SETTING THE AGENDA: THE SIGNIFICANCE OF PATH DEPENDENCY ON MENTAL HEALTH RECOVERY, POLICY AND HOUSING IN ONTARIO, CANADA

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Background

In 2003, the World Health Organization emphasized the significance of a person's ability to access basic needs to be healthy, and flourish as a productive member of society. Accessibility to food, housing, employment and primary health care were identified as necessary, minimum requirements to achieve "health". This criterion, recognized as the broader determinants of health, form a direct link to the overall well-being of a person's mental and physical health. In almost all cases, individuals that lack access to basic needs live at or below the poverty line. As a result, people living in poverty are at an increased risk of poor physical and mental health (Raphael, 2009).

The broader determinants of health have not only been recognized by the World Health Organization, but by many governments, researchers and political actors, including those in Ontario, Canada. Several reports released by the government of Ontario, have identified the importance of addressing the broader determinants of health in order to improve overall health and well-being in the province. Yet, despite this recognition, there are still over 1.8 million people living in poverty in Ontario alone (Canadian Mental Health Association, 2010). More significantly, over thirty per cent of these poverty-stricken individuals suffer from some form of serious mental illness (Canadian Mental Health Association, 2010).

Mental illness is characterized by alterations in thinking, mood or behaviour, which results in significant distress and impaired functioning. Major depression, schizophrenia, and bipolar disorder are examples of serious mental illness (Public Health

Agency of Canada, 2009). Serious mental illness can be defined as an involuntary condition, and enduring disability where the individual may experience periods of psychosis, engage in bizarre behaviour, needs and benefits from medical attention, in some cases requiring hospitalization (Davis, 2006). Individuals struggling with mental illness vary in their frequency of hospitalization, and their duration of stay. Once the consumer has left the hospital to begin their recovery from mental illness, they will typically require treatment through medication, and support to transition from the hospital into the community. Assistance from the community sector can include many forms of support such as psychiatry, case management, and peer support. Ideally, there is a seamless transition from the hospital to the community for the consumer. However, this continuum of care does not occur in most cases, leaving many consumers without community supports once they have left the hospitals, and to pursue recovery on their own accord (Forchuk, Russel, Kingston-Macclure, Turner & Dill, 2006).

As the recovery model suggests, recovering from mental illness requires attaining a minimum quality of life that enables consumers to actively participate in the direction of their treatment, and to successfully pursue future goals (Laudet, 2007). Therefore, consumers must have access to basic needs, and also, support from the community to assist in the recovery process. For persons living in poverty, obtaining a quality of life that allows for conditions of recovery is absent. Housing, in particular, is often a significant barrier to recovery for individuals living in poverty and struggling with mental illness (Canadian Mental Health Association, 2009).

Housing is recognized as a human right by the United Nations, and a major determinant to the mental health of every community (Canadian Mental Health Association, 2004). Without access to adequate and stable housing, consumers are less likely to recovery from serious mental illness, and flourish as productive members of society. The link between poverty and mental health suggests that a safety net is needed to ensure that those suffering do not fall below a minimum standard of living. However, current social assistance in Ontario offered to marginal populations through The Ontario Disability Support Program and Ontario Works is minimal, and does not provide persons struggling with serious mental illness sufficient income for monthly rent.

As mentioned, the government of Ontario has produced several strategic reports since the 1980s including Every Door is the Right Door: 10-year mental health and addictions strategy (2009), Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health and Addictions Strategy (2010) and most recently, Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions strategy (2011) (Ministry of Health and Long-Term Care Newsroom, 2011). These reports have outlined the need to reform mental health policy to incorporate the broader determinants of health, and also the importance of increasing the availability of supportive housing for those with serious mental illness. Yet, despite significant mental health restructuring in recent years from institutions to community-based mental health care, the policy arena has failed to respond. Significant policy change, as outlined by Tuohy (1999) is difficult, particularly when specific policies are institutionalized within society. Therefore, policies become

path dependent in that they tend to follow a historical pattern, and once this particular path is created, it can become difficult to remedy.

This paper will argue that despite the acknowledgement from the World Health Organization, and several reports written by the Ontario government including the Hellestine Report (1983), Graham Report (1988), Putting People First (1993), Making it Work (2000), Making it Happen (2001), The Time is Now (2003), Every Door is the Right Door (2009), Respect, Recovery and Resilience (2010), and Open Minds, Healthy Minds (2011), path dependency has become a significant barrier to the creation of mental health policies addressing the broader determinants of health. Furthermore, it has also contributed to the lack of recognition mental health has received from the political arena. The lack of policy change and recognition from policymakers has a direct impact on persons with serious mental illness that are living in poverty with inadequate housing. Unless there is significant mobilization on behalf of the government sectors including the Ministry of Health and Long-Term Care, the Ministry of Community and Social Services, as well as consumers, provincial organizations like the Ontario Medical Association, or the Canadian Mental Health Association, psychiatrists, and other health care professionals, these marginalized groups will continue to lack opportunities that offer the ability to recover and attain an adequate quality of life.

This paper will begin with a discussion on the importance of the recovery for persons struggling with serious mental illness, and then identify the relationship between mental illness for those living in poverty as well as the importance of housing for

recovery. By focusing on people with serious mental illness, this paper will be limited to discussing persons who have left psychiatric hospitals and have begun their transition into the community. It is also important to acknowledge the benefits that the Assertive Community Treatment (ACT) teams in Ontario have on serious and persistent mental illness. However, most people that are in crisis do not have access to ACT teams as their mandate is very strict, as they are only able to service a limited number of people with the most serious and persistent mental illness, and will therefore not be discussed in this paper. Also, this paper recognizes that men, women, children, youth, and Aboriginal Peoples, and Newcomers experience mental illness differently in Ontario. However, this paper will provide a more general focus to gain input on mental health policy as a whole in Ontario. An analysis of past and current mental health reform will be offered, illustrating the history of path dependence in mental health policy. Furthermore, a brief comparison will be made between Ontario and Finland to highlight the "window of opportunity" that appeared in Finland to allow for policy change and access to housing. Finally, this paper will conclude by providing recommendations for the government of Ontario to address policy change in order for persons with serious mental illness and living in poverty to achieve an adequate quality of life.

Theory

Path dependency, a form of historical institutionalism identifies the extent to which policies have become institutionalised in the policy arena (Tuohy, 1999). The theory of path dependency argues that once policies of the past have become fully

engrained into the political system, they become extremely difficult to change. In this case, history matters, and plays a significant factor in explaining why certain policies exist today, and why some rarely change, and how the current system came to be (Kuipers, 2009).

Policy change does occur, according to the path dependency model, but it tends to be incremental in nature (Howlett, 2009). However, there is possibility for policies to undergo substantial change, but in order for this to occur there must be a paradigmatic change. This paradigmatic change, a process where deep values in policy subsystems are altered, leading to a realignment of other aspects of policy development, is correlated very closely with events which transform policy outcomes (Howlett, 2009). More simply put, this paradigmatic change, or critical juncture as outlined by Tuohy (1999), only results when there are significant changes in the political system which allow for policy change. There are several ways that policy change can occur, but often involves anything from significant political change or party alignment, the role of interest groups, public opinion, or the policy has become a pressing issue in society.

As Tuohy discusses, the Conservatives party's dominance in Ontario for decades helped set the stage for policy and political direction. Specific policies that were introduced to the health care system, involved the input of the medical realm, resulting in critical junctures where policy change took place (1999). Therefore, health policies in Ontario tended to result in medical views that did not account for the broader

determinants of health, as they were not considered to directly affect the health of the patient.

Unfortunately, creating significant policy change can be difficult particularly when moving from broad policy change to specific areas of policy that require reform (Tuohy, 1999). However, there are means through which policy change can occur. As Skocpol and Pierson (2002) identify, a "window of opportunity" can arise where major policy changes can occur. However, in order for this change to result, there has to be sufficient mobilization by political actors to take action, along with supportive public opinion to assist in "sweeping majority governments and establishing the broad outlines for the policy agenda to change" (p.114). Along with mobilization by political actors and policymakers, the issue must be significant in order to be brought onto the political agenda.

John Kingdon (2002) argues that there are three policy streams which help to bring an issue to the political agenda. These three independent streams, problem recognition, policy regeneration, and the political processes, must be aligned in order to create a policy window. Problem recognition means that a potential policy must be perceived as a serious issue for it to be considered high on the political agenda (Kingdon, 2002). Policy regeneration involves the gradual accumulation of knowledge and perspectives, and ultimately the generation of policy proposals. Finally, the political processes that occur within the system that affects the likelihood of policy being at the

forefront of the political agenda. These political processes include swings of national or provincial mood, election results, as well as changes in administration and turnover.

Methods

In order to conduct a review of the literature, several methods of research were used. This required the use of peer reviewed literature accessed through the York University Library E-Resources. My search of peer reviewed literature ranged from 1983 to 2011. Keywords that were used to search for articles included the following: mental health recovery in Ontario, Ontario mental health policy, community mental health in Ontario, social assistance in Ontario, mental health recovery and housing, mental illness and housing mental health recovery and poverty, social determinants of health and mental health policy, social determinants of health and mental health policy in Ontario, Consumer Survivor Initiatives, mental illness and the biomedical model, mental illness and recovery model, gender and mental health recovery, mental health policy documents in Ontario, mental health and human rights in Ontario, homelessness and mental illness, supportive housing and mental health recovery, path dependency, path dependency and mental health policy, path dependency and mental health policy in Ontario, mental health recovery in Finland, mental health policy in Finland, housing and social assistance programs in Finland, supportive housing in Finland.

Journals that were accessed through my research included specific journals such as the Community Mental Health Journal, Psychiatric Rehabilitation Journal, Journal of Mental Health Promotion, Social Science and Medicine, Canadian Public Administration,

and Health, Economics, Policy and Law. Electronic academic databases such as Wiley Online Library, Scholars Portal, Medplus, IngentaConnect, and Springerlink were also used to find specific journal articles. These academic databases were also accessed through the York University Library through E-Resources. The research also used peer reviewed journals through Google Scholar including the Journal of Public Health and BMC Health Services Research. Websites such as the Homeless Hub for journal articles on mental health and housing, as well as the World Health Organization, Centre for Addiction and Mental Health, Canadian Mental Health Association were also used. Several books were also referred to in the paper from the University of Toronto Library, and, online versions through Google.

In this paper, government reports and policies were accessed through websites from the Canadian Mental Health Association, the Centre for Addiction and Mental Health, as well as the Ministry of Health and Long-Term Care, the Ministry of Community and Social Services, the Government of Finland, the Ministry of Social Affairs and Health in Finland. Reports such as the Hellestine Report, the Graham Report, The Time is Now, Making it Happen, and Making it Work were accessed through the Canadian Mental Health Association. Every Door is the Right Door, Respect, Recovery and Resilience, and Open Minds, Healthy Minds were obtained through the Ministry of Health and Long-Term Care websites.

These sources used in this paper were based on whether they were academic sources, research papers or documents from provincial mental health organizations,

and/or government documents outlining the specific mental health strategies that were being reviewed. Canadian sources, particularly Ontario focused were preferred to highlight the relationship between mental illness, housing and poverty in Ontario.

The themes discussed in the paper include serious mental illness and the broader determinants of health. The paper, while looking at supportive housing and poverty in particular, attempts to highlight the need for the broader determinants of health for both achieving recovery from mental illness. It proposes the adoption of the recovery model, or incorporates of its elements to complement the traditional biomedical approach. The paper focuses on mental health policy in Ontario from the 1980s, identifying similarities between government reports advocating the need for a recovery approach, while acknowledging the broader determinants of health. The paper uses a theoretical approach of path dependency to explain the lack in policy change, even with similar reports.

To show the potential impact of including better social supports such as supportive housing, and income supports, Finland was used for comparison. Finland was chosen as a result of its proactive social policies that recognize the importance of mental health promotion and its relation to the broader determinants of health to ensure that services are offered to prevent people from falling through the cracks. Finland has a national mental health strategy, and with one of the highest suicide rates in the world, has made significant changes to their mental health system in recent years. Furthermore, much of the treatment for mental health in Finland revolves around the recovery model.

Focusing on Finland rather than another province within Canada, or to another country with similar political and social structures was a result of comparative literature which highlighted similar challenges in acknowledging the broader determinants of health in mental health policy, providing a sufficient continuum of care, and social supports for people with serious mental illness.

Findings

Mental Health Recovery

The term "recovery" in mental health can be controversial, offering many different theories on what type of model is appropriate. Historically, treatment for mental health has primarily relied upon a psychiatrist's use of the biomedical model (Raphael, 2009). The biomedical differs from other models in that it insists that mental illness is a result of a biological impairment. Some forms of serious mental illness, such as Schizophrenia and Bipolar Disorder, have linked biological abnormalities in the brain and identified genetic predispositions to its onset (Davis, 2006).

Health service providers adhering to the biomedical approach tend to promote mental health recovery through medication, and counselling (Repper & Perkins, 2003). Not all health care professionals strictly adhere to the biomedical model, and many do consider the clients' past experiences, and environment when choosing the direction of their treatment. The benefits of medicinal use, particularly in the case of severe mental illness cannot be argued. There is also a great deal of evidence highlighting the positive

effects of treatment through psychiatry, and there are many survivors of mental illness that can attest to this claim (Davis, 2006).

However, there are several concerns with the reliance on the biomedical model. Despite scientific evidence outlining the connection between serious mental illness and biological abnormalities, there is no evidence that can strictly identify this as the direct cause of mental illness (Castillo, 1997). There is an also an additional concern with the medicalization of mental illness. It has the potential to place mental illness on an equal playing field with physical illnesses such as cancer, where treatment tends to focus on symptom management, recovery through medical treatment, and lifestyle changes.

Even more problematic may be the client's relationship with their psychiatrist. Under the biomedical model, the patients' treatment, and path to recovery often occurs through the advisement of the client's psychiatrist (Repper & Perkins, 2003). This type of relationship may leave the patient with little involvement in deciding what form of treatment serve their best interest. Although the role of the psychiatrist is important in supporting the client's path to recovery, it does not extend past the hospital or office space and into the community.

The biomedical model addresses mental health recovery as one that must include medical treatment. Although successful treatment of serious mental illness almost always includes the use of medication and counselling services, it is concerning that there is no attempt to consider social supports, despite many psychiatrists acknowledging the effects that environment, and socioeconomic status have with mental illness. Maintaining a

minimum quality of life after serious mental illness is detrimental to the recovery model. This holistic form of treatment has received widespread attention on its effectiveness of treatment through its adherence to individual recovery (Repper & Perkins, 2003).

The recovery model resulted from the consumer/survivor movement, focusing on client empowerment, allowing the consumer to take control and responsibility of his or her own life (Jacobson & Curtis, 2000). Although this notion of recovery was driven through the consumer/survivor movement, there is no agreed upon definition, with the term "recovery" having different nuances. Jacobson & Curtis identify recovery as having several different meanings, like the restoration of normal health, or the challenge of not allowing a serious or long-term condition continue to consumer or dominate one's life (2000).

Recovery not only includes treatment through medication, but aims to integrate patients from hospitals into the community through a variety of support services. Most importantly, it encourages individuals struggling with serious mental illness to actively participate in the direction of their treatment, and identify their own personal path to recovery. Recovery from mental illness is very individual, and every person approaches their path to wellness in a different manner, which is a significant acknowledgement of the recovery model, and in stark contrast to the biomedical model. Recovery through this model provides these individuals with a sense of hope, which is essential for recovery and is improved when they are given more control over the direction of their lives (Shepherd, Boardman & Slade, 2008).

The concept of hope for recovery allows those with mental illness to identify areas to work on such as their own personal feelings, desires, competencies, and to commit to future plans (Repper & Perkins, 2003). Recovery from mental illness is a "process that is generated by the role as an actor that the individual adopts to rebuild his or her sense of self and to manage the imbalance between internal and external forces with the objective of charting a path through the social world and regaining a sense of well-being on all psychosocial levels" (Noiseux et al, 2009, p.78). This implies that a person with a mental illness must be able to identify goals which they feel are able achievable in order to live a healthier, balanced life.

These goals involve attaining a quality of life that allows an individual the opportunity to contribute as a productive member of society. As the National Director of Mental Health in the United Kingdom describes, it is about incorporating "quality of life – a job, a decent place to live, friends and a social life" (Shepherd, Boardman & Slade, 2008). Although not advocates of the recovery model, the Ontario Medical Association (OMA) in its comment to the Ministry of Health and Long Term Care identified the importance of self-determination, self-management, and the development of occupational and social roles for these individuals (OMA, 2009). Despite the OMA's strong support of the biomedical model, the association still acknowledges the importance of actively participating in one's recovery and also the effect that society has on the patient's ability to live a healthier life. In fact, longitudinal research has shown that all people that are diagnosed with a serious mental illness can learn to control their symptoms, work and live

independent lives, and in some cases, recover completely (Corrigan & Phelan, 2004). Although recovery does not necessarily mean a "cure" from mental illness, it does provide a person with the opportunity to move forward in their lives, and in the end, regain his or her identity. As one patient describes, "Recovery, I just…What is it for me? It's going back to me. Being introduced to me…" (Laudet, 2007). Finally, the concept of recovery identifies the importance of the broader determinants of mental health, which the biomedical model fails to acknowledge.

The Broader Determinants of Health

The broader determinants of health (BDH), as defined by the World Health Organization (WHO), are the conditions in which people are born, grow, live, work and age, including the health system (2010). These social conditions have a direct impact on a person's health and well-being. For individuals struggling with serious mental illness, their social conditions have a direct impact, whether it exacerbates their condition or contributes to the cause. The biomedical model is limited as it does not sufficiently acknowledge the broader determinants of mental health, and as a result, does not sufficiently consider the impact of external forces on a person's health once transitioned back into the community. However, most health service providers do recognize the effect of social and environmental factors on a person's recovery. The failure to take the broader determinants of mental health into consideration during treatment implies that a patient's environment has no effect on their condition and that that treatment through medication and therapy are adequate to maintain the health of the individual. However, there is

significant evidence that the broader determinants of mental health have a direct impact on the conditions of the patient. As Bambra (2005) outlines, inequities in health are largely determined by income inequalities, the distribution of wealth and other areas of social and class inequalities.

The notion of recovery identifies the significance of determining interpersonal and societal goals that are achievable to obtain a quality of life the patient may desire. However, if the patient has inadequate broader determinants of health how attainable are the goals that they set for themselves? For individuals living in poverty, the concept of recovery can be extremely challenging. Patients recovering from serious mental illness and living in poverty do not have access to adequate housing, income and employment. This relationship between poor broader determinants of health and serious mental illness becomes more evident when examining the impact on gender.

Despite similar prevalence rates of psychiatric disorders among men and women, there are striking gender differences found in the patterns of mental illness. For example, gender differences occur particularly in the rates of common mental disorders including depression and anxiety, with women experiencing much higher rates. Furthermore, as a whole, women are more likely to experience greater challenges while in recovery from serious mental illness. These challenges are often a result of poor broader determinants in health including gender-based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status, as well as their role as care giver (World Health Organization, 2011). In fact, as a result of gender inequality and

discrimination, women represent the majority of social assistance recipients and those that hold the lowest paying jobs. Women, particularly of Aboriginal and Black descent also represent the fastest growing number of homeless people using shelters in Canada (National Working Group on Women and Housing, 2006).

Lesbian, Gay, Bisexual, Queer, Transgendered and Inter-sexed (LGBQTI) populations also experience similar challenges to recovery from serious mental illness. LGBQTI represent some of the poorest populations in Ontario and throughout Canada. In fact, approximately 40 per cent of LGBQTI youth represent the homeless population in Toronto, Ontario (Ministry of Children and Youth Services, 2008). In addition to many living in poverty, LGBQTI populations are exposed to high levels of stigma and discrimination, which often results in social exclusion and depression (Ministry of Children and Youth Services, 2008; ILGA-Europe, 2006). Aboriginal Peoples in Ontario face similar circumstances as they are more likely to be unemployed, receive lower income and face social exclusion as a result of cultural and communication barriers (Ministry of Children and Youth Services, 2008).

Newcomers experience with mental illness differs vastly from other populations in Ontario. In fact, upon arrival Newcomers experience better mental health in post-migration than persons native to Ontario (Khanlou, 2010). However, this advantage diminishes over time as a result of poor social determinants of health that are directly related to their migrant status. Newcomers experience numerous challenges including economic integration barriers, difficulty accessing social and health services as a result of

language and cultural barriers, as well as a lack of social networks (Khanlou, 2010). Underemployments, unemployment, a lack of culturally sensitive mental health services, as well as discrimination, are some of the challenges that face Newcomers (Khanlou, 2010). Women, youth, adolescents and the elderly face additional barriers. Women with precarious immigration status for example, are at risk of being exploited, and often work in environments that are unsafe (Khanlou, 2010). As a result of these poor determinants of health over time, vulnerable populations such as women, LGBQTI, Aboriginal Peoples, and Newcomers can face significant barriers to their mental well-being.

As a result, there must to be greater significance attached to the concept of recovery from serious mental illness by psychiatrists and the health care system such as hospitals that contribute to discharge plans. Most importantly, it is crucial that health service providers acknowledge significance of the broader determinants of health not only for mental health, but also in its impact on recovery, particularly for vulnerable populations. Finally, there should be greater attention to the relationship between mental health and poverty to identify the importance of adequate housing for recovery.

The Relationship between Housing and Mental Health

Individuals considered to have adequate mental health are those who achieve a "state of well-being in which every individual realizes his or her own potential and is able to cope with the normal stresses of life with the ability to work productively and fruitfully, and is able to make a contribution to his or her own community" (Marmot, 2008, p.5). For

those who lack access to sufficient housing, achieving mental health becomes insurmountable.

Housing, as outlined by the Canadian Mental Health Association is a major determinant of mental health in all communities (2004). It is also recognized by the United Nations as a human right that is protected under international law and endorsed by the Canadian Charter of Rights and Freedoms stating that all citizens have the right to an "adequate standard of living including adequate food, clothing and housing" (Canadian Mental Health Association, 2004). This entitlement is further endorsed on a provincial basis through the Ontario Human Rights Commission (Ontario Human Rights Commission, 2011). Despite this entitlement to a minimum standard of living, many people that are struggling from poor mental health are unable to obtain access to adequate housing, particularly supportive housing.

There is significant evidence to suggest that housing is a major determinant of health. A person's place of dwelling often represents more than just the physical nature of the house. Moloughney (2004) suggests that the home is more than the physical space that it occupies, that it provides a level of psychological well-being, known as "ontological security". Ontological security is defined by Moloughney (2004) as a sense of confidence, trust, and reliability in the world as it appears to be. This ontological security offers those with serious mental illness, a source of refuge, and more importantly, personal empowerment. What results, is a home that not only provides a place for attachment, identity, permanency and continuity, as well as a sense of achievement and pride

(Moloughney, 2004). Even more importantly, people with serious mental illness identified both housing and income as the most important factors for achieving and maintaining physical and mental health (Waegemakers, Schneider and Schiff, 2007).

There are several housing options for persons struggling with serious mental illness that are transitioning from the hospital back into the community. Supportive housing, in particular, has been identified in having the greatest benefits to people transitioning from the hospitals. Supportive housing offers housing for persons with serious mental illness that can be linked with supports. Typically, staff members are employed in these units to provide a level of support required for resident. The level of support often varies from low level to high level assistance, depending on the severity, persistence and length of hospitalization a person has endured. Support is often through group home settings, and funded mainly by the government of Ontario (Centre for Addiction and Mental Health, 2009).

Supportive housing for people transitioning back into the community is significant. People are provided ontological security, a feeling of attachment, peer support from others living in their homes, and access to support for their mental illness as needed. In one particular study, it was reported that the experience encouraged personal empowerment, and reduced their hospital stays significantly (Waegemakers, Schneider, and Schiff, 2007). Another study documented that people with serious mental illness were able to increase their socialization, self-esteem, adult learning skills, and manage their

psychiatric symptoms in supportive housing. The benefit of housing with supports is further confirmed with the discharge of clients from the psychiatric ward.

A study in the United Kingdom took clients that stayed in the hospital for at least one year, and monitored them for a period of five years from the point of discharge into the community. Of the total 523 participants that were monitored over this five year period, 89.6 per cent remained housed within the community (Forchuk et al, 2009). Alternatively, a study in London, Ontario highlights the difficulties that people with serious mental illness experience when they do not have a 'fixed address' to return to once being treated at a psychiatric facility. Therefore, the client was either discharged to a shelter or remained homeless (Forchuk et al, 2009). Shelter data reveals that discharges from psychiatric shelters or the street occurred approximately 194 times in 2002 in London, Ontario (Forchuk et al, 2009). The consequences of discharging people from psychiatric facilities to shelters can include re-hospitalization as well as prolonged homelessness. The study by Forchuk et al shows the benefit of housing and supports when intervening with people that were considered to have serious mental illness, and at risk of homelessness. The intervention required immediate attention from health service providers to ensure access to supports like housing was available. The clients also received assistance with paying their first and last months rent. The outcome of the study identified that those that received immediate assistance from health service providers maintained housing after a period of three and six months (Forchuk, 2009). This study by Forchuk identifies the significance of receiving immediate assistance from health service

providers prior to being discharged, but also how critical housing and supports are to lower re-hospitalization rates, and in promoting recovery and integration back into the community. As a result, housing with supports for those that have experienced extended periods of hospitalization, offers people with serious mental illness the ability to not only improve their physical and mental health, and integrate back into the community, but encourage personal achievement and growth (CAMH, 2009).

Unfortunately, persons with serious mental illness do not always obtain access to supportive housing, as there are only 8500 supportive housing units allotted towards persons with mental illness in Ontario (Canadian Mental Health Association, 2010). This number of supportive housing units is much too low, and results in extremely long waiting lists. Persons with serious mental illness can experience anywhere between one to six years on a waiting list to obtain access to supportive housing units in Ontario (Canadian Mental Health Association, 2010). In Toronto, the Coordinated Access to Supportive Housing (CASH) outlined that the waiting list for those with mental illness has increased in a year and a half from 1400 people to 3000 to gain access to supportive housing (CASH, 2010).

A study done by the Ontario Non-Profit Housing Association (ONHPA) examined the wait lists for supportive housing and determined that there were over 142,000 households that were wait listed (2010). The current vacancy rate for assisted housing decreased from 3.3 per cent to 2.7 per cent since 2008 (ONHPA, 2009). Furthermore, another report released by ONPHA (2008) estimated that “the annual need for purpose-

built additional rental housing is approximately 10,000 units per year – roughly triple of what was produced annually between 2000 and 2005. Yet, in 2008, only 3,000 new rental units were built" (p.3). As a result, inadequate income and housing support prevents people with mental illness from rebuilding their lives. The stressors of daily life as a result of the lack of income support and housing really fall short in assisting these individuals. Furthermore, if they do not receive any government assistance for housing, there is a significant chance that they may fall "through the cracks".

Supportive housing for people with serious mental illness falls under the mandate of the Ministry of Health and Long-Term Care. The Ministry's central Supportive Housing Unit provides housing agencies with the operating costs and rent subsidies to cover the housing costs, while Ministry Regional Offices provide agencies with the necessary funding to deliver support to clients (Durbin, George, Koegl & Aitchison-Drake, 2005). However, there has been little done by the Ministry, and the government of Ontario to address the shortage of supportive housing in Ontario. There has been little to no increase of supportive housing units throughout Ontario since the early 1990s (Canadian Mental Health Association, 2010). Furthermore, despite many other countries adoption of a national housing strategy, Canada has yet to implement one, particularly for supportive housing (Sylvestre et al, 2007). This is due to the absence of adequate funding required to increase the number of units available for persons with serious mental illness. An increase in funding for supportive housing would be extremely beneficial not only to persons with serious mental illness, but for hospitals as well. Increasing the number of

supportive housing units not only increases the likelihood of recovery for consumers, but has a direct impact on the number of hospital stays and duration (Canadian Mental Health Association, 2010). Also, it is more economically efficient as a hospital stay can range anywhere from 500 to 800 dollars per day, while supportive housing would only cost 250 to 400 per day (Centre for Addiction and Mental Health, 2010).

For people living in poverty, supportive housing is only one of the opportunities that help them to transition effectively into the community. By providing support, and housing, which they would not be able to obtain on their own, this offers them a chance to pursue recovery from mental illness, and eventually become more confident, independent and secure. Without ontological security and access to adequate housing, these individuals then worry about day to day living, and whether they will have a place to sleep, or afford their rent for the next month. Without this feeling of security, recovery from serious mental illness can be insurmountable. However, this is a common concern for persons with serious mental illness that do not have access to supportive housing as government services fail to offer additional assistance for housing. Often enough, many people with serious mental illness live in substandard accommodation that are physically inadequate, and are crowded and noisy, and located in undesirable neighbourhoods. The challenge of providing stable housing is reflected in the estimated 67 per cent of homeless persons that are believed to have had a history of mental illness at some point in their life (Waegemakers, Schneider, and Schiff, 2007).

When persons with serious mental illness are unable to access supportive housing, they often look to renting through private homes or apartments, or share units with family or friends (Sylvestre et al, 2007). If these individuals have very low levels of income, then they are unlikely to be able to afford market rent housing or apartments. As mentioned earlier, this is particularly the case for vulnerable populations such as women, and LGBTQI. If they are unable to share units with family or friends, they may have great difficulty obtaining housing, and finding a home that is in a safe and secure neighbourhood, or worse, homelessness. Even if these individuals are able to obtain housing, they do not have consistent access to community mental health services that are available to persons living in supportive housing, or peer support which can all help to contribute to one's own recovery. Living in independent housing leaves these individuals to navigate the system on their own, which can be extremely complex and confusing, particularly if that person is disconnected from the system. Women in particular have greater difficulty navigating the mental health system. In a focus group held by Sheyett and McCarthy (2008), one women said, "I spent a lot of time struggling to know what was going on-not [to get] help to get better, but to see how the system worked." Many of the women in the focus group identified difficulty in getting their providers to communicate to coordinate their services into a coherent treatment plan (Sheyett and McCarth, 2008). The lack of access to services such as housing, and consistent access to community health services contributes to the complexity of navigating the system, and ultimately serve as barriers to recovery.

Government services available for persons with serious mental illness in Ontario are also limited. It is thus not surprising that many people with serious mental illness live in poverty. Housing assistance is often restricted to specific individuals, depending on their net wealth and severity of illness. In order to meet the requirements for income support, either through welfare (Ontario Works) or disability services (Ontario Disability Services Program), the person must have a serious mental disorder that lasts a minimum of one year. This criterion is based on the current definition for disability which is defined as "a substantial physical or mental impairment that is continuous or recurrent and expected to last one year or more. The impairment must substantially restrict the person in one or more activities of daily living" (Ministry of Community & Social Services, 2007). Furthermore, for Ontario Works, if a person exceeds over $587 in liquid assets, then they are ineligible for income support. This is similar for the Ontario Disability Services Program (ODSP) which states that a single person cannot exceed liquid assets of $5000 (Ministry of Community & Social Services, 2007). The rules and regulations placed on qualifications for income support, such as disability criteria and liquid assets, prevent many people from receiving the social support that they require to support their basic needs. It allows many people to "slip through the cracks". People unable to meet the minimum criteria that just fall short may not have access to the basic needs that they require, and as a result, recovery from mental illness and removal from poverty is bleak.

If people do qualify for income support through Ontario Works and ODSP, the amount of income provided to them is limited. The maximum amount of basic needs as

listed by the Ministry of Community and Social Services is $587 per month for a single person (2007). The individual will also be allotted a maximum for a single person of $464 for a monthly shelter allowance (Ministry of Community & Social Services, 2007). There was an additional $250 for the special diet allowance which provided additional income to purchase groceries per month, but has been cut as a result of cost. The combination of shelter allowance and income support do not provide the person with sufficient assistance to rise above poverty levels. This is especially the case if the individual is living in independent housing. The monthly rent likely exceeds the amount that the person will be able to afford in order to live the quality of life that they desire. Also, even if the person qualifies for ODSP there is significant turnaround time to receiving funding. Furthermore, when the individual is concerned with day to day living, the likelihood of their ability to focus on recovery is minimal.

To further illustrate the relation between mental health, poverty and housing, one only needs to look at the community of St. James Town, a central Toronto neighbourhood in Ontario. St. James Town is located in the northeast corner of downtown Toronto with approximately 30,000 people occupying the community. The area is one of the most densely populated areas in Canada, with many Newcomers and people of low-income. The community has faced consistent challenges as many in the community are marginalized, and is reflective in the physical infrastructure. Many people in St. James Town are low-income renters, and live in apartments that are subsidized. As a result, the conditions of the buildings are often poor, small, and overcrowded as people tend to share

accommodations. In fact, most of the people in St. James Town occupy the community's eighteen high-rise apartments (The Wellesley Institute, 2010).

The average income in St. James Town is just over 30,000 dollars per year, but the majority of people in the community make less than 20,000 dollars (Hutchinson & Grey, 2008). Therefore, most people in St. James Town either live at or significantly below the poverty line. As a result, many people living in St. James Town have described their income and housing conditions as poor. Furthermore, there have been several challenges in terms of overcrowding, drug trafficking in the area and concern for one's safety (Hutchinson & Grey, 2008). The struggle to make ends meet in the communities, combined with the challenges the community itself faces creates significant stress on the residents and affects their overall physical and mental well-being.

In a study done by Hutchinson and Grey many residents felt that the stressful conditions that they lived in had negative effects on their mental health (2008). Stresses including isolation and fear were listed as significant concern. Furthermore, a lack of availability of mental health services added to this additional stress. Residents expressed that limited counselling services were available in their communities, particularly for depression. Residents reported an extremely high rate of suicide in the community as well (Hutchinson & Grey, 2008).

The illustration of St. James Town highlights the challenges many residents face when accessing mental health services, particularly when living in poverty, but more importantly outlining the effect that inadequate housing has on the mental health of its

residents. For persons living with serious mental illness that only have the option to live through market rent, they would likely be living in a community similar to St. James Town. A community with little access to mental health services, poor housing conditions, and isolation does not assist in the recovery process for persons with serious mental illness

The government of Ontario has recognized that community support, such as access to supportive housing are necessary in the recovery of persons suffering from serious mental illness. It has provided numerous documents since the 1980s to highlight the benefit of community supports such as housing, income and access to mental health services. Despite this acknowledgement, those suffering with serious mental illness continue to face significant challenges in accessing supportive housing, as well as other forms, and the government of Ontario continues its reluctance to provide appropriate community services. Now the question becomes, if the government of Ontario recognizes that increasing social supports such as supportive housing would assist in the recovery of persons struggling with serious mental illness, why have there not been any changes in public policy to reflect this?

Ontario Public Policy and Mental Health Recovery

Historically, mental health care has not been a priority of policymakers or government action in Ontario. In fact, it has always maintained a "backseat" to physical health. This has occurred despite recognition from human rights documents from the World Health Organization and the United Nations Charter of Human Rights which

identifies the right to health, which includes both physical and mental health. The World Health Organization defines health as, "A state of complete, physical, mental and social well-being, and not merely the absence of disease" (2011). The United Nations Declaration of Human Rights to Health goes further in Article 25 by claiming that everyone has a right to a standard of living adequate for the health and well-being of his or her family, going as far to include housing, medical care, and social services. Furthermore, it states that everyone also has the right to security in the case where situations beyond their control, if health conditions or disability occur (United Nations, 2011). Therefore, not only is mental health recognized as a prerequisite for overall health, it is a right. The question then becomes, if considered a human right, why is this not reflected in policy? The Canada Health Act from 1985 also recognizes an individual's right to health, and access to medically necessary services to its citizens. However, access to "medically necessary" services is narrowly defined. The Canada Health Act does not recognize the role of social services, supports, or human rights for people with serious mental illness (Department of Justice, 2011). If supported by international law, it seems that there should be a greater role, and interest by the government of Ontario as well as the rest of Canada to ensure that these rights are met for their citizens, including access and availability to services.

In particular, the United Nations charter identifies the importance of a minimum standard of living to reach an adequate level of health. However, with almost 67 per cent of homeless people having a history of mental illness, this need is not being met (Ministry

of Community and Social Services, 2008). Despite documents such as the United Nations Declaration on Human Rights, or advocacy from the World Health Organization identifying the need for mental health, they do not have the mandate to hold other countries accountable. Furthermore, the extent to which the government should be responsible to their citizens is unclear. What is considered to be an adequate standard of living as stipulated by the United Nations, and to what extent is the individual responsible for their own health? Article 25 and the World Health Organization's definition leave room for interpretation, and potential to ignore particular areas such as mental health.

Furthermore, it is also concerning that mental health continues to take a backseat to physical health despite significant evidence outlining the relation between good mental health and positive health outcomes (Raphael, 2009). This connection is significant, as it implies that if an individual has good mental health, then they are less likely to develop poor physical health, and vice versa. Therefore, rather than simply focusing on health promotion through physical health, the government of Ontario must include mental health promotion as well.

Unfortunately, government funding for mental health remains a small portion of the funding pie with respect to health care costs. In fact, the Ontario government was projected to spend approximately 43.5 billion dollars for health care in 2010 (Government of Ontario, 2010). To put this further into perspective, the World Health Organization states that governments should aim to spend approximately 8 cents per health-care dollar on mental health (Ontario Public Service Employees Union, 2010). Countries like Britain

spend approximately 8 cents per dollar on mental health, while Ontario manages to allot only 5.4 cents per dollar (Ontario Public Service Employees Union, 2010).

The lack of funding and attention by government officials and policymakers is concerning, particular with substantial evidence linking physical and mental health. Persons with serious mental illness or those at risk of developing mental illness are more susceptible to developing physical conditions such as cardiovascular disease and premature mortality. This situation worsens for people living in poverty, as their chances of developing poor health and premature mortality is more than double than that of a wealthy person (Cobourn, 2004). The broader determinants of health also play a significant role as the living conditions of a person with serious mental illness or a person at risk of developing it will be poorer. Therefore, for persons with inadequate access to housing, the likelihood of poor mental and physical health is more likely, as well as the risks for premature mortality.

These concerns seem to suggest that mental health and the broader determinants of health should be a priority on the agenda of policymakers in order to ensure the health of people living in Ontario. It is not only beneficial to provide greater funding to mental health services, and the broader determinants of health to promote mental wellness, but it also serves to benefit the government of Ontario. Mental illness costs the government of Ontario over 39 billion dollars per year in disability costs (Caplan, 2009). If this money was channelled into community support services, and supportive housing, this could not only impact persons with serious mental illness but act as a preventative mechanism for

persons susceptible to its development. Furthermore, it would assist in providing the necessary supports for people living in poverty, providing them with an adequate chance of recovery. Unfortunately, there appears to have been little in the way of mental health care reform over time that addresses these issues. The question then becomes, why, despite mounting evidence that socioeconomic conditions and mental health are related, and affect physical health, why has policy not changed in Ontario to address this? I attribute this lack of change to a result of path dependency paralysis.

Kindgon's three policy streams help to explain why mental health policy has experienced difficulty in being a priority on the political agenda. In almost all cases, attempts to bring significant policy change in mental health care have not been successful. Prior to providing greater analysis on this, it is necessary to look at the history of mental health policy in Ontario.

The historical similarity and concerns of mental health reform exist today as they did over fifty years ago. Themes such as a lack of coordination across ministries, an inadequate continuum of care from hospital to community services, and the absence of a coordinated provincial strategy for mental health have been identified as concerns since the 1960s (Hartford et al, 2003). Unfortunately, many of these themes are reoccurring and still remain relevant concerns for current mental health policy reform. Since the late 1800's mental health care was organized through psychiatric institutions, where most patients were cared for (Mulvale, Abelson & Goering, 2007). Psychiatrists, physicians and health care professionals dominated mental health policy. Psychiatric institutions

remained an isolated location for people with serious mental illness for decades. However, in the 1950s, several complaints and issues surfaced. An insufficient number of beds for consumers, complaints of inadequate care and abuse, and there was also criticism of a lack of continuum of care for consumers once their treatment was completed (Hartford et al, 2003). What resulted was the decision to eventually move from treatment from a psychiatric hospital, to community-based centre approach, which required some form of government action.

During the late 1980s and 1990s there appeared to be a considerable opportunity towards mental health reform. In 1983, the Hellestine Report was released by the Liberal government, in hope to provide support for the development of a continuum of service delivery, while taking a community-based approach to ensure that people with mental health issues were able to receive the care that they required in their own communities (Canadian Mental Health Association, 2010). This report was significant as it was the first report to outline a need for a continuum of care, and move to a system of community support for persons with serious mental illness.

This report was followed up with through the Graham Report was released by the Liberal government in 1987. The Graham Report noted the lack of government spending on mental health in relation to other health care services, determining who should be provided with mental health supports, the need for greater coordination between ministries and unequal provision of services (i.e. rural vs. urban) (Canadian Mental Health Association, 2010). The Graham Report was significant in that it sought to

transform the institutionally-based system into a community focused system. The Report also recommended devolving administrative, fiscal and clinical responsibility for mental health care to regional authorities (Hartford et al, 2003).

In the early 1990s, with the election of the New Democratic Party (NDP), "Putting People First" was released. This followed the Graham Report, but it recommended increased funding for community health services to 60 per cent of the budget, while decreasing funding to institutions to 40 per cent (Ministry of Health, 1993). "Putting People First" was significant as it focused on the patient as priority rather (Wiktorowicz, 2005) than the institution, and led initiatives that focused on housing, crisis care and other means that addressed the barriers that prevented individuals from achieving mental health. The report also highlighted the need to attach high priority to individuals requiring the most care (Ministry of Health, 1993). However, as Wiktorowicz (2005) points out, the policy community was not consulted until after the report was released, thereby removing the likelihood of acceptance by key stakeholders. The NDP was replaced by the Harris Conservative government in 1995 and, "Putting People First" appeared to be the first mental health strategy by the Ontario government that pushed for the restructuring of services to include greater aftercare for patients. However, policy reform was minor as the priority of the government was to decrease social spending in order to cut taxes. This was evident in the appointment of the Health Services Restructuring Commission which highlighted areas in spending that could be minimized. This resulted in the closure of several psychiatric hospitals, and reduction in overall psychiatric beds (Hartford et al,

2003). The impact of this was significant because it increased the overall emphasis of care onto community health services without significant social support structures to assist them (Wiktorowicz, 2005).

With the election of the McGuinty government in 2000, there have been several mental health reports released. There is a consistent tone throughout highlighting concerns for adequate income support, social relationships, and employment. In 2000, the report "Making it Work" was released, identifying the need for addressing employment supports for people with mental health issues, and acknowledging the need to mitigate the stigma associated with mental illness (Ministry of Health & Long Term Care [MOHLTC]). More importantly, the document acknowledges that over 75 per cent of those who are seriously ill are unemployed, which identifies the need for an increase in overall social support systems specifically for housing, and income support (MOHLTC, 2000). That being said, access to housing and other social supports that were of concern in the 1970s, still remain a relevant issue.

In 2000 and 2001, regional task forces were created by the Ministry of Health and Long-Term Care. The mandate was to focus on creating recommendations for regional and local improvements to mental health services throughout the province, in accordance with the ministry's mental health policy "Making it Happen" (Ministry of Health and Long-Term Care, 2002). Although the Task Force offered significant hope for reform in mental health, none of the recommendations submitted to the government were actually implemented. Finally, in 2003, the Ministry of Health and Long Term Care (MOHLTC)

released the report the "Time is Now" which identified the need to enact the recovery model for mental health, pursuing the health of the patient through adequate social support systems (Canadian Mental Health Association, 2010).

Despite these reports released by the Liberal government, there has been little action with respect to public policy. Although these reports have highlighted several important, recurring themes, little has been addressed. Furthermore, there is still a lack of acknowledgment of the social determinants of health (SDH) in these reports as well. The SDH would be beneficial in government policy, as it would require that governments maintain accountability for people with mental illness that require supportive housing.

In 2009, former Minister of Health, David Caplan, released the report "Every Door is the Right Door". This report, though not directly acknowledging the social determinants of health, appears to be headed in the appropriate direction. The framework discusses the efficient coordination between ministries, and support not only for those that are severely ill but those who are mild and moderate (Caplan, 2009). Furthermore, it identifies the importance of housing, particularly supportive housing for the recovery process, and providing support services for people living in poverty.

In June 2011, the Liberal government released the new 10-year mental health strategy, "Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy" (Ministry of Health and Long-Term Care, 2011). The strategy is broad and comprehensive, building on the recommendations provided by the Minister's

Advisory Group in "Respect, Recovery, Resilience: Recommendations for Ontario's Mental Health Strategy" (Ontario Federation of Community Mental Health and Addiction Programs, 2011). The strategy plans to target children and youth for the first three years, focusing on fast access to high-quality services, early identification and support, and helping vulnerable children with unique needs. Open Minds, Health Minds focuses on building awareness and support around mental health by reducing stigma, discrimination, high quality and timely supports, and building on current government strategies in relation to poverty and affordable housing (Ontario Federation of Community Mental Health and Addiction Programs, 2011).

Although the strategy is significant in linking other government initiatives such as affordable housing and poverty, and also increasing funding and services to children and youth, it fails to identify what services will be available to adults. Furthermore, it is also important to consider whether the strategy will be implemented after the 2011 election in Ontario, particularly should there be a change in government. However, in order to create substantial change in mental health services in Ontario, there needs to be an increase in health care spending in order to address these issues appropriately. Most importantly, this report appears to reiterate many of the same issues from the 1990s, thus it is questionable whether they will be implemented into policy.

With the release of "Every Door is the Right Door", and "Open Minds, Healthy Minds", mental health is gaining more traction in Ontario. However, previous strategic policy documents that have been released since the 1980s have outlined similar concerns,

without considerable policy change. Therefore, it is important to try to understand why there has been a lack of policy change over time, even though there has been a considerable attempt by mental health providers and consumers to push for change. It is also important to question why mental health policy has lacked attention, despite the move from institutions to community health care in recent years. This move would require significant change within the community health sector in order to adequately prepare for the shift from hospitals. By understanding the path dependency model, and how it relates to policy making in Ontario, it may be easier to understand why mental health policy has lacked attention, and may also assist consumers and providers with how to move forward and push it onto the policy agenda.

As Howlett (2009) states, policy change is often incremental, only resulting in significant change when a paradigmatic shift occurs. Therefore, there must be a complete shift in political views, priorities, and agenda for the political system to make room for such change. With the exception of the shift from institutions to community-based approach, change has been incremental rather than significant. There have been countless strategic reports released by the Ministry of Health and Long-Term Care identifying the need for mental health policy reform, particularly identifying a better continuum of care for consumers, and also the need for housing and other social supports to ensure recovery from serious mental illness. Furthermore, there have been several advisory groups, and tasks forces, and despite the recommendations, it has not translated into policy. Consideration of Kingdon's three streams of policy may provide a clearer explanation as

to why mental health continues to be a significant but overlooked part of the health care political agenda.

Kingdon outlines that for an issue to make it onto the political agenda, it must receive problem recognition, policy generation, and a political process (2002). In the overall scheme of things, mental health appears to have had little influence on the political agenda in comparison to most areas of health care. There appears to be a lack of understanding of the significance of mental health, not only with policymakers but with the general population. Furthermore, the stigma that arose with institutions is still a remnant, which results in a lack of understanding and awareness from the public. Also, the level of funding across the province for community mental health is significantly lower than other health expenditures. Finally, the actors pushing for policy change in mental health are typically mental health service providers and consumers. Doctors, psychiatrists and provincial organizations such as the Ontario Hospital Association (OHA) and the Ontario Medical Association (OMA) are ultimately at the forefront of making policy decisions. Therefore, the interests of the medical profession tend to dominate, and social supports required for recovery, particularly housing, are more likely to receive minimal attention (it should be noted that the dominance of the biomedical model is not the sole reason why mental health services receive less funding, but it is also a result of the complexities of funding in deciding what services should receive more funding). Though doctors, psychiatrists and other health care providers are important

stakeholders, there must be a greater voice for consumers, mental health agencies, providers, and the public.

Mental health policy in Ontario has had little influence on the political agenda in comparison to most areas of health care. Clearly, potential policy reform in mental health is not considered to be a priority in comparison to other areas of health care, resulting in a lack of acknowledgement on the political agenda. To show how little significance is attached to mental health care, one only need to look at funding levels for mental health care in comparison to other areas of health care in Ontario from the Ministry of Health and Long-Term Care. The Ministry of Finance identified that spending on community mental health from 2010 to 2011 totalled $547.7 million, which represents only 2.52 per cent of LHIN spending across the province (Ministry of Finance, 2011). The 2011 budget for both mental health and addictions was allotted approximately 93 million for children and youth, without identifying how much will be spent on adults, despite a provincial health care budget of almost 48 billion dollars (Ministry of Finance, 2010). In fact, Ontario spends the lowest per capita on mental health at $152 per person, versus the national average of $172, while British Columbia spends the highest at $230. Until mental health becomes significant part of the political agenda, it will continue to be under funded (Ontario Public Service Employees Union, 2009).

Furthermore, mental health has never seemed to gain the same ground as physical health. Chronic illnesses such as heart disease, or cancer, receive millions of dollars in funding each year. Even though mental health and physical health go hand in hand,

mental health seems to be left by the wayside. Historically, there has always been an onus on physical health, and the significance of health promotion and prevention. Mental health on the other hand, has always appeared to be less accepted, possibly as a result of its history in institutions, and a lack of awareness in the population as a whole. The stigma attached to mental illness has been difficult to overcome, and despite many efforts through public awareness campaigns, and education, people still make assumptions about people living with serious mental illness.

Many policymakers and political actors would argue that mental health is not a priority, nor a pressing issue. Part of this could be a lack of knowledge on the predominance of mental illness on the general population, or perhaps the stigma attached to serious mental illness, so that it does not become a pressing issue on the system. However, for a government that places its focus on efficiency and effectiveness, placing it on the policy agenda would have a positive impact on the 39 billion in disability costs per year as a result of mental illness the provinces faces on a yearly basis. By looking at the effect of mental health on overall physical health, it would serve in the government of Ontario's best interest to have mental health on the political agenda.

The next issue that Kingdon identifies as necessary to be promoted to high agenda prominence is that of policy generation. Policy generation is the gradual accumulation of knowledge and perspectives, and ultimately the generation of policy proposals (2002). There have been many policy papers highlighting the extent to which mental health requires restructuring, a greater continuum of services, and an increase in community

support for people that require it. There has been a gradual accumulation of knowledge on the effects of mental health on the health care system, and the economic and social costs of not addressing these issues. However, mental health care in relation to the broader determinants of health has only been addressed recently with reports such as "Open Minds, Healthy Minds" and "Every Door is the Right Door", by directly outlining the impact that housing, income support and employment have on mental health recovery. Although all of these mental health strategies since the Hellestine Report have acknowledged the importance of a continuum of services and social supports, it is only recent reports that have outlined the need for social supports for mental health recovery.

There are several reasons to suggest why mental health policy was never altered to reflect the shift from institutions to a community-based approach, all of which tie to the notion of path dependence. Firstly, dominance of the actors and institutions involved in planning mental health policy over the past several years has remained strictly medical. Therefore, the dominance of psychiatrists, physicians and other health care professionals has prevented policies that reflect social conditions from occurring (Mulvale, Abelson & Goering, 2007). Incorporating the broader determinants of health into mental health policy challenges the medical profession, particularly psychiatrists that rely so heavily on the medical model. Serious mental illness to psychiatrists is the result of biological causes, and not due to external socioeconomic conditions. Therefore, incorporating the concepts of the recovery model and the broader determinants of health would pose as a significant challenge to the medical world. Furthermore, since mental health policy-

making is primarily rooted in the medical model, and those that play a major role in policy are physicians and other health care professionals, it is unlikely that the focus in policy will shift to a focus on community-based care (Mulvale, Abelson & Goering, 2007). The medical model is deeply entrenched into the health care system, professionals and policy, and has been the dominant paradigm for decades. Therefore, the reliance on the medical model for policy-making has become path dependent, and difficult to change. Secondly, the public perception of mental health also serves as a barrier to policy change. As highlighted by Mulvale, Abelson and Goering (2007), people tend to follow political parties that they are comfortable with, and offer them changes that tend to work in their favour. Also, politicians play a significant role in policy change. Their political power is a result of the public that has put them in that position. Therefore, policies will be chosen or changed in response to the agenda that was reflected by politicians or set out in their party platforms (Tuohy, 1999). Politicians will have no interest in mobilizing to create policy change if it will affect their opportunity to remain in office.

How Does Ontario Fare? A Comparison to Finland

In order to see how Ontario's mental health system can improve, it is important to look at other systems for comparison. Other provinces in Canada, such as British Columbia and Quebec face similar barriers, such as a lack of social supports and high levels of poverty for people with mental illness. Therefore, it is necessary to look at a system that provides a minimum standard of living, supportive housing, and promotes

good mental health. I have chosen to look at Finland, a social democratic country to provide this comparison.

Social democratic regimes are defined by Navarro and Shi (2000) as countries that provide universalistic social policy. Social democratic regimes have high social security expenditures, high employment in health services, education and welfare (Navarro & Shi, 2000). As a result, social democratic governments tend to provide greater social supports and access to social programs for their citizens as a way to decrease inequalities within the population.

Under the Finnish constitution, all residents in Finland have access to basic social security, social and health services throughout their lives (FEANTSA, 2003). The country is focused on providing its citizens a minimum standard of living. There are specific policies that are focused around "improving people's life management skills" (Government of Finland, 2003). Most importantly, Finland has a specific policy that provides early-intervention benefits and low-threshold forms of support which prevent their citizens from falling into poverty. The country focus is primarily on preventive action in social welfare to safeguard individuals, and includes cooperation between the social and health care sector (Ministry of Social Affairs and Health, 2006).

As highlighted earlier in the paper, Ontario provides limited support through welfare and disability spending. Finland provides substantial social supports in comparison. For persons living at or below the poverty line, there are various measures in place to prevent them from "falling through the cracks". For example, individuals and

families living below a certain level of income may qualify for basic benefits which cover food, clothing, minor health care costs and housing. More importantly, Finland provides its residents with preventative social assistance if necessary so that families can prevent themselves from falling below a certain level of income. The government also provides loans to families, and has a family policy which provides benefits for children such as allowances and daycare costs (Ministry of Social Affairs and Health, 2006).

Ontario, on the other hand, has policies which tend to be more reactive, than preventative for people that have already fallen below the poverty line. Furthermore, there are very strict guidelines to qualify for any government assistance in Ontario, providing little to no options for people that have the potential to fall into poverty. Residents of Ontario are not guaranteed income support through ODSP or Ontario Works unless they meet the required criteria, which still does not provide sufficient income for these individuals to live comfortably.

In mental health, the contrast is even greater. Although the statistics for mental health spending are not available, there is a significant portion of health care spending that is allotted to mental health. In 2006, mental health accounted for over 33 per cent of disability costs (Academic Network of European Disability Experts, 2007). The total amount of money paid in all disability benefits was approximately 109 million Euros for 2007 (Academic Network of European Disability Experts, 2007). For a population of little over 5.3 million, this is significantly greater than Ontario's expenditure on disability

benefits which accounted for just over 34 million dollars directed to a population of approximately 13 million.

Not only is spending on disability benefits related to mental health care greater in Finland, than in Ontario, the significance attached to mental health promotion is much greater also. In Finland, the government created an action programme for Social Welfare and Health Care in 1999 where mental health was chosen as one of the top eight priorities (Lehtinen & Taipale, 2001). The Ministry of Social Affairs and Health (2006) has also produced quality guidelines for mental health services, and has been actively working on creating guidelines for supportive housing. Finally, national strategies such as Health 2015 public health programme not only aim to improve mental health, but also to reduce poverty and social exclusion for persons with mental health issues. As a result, these programmes attempt to reduce poverty, and mental health issues long-term (Ministry of Social Affairs and Health, 2006). Mental health and the provision of services are yet to be identified as a top priority in health care for Ontario. Moreover, mental health was not included in a recent national "Health Care Wait Time Strategy" that priorized a list of acute care services for which focused funding and strategies where implemented to address service inadequacies.

Finally, there is a substantial difference between government systems. In Finland, the Meaningful Life Programme, which was created for 1998-2003, and is still on-going, promotes multi-sectoral co-operation, to improve the quality of life for people suffering from or have the potential for developing poor mental health. Multi-sectoral coordination

is evident as the Department of Mental Health and Substance Abuse, where social welfare and health care are integrated at both the national and provincial level (World Health Organisation, 2005). Ontario typically operates in silos, with the Ministry of Health and Long-Term Care, and other ministries such as the Ministry of Community and Social Services working separately and do not coordinate their services, programs or policies with one another (Caplan, 2009)

There are obvious discrepancies in supportive housing between Ontario and Finland. In Finland, the Central government funds approximately 10,000 new dwellings annually (Government of Finland, 2003). This is contrary to the social housing policy in Ontario which only created 3,000 new units for rent in 2008 (as seen above). Furthermore, in order to combat poverty and social exclusion, Finland has adopted a universal housing-based social protection system which is supplemented through benefits and services and targeted towards at risk groups (Government of Finland, 2003). The adoption of these policies would provide individuals suffering from mental illness with access to the basic needs that they require, without concern of these benefits being taken away.

The question becomes, why have opportunities for policy change resulted in the Finland? What opportunities are available in Finland, versus a liberal province like Ontario? Finland too, like Ontario, moved from institutions to a system of community mental health. How has Finland been able to move forward with significant policy change, while Ontario has been path dependent?

Finland made a similar transition from psychiatric institutions and hospitals to community-based care. However, this transition took place in the 1980s, approximately 20 years later than deinstitutionalization in Ontario (Lehtinen & Taipale, 2001). In the late 1980s, there was a significant decrease in the number of hospital beds for mental health in Finland. The number reduced from over 20,000 to just over 6,000 in a short period of time. As a result, mental health services were re-directed to the community, and out-patient services (Lehtinen & Taipale, 2001). Furthermore, there was a change in the definition of mental health care, which moved from a medical model to a recovery-centred approach. This definition acknowledged not only aspects of the recovery model, but also highlighted the significance of living conditions, and the broader determinants of health (Lehtinen & Taipale, 2001). What was significantly different in Finland from Ontario, were the changes made within government sectors to accommodate serious mental illness. In Finland, there was a focus on integrating mental health services with primary care and social welfare services. Most importantly there was the co-operation of government sectors to ensure that serious mental illness was addressed from other areas of government other than health care alone.

Several reasons suggest the successful implementation of government programs and policy for mental health. As Kingdon outlined (2002), a policy issue must be considered a serious matter before becoming a significant issue on the political agenda. Mental health policy in Finland was considered to be a priority in health care, particularly from the mid to late 1990s. Part of this reason may have resulted from the shift in

institutions to community-mental health care. However, much may have attributed to the astronomical suicide rate in Finland. For decades, Finland had been the number one leader for teen suicide, and in the top three among the world for overall suicides (World Health Organization, 2003). The number has since declined, perhaps attributed to the attention greater attention to mental health, a national strategy for suicide prevention, and also an increase in co-operation among government sectors to promote not only mental health but adequate living conditions as well. As a result, Finland was able to open a policy window which allowed for the implementation of programs, change to legislation, and a new definition on mental health work.

The political system in Finland is also to be more accepting of policies that serve to better the overall living conditions of residents in their country. As a social democratic system, working class movements are strong, with a focus on unity that essentially created strategies that addresses the division of people on the basis of class (Esping-Anderson, 1990). As a result, the acceptance of mental health recovery, and the need for a minimum standard of living, such as access to housing, is more acceptable in this type of political environment. Furthermore, in a social democratic society, policies are written to reduce inequalities within society. This is evident in Finland's policies throughout the 1990s to present day, where the focus has been on reducing disparities by providing a minimum level of social security, health care and housing requirements. The government in 2008 also announced an action plan which outlines the measures to reduce socioeconomic health inequalities in Finland. As a result, there is a much greater acceptance overall of

the broader determinants of health. A policy window that allowed significant change for mental health also contributed to political alignment within Finland.

Discussion

By looking at the changes that Finland was able to make with mental health over a period of twenty years, it is necessary to re-examine mental health policy in Ontario. Mental health restructuring has been taking place since deinstitutionalism in the 1960s. Although there have been some measures of change, Ontario's path dependent policies have prevented significant change to occur. In order to promote such change, there must be a strong, well-organized group to represent mental health.

Mental Health Advocacy in Ontario

Current groups representing the mental health system in Ontario include consumer groups, provincial organizations, hospitals, researchers and other mental health service providers. Unfortunately, current groups in Ontario lack the resource capacity to form unified and successful vocalized groups. Consumer advocates are an important voice to initiative system change. Despite their potential to impact policy decisions, Consumer Survivor Initiatives currently lack resource capacity as a result of poor funding, and face challenges with discrimination, and representation in policy forums.

Consumer Survivor Initiatives continue to be significantly under funded in Ontario (O'Hagan, McKee and Priest, 2009). As a result, these groups lack the resource capacity to be key players in the policy arena. In 1991, Ontario recognized Consumer Survivor

Initiatives as part of the core services offered within the mental health sector, and funded over 40 of these groups across the province. Evidence-based research demonstrates that Consumer Survivor Initiatives reduce hospitalization and 'symptom' distress, and help to increase the quality of living and social networks for people diagnosed with mental illness (O'Hagan, McKee and Priest, 2009). Despite this evidence, many Consumer Survivor Initiatives have been forced to close down, operate virtually as they are unable to afford the administrative costs, or integrate with hospitals which ultimately results in the loss of an independent consumer voice (O'Hagan, McKee and Priest, 2009).Without adequate funding levels, these groups lack the capacity to take on projects, or to engage in political lobbying. Furthermore, there ability to operate as effectively as other organizations in the system can be hindered as result of mental illness. Finally, many of the consumers have poor social determinants of health which also can create additional difficulties which can affect the operations of the organization (Davis, 2006).

Consumer groups in Ontario tend to be fragmented, and operate in stark contrast to one another. For example, some Consumer Survivor Initiatives may focus on anti-psychiatry, while other groups promote the successes of psychiatry and hospitalization for recovery (O'Hagan, McKee and Priest, 2009). It is crucial to have different forms of representation among consumer groups, but this fragmentation can hinder their ability to promote system change. For example, many consumer groups disagree on a definition of recovery, or are in competition for funding. This prevents CSIs from representing the consumer population's best interests as a whole.

The Midwifery movement, and also the AIDS movement are some examples of alliances between consumers for the benefit of their cause (Benoit et al, 2005). The Midwifery movement formed one unified voice to legitimize their midwifery as a legitimate profession. This was also the case with women's rights, civil rights and other movements that pushed for significant policy change to encourage system change. As a result, these movements created a "window of opportunity" for change, and became an important issue on the political agenda (Benoit et al, 2005). Therefore, in order for a policy window to occur, there must be less fragmentation among Consumer Survivor Initiatives, and the groups must work together to speak as one voice.

Provincial organizations representing CSIs such as the Ontario Peer Development Initiative and the Ontario Association of Patient Councils represent a variety of consumer groups. There are also additional organizations such the Empowerment Council representing consumers from the Centre for Addiction and Mental Health. It is important that these groups operate through once voice to push system change. This is not to suggest that the organizations integrate, but that it is important to represent consumers as a whole to gain importance on the political agenda, and encourage system change. Despite the lack of resources, and competition for funding, these groups do have the capabilities to initiate change. In order to see the potential of such a movement, one only needs to look at the Ministry of Health and Long-Term Care's recent attempt to divest the Psychiatric Patients Advocacy Office (PPAO) to the Canadian Mental Health Association. The PPAO is an arms-length body that provides advocacy services to in-patients across the province

protecting their individual rights (Psychiatric Patient Advocacy Office, 2011). These provincial consumer groups argued that the divestment represented a conflict of interest for the Canadian Mental Health Association, and prevented an independent PPAO which then received the support from other provincial mental health organizations. As a result, the Ministry of Health and Long-Term Care has delayed the divestment (Coalition for an Independent PPAO, 2011).

O'Hara, McKee and Priest suggest that despite the differences within consumer groups, they have similar values and interests that should encourage acting under one voice (2009). Consumer groups can relate to one another as a result of their unique understanding of mental health issues, the significance of remaining independent from other mental health organizations and hospitals, and can identify with one another's experiences (O'Hara, McKee & Priest, 2009). By reflecting on these commonalities, these groups can come together for larger policy issues and benefit consumers across the province.

Provincial organizations and hospitals also have the ability to create policy change. In particular, the Canadian Mental Health Association, and the Ontario Federation of Community Mental Health and Addiction Programs (OFCMHAP) have the ability to influence provincial policy, as they are a member association made up of various groups such as housing providers, case management groups, consumers, and hospitals. However, as similar to consumer groups, many of these organizations are in competition with one another for funding, and have different definitions of recovery. Often, the Canadian

Mental Health Association of Ontario, and OFCMHAP collaborate on projects, and policy documents. Also, there is similar work being done by these organizations. If there was better alignment on issues, and the organizations worked together to promote system change, this could potentially result in improvements in policy change, rather than reflecting the sole interests of one group over the other. Also, if these groups were to align their policies with provincial consumer survivor groups, and collaborates on larger issues this could potentially result in a greater impact on policy making in the province. Until these groups develop a unified voice, mental health policy will continue to see strategies that outline the significant of recovery and the broader determinants of health that will never be implemented into policy. Also, people who are living in poverty with serious mental illness will continue to fall through the cracks, unless significant change occurs.

Broader Determinants of Health, Recovery and Mental Health Policy

The broader determinants of health and the recognition of the recovery model are crucial to recognize in mental health policy. As highlighted throughout the paper, poor broader determinants of health play a role in the onset, re-occurrence, and worsening of serious mental illness. Previous mental health policy has focused on some elements of the broader determinants, acknowledging their impact on mental illness but is not incorporated into policy. Poor broader determinants of health, such as housing and income play a central role to a patient's recovery. In order to encourage an increase in funding, and a higher priority on the political agenda, there must be a stronger recognition of the broader determinants of health.

In health care, decisions for health care spending and policy are complex. Decisions however, are much easier when health service providers are able to demonstrate health outcomes. Providing information on chronic diseases, is much easier to report however, than mental health. Measuring outcomes includes areas such as supportive housing, and also programs for income assistance. This is particularly the case when adhering to the recovery model, as the process is individual, and "success" may or may not be measurable (Gray & Lum, 2009).

Measuring health outcomes is difficult particularly with supportive housing. There are various definitions of supportive housing in Ontario, with many providers offering a wide variety of programs, supports, and differ in their contract arrangements (Gray & Lum, 2009). Furthermore, some argue that it is extremely difficult to define and measure service quality, and cost effectiveness of the community-based sector as a result of its complexity. The benefits to supportive housing and social assistance programs for income support clearly identify an improvement in quality of life for many people with serious mental illness, but as identified above, this can be extremely difficult to measure. However, performance measurement has become increasingly important for health and social programs, particularly in the voluntary non-profit sector (Gray & Lum, 2009). This is in part, a result of increased health care costs, but also the limited resources available. Non-profit organizations, including those that provide services for people with serious mental illness are under pressure to demonstrate their "worth" to continue to receive public funding (Gray & Lum, 2009).

In order for the broader determinants of health to gain more traction in policy, and funding for mental health, providers and agencies of supportive housing, and social assistance programs must be able to demonstrate positive health outcomes for their services. This is particularly important so that the organizations continue to receive public funding, and if they are able to demonstrate their effectiveness there may be more likelihood, and acceptance of these services. Quality indicators are becoming extremely important for health care services in Ontario, as can be seen with the implementation of Health Quality Ontario in 2008, which provides recommendations for funding to the Ministry of Health and Long-Term Care (Health Quality Ontario, 2011).

Unfortunately, there are many challenges that face non-profit organizations providing services for housing, and also in identifying the benefit for social assistance. In particular, performance measurement can be very costly to non-profit agencies as a result of contractual arrangements. Furthermore, it can be difficult to obtain reliable data around their programs. Finally, the data highlighting the "success" of the programs may not accurately represent the services being provided. Despite the challenges to reporting the benefits of supportive housing, income assistance, and other forms of social supports for mental health, this might provide a means to legitimize the benefits of the broader determinants of health, and its impact on mental health. This may also result in mental health policy that reflects the broader determinants of health, and concepts of recovery.

The Recovery Model

In order to improve mental health services, and policy, it is necessary to promote a greater acceptance of the broader determinants of health by the public, and by advocates of the biomedical model. Raphael (2009), and the World Health Organization have suggested that in order for reforms to be made to the system, there needs to be an acceptance of the broader determinants of mental health. Raphael, the WHO, and the Canadian Mental Health Association, identify the need for the broader determinants of health to be adopted in mental health policies, while Raphael identifies the need to go further by implementing a policy explicitly outlining the broader determinants of health. This will help not only to establish socioeconomic conditions as a significant determinant of health, but will also serve to make the government more accountable for their citizens' health. Furthermore, this recognition of the broader determinants of health will push governments to put more focus on health inequalities within Ontario. As a result, the government will be more inclined to reduce disparities, particularly poverty reduction. Most importantly, in order to reduce disparities among the population, this will require that the government provide an increase in social assistance and supports, particularly supportive housing. This could have a positive affect for people struggling with serious mental illness and living in poverty. By including greater social supports and access to programs and services, these individuals will not only have an easier time navigating the system, but will have the opportunity to recover from serious mental illness.

However, this requires significant change, and will be a challenge for policymakers to propose such a policy. These policies must be approved by cabinet

members, and the policy must be designed in such a way that it aligns with the government's strategies (Wiktorowicz, 2005). Therefore, depending on the government in place in Ontario, it may be a difficult policy to implement. Furthermore, in order to support an increase supportive housing, and a reduction in poverty, government resources are required. Historically, governments have tended to cut social supports in order to lower taxes to serve in the interests of the population, as seen in the mid-1990s under the Harris government. An increase in social supports not only mean more money directed towards welfare, but potentially more taxes which typically results in a negative response from taxpayers. In order to combat this reaction, it may be beneficial to focus on the negative costs that result in not providing sufficient funding into the mental health system. The economic costs of mental illness and substance abuse account for over 39 billion per year (Caplan, 2009). With Ontario's focus on neoliberal ideology, advocating this shift in order to pursue a system that will provide greater efficiency and effectiveness long-term may be a much more useful strategy to follow. However, implementing a policy specifically on the broader determinants of health is not the only change that must occur.

With the transition from institutions to community-based mental health, there has been an increase in support for the recovery model. However, the traditional biomedical approach is still dominant, particularly in the hospital sector. If mental health is to continue to be pushed into the community, health care providers, hospitals and policymakers need to reflect this. Therefore, it is necessary to adopt the recovery model into policy so that standards can be created not only by the government, but by mental

health agencies and hospitals to effectively promote recovery. Again, this may be difficult as many that are influential in mental health policy in Ontario include hospitals, psychiatrists and other health care providers that are strong proponents of the biomedical model. However, perhaps by looking at Finland's approach it may be helpful. The Ministry changed its definition of mental health work to include aspects of recovery, and the broader determinants of health to adequately address the shift from institutions to community-based care. By taking a similar approach, this may at least help to provide incremental change to reflect the recovery model in Ontario.

Perhaps the most effective way to overcome path dependency is to encourage advocacy from the medical profession, consumer groups, and provincial organizations. Part of the reason that health policies in Ontario are path dependent is the prominence of the medical model, and the influence of physicians. Historically, there has always been a high level of trust between physicians and their patients. If physicians are likely to advocate the biomedical model, then citizens are more likely to accept it. This does not imply that the biomedical model should be replaced by the recovery model. Nor does it suggest that the biomedical model is not effective. In fact, it suggests that elements of the recovery model be considered during treatment, which would include the recognition of the broader determinants of mental health. However, for this to be effective, promoting the recovery model, and the social determinants of health must be directed at organizations like the Ontario Hospital Association that represent the delivery of care in hospitals, and the Ontario Medical Association that represent doctors across the province.

It is important to identify that many doctors, on an individual basis do acknowledge the effect of poor socioeconomic status on a person's health (Davis, 2006).

However, on a provincial basis, supporting the recovery model may pose a threat to the validity of their practice, and the importance of science in determining a person's health. There is already scientific evidence stressing the link between biological impairments in the brain and serious mental health issues. Furthermore, there is a multitude of evidence identifying positive health outcomes for people with mental illness that receive medical treatment. There are several consumer groups that are proponents of the biomedical model, and identify medical treatment as the reason for their recovery (Davis, 2006). It is important to stress that the recovery model does not denote the importance of medical treatment, or psychiatric counselling for recovery. The Recovery model takes medical treatment further by focusing on goal-setting, and maintaining a minimum standard of living. Ultimately, it aims to improve a person's quality of life, helping to improve their mental health. Provincial organizations such as the Ontario Medical Association need to acknowledge that the recovery model is successful in improving mental health, and could be beneficial alongside medical treatment. Perhaps just by addressing these socioeconomic factors and the importance of supportive housing and adequate income for recovery, along with medical treatment, this may create a window of opportunity where policy change could occur.

It is also extremely important to address the systemic discrimination that people with mental health experience in order to promote significant policy change.

Generalizations are often made among the general public, in workplace environments, academic institutions, hospitals and even within families of persons with mental illness. The stigma associated with mental illness results in indifference across the province, resulted in little policy change, or attention to the broader determinants of health (Health Canada, 2002). Historically, people with severe mental health issues have been portrayed as sick persons that were removed from society, often for the benefit of its residents. Though institutions have helped some people recover from their mental health issues, it has also created a negative perception with the general population. Furthermore, the medicalization of serious mental illness has also contributed to the stigmatizing of these individuals. In order to push for policy change, there needs to be a significant shift in ideology. In recent years, there has been an increase in mental health awareness and a push for more education by agencies such as the Centre for Addiction and Mental Health, and the Canadian Mental Health Association. Yet, mental illness portrayed in the media, particularly in the newspaper and in news stories, tend to look at negative issues, rather than on stigma, mental health promotion, or the broader determinants of mental health (Canadian Mental Health Association, 2010). Some campaigns have focused on the fact that mental illness does not discriminate, and can affect anyone at any point in their lives. This approach is important, but it fails to address several issues. Mental illness can affect anyone, but poor mental health can result in poor living conditions, particularly for those living at the poverty line, or in poverty, and for those that do not have access to safe, stable and secure housing. Therefore, it is necessary to focus on how the broader determinants of health can impact one's mental health.

Conclusion

For people in Ontario to be considered healthy individuals, they need to achieve a minimum standard of living. Access to basic needs, particularly to housing and income, are essential to obtain a minimum level of health (World Health Organization, 2003). Without these opportunities, people are likely to fall into poverty, and are not only at risk for the development of physical conditions, but poor mental health.

As the development of physical conditions can result in part from one's living conditions, so too does mental illness. The World Health Organisation and the government of Ontario have acknowledged the significance of the broader determinants of health. The broader determinants of health have not only been acknowledged through strategic government reports, but also by the Ministry of Health and Long-Term Care, and health care providers and agencies. Unfortunately, there has been little government action in Ontario to address the broader determinants of health. Many people continue to live at or below the poverty line, and lack access to basic needs, particularly to housing.

This has been the case for persons struggling with serious mental illness. Most individuals with serious mental illness are living in poverty, and often do not have access to housing. This is particularly the case for people that have been hospitalized as a result of their illness, as there fails to be a continuum of care available for these individuals. Once these individuals leave the hospital, there often fails to be services available to them to ensure that they have the opportunity to recover.

In order to achieve mental health recovery, it is necessary for those struggling with serious mental illness to have the opportunities available to recover. Meaning, social supports, including housing, and government assistance are available once these individuals have left the hospital. Recovery implies that individuals are able to create goals, and create their own, individual path to recovery. However, in a system where these social supports are not available, it becomes difficult for people struggling with serious mental illness to engage in their own recovery. For people that are living in poverty, and do not have access to sufficient housing, they are unable to obtain future goals, and instead are more likely to be concerned with daily survival. This ultimately prevents any ability to recover, and fosters negative beliefs, often sending these individuals back to the hospital for further treatment.

There are significant benefits in obtaining supportive housing for people that are living in poverty, with serious mental illness. Supportive housing allows individuals to maintain a level of independence, work on their recovery, and offers safety, security and stable housing. Most importantly, it assists people in transitioning back into the community. However, there is not only a lack of supportive housing, and other housing supports, but there is also a lack of continuum of care to ensure that people that require the assistance get into supportive housing units (Canadian Mental Health Association, 2010). If people do not have access to supportive housing upon exiting the hospitals, the only other options that are available include receiving income support from the Ontario Disability Support Plan, or through Ontario Works. Unfortunately, recipients of the

Ontario Disability Support Plan and Ontario Works barely receive sufficient income to cover monthly rent.

There has been little policy development in recent years to address the broader determinants of mental health, and policies which encourage mental health recovery. Since the 1980s with the Hellestine Report, which identified the need for a continuum of care for mental health, and the need for patient-centered care, there have been many strategic reports outlining similarities, but have failed to be translated into policy. Policy-making in Ontario, particularly with health care appears to be path dependent, entrenched in our institutions, and thus extremely difficult to alter without significant government mobilization, or unless it is considered a serious issue to become a part of the political agenda. Mental health care continues to operate on a small budget in comparison to the health care budget, and despite several calls for an increase in funding the government fails to adequately respond.

The government of Finland operates in stark contrast to Ontario. By providing their citizens with access to basic social security and support systems, residents are able to achieve a minimum standard of living. Furthermore, it has preventative policies that help to stop people from falling through the cracks and living in absolute poverty. Despite a similar shift from institutions to community-based care, Finland has been able to successfully transition, and not only offers its citizens adequate mental health care programs, but also sufficient access to supportive housing, and income support from the government. Policy change was able to take place in Finland as a result of government

alignment, recognition of the need for change, and a political system that already focused on minimizing inequalities within the population. Even though Finland only began to move from institutions to community-based mental health care in the 1980s, it has made substantially greater progress in mental health policy, programs and access to support systems to ensure a continuum of care for recovery.

The Ontario government needs to reassess their current policies, as well as the rest of Canada by acknowledging the broader determinants of mental health. This will create relevant policies which will force the government to focus on the need for greater provision of social support. There needs to be a push from the macroeconomic level that focuses on greater coordination among ministries to improve housing, and create a housing strategy. More funding is required from this area, especially through Ontario Works, and the Ontario Disability Support Program so that individuals suffering from mental illness can afford housing if supportive housing is unavailable. Greater public participation is required, and the application and advocacy of the recovery model or elements of the model along with the medical treatment required in the biomedical model. Individuals with mental health will have more opportunities to succeed if given the tools. Until then however, social stratification, mental illness, and vast inequities will continue to pervade the system as a result of neoliberal policies. Policymakers need to put people first, and promote the recovery for individuals suffering from mental illness, to flourish as productive citizens as they rightfully deserve.

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