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The History of Mental Health Services in Canada

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Abstract

The history of the development of mental health services in Canada parallels that of the other countries, France, Britain, and U.S.A. which have most influenced it. But there are a number of significant differences which caused the system in Canada to be different from the others. In the late twentieth century, the mental health system in Canada, as in most other parts of the industrialized world has been subjected to increasing ideological attacks. In the last two decades (1980-1999) the system of mental health treatment as a publicly provided service has gone through wrenching change and suffered debilitating cuts in funding. This onslaught was primarily directed at mental health professionals in both provincial institutions and general hospitals. No one was left unscathed. The ripple effects reached all those involved in the delivery of mental health care from the family physician, social worker to the psychiatrist in private practice. People who earlier had entered the field because of altruistic concern for the plight of society's unfortunates were caught in a maelstrom of charges, counter charges, accusations and battles to reform the system.

Suddenly the professionals and others in the hospitals, who were trying to help, found themselves being pilloried for reasons which they couldn't fathom. They were accused of causing all the problems of the system, ignoring human rights and abusing patients, and refusing to accept change, when they were the very people who thought that they were initiating change. The result of this has been a serious deterioration in service and the flight of professionals, not only from these hospitals but from the mental health service as a whole. The main sufferers have been not only patients and care-givers, but society itself. Those who have lived through this chaotic period, find it hard to believe all the things which they have witnessed.

The result of this internecine struggle between bureaucrats, politicians with the professionals involved led to the destruction of the old institutionally-based mental health system, and the failure of the new community oriented mental health care system to provide either succour or treatment to the discharged psychiatric patient or the newly arrived mentally ill. Despite all the fine rhetoric and claims of better care, conditions for the seriously mentally ill have become worse. In a sense they have reverted back to the conditions of an earlier time, home lessness and higher rates of the mentally ill in prisons and on the streets of large and small population centers are not uncommon phenomena in Canada.

Keywords: Psychiatric; Mental health; Century; Dehospitalisation; Enthusiastically.

Review

In the mid twentieth century, the large publicly funded institutions made up almost all of the mental health services in Canada. Over the four decades from 1960 to 2000, they almost completely disappeared. At the start of the third millennium, those that remain are shells of their former selves and often poorly funded appendages of other facilities. The seriously mentally ill are still not welcome at the more upscale hospitals and the inadequacy of resources hearkens back to the days of Dorthea Dix who had an effect on the development of mental

health services in Canada. Her based on principles of both humaneness who in the late nineteenth century had a services which have replaced them. As a result, many of the former patients fill the jails, or live on the street. The United States and Canada have gone through very similar experiences. Recent reports indicate that in the U.S. the largest provider of mental health care is the Los Angeles County Jail.

In the 1960s and '70s, the move from institutional to community care became the prevailing ideology. It was a grand design, which was seen by its advocates as more humane, and far superior to the regimented, neglectful, and sometimes abusive, care provided in the huge mental hospitals. The problem was, however, that community care was not for everyone, and those discharged patients who couldn't cope with community life found that the beds they had recently occupied were gone and they could not go back to familiar faces and places. In the new model, out-patient clinics and case management services were supposed to help these people to improve their coping skills and to live successfully in the community environment. It clearly has not worked. So what went wrong?

The flaw, we suggest, was a disruption of the overall system of care and the resultant effect was that modern, comprehensive programs of treatment and rehabilitation, which depended on more structured settings, lost efficiency and effectiveness and were decidedly underutilized. Providing equivalent care in the community turned out to be less efficient and more costly. The notion that patients would function better when away from the debilitating effects of "institutionalization" was true for some, but not for all.

The result was that it never became possible to provide equivalent services, and the cost of the new system was increasing instead of decreasing as promised by its advocates. Soon, rising costs became a political consideration. The bureaucrats assumed that the problem was that mental health professionals were not good fiscal managers—no-one thought to consider that there might be a problem with the basic approach. The cost-cutters moved in. They seemed to work on the principle that if we could get by with half as many beds, why not a quarter? Even less? In fact the number of psychiatric beds per 100,000 population in Canada was reduced from about 430 in 1959 to about 70 today, a six-fold decrease. Meanwhile, the increase in community-based services has been significant, but clearly is unable to compensate for that huge loss of service. And there were certain functions provided by the old mental hospitals which simply could not be duplicated in the community at any cost.

In this book we first examine the history of the public delivery of mental health care in Canada from its earliest beginnings in colonial times down to the height of its modern development in the second half of the twentieth century. We then examine the rise and fall of specialized social institutions in an historical, political and systems-planning context. We advance the argument that societies create institutions to solve perceived problems and destroy them when they no longer appear to be meeting those social needs. The problem posed by mental illness, of course, is that it is still perceived by too many people as a social control problem and not, despite much rhetoric and argument, as a health problem.[i] But our society already has a well-established system for social control problems—the criminal justice system, and it is not doing all that well either.

Jurists have recognized for many centuries that there were certain kinds of human behaviours and dysfunctions which the criminal justice system did not manage effectively. Madness or insanity was recognized as requiring special treatment by the ancient Greeks. Legal issues about competency to manage affairs go back to Roman times. So is this behaviour socially deviant? Or is it a product of mental illness? Is it 'bad' or 'mad'? Should certain people be excused from the normal social and legal consequences of their actions because they apparently did not know what they were doing? Should a mentally ill offender be confined in a madhouse or a prison?

The issue was not of great concern when conditions of life in the old madhouses were certainly no better than in the prisons, and often much worse. However in the late eighteenth century, Philippe Pinel in France and William Tuke in England introduced Moral Treatment, a humane new concept of care. The old madhouses were converted into asylums or 'places of refuge' where humane treatment of the mentally ill was a required form of care. In Moral Therapy, the punitive aspects of care, which were society's traditional way of dealing with offenders, were increasingly abjured. It became important to decide whether an offender was mad or simply bad, because the consequences of that decision could be profoundly different. This was reflected in the legal tests for insanity such as the "McNaughton Rule" (1846), which dominated the legal and philosophical discussions of insanity until relatively recently.

The first half of the nineteenth century saw a spate of asylum building, particularly in the British Isles and in the United States. By the 1830s, many jurisdictions in British North America were starting to plan their own places of refuge for the mentally ill. A hundred years later, the system was well developed across North America. But during much of this time, confinement in an asylum remained a legal issue. Medical Certificates of Insanity only appeared late in the nineteenth century and did not constitute the main method of admission in most states and provinces until the beginning of the twentieth century. However, as the number of asylums grew, they could not keep pace with the flood of admissions. Overcrowding and deteriorating conditions in the institutions meant that the fine principles of moral therapy were seldom carried out, and some of the crumbling, overcrowded and understaffed asylums were scarcely better than the madhouses of two centuries earlier.

Despite the dreadful conditions in the asylums of the nineteenth and early twentieth century's, society tolerated them because they were seen as not significantly different from the prisons. And the punitive approach of the criminal justice system was reflected in the care and treatment as well. A condition known as "lunatic's ear" was widespread in the

hospitals in the nineteenth and early twentieth century's. Patients had purulent discharging ears which eventually made them deaf. When the practice by attendants of "boxing the ears" to enforce discipline was abolished, the condition disappeared within months.

Another factor which meant that mentally ill offenders were often subjected to more punitive treatment than inmates in the prison system was the fact that the legal warrants of remand and warrants of admission were indefinite. In many jurisdictions in Canada, the superintendent of the institution was charged to: "….safely keeps…until the pleasure of the Lieutenant Governor is known." This meant that if defendants were found "not guilty by reason of insanity", by the court, they could expect to remain in a mental hospital for the rest of their lives, regardless of the type of the offense or the length of the sentence they otherwise would have received. Even though the person was technically not guilty, the public had to be satisfied that the perpetrators were not "getting off scot free" [ii].

But by 1960, two factors had changed the public perception of the mentally ill offender. The rapid advances in the neuro-sciences, social sciences and psychiatry meant that patients were being discharged much more quickly or treated in the community without admission making the idea of lifetime incarceration less and less tenable. Conditions in the hospitals had improved to the point that they could no longer be compared to the prisons. The penal system too was improving so the old "prisons/hospitals" for forensic patients—unchanged since they were built in the late nineteenth century—had become totally anachronistic. Instead, special forensic institutions were set up for these people although the legal requirements of their treatment and remand under the criminal justice system were no longer congruent with the more modern treatment approaches offered to patients in the regular health services. These differences only served to emphasize the stark contrast in treatment paradigms between the mental health and criminal justice systems.

English Canada at that time was basically agrarian, rural and largely undeveloped. The need for an asylum was not recognized until the 1830s and then, temporary quarters in condemned or outdated buildings, such as prisons or cholera fever hospitals. The first purpose-built asylums were the New Brunswick Lunatic Asylum in 1847 (?) and the Toronto Lunatic Asylum in 1850. In French Canada, facilities started much earlier. The Hotel Dieu in Québec provided care for indigents, the crippled, idiots and lunatics in 1639.

Of all the countries in the Old World which sent explorers and colonists to North America, France and England had the most influence on the development of institutions for the mentally ill in Canada.

In 1844 Sir Charles Metcalfe initiated government action to establish an asylum near Quebec City in Beauport, Quebec. A year later, on 15 September 1845, the Beauport Asylum opened its doors to accommodate 120 patients. It was reported that "[l] lunatics in the charge of the religious ladies of the General Hospital of Quebec" were sent to the asylum on that date. [iii] This, however, was not a state institution but a "propriety" institution operated by Drs. Douglas, Fremont and Morin, under the "farming out" system, whereby the state made per diem payments to the proprietors via Orders in Council.

Historical Survey

The 1864 Report on Colonial Hospitals and Lunatic Asylums in Canada authored in Whitehall, as Canada was a crown colony until the British North America Act created the Dominion of Canada in 1867. This report offers the sweeping observation: "insanity almost engrosses public attention and care...in the North American colonies." This was a reference to the care given to over 1500 insane persons then confined to the Crown supported asylums established in Quebec and Ontario which were under the supervision of the Board of Inspectors of Prisons, Asylums and Public Charities.

Let the establishment be an asylum-not a mere hospital or prison-an asylum where disturbing influences are absent, and regulating influences are in full operation...the grounds should be a good specimen of British landscape gardening, and this with an adaptation healthily to affect the minds of the insane...then within this house should be officers who understand that cardinal principle of the British Army, being kind and patient without being familiar. It is, we believe, quite practicable to have in such institution regularity as perfect as that of the Post Office, and discipline as effective as that of the Army.

—The Globe, 2 February 1850

(Editorial: Toronto Asylum)

This classic account by "Brown of the Globe", one of Canada's most prominent pioneer statesman, newspaper editor and prison reformer, draws together several pre-Confederation ideas and conventional wisdom about mental hospitals.

Dorothea Dix the American social activist visited the poorhouse in Halifax, Nova Scotia, Canada in September of 1849 and the impressions she formed were part of her address to the members of the Nova Scotia Legislature on 10 December 1849. Evangelistic fervour characterised her address. She presented a voluminous array of statistics and quoted from nearly all the leading authorities on the "insane" in the United States and the United Kingdom. Claims of cure rates of between 80 and 90% were the norm.

Moral treatment of the insane promulgated by the tukes in England and Pinel in France had a buoyant view of man and a conviction that insanity could be easily cured in a setting which was in contradistinction to neglectful community. The consideration given to the location, floor plan, and the provision of amusements, occupations and religious worship especially by the Tuke Quakers were all part and parcel of the "treatment moral" of Pinel and the "Moral therapy" of Tuke.[iv]

Most of the objects amongst which the disease is contracted, becomes sources of annoyance to the patient, thereby increasing his irritability and disease-the obvious consequence therefore in removing him to a spot where new objects, and

those of a pleasing and interesting nature are to be found, has a tendency at once to change his delusions, and create a feeling very favourable to his recovery; for this reason, therefore, much attention is shown to appearances in every way. The extent of the grounds is also another important consideration; these should be sufficient to admit of a tolerable sized farm, with gardens and walks, in which labour, exercise and amusement may be combined.

The assumption supporting this attention to architecture and landscape was based on the undisputed conviction that the external appearance as well as the internal administration of the asylum was considered to exert an important moral influence on not only the patients but on the community in general through "self respect and a disposition to self control." It was also assumed that "all those who by reason of insanity are rendered unfit for society" would be attracted to the asylum on a voluntary basis.

Moral treatment emphasised Esquirol's observation regarding the isolation of the patient away from his family:

The English, French, German, and we may now add the American physicians agree with respect to the utility and necessity of separating the insane from those with whom they have always lived. New and unexpected impressions strike and arrest and excite the attention of the lunatic and render him ore accessible to those councils which ought to bring him to reason. Among friends the insane become timid and suspicious; leave an insane person in the bosom of his family, and immediately the whole character becomes altered, and we have little hope for, if we change not his moral condition. The insane therefore should be placed in an institution devoted exclusively to the treatment of mental diseases.

Additional points on treatment were regarding the necessity of an abundant supply of good food as an aid to producing gentleness and tranquillity, the harm of all depletion whether by the "lancet, purging or low diet," the superior remedial effects of occupation both within and outside the institution, amusements such as riding, walking, music, chess, draughts and local newspapers, and religious training as well as lectures on scientific subjects aided by the provision of a library of well selected books.

Religious exercises especially promulgated by the Quakers were viewed as being the most conducive of all the moral treatment means available to the staff for the recovery of the patient. Benefits from these exercises were alleged to be tranquillity, habits of self-control, giving a favourable impression in the community of the asylum and increasing the patient's confidence in "their officers." The Sabbath, according to the author of a Report, "comes to the insane with healing on its wings" and was the happiest day of the week for many of the patients. The curability of the insane, when patients were admitted during early stages of the illness, was given limited attention, and it would appear this optimism on cure was taken for granted.

Norman Dain observes that half of the eight asylums built in the United States before 1824 were patterned after the "Friends' of the Retreat" of York, England an institution in York founded on Quicker principles by William Tuke,

In New Brunswick, Canada in 1836, a Royal Commission was struck to plan the first asylum. A central theme of this report was that the mentally ill should be offered "diversions and interests, excite conversation, supply constant proofs that they are in a world of hope, and among beings who are engaged in the everyday business of life. The grounds should be ornamented, and everything about the establishment should give evidence of care and comfort." The original idea throughout the premises was one of a relatively small institution operated on a personal, family group concept with the medical superintendent as the central figure. In a 1844 report, reference is made that to "allow a man to indulge his reveries in idleness until he has sunk into a state of confirmed insanity, will be observed, a gross and cruel neglect of duty." Work was to be viewed as a part of treatment. "Religious worship and instruction was emphasised and was considered an aspect of asylum care and treatment. The Commissioners were of the opinion that insanity was on the increase but they were reassured by the observation of leading writers on the subject that the disease was not considered of so formidable a nature as it seemed to be because patients treated in the early stages of the disease recovered quickly

Enthusiastically the Commissioners depicted an asylum as a comfortable retreat where patients were to find refuge-a place to which they went on their own accord whenever they began to feel themselves in danger. Moral treatment was confidently upheld as a mild and gentle approach replacing the severe discipline of former times. Lee wrote this account of moral treatment:

The day has gone by for mystery in relation to the treatment of the insane; we have no machinery, we neither drown or torture them into reason, we meet them as friends and brothers, we cultivate their affections, interest their feelings rouse their attention, and excite their hopes; we cheer the desponding, soothe the irritated, and repress the gay as far as possible. We occupy all in doing this; we consult their tastes and feelings, their former habits and pursuits, games of all kinds, chess, chequers, backgammon, cards, ninepins, quoits, battle dome, graces reading, writing, walks, rides, and field sports, are some of their occupations. We invite the quiet and convalescent into our family, seat them at our table, and give weekly parties for their amusement and benefit.

As time went on, the optimism expressed by 80% cure rates after two decades of applying asylum care revealed the somewhat disquieting contrast of a recovery rate nearer to 40%. A rationale for this low recovery rate is revealed in the medical superintendents' annual reports. The previous attention to the idealism of moral treatment and references to English American and French reformers gave way to what appeared as a preoccupation with the practical minutia of institutional routine-improvements in heating, plumbing and furnishings, the extension of buildings, restriction of admissions and the constant worry about locating funds. Overcrowding, lack of resources the admission of the physically ill, paupers, "unpredictable inebriates" and an increase in political controversy over how asylums should be financed and administered became cardinal considerations. The well-known therapeutic father-like role of the medical superintendent, so common in the Quaker-influenced asylums, was seriously threatened.

The original mental hospital plans called for a pleasant, small (100 to 250 beds) sanctuary situated in the pastoral countryside within a few miles of urban areas. A high premium was placed on the therapeutic effect of staff-patient interaction as well as attention to the patient's physical well being-good food, recreation and an abundance of fresh air. However, this was only secondary compared to the consistent objective of providing aspects of what most 19th century English middle class families would have considered as the "proper" way to mould character-education and crafts, personal routine and respect for discipline, the cultivation of social graces and regular spiritual instruction. Consequently, the medical superintendent assisted by a matron and nurses was expected to maintain a paternal role and enable the institution to provide what the patient's family or the environment was thought to have failed to offer. In broadest terms, Canada's first form of mental hospital administration was the result of an attempt to apply an absolute ideal which consisted of methods of treatment generally based on a positive view of man's nature (moral treatment was directly influenced by the philosophy of the Enlightenment) within an institutional setting similar in many respects to a well established Victorian household.

By 1867 the prospects for the care of the mentally disordered in Canada were bleak. Within a few decades an almost full circle had been turned which began with an introduction of positive reforms sufficiently successful to be convincing of their merit; and then, often within months, new admissions poured in until overcrowding became a stifling affront to any sincere attempt to apply the ideal of moral treatment. The natural consequence was some variation of custodial care which, when encountered the second time around, was complicated by the absence of any alternatives. The ambitious vogue of reforming conditions for the mentally disordered had quietly subsided.

Many of the new asylums became so large-Hospital St Jean De Dieu in Montreal housed almost 6,000 patients in the 1950s-that the principles of "moral treatment" could no longer be applied since one of its main tenets was that lunatics were to be treated as individuals not as part of an amorphous mass. Tuke's admirable principles had therefore rebounded on themselves, for his insistence that earl

Twentieth Century in Canada

Throughout Canada, mental health services were institutionally based by 1900, but substantial changes were in train. The period was characterized by four primary features: (i) the collapse of moral therapy; (ii) the development of an organic neuro-pathological orientation which offered psychiatrists an opportunity to move closer to mainstream medicine; (iii) the beginning of a volunteer/voluntary movement; and (iv) the impact of World War I.

Dr Clare M. Hincks at the end of World War I organised the Canadian National Committee for Mental Hygiene, the forerunner of the present Canadian Mental Health Association. Dr Hincks was influenced by Clifford Beers, founder of the so-called Mental Hygiene Movement in the United States. Beers who had firsthand experience of the abuse and cruelty meted out to psychiatric patients in the USA, enabled Dr Hincks in his quest to apply "the knowledge of mental illness" after he had consulted with leading neurologists and psychiatrists in the USA.

His conclusion was that "our asylums were inadequate." Approximately four decades passed in Canada when there were only 32 psychiatric units in general hospitals with a total in-patient population of 872 patients. In 1959 the bed capacity in mental hospitals in Canada was 65,000. In that same year, legislative reformers throughout the land were starting similar objectives as Dr Matthew Dymond, the Minister of Health in Ontario when he stated forty years ago that: "I want to say very emphatically that the mental hospital will not be considered as an institution for custodial care". In 1970 there were 86 general hospitals offering services to 3,000 patients. By 1976 there were 15,000 patients in provincial mental hospitals and close to 6,000 in general hospitals. Community care had very much become a feature of the mental health system in Canada.

The Last Fifty Years

During the past fifty years the journals in the Western World have been replete with "studies" revolving around the hospital as the locus of activity regarding the mentally ill and the community. It is clear that community care has become both the prevailing treatment practice and ideological motive force. Twenty-two years ago, Leona Bachrach stated:

the emphasis must be moved away from programs and places toward the patients themselves. We remain entrenched in concerns about locus of care, confusing it with the humaneness, effectiveness, and quality of care.

In eighteenth-century America, the mentally ill were confined to poor houses and jails. Dorothea Dix in 1842 stated that "...jailing the mentally ill made as much sense as jailing someone for contracting tuberculosis".

A former governor of Virginia, USA, expressed dismay that he was "forced to authorise the confinement of persons with mental illnesses in the Williamsburg jail, against both his conscience and the law." Why? Because of a lack of appropriate services. That was in 1773. In July 1999 the Bureau of Justice Statistics estimated that 16 percent of America›s jail and prison populations are seriously mentally ill. (While 16 percent may seem high, that figure is probably low because the Department of Justice relied upon self-reporting for its methodology.) The American Jail Association now estimates that there are between 600,000 and 700,000 bookings of mentally ill offenders each year. The largest provider of mental health in the USA is the Los Angeles County Jail.

I think the contemporary debates revolving around community care and institutionalization are really a red herring. They do the mentally ill serious harm. It is treatment that counts not whether it takes place at home, the "community" or the institution. For the seriously mentally ill community care alone is of a limited advantage.

Homelessness and an increasing reliance on elderly caregivers, themselves burdened with physical and emotional problems, put at risk current and future care. In addition, Professor of Psychiatry in the UK, Wing, stated in 1992 that, "there have been no major advances in the theory of practice of psychosocial methods of treatment, enabling, care or support during the past thirty years". Professor of Psychiatry in the UK, Robertson states that "Madness cannot be abolished by relocating it Its effects can be modified by treatment." (1991).

Deinstitutionalisation: Myth or Mistake

Deinstitutionalisation can be seen as reaction to the negative consequences of life in institutions. De-hospitalisation can be viewed as one approach to deinstitutionalisation. The way it is pursued-for example-within tight time or budgetary constraints is of the utmost importance. Witness the defects and pitfalls of institutionalisation brought about in no small measure by overcrowding and lack of funding.

Witness our contemporary views of the period of institutional expansion. Future generations as well will judge the era of de hospitalisation by reference to its outcomes and consequences, not to its good intentions.

The present situation its own contradictory problems, and uncertainties about long-term benefits for mentally ill people. The post-World War II period in Canada, and, indeed, in the Western World has given rise to two interrelated «movements», both of which can be seen as responses to the early period of institutionalisation in which asylums very rapidly became overcrowded, custodial in nature, and counter-therapeutic. The deinstitutionalisation movement can be seen as a philosophical or «theoretical» reaction to the negative consequences of life in institutions. Dehospitalisation was one of several policy approaches to deinstitutionalisation. It can be viewed as being driven by a variety of factors, such as government parsimony and the problems of over-crowding in existing institutions. Deinstitutionalisation and dehospitalisation are far from synonymous, especially when dehospitalisation is pursued within tight time or budgetary constraints.

In sharp contrast to the thrust toward community care in most Northern Hemisphere countries, Japan's system is highly instititutionalised. More than 60% of all patients are kept behind barred metal doors and windows which are kept locked twenty-four hours a day. Length of stay is among the longest in the world with more than half of all patients having been confined in hospital for over five years.

Professor E. Fuller Torrey of the USA in March of 2000 stated that deinstitutionalisation in America is a myth.

Instead, 'transinstitutionalisation' is the reality for hundreds of thousands of individuals suffering from severe mental illnesses, such as schizophrenia, and manic-depressive illness. Had the intent of the last thirty years of deinstitutionalisation been realised, individuals with severe mental illnesses would be free to live healthy, productive lives in their own communities. Instead, many are imprisoned by the untreated symptoms of their illnesses.

These individuals have been Trans institutionalised to jails, prisons or to our city streets. Approximately 40% of all individuals with severe mental illnesses are not receiving treatment at any given time resulting in devastating consequences. Despite the fact that people untreated for severe mental illnesses consist of less than one percent of the population of the United States, these individuals:

1) Comprise at least 10 percent of the nation's jail and prison populations;
2) Represent at least 33 percent of the homeless;
3) Commit between 4 and 5 percent of annual murders, or approximately 1,000

Homicides a year;

4) Commit suicide at a rate 10 to 15 times higher than the general population.

He goes on to state:

The intent of deinstitutionalisation was not flawed—it was the implementation that failed. The promise of integrated community services to replace the hospital beds never materialised.

To some health planners, mental illness is viewed as it was in the pre-1800s, primarily as a social rather than a medical problem. Emphasising either the social or medical aspects of mental illness is bound to bring about only a partial solution to the misery inherent in mental illness. Partnership in service and provision is essential.

What Is To Be Done?

Community care should be about providing adequate treatment and not only about the closure of mental hospitals. This should not be a war between community care and institutional treatment. Treatment of a bio psychosocial nature is what matters, not whether the treatment is intramural or extramural. The careful selection of patients to be placed in community living and 24-hour availability of professional help are indispensable ingredients for successful programs.

Bureaucratic indifference to inadequate funding, legislative indifference to untreated psychotic behaviour, and the lack of compliance with treatment plans where violence is an issue, do much to reinforce hostility toward community care. Health planners cannot and must not be oblivious to society's responsibility for the treatment of the vulnerable mentally ill population.

As we judge the period of institutional expansion, future generations will judge the era of community care, dehospitalisation, and deinstitutionalisation with reference to its outcomes and consequences, not to its good intentions.

In a keynote address to the American Psychiatric Association in 1999, the Reverend Jesse Jackson stated that the wave of deinstitutionalisation of the 1960s and '70s left the mentally ill with no place to go. "The jail-industrial complex gobbled up these lost and lonely people with no concern for their health." A national jail survey released by the National Alliance for the Mentally Ill found that jails are still being used in some states in the USA to house mentally ill people even if they have not been charged with a crime.

Appropriate treatment should be the driving force behind mental health restructuring. Too often it is related to vested interests, misguided idealism, blind ideology, and planned government savings. If no treatment is provided to the

severely mentally ill this will be a precursor to violence, suicide and serious social consequences. Health caregivers, be they doctors or others, will not be assessed on good intentions but on results in alleviating human suffering.

The attempts at deinstitutionalisation on a worldwide basis have had mixed reviews. The shift will be judged not on semantic grounds (the change in name for a psychiatric patient, to consumer, then to consumer-survivor), lofty idealism nor ideological persuasion. Our most vulnerable patients, the mentally ill will be doomed if we do not recognise that pharmacological treatment, coupled with an array of social services are required.

Let us remember that the community care model may create scenes and situations in our urban and rural landscape reminiscent of Dante's Inferno for the severely mentally ill. In many instances, we have gone far enough with regard to dehospitalisation and what is required now is a fine tuning of the existing system. The alleged soul-destroying hospitals of the past are not the present reality.

There is no need to fight battles that have already been won. The current psychiatric hospitals may provide the best of both worlds.

Community care should not be just about the closure of mental hospitals but about providing adequate treatment. Community care and institutional treatment should not be at war. Treatment of a bio psychosocial nature is what matters, not whether it is intramural or extramural. Nevertheless, the careful selection of patients to be placed in community living and round the clock availability of professional help are indispensable ingredients for successful programmes. Bureaucratic indifference to inadequate funding, legislative indifference to untreated psychotic behaviour, and the lack of compliance with treatment plans where violence is an issue do much to reinforce public hostility to community care. Health planners cannot and must not be oblivious of society's responsibility for the treatment of the vulnerable mentally ill.

In North America and Western Europe, in the latter part of the twentieth century, large institutions for the mentally ill were downsized, divested by governments, and in many cases closed or converted for other purposes. This was called "Deinstitutionalisation", and/or "Community Care". But the community care alternative was not able to replace the total care of the institutions, so large numbers of the seriously mentally ill were discharged, placed in living arrangements which were inferior to the old "backwards", in fact "Tran institutionalized", or simply left to their own devices in a largely unsympathetic urban society.

The twentieth-century reformers claimed that community care was humane, efficient, and that the institutions were inhumane, abusive, and increased mental illness rather than reduced it. (More often than naught community care became synonymous with no care and no treatment on both sides of the Atlantic) In the 19th century, with the terms "institution" and "community" reversed these were exactly the arguments utilized by social reformers to justify the creation of the asylums.

This "Dehospitalisation" continued despite intensive efforts to reform the institutions from within, and to correct the abuses and improve the treatment of patients. These efforts were largely successful, so that by the end of the 20th century, the treatment offered in these facilities was effective within a compassionate environment. However, the juggernaut of reform was rolling and could not be stopped. Currently, conditions for the seriously mentally ill are scarcely better than they were before the whole process started two centuries ago. "Tran institutionalization" into the prison system, homelessness, and desperation, often leading to suicide was the documented result.

Conclusion

A review of the history on both sides of the mighty Atlantic Ocean provides many examples of other social reform movements which had similar results. The dissolution of the Monasteries in sixteenth century England parallels the socio-political movement to close the mental hospitals in the twentieth century. Deinstitutionalization has been presented as a planned logical response to the abuses inherent in the mental hospital system. The solution proposed was to replace institutions with a network of community based programs. The resulting unanticipated outcomes have been disastrous for the vast majority of the seriously mentally ill throughout the western world.

The prevailing ideological paradigms and consequent events are part of the well-trodden path of social reform. Notwithstanding the best intentions of the reformers, conditions "naturally" tend to return to a state reminiscent of the period before the whole reformist cycle began. Although it may appear that nothing has been gained, perhaps in the very structure and function of society, progress does not occur without this cyclical phenomenon.

Deinstitutionalization at its zenith addressed the inhumanity of mental hospitals and necessity of the "wholesale" closure of asylums. This cause celebre in many respects was Quixotic, in that the vast majority of chronicled abuses were being addressed and remedied.

[i] In fact it is a bit of both. But whether it should be the legal or the health system which controls them remains a contentious problem. The bureaucrats and the media sometimes favour one side, sometimes the other. And sometimes it almost seems they would favour locking up the mental health professionals and putting the patients in charge.

[ii] The term "Scot free" meant that one was not required to pay the 'scot and lot' which was a municipal tax or assessment on property in Britain. It became a general term for escaping the usual consequences of one's actions.

[iv] "Moral Therapy" coined by the Tukes in York. U.K. was rooted in Quakerism. "Treatment moral" ideological under pinning of Rousseau.

Reference

1. Burgess TJW. A Historical Sketch of Our Canadian Institutions for the Insane. Transaction Section IV. *Royal Society of Canada*. 1898; 48.