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Resident Work in High-Support Housing: A Mad Feminist Political Economy Analysis

Tobin LeBlanc Haley, Part-Time Professor of Disability Studies, King's College

ehaley5@uwo.ca

Abstract

While feminist political economists have identified social service provisioning as socially reproductive work and have examined its reorganization under neoliberalism, little attention has been paid to the mental health care sector. Furthermore, within feminist political economy scholarship on work in the social service sector, little attention has been paid to the contributions of service users. I address some of these gaps by developing a Mad feminist political economy framework to analyze the unpaid socially reproductive work completed by residents in high-support psychiatric housing in Ontario today.

Drawing on data from interviews with 23 residents and 15 service providers in high-support psychiatric housing in Ontario, as well as a review of government and non-profit organization documents, I argue that the work done by residents alleviates demands on social service workers in a time of neoliberal restraint, intensified workplace demands, and a heightened focus on service user independence in all aspects of life. I then conclude with recommendations for change.

Keywords

Mad Studies, Feminist Political Economy, social reproduction, housing, neoliberalism

Introduction

Feminist political economists interested in the organization of social reproduction demonstrate the interconnected trends of intensifying workplace demands and unpaid hours experienced by workers in the social service sector (Baines, 2004; Vosko, 2006; Baines, Davis, & Saini, 2009; Braedley, 2012). This scholarship draws attention to the lack of funding to support work in the social service sector and the concomitant pressures placed on social service providers to take responsibility (often without pay) for filling gaps in supports. The social service sector is one more space where demands on the time and energies of people engaged in social reproduction are intensifying, and these demands are experienced disproportionately by women, especially racialized women, and increasingly immigrant and migrant workers. What is missing

from this scholarship is consideration of the socially reproductive work completed by social service *users* alongside social service providers. In this paper, I consider the unpaid work completed by residents in high-support psychiatric housing in Ontario as an entry point for better understanding the organization of socially reproductive work under neoliberalism, as well as for building a Mad feminist political economy analytic.

Within high-support psychiatric housing in Ontario, residents are engaged in the work involved in running the homes. However, this work is often invisible due to housing literature that takes homes as the smallest unit of analysis,[1] the continued marginalization of household work as commonplace and non-valuable, and pervasive assumptions that people living in high-support housing are incapable of engaging in the day-to-day work involved in living in and sustaining a community. There is a need to make visible resident contributions within high-support housing sites as a means of challenging the notion that residents in such spaces are simply "cared for," to consider the broader context that gives rise to this work without fair compensation, to reconfigure the conditions under which their work is performed and to unsettle the unequal power relations between staff and residents in relation to this work. Such an intervention contributes to both Mad Studies and feminist scholarship an improved understanding of the continuities through change characterizing the landscape of unpaid work performed by people living with mental illness labels.

The performance of unpaid work within sites of "mental health care" is not a new phenomenon. The use of people institutionalized in provincial psychiatric hospitals as sources of unpaid work was well-established as both a therapeutic and cost-saving practice by the mid-

[1] Taking a home, whether a household or a high-support housing site, as the smallest unit of analysis means not looking into the homes themselves, thus foreclosing the opportunity to delve into the everyday practices and relations that construct life in these sites.

nineteenth century.[2] Common tasks performed by patients included cleaning, gardening, cooking, sewing, maintenance, construction and laundry (Reaume, 2004; Reaume, 2009). With the initial waves of psychiatric deinstitutionalization in Ontario more than 50 years ago (Finkler, 2013; Simmons, 1990), the official practice of using patients as sources of unpaid work appears to have fallen out of favour, and is now regarded as one of many abuses suffered by in-patients during the era of institutionalization. Yet, as I demonstrate, patient work persists in familiar unpaid forms (Fabris, 2013; Usar, 2014), although the spaces and meaning of this work have changed under neoliberalism.

To explore, in part, how service user work is being mobilized, I propose a Mad Studies-informed feminist political economy framework to analyze resident work in high-support psychiatric housing in Ontario, situating this work in the broader reorganization of social reproduction under neoliberalism. A Mad feminist political economy is the most appropriate framework for analysis, as feminist political economy analyzes the organization of socially reproductive work both within and outside of households, situating this work within the prevailing social relations of gender, race, class, ability and citizenship that condition where and how the work involved in remaking and sustaining life and social norms takes place. Mad Studies draws attention to the ever-changing constructs of mental illness that contribute to the erasure of the structural and interpersonal nature of the oppression of people living with mental illness labels.

Neoliberalism, for the purpose of this analysis, can be understood as a socio-economic order wherein the principles of the free market are embedded in and reproduced through the

[2] It was not only people labelled mentally ill institutionalized in Ontario who were used as sources of unpaid labour. People labelled with various disabilities worked in "segregated facilities" as early as the sixteenth century in France (Reaume, 2004, pp. 467-468).

state, the economy, the third sector, and daily life. Neoliberalism is enacted through the implementation of political-economic strategies, including the erosion of protections for workers, the privatization of state assets, the reorganization and roll-back of state supports and the promotion of individualism and self-reliance in policy making (Clark, 2002; Peck & Tickell, 2002; Harvey, 2005; Bezanson & Luxton, 2006b; Graefe, 2007; McBride & McNutt, 2007; Herd, Mitchell, & Lightman, 2005; Wacquant, 2010).

I draw on interview data from 23 residents and 15 staff in high-support psychiatric housing sites, as well as reviews of government policies and programs and non-profit documents. I demonstrate that the work of residents in high-support housing is socially reproductive work that contributes directly to the functioning of the housing system, and is the same type of work being done by staff for a regulated wage, often in unionized workplaces. I argue that the work performed by residents alleviates demands on social service workers in a time of neoliberal restraint and intensified labour demands. Furthermore, housing sites, rather than unidirectional sites of care, are spaces of interconnection, both among residents and between residents and staff.

I proceed in five parts. In the first part, I describe the high-support housing system in Ontario and the sites examined. In the second part, I review the methodology and methods employed. In the third part, I document the work undertaken by residents in the sites. In the fourth part, I analyze the broader context in which this work takes place. Finally, I offer Mad- and feminist-informed recommendations for change. Recording and analyzing the kinds of work done by residents in high-support housing makes both theoretical and empirical contributions to the fields of Mad Studies and feminist political economy. At the theoretical level, I demonstrate the utility of blending the feminist political economy lens with Mad Studies in facilitating better

understanding of the contours of marginality experienced by people living with mental illness labels under neoliberalism. Empirically, I document some of the work that residents do within the high-support housing programs in contemporary Ontario. It is important to note that it is not the amount of work that residents are doing that is the most important issue, but rather the conditions under which the work is being completed.

Ontario's High-Support Housing System

High-support mental health housing is one housing model within Ontario's larger supportive housing network, which involves both subsidized and social housing funding arrangements. Within this housing network, there are more than 23,000[3] "mental health and addiction" supportive housing units. Supportive housing, as a concept, indicates a focus on recovery and independence, and is developed in response to concerns about the custodial nature of housing services that emerged with deinstitutionalization (Suttor, 2016). The goal of supportive housing is to move away from one-size-fits-all approaches and the focus on deficit, embracing instead individualized care and recovery (Ministries of Municipal Affairs and Housing, 2014; Suttor, 2016; Ministries of Municipal Affairs and Housing, 2017). Supportive housing, including high-support models, is typically run by non-profit organizations, and funding, often allocated through competitive grant applications, comes from federal, provincial and municipal governments.

High-support housing typically involves a form of congregate living[4] with staff members on site at all times. The staff members provide support for the activities of daily living, such as

[3] An exact count is not available (Suttor, 2016).
[4] Congregate high-support housing means residents have their own units but live in a building, or dedicated wing of a building, for people with psychiatric diagnoses and/or an addictions label.

laundry, cooking, light maintenance, cleaning, medication and money management, as well as support around medical appointments, income, travel, transportation and recreational and occupational activities. Usually, residents in high-support housing are accessing income-support services and are labelled "seriously mentally ill," a nebulous term that denotes a high rate of service use. These homes are simultaneous spaces of social reproduction, specifically spaces where the *daily* needs of residents are met, and where normative understandings of mental illness are reproduced, in part through the activities involved in satisfying those daily needs.

Methodology

Feminist Political Economy

Precisely because high-support housing sites are spaces of social reproduction, specifically a form of social reproduction that often reproduces biomedical norms, I develop and mobilize a Mad feminist political economy framework to analyse resident work in the homes in Ontario under neoliberalism. Feminist political economists define social reproduction as the daily and intergenerational paid[5] and unpaid work involved in maintaining and reproducing workers, future workers, people who are not working and the social order that offers capitalism stability (Bezanson & Luxton, 2006b). This socially necessary work is organized around a gendered and racialized division of labour, and is completed using the resources obtained through individual labour, communities and state services (Bakker & Gill, 2003; Bezanson & Luxton, 2006a; Brodie, 2010).

[5] This work does not typically command a high wage, especially when performed by women and/or members of the BIPOC communities.

Feminist political economists demonstrate how the enactment of neoliberal political-economic strategies has transformed the organization of the work involved in reproducing people and social norms. As states reduce supports for this socially necessary work through the enactment of neoliberal social policy (e.g. high thresholds for state-supplemented parental leave, reduced financial supports for social service provisioning), and as rates of precarious employment[6] continue to grow, increased demands are placed on individuals, families and communities to complete the work of recreating and sustaining life without sufficient resources and supports. This combination of increased demand and reduced support is borne disproportionately by women, especially BIPOC women, immigrants, migrant workers and/or people living in poverty. Underpinning this organization of social reproduction is the promotion of individual responsibility as the hallmark of the "good citizen," that is, someone who completes the activities of social reproduction using wages earned in the labour force and does not access income assistance or other welfare state services.[7] Ontario has not been immune to neoliberal policies and practices; indeed, the last three decades have witnessed the implementation of this socio-economic order throughout the social service sector, arguably entrenched with the "Common Sense Revolution" pursued by Premier Mike Harris between 1995 and 2002 (Hackworth & Moriah, 2006).

Often, the analysis of the implications of neoliberal restructuring of social reproduction focuses on workers and their families, sidelining the experiences of people who depend on the state and non-profit organizations for their daily and intergenerational needs. Yet, the redesign

[6] Precarious employment can be defined as employment involving uncertainty regarding the continuation of employment, lack of worker control over the labour process (e.g. absence of unions), low regulatory protection and insufficient wages for self or family maintenance (Cranford, Vosko, & Zukewich, 2003).
[7] It is useful to note that in Canada people with permanent status all access some amount of welfare state services (e.g. healthcare, education). It is accessing services beyond those universally provided that is pathologized.

and roll-back of social supports, the promotion of individualism and the lack of access to secure and benefitted employment are also felt acutely by people dependent on state and community services, such as people living in high-support psychiatric housing. There is a need for a sustained feminist political economy analysis of these spaces as part of the project of building a rich understanding of the contours of exploitation and oppression under neoliberalism. However, simply applying the lens of social reproduction to issues of mental health care is not sufficient. The insights from Mad Studies scholars on the shifting nature of mental illness constructs, their reproduction through "care" work, and continuities and changes that characterize Mad oppression must also be integrated into the analysis.

Mad Studies

Although the feminist political economy analysis has yet to be sustained in addressing mental health topics, Mad Studies scholars,[8] activists and allies have studied the effects of neoliberal restructuring for people labelled as mentally ill or disabled (see, for example, Cohen, 2013; Chouinard & Crooks, 2005; Costa et al., 2012; Moncrieff, 2008; Morrow, 2004; Morrow, Wasik, Cohen, & Perry, 2009; Tompa et al., 2006; Wilton, 2004; Wilton and Schuer, 2006). In addition to this work on the effects of neoliberalism, I draw on two key insights from Mad Studies when constructing a Mad feminist political economy framework: 1) that categories of mental illness and disability are not static, but rather rooted in material conditions, and, as such, change across time and place (Busfield, 1986, 1996; Reville, 2013; Shimrat, 2013), and 2) that

[8] While some mad people identify as disabled or as a person with a disability, many do not, but recognize similarities among and overlaps between the disabled and mad communities (Nabbali, 2009). Mad Studies (LeFrancois, Menzies, & Reaume, 2013) has emerged in Canada in the last decade as a sort of sister discipline to Disability Studies. Mad Studies is a unique field of scholarship directly concerned with the history, experiences, issues and challenges associated with being mad or labelled as mentally ill.

sites and practices of mental health care, although sometimes providing resources for daily needs, must be critically unpacked as spaces where pathologizing norms are perpetuated. Not including these insights from Mad Studies risks developing a feminist political economy analysis about mental health that reproduces pathologizing tropes of people living with mental illness labels, erases oppression, and does not take into account the rich body of scholarly and activist interventions developed by people living with mental illness labels. Examining the processes of social reproduction under neoliberalism with an eye to implications for people with mental illness labels means remaining attuned to how this socially necessary work can be organized in ways that reproduce saneism.

Methods

The data I am analyzing is part of a larger data set that was gathered for my doctoral dissertation. In addition to 38 interviews, I analyzed current governmental documents and completed archival research at the City Archives of Toronto, the Provincial Archives of Ontario, and the Centre for Addiction and Mental Health Archives. I obtained access to research participants through supportive housing networks in the province, and interviews with service providers and residents were arranged on-site.[9] All interviews were conducted under the promise of confidentiality. As a white-settler and cis-gender woman who is Mad, normatively-abled physically, heterosexual and middle-class, my position in these interviews was, for the most part, one of privilege. Despite my own psychiatric history, and a brief period working in social and psychiatric housing, I am not writing from the position of an insider who knows or understands

[9] This research project was reviewed and approved by the Office of Research Ethics at York University, Toronto, ON.

firsthand what it is like to live and work in these spaces, but as an outsider with much to learn. To protect confidentiality, I do not disclose the sites I visited or the specific number of sites. The high-support housing community in Ontario is very small, and the data I collected very sensitive; to ensure that I do not identify anyone or build a profile of a particular site, I will simply say that I visited more than one and fewer than five sites in the province of Ontario. I did not visit all of the high-support housing sites in the province, nor did my interviews solely focus on resident work in the homes.

Resident engagement in social reproduction in the homes

The data set is small, but it provides an entry point into a broader discussion of the reorganization of mental health care services, and housing specifically, under neoliberalism. What is more, from a Mad Studies perspective, the size of the data set or the amount of work performed by residents is secondary to the neoliberal arrangements in social policy that not only allow this work to be completed by residents for no pay, but to be cast as "therapeutic" and "progressive." The work of residents is an entry point into this larger discussion.

It was through interviewing people about the implications of neoliberal-style developments in mental health care policy that I learned about resident involvement in the operation of high-support housing. The work I am analyzing does not include the basic personal hygiene and cleaning of individual units that is required of all residents. Rather, I am focused on the work performed by residents that involves sustaining the housing sites themselves, activities that parallel the work being performed by paid staff within the housing sites. Of the 23 residents I interviewed, 10 self-reported to be engaged in work similar to that performed by staff for a wage. Staff interviews revealed that more than these 10 residents were involved in this work.

Common work performed by residents included sweeping, mopping, dusting, taking out garbage, running errands for staff and housemates and doing emotional work. Residents described this work as helping out, completing chores, and as a means of getting small amounts of money (typically $5), a coffee or cigarettes. Notably, small amounts of money or goods were not available at all sites. Residents reported the following:

> I mop every night.
>
> I clean up here.
>
> I sweep the balconies upstairs. I help out, no pay.
>
> I help out as much as I can. I do garbage at nights. They have got me doing a couple of chores. They've got a couple things around the house certain people do, certain people do.
>
> I sometimes go [run errands] for [another resident]. She is unable to walk so she buys me coffee to get things for her. Also, they give me mail and I give it to the places where it needs to be sent and they give me $5 for that. Sometimes we pick up food and bring it to [a site]. We get a little bit of money for that.
>
> I mop once a week.

Another resident who did not want to be quoted stated that they cleaned and tidied up the home. Most residents engaged in these activities stated that they did not mind working, and/or saw it as a contribution to the community. When asked about residents' daily routines, the staff confirmed the tasks described by residents, and added that residents also watched more "vulnerable" housemates during outings and cleaned the kitchen. Staff stated the following:

> There is a lot of that [volunteering]. Cleaning, taking out the garbage, feeding the cats.
>
> Some clean [a specific space], kitchen, dishwasher, and dust, but, not laundry, and some sweep. Some get paid right away, some save. It is not a lot; sometimes they want a cigarette or a coffee the same day. It is whatever they prefer. We trained [a resident] to do it [go get drugs from the pharmacy]. It is like their little job.

> We do have a building committee where we have started groups, gardening groups and things to get everyone involved in the community and looking after the building. So in that sense it is not paid employment, it is volunteering.

Overall, the fact that residents were performing these tasks is seemingly banal. What cannot be overlooked, however, is that the tasks that residents were described as performing for free or in exchange for a coffee, cigarettes or $5 (what Reaume [2004] would call a pittance) are many of the same tasks that service providers reported to be doing for a regulated wage.

When asked to describe their jobs, staff reported that, despite different professional designations, all engaged in cleaning, light maintenance work (e.g. plunging toilets and changing light bulbs), cooking, laundry, shopping with or for residents, offering talk therapy (formally and informally), coordinating appointments with doctors, blood labs, case managers, bankers, income support workers, and probation officers, talking to family members, coordinating travel plans, finding appropriate services within the community, tutoring, helping with money management, and administering medications. While service providers did provide what were referred to as "clinical supports," such as cognitive or dialectical behavioral therapy and medication administration, much of the non-clinical work performed by staff, such as cleaning, running errands, and providing emotional support, was very similar to the tasks performed by residents. The table below (Table 1) provides a useful visualization of the distribution of tasks among service providers and residents within the sites.

Table 1

Tasks performed at the sites	**By staff**	**By residents**
Administration of Medication	✓	
Cleaning	✓	✓
Cooking	✓	✓

Coordinating/Finding Services	✓	
Emotional Support	✓	✓
Errands	✓	✓
Light Maintenance	✓	✓
Money Management	✓	
Therapy	✓	

Image description: Table 1 is divided into three columns. The headings for the columns, left to right, are: 1) tasks performed at the sites, 2) by staff and 3) by residents. Underneath the first heading are nine rows. Each row represents a task performed at the sites. Check marks underneath the columns by staff and by residents indicate which group performed the task within the home. The nine tasks listed are: administration of medication, cleaning, cooking, coordinating/finding services, emotional support, errands, light maintenance, money management and therapy. Check marks indicate that staff perform all the tasks listed, while residents perform cleaning, cooking, emotional support, errands and light maintenance.

It would be easy to dismiss the work arrangement in these homes as anomalous, the result of poor housing regulations, occurring only in those spaces where housing providers are seeking to turn a profit or where service providers are less caring or concerned for the well-being of the residents. However, most high-support housing is operated by non-profit organizations, regulated by government and receives some amount of state funding.. Furthermore, the residents reported general, although not complete, satisfaction with their housing situation, and service providers appeared to be dedicated and caring, often working beyond the parameters of their jobs to fill in the gaps in services experienced by the residents.

It would also be easy to dismiss this work as part and parcel of living in a community and within a household, something everyone does that is of no value. While certainly socially reproductive work is common, everyday work, it is also necessary and valuable. Cooking, cleaning, emotional work and light maintenance are all tasks that make a household function, and these homes are, in a sense, a kind of a household where social reproduction is completed

through a mixture of paid and unpaid work. And, as discussed in the next section, it is not only residents who are doing unpaid work. Staff members are also working more hours than they are paid for, and are experiencing intensification of their workplace demands. Yet, as stated, there is considerable scholarship on workers' unpaid contributions in the labour force under neoliberalism, especially when this work involves socially reproductive tasks (e.g. social work). Less attention has been paid to the work performed by people receiving services.

As stated at the outset, this is not a new phenomenon, and is less quantifiable than, for example, the numbers of unpaid hours completed by staff. Yet, while this work is not new, the context within which it is undertaken is specific to neoliberalism and the neoliberalizing mental health care system in Ontario. The next section will contextualize the work performed by residents of psychiatric housing within the development of Ontario's mental health care system under neoliberalism. Specifically, I will demonstrate how attempts on the part of the provincial government to offload financial and administrative responsibility for service users through aggressive application of principles of privatization, downloading and individualization has created and legitimized a systemic reliance upon increased demands placed on staff members, as well as a continued demand for the work of people living within Ontario's psychiatric system.

Gaps in care: Downloading of responsibility and privatization of mental health care services in Ontario

In the 1960s in Ontario, long before the neoliberal turn, the largely unplanned process of psychiatric deinstitutionalization downloaded and privatized state services for people with psychiatric diagnoses, resulting in widespread poverty, inadequate housing, homelessness and death among former patients (Capponi, 1992; Marshall, 1982; Simmons, 1990). All levels of

government attempted to address this crisis through piecemeal intervention, such as pilot projects for community treatment, contracts with non-profit service providers, and attempts to regulate the primarily privately-owned boarding home system. These interventions did little to solve the problems created by unplanned and ad hoc psychiatric deinstitutionalization in Ontario, but firmly solidified the position of the provincial government as no longer solely responsible for the needs of people with psychiatric diagnoses (Simmons, 1990). Since the late 1980s, the provincial government has produced numerous reports and associated strategies aimed at "fixing" the mental health care system, primarily seeking to contain costs, to avoid responsibility for the crisis of psychiatric deinstitutionalization, and to further download responsibility to regional bodies, privatizing services and placing responsibility for acquiring and coordinating supports and basic needs on service users themselves.

The most recent downloading strategy was implemented in 2006 following the reduction in federal transfer payments to the provinces for somatic health care and psychiatric units in general hospitals. This strategy involved the replacement of the 16 District Health Councils that provided recommendations to the provincial health ministry about local health care needs, including mental health, with 14 regional non-profit organizations called Local Health Integration Networks (LHINs). These regional health bodies are now provided with provincial funds, which are then distributed among service providers in the appropriate catchment areas at the discretion of each LHIN. This allocation of funding takes the form of contract funding opportunities and competition among agencies for funding. The focus in determining allocation of funding is on efficiency, and non-profit organizations are now expected to collaborate with business and government for the delivery of services within a local arena (see Local Health System Integration Act, 2006).

Within this downloaded regional system, mental health care is receiving less funding than other health care services (Martin & Hirdes, 2009).[10] As of 2011, the Ontario government was spending less than the national average[11] on mental health care services, and, according to the Auditor General's follow-up report on community mental health in 2010, was at that time spending disproportionately in the area of institutional services versus community-based care. This same report described the challenges faced by community service providers in "maintaining service levels and qualified staff given minimal increases in funding" (p. 330), a lack of appropriate services and long wait-lists (p. 329).

The challenges and frustrations reported by the Auditor General were expressed by service providers working in the housing sites I examined. Without exception, the major point of concern was funding: funding for more units, for better programs, for higher income support rates, for more staff, for more specialists, for transit, for job training and for better wages for both service providers and for those few residents employed outside of the homes. Service providers were acutely aware of the struggles experienced by the residents, and people with psychiatric diagnoses generally, within the current arrangement of governmental and non-governmental services, and the toll these struggles take on both residents and service providers themselves. One service provider described his workplace experience as moving from crisis to

[10] Martin and Hirdes (2009), reviewing mental health care in Ontario, reference a 2008 report by Addictions Ontario, the Canadian Mental Health Association (CAMH), CAMH Ontario, and the Ontario Federation of Community Mental Health and Addictions Program demonstrating that only half of Ontario LHINs prioritized mental health care. The 2011 *Open Minds, Healthy Minds: Ontario's Comprehensive Mental Health and Addictions Strategy* refers to an increased focus by LHINs on mental health and addictions and the need to streamline and invest in community services across the province. This strategy, however, prioritizes children for the first three years, and places emphasis on early intervention, appropriate service use, reducing the burden on tax-payers, and providing Mad people with the opportunities to "achieve" the social determinants of mental health.

[11] The national average was 7.2% of provincial health care expenditures being directed to mental health care (CMHA, 2014).

crisis: "you field everything that comes through the door, there is not much room for personal interaction in [a] significant way, other than in passing."

In response to the problems created by a lack of funding and appropriate services for mental health care, and specifically community-based mental health care services, service providers in these sites work more hours than they are paid for, and work beyond the parameters of their positions. They view this as the secret to program success, but are well aware of the fact that they are being stretched due to a lack of funding.

> There are not enough hours in the day and week to get it all done. You do go beyond… you don't go 9:00 to 5:00 and say, "well, it's 5:05 pm, I am not going to pick up this call."
>
> I do counseling, assistance with cooking, budgeting, crisis intervention with tenants in the building who are not my clients.
>
> Well that is the secret, why we look askance at some of these agencies who come in with a list they need to check off and there they go.

The struggles of community service providers described in the Auditor General's 2010 report and by service providers at these housing sites are neither new nor limited to the mental health care sector and psychiatric housing. The last three decades of retrenchment and redesign of supports for childcare (Mahon & Brennan, 2013; Vosko, 2006), income support (Chouniard & Crooks, 2005; Little, 1998), housing (Colderly, 1999; Gaetz, O'Grady, & Buccieri, 2010), and health care (Armstrong & Armstrong, 2010), to name a few, have been well mapped and analyzed by critical scholars. It is within this context that residents are being asked and encouraged to step in and do some of the work involved in maintaining the home and the levels of care provided to residents. When a resident picks up medications, cleans, or offers support to another resident, they are doing the work of a service provider, alleviating the increased demand on service providers to complete these necessary activities in a context where they are provided

with minimal resources and supports. It is cheaper for a non-profit organization with limited funds to provide minimal or no compensation to a resident than it is to hire a service provider at the prevailing market rate. Moreover, with the rise of consumer involvement demands and the appropriation of these demands, such arrangements are often seen as progressive (an issue I explore below). Residents, like service providers, are caught in a system where need far outstrips available resources, and one solution is for both groups to perform unpaid work. Yet, for residents, the engagement in this work, in addition to being personally fulfilling and providing the occasional access to a pittance, reproduces the understandings of wellness and recovery advanced in government strategies, thus making possible (and even coding as progressive) the withdrawal of supports.

The individualization of personal responsibility: Changing understandings of mental illness in the neoliberal age

Resident work, while always present in sites of psychiatric intervention, is today taking place in the context of downloaded and privatized supports for mental health care and social reproduction more broadly. The acceptability of the use of residents as sources of unpaid work, despite the acknowledgement that in-patient work in institutions is exploitative and abusive, finds its roots in the new understanding of what it means to be mentally ill that is currently being rolled out by the provincial government. This new view of what it means to be mentally ill is closely aligned with the neoliberal citizenship regime that understands each individual to be responsible for the risks associated with everyday living, including those risks associated with having a mental illness.

Whereas people with mental illness labels were once constructed and treated as incapable of labour market attachment or independence in the activities of everyday life, the Ontario government's most recent mental health care strategy, *Open Minds, Healthy Minds* (2011), promotes capacities for labour-market attachment and the associated independence in the activities of everyday life as part of a renewed state focus on the social determinants of health. This recognition of capacity for labour market attachment and independence in daily living is being framed by the government as the newest, most progressive approach to mental health care. It is suggested that this approach will address the problems of social exclusion, poverty, stigma and discrimination experienced by people with mental illness labels by providing them with the opportunities to "access the social determinants of health" (p. 12). These social determinants of health include, according to the provincial government, education, employment, income, housing and a sense of competence and connection in everyday life. This strategy suggests that "each person has the potential to become much more resilient and to better cope with adversity" (p. 10). Resiliency and recovery involve accessing fewer welfare-state resources and living as independently as possible, thereby "reduc[ing] the personal, social and financial burdens of mental health and addictions" (p. 8). Economic and social independence, or what is now constructed as wellness, is presented as relieving the province, and taxpayers, of the financial burden of "mental illness" in a time of great economic insecurity.

While the recognition of agency and capacity to work is a positive development, how and why these capacities are being recognized by the provincial government must be critically examined. In proposing a symbiotic relationship between well-being and increased labour market attachment, independence in daily living, reduced service use, cost-savings and economic growth, those existing services that provide decommodified supports for social reproduction

appear to treat people with mental illness labels as unable to work or live independently. The view that people with mental illness labels are able to assume the risks and responsibilities of competing in the labour market and completing social reproduction independently casts supports such as the Ontario Disability Support Program (ODSP) and fully-funded housing sites as regressive and undermining of the solution "discovered" by the provincial government, which purports to serve both the goals of promoting inclusion and fiscal restraint. A survey of the 16 individual LHIN Integrated Health Services Plans (IHSPs) for 2013–2016[12] reveals that a commitment to this strategy has been successfully communicated at the regional level. LHINs, those regional bodies involved in allocating funding for health care services, are also focused on fiscal restraint, the promotion of economic growth and the importance of creating opportunities for service users to improve their lives by achieving desired levels of employment, education, income, housing and social inclusion. It is within this context that the use of resident work can be seen as acceptable and markedly different from the use of patient labour during psychiatric institutionalization. Today, the engagement of residents in the homes is perceived as progressive recognition of their capacity to work and to achieve some of the social determinants of health, such as independence in activities of daily living and a sense of community and competence, while simultaneously reducing the burden on taxpayers. It is not understood as the forced labour of those who cannot leave, characteristic of the institutionalized environment. Yet, residents are not being paid fairly for their time and energies, both of which appear to be essential supports for a housing system which is cast as providing supports and services for its residents.

Conclusions and Recommendations

[12] IHSPs from individual LHINs are available on their individual websites, which are accessible at www.lhins.on.ca/home.aspx.

The motivation behind the current organization of the mental health care system is to save money, not unlike the desire to offset the costs of psychiatric institutions by harnessing the labouring capacity of the patient population. However, unlike the period of psychiatric institutionalization, this current use of the capacities of service users within these housing sites is not directly motivated by the desire to save money within the homes themselves and to establish a quid pro quo between the residents and the sites of care. Rather, the reliance on, and justification for, the use of service users as workers is generated by broader attempts to reduce mental health care spending and the gaps in service provisioning created as a result. Furthermore, unlike the era of psychiatric institutionalization, which was characterized by a perception that patients could not obtain and maintain labour market attachment and independence in the activities of daily living, residents, and all those characterized as mentally ill, are today perceived at the level of social policy as having the potential to obtain employment and independence. However, labels also often appear to be mobilized, so long as service users continue to access services like high-support housing, to erase the value of their work within sites of service provisioning. While the recognition that service users are not unfit to participate in society is certainly important, the erasure of the valuable work people are doing within sites of care must be critiqued alongside the co-optation of this recognition as a means to justify retrenching support services.

There are a number of ways forward in addressing the unequal treatment of the work of service users within social provisioning sites as the system current exists. I list three here as a means of initiating a conversation on this subject, but these are by no means exhaustive. The first step in addressing the unpaid work of residents must be to pay residents for their work at the same rate that staff members are paid. This first step should be relatively straightforward.

Residents should be paid, per hour, by the housing provider at the same rate as staff members; ideally in cash to avoid unnecessary travel for banking and related transportation and transaction fees. The second step must be to ensure that compensating residents for the value of their work does not result in a decrease in any income support payments or eligibility. Currently, people accessing ODSP and Ontario Works can earn an additional $200 per month before the province claws back half of their income (ODSP Directive 5.3, OW Directive 5.3)[13]. Eliminating this claw back in relation to paid work within sites of care, and ensuring that this income cannot be used to remove a person from income support, will require political action and organizing to educate government officials about resident work and its value, and to demand that the directive be amended. The third step is to ensure that residents working in the home and accessing ODSP not be removed from ODSP because they are working. The ODSP requires that each recipient experience a verified "impairment" lasting at least a year which restricts activities of daily living (including caring for the self and employment) (ODSP Directives 1.2; 2.1). Resident work within sites of care must not be used by ODSP administrators to challenge the assignment of an "impairment" label that permits access to ODSP and essential medical coverage. This will require an inclusion in ODSP directives that work within homes not be taken into account when evaluating the presence or absence of "impairment."

In addition, ongoing efforts must be made to secure increases in rates of income support, while simultaneously challenging the division between the "deserving and underserving poor," providing meaningful and self-sustaining employment when desired, and expanding depathologized and survivor-operated housing to provide greater control over the organization of

[13] The link for all ODSP and OW directives is provided in the bibliography under Ministry of Community and Social Services. *Social Assistance Policy Directives*.

socially reproductive work. In the meantime, the short- and medium-term goals listed above provide a mechanism for recognizing and compensating the work of service users in the context of high-support housing.

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