Research Council of BC.
- Lurie, S. (1984). More for the mind: Have we got less? *Issues in Canadian Human Services*. Toronto: OISE Press.
- McCubbin, M. & David, C. (1996). Extremely unbalanced: Interest divergence and power disparities between clients and psychiatry. *International Journal of Law and Psychiatry*, 19(1), 1-25.
- McGrew, J.H. (1999). Special section: Multiple perspectives on the closing of a state hospital. *Journal of Behavioral Health Services and Research*, 26, 236-328.
- McNaughton, E. (1992). Canadian mental health policy: The emergent picture. *Canada's Mental Health*, 40(1), 3-10.
- McQuaig, L. (1995). *Shooting the hippo: Death by deficit and other Canadian myths*. New York: Viking Press.
- Mimoto, H., & Cross, P. (1991). The growth of the federal debt. *Canadian Economic Observer*, 3(1).
- Minkhoff, K. (1987). Beyond deinstitutionalization: A new ideology for the post-institutional era. *Hospital and Community Psychiatry*, 38, 945-950.
- Mishra, R. (1999). *Globalization and the welfare state*. Cheltenham: Edward Elgar.
- Morrow, M. (2002). *Violence and trauma in the lives of women with serious mental illness: current practices in service provision in British Columbia*. Vancouver: British Columbia Centre of Excellence for Women's Health.
- Morrow, M., & Chappell, M. (1999). *Hearing women's voices: mental health care for women*. Vancouver, BC: British Columbia Centre of Excellence for Women's Health.
- Penfold, S., & Walker, G. (1983). *Women and the psychiatric paradox*. Montreal: Eden Press.
- Prince, P., & Prince, C. (2002). Perceived stigma and community integration among clients of Assertive Community Treatment. *Psychiatric Rehabilitation Journal*, 25(4), 323-331.
- Ramon, S. (Ed.). (1991). *Beyond community care. Normalisation and integration work*. Basingstoke: Macmillan.
- Reinhartz, D., Contandriopoulos, A., & Lesage, A. (2000). Downsizing psychiatric hospitals: III Organizational analysis of deinstitutionalization in a psychiatric hospital. *Canadian Journal of Psychiatry*, 45(6), 539-543.

- Reinharz, D., Lesage, A., & Contandriopoulos, A. (2000). Downsizing psychiatric hospitals: II Cost effectiveness analysis of psychiatric deinstitutionalization. *Canadian Journal of Psychiatry*, 45(6), 533-538.
- Romanow, R. (2002). *Building on values: The future of health care in Canada*. Ottawa: Commission on the Future of Health Care in Canada.
- Rose, S.M. (1979). Deciphering deinstitutionalization: Complexities in policy and program analysis. *Millbank Memorial Fund Quarterly*, 57(4), 429-460.
- Rothbard, A., & Kuno, E. (2000). The success of deinstitutionalization: Empirical findings from case studies on state hospital closures. *International Journal of Law and Psychiatry*, 23(3/4), 329-344.
- Sartorius, N. (2004). The world psychiatric association global programme against stigma and discrimination because of stigma. In A. Crisp (Ed.), *Every family in the land*. London: Royal Society of Medicine Press Ltd.
- Shera, W., Aviram, U., Healy, B., & Ramon, S. (2002). Mental Health system reform: A multi-country comparison. *Social Work in Health Care*, 35(1/2), 547-576.
- Skull, A.T. (1984). *Decarceration, community treatment and the deviant: A radical view*. New Brunswick, NJ: Rutgers University Press.
- Swenson, J.R. (2002). Mental health reform and evolution of general psychiatry in Ontario. *Canadian Journal of Psychiatry*, 47(7), 645-651.
- Szasz, T. (1974). *The myth of mental illness*. New York: Harper and Row.
- Tansella, M., & Thornicroft, G. (1998). A conceptual framework for mental health services. *Psychological Medicine*, 28, 503-508.
- Trainor, J., Shepherd, M., Boydell, K.M., Leff, A., & Crawford, E. (1997). Beyond the service paradigm: The impact of consumer/survivor initiatives. *Psychiatric Rehabilitation Journal*, 21(2).
- Wahl, O. (1999). Mental health consumers' experiences of stigma. *Schizophrenia Bulletin*, 25(3), 467-478.
- Warner, R. (1994). *Recovery from schizophrenia, psychiatry and political economy*. London: Routledge.
- Wharf Higgins, J. (1999). Closer to Home: The Case for Experiential Participation in Health Reform. *Canadian Journal of Public Health*, 90(30-34).
- White, D. (1996). A balancing act: Mental health policy making in Quebec. *International Journal of Law and Psychiatry*, 19(3/4), 289-307.
- White, D. & Mercier, C. (1991). Reorienting mental health systems: The dynamics of policy and planning. *International Journal of Mental Health*, 19(4), 3-24.
- World Health Organization. (1986). Ottawa charter for health promotion. *Canadian Journal of Public Health*, 77, 425-430.