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The Rise and fall of Institutional Psychiatry In 20th Century Canada and Ontario: An Historical Review

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Towards the middle of the nineteenth century in Canada, social movements for the mentally ill, of clerical, philanthropic and humanitarian, political and journalistic dimensions were very much apparent. The Moral Treatment philosophy of the Quakers in Great Britain, who lobbied for and were an advocacy force for the establishment of humanitarian institutions with therapeutic surroundings of a non-custodial and non-coercive nature, appeared in Canada. This movement had grown up in the wake of the Enlightenment and on a wave of corresponding new feelings of social responsibility in Canada. It was influenced primarily by the prevailing philosophy of the time in Great Britain and by example, the creation of asylums in the U.S.A.

Even before Canada became a nation, a policy shift emerged characterized by a sense of responsibility towards the mentally ill. The provision of care, protection, and treatment of the mentally ill took the form of asylums. The 1830s and 1840s already had seen the beginnings of asylum construction in Ontario, Quebec, and New Brunswick.

Prior to the construction of these asylums, the mentally ill in Canada, if considered harmless, were often left to wander at will as beggars. They were stigmatized as public nuisances at best. At worst they were often detained and incarcerated in restrictive environments such as jails and poorhouses where they were subject to deficient diets and substandard shelter, and where no attempts at "rehabilitation" were made.

The first purpose built asylums in English Canada were the New Brunswick Lunatic Asylum in 1847 and the Toronto Lunatic Asylum in 1850 later known as Queen Street and now the Centre for Addiction and Mental Health. By 1900 the prospects for the care of the mentally disordered in Canada were especially bleak. Within a few decades an almost full circle had been turned.

This began with an introduction of positive reforms sufficiently successful to be convincing of its merit; and then often within months new admissions poured in until overcrowding and underfunding became a stifling affront to any sincere attempt to apply the ideal of caring and treatment. The natural consequence was custodial care in the absence of any alternatives. The ambitious vogue of reforming conditions for the mentally disordered had quietly subsided. Many of the new asylums in Canada became so large that, for example, the Hospital St. Jean de Dieu in Montreal housed almost six thousand patients in the 1950s.

The principles of Moral Treatment and the philosophy which this entailed could no longer be applied. This period, from 1900 to 1945, for the mentally ill could be characterized and depicted as being a period of nihilism as well as hope in the therapeutic realm. This, nihilism, was reflected in the asylums' medical superintendent annual reports, which were replete with budgetary references, accounting, and administrative matters. In previous decades, therapy, humanitarian and rehabilitative efforts and positive outcomes had been expounded upon. Hyperbolic references to cure rates of eighty to ninety percent were common in these earlier reports.

Concurrent with the above the 1900s saw substantial changes in train. The period was characterized by four primary features: 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 movement, the Canadian Mental Health Association; and 4) the impact of World War I.

Table one

The First World War (1914 to 1918) had a strong impact on psychiatric thinking. Unlike previous conflicts fought by professional soldiers, large numbers of civilians were recruited into the military and many of them were incapacitated by "shell shock", a condition we now realize and recognize as a form of "post-traumatic stress disorder." Hospital and other mental health services which had focused on chronic psychosis and dementias now were called upon to treat "normal" people back from the war. An example of this would be the Hospital for the Insane, in Whitby, Ontario. This ''hospital'' while still under construction, was converted to a military hospital in 1918 to treat these returning troops.

In 1930 a Royal Commission Report concluded that the provincial psychiatric hospitals throughout Canada were a step far beyond the jail and county poor houses but they were certainly and without equivocation found wanting from either a therapeutic or decent accommodation perspective.

By the 1930s, it was generally the case that all provincial psychiatric institutions were deteriorating due to overcrowding and a corresponding lack of resources. The Royal Commission Report of 1930 recommended capital expenditures in the amount of 20 million dollars to upgrade existing facilities. Unfortunately, the worldwide Depression had its effect upon mental health services in that conditions for the mentally ill became both unmanageable and in a state of deterioration. The decade of the 1930s until the end of World War 11 can be referred to in Canadian mental health services as years of neglect of the mentally ill. An example would be that by the early 1930s the whole emphasis of treatment shifted to one of social control. Keeping the mentally ill away from the public in the most segregated of geographical locations became the modus vivendi.

The end of the Second World War did bring about an increased awareness of the mental health needs of the entire populace in Canada and an increase in funding did occur. Mental illness was at last considered to be a concern of all citizens of Canada and not solely a matter for the "asylum". Constitutional considerations and federal involvement were paramount in this transformation of thought, attitude and action.

In 1945, the Canadian Department of National Health and Welfare became more involved in mental health. In 1948, the government of Canada created the National Health Grants (Mental Health Grants) whereby amounts up to $7,000,000 were provided by the federal government to the provinces. Priority was given to the training of professional personnel. This had the effect of raising standards in mental hospitals as well as increasing the existing pool of mental health professionals.

In 1963, More for the Mind was published under the auspices of the Canadian Mental Health Association (CMHA) and the federal government of Canada. This volume had two essential aspects: a) a policy of regionalization of personnel and facilities for the mentally ill, and b) comprehensive care of the mentally ill within the community.

More for the Mind among other things advocated the treatment of mental illness on the same basis as physical illness and that the standards of care and facilities should be equal. It emphasized the grossly inadequate services for the mentally ill in general and the appallingly bad conditions in the mental hospitals in particular. It made many sweeping recommendations but the bottom line was equivalency of services for mental illness in relation to physical illness.

At the same time, a Royal Commission on Health Services, chaired by Mr. Justice Emmett Hall, was in active session. The Hall Commission recommended a sweeping change in the way in which mental health was conceived and treated in legal and medical terms. The Commission proclaimed, "that henceforth all discrimination on the distinction between physical and mental illness, and 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".

Table two

Even before the Hall Commission in 1959, the bed capacity in mental hospitals in Canada was sixty-five thousand. Legislative reformers throughout the land were stating that the mental hospitals should not be considered as institutions for custodial care and that treatment even if prolonged should be the cardinal feature.

By 1970, there were eighty-six general hospitals in Canada, offering services to three thousand patients. It however became apparent in the 1970s that the general hospital psychiatric units did not provide treatment for those suffering from severe and chronic illnesses.

In 1978 McKenzie and Company, a management and consulting company, stated in their commissioned report that in Ontario, provincial psychiatric hospitals and general hospital psychiatric units were serving different patient populations. Notwithstanding their explicit recommendation to keep Lakeshore Psychiatric Hospital open the government of the day, which had paid for this expensive and comprehensive report closed the hospital. (McKenzie and Co. explicitly stated that when Lakeshore was compared with world-renowned institutions from Sweden to private psychiatric institutions in the USA, its treatment regimen was an on a par.) It is obvious that the recommendations did not meet the political and bureaucratic goals and objectives, which the government had hoped for.

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 (e.g. From approximately 28% percent 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. In other words, what started as an encouraging drop in hospital bed numbers brought about by the success of new treatment regimens in the 1960s has brought a reduction in the service offered to those most in need of full-time hospitalization along with a sharp decline in outpatient services.

By 1976, there were fifteen thousand patients in provincial psychiatric hospitals in Canada and close to six thousand in general hospitals. Community care had very much become a feature of the mental health system. In the mid-twentieth century the largely provincially funded institutions made up almost all of the mental health services in Canada. Over the four decades from 1960 to 2000, the psychiatric hospitals almost completely disappeared.

It was not until the 1990s that the overall days of inpatient care began to decrease. Per capita expenditures on community-based psychiatric services increased throughout this period. Overall in Canada, the combined days of care in provincial psychiatric hospitals and psychiatric units in general hospitals decreased by 38%, from 464 per 1000 population in 1985–1986 to 286 in 1998–1999.

Table three

Ontario, Nova Scotia, Quebec, and Alberta decreased their days of care in these institutions by 44% to 49%. In contrast, Prince Edward Island, New Brunswick, and Manitoba actually increased their rate of days of care in psychiatric facilities. In 1985–1986, 60%

of days of care for people with mental illness were within provincial psychiatric hospitals, and the percentage decreased to 57% by 1998–1999.

In Ontario, the days of care in psychiatric hospitals went from 174 per 1,000 population in 1985 to 110 days by the year 1999, a decrease of 37%. The average length of stay in the provincial system went from 93 days to 86 days, a 7 % decrease.

Table four

Per 1000 population in Ontario, the days of care in general hospital units went from 138 days to 61 days from 1985 to 1999, a 56% decrease. The average length of stay in the general hospitals saw a 47% decrease from 24 days to 13 days from 1985-1999, in a relatively short span of 14 years.

Table five

In Canada, the average length of stay decreased 5% for provincial psychiatric hospitals between 1985 and 1999, whereas the average length of stay decreased 25% for psychiatric units in general hospitals in the same time period.

Table six

The length of stay in psychiatric units in general hospitals actually increased between 1985 and 1995 but then began to decrease. Nevertheless, most inpatient days of care clearly continued to be within provincial hospitals.

In Ontario, from 1995 to the year 1999, total expenditures on community based psychiatric services increased less than 2%. The total expenditures on all psychiatric services in Ontario devoted to community based programs, was about 27.4%.

At the start of the third millennium, those remaining psychiatric hospitals are shells of their former selves, and often poorly funded appendages of other facilities such as general hospitals. The seriously mentally ill are still not welcome at the general hospitals. With the deinstitutionalization movement in its fifth decade, questions are being raised concerning its relevance for long-stay in patients with severe disabilities and the risk that those discharged into the community may be abandoned. As a result, many of the former seriously mentally ill patients fill the jails or live on the streets. In Canada as elsewhere, it has not become possible to provide equivalent services in the era of deinstitutionalization which can more accurately be described as de-hospitalization.

The cost of the new "system", community care and general hospital in-patient facilities was increasing instead of decreasing as promised by its advocates. Soon rising costs became a political consideration. Operational principles based on government parsimony articulated that if jurisdictions in Canada could get by with half as many beds, why not a quarter or even less. In fact, the number of psychiatric beds per hundred thousand population in Canada was reduced from about 430 in 1959 to about 50 today, an eight-fold decrease, with targets of less than 30 beds per hundred thousand population.

Increasing community-based services has been significant but clearly unable to provide community care as an equal service provider. Inadequate funding for this disadvantaged group has become an integral feature of the landscape created by all provincial governments in Canada.

The political dimension and will as expressed in funding, to effectively create a workable community care system and an adequate in-patient service is however decidedly lacking in Canada.

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