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Fact and Fiction in the Concept of Community Care: A Historical Geographic Psychological Conundrum

Research Article

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Introduction

In the first part of this paper, I will look at the backgrounds of Canadian psychiatric services by examining the people, ideas, and institutions of the mother country England, the USA and France which provided the prime sources of influence in the delivery of mental health services.

We shall see how the Canadian system has fared in the new regime of managerial expediency-and thus why we are in the crisis that we are. This is a crisis prevalent throughout the Western World. History and psycho-geographical study are relevant only as we can apply their insights to current circumstances. Modern problems become more amenable to solution when we know how they came about.

Historical Survey

The 1864 *Report on Colonial Hospitals and Lunatic Asylums in Canada* authored in White hall. At that stage Canada was still a crown colony, not becoming an independent nation until the British North America Act of 1867 created the Dominion of Canada. The report offers this sweeping observation: "insanity almost engrosses public attention and care...in the North American colonies" in reference to the care given to over fifteen hudnred insane persons then confined to the Crown-supported asylums established in Quebec and Ontario both of which future provinces 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 an 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 statesmen, newspaper editors and prison reformers, draws together several pre-Confederation ideas and conventional wisdom about mental hospitals.

Two decadex earlier, Dorothea Dix,the American social activist, visited the poorhouse in Halifax, Nova Scotia in Maritime Canada in September of 1849. The impressions she formed during this visit ere 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.

In the early decades of the nineteenth century, moral treatment of the insane promulgated by the Tukes in England and Pinel in France had been built on a buoyant view of man and a conviction that insanity could be easily cured in a setting which was in contradistinction to the historical eality of a neglectful community. The consideration given to the location, floor plan, and the provision of amusements, occupations and religious worship especially by the Tukes, both of them Quakers, were all part and parcel of the "*traitement moral*" of Pinel and the "Moral therapy" of Tuke.

> 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

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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 an asylum was considered to exert important moral influences, not only on the, 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 another early nineteenth-century French imbued with Enlightenment optimism, 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 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 practices 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 the 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 had been admitted during early stages of their illness, was given limited attention, and it would appear that 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 innovative institution in York founded on Quaker principles by William Tuke.

On the other side of the Atlantic, at New Brunswick in 1836, a Royal Commission was struck to plan the first Canadian 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 every thing about the establishment should give evidence of care and comfort." The original idea throughout the statement of principe was one of a relatively small institution operated on a personal, family group concept, with a medical superintendent as the central figure. In a 1844 report, further 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 necessary 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 painted the ideal of the 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. In mid-nineteenth-century Victorian terms, moral treatment was confidently upheld as a mild and gentle approach replacing the severe discipline of former times. Lee thus 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, soo the 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, battledome, 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 contrasted to the somewhat disquieting reports 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 minutiae 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 in Canada 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, recrea-

tion and an abundance of fresh air. However, this was only secondary compared to the consistent objective of providing aspects of what most nineteenth-century Victorian 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, then, 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 year of Confederation, however, the prospects for the care of the mentally disordered in Canada were bleak. Within a few decades an almost full circle had been turned, a turn which began with the introduction of positive reforms sufficiently successful to be convincing of their merit; but 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 consequence was usually 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 quietly subsided.

Many of the new asylums became so large-Hôpital 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 early treatment was essential was in part the cause of asylums becoming too large to practice moral treatment.

The Early Twentieth Century in Canada

Granted the setbacks and loss of idealism, mental health services were institutionally based throughout Canada by 1900, but substantial changes were already in train. The fin de siècle period was characterised 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.

At the end of World War I, Dr. Clare M. Hincks 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 first hand 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." Change came, slowly but surely. 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. But by 1959 the bed capacity in mental hospitals in Canada was 65,000. In that same year, legislative reformers throughout the land were formulating 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". As a consequence of this ideological position, 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. What had happened to cause these fluctuations in numbers? 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. For example, 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.

This remark reflects major ideological shifts since the beginning of the nineteenth century. But have we reversed ourselves and gone back to pre-Enlightenment days?

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. But in July 1999 the Bureau of Justice Statistics estimated that 16 percent of America's jail and prison populations were 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. Should we therefore be surprised that the largest provider of mental health in the United States is the Los Angeles County Jail?

I think the contemporary debates revolving around community care and institutionalization really are nothing less than a red herring. In fact, all this empty talk does the mentally ill serious harm. It is treatment that counts, not whether it takes place at home, in the "community" or within an 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 Wing stated of psychiatric care in the UK in 1992 that, "there have been no major advances in the theory of practice of psychosocial meth-

ods of treatment, enabling, care or support during the past thirty years". Another Professor of Psychiatry in the UK, Robertson, states that "Madness cannot be abolished by relocating it...Its effects can be modified by treatment." (1991).

Deinstitutionalization: Myth or Mistake

Deinstitutionalization can be seen at best as a reaction to the negative consequences of life in institutions. De-hospitalisation can also be viewed as one approach to deinstitutionalization. But the way it is pursued-for example, within tight time or budgetary constraints--is of the utmost importance. Witness the defects and pitfalls of deinstitutionalization, problems brought about in no small measure by overcrowding and lack of funding.

Witness, too, our contemporary views of the period of institutional expansion. Future generations will surely judge the era of dehospitalisation by reference to its outcomes and consequences, not by 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 on the whole, 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 first, 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 institutionalised. More than 60% of all patients are kept behind barred metal doors and windows that 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.

It is therefore salutary to note that Professor E. Fuller Torrey of the USA in March 2000 declared 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.

In America and the countries which have followed its ideological lead on this score, these individuals have been transinstitutionalised to jails, prisons or to city streets. Approximately 40% of all individuals diagnosed with severe mental illnesses are not receiving treatment at any given time, a situation 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.

Torrey goes on:

> 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, problem. Emphasising either the social or medical aspects mental illness is viewed as it was in the pre-1800s, primarily as a social rather than a medical 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--not only about the closure of mental hospitals. This should not be a war between community care and institutional treatment. Treatment of a biopsychosocial 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 biopsychosocial 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". Let me repeat: 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 "back wards", in fact "transinstitutionalized", or they were 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. "Transinstitutionalization" into the prison system, homelessness, and desperation, often leading to suicide is 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 *célebre* in many respects was Quixotic, in that the vast majority of chronicled abuses were being addressed and remedied.