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Psychiatry in Ontario and Throughout Canada in the Twentieth Century

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Article Info

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Abstract

This paper traces the evolution of psychiatry in Canada from the promise of moral therapy to institutionalization and community care. Paradoxically homelessness and incarceration in the penal system are the unintended consequences.

Four primary features characterized the beginning of the 20th century in Psychiatry in Ontario and throughout Canada.

1) the collapse of moral therapy,
2) the development of an organic, neuro-pathological orientation which offered psychiatrists an opportunity to move closer to mainstream medicine,
3) the beginning of a voluntary/volunteer movement
4) The impact of the World Wars.

In 1918, the Canadian National Committee for Mental Hygiene (CNCMH) a forerunner of the Canadian Mental Health Association (CMHA) was founded. (Dr. Hinks) From 1918 -1924 surveys of mental hospitals were commissioned to CNCMH by provincial governments to assess the conditions of mental hospitals.

Post World War I phenomena such as the introduction of intermediate hospitals the Toronto Psychiatric Hospital in 1925 (Drs. Clarke and Farrar) (and as such a beginning attempt to break away from large mental hospitals) hospital surveys, and the introductions of child guidance and outpatient clinics of a stationary and traveling nature in the 1930s, 1940s and 1950s did bring Psychiatry in Ontario to the forefront of the community. The end of the Second World War did bring about an increased awareness of the mental health needs of the entire populace in Canada. Mental illness was at last considered a concern of all residents of the country and not solely a matter of "asylum". The effect of the two World Wars was to bring countless people into contact with psychiatric services who would not otherwise have been exposed to such services.

By April of 1972 all the provinces and the two territories of Canada adopted Medicare the universal health care plan of this country. Psychiatric patients and their treatment were covered by the various provincial government plans. Concurrent with the introduction of Medicare, the federal spending power provided grants for hospital construction. This created linkages to the community; in a substantive, substantial, concrete manner.

Provisions of treatment and care with community and familial linkages were extended to groups of patients who were not, overall, as severely debilitated as the traditional "asylum patients." The long term effect was to introduce a range of new mental health services and corresponding models, e.g. care in general hospitals.

Introduction

Psychiatric units in general hospitals were established throughout Canada and Dr. William Henderson (formerly the Executive Director of the Government of Ontario's Mental Health Division) stated in Pioneers of Mental Health and Social Change that the grants for psychiatric beds were even higher than for acute medical treatment beds in general hospitals.

However, psychiatric units were not established in all instances in a harmonious way; in many general hospitals throughout Canada, there was great reluctance to develop them. The legislation which permitted psychiatric units in Ontario did so under two conditions. The first was that the provisions for detention in the psychiatric unit of a general hospital would be identical to those of a provincial psychiatric hospital. The other requirement was that the patients in a psychiatric unit would be under the care of psychiatrists. In many instances the latter condition was interpreted very broadly by hospital administrators to mean a medical ward exclusively for psychiatric patients without the necessary treatment infrastructure for the treatment of mental illness (e.g. psychiatrists, psychiatric nurses and the multidisciplinary team).

The significance which Medicare had for the quality of care regarding provincial psychiatric institutions in Ontario (which was not atypical for the rest of Canada), was summed up by the following quote

Dr. Henderson:

"Some of the superintendents openly resented the development of service in general hospitals which took psychiatrists and other personnel, which they felt were better deployed in mental hospitals...

...the only way of upgrading the resources and facilities of provincial hospitals was to have something else out there for purposes of comparison and it helped..."

The National Health Grants Program introduced in mid 20th century Canada recognized the fiscal inability of the provinces left to themselves to upgrade mental health facilities and resources. It provided funds for outpatient services in general hospitals as well as capital costs for psychiatric beds in new general hospital facilities. It discriminated between acute care beds and psychiatric beds in the amount of $500.00 (Acute care beds were funded at $1000 per bed and psychiatric beds were funded at $1500 per bed).At the end of World War II a large number of psychiatrists who had seen service were engaged in private practice. While there were very few psychiatrists employed in private practice prior to World War II, by 1950 it was estimated that there were at least 400. This growth in private psychiatry increased the acceptance of psychiatrists outside the provincial mental hospital setting and provided something of a base for the later developments in community psychiatry. Despite the fact that there was a growing acceptance of psychiatry throughout the land, there was still great reluctance to establish psychiatric units in general hospitals.

The bed capacity in mental hospitals in Canada went from approximately 46,000 to 65,000 from 1949 to 1959 and patients on the books went from 58,400 to 76,400 during this same time period. Moreover, by 1959 there were only thirty-two psychiatric units in general hospitals with a total inpatient population of 872 patients.

By 1970 there was a marked change throughout Canada with 86 general hospitals offering psychiatric services to approximately 3,000 patients. By 1990, 191 general hospitals had psychiatric units, a further indication of the reversal of the nature of psychiatric care provided in the past in Canada. There were many reasons for this reversal which had synergistic and interactional qualities. They are as follows:

1) The financial incentives provided by the federal government in the form of Medicare's universal hospital insurance and hospital construction grants,
2) The growing acceptance of psychiatry, and
3) The willingness of the provincial governments, and Psychiatrists to participate in federal endeavours to "mainstream" psychiatric care from the provincial mental hospitals to general hospitals.

All this did much to bring about the practice of psychiatry in general hospitals and contributed significantly to the philosophy and practice of community care.

This was aided and abetted by the community psychiatry movement, the advocacy of social reformers and volunteer associations as well as advances in psychopharmacology, especially the introduction of phenothiazines, anti-depressants and anti-anxiety medications in the 50s and 60s. All of these forces had a synergistic, complementary and interactive effect upon each other. By 1970, there were 249 full-time mental health clinics which represented almost a 100% increase since the end of World War II.

In 1964 the Royal Commission on Health Services recommended:

"That henceforth all the discriminations on the distinction between physical and mental illness in the organization and provision of services for the treatment and attitudes upon which these discriminations are based be disavowed for all time as unworthy and unscientific."

Patient populations in all psychiatric hospitals plummeted due to the increased numbers of patients in general hospitals, nursing homes and special care facilities throughout Canada. This dehospitalization and corresponding depopulation of provincial institutions was in consonance with the 1964 Royal Commission on Health Services, which stated:

"We believe that provinces should move with all due speed to remove all patients receiving or capable of receiving active care from mental hospitals and transfer them to general hospitals."

By 1976, there were 15,011 patients in provincial mental hospitals in Canada compared to 47,633 in 1960 when the numbers of patients started to decline. In 1959, there had been 76,400 patients in mental hospitals. The large decreases can be attributed to the use of phenothiazines and the beginnings of community care.

It became apparent in the 1970s that the general hospital psychiatric units did not provide treatment for those suffering from severe and chronic psychiatric illnesses

In 1978, McKinsey and Company stated that provincial psychiatric hospitals and general hospital psychiatric units

> "...serve fundamentally different patient populations... public psychiatric hospitals treat virtually all longer term inpatients and the more difficult to manage outpatients and short-term inpatients. In contrast, psychiatric units serve larger numbers of exclusively short-term patients who are much less difficult to manage."

While this two-tiered system was and still is , a reality in Canada, the number of patients discharged from general hospitals with a diagnosis of functional psychosis increased from approximately 28% to 40% from 1971 to 1986. In short, the overlap between the two types of hospital patients is increasing as general hospitals accept more severe cases.

Despite this "progress", homelessness, trans-institutionalization and an increase in mentally ill patients who find themselves in penal institutions are very much part of the overall mosaic of psychiatric services in Canada.

"In the 20th century, psychiatric care moved from large 19th century asylums to a largely community-based practice with tremendous changes in care patterns and approaches to mental disorder. In the 19th century, the institutions had become largely custodial. The hospitals were similar to the prisons in many respects, and until 1920, when the Department of health was created, were run by the same department of government that ran the prisons. Before 1960, the large mental hospitals made up nearly all of the psychiatric care system in Ontario.

After World War II, the mental hospitals were overcrowded with deplorable conditions and ineffective and often abusive treatments. The overcrowding reached a peak in 1959-60 when 423 of every 100,000 Ontarians were in a mental hospital. Change was on the way.

Several factors were important. Among them were:

- The demographic studies of the 1950s and '60s indicated that mental illness was a far larger problem than anyone had previously suspected.
- This led to government reports such as "More for the Mind" which concluded that urgent reforms were necessary-leading to very ambitious reforms.
- At the same time Canada was embarking on an ambitious program of Medicare to bring Government-funded health care to every citizen. By 1975, the costs had started to mount.
- A strong reform movement which became allied with a growing civil rights movement

The public hardly noticed these events at the time but when the full impact was felt in the last 3 decades of the century, it resulted in wholesale closing of mental hospitals, homelessness for large numbers of people, and the deterioration of psychiatric services generally. In the 21st century, we still have not recovered from the effects."

Four primary features characterized the beginning of the 20th century in Psychiatry in Ontario and throughout Canada.

5) the collapse of moral therapy,
6) the development of an organic, neuro-pathological orientation which offered psychiatrists an opportunity to move closer to mainstream medicine,
7) the beginning of a voluntary/volunteer movement
8) the impact of the World Wars.

In 1918, the Canadian National Committee for Mental Hygiene (CNCMH) a forerunner of the Canadian Mental Health Association (CMHA) was founded. (Dr. Hinks) From 1918 -1924 surveys of mental hospitals were commissioned to CNCMH by provincial governments to assess the conditions of mental hospitals.

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Conclusion

Despite this "progress", homelessness, trans-institutionalization and an increase in mentally ill patients who find themselves in penal institutions are very much part of the overall mosaic of psychiatric services in Canada.

No conflict of interest

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