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## Neoliberalism and Mental Health Care in Ontario: A Critique of Internet-Based Cognitive Behavioural Therapy

### Néolibéralisme et soins de santé mentale en Ontario : une critique de la thérapie cognitivocomportementale par Internet

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#### Abstract

In this paper, I offer a critical analysis of Ontario's mental health strategy, "Roadmap to Wellness," and the government's investment in internet-based cognitive behavioural therapy (iCBT) programs as a frontline strategy to address the province's mental health crisis. Though I acknowledge that publicly funded mental health care is a step in the right direction, I argue that the choice to provide cognitive behavioural therapy (CBT) as the *only* form of publicly funded therapy indicates a problematic commitment to the maintenance of neoliberal governance. To argue this point, I use discourse analysis to explore the language present in Ontario's two current iCBT programs – AbilitiCBT and Mindbeacon – and demonstrate the ways in which they reinforce a neoliberal discourse of mental health by emphasizing the values of 1) individual responsibility, 2) productivity, and 3) recovery. More broadly, I argue that neoliberal forms of governance ultimately produce the mental health crises that they seek to address through neglecting the social determinants of health and defunding of social services and assert that critiques of mental health care must address the socioeconomic conditions within which they are implemented, given the intimate relationship between neoliberalism, managerialism, and public policy.

#### Résumé

Dans cet article, je propose une analyse critique de la stratégie de santé mentale de l'Ontario, « Vers le mieux-être », et de l'investissement du gouvernement dans les programmes de thérapie cognitivocomportementale par Internet (TCCI) comme stratégie de première ligne pour faire face à la crise de santé mentale de la province. Bien que je reconnaisse que des soins de santé mentale financés par l'État sont un pas dans la bonne direction, je soutiens que le choix de fournir une thérapie cognitivocomportementale (TCC) comme seule forme de thérapie financée par l'État indique un engagement problématique envers le maintien de la gouvernance néolibérale. À cet effet, j'utilise l'analyse du discours pour explorer le langage présent dans les deux programmes actuels de TCCI de l'Ontario, AbilitiTCCI et Mindbeacon, et démontrer les façons dont ils renforcent un discours néolibéral sur la santé mentale en mettant l'accent sur les valeurs de 1) la responsabilité individuelle, 2) la productivité, et 3) la réhabilitation. Plus largement, je soutiens que les formes de gouvernance néolibérales produisent en fin de compte les crises de santé mentale qu'elles cherchent à résoudre en négligeant les déterminants sociaux de la santé et le

financement des services sociaux. Finalement, compte tenu de la relation intime entre le néolibéralisme, le managérialisme et les politiques publiques, j'affirme que les critiques des soins de santé mentale doivent tenir compte des conditions socio-économiques dans lesquelles elles sont.

### **Keywords**

Mental health; Neoliberalism; Cognitive behavioural therapy; Medicalization, Online therapy

### **Introduction**

In March 2020, Doug Ford's Conservative government revealed a new mental health and addictions policy called "Roadmap to Wellness: A Plan to Build Ontario's Mental Health and Addictions System" (Government of Ontario). Primarily, this policy seeks to address long wait times and barriers to access for mental health and addictions care, a lack of funding for mental health and addictions services, and a lack of data on issues relating to mental health and addictions (Government of Ontario). One major element of the "Roadmap to Wellness" strategy is a focus on the implementation of two internet-based cognitive behavioural therapy (iCBT) programs, AbilitiCBT and Mindbeacon, made free to Ontario residents through the Ontario Health Insurance Plan.<sup>1</sup> Cognitive behavioural therapy (CBT) focuses on assisting individuals in identifying and changing unhelpful thoughts and behaviours that contribute to mental distress and is considered the "gold standard" form of therapy for treating anxiety and depression (David et al.). According to "Roadmap to Wellness," anxiety and depression are the most common mental health issues that impact Ontarians. It suggests that by implementing iCBT programs those who are struggling with anxiety and depression will be able to build resilience, aimed at

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<sup>1</sup> Though "Roadmap to Wellness" encompasses both mental health and addictions, there appears to be a separate strategy for each. For example, iCBT programs are framed as being offered to help people with anxiety and depression, not addictions. In fact, any reference to addictions is strikingly absent from the government's plan for a "Ontario Structured Psychotherapy Program" which includes iCBT (Government of Canada). Though Mindbeacon has a program designed to help people manage alcohol use, both Mindbeacon and AbilitiCBT are mostly oriented toward helping people with anxiety and mood disorders.

lowering the number of mental health-related emergency room visits and hospitalizations (Government of Ontario).

Although providing Ontarians with access to government-funded therapeutic care is a step in the right direction, I argue that Ontario's decision to provide CBT as the *only* form of publicly funded therapy is a choice imbued with neoliberal political and economic interests. Using discourse analysis, I show how the language present in the AbilitiCBT and Mindbeacon program websites, as well as those of their parent companies, employ language that represents and reinforces a neoliberal ideology by emphasizing the values of 1) individual responsibility, 2) productivity, and 3) recovery. I problematize these emergent themes, situating them within the broader political and economic landscape of Ontario, and assert that neoliberal forms of governance ultimately produce the mental health crises that they seek to address through neglecting the social determinants of health and the defunding of social services. While critiques of neoliberal approaches to mental health care are nothing new, my paper contributes to the existing literature by examining these new iCBT programs and the ways in which increasing trends toward online, on-demand therapy are compromising attention to social change and trauma-informed approaches to mental health care.

I begin this paper with a discussion and critique of CBT, followed by a brief overview of the neoliberalization of mental health care and mental health policy in North America. I then offer an overview of Ontario's mental health care strategy, "Roadmap to Wellness," focusing on its key pillars, and situate the role of iCBT programs within the implementation of the government's goals. Next, I analyze the language present in Ontario's two current iCBT programs – AbilitiCBT and Mindbeacon – and demonstrate how they reinforce a neoliberal discourse of mental health by emphasizing the neoliberal ideals of 1) individual responsibility, 2)

productivity, and 3) recovery. Finally, I contextualize the use of iCBT programs as a strategy for mental wellness within the broader politics of Ontario, namely severe cuts to social services and programs that would otherwise support both individual and collective wellbeing, to show how iCBT programs ultimately fit into the status quo.

### **What is CBT?**

CBT is a popular therapy modality which seeks to target a person's negative thoughts and replace them with "healthier" or "more accurate" thoughts and is lauded as one of the best "evidence-based strategies for helping people cope with their mental health (HealthLink BC). Though most often used to treat anxiety and depression, many mental health professionals claim CBT to be a one-size fits all approach that can be used to treat a wide variety of mental health problems, including bipolar disorder, obsessive-compulsive disorder, and schizophrenia (Centre for Addictions and Mental Health, "Cognitive Behavioural Therapy"). CBT is so omnipresent that it is often the only form of therapy available in both private and public mental health services (Watts). According to Leichsenring et al., some researchers and practitioners have even argued that CBT should become the only form of psychotherapy (Leichsenring et al. 1).

Though the benefits of CBT have been widely reported by psychiatrists, psychologists, social workers, and even patients, not everyone benefits from CBT equally; in some cases, CBT can cause greater harm than good. CBT operates within a medical model of mental illness—a model which asserts that emotional distress is caused by biochemical imbalances in the brain. As A. J. Withers writes, "the medical model is a 'find it and fix it approach'" (31) which diagnoses people as problems – problems that can and should be remedied by medical intervention

(Withers 31). Although CBT is also a form of social intervention, practicing CBT alone often does not account for the role of environmental factors, such as early childhood trauma, abuse, and oppression, including but not limited to racism, sexism, homophobia, transphobia, and/or classism. Instead, CBT programs place the burden of change on the individual, rather than the collective (Enns 77), as though this strategy can undo trauma and systemic harm. As Farhad Dalal argues, CBT is not oriented to figuring out *why* someone is experiencing distress, as, under this modality, it is assumed that emotional distress is a symptom of a mental disorder, not something that may have been socially produced. Thus, the possibility that one's distress may arise as a "reasonable response to a devastating life event" (Dalal 1) goes largely unrecognized.

Why then, is CBT such a widespread form of therapy? Daniel David et al. write that CBT is considered "the gold standard" in psychotherapy not necessarily because it is the best form of treatment, but because it is the most researched form of therapy (1). As such, CBT is easily marketed to institutions that wish to address mental health problems. Since the most time and money is invested into CBT research, other less individualizing forms of therapy such as narrative therapy and feminist therapy are overlooked; the comparative lack of research on alternatives to CBT situates these alternatives as less evidence-based and thus more easily excluded from governmental health care strategies (Teghtsoonian 34).

### **CBT and Neoliberal Politics**

In the context of public policy, scholars such as Farhad Dalal have critiqued CBT for the role it plays in upholding neoliberal and managerialist politics. As Dalal argues, both managerialism<sup>2</sup>

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<sup>2</sup> While there is no universally accepted definition of managerialism, generally speaking, managerialism refers to "the adoption of private sector practices and concerns, notably efficiency, effectiveness and excellence" (Shepherd 1668). Essentially, under managerialism, governments are run like businesses. As Sue Shepard argues, "its influence

and CBT claim to operate on evidence-based principles (88) that can be implemented in a systematic and effective manner through a top-down model whereby knowledge is transferred from expert to client (86). For Dalal, it makes sense that the CBT has come to flourish “in the time of neoliberalist austerity” (80), given that CBT’s orientation towards addressing mental illness at the site of the individual aligns closely with the values of neoliberalism and managerialism that dominates much of Western politics (81).

CBT enforces what Dalal calls the “Happiness ethos,” the belief that happiness is the goal of all rational beings (14). The idea that CBT is “the road to happiness” (Dalal 15) is a marketable one; it can easily be sold to both governments and individuals alike who seek to address mental health problems expeditiously. This overlap between healthcare and business is reflected in the goals of AbilitiCBT’s parent company LifeWorks, whose motto is “Improving lives. Improving business” (LifeWorks, *Morenau Shepell Rebrands to LifeWorks*). They state, “LifeWorks remains driven by the principle that happy, healthy and empowered employees are the key to high-performing and resilient organizations,” and note that “by improving a person’s life, their performance at work will also improve” (LifeWorks, *Morenau Shepell Rebrands to LifeWorks*). Though Ontario’s version of AbilitiCBT appears to be broader in scope, the Ontario program website nevertheless includes a section under “Self-Guided Help” called “Work” with articles such as “Helping Employees Stay Focused During Times of Change and Uncertainty” and “Your Role as a Leader in Building Team Resilience,” marketing itself, in this instance, to employers. Similarly, Mindbeacon offers a program for workplaces, stating that 378,150+

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is said to have extended far beyond the organizational setting into economic, social, cultural and political spheres and to have become so pervasive that it has ‘infiltrated every eventuality of human existence’” (1668).

employees are part of their employee program and that their program creates a “stronger workforce” and “a stronger business” (Mindbeacon, *Work With Us - Workplace*).

While there is nothing fundamentally wrong with wanting to feel “happy” or “better,” when the Happiness ethos becomes integrated into political and economic life it can lead to an over-reliance on individualized forms of treatment to manage economic problems associated with psychiatric disabilities, such as absenteeism and increased health care spending. Such strategies may also help governments justify making cuts to other forms of social services that prevent and address mental health problems, such as employment, housing, and domestic violence policies, as has been the case in Ontario. The Happiness ethos is thus part of a neoliberal regime of government which needs to be unpacked within the context of the neoliberalization of mental health care.

### **Neoliberalization of Mental Health Policy and Care**

The neoliberalization of mental health care has been the result of ongoing processes of the deinstitutionalization of psychiatric care in Ontario and North America more broadly. Beginning in the 1960s, pressure from Mad activists and psychiatric survivors led to the “rapid movement of patients out of hospitals and into the community, accompanied by a slow growth of community mental health services” (Sealy and Whitehead 249–50). Though some have argued that deinstitutionalization marked a benevolent response to activist pressures, others such as Liat Ben-Moshe, have noted that deinstitutionalization represented little more than “an ideological shift in the way we react to difference among us” (274), with little to no community-based mental health supports. As Sealey and Whitehead argue, the implementation of community-



based mental health services has not yet come to fruition in any health jurisdiction, and there is no clear direction for what it will look like when it's "finished" (250).

Deinstitutionalization coincided with the rise of pharmaceuticals used to treat mental illness (madness),<sup>3</sup> particularly the invention of antipsychotics. Having antipsychotics available to treat Mad people meant that people with severe mental health problems could now be "managed" within the community. This shift proved to be more cost-effective than institutionalized care (Esposito and Perez 417), supporting growing neoliberal ideologies and the dismantling of the welfare state that was occurring in the same period. The use of psychiatric drugs to treat mental health problems has been conceptualized by some as chemical incarceration (Fabris; Fabris and Aubrecht), meaning that drugs are merely an extension of the types of control that were enacted over patients in psychiatric hospitals. This need to manage Mad people via the use of drugs is part of the broader manifestation of the medical model of mental illness which informs and upholds CBT.

Alongside the rise of pharmaceuticals, Heidi Rimke links the emergence of neoliberal forms of mental health care with the emergence of the psy complex<sup>4</sup> in Western society in the 19<sup>th</sup> century (5). Neoliberalism and the psy complex have produced what Rimke refers to as psychocentrism, the belief that human problems are the cause of individual biological deficits (5). For Rimke, psychocentrism constitutes a form of social injustice, given that it does not work to "improve social conditions of those who are politically, economically and socially

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<sup>3</sup> I prefer the term "madness," given that it is less pathologizing and is the type of language used by those who reject the biomedicalization of emotional distress and behavioural difference.

<sup>4</sup> Heidi Rimke defines the psy-complex as "...a hegemonic formation comprised of a loosely defined group of experts connected through their professional and social status, particularly psychiatrists, psychologists, psychiatric nurses, psychotherapists, psychoanalysts, and social workers... conceived as a heterogeneous network of agents, sites, practices, products and techniques for the production, dissemination, legitimation, and utilization of psy truths" (6).

disadvantaged and marginalized” (6). Instead, neoliberal subjects are called upon to attain their own health to achieve societal mental health standards, using tools built within the psy complex. On a similar note, Nikolas Rose argues that neoliberal forms of mental health care force individuals to become “enterprising selves” (154). The rhetoric of neoliberal governance forces us to steer ourselves towards wellness to maximize our human capital. The “enterprising self” is “a self that calculates *about* itself and acts *upon* itself in order to better itself” (Rose 154). The notion of the enterprising self emerges in my analysis of AbilitCBT and Mindbeacon later on in this paper.

To summarize, under a neoliberal model of governance for mental health care, behaviours that “deviate from what the market defines as functional, productive, or desirable” become pathologized and subject to discourses of individual responsibility and recovery (Esposito and Perez 417). Propped up by the medical model of mental illness, neoliberal forms of governance shape ideas of normalcy through the maintenance of individualizing social, political, and economic systems (Esposito and Perez 417), including but not limited to managerialism and capitalism. When these systems are taken as the natural order of things, and without a broader examination of the social, political, and economic factors that contribute to emotional distress, individuals become minds to be managed rather than people living under complex structural inequalities. This then leads us into dangerous territory wherein madness comes to be increasingly defined as deviant and problematic, meaning that Mad people are more likely to be exposed to psychiatric harm.

### **Roadmap to Wellness and iCBT Programs in Ontario**

The Ontario government’s mental health care strategy, “Roadmap to Wellness: A Plan to Build

Ontario’s Mental Health and Addictions System” adopts a clearly neoliberal, psychocentric approach to their plan for the “Ontario Structured Psychotherapy Program,”<sup>5</sup> which includes iCBT. The policy is structured around three main pillars: “improving quality: enhancing services across Ontario,” “expanding existing services: investing in priority areas,” and, “improving access: a new provincial program and approach to navigation” (Government of Ontario). A major aspect of this policy is designed to provide Ontarians with access to cognitive behavioural therapy, an “evidence-based” and “effective intervention” for those living with anxiety and depression (Government of Ontario). The policy states that these services will be provided in various formats including “telephone coaching and clinical counselling, psychoeducational groups, *internet-based cognitive behavioural therapy* and face-to-face group and individual counselling” (Government of Ontario, emphasis added). In reading the summary of the policy’s strategy, it is clear that the government is mainly relying on increasing access to therapy; in fact, it is mentioned in the timeline six times. There is no mention of social factors relating to mental health and addictions and no part of the strategy addresses improving access to social services other than therapy. Thus, the focus remains on trying to solve a broad, systemic problem at the level of the individual—a strategy which very much aligns with Doug Ford’s Conservative government’s policies in other areas.

## **Methodology & Analysis**

### *Discourse Analysis*

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<sup>5</sup> It is important here to note that this aspect of the policy does not reference people with addictions, despite the assertion that “It is important to have stronger linkages between the mental health and addictions system, the social assistance system and broader human services” (Government of Ontario). It is unclear as to whether people with addictions are going to be able to benefit from iCBT programs.

In the remainder of this paper, I delve into my discourse analysis of “Roadmap to Wellness,” and the AbilitiCBT and Mindbeacon websites. Discourse analysis is a qualitative methodology concerned with the study of text and talk in relation to the sociocultural and political contexts within which they occur (Lupton 145). The goal of discourse analysis is to “document the links between textual and oral communication and their relation to society and social change” (Lupton 145). In this project, I used discourse analysis to identify themes regarding definitions of mental health and attitudes toward recovery. The three most common themes that I extrapolated were: individual responsibility, productivity, and recovery. Here, I explore these three themes, showing how these values are being communicated using both direct and indirect language. I then contextualize these themes within the broader political and economic landscape in Doug Ford’s Ontario to demonstrate the links between these discursive themes and sociopolitical action.

*Theme 1: Individual Responsibility*

The ways in which we are asked to govern ourselves in relation to mental health has become ubiquitous. As Heidi Rimke and Deborah Brock write, questions such as “Has life got you down?” “Do you have trouble getting out of bed in the morning?” or, “Do you experience feelings of helplessness, meaninglessness, worthlessness, or powerlessness?” appear almost everywhere, from magazines, to television, and on the internet (182). Unsurprisingly, the homepage of AbilitiCBT asks, “Feeling anxious? Sad? Not yourself?” (AbilitiCBT). Though these questions may help people identify problems that they want to address, these questions “might [also] create a crisis in the reader’s sense of ‘normalcy,’ suggesting to the reader that s/he may be suffering from a treatable mental or emotional disorder, requiring professional help” (Rimke and Brock 182). Such lists include common symptoms that many of us will experience over our lifetimes, such as anxiety and sadness, which may not necessarily be indicative of a

mental disorder. These types of questions do not ask people to think about the source of these feelings, but rather how they might change or eliminate them.

Turning back to Rose's concept of the enterprising self, the theme of individual responsibility manifests in Ontario's iCBT programs through the promotion of such programs as self-guided. Clients can access therapy anytime and anywhere, and this is used as a key selling point for the programs.<sup>6</sup> Both AbilitiCBT's and Mindbeacon's ideas of "anytime, any place" is tailored to a neoliberal world within which people must prioritize productivity over mental health care. Mental health thus becomes something to be built into a busy schedule, rather than as something that should be integrated into all aspects of social life and public policy.

Though the idea that people can access therapy "at their own pace" (AbilitiCBT) or "on [their] own terms" (Mindbeacon, *Home / MindBeacon*) can be framed in a positive light given that this can increase accessibility, the term self-guided individualizes the experience of the program and puts the onus on the person seeking iCBT<sup>7</sup> to finish the program on their own.<sup>8</sup> It is the responsibility of the individual who is experiencing mental health problems to reach out for help, reinforcing the idea that mental illness is an individual problem and that reaching out for help becomes synonymous with being a responsible citizen. Because these programs now exist in Ontario, people have no excuse for not reaching out for help; if one refuses to go to therapy, they may be framed as a "bad" or "irresponsible" citizen.

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<sup>6</sup> Although Mindbeacon also offers live therapy sessions, for the scope of this paper, I will be focus only on its self-guided program. It is also worth noting here that their live, in-person sessions are limited to three clinics in the Toronto area.

<sup>7</sup> Although the same critique could likely be made of individual, in-person therapy, these two modalities differ in the extent to which one has contact with a mental health professional, and the space within which therapy is conducted.

<sup>8</sup> Those who participate in both AbilitiCBT programs and Mindbeacon programs have regular check-ins with therapists to monitor their progress, but these check-ins are framed as additions to the self-guided nature of the programs, not as its main feature.

Notions of individual responsibility also emerge in “Roadmap to Wellness.” As mentioned earlier in this paper, Ontario’s policy uses the term resilience as an end-goal for their structured psychotherapy program. The idea is that individuals will engage in iCBT programs so that they can better develop resilience—the ability to handle one’s problems on one’s own—so that the burden on the health care system, namely in the form of emergency room visits and psychiatric hospitalizations, will go down (Government of Ontario). As many have argued, resilience is deeply embedded in neoliberalism given its individualistic orientation (see Joseph; Lamont et al.; Mavelli). Resilience once again places the issue of mental illness or emotional distress within the individual; it is not the state or society that is the problem, but the individual who refuses to adapt. If one does not desire and/or work to “adjust their attitudes, habits, and behaviors to fit market demands” (Esposito and Perez 416), one may be regarded as irrational, unproductive, and subsequently deviant and pathological (Esposito and Perez 416). Thus, not only are the iCBT programs reinforcing the neoliberal ideal of individual responsibility in mental health recovery, but they are also implicitly reinforcing ideas of normalcy attached to rationality and responsibility.

### *Theme 2: Productivity*

The notion of productivity in mental health discourse is not unique to Ontario’s iCBT programs. Numerous studies in public health and nursing write about and problematize the economic burden of mental illness, and thus frame the accessibility and affordability of mental health care services as a solution to an economic and governmental problem, rather than as something to benefit the welfare of those experiencing emotional distress. For example, the Centre for Addictions and Mental Health (CAMH), estimates that the economic burden of mental

illness in Canada is approximately \$51 billion per year (“Mental Illness and Addiction”). CAMH also cites that at least 500,000 people are unable to go to work each week because of mental health problems, that the cost of disability leave for someone with a mental illness is twice that of a leave for someone with a physical disability, and that “patients with high mental health costs incur over 30% more costs than other high-cost patients” (“Mental Illness and Addiction”). Furthermore, Ontario’s iCBT program Mindbeacon notes that “\$24,180 [is] lost annually in productivity due to absenteeism” (*Work With Us - Workplace*). LifeWorks, the company behind AbilitiCBT, also cites economic-based data to sell its platform, stating that “[a] lack of mental health support in the workplace costs the Canadian economy \$50 billion a year,” and that those with mental disorders “will cost the global economy \$16 trillion by 2030” (“Mental Health”). LifeWorks also markets its program heavily to businesses/organizations, citing that “untreated mental health issues can drive costs related to productivity, absences, and disability claims” (*ICBT - Internet Cognitive Behavioural Therapy*).

Another way in which the concept of productivity is reflected in Ontario’s iCBT programs is inherent to the structure of the programs themselves. Both AbilitiCBT and Mindbeacon’s self-guided programs are conducted over a limited time – anywhere from 8-12 weeks, the standard in CBT treatment (HealthLink BC). The idea that one’s mental health can be improved in a short amount of time is part of CBT’s ethos, and the increasingly popularized use of short-term therapy largely shaped by economic concerns (insurance, affordability, etc.). However, the limited nature of these mental health programs may also reflect a desire to get people feeling well as soon as possible to maximize their productivity in the workforce. This strategy also assumes that everyone has the same level of need. For some, limited term therapy may be beneficial, but it depends on the type of mental health concern and its severity. The

limited-term availability and inflexibility of Ontario's iCBT programs is thus oriented toward expediency, not necessarily mental well-being. If the government is truly invested in improving mental health for all Ontarians, it would take into consideration the diverse needs of people with different mental health concerns, such as those who would benefit from different modalities and long-term therapy.

*Theme 3: Recovery*

Closely related to the concept of productivity is the concept of recovery. Though the term itself can be fundamentally defined as regaining something once lost, or as a “restoration or return to health from sickness” (Dictionary.com), the term has become highly politicized and is often mobilized differently based on one's proximity to positions of power. For example, the most dominant definition of recovery in Western society is the definition forwarded by mental health professionals, largely tied to the medical model of mental illness. Such definitions can be found in Foucault's critiques of 18<sup>th</sup>-century moral treatment and psychiatric rehabilitation (McWade 62), as well as during the deinstitutionalization era and the pharmaceutical revolution (Braslow 781). Though it is true that many Mad people do desire recovery as defined by biomedicine, it is important to understand the context within which biomedical notions of recovery originated. Eighteenth century psychiatrists asserted that madness, like any other illness, was manageable and curable (Spitzer 9). Psychiatrists of this era went so far as to exercise dominance over their patients, viewing madness as something completely undesirable and in need of eradication (Spitzer 10). Modern biomedical approaches to madness and recovery,



though perhaps less domineering and abusive than such treatments<sup>9</sup> that were used in the eighteenth century, still operate on a model that madness can and must be treated like any physical ailment. Today, recovery has become a kind of buzzword used by both mental health professionals and lay people alike (McWade 63): something that individual people can and *should* desire and achieve. Indeed, in Ontario’s iCBT programs, the concept of recovery is framed as a commodity that people seeking mental health care should desire.

Ideas of recovery are sold to teheclients of Ontario’s iCBT programs in different ways. LifeWorks sells the AbilitiCBT program by stating that it “reduces absenteeism and shortens the time employees need to *recover*” (“ICBT...,” emphasis added). It lauds iCBT as a form of therapy that is just as effective as “drug therapy for anxiety and mild to moderate depression” and that people who undertake this program will see “show a marked improvement of their symptoms... [as] measured using GAD7 & PHQ9 standardized clinical assessments for diagnosis and grading of symptom severity” (LifeWorks, *ICBT - Internet Cognitive Behavioural Therapy*). Mindbeacon claims that its CBT program is specifically designed to improve return-to-work outcomes by empowering clients to “take responsibility to communicate with each stakeholder –insurance company, healthcare professional, union, employer, and BEACON – and understand how to enhance coordination for their successful return [to work]” (*How BEACON Can Improve Return to Work (RTW) Outcomes*). In this case, “return to work” can be interpreted as a euphemism for recovery. Certainly, in “Roadmap to Wellness” it is mentioned that “many individuals looking for work with anxiety and depression who had access to the service returned to work more quickly than their peers who didn’t have access to a mental health service”

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<sup>9</sup> For example, spinning machines, painful blasts of water—the “Bath of Surprise”—and temporary drowning (Spitzer 11-12).

(Government of Ontario). Though this is not the *only* marker of recovery in the policy, it is referenced frequently enough to suggest that facilitating a return to work through mental health service provision is a priority for the Ontario government.

While many people may choose to understand their emotional distress through the framework of the medical model, and may desire to recover from their mental illness, professionalized notions of recovery offer a limited framework through which we can view support for people experiencing mental health problems. Individual approaches to recovery and social approaches to recovery differ in significant ways (Vandekinderen et al.). For instance, psychiatric survivors have sought to develop definitions of recovery which critique its individualizing and medicalized notions, and which seek to empower Mad people to define recovery on their own terms. It is important to note here that the concept of recovery originated from anti-institutionalization movements, (such as the psychiatric survivor and Mad Pride, and Mental Patients Liberation movements) and that Mad conceptualizations of recovery have been co-opted by psychiatry, psychology, social work, and governments to forward a new medical-political agenda oriented toward eliminating emotionally deviant behaviour.

Mad activists have argued that living a meaningful life can occur simultaneously with symptoms of mental disorder. For example, someone who hears voices, whom psychiatry may consider to be “psychotic” and in need of serious medical intervention, may find the voices that they hear helpful and not distressing to them. Similarly, some people who engage in self-harm may not see their behaviours are problematic or harmful to their wellbeing. As argued by Leamy et al., Mad notions of recovery might not look like a remission of symptoms, but may instead look like:

- Empowerment and reclaiming control over one's life

- Rebuilding positive personal and social identities (including challenging stigma and its impacts)
- Connectedness with family, friends, and society
- Hope and optimism about the future
- Finding purpose and meaning in life. (Leamy et al. qtd. in Tew 77)

The starting point for thinking about recovery in this way was grounded by disability scholars and activists in their formation of the social model of disability. However, “whereas the social model of disability proposed that the focus of action fell fairly and squarely within the field of social and political activity, recovery implies an equal focus on intra-personal experience as a key site for awareness and raising change” (Tew 78). With limited options for mental health care in Ontario, Mad notions of recovery may not be possible, given that iCBT’s structured plans have specific goals in mind.

### *Discourse in Context*

The issues presented in my above analysis become further problematized when contextualized within Ontario’s broader political landscape and the implementation of austerity measures in the province since 2019, most notably the decision to cut \$2.1 billion in proposed funding for mental health care. Consequently, wait times for children and youth seeking mental health care doubled between 2017 and 2019 after these changes were implemented (PressProgress). The Ford government has also proposed and made cuts to a number of social

services, including cutting roughly \$17 million<sup>10</sup> from services supporting victims of violence and women’s shelters (Benzie), proposing to “quietly shave” \$222 million dollars from the Ontario Disability Support Financial Assistance (PressProgress), reducing funding for the Ontario Autism Program from full coverage to \$20,000 a year (“Autism”),<sup>11</sup> withholding approvals or overdose prevention sites in major cities, and reducing public health funding in Toronto. This is a partisan attack on public health “unprecedented in recent history, according to health experts and academics” (Glauser). Ford’s government also swiftly defunded the \$150 million Basic Income Pilot established by the former Liberal Government, doing so “after being informed by ministry officials that it was failing to help people become ‘independent contributors to the economy’” (Gollom).

Though these policies may not seemingly be related to mental health, disability scholars and activists have been arguing for decades about the importance of addressing social and environmental factors when discussing issues of disability and/or health. In relation to madness, Jerry Tew argues that “whatever may be its biomedical correlates in terms of brain functioning, and whatever part may be played genetically derived sensitivities, we start with the foundational position that mental distress may be understood as a meaningful response to life circumstances” (80). As cuts to social services become increasingly framed as savings, the material impact of these “savings” result in human distress due to a lack of social support— distress which then often comes to be framed as mental illness (Dalal 5). In many cases, such as in Ontario, CBT then steps in as a sort of management: a way for governments to avoid investing in social

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<sup>10</sup> It should be noted that the actual dollar amount of such cuts have been debated, with Community and Social Services Minister Lisa MacLeod arguing that the government had actually increased spending on these services the previous year and that the numbers were misleading (Benzie).

<sup>11</sup> Some cases cost up to \$100,000 per year for diagnosis, therapeutic resources, and treatment (“Autism”).

services that may prevent mental health problems from arising in the first place (Dalal 5).

Indeed, the Ontario government is relying on individuals to be “responsible citizens” and reach out for the publicly funded help when the need arises, which reinforces the idea that mental health is an individualized problem and that it is therapy, not the improvement of material conditions, that generates wellness.

### **Conclusion**

Though no small victory, the Ontario government’s implementation of free iCBT programs do not provide a comprehensive nor sustainable strategy for improving the emotional wellbeing of Ontario residents. The Ontario government’s commitment to CBT as the only method of free therapy demonstrates that the government believes the issue of mental illness lies within individuals, and that to effectively address mental health problems, individuals must learn how to think differently to return to “normalcy.” This desire to return people to normalcy is grounded in economic interests because mentally ill people are framed as burdens to the economy due to both loss of revenue caused by sick days, as well as increased healthcare spending. When contextualized within the broader political landscape of Ontario’s Ford government, I argue that through the procurement of AbilitiCBT and Mindbeacon, the government’s mental health strategy is fundamentally an economic policy and not a health policy. This points to an urgency for Mad and disability scholars to remain critically aware of policy shifts in the realm of mental health care, as it is evident that policies which appear to be benevolent, such as access to free therapy, may be upholding current political and economic systems that generate an overwhelming need for mental health care in the first place.

It is not my intention to deny that CBT is a helpful strategy for many, nor do I wish to suggest that people should not be taking advantage of Ontario's free mental health programs. Of course, most forms of therapy warrant critique. Anything that focuses solely on the individual, and which relies on changing an individual's behaviour rather than their environment and life circumstances, offers limited options and opportunities to address mental health in meaningful ways. Rather, the goal of my paper has been to reveal the shortcomings of Ontario's mental health strategy and its iCBT programs. As I have argued, Ontario's iCBT programs are both a product of, and reinforce, neoliberal ideologies, evidenced in the type of language present in the descriptions of the AbilitiCBT and Mindbeacon programs, as well as within AbilitiCBT's parent company, LifeWorks. Although the flexibility of these programs may potentially address some of the accessibility challenges and long wait times associated with mental health care in Ontario, (especially for people with physical disabilities and people living in rural areas) iCBT interventions will continue to be a band-aid solution for Ontario's mental health crisis alongside cuts to social services, and Ontarians deserve better.

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