Contemporary Canadian Mental Health Care
Until the 19th century, mentally ill people mainly were kept at home and cared for by their families. Sometimes their legal guardians boarded them with other families for a fee, as part of a broader poor-relief system. Only the most seriously afflicted people, whose behavior was severely disturbing or who were considered a danger to themselves, their families, or other citizens, were locked in, often in prison or a poorhouse. Indigent mentally ill people were grouped with old, sick, orphaned, or convicted people, and the circumstances in these scanty public facilities were most basic and often harsh. For those who could afford it, privately maintained institutions emerged as well (Boschma, 2003; Shorter, 1997).

**EARLY FORMS OF INSTITUTIONAL CARE**

Around the turn of the 15th century—the beginning of the European Renaissance—some towns in Europe established small-scale asylums as charitable enterprises, each one initially housing about 10 people. Most often they were civilian, charitable initiatives in which neither the church nor doctors were involved. London’s Bethlehem Hospital (famously known as “Bedlam”) (Fig. 1-1), founded in 1371, and the Reinier van Arkel asylum, founded in 1442 in the Dutch town of Den Bosch, are early examples of the insane asylums or “mad houses” that would over the next centuries spread throughout...
Europe and, in the wake of colonialism, other parts of the world. These asylums were managed as large households, like other guesthouses or poorhouses, and administered by a board of noted citizens, with a steward and matron, often a married couple, taking charge of day-to-day management with the assistance of a few servants. With the social and economic changes of the 18th and 19th centuries, these homes grew into larger institutions (Boschma, 2003).

Religious orders, often under the protection or authority of the church, also involved themselves with charitable work and poor relief. Roman Catholic orders, for example, reemerged in 17th-century France during the Counter-Reformation, and many of them managed the care in small-scale, premodern hospitals. The orders themselves sometimes owned the houses. Influential cases in point were the male order of the Congregation of Lazarists and the female congregation of the Sisters of Mercy (or Daughters of Charity), founded by Vincent de Paul in 1625 and 1633, respectively (Jones, 1989). These orders produced early models for nursing work as a socially respectable endeavour at a time when medical care had barely developed and was scarcely available (Nelson, 1999, 2001; Porter, 1993). In the Americas, one of the first institutions that took in mentally ill people was San Hipólito in Mexico City, which opened in 1589 as a hospital for the insane, under the auspices of the Roman Catholic Church. It was run by the brothers of the order of La Caridad y San Hipólito, who, vowing poverty and charity, relied on alms to support themselves and worked as attendants in the institution (Leiby, 1992). The earliest forms of institutional treatment in Canada date back to the 19th century.

Diverse beliefs and approaches to deal with mental illness or attempts to treat it have been employed and must be understood in their historical context. Spiritual, biologic, and social explanations commonly were intertwined in popular perceptions of causes of mental illness. Evil spirits, sin, demonic possession, contagious environments, or brain disturbances have figured in explanations of mental disorders and accordingly shaped people’s responses and medical treatment. The various ways of caring for mentally ill people typically depended on such views and on a community’s perceived notions and fears of those with mental disorders as well as on community resources.

History reflects that, generally, social fears and tolerance for what is deemed deviant behaviour are related to social stability and availability of resources. In periods of relative social stability, individuals with mental disorders often have a better chance to live safely within their communities. During periods of rapid social change and instability, there are more general anxieties and fears and, subsequently, more intolerance and ill-treatment of people with mental disorders. As industrialization and urbanization increased during the 18th and 19th centuries, the rising middle class became concerned about a growing number of poor and deviant people who were not able to work and sustain themselves. At the same time, under the influence of ideas associated with the Enlightenment, medical and social ideas about mental illness changed, and medical concern with the treatment of mental illness increased. The insight gained ground that, rather than being afflicted by loss of reason, mentally ill people were rational beings with a human nature common to all human beings. The idea that spirits or demons kept the insane in a bestial stage—which legitimized the use of restraints or enchainment—was rejected in favour of the view that mentally afflicted people should be treated humanely. The idea of a moral, pedagogical treatment thus emerged that would help the suffering restore their innate capacity for self-control (Boschma, 2003; D’Antonio, 2006).

**Key Concepts** Social change, the structural and cultural evolution of society, is constant but often erratic. Psychiatric and mental health care has evolved within a historical context of social, economic, and political influences and cannot be separated from such realities.

**A Revolutionary Idea: Humane Treatment**

By the height of the French Revolution in 1792, moral treatment became an influential idea that altered the care of the mentally ill and gave rise to important initiatives in which reform-minded physicians had an influential role. During this time, Philippe Pinel (1745–1826) was appointed physician to Bicêtre, a hospital for men, which had a very poor reputation. Pinel, influenced by...
Enlightenment ideas, believed that the insane were sick patients who needed humane treatment, and he ordered the removal of the chains, stopped the abuses of drugging and bloodletting, and introduced more appropriate medical care. Three years later, the same standards were extended to Salpetrière, the asylum for female patients. At about the same time in England, William Tuke (1732–1822), a Quaker tea merchant in York and a member of the Society of Friends, raised funds for a retreat for mentally ill members of his Quaker community. The York Retreat, which opened in 1796, became another influential example for reform initiatives (Fig. 1-2). Tuke also introduced a regimen of humane, moral treatment, a pedagogical approach of kind supervision, proper medical treatment, and meaningful activities and distractions. Those reformers believed that a purposefully designed asylum provided a proper environment to indeed cure the mentally ill (D'Antonio, 2006; Tomes, 1994).

Based on these influential examples, initiatives emerged throughout the Western world to establish purposefully designed asylums that provided sympathetic care in quiet, pleasant surroundings with some form of industrial occupation such as weaving or farming. In the United States, the Quaker Friends Asylum was proposed in 1811 and opened 6 years later in Frankford, Pennsylvania (now Philadelphia), to become the second asylum in the United States. The humane and supportive rehabilitative attitude of the Quakers was seen as an extremely important influence in changing techniques of caring for those with mental disorders (D’Antonio, 2006).

### THE 19TH AND EARLY 20TH CENTURIES: AN ERA OF ASYLUM BUILDING

In Canada, New Brunswick was the first of the old British North American provinces to open a mental institution. In 1835, a committee was appointed to prepare a petition to the provincial legislature proposing the establishment of a provincial lunatic asylum. Until that time, counties had carried the responsibility under the Poor Laws system to confine indigent insane who could no longer be managed within the family, in local jails, or in poorhouses. As the population increased in the early 1800s, so did the number of mentally ill people in need of publicly provided care. In that same year, the provincial government approved the conversion of a building in Saint John, formerly a hospital for cholera patients, to a Provincial...
Lunatic Asylum until a new facility could be built. By 1848, this new facility was ready for use (Fig. 1-3) (Hurd, 1973/1916–17; Sussman, 1998).

During the latter half of the 19th century and beginning of the 20th century, each Canadian province established an asylum (Table 1-1). Involuntary confinement and institutional care became the dominant treatment modality for mentally ill people, replacing older forms of familial care and Poor Law–based approaches (Moran, 2000; Moran & Wright, 2006). In-depth historical analyses of admission patterns, one of the Ontario-based Homewood Retreat, for example, showed that gender differences were reflective of the social situation of the time (Warsh, 1989). Another analysis of the British Columbia psychiatric system revealed that many Aboriginal patients died soon after being admitted to the asylum, often from tuberculosis (Menzies & Palys, 2006).

The Legal Basis for Mental Health Care

Following the terms established by the British North America Act of 1867, the organization of mental health care in Canada became provincially based and each province developed its own legislation to deal with problems created by mental illness. In the late 19th century, all provinces passed legislation, most often called an Insanity Act, to provide a legal basis to publicly supported confinement of the mentally ill. In the course of the 20th century, the legislation had been changed and updated several times and eventually renamed a provincial Mental Health Act, reflecting changing views and a stronger medical influence on the care and treatment of people.

Table 1-1  The First Asylums in British North America and Canada

<table>
<thead>
<tr>
<th>Province</th>
<th>Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quebec</td>
<td>1845</td>
<td>• Beauport, or the Quebec Lunatic Asylum, was opened.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A small dwelling for 12 mentally ill women was erected by Bishop St. Vallier.</td>
</tr>
<tr>
<td></td>
<td>1714</td>
<td>• The Hotel Dieu cared for indigents, the crippled, and “idiots.”</td>
</tr>
<tr>
<td>New Brunswick</td>
<td>1848</td>
<td>• The Provincial Lunatic Asylum was erected.</td>
</tr>
<tr>
<td></td>
<td>1835</td>
<td>• Canada’s first mental hospital opened in a small wooden building, a former cholera hospital, and was used as a temporary asylum.</td>
</tr>
<tr>
<td>Ontario</td>
<td>1850</td>
<td>• Mentally ill people were placed in county jails until 1841, after which the Old York Jail served as a temporary asylum.</td>
</tr>
<tr>
<td></td>
<td>1841</td>
<td>• The Provincial Lunatic Asylum in Toronto admitted patients.</td>
</tr>
<tr>
<td>Newfoundland</td>
<td>1854</td>
<td>• An asylum for mentally ill patients was erected and admitted its first patients.</td>
</tr>
<tr>
<td>Nova Scotia</td>
<td>1857</td>
<td>• The first patients were admitted to the Provincial Hospital for the Insane.</td>
</tr>
<tr>
<td>British Columbia</td>
<td>1872</td>
<td>• A remodelled provincial general hospital (the old Royal Hospital) was opened as the Asylum for the Insane in British Columbia.</td>
</tr>
<tr>
<td>Prince Edward Island</td>
<td>1877</td>
<td>• The Prince Edward Island Hospital for the Insane was built.</td>
</tr>
<tr>
<td>Manitoba</td>
<td>1886</td>
<td>• The Selkirk Lunatic Asylum was opened.</td>
</tr>
<tr>
<td>Saskatchewan</td>
<td>1914</td>
<td>• The Saskatchewan Provincial Hospital admitted the first patients.</td>
</tr>
<tr>
<td>Alberta</td>
<td>1911</td>
<td>• The Provincial Asylum for the Insane opened in Ponoka.</td>
</tr>
<tr>
<td>Yukon and Northwest Territories</td>
<td>1914</td>
<td>• These districts had no asylums in the early 20th century. The Royal North West Mounted Police assisted in transporting mentally ill patients to asylums in neighbouring provinces.</td>
</tr>
</tbody>
</table>

with mental illness. In the beginning of institutional psychiatric care in Canada, all patients admitted to public institutions were certified patients. Today, patients are being admitted to an institutional facility on either a voluntary or a certified basis. A carefully designed legal process has to be followed for patients admitted as certified patients under the terms of a mental health act, although criteria may differ between provinces. In several provinces, the use of community treatment orders is a new development under the mental health act (see Chapter 3 for the current legal context of mental health care).

A Social Reformer: Dorothea Lynde Dix

An ardent advocate for this new form of state-supported, public care was Dorothea Lynde Dix (1802–1887). Her crusade for more humane treatment generated much of the reform of mental health care systems in North America in the 19th century (Fig. 1-4). Almost 40 years of age, Dix, a retired school teacher living in Massachusetts, was solicited by a young theology student to help in preparing a Sunday school class for women inmates at the East Cambridge jail. Dix herself led the class and was shocked by the treatment of inmates with mental disorders. It was the dead of winter, and the jail was providing no heat. When she questioned the jailer about this, his answer was that “the insane need no heat.” The prevailing myth was that the insane could not feel. The conditions of jails and the plight of mentally ill people, while promoting the building of mental hospitals. In Canada, she was instrumental in advocating for mental institutions in Halifax and St. John’s (Hurd, 1973/1916–17; Lightner, 1999). Dix eventually expanded her work into Great Britain and other parts of Europe.

Life Within Early Institutions

Despite the good intentions of early reformers, the approach inside the institution was one of custodial care and practical management, and treatment rarely occurred. The major concern was the management of a large number of people, many of whom exhibited disruptive behaviours. Patient numbers grew rapidly after provinces became legally responsible for financing care of the mentally ill. Institutions soon experienced severe overcrowding and had little more to offer than food, clothing, pleasant surroundings, and perhaps some means of employment and exercise. Limited resources made life in these institutions difficult. Although they were typically under the direction of a medical superintendent, overcrowding and resource shortages created rowdy, dangerous, and often unbearable situations. Quiet patients were involved in work as institutions grew into self-contained communities that produced their own food and made their own clothing. Day-to-day care was in the hands of lay personnel who shared with patients the routines of eating, sleeping, and working. Once admitted, many patients remained cut off from society.

Ontario psychiatrist Charles K. Clarke (1857–1924) had an influential role in bringing about new models of care to change this situation. As superintendent of various Ontario psychiatric hospitals (e.g., Rockwood Hospital, 1881–1905), he was aware of the enormous problems that asylums experienced (Brown, 2000). The asylums under his direction saw continuous improvements, including the introduction of nurse training for asylum personnel. To find better treatments and approaches, he sought to start an urban centre for the treatment of acute mental illness under the best possible conditions and supported by university-based scientific research. His dream was eventually realized with the establishment in 1925 of the Toronto Psychiatric Hospital. Clarke’s name was commemorated when the hospital became the Clarke Institute of Psychiatry in 1966 (Greenland, 1996). Following a merger with other Ontario institutions, the Clarke Institute would become part of the Centre for Addiction & Mental Health.

The deplorable state of large mental institutions soon gave rise to public commotion. In 1908, the American Clifford Beers (1876–1943) published an autobiography, A Mind That Found Itself, depicting his 3-year experience in three different types of hospitals: a private for-profit hospital, a private nonprofit hospital, and a state institution. He reported that in each facility, he had been beaten; choked; imprisoned for long periods in dark,
dank, padded cells; and for many days had been confined in a straitjacket. He became an ardent advocate of the reform of psychiatric care. Beers’ cause was supported by a prominent neuropathologist, Adolf Meyer (1866–1950), who suggested the term “mental hygiene” for bringing about improvement of people’s mental health in a manner similar to other public health initiatives. By 1909, Beers had helped form a National Committee for Mental Hygiene, through whose efforts there developed child guidance clinics, prison clinics, and industrial mental health approaches. Beers and Meyer found a close Canadian ally in Clarence Hincks, a leading Toronto psychiatrist who was instrumental in founding the Canadian National Committee for Mental Hygiene (CNCMH) in 1918, together with his colleague Charles Clarke.

The appalling situation of Canadian provincial mental hospitals triggered particular political concern following World War I, when returning veterans suffering from shell shock had to rely on existing psychiatric facilities in their home provinces. A new belief gained ground in scientific approaches and reliance on expert knowledge in the prevention of mental illness. These views were intertwined with class-based concern about an alleged weakness among lower social classes and the need for betterment of the human race, influenced by eugenic ideas of the time. This context of change provided a climate for expanding professionalism of many groups, including psychiatrists, psychologists, and nurses. The CNCMH clearly promoted improvement of mental hospitals. Introducing a trained nursing staff was part of this strategy. Voluntary admission controlled by physicians was supported, thus advancing the view that mental illness was similar to any physical illness.

**Development of Psychiatric and Mental Health Nursing**

**Early Developments**

In its many surveys of institutional facilities, the CNCMH promoted the introduction of training schools for mental nurses, later called psychiatric nurses, similar to nurse training schools in general hospitals (Boschma, Yonge, & Mychajlunow, 2005; Tipliski, 2004). During his tenure as superintendent of Rockwood Mental Hospital (1881–1905), Charles Clarke was instrumental in establishing one of the first nurse training schools for female personnel at this hospital and then at the Provincial Hospital in Toronto (Brown, 2000). Well-educated women with a sense of order and compassion had been essential in the introduction of training schools in general hospitals. In their efforts to model psychiatric hospitals after the general hospitals, psychiatrists took that ideal and geared the training of mental nurses toward women. The trained nurses provided them with the assistance they needed for new therapies and enhanced the hospital’s reputation (Boschma, 2003; Brown, 2000; Connor, 1996), as it was thought that women had the right moral, feminine characteristics for good patient care. Whereas in general hospitals, the care of male patients was put in the hands of female nurses assisted by male orderlies, in psychiatry this shift was less easily made, owing to the nature of difficult patient behaviour. Male attendants retained a prominent place in the care of the mentally ill, but their training obtained a lower status, or, in the Ontario mental hospitals, they initially did not receive any training at all (Tipliski, 2002). See Box 1-1 for historical highlights.

**Regional Influences**

In western Canada, which had a stronger orientation to British traditions of institutional care, the introduction of mental nurse training schools did not occur until the 1930s, by which time men were also being trained. In Alberta, for example, in 1932, the Department of Health hired psychiatrist Charles A. Barager, initially as acting superintendent and soon as commissioner of mental health service, to implement reform. Barager came from Manitoba, where he had introduced a nurse training school as superintendent at the Brandon Asylum (Dooley, 2004). He had a strong belief in the ability of female compassion: “The nursing of mental patients requires women of finer personality, of wider sympathies, greater self-control and higher intelligence than even the nursing of those who are physically ill” (Tipliski, 2002, p. 95).
Barager’s term in Alberta was short-lived (he died in 1936), but the training for nurses and attendants that he initiated in the Alberta Hospital at Ponoka had a lasting influence. Despite opposition to his ideas from the Registered Nurses Association in Alberta, which had controlled the registration of nurses since 1916, he was able to secure approval for a new diploma in mental nursing through the Alberta Department of Health. He also established arrangements with general hospitals so that, after 2 years of training in the mental hospital, female nurse students could undertake an additional 18 months of training at a general hospital and take licensing exams for registered nurses, after which they would return to the mental hospital. For male attendants, a 3-year certificate course was implemented, leading to a diploma in mental nursing. Male graduates did not obtain registered nursing status, reflective of the gendered context in which mental nurse training emerged. Skilled nursing was essential for new therapies, such as electroshock and insulin coma therapy introduced in the 1940s. Alberta Hospital at Ponoka also had a large infirmary with many frail and sick elderly patients (Boschma et al., 2005).

This climate of change created many new opportunities for working- and middle-class men and women to pursue careers as psychiatric nurses, and nurses began to articulate nursing knowledge in nursing textbooks. The first psychiatric and mental health (PMH) nursing textbook that appeared in North America was Nursing Mental Diseases, written by Bailey (1920). The content of the book reflected an understanding of mental disorders of the times and set forth nursing care in terms of appropriate procedures.

MODERN THINKING

As PMH nursing began to develop as a profession in the early 20th century, it incorporated new perspectives on mental illness that were emerging, particularly ideas on prevention as well as biologic views on mental illness. These new theories would profoundly shape the future of mental health care for all practitioners. Chapter 8 examines the underlying ideologies, but it is important to understand their development within the social and historical context to appreciate fully their impact on treatment approaches.

Evolution of Scientific Thought

In the early 1900s, there were two opposing views of mental illness: the belief that mental disorders had biologic origins and the belief that the problems were attributed to environmental and social stresses. Psychosocially oriented ideas proposed that mental disorders resulted from environmental and social deprivation. Moral treatment grew out of this idea, and the notion of prevention advocated by the mental hygiene movement also reflected a psychosocial orientation. The biologic view held that mental illnesses had a biologic cause and could be treated with physical interventions. However, biologic approaches and physical treatments such as bed rest, wet packs—which entailed wrapping patients in wet sheets—and prolonged baths became popular as new treatments around 1900 as part of the rise of scientific psychiatry. They were grounded in the idea that overstrained nerves should obtain rest. Such treatments turned out to be largely ineffective.

Meyer and Psychiatric Pluralism

Adolf Meyer bridged the ideologic gap between the two approaches by introducing the concept of psychiatric pluralism, an integration of human biologic functions with the environment. He focused on investigating how organic functions related to the person and how the person, constituted of these organs, related to the environment (Neill, 1980). Unfortunately, this included the surgical treatment of psychosis by one of his disciples, Henry Cotton, who believed infection caused insanity and attempted to cure patients by removing sites of sepsis such as the teeth, tonsils, and colon (Scull, 2005). Meyer’s ideas had little chance to evolve and flourish as the emerging psychoanalytic theories would soon dominate the psychiatric world in North America for a long time to come. It was not until after World War II, when a new emphasis on community-based care evolved, that environmental views and psychosocial approaches gained renewed prominence with the application of psychosocial rehabilitation models for people living with severe and persistent mental illness (Shephard, Boardman, & Slade, 2008).

Freud and Psychoanalytic Theory

Sigmund Freud (1856–1939) and the psychoanalytic movement of the early 1900s promised a radically new approach to PMH care. Trained as a neuropathologist, Freud developed a personality theory based on unconscious motivations for behaviour, or drives. Using a new technique, psychoanalysis, he delved into the patient’s feelings and emotions regarding past experiences, particularly early childhood and adolescent memories, to explain the basis of aberrant behaviour. He showed that symptoms of hysteria could be produced and made to disappear while patients were in a subconscious state of hypnosis.

According to the Freudian model, normal development occurred in stages, with the first three—oral, anal, and genital—being the most important. The infant progressed through the oral stage, experiencing the world through symbolic oral ingestion; into the anal stage, in which the toddler developed a sense of autonomy through withholding; and on to the genital stage, in which a beginning sense of sexuality emerged within the framework of the oedipal relationship. Freud posited that any
interference in this normal development, such as psychological trauma, would give rise to neurosis or psychosis.

Primary causes of mental illnesses were now viewed as psychological, and any physical manifestations or social influences were considered secondary (Malamud, 1944). Psychoanalysts believed that mental illnesses originated from disturbed personality development and faulty parenting. They categorized mental illnesses either as a psychosis (severe) or as a neurosis (less severe). A psychosis impaired daily functioning because of breaks in contact with reality. A neurosis was less severe, but individuals were often distressed about their problems. The terms psychosis and neurosis entered common, everyday language and added credibility to Freud’s conceptualization of mental disorders. Freud’s ideas would soon represent the forefront of psychiatric thought, and they shaped society’s view of mental health care. Freudian ideology dominated psychiatry well into the 1970s. Intensive psychoanalysis, aimed at repairing the trauma of the original psychological injury, was the treatment of choice. Psychoanalysis was costly and time consuming and required lengthy training; few could perform it, and as a result, thousands of patients in state institutions with severe mental illnesses were essentially ignored.

Integration of Biologic Theories into Psychosocial Treatment

Until the 1940s, the biologic understanding of mental illness was unsophisticated and did not result in effective treatment. Early somatic treatments based on these views often were unsuccessful because of the lack of understanding and knowledge of the biologic basis of mental disorders. As discussed, the use of hydrotherapy, or baths, was an established procedure in mental institutions. The use of warm baths and, in some instances, ice cold baths were thought to produce calming effects for patients with mental disorders. However, the treatment’s success was ascribed to its effectiveness as a form of restraint because the physiologic responses that hydrotherapy produced were not understood. Baths often ended up as a form of restraint rather than as a therapeutic practice. During the 1930s and 1940s, other biologic treatments emerged, which sparked new hope that they would result in effective treatment, such as insulin coma therapy and electroconvulsive therapy (ECT) (Shorter & Healy, 2007; Kneeland & Warren, 2002). Yet, often these biologic procedures were applied either indiscriminately or inappropriately with substantial side-effects including psychosurgery and ECT (see Chapter 13). ECT, the application of a short (1 to 2 seconds) electrical current to the brain in order to generate a convulsion for an allegedly healing effect, was first used around 1940. Unlike the original procedure, contemporary ECT is modified by being applied under anesthesia. Psychosurgical treatment, direct surgical intervention in lobes of the brain, also called lobotomy, began to be applied as of the late 1940s. Results from such brain therapies were mixed, and by the 1970s, the use of lobotomy became increasingly controversial; the use of ECT as treatment across a broad range of disorders was also questioned, but it remained widely used for the treatment of depression (Kneeland & Warren, 2002; Pressman, 2002; Tomes, 1994). Recent insights resulting from brain research and new technologic advancements such as electromagnetic brain-stimulating techniques have generated a renewed interest in biologic treatments, offering new possibilities for treatment of depression and other neurophysiologic disorders (George, 2003). Thanks to modern technology and improved methods, neurosurgical techniques, such as deep brain stimulation, as well as ECT and transcranial magnetic stimulation can now be applied more humanely with positive therapeutic outcomes for some psychiatric disorders (George, 2003; Rai, Kivisalu, Rabheru, & Kang, 2010; Sadowsky, 2006).

Support for the biologic approaches received an important boost in the early 1950s as successful symptom management with psychopharmacologic agents became a more widespread possibility. Psychopharmacology revolutionized the treatment of mental illness and led to an increased number of patients discharged into the community, and the eventual focus on the brain became a key to understanding psychiatric disorders. Chlorpromazine was an early neuroleptic drug that became widely used. Profound behavioural changes observed as a result of this medication in long-term mentally ill patients created an enormous enthusiasm about the potential of new medications. Understanding of the working of these drugs was in infancy, however, and their side effects soon became serious drawbacks. As knowledge increased and the management of side effects improved, psychopharmacotherapeutics obtained a central place in the treatment of mental illness. The introduction of lithium in the early 1970s brought a lasting change in the treatment of bipolar disorder, as did antidepressants in the treatment of mood disorders (LaJeunesse, 2000). Nurses obtained an essential role in administering medications, monitoring their effects, and teaching patients about their effects.

New Trends in Post–World War II Mental Health Care

Following the experiences of World War II, insight grew among governments, as well as health professionals, that psychiatric services had to be placed on a new footing. By the end of the 1940s, patients in overcrowded and isolated psychiatric hospitals outnumbered the number of patients in other health care facilities, including general hospitals. Increased federal funding for health services and training of health care personnel created new opportunities. The implementation of universal health insurance for hospital care and medical services during the 1950s and 1960s, based on a 50/50 cost sharing between federal and
provincial governments, generated funding for the establishment of psychiatric departments in general hospitals, shifting the focus of services away from large provincial institutions (Ostry, 2009).

The Canadian Mental Health Association (CMHA), renamed from the earlier CNCMH, had an instrumental role in policy development for integrated services in general hospitals and the community. In its influential 1963 report, *More for the Mind*, the CMHA argued that mental illness had to be dealt with in ways similar to those of physical illness, and it argued for the application of multiple perspectives—medical, social, and familial—in multidisciplinary services and community treatment. A broader movement of social critique also emerged, protesting the poor circumstances in large mental hospitals and the lack of patient rights. Psychiatry became the target of fierce debate and antipsychiatric critique in the 1970s (Crossley, 2006). Power relationships and the dominance of the medical model were questioned, and an emerging patient movement obtained a new voice and presence in mental health. Improving support and resources for people with mental illness within the community was a key target (Fingard & Rutherford, 2011).

A shift in mental health policy resulted in deinstitutionalization, the downsizing of the large provincial psychiatric hospitals, and a new orientation on community-based services to support people with mental illness within their own communities (Boschma, 2011; Dyck, 2011). Services and treatments diversified. Biologic approaches, such as use of psychopharmacology and safer application of ECT, were complemented by new rehabilitative services, the use of group therapy and other psychotherapies, as well as the provision of day treatment. In the 1950s, mental hospitals began to reduce their size and, over the course of the next decades, many closed, or changed their focus—a process that in Canada would last until the end of the 20th century. In British Columbia, for example, the provincial mental hospital Riverview closed its doors permanently in 2012 (Hall, 2012). During the second half of the 20th century, funding for mental health care became part of the larger health care system, with a stronger emphasis on general hospital–based psychiatric care and community-based care. Nurses had an essential role in this transformation in the emerging field of community mental health nursing (Boschma, 2012).

In the late 1970s, the federal government shifted to a new funding structure for health care, reducing its share in the cost. Provinces developed different models and strategies to fund specialized services such as alcohol- and substance-abuse treatment programs, which following World War II were pressing mental health care needs. To address the needs of different population groups, subspecialties also emerged, such as child psychiatry, forensic, and geriatric services. The perception of health care as a human right enhanced consumer and volunteer involvement, as well as public education on mental illness, and it increased the demand for patient autonomy.

**Continued Evolution of Psychiatric and Mental Health Nursing**

The new multidisciplinary approaches and services generated a pressing need for more and better trained mental health care personnel, including nurses. The changes created a context for new developments in PMH nursing education. Organized responses of provincial professional nurses’ organizations, as well as efforts of hospital administrators and psychiatrists to continue staffing psychiatric hospitals through hospital-based nurse training programs, resulted in a diverse pattern of PMH nurse education. As of the 1950s, Canada entertained two models of education for PMH nursing, resulting in the preparation of two different professional nursing groups for nursing care in mental health services. Regional influences played a large role in the generation of the two models. On the one hand, general hospital–based schools of nursing, especially in eastern Canada, began to integrate psychiatric nursing into their curriculum. In Ontario, for example, under the influence of the mental hygiene movement, as of the 1930s, general hospital training schools began to include care of mentally ill patients into their training. Student nurses attended the provincial psychiatric hospitals for a brief period of training, called an affiliation program. Conversely, mental nurse trainees, mostly women, from the psychiatric hospital–based nurse training programs opted for an affiliation to the general hospital, resulting in both groups’ obtaining the title of registered nurse. After World War II, the provincial government and the provincial association of registered nurses in Ontario formalized this pattern into a permanent structure. Gradually, the psychiatric hospital–based programs decreased in number and size, and the registered nurse became the main nursing care provider in mental health services (Tipliski, 2004).

In the less densely populated western Canadian provinces, the pattern emerged of general hospital nurse trainees choosing affiliation experiences at the psychiatric hospitals, but the bulk of nursing care in the provincial hospitals continued to be provided by nurses and attendants graduated from psychiatric hospital–based nurse training programs. As noted previously of Alberta Hospital in Ponoka, some western provinces established an affiliation program for female mental nurse trainees, and its graduates obtained the title of registered nurse. The program was limited in size, however, and many women worked in the institution as untrained attendants until the 1960s. Male trainees received a diploma in mental nursing. In British Columbia, a training school for mental nurses, later called psychiatric nurses, was established in 1930 at Essondale, which eventually became Riverview Hospital (Fig. 1-5).
In the western provinces, the government had less control over nurse training than in neighbouring Ontario. Provincial associations of registered nurses in western provinces failed to support affiliation for psychiatric hospital–based nurse trainees, while medical superintendents of psychiatric hospitals retained much of their influence over psychiatric nurse education (Boschma et al., 2005; Tipliski, 2004). Around 1950, attendants in the province of Saskatchewan took the lead in obtaining political support for a different pattern of nurse education that would lead to a separate Psychiatric Nurses Act and subsequent training acts independent of provincial registered nurse practice acts. In Saskatchewan, registered nurses had never successfully integrated into the mental hospitals. Although the psychiatric training program that had existed for Saskatchewan asylum attendants since the 1930s was expanded after World War II to address the new need for psychiatric expertise, it never resulted in registration as a nurse. Dissatisfied with their exclusion from any professionally recognized nursing title, provincial hospital attendants, who in Saskatchewan had obtained the right to unionize after the election of the new Co-operative Commonwealth Federation government in 1944, became instrumental in generating union support, as well as backing from the new government, for legislation of a separate psychiatric nurses act, which passed Parliament in 1948. In 1950, the Psychiatric Nurses Association of Canada was formed. Their action resulted in a distinct professional group of psychiatric nurses. By 1963, two U.S.-based nursing journals, the Journal of Psychiatric Nursing (now the Journal of Psychosocial Nursing and Mental Health Services) and Perspectives in Psychiatric Care, as well as the Canadian Journal of Psychiatry, had been established, providing a platform for the dissemination of research and practice in psychiatric nursing.

In the post–World War II era, nurses continued their work in facilitating the therapeutic climate within psychiatric hospitals (Fig. 1-6). The shift to community mental health and deinstitutionalization generated many new functions for PMH nurses (Boschma et al., 2005; Church, 1987). Nurses obtained a central role in supporting large numbers of discharged patients in their transition to living in the community. In the psychiatric hospitals and general hospital units, nurses obtained new therapeutic roles in group therapies, and their work in community mental health services expanded (Boschma, 2012). New theoretical models became available that emphasized building therapeutic nurse-patient relationships and holistic nursing approaches. Hildegard Peplau, who in recent scholarship has been considered the most important psychiatric nurse of the 20th century, proved to be a strong leader in the development of these new frameworks for psychiatric nursing (Boschma et al., 2005; Calaway, 2002). Expansion of Holistic Nursing Care

In 1952, Peplau published the landmark work Interpersonal Relations in Nursing. It introduced PMH nursing practice to the concepts of interpersonal relations and the importance of the therapeutic relationship. In fact, the nurse-patient relationship was defined as the very essence of PMH nursing and supported a holistic perspective on patient care (see Chapters 5, 6, and 7). These new frameworks underscored a new professional and disciplinary independence for nurses.

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Psychiatric Nursing (1975–1990), focused on psychiatric nursing. Also, the Canadian Journal for Nursing Research began to publish PMH nursing research. During the 1980s, the Canadian Federation of Mental Health Nurses (CFMHN) formed as an interest group of the Canadian Nurses Association with a view to promoting the interests of mental health nurses and bringing matters of mental health nursing interest and psychiatric patient care to the attention of the public at large. In 1995, this group published the Canadian Standards of Psychiatric and Mental Health Nursing Practice. Based on the influential work of Patricia Benner (1984), the standards were written within a framework of “domains of practice.” This promoted a holistic perspective on nursing care, with PMH nurses practicing in a variety of settings with a variety of clientele. The emphasis was on activities ranging from health promotion to health restoration. The standards reflected the belief that PMH nursing should be research-driven, continually incorporating new findings into nursing practice. Relying on these standards, the Canadian Nurses Association created the opportunity to become certified in mental health nursing as part of their larger certification program of specialty nursing areas established during the 1980s. The CFMHN updated its standards in 2006 and again in 2014 to incorporate the most recent perspectives on PMH care. The 2006 revisions to the standards were unique in that input was sought for the first time from mental health care consumers (Beal et al., 2007).

Contemporary Issues

During the 1980s, wrinkles in the social fabric of mental health care emerged. The mixed results of deinstitutionalization became apparent and generated a series of government-commissioned reports in all provinces to improve mental health services. Enormous variation existed among provinces in the extent and timing in which they implemented deinstitutionalization policies. People with mental disorders were discharged into communities that were often ill prepared to offer sufficient support in the way of community support programs, housing, or vocational opportunities. Communities were sometimes hesitant in accepting people with persistent mental illness in their midst, and stigma remained attached to mental health services (Hector, 2001; Sealy & Whitehead, 2004). The 1981 Charter of Rights and Freedoms reflected a public statement intended to counter such responses (Greenland, Griffin, & Hoffman, 2001).

Self-help groups and family and consumer organizations, such as the Schizophrenia Society of Canada and the Mood Disorder Society of Canada, have become active participants in mental health care services during the past decades. Outreach and mobile crisis response teams emerged to address problems people with severe mental illness experienced in the community. A new category of “revolving door” patients signified that long-term, severe mental illness remained a persistent problem, with patients continuously moving in and out of the acute care system. Also, the interconnected issues of severe mental illness, substance dependency, and inadequate community resources and housing have resulted in a growing number of homeless people with mental illness, as well as a large population of mentally ill winding up in the criminal justice systems. Within these groups, the specific mental health needs of women remain poorly addressed. Likewise, there exists a growing awareness that diverse cultural populations have distinctive mental health needs and experience inequity in the social and mental health pressures placed upon them. Aboriginal mental health is a critical issue in Canada because Aboriginal communities experience disproportionate rates of both physical and mental illness due to an unbalanced health care system that has not been adaptive to the specific health needs of Aboriginal peoples (see Chapter 3). Today, mental health services are still fragmented and not sufficiently developed to meet the need. Millions of adults and children are disabled by mental illness every year. When compared with all other diseases, mental illness ranks first in terms of causing disability in North America and Western Europe (Hart Wasekeesikaw, 2006; Morrow, 2002; World Health Organization, 2001).

The New Era of Health Care Reform

Both public and private expenditures for health care services have increased in North America. Financial and social barriers continue to affect the overall funding for mental health. Now, large networks of public and private organizations share responsibility for mental health care, with the state remaining as the major decision maker for resource allocation. The emphasis is on reducing expensive institutional care and increasing the resources devoted to community-based care for the mentally ill, such as those in clinics, homes, schools, and treatment centres. With so many organizations involved in mental health services, the voice of mental health care remains fragmented. It became clear during the 1990s that new federal initiatives in mental health policy were urgently needed. In 1998, the Canadian Alliance on Mental Illness and Mental Health (CAMIMH) was formed as a joint initiative of the Canadian Psychiatric Association, the CMHA, the Mood Disorder Association of Canada, the National Network for Mental Health, and the Schizophrenia Society of Canada. Consumers and service providers jointly began to lobby the federal government to come to an action plan and a new national agenda for mental health care (Beauséjour, 2001). Two years later, the CAMIMH joined the Canadian Collaborative Mental Health Initiative, which was formed to focus specifically on the improvement of mental health care in the primary health care setting. Consumers and caregivers
Services in Canada (Kirby & Keon, 2006) highlighted Transforming Mental Health, Mental Illness and Addiction Out of the Shadows at Last: the need for better service: health care system led to another influential report urging change from traditional institutional care to general hospital care underscored the need for additional and improved acute and community-based mental health services. A senate-commissioned review of the Canadian health care system led to another influential report urging the need for better service: Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada (Kirby & Keon, 2006) highlighted the fragmented mental health care for Canadians and in particular the disparate services provided across the provinces. Woven throughout the report are stories of Canadians suffering from mental illness, illustrating the complex issues of stigmatization and discrimination. The report also drew attention to the far-reaching social, economic, and policy effects on health, health care, housing, employment, social welfare, as well as the justice system for Canadians with mental health concerns (Kirby & Keon, 2006). Also highlighted were disparities in access to care between urban and rural Canada, which are further complicated by unique regional multicultural needs. Regional discrepancy has been blamed on the lack of a nationwide mental health strategy and the inconsistency between provincial jurisdictions that determine mental health policies and the allocation and delivery of services for Canadians. While the report has been embraced by many mental health care consumers and caregivers, some critics noticed a lack of emphasis on “preventative determinants” and a lack of recognition of the depth of disability caused by mental illness (Arboleda-Flórez, 2005). Some women’s advocate groups challenged the report’s “silence” on the disparities between mental health and addiction services for men and women, while others critiqued the report’s alleged neutrality to ongoing erosion of the publicly funded health care system (Canadian Women’s Health Network, 2006). The data from the CAMIMH and Kirby reports laid bare the need for continued, integrated mental health policy development across Canada, for all Canadians. The need to develop a national mental health strategy became the impetus for the establishment in 2007 of the Mental Health Commission of Canada.

Developing a National Mental Health Strategy

Canada’s national health strategy was first adopted in 1984 through the Canada Health Act, which set out the values, principles, and guidelines for health care. While to some degree mental health care principles are enshrined in the overall Act, there continued to be significant gaps and inconsistencies in mental health care across the country, and Canada continued to be the only one of the eight wealthiest nations without a national mental health strategy (Kirby, 2009).

To address these gaps, Health Canada funded the Mental Health Commission of Canada, a 10-year initiative. While the MHCC was established outside the federal health mandate, the federal government continues to contribute funding to support the commission’s work, and the commission’s structure mirrors inclusive intentions (Goldbloom & Bradley, 2012). For example, its membership consists of all levels of government and a wide range of stakeholders, from health care professionals to individuals living with mental illness and their family members.

The MHCC was originally assigned three primary objectives: to develop a mental health strategy for Canada, begin an anti-stigma campaign, and create a knowledge exchange centre to promote research and build capacity and opportunities in evidence-based mental health strategies. Several additional objectives and initiatives have been added since its inception (Box 1-2). We highlight two of these initiatives. The At Home/Chez Soi initiative

**Box 1-2 The Mental Health Commission of Canada Initiatives and Projects**

The original goals of the commission have expanded to include six key initiatives and projects:
- Opening Minds addresses stigma as a barrier to seeking help. Antistigma initiatives have focused on health care provider education, early intervention for youth aged 12 to 18, mental health awareness in the workforce, and decreasing negative stereotypes in media.
- Mental Health First Aid parallels the training for physical emergencies with the need to train Canadians for mental health emergencies.
- Mental Health Strategy for Canada addresses the need for change to ensure equitable care of Canadians with mental health concerns.
- Knowledge Exchange Centre is intended to ensure access, sharing, and exchanging of mental health knowledge for all.
- At Home addresses the social determinant of housing as a fundamental component of mental health for Canadians.
- Peer Project is the latest initiative to address the importance of peer support for individuals with mental health concerns.


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**Study Note**

Current mental health policy’s focus on community-based care and integration aims at moving away from older, more stigmatizing approaches of long-term institutionalization and custodial care.
constitutes a large federally funded ($110 million) mental health research project examining housing for mentally ill individuals in five large urban settings. It explores the effectiveness of providing housing to individuals with mental health and addictions without also requiring them to be in treatment or sober, while providing a range of supportive health and social services (Hwang, Stergiopoulos, O’Campo, & Gozdzick, 2012). Another initiative addresses Mental Health First Aid and involves provision of training to the public on how to identify the early signs and symptoms of mental illness and suitable interventions for the unique needs of youth or adults. Educating first-aid trainers for the workplace, including teachers and health care providers, plays an essential role in disseminating awareness of mental health issues and the importance of early intervention to minimize long-term harm.

The work of the MHCC in the past 5 years has been prolific and received with much enthusiasm. Many insights have been gained through the MHCC initiatives, which resulted in the 2012 release of a comprehensive set of guidelines with six key strategic directions to address mental health needs for Canadians (Box 1-3). As some of the research initiatives are coming to an end, however, a note of caution is also warranted. A significant source of concern is that financial support for continuation of the research initiatives are coming to an end, however, of this writing, the financial sustainment of this novel project, which comes to an end in 2013, and at the time of this writing, the financial sustainment of this novel approach is unclear (Goldbloom & Bradley, 2012). This brings to the fore concern that the lack of continuity of promising initiatives might constrain resources and as a consequence cause further harm for this population.

Such fundamental and persistent challenges stay on the policy agenda, and the priority of continued community-based care for Canadians with mental health concerns, and their families, remains. While we come to the end of an era of mental illness invisibility, we still need more ways to provide permanent and persistent support for the most vulnerable populations. These challenges are not unique to Canada. They have been recognized at a global level by the World Health Organization. Accepted by the World Health Assembly in May 2013, the Comprehensive Mental Health Action Plan 2013–2020 has four major objectives:

- Strengthen effective leadership and governance for mental health
- Provide comprehensive, integrated, and responsive mental health and social care services in community-based settings
- Implement strategies for promotion and prevention in mental health
- Strengthen information systems, evidence, and research for mental health.

This plan promotes and guides a transformative worldwide mental health agenda (WHO, 2013).

The challenge before Canadian nurses at this time is to strive to address these national and global goals. We must work with a view to include mental health around the world while working within existing constraints to provide cost-effective services. To address pressing mental health care needs in the 21st century, nurses must continue to participate in devising and implementing a continuum of mental health services that provides access for all and to develop appropriate partnerships with other health professionals and consumer groups.

**BOX 1-3 Changing Directions, Changing Lives: The Mental Health Strategy for Canada (May 2012)**

Six key strategic directions to address the mental health needs for Canadians.

- Promote mental health across the life span in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.
- Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.
- Provide access to the appropriate combination of services, treatments, and supports, when and where people need them.
- Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
- Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights, and cultures.
- Mobilize leadership, improve knowledge, and foster collaboration at all levels.


**SUMMARY OF KEY POINTS**

Throughout history, attitudes and treatment toward those with mental disorders have drastically changed as a result of the changing socioeconomic backdrop of our society and the development of new theories and study by key individuals and groups.

During the 1800s, as mental illness began to be viewed as an illness, more humane and moral treatments began to develop.

Social reformers such as Dorothea Dix, Charles Clarke, Clifford Beers, and Clarence Hincks dedicated their efforts to raising society’s awareness and advocating public responsibility for the proper treatment of persons with mental illness. At the turn of the
19th century, mental hospitals started implementing Schools of Nursing to build psychiatric nursing capacity and quality within the hospitals.

- Theoretic arguments characterized the evolution of scientific thought and psychiatric practice. Gradually, the importance of the biologic aspect of mental disorders was recognized while psychosocial approaches were also developed. After the 1950s, the discipline of nursing began to add to the theoretical basis of mental health practice, adding holistic and interpersonal frameworks of psychiatric nursing.

- Although the need for PMH nursing was recognized near the end of the 19th century, initially there was resistance to training attendants for the care of the insane. At the initiative of Charles Clarke, medical superintendent of Rockwood Hospital (1881–1905), the first Training School for Mental Nurses was established in 1888.

- All provinces gradually adapted to education for PMH nurses. By the 1930s, all provinces had established training schools for asylum attendants and nurses. In the era following World War II, provinces started to downsize mental hospitals in a process of deinstitutionalization and a shift to community-based care. Two models of education for psychiatric nurses emerged, leading to two distinct professional groups.

- Key federal and provincial initiatives generated political support and funding for mental health services, but these remain inadequate to many pressing mental health issues.

- Initiatives such as the CAMIMH, the Canadian Collaborative Mental Health Initiative, and reports such as Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada (Kirby & Keon, 2006) highlight the importance of a national mental health strategy.

**CRITICAL THINKING CHALLENGES**

1. Compare the ideas of psychiatric care during the 1800s with those of the 1990s and 2000s and identify some major political and economic forces that influenced care.

2. Analyze the social, political, and economic changes that influenced the transition to community mental health.

3. Explain how training and education of nurses became essential in psychiatric care.

4. Present an argument for the need to develop alternatives to large mental hospitals.

5. Trace the history of biologic psychiatry and highlight major ideas and treatments.

6. Identify the strengths and challenges of accessible community-based care.

**REFERENCES**


