Bitter pills: the impact of medicare on mental health

ERIKA DYCK*

Canada Research Chair, History of Medicine

Abstract: Medicare shifted the emphasis for mental health care into outpatient psychiatric wings connected to general hospitals and away from large custodial facilities that had been at the centre of the mental health system for decades. The shift to care in the community expanded the patient population, and arguably improved mental health care for many individuals who could now seek a variety of outpatient services rather than succumb to long-stay institutionalization. However, this shift also introduced new challenges as patients were increasingly expected to take responsibility for their own health care plans, whether that involved doctors' appointments, drug regimens, or the need to find sheltered employment, safe housing and a social support network. Analysing first-hand experiences suggests that despite the need for clinical care at times, the major challenges to independence are political and economic. In this paper, I examine some of these tradeoffs and consider some of the historical lessons for continued discussions on public policy in the mental health care arena.

In December 2016 Canadian premiers walked away from a deal that promised to invest $25 billion federal dollars in provincial health care budgets, with targeted spending on mental health care and home care (Bryden, 2016). News reports indicated that the provinces rejected the offer because they resented the federal government's imposition in their jurisdiction. In spite of this historic conflict over jurisdictional rights concerning health care spending and programme delivery, the Mental Health Commission of Canada maintains that mental health care is sorely under-funded nationwide, resulting in annual losses of $50 billion in productivity (Bryden, 2016). Despite repeated claims that mental health care in Canada is inadequate, the issue continues to confound policy initiatives as it crosses jurisdictions and programs, stretches budgets and continues to operate under the umbrella of health care in spite of the pervasive complaints from individuals about

*Correspondence to: Professor Erika Dyck, Department of History, University of Saskatchewan and Canada Research Chair, History of Medicine, Saskatoon, Saskatchewan S7N 5A5, Canada. Email: erika.dyck@usask.ca

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under-employment and poverty, which no amount of medicalising or clinical care can resolve. For a growing contingent of ex-patients, families, and consumers or clients of the mental health care system, the solution is not medical: it is political. Moreover, investments in health care budgets, such as this one proposed by Prime Minister Trudeau, miss the mark by continuing to frame the issue as one requiring more resources in medical research and treatment. That money might do more to improve the mental health of Canadians by replenishing and building social infrastructure to alleviate poverty.

For Canadians the introduction of universal, publically funded health care was cause for celebration. The universal health coverage policies that produced what we now call medicare helped distinguish this system as one sensitive to a federalist framework, one that did not copy the National Health System in Britain and that differed significantly from an American-styled means or age-approved security net. The made-in-Canada solution helped to coordinate services and payments, alleviating financial questions for patients and physicians and instead allowing them to concentrate on the clinically relevant decisions. From the outset, medicare offered a set of public policies that at its core addressed concerns about the ability to pay for one's health.

Prior to the introduction of medicare most mental health care took place separately, in purpose-built facilities, such as asylums, provincial mental hospitals, or homes for feeble-minded or mentally defective children. Many of these places were paid for by the state, and while patients or families occasionally paid upkeep fees, the costs were largely borne by the state while maintenance and day-to-day tasks were shouldered in most cases by the patients themselves, whether building walls, farming, sewing, laundering or cooking (Reaume, 2006). Residence in such a facility was often for life, and the stigma associated with incarceration negatively affected patients, staff and families who were even considered at risk of becoming insane due to proximity and exposure (Philo *et al*., 2004; Dyck and Deighton, 2017).

Moving away from an approach of segregating patients with mental difficulties in separate custodial facilities had the potential to usher in a new era of tolerance. A key feature of this shift involved the medicalisation of mental health issues, which occurred at the level of policy as well as through clinical encounters. Identifying madness or insanity as a medical concern rather than a criminal or social one had many advantages, not the least of which involved improvements in programmes and services within the health care arena. There were, however, drawbacks associated with medicalisation, which have resulted in treatments that are focussed on acute care rather than the chronic, and aggravating factors, that are often more social and economic in nature.

Historical background

In a pre-medicare era the Canadian institutional health care landscape was a patchwork of private and public facilities that catered to different regional,

jurisdictional, legal and medical needs. Provincially run tuberculosis (TB) sanitaria dotted the landscape throughout much of the country, while federally supported leprosaria existed only on the outer margins; the federal government paid for Indian Hospitals, which often relied on provincially trained staff and inadequate facilities on loan from others, whether discarded military barracks or empty schools (Lux, 2016). Pre-confederation Newfoundland maintained cottage-styled health care facilities as well as a marine-based set of travelling physicians tending the isolated communities of Newfoundland and Labrador (Connor *et al.*, 2015). Religious orders ministered the sick and chronically disabled populations, and some of these relationships helped to foster fruitful research and training institutions outside of the federalist landscape. Provinces, research institutes, regions and ethno-religious communities contributed to this institutional tapestry in part by establishing facilities that tailored their needs to the regional priorities of the local residents, while the federal government continued to provide services in aid of the military, or quarantine care at points of immigration or in states of national crisis (Gagan and Gagan, 2002; Shorter, 2013; Feindel and Leblanc, 2016). Municipalities also played their part in providing services, oftentimes under the umbrella terms of health or relief, which combined economic and health priorities (Chunn, 1992). The design and operation of health care facilities represented a blending of local initiatives and national priorities.

During this period the asylum, or mental hospital, sat alongside the other health care facilities, the general hospital, the TB sanitarium, the Indian Hospital or the leprosarium, as a purpose-built facility for accommodating mental health care needs. It differed, however, in its relationship with its local environment and residents. These mental hospitals were rarely outcroppings of religious orders, but instead relied on support from provincial budgets, including funds that paid for their operations, and often this included staff as well as bricks and mortar. The buildings themselves represented a monument to the state, more readily comparable to buildings reserved for government business, such as legislative assemblies, court houses or universities (Miron, 2011; Deighton, 2016). Indeed, some of the early asylum architects were the very same firms that designed municipal and provincial government buildings. These facilities also functioned differently than many of the other health care institutions because they relied directly on the state's legal apparatus to determine the committal policies for inmates, residents, or eventually, as these people would be called, patients, and later clients or consumers. Early on, therefore, mental health care maintained a precarious position with respect to physical health care, operating in a blend of legal and medical jurisdiction that invoked state infrastructure and security.

During and immediately after the Second World War, national surveys confirmed that most of these state-run psychiatric facilities were grossly overcrowded and in significant need of reform. Psychiatrists throughout the Western world began experimenting with asylum populations in a manner that

appeared both desperate and humane. Somatic or bodily therapies, including lobotomies, promised to restore health to psychiatric patients and to bring clinical optimism to the profession. The gross overcrowding and problematic conditions experienced in asylums required drastic measures, and even lobotomies offered some positive testimonials (Pressman, 1998). Historian Edward Shorter characterizes this period within the history of psychiatry as intensely 'desperate' and in search of alternatives to warehousing patients in institutions. He suggests that "all of these alternatives had an aura of desperateness about them, seemingly radical and possibly quite dangerous innovations. … asylums were filling, and psychiatry stood helpless in the face of disorders of the brain and mind" (Shorter, 1997: 190). The temporary embrace of such drastic and irreversible interventions indicated that the asylum had created inhumane conditions for patients and psychiatrists alike, which had helped to justify experimenting with crude interventions in an effort to alleviate some of the administrative and psychological strain caused by the hopelessness associated with mental disorders.

By mid-century therapeutic relief emerged on the horizon in the form of psychopharmaceuticals (Healy, 1997). The same year that the first anti-psychotic medication became commercially available in Europe and in Canada, 1952, the American Psychiatric Association released its first version of the *Diagnostic and Statistical Manual of Mental Disorders*. These professional and structural developments in psychiatry coincided with new research directions within the discipline. Some advocates even claimed that the so-called pharmacological revolution would transform mental health care, alleviating the reliance on long-stay custodial institutions by controlling psychiatric symptoms and allowing patients to live normal lives in regular communities.

The introduction of psychopharmaceuticals appeared at mid-century as a viable solution to the otherwise grim prospects of recovery from mental illness. As drug therapies gained traction, some categories of patients responded better than others. Psychotic patients, typically those diagnosed with schizophrenia or bi-polar disorder (sometimes then also called manic-depressive disorder), responded inconsistently to the much-celebrated blockbuster anti-psychotic medication, chlorpromazine. Administrators likewise worried that for patients with low intelligence quotients, those considered mentally deficient or feeble-minded, medication would not foster independence, nor protect these people from exploitation and abuse in the community.

Some provinces already maintained separate facilities for people considered mentally deficient – Huronia (Ontario), Woodlands (British Columbia), Michener Centre (Alberta) – while others explored options for securing separate custodial accommodations, such as Saskatchewan, which then relied on abandoned military buildings for repurposing into Provincial Training Schools at Moose Jaw and Prince Albert. Under the umbrella of mental health care, the institutional landscape changed in response to a growing realization that some psychiatric illnesses could respond positively to clinical treatment, and that others required a

lifetime of support, including custodial care. Politically, governments after the Second World War in industrialized countries began implementing measures to support a welfare state, ostensibly with the capacity for supporting a greater number of economically vulnerable citizens too, such as those who were leaving a lifetime of institutional care. Without explicitly tying these policies together, mental hospital administrators looked favourably upon the idea that the welfare state could generate more caring communities by supporting a variety of services that fostered independence for ex-patients, while clinical decisions could be focussed on drug prescriptions in a family physician's office. These twinned imperatives worked in tandem to facilitate a move away from long-stay hospitalization as the main way to address individuals with mental disorders.

Medicare was poised to support this transition by shepherding mental health cases into general practice, where the first point of care was from family physicians who ultimately could then make strategic referrals for more severe cases requiring either a psychiatric or short-term hospitalization. Patients need not be concerned that a psychiatric diagnosis spelled a lifetime separated from family and life in an institution. Physicians, meanwhile, were better equipped with pharmaceutical solutions that not only improved efficiency, but also helped to address the underlying concerns about autonomy and independence for patients with mental health difficulties.

Independence and care in the community

Patients returning to the community had predictably uneven experiences. Although experiences ranged widely, some made concerted efforts to record their transition. One such person was Doreen Befus, who left the Provincial Training School for Mentally Defective Children (the Michener Centre) in Red Deer, Alberta. Upon leaving she was told: "'You'll never make it out in the world, Doreen. You'll never be able to learn enough to live like a normal person.' … I was labeled as being too 'retarded'" (Befus, 1990). Doreen joined thousands of other Canadians who were relocated in communities as mental health facilities closed beginning in the 1960s. She lived semi-independently at first with the help of social services, including keeping regular contact with a social worker, and relying on a variety of public supports, from church services, to public transportation, library resources and hospital care. Her reliance on medical programmes became one part of a much larger and comprehensive set of resources that she required to live on her own for the first time in her life.

For the first few months she remained in regular contact with her institutional doctor, but his support only went so far. Her move into the community triggered a dramatic set of changes in her life, not the least of which were living on her own, paying her own bills, becoming an active member of her church, securing appropriate employment, maintaining social services appointments, cooking, cleaning and assuming a host of responsibilities. She was familiar with some of these

activities, having cooked and cleaned as a trainee in provincial institutions. Managing money, however, had only ever been an exercise within the protective walls of the institution, while taking public transit and making appointments with social workers, doctors, psychiatrists and others had never been part of the closely monitored functions of the institution. Life on the outside was very different, and people like Doreen, who had spent their entire lives in a carefully structured and supervised environment, carried many of their institutionalized habits into the community.

Red Deer, like many Canadian communities that had once hosted large-scale institutions, is relatively modest in size. Former patients who might have exhibited characteristics of an institutionalized existence or who required extra time at the grocery till or needed help figuring out the bus schedule were not necessarily easily absorbed into the community. Although health care administrators had long argued that sending patients to family physicians instead of mental hospitals would dramatically reduce the public stigma, and even fear, associated with mental health concerns, the change in policy did not necessarily result in changes in ex-patient experiences.

The combined social stigmas of disability, mental illness (in the most colloquial sense), and institutionalization that followed people out of provincial facilities into such communities created a new set of challenges for individuals as well as service providers who confronted the gaps in service provision without clear indications as to whether deinstitutionalization, or the closing of long-stay psychiatric facilities, triggered responses from a health department, (un)employment insurance, education, policing or housing authorities. As Chris Dooley has argued, ex-patients were not alone in facing these challenges in the community; staff also experienced stigma as they moved into community-based positions (Dooley, 2016). The new approach to mental health care required a combination of services that also required crossing jurisdictions, from municipal through provincial and federal lines, which for many deinstitutionalized people created significant obstacles, particularly for the thousands of deinstitutionalized Canadians who had lived their lives in an environment where there was only one jurisdiction, that of the hospital.

The cost of medicare

In the early 1960s, when medicare was introduced across the country, provinces claimed in some cases to be spending nearly half of their health care budgets on mental health care; by the 1970s that number dropped to less than 10% in most jurisdictions (Dyck and Deighton, 2017). Those earlier figures represented all construction, maintenance and staff costs. But, the numbers can be misleading. By the end of the 1960s, the health budget in Saskatchewan, for example, had risen by 30%, signalling investment in the expanding services that spelled optimism for the architects of care in the community, but many of the mental health services

moved off the health care budget and shifted onto other line departments.[1] Part of the drop in the numbers is explained by a reliance on general health care budgets, rather than earmarked funding for mental health services, but there was also a noticeable gap between the promises for services in the community and the financial support to establish those services.

Medicare, however, did not cause deinstitutionalization. The process of closing asylums was multi-faceted and, while it took a different form and timeline in various locations, had a combination of economic, political, cultural and medical triggers (Kritsotaki *et al.*, 2016). American historian Gerald Grob, one of the leading scholars on the history of mental health care policy in the United States, argues that there were several distinct factors that culminated in what became a transnational phenomenon called 'deinstitutionalization' (Grob, 1991, 1994, 1997). He suggests that psychotropic medications and changes within the professional landscape of psychiatry, including a shift towards more private practice and an increased reliance on general practitioners; more federal funding for intensive research programmes into mental disorders; a changing politico-economic climate that coincided with the dismantling of the welfare state; and the rise of human rights and humanitarian campaigns, including those leveling critiques at the plight of institutionalized individuals, were critical ingredients in the history of deinstitutionalization.

Deinstitutionalization involved the closing or down-sizing of long-stay psychiatric facilities and shifted the onus of care ostensibly to the community, and reoriented the portal of entry for clinical psychiatric care to emergency wards and family doctors' offices. Although ushering mental health patients through the same hospital doors as general health patients simplified health policy and hospital administration, it misinterpreted the experience of mental illness and introduced new fiscal pressures on the now universalized health care system. As Greg Marchildon has argued, "The other uniquely Canadian feature is the extent to which mental health policy is determined at the substate rather than the national level of government. This is a consequence of a decentralized federation where, for constitutional reasons, the provinces have primary jurisdiction over health care. This means there have been significant differences among provinces in terms of the type and timing of mental health policy and programmes, as well as the civil society movements – also highly provincialized – that have influenced the governments of these provinces" (Marchildon, 2011). Marchildon points out that

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1 Based on a review of Saskatchewan Annual Reports. Although the number of patients in mental hospitals has decreased so much we have very substantially *increased* expenditures on the program as a whole over the past five years. As a result of this, the 1964–1965 budget for Psychiatric Services of $12,763,970 had risen by 1969–1970 to $16,641,530. This represents an increase of $3,877,560 or 30.4%. This year's budget was increased y 12.05% or $1,644,610, the largest addition in the history of the program by a wide margin. Because of the very large drop in the mental hospital patients at the Saskatchewan Hospital Weyburn there have been some reductions of staff over the years but in general these have been counter-balanced by the creation of additional positions elsewhere. In 1964–1965 the permanent establishment was 2111 in 1969–1970 it is 2058.

these constitutional arrangements realigned mental health care within provincial priorities, but also introduced financial disincentives for designing systems that offered alternatives to hospital-based care.

Hospitalization and medically necessary services

The Hospital Insurance and Diagnostic Services Act (HIDS), introduced by the Liberal St. Laurent federal government in 1957, entered the provinces into a cost-sharing agreement that provided for half of the cost of hospitalization. The terms of this policy meant that provinces were ineligible for the federal funds if they opted to design a health care system that did not centre itself around the general hospital. Nearly a decade later, with the introduction of the Medical Care Act (1966), procedures considered 'medically necessary' or 'medically required' were defined under a set of principles that later became enshrined in the Canada Health Act (1984). Provinces, however, remained ineligible for cost-sharing benefits in psychiatry if they invested in mental hospitals, rather than constructing general hospitals with accommodations for psychiatric wings. This arrangement remained in effect until 1977 when these conditions were relaxed to allow for greater flexibility, and provinces had more autonomy in designing the shape and dynamics of their health care institutions, as long as they adhered to the principles of the Medicare Act. These policies built upon the desire to balance provincial or regional flexibility with the federal government's capacity for redistributing resources and ensuring that all the health care systems aligned with national goals of universality, comprehensiveness, public administration, portability and accessibility (Marchildon, 2012).

While the HIDS Act certainly favoured a universal health care system that de-emphasized specialized facilities, and instead centralized services through the general hospital, it merely hastened the shift away from large-scale custodial psychiatric facilities that was already underway. By the late 1960s large-scale psychiatric institutions in all Canadian provinces reduced their patient populations. Some provinces, such as Saskatchewan, moved quickly, while Alberta adopted a more gradual approach. In Quebec, Hospice Saint-Jean-de-Dieu's patient population reached a high point in 1961 with over 9000 patients; a decade later there were 304 who remained in the facility, with another nearly 600 living in approved homes monitored by the institutional health care staff (Dagenais, 2016). Similarly in Halifax, the provincially run Nova Scotia Hospital discharged nearly 4000 patients in 1973, precipitating a rapid decline in the long-stay population (Baker, 2016).

Deinstitutionalization may have signalled the end of the age of the asylum and the dawn of a new mental health care era aimed at reducing stigma and medicalizing illness, treating it as any other disease or disorder requiring clinical care. But, this shift in policy did not coincide with a decline in the numbers of individuals and families seeking assistance. Quite the opposite occurred. Where the asylum had

ostensibly provided a set of services under one roof, problematic though they may have been, the post-asylum world involved a complicated matrix of fragmented services. The mental health system that emerged was thus not under the jurisdiction of any one governmental department, and did not necessarily fit neatly into Canada's constitutional federalist framework. Medical services, housing and employment needs along with financial and family support services required a delicate degree of bureaucratic coordination in a Kafkaesque world of red tape, which was challenging for civil servants to negotiate, let alone for patients and families to sift through successfully. The transition in service delivery was often slow and piecemeal, exposing gaps between programmes and needs and stimulating ex-patient activism. Health activists criticized the poor state of mental health services that forced people into emergency wards or onto the streets, but offered few supported services in between (Mitchell, 2016).

In 2004, Canadian psychiatrists Patricia Sealy and Paul Whitehead assessed deinstitutionalization over a 40-year period beginning in the 1960s. They suggested expanding the definition from a simple movement out of custodial care to a wider understanding that includes a broader and more varied set of experiences. At its core, a weakened dependence on large-scale hospitalization persisted, but the process of reorganizing the system also introduced new features of transinstitutionalization, or the movement through a new set of institutions, whether penitentiaries, nursing homes, hospitals and, or, outpatient psychiatric facilities. They found a distinctive rise in the number of short-stay admissions in general hospitals, alongside a proliferation of community-based outpatient services. Sealy and Whitehead concluded that deinstitutionalization involved fundamental changes in service delivery, which ricocheted through the provinces in uneven ways, creating new state expenditures and putting pressure on traditional systems to absorb the impact of these decisions (Sealy and Whitehead, 2004).

Between 1975 and 1980, 62% of the closures associated with this strategy took place across Canada, whereas before the Second World War nearly 75% of patients in psychiatric hospitals spent their entire lives institutionalized once they entered a psychiatric facility. By the 1970s some patients, especially the young and middle aged, went into new facilities, or were released permanently into the surrounding communities. Many elderly patients were transferred to old age homes, continuing a life of institutionalization and moving onto a different budget line, outside the domain of health care *per se*. Staff often followed patients into the community or into adjacent institutions, including nursing homes. Historian Chris Dooley interviewed former psychiatric nurses working in Manitoba and found that: "Several former practitioners singled out nursing homes as sites of inadequate care, noting that former patients living in these facilities were far more likely to be subject to restraint – physical and chemical – and more apt to be over-medicated than they had been in their prior institutional settings". One interviewee put it simply: "the nursing homes were often the worst" (Dooley, 2016).

Assessing care in the community

Saskatchewan, the province that had pioneered both medicare and Canada's experiment with psychiatric care in the community, became a focal point for follow-up studies in an attempt to measure the impact of the policy changes on the ground. Carl D'Arcy, professor of psychiatry at the University of Saskatchewan, found that, '~123,000 patients who received treatment in the province during the period 1971–1972, 80% or more were seen in the private sector', that is, outside of the publicly funded health care arena, whether through private counsellors or insured services that fell outside of the list of medically necessary procedures. D'Arcy looked back at the changes since 1962, arguing that overall it had resulted in an increase in the volume of people in the mental health system, "with the greatest increase occurring in the private sector; and an increase in the proportion of persons being treated as outpatients rather than inpatients" (D'Arcy and Fritz, 1979). The increased reliance of private services suggests that more people used private insurance, or paid for services rather than resorting to the options available through medicare. Resultantly, those seeking hospital-based care for psychiatric illnesses were those who could not afford private care or had no private insurance. Already identified among the lower socio-economic ranks, these patients entered the system through family physician offices and emergency rooms.

The most significant change in the system, according to D'Arcy, was not the numbers, but the types of people who were increasingly sought private care. He showed that "the top two categories [for admission], managerial and professional, show an increase in rates of hospitalization during the 1960s, whereas the bottom three categories, craftsmen and miners, labourers, and not stated, had considerable decreases" (D'Arcy and Fritz, 1979). He suggested that the change in socio-economic demographics be explained in part due to the decreasing stigma sur-rounding mental illness as a result of treating it in general facilities, like other physical ailments. But, perhaps even more significantly, the reorientation into a centralized system meant that the facilities themselves were dramatic improvements over the often dilapidated buildings that housed patients in the past. Patients were more willing to come to a hospital's emergency department for psychiatric care, armed with the knowledge that acute care options were not only available but preferred over long-term, chronic care or spending the rest of one's life in an institution. He went on to suggest that, "lower socioeconomic stratum individuals are more likely to actively seek out medical intervention early in the course of a psychiatric disorder". This finding was particularly significant as early detection more often resulted in better outcomes, both in terms of clinical care and inde-pendence, defined by an ability to retain employment, housing and social networks.

D'arcy's study also revealed drastic differences in the way that Indigenous com-munities accessed the mental health system, citing severe underutilization in the new provincialized system. Indigenous cases fell to the bottom of the list in terms of accessing mental health services, suggesting both long-term concerns about service

provision in Indigenous communities, as well as long-held assumptions about inherent differences in the kinds of care required and whether the federal or provincial government was ultimately responsible for the cost of these services (D'Arcy and Fritz, 1979). While his study focussed on experiences in Saskatchewan, his findings pointed to a serious disparity in health care use and outcomes among the Indigenous population that applied more broadly across Canada. D'Arcy suggested that community-based services were lacking in regions with a higher Indigenous population, forcing people in need of mental health treatment to leave their communities and seek care that required hospital stays, or to seek care only when problems were severe enough to warrant more intensive, in-hospital treatment. As historian Maureen Lux has also shown in the case of Indian hospitals, there were also much deeper challenges plagued by mistrust, racism and non-Indigenous staff that compounded the issue of seeking care (Lux, 2016).

Other researchers and service providers began conducting further assessments of the effects of deinstitutionalization on the quality of care for people with mental illness and routinely found a disturbing correlation between a lack of services and growing socio-economic disparities. In 1989 Saskatchewan-based researchers Colin Smith and Nancy Herman indicated that, "in Canada like the United States, there was no absence of problems. Few mourned the shrinkage or loss of mental hospitals, but soon, there were complaints of patients being 'dumped' into the community with some ending up in nursing homes, gaols, or ghettoes" (Herman and Smith, 1989). Teaming up with a sociologist in Atlantic Canada who conducted interviews with ex-patients, they found that there were universal experiences among the deinstitutionalized psychiatric patient population, which included stigma, inadequate housing, a lack of basic living skills and rampant unemployment. Indeed, "93% of the ex-patients listed poverty as a problem". Whereas, "89% of the respondents in this study complained about the quality of care they were receiving in such facilities, specifically in terms of food, space and general living conditions" (Herman and Smith, 1989). These comments suggested that conditions outside the institution may have produced some improvements in personal autonomy, but those benefits were curtailed by inadequate provisions for exercising independent living. Researchers concluded that during the contemporary economic recession, "in this era of high unemployment, how can a 'mental' patient find a job? For 78% of the sample, securing a 'normal' job was impossible". They went on to show that, "approximately two-thirds of the sample had tried on numerous occasions to secure non-sheltered employment but failed," revealing a compounded set of problems that moved well beyond the scope of the health care system:

> In fact, such persons felt that they were in a 'catch-22' situation: Ex-patients indicated that if they disclosed on job application forms that they had a 'history of psychiatric illness,' they were disqualified; so too, did ex-patients state that if they lied on these forms, and their 'illness' was subsequently 'discovered' they would be fired (Herman and Smith, 1989).

This ethnographic inquiry helped to shed light through some of the cracks in the system, exposing the realities of an under-funded and decentralized approach to fostering care in the community, with primary health services comprising only a small or occasional point of contact for individuals struggling to cope with mental disorders. Indeed, the public perception of mental illness often conflated it with homelessness, and worse, criminality (Grob, 1994; Layton, 2008). While this popular conceptualization was often over simplified, the connection between poverty and mental illness persisted, whether from the perspective of ex-patients or civic leaders (Whyte, 2016a).

In the 1990s psychiatrist Hugh Lafave, at the Brockville Psychiatric Hospital in Ontario, confronted the question of how poverty and mental illness related. Lafave had been one of the original architects of community care in Saskatchewan, and remained one of the chief proponents of closing mental hospitals. But, he was increasingly frustrated by the way that the transition out of the mental hospital had been splintered into different policy arenas. Clinical care was only part of the care required to accommodate mental health needs. Without coordinated services across jurisdictions and policy silos, deinstitutionalized patients were disproportionately left occupying the lower socio-economic rungs of society, making mental health care more of a political issue than a medical one.

At Brockville Lafave worked with a community team, including a social worker and several research psychologists, including the director of rehabilitation services. Together, they conducted a study of the effects of poverty on psychiatric patient care. Recognizing that a majority of patients lived below the poverty line, they looked at patterns of hospital use and found high rates of readmission and heavy use of the mental health system. They also found that consumers who relied significantly on psychiatric services had a more difficult time influencing service delivery, citing the combined effects of poverty and lack of influence as the two key features curtailing their health. Clinical care remained intact, but the conditions of its use were often not health problems per se, but socio-economic.

Using a comparative controlled trial, they selected 54 mental health care consumers and randomly divided them into two groups. One group was monitored for their use of psychiatric services, but left to navigate the system on their own, with whatever resources they could muster. The other group was given $160 a month and forgivable loans to keep them above the poverty line for the period of the study. The results culminated in a 70% reduction in hospitalization for the participants who were maintained at the poverty line with the $160 stipends. The change "represents a decrease in the average cost of hospitalization from $47,300 a year for each participant before the study to an average cost of $13,500 a year during the study" (Lafave *et al.*, 1995). The research team concluded that "People with serious mental illness living in the community face perennial problems. Many do not receive coordinated individualized services responsive to their needs, and they often live below the poverty line". They argued that "true partnerships between clients, their peers, volunteers, and mental health agencies can contribute

to a significant reduction in hospitalization, particularly when clients have a voice in service delivery…" (Lafave *et al.*, 1995). While acknowledging that the relationship between financial security and personal control is more complicated, the researchers nonetheless helped to highlight how poverty compounded the problems associated with care in the community, and created a pattern of overreliance on hospitalization to cope with the burden of mental illness in the absence of alternative sources of support. Again, this study further reinforced the idea that medicare had helped to coordinate clinical services, but had also reinforced a more expensive reliance on hospital-based care due to a lack of emphasis on primary or preventative care, and most importantly, on financial security.

People seeking attention for mental health issues were left with few choices in some cases but to resort to the hospital services, which were much more expensive to the state than providing people with financial supports that allowed for some baseline security. Ex-patient Jayne Whyte's personal experience in Saskatchewan was a case in point: she received less in a month from social services than the cost of keeping her in the hospital for a day. Caught in a cycle of poverty and semi-dependency, Jayne felt that she was shuffled between places and told that she was better off now that she was living independently, but she felt constrained by her inability to exercise a more efficient range of programme options due to severe poverty.

After several years of experience, Jayne began recording her reflections and explained, deinstitutionalization helped to establish a new set of 'hotlines' or crisis prevention services, largely focussed in hospitals, aimed at addressing acute needs, but what many people needed were 'warm lines': a friend to talk with, an advocate to help navigate a piece of bureaucracy or a complicated application, a companion to share meals with after relocating to a lonely apartment in a new community. "Every day I stay out of the hospital", Jayne explained, "I save the province $1000 dollars. That is more than they offer me in social services benefits for a whole month. It doesn't add up" (Whyte, 2016b). The corresponding supports for mental health care beyond those elements deemed 'medically necessary' were few and far between and difficult to tailor to the needs of people managing in the community.

Mental health care, in the context of medicare, transformed its service delivery model into one that relied on a more individualized and client-oriented series of services. The onus shifted from the state and medical authorities to consumers, patients and families who needed to navigate the contours of a patchwork of services, supports and gaps in a modern mental health care context. Contrary to the claims of proponents of community care, the community did not become a caring place with a change in policy, but community services were increasingly held accountable for absorbing mental health patients into their workplaces, educational facilities and homes. People with severe mental illnesses returned to an older set of criteria, which had been in place since the 19th century: those who represented a danger to themselves or others forfeited their individual rights and

could be apprehended by police or medical authorities and held in custody, whether in remand centres in penal institutions or in the limited psychiatric facilities now attached to general hospitals. Although the faces and front foyers differed, the policy of assessing psychiatric needs through the lens of 'danger' resurrected an older set of ideas about the relationship between criminality and mental illness, violence and illness, and stability and unpredictability, once again moving it away from the reach of medicare.

Conclusion

In 2016 Canadian Prime Minister Justin Trudeau pledged $70 million to address mental health issues in Indigenous communities across Canada (Mas, 2016). His promise came in response to the growing identification of the desperate need for culturally appropriate clinical interventions, especially for Indigenous youths who disproportionately contributed to rising rates of suicides in the territories. Trudeau's gesture is important for two reasons. First, this gesture acknowledged a gap in service delivery that has long been identified by policy makers and service providers when it comes to addressing mental health needs in Indigenous communities. Second, his statement incorporated the language of culturally appropriate services. But, Trudeau's pledge continued to frame the issue as one requiring improved health care services, rather than recognizing the exacerbating factors of poverty that go hand-in-hand with mental health care needs.

We may not need to overhaul medicare, but we could embrace a more expansive idea of what is considered 'medically necessary' or acknowledge that healthy outcomes do not always require medicine or professional interventions. A careful review of the experiences of patients, ex-patients and consumers of the mental health care system over the past 80 years furnishes us with evidence to suggest that many of the challenges are not health issues *per se*, but the health care system has become the front door to a set of supports that might be carried out more effectively elsewhere.

Successive health commissions have reinforced this perspective, perpetuating a sometimes conflictual relationship between care for the body and care for the mind that continues to challenge service providers and law makers in the mental health field. In his 2002 commission report, *Building on Values: The Future of Health Care in Canada*, Roy Romanow described mental health as the 'orphan child' of Canadian health care. He claimed that "today, mental health care is largely a home and community-based service, but support for it has too frequently fallen short. It is time to take the long overdue step of ensuring that mental health home care services are included as medically necessary services under the *Canada Health Act*, and available across the country" (Romanow, 2002).

Revisiting the history of mental health care in the context of medicare offers a timely opportunity to consider the combination of health and welfare required to produce positive mental health outcomes. Medicare helped to centralise,

destigmatise and medicalise mental illness in ways that have sometimes been beneficial to individuals with mental disorders, but it has also contributed to the growing medicalisation of problems that are often more political than medical.

One of the strengths of medicare was its capacity to operate within a federalist system, allowing for flexibility and diversity, while creating a degree of cooperation and coordination. The same spirit of cooperation, harnessed across departments, could enhance the mental health care system by bringing clinical decisions into alignment with socio-economic and cultural conditions. Investing in mental health services means more than securing additional hospital beds or crisis hotlines, it requires shifting the focus away from emergency services, and investing in preventative, primary care, which includes housing, education and peer support. In the case of mental health care, these primary care elements have much more to do with the political recognition of madness as a concept free from the specific medical connotations that come from framing the issue as mental health or illness. We know that smoking significantly increases health risks, and produces enormous costs to our public health system, which has meant that public health campaigns have supported anti-smoking measures. We know that poverty is at least as risky as smoking, and within mental health circles poverty is endemic. But, are we genuinely prepared to invest in people and autonomy, or are we more comfortable continuing to pour money into medicare band-aids each time we fall down in crisis? Ontario's government has agreed to pilot a guaranteed-annual-income programme, which may provide a test case. Manitoba has similarly experimented with targeted northern communities. The impact of income adjustment on health outcomes is far from clear, but Canadians remain sceptical of the correlation, and do not yet seem ready to fund such bottom-up approaches (Beeby, 2016). By contrast, the federal government is continuing to earmark special funding to address crises in mental health – suicide prevention in northern communities tops the list at the moment. Trudeau's $70 million will undoubtedly make a difference in many lives, but most of the recipients of that help are already among the most marginalized people in our country; channeling them through the health care system is not going to change that, but we have yet to convince Canadians that income security is a healthy choice.

Acknowledgement

References

Baker, L. (2016), 'Nova Scotia Hospital', After the Asylum, http://aftertheasylum.apps01. yorku.ca/en/deinstitutionalizationPostcards/NovaScotia [29 January 2017].
Beeby, D. (2016), 'Ontario to test guaranteed-income program amid warnings about costs, effectiveness', *CBC News*, 20 August, http://www.cbc.ca/news/politics/minimum-income-hugh-segal-ontario-budget-1.3740373 [19 May 2017].

Befus, D. (1990), 'Who Says 'Impossible'?', Red Deer & District Archives, Doreen Befus Files, Box 4, *Decision Magazine*, March, 16–17.

Bryden, J. (2016), 'Trudeau urges provinces to spend on mental-health care', *The Star*, 21 December 2016, https://www.thestar.com/news/canada/2016/12/21/trudeau-urges-provinces-to-spend-on-mental-health-care.html [29 January 2017].

Chunn, D. (1992), *From Punishment to Doing Good: Family Courts and Socialized Justice in Ontario, 1880–1940*, Toronto: University of Toronto Press.

Connor, J. T. H., M. G. Kidd and M. Mathews (2015), 'Conceptualizing health care in rural and remote pre-Confederation Newfoundland as ecosystem', *Newfoundland and Labrador Studies*, 30(1): 113–138.

Dagenais, D. (2016), 'Hopital Saint-Jean-de-Dieu', After the Asylum, http://aftertheasylum.apps01.yorku.ca/en/deinstitutionalizationPostcards/StJeanDeDieu [19 June 2017].

D'Arcy, C. and W. Fritz (1979), 'A mental health system in transition: profiles of change', *Canadian Journal of Psychiatry*, 24(2): 121–131.

Deighton, A. (2016), 'The Last Asylum: Experiencing the Weyburn Mental Hospital, 1921–1939', unpublished MA Thesis, University of Saskatchewan, Saskatoon.

Dooley, C. (2016), 'Working between mental health worlds', After the Asylum, http://aftertheasylum.apps01.yorku.ca/en/workingBetweenMentalHealthWorlds [29 January 2017].

Dyck, E. and A. Deighton (2017), *Managing Madness: The Weyburn Mental Hospital and Transformations of Psychiatric Care in Canada*, Winnipeg: University of Manitoba Press.

Feindel, W. and R. Leblanc (2016), *The Wounded Brain Healed: The Golden Age of the Montreal Neurological Institute, 1934–1984*, Montreal: McGill-Queens University Press.

Gagan, D. and R. Gagan (2002), *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890–1950*, Montreal: McGill-Queen's University Press.

Grob, G. (1991), *From Asylum to Community: Mental Health Policy in Modern America*, Princeton, NJ: Princeton University Press.

Grob, G. (1994), *The Mad Among Us: A History of the Care of America's Mentally Ill*, New York: The Free Press.

Grob, G. (1997), 'Deinstitutionalization: the illusion of policy', *Journal of Policy History*, 9(1): 48–73.

Healy, D. (1997), *The Anti-Depressant Era*, Cambridge: Harvard University Press.

Herman, N. J. and C. Smith (1989), 'Mental hospital depopulation in Canada: patient perspectives', *Canadian Journal of Psychiatry*, 34(5): 386–391.

Kritsotaki, D., V. Long and M. Smith (eds) (2016), *Deinstitutionalization and After: Post-War Psychiatry in the Western World*, New York: Palgrave McMillan.

Lafave, H., H. R. De Souza, P. N. Prince, K. E. D. Atchison and G. J. Gerber (1995), 'Partnerships for people with serious mental illness who live below the poverty line', *Psychiatric Services*, 46(10): 1071–1073.

Layton, J. (2008), *Homelessness: The Making and Unmaking of a Crisis*, New York: Penguin.

Lux, M. (2016), *Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s*, Toronto: University of Toronto Press.

Marchildon, G. P. (2011), 'A house divided: deinstitutionalization, medicare and the Canadian Mental Health Association in Saskatchewan, 1944–1964', *Social History/Histoire sociale*, 44(88): 305–330.

Marchildon, G. P. (2012), 'Canadian Medicare: Why History Matters', in G. P. Marchildon (ed.), *Making Medicare: New Perspectives on the History of Medicare in Canada*, Toronto: University of Toronto Press.

Mas, S. (2016), 'Trudeau announces nearly $70M over 3 years for Indigenous mental health services', *CBC News*, http://www.cbc.ca/news/politics/trudeau-attawapiskat-youth-chief-meeting-1.3629960 [29 January 2017].

Miron, J. (2011), *Prisons, Asylums, and the Public: Institutional Visiting in the Nineteenth Century*, Toronto: University of Toronto Press.

Mitchell, T. (2016), 'Survivor culture', After the Asylum, http://aftertheasylum.apps01.yorku.ca/en/survivorCulture [29 January 2017].

Parr, H., C. Philo and N. Burns (2004), 'Social geographies of rural mental health: experiencing inclusions and exclusions', *Transactions of the Institute of British Geographers*, **29**(4): 401–419.

Pressman, J. D. (1998), *Last Resort: Psychosurgery and the Limits of Medicine*, Cambridge: Cambridge University Press.

Reaume, G. (2006), 'Patients at Work: Insane Asylum Inmates' Labour in Ontario, 1841–1900', in J. Moran and D. Wright (eds), *Mental Health and Canadian Society: Historical Perspectives*, Montreal: McGill-Queen's University Press, 69–96.

Romanow, R. (2002), 'Building on Values: The Future of Healthcare in Canada', Final Report. Commission on the Future of Health Care in Canada, Ottawa.

Sealy, P. and P. Whitehead (2004), 'Forty years of deinstitutionalization of psychiatric services in Canada: an empirical assessment', *Canadian Journal of Psychiatry*, **49**(4): 249–250.

Shorter, E. (1997), *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, New York: John Wiley & Sons, Inc.

Shorter, E. (2013), *Partnership for Excellence: Medicine at the University of Toronto and Academic Hospitals*, Toronto: University of Toronto Press.

Whyte, J. M. (2016a), 'CMHA White Cross Centres in Saskatchewan', After the Asylum, http://aftertheasylum.apps01.yorku.ca/en/CMHAWhiteCrossCentres [29 January 2017].

Whyte, J. M. (2016b), 'Mental Health and Advocacy', presentation at Next Up, Saskatoon, March 7.