2009

Deinstitutionalization of Mental Health Care in British Columbia: A Critical Examination of the Role of Riverview Hospital from 1950 to 2000

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Cambridge Scholars Publishing

DEINSTITUTIONALIZATION OF MENTAL HEALTH CARE IN BRITISH COLUMBIA: A CRITICAL EXAMINATION OF THE ROLE OF RIVERVIEW HOSPITAL FROM 1950 TO 2000

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SUMMARY: During the 19th century, ideas based on moral treatment, pedagogical guidance of mentally ill patients and hospitals specializing in caring for the mentally ill, were viewed with high regard as innovative and progressive institutions. As mental hospitals grew into large custodial institutions, they experienced criticism in regards to issues of overcrowding, inadequate funding and provision of care, alienation, and isolation of patients from society. These criticisms resulted in public pressure for deinstitutionalization, increased emphasis on the importance of community care and regionalization of mental health services in the post World War Two era. The purpose of this paper is to analyze how this transformation evolved in British Columbia. Riverview Hospital was established as a centralized mental hospital for the province. The period of the early 1950s ushered in the move towards decentralization and saw the beginning of the decline of Riverview's population and eventual diminution of its role in the province. Popularity of the idea of deinstitutionalization grew swiftly, however, its operationalization and the practical consequences of this shift in care seems to be minimally informed.

KEYWORDS: Deinstitutionalization; Mental Health Services; 20th Century History; Hospitals, Psychiatric; Health Policy, Government Publications.

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Introduction

The shift towards "deinstitutionalization" was a movement in mental healthcare that gained swift global popularity by the early 1960s. In British Columbia, implementation of this ideal was exemplified by the downsizing and proposed closure of the provincial mental facility, Riverview Hospital. An additional goal to the proposed closure was to

work towards rehabilitating and reintegrating residents back into society. In pursuit of this endeavour, extensive evaluations of psychiatric services in the province were carried out and detailed downsizing plans for Riverview Hospital were outlined in several reports from 1950 to 2000. Focusing on reports and policy documents from the 1970s to the 1990s, this paper will examine the contextual factors that influenced the downsizing process as well as the outcomes and repercussions of these plans for patients, families, and communities in the province.

Background

Prior to the late 19th century, treatment means for those afflicted with mental illness were limited. As a result, individuals were left to cope with their symptoms and illness on their own. Only people who were deemed dangerous were imprisoned. Other than that, people were cared for in their families.[1] Recognition of the need for specialized treatment for mental illness began to develop in the late 1800s with a theory that separation of the mentally ill from the rest of society during treatment was an important key factor in rehabilitation.[2] Subsequently, the idea of institutionalizing the mentally ill in specialized facilities grew to be an attractive option because: (1) it absolved families from the responsibility of caring for their ill family member; (2) it had become a widespread belief that isolation was beneficial for communities (as it removed "dangers" and "undesirables" from society); and (3) it was essential for rehabilitation (e.g. involving patients in labour, on these grounds, was seen as helping to cure them).[3] In the 19th and early 20th century, rapid

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[1] Geertje Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890-1920* (Amsterdam: Amsterdam University Press, 2003).

[2] John Conolly, *The* Construction and Government of Lunatic Asylums and Hospitals for The Insane (London: Churchill, 1847), pp. 8-9; Thomas S. Kirkbride, *On the Construction, Organization, and General Arrangement of Hospitals for the Insane* (New York: Arno Press, 1973; reprint of the 1880 edition), pp. 25-27; Mental Health Branch Department of Health Services and Hospital Insurance, *A Summary of the Growth and Development of Mental Health Facilities and Services in BC 1850-1970* (Vancouver: British Columbia Mental Health Branch, 1970).

[3] Geertje Boschma, Marlee Groening and Mary Ann Boyd, "Psychiatric and Mental Health Nursing from Past to Present," in: *Psychiatric Nursing for Canadian Practice*, eds. Wendy Austin and Mary Ann Boyd (Philadelphia: Lippincott Williams and Wilkins, 2008), pp. 3-17; Kirkbride, *On the Construction, Organization, and General Arrangement of Hospitals for the Insane*, pp. 269-272).

popularization and public funding of centralized mental health hospitals saw peak numbers of institutionalized patients as a widespread phenomenon in the Western World. For example, the provincial mental hospital in British Columbia, Riverview Hospital, saw an astounding peak population of 4,630 patients in 1951.[4]

The Move towards Deinstitutionalization

Treatment of mental illness away from institutions and into communities was a major shift in thought that became widespread in the mid-twentieth century. Western Europe, the United States, Australia, and Canada were only a handful of world regions to undergo mental health care reforms that included goals to decentralize mental health care.[5] Controversy arose over large institutions as critics underscored the lack of scientific evidence supporting institutional care. They argued that institutionalizing individuals had become an alternate way of dealing with dissenters and putting away "undesirables".[6]

Rapid growth of the asylum population had introduced problems of overcrowding and raised many ethical questions about the quality and effectiveness of non-therapeutic, custodial care, further fuelling the controversy. Questions about long-term effects of institutionalization on both patients and families also came under scrutiny. Dramatic increases in operational and maintenance costs of institutions were additional factors which led to the move towards decentralizing mental health services.[7]

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[4] British Columbia Mental Health and Addiction Services, *History*, 2008; retrieved 10 January 2009 (http://www.bcmhas.ca/AboutUs/History.htm).

[5] Pat Armstrong et al., *Exposing Privitazation: Women and Health Care Reform in Canada* (Aurora Ontario: Garamond Press, 2002); Walid Fakhoury and Stefan Priebe, "The Process of Deinstitutionalization: An International Overview," *Current Opinion in Psychiatry* 15 (2002), pp. 187-192.

[6] James E. Moran and David Wright, *Mental Health and Canadian Society: Historical Perspectives*, (Montreal & Kingston: McGill-Queen's University Press, 2006); Marina Morrow, "Mental Health Reform, Economic Globalization and the Practice of Citizenship," *Canadian Journal of Community Mental Health 23* (2004): 39-50; Gerald N. Grob, "The Transformation of Mental Health Policy in Twentieth-Century America," in: *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, eds. Marijke Gijswijt-Hofstra, Harry Oosterhuis, Joost Vijselaar and Hugh Freeman (Amsterdam: Amsterdam University Press, 2005), pp. 141-161.

[7] David Wright, Shawn Day, Jessica Smith, and Nathan Flis, "A Janus-like Asylum: The City and the Institutional Confinement of the Mentally Ill in Victorian Ontario," *Urban History Review* 36 (2008), pp. 43-52.

Specifically, the rapid expansion and growth of facilities increased demand to hire more staff to accommodate the growing numbers of institutionalized patients made deinstitutionalization very attractive.

A principle that heavily influenced the call for change in mental health treatment was that of *normalization*, advocated by Wolf Wolfensberger (b. 1934). Wolfensberger, a renowned mental retardation research scientist at the Nebraska Psychiatric Institute in the United States, defined *normalization* as the importance of exposing a patient to an as normal environment as possible while receiving therapeutic mental health treatment. *Normalization* emphasizes the importance of inclusion into a community and social integration (versus social isolation which was a hallmark of institutional care) as essential to treatment and recovery from mental illness and the eventual goal of reintroducing the individual as a functional member of society.[8] In addition, the advent of new therapies and medications that helped to control symptoms was thought to better allow for the option of treating the mentally ill within their own communities, in as a "normal" an environment as possible[9].

Changes in the current approaches to mental health care that were beginning to take place in other parts of the world also prompted the Canadian Mental Health Association's thorough examination of the state of mental health care in Canada.[10] This was carried out as part of the Royal Commission on Health Services, a national review of the health of Canadians.[11] Resulting from this inquiry was the *More for the Mind* report published in 1963 that describes in detail the existing patterns of psychiatric care and identifying gaps in existing services in Canada. Recommendations made in the report to transform mental health care approaches and services were driven by the committee's idiom, the "*McNeel Ideal*" which stated that psychiatric treatment should cause minimal disruption to a patient's life; the ideal shared by the deinstitutionalization movement as a whole.[12] The *McNeel Ideal* placed

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[8] Wolf Wolfensberger, *Principle of Normalization in Human Services* (Toronto, Canada: National Institute on Mental Retardation, 1972).

[9] Boschma, Groening, and Boyd, *Psychiatric and Mental Health Nursing from Past to Present*, p. 11.; Grob, *The Transformation of Mental Health Policy in Twentieth-Century America*, p. 146.

[10] James D. Griffin, "More for the Mind: The Canadian Mental Health Association Report and its Implications," *American Journal of Psychiatry* 121 (1964), pp. 446-450.

[11] Canadian Mental Health Association Ontario, *History of CMHA*, 2008; retrieved 15 March 2009 (http://www.ontario.cmha.ca/inside_cmha.asp?cID=7620).

[12] Griffin, *More for the Mind*, p. 448.

emphasis on transferring care away from centralized institutions to community-based services, as well as proposing the expansion of regionally based psychiatric services in hospitals, clinics, and other agencies.

The combination of rising costs of operating large mental health institutions, led to questions regarding the ethical care and negative consequences of institutionalization on patients and their families lack of scientific evidence supporting this method of treatment, and development of new medications and ideals in mental health treatment worldwide, all acted to shift the demand for a different standard of mental health care. Riverview Hospital was British Columbia's example of a mental health institution that felt these pressures and was a key target of mental health care reform proposed to take place in the province.

Beginnings of Deinstitutionalization in British Columbia

The 1970s saw the province's own initial steps in putting the policy into action in the movement towards deinstitutionalization. In 1979, the provincial government undertook a detailed evaluation of the state of mental health approaches and services. The *Mental Health Planning Survey*, as one of the initial steps in planning for the shift of care from centralized institutions to regionally-based mental health services. This was the one of several initial reports by the province with specific recommendations for how to operationalize downsizing of Riverview Hospital. In the 1960s however, there was already evidence of the commitment towards decentralized mental health care as seen in the steady decline of patients in Riverview Hospital from more than 2,500 patients in residence at the beginning of 1968 to approximately 1,100 patients at the beginning of 1978.[13] This decline was a result of the introduction of more stringent and exclusive admission criteria at Riverview Hospital.[14] In the *Report of the Mental Health Planning Survey*, findings at Riverview hospital highlighted issues such as the lack of delegating authority or responsibility at any level of program development, provision of custodial care, little evidence of coordination of therapeutic programming, difficulties in inter- and intra-hospital transfers, and problematic accounting and

[13] Mental Health Planning Survey Staff, *Report of the Mental Health Planning Survey* (Crown Publications: Queen's Printer for B.C., 1979), pp. 57-58.

[14] Mental Health Planning Survey Staff, *Report of the Mental Health Planning Survey*, p. 58.

budgeting systems.[15] Broad recommendations made by the report for Riverview Hospital were to address these issues.[16] Similar recommendations were made at all levels of mental health services with the move towards a community-based care structure. This was stated as a top priority throughout the document.

The planning process to address the deficiencies outlined in the *Mental Health Planning Survey* began in 1985 and resulted in the first official plans for Riverview Hospital downsizing in 1987. The 1987 *Mental Health Consultation Report* was to serve as the blueprint for the development and improvement of mental health services in the province as well as the initial steps to downsize and eventually replacing Riverview Hospital with community-based services.[17] Similar to the *McNeel Ideal*, a core philosophical value stated in this report was the integration of mentally ill people into their families and communities as well as working with individuals to maximize their mental and behavioural potentials to maintain as normal a lifestyle as possible;[18] an alternative made possible by developments in psychiatric care at the time such as new medications, therapies, rehabilitation, and patient management method.[19] Recommendations in this report were built on key assumptions including the certainty in the ability to provide mental health care in communities for all but the most seriously mentally ill individuals and secondly, the importance of the mentally ill being united with their family, friends, and society in order to reinforce normalization.[20] Downsizing of Riverview hospital was identified as a top priority in the *Mental Health Consultation Report* and a five-year plan for the replacement and closure of Riverview Hospital was put forward. In order for this proposed five-year plan to succeed, the report emphasized the need for replacement services to first be established as well as the reallocation of funds from Riverview Hospital to community services, before any reductions or adjustments are made to existing services.

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15 *Ibid*., pp. 56-64.
16 *Ibid*., pp. 132-134.
17 British Columbia Ministry of Health, *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital* (Victoria, B.C.: Ministry of Health, Province of British Columbia, 1987), pp. 1-2.
18 *Ibid*., pp. 7-8.
19 See: note 60.
20 See: note 69.

Prolonged Implementation and Continued Evaluation

Despite the ambitious five-year plan outlined in the *Mental Health Consultation Report* in 1987, progress of the proposed redevelopment and much of the transformation of mental health services in British Columbia still had to occur by the early 1990s. To continue the move towards deinstitutionalization, two more reports were created in 1992 and 1993, both of which formed the *Strategic Mental Health Plans of British Columbia*. They were stated to be part of a continuous evaluation process whose goal was to outline the strategy for mental health service development in British Columbia. Although the *Strategic Mental Health Plans* stated they were not meant to be replications of the *Mental Health Consultation Report*, there were many similarities. Both reports maintained the fundamental priority to move towards decreasing the population of institutionalized persons in the province and promoted the treatment of mental illness in community-based services.[21] In addition, the reports also carried out an evaluation of the state of mental health services in the province at the time. Issues identified in the *Strategic Mental Health Plans* included an overall inadequacy in the current organization of mental health care citing issues such as the lack of division between service delivery and quality assurance roles, lack of community involvement in planning and implementation of local mental health services, and insufficient coordination between different levels of service (e.g. acute hospital care, continuing care, alcohol and drug programs). Recommendations made by the *Strategic Mental Health Plans* included one and five-year plans targeted issues that were needed to be addressed in all sectors of mental health as well as to provide a more explicit and specific recommendations and goals for both provincial and regional levels of service delivery.

Though limited, those reports did note that some progress had been made at Riverview Hospital in moving towards community-based care. Notable developments included the initiation of the planning process for replacement facilities underway in a number of regions in the province, and the creation of project teams to provide input in the transfers of patients and resources into the community which included members from community agencies, patients' families, and other mental health centres.[22]

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[21] British Columbia Mental Health Services, *Strategic Mental Health Plan for British Columbia 1992* (Victoria: Ministry of Health, Mental Health Services Division, 1992), pp. 3-5.

[22] British Columbia Mental Health Services, *Strategic Mental Health Plan for British Columbia 1993* (Victoria: Ministry of Health, Mental Health Services Division, 1993), pp. 41-43.

Initial Outcomes

As the impact of transfer of patients from Riverview Hospital to the communities began to be seen in the 1990s, difficulties that mentally ill individuals faced while residing in communities began to catch the public eye. Issues such as the shortage of affordable housing, long wait lists, and increased rejection of the mentally ill residing in communities caught media attention in 1991 and resulted in a newspaper article questioning the appropriateness and readiness of community-based mental health services to take on transitioning mentally ill persons.[23] This article led the Greater Vancouver Regional Hospital District Board to call for an inquiry of municipal services and the impact of psychiatric patients transitioning back into their communities. The resulting report: *Psychiatric Patients Living in the Community: Impact on Municipal Services* (1992), focused on municipality responses regarding the impact of Riverview Hospital downsizing initiative, outlined difficulties faced by communities, and made recommendations regarding care of psychiatric patients in the community.[24] The summary of concerns voiced by the municipalities included the excess demand for housing and residential care over available supply, an inadequate supply of qualified workers, an increase in psychiatric criminal cases, and the increased severity and incidence of violent behaviour and chronic cases.

Other impacts on municipalities included limitations and decreases in psychiatric services for the geriatric population, facilities that are ill equipped to handle acutely psychiatrically ill patients and still being forced to keep them, delays in transfers from Riverview Hospital to general hospital's psychiatric units, increased wait times for residential placements, and mentally ill individuals being housed in inappropriate settings (e.g. seniors centres seeing increasing numbers with social and mental deficiencies). Other deficiencies named in the report were similar to those already identified in the *1987 Mental Health Consultation Report;* these deficiencies were predicted to continue being barriers to downsizing if they continue to remain unaddressed.[25] Overall, the report found that community-based mental health services were overburdened and insufficiently equipped to handle the increasing numbers and increasingly

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[23] Greater Vancouver Regional Health District, *Psychiatric Patients Living in the Community: Impact on Municipal Services* (Burnaby, B.C.: Greater Vancouver Regional Hospital District, 1992), pp. 54-55.

[24] *Ibid.*

[25] Greater Vancouver Regional Health District, *Psychiatric Patients Living in the Community: Impact on Municipal Services*, p. 77.

complex psychiatric patients who were now residing in communities. The limited response capacity of community-based mental health services had then led to an increased demand on additional support services, support from friends and family, and other public support.

Inadequate projection of the cost of transitioning by the *1987 Mental Health Consultation Report* was named by the *Impact on Municipal Services* report to be another significant factor strongly influencing the development of complexities in transitioning to community-based mental health care. The *Impact on Municipal Services* report reveals that although the *Mental Health Plans of 1992 and 1993* were reviewed by the Provincial Cabinet, they were never implemented into government policy and therefore, the additional funding required to support the transition process as identified in the *1987 Mental Health Consultation Report* was never secured. The *1987 Mental Health Consultation Report* estimated the total cost of directly replacing Riverview Hospital programs would require $73 million, with an additional $20 million to meet existing service shortfalls within that time period.[26] Meanwhile, budget reductions and reallocation of existing funding from Riverview Hospital to regional mental health services had occurred. Actions explicitly outlined in previous planning reports as not to take place without first establishing replacement regionally-based services. In the fiscal years of 1989–1990, $1.6 million was transferred from the British Columbia Mental Health Society's Riverview budget, $1.1 million of which went to the Greater Vancouver District and the Fraser Valley.[27] Despite funding reallocation from Riverview Hospital to community services, financial resources available to community services still fell well below of what was required for a successful transitioning process. In the *Impact on Municipal Services Report*, the municipalities included in their recommendations the need to secure committed funding to support the transition to deinstitutionalization and increase funding to all aspects of mental health service delivery.

In issues accompanying housing shortages were the limited availability of basic resources for living, increasing complexity of psychiatric cases, increased incidence of psychiatric criminal cases, long waiting lists for residential placements, and an overall limited response capacity of primary mental health care.[28] The inability to establish replacement mental health services in the communities with concurrent decreases in Riverview Hospital services resulted in an overburdening of community-based mental

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[26] Greater Vancouver Regional Health District, *Psychiatric Patients Living in the Community: Impact on Municipal Services*, p. 73.
[27] *Ibid.*
[28] *Ibid.*, pp. 61-68.

health services. Several of the deficiencies and issues identified by British Columbia's municipalities in the *Impact on Municipal Services* report were those that remained unaddressed from the *1987 Mental Health Consultation Report*. These deficiencies are highlighted as ongoing concerns and calls for the province to make mental health care a priority.[29]

Ongoing Complexities in Transition

An overburdening of community-based mental health services was a continuing issue in the province of British Columbia through the 1990s with little progress reported in addressing the concerns mentioned in the *Impact on Municipality Services* report in 1992. The ongoing difficulties with the transfer of patients from Riverview Hospital to the community led to a temporary suspension of Riverview Hospital's downsizing initiative that was declared by the Minister of Health in February 1996. It was indicated by the former minister that downsizing was only to resume once mental health stakeholders were satisfied that necessary mental health services were in place and would be capable of supporting the transfer of patients into the community.[30] Collaboration between the Provincial Mental Health Advisory Council (PMHAC) and the British Columbia Mental Health Society (BCMHS) established a working group to identify resources required to resume Riverview Hospital downsizing.[31]

The group's 1996 report, *Working Group to Identify the Regional Resources Necessary to Resume the Downsizing of Riverview Hospital*, echoed difficulties identified in previous evaluation reports as well as in the international literature more widely.[32] One major barrier to downsizing was the decreased funding averages when patients were transferred to the community. Another was the inability of acute and emergency mental health services to compensate for Riverview's decreased capacity; a barrier shared by deinstitutionalization elsewhere.[33] Implications of these difficulties include lack of resources for health care professionals to carry

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[29] *Ibid*., pp. 76-77.

[30] Provincial Mental Health Advisory Council, *Working Group to Identify the Regional Resources Necessary to Resume the Downsizing of Riverview Hospital Report* (Vancouver: Provincial Mental Health Advisory Council, 1996), p. 1.

[31] *Ibid*.

[32] See: note 56.

[33] Jerzy Krupinski, "De-Institutionalization of Psychiatric Patients: Progress or Abandonment?," *Social Science and Medicine* 40 (1995), pp. 577-579.; Paula Goering, Donald Wasylenki, and Janet Durbin, "Canada's Mental Health System," *International Journal of Law and Psychiatry* 23 (2000), pp. 345-359.

out their jobs, and the heavy burden placed upon families, some of whom were threatened by criminal charges in order to obtain medical care in forensic psychiatric institutions.[34] Patients without families and housing to return to often ended up homeless, an experience that was not unique to British Columbia alone.[35] This only furthered the public stigmas attached to mental illness and hesitation within communities to accept mentally ill individuals.[36]

In order to resume Riverview Hospital's downsizing in British Columbia, recommendations made by the group included improvement of existing regional services to compensate for the decreased service capacity at Riverview Hospital. The *Working Group* report identified funding as playing an important role in the successful transition of patients into the community; this issue has been identified repeatedly in previous reports as well. The *Working Group* report mentions a recently completed *Riverview Hospital Replacement Project Report in 1994* which was a result of a Vancouver mental health study that recommended the creation of a separate mental health authority with a protected budget for the development of community and hospital psychiatric services in the city. Although multiple barriers had been identified by the *Working Group* report, the inquiry also revealed a successful model of transition from Riverview Hospital to community care; the key factor being a full reallocation of funding concurrently taking place with the transfer of patients.[37] Other recommendations made by the *Working Group* reiterated deficiencies and barriers that had been identified by previous mental health planning reports. Namely, these included securing committed funding and ensuring funding follows patient transfers, improving coordination of transfers between Riverview Hospital and regional psychiatric services, ensuring that programs already in place function collaboratively to

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[34] Provincial Mental Health Advisory Council, *Working Group to Identify the Regional Resources Necessary to Resume the Downsizing of Riverview Hospital Report*, pp. 1-3.; see: note 56.

[35] See: note 55; Ellen L. Bassuk, Lenore Rubin and Alison Lauriat, "Is Homelessness a Mental Health Problem?," *American Journal of Psychiatry* 141 (1984): 1546-1550; H. Richard Lamb, "Deinstitutionalization and the Homeless Mentally Ill," *Hospital and Community Psychiatry* 35 (1984), pp. 899-907.

[36] Boschma, Groening, and Boyd, *Psychiatric and Mental Health Nursing from Past to Present*, pp. 13; Amerigo Farina, Jeffrey D. Fisher, and Edward H. Fischer, "Societal Factors in the Problems Faced by Deinstitutionalized Psychiatric Patients" in *Stigma and Mental Illness*, eds. Paul Jay Fink and Allan Tasman (Washington, D.C.: American Psychiatric Press, 1992), pp. 170-172.

[37] See: note 85.

compensate for the decreased capacity of Riverview Hospital, commitment to staff recruitment and expansion and funding of general hospital psychiatric services and specialized community services, and a greater consideration of the impacts of related social services on people with mental illness (e.g. forensic psychiatric services, eligibility for social services, etc.).

Tentative Gains of Downsizing

British Columbia's attempts at deinstitutionalizing mental health care had been met with unexpected barriers and complications. Difficulties with securing funding and lack of political commitment to the move towards community-based mental health care resulted in a fluctuating progression in the attempts to transfer patients from Riverview Hospital to their communities. Media attention to the repercussions of transitioning care of the mentally ill to their communities was negative at the outset. However, they had a positive effect in increasing public awareness of mental health issues resulting in a call for change from the public and placing great pressure on the provincial government to act. Public criticism of the merits of institutional care provided in Riverview Hospital arose and resulted in the British Columbia Ombudsman's inquiry into operations at Riverview Hospital.

The document *Listening* which examined details of administrative operations and services provided at Riverview Hospital was produced by the office of the British Columbia Ombudsman in 1994. The *Listening* report involved participation of community stakeholders, patients' families, and former patients themselves as participants in the inquiry process.[38] The *Listening* report questioned whether current practices at Riverview Hospital were outdated and identified a number of other deficiencies in administration and therapeutic services provided by the institution. *Listening* gave recommendations for improvement of therapeutic services at Riverview just like the recommendations made by previous mental health service reports. In addition, *Listening* highlighted progress that had already taken place at the institution. This included a charter of patient's rights developed at Riverview Hospital; a progressive step in mental health care in the province. Elsewhere, increasing mental health activism and involvement of former patients in advocacy groups

[38] British Columbia Office of the Ombudsman, *Listening: A Review of Riverview Hospital* (Victoria, B.C.: Office of the Ombudsman, 1994), pp. i-ii.

also occurred as one response to deinstitutionalization attempts.[39] Alongside the commitment to protecting patients' rights while institutionalized, *Listening* made explicit its adoption of the Psychosocial Rehabilitation (PsR) Movement as an approach to treatment of mental illness. PsR is a multidisciplinary approach which acknowledges that treatment extends beyond chemical therapy and places emphasis on developing patients' social and vocational skills.[40] In line with Wolfenberger's concept of *normalization*, PsR focused on enabling an individual to develop to their fullest capacity in order to reintegrate themselves back into the community.[41]

Global Comparison

The movement towards deinstitutionalization in British Columbia was one of many attempts taking place in the late twentieth century in several countries throughout the globe, and its struggles resonated with similar challenges experienced elsewhere.[42] Jones' study examining mental health care reforms in Britain and Italy, for example, provides a basis for comparison for British Columbia's progression through the deinstitutionalization process.[43] The cities of Sheffield in the United Kingdom and Verona in Italy, like British Columbia, saw a prolonged process of decentralization of mental health services. For example, national policies to close down centralized mental hospitals were introduced to Britain and Italy in 1962 and 1978, respectively. However, neither locale saw any hospital closures until the 1980s and remained in periods of transition well in the mid-1990s. Furthermore, the difficulties encountered by these cities include the lack of coordination between different levels of mental health services, lack of legislative commitment to mental health reforms, issues with funding and community-based

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[39] Donald J. Scherl and Lee B. Macht, "Deinstitutionalization in the Absence of Consensus," *Hospital and Community Psychiatry* 30 (1979), pp. 599-604; Nancy Tomes, "The Patient as a Policy Factor: A Historical Case Study of the Consumer/Survivor Movement in Mental Health," *Health Affairs* 25 (2006), pp. 720-729.

[40] British Columbia Office of the Ombudsman, *Listening: A Review of Riverview Hospital*, pp. 6-5 to 6-6.

[41] Leona L. Bachrach, "Psychosocial Rehabilitation and Psychiatry in the Care of Long-Term Patients," *American Journal of Psychiatry* 149 (1992), pp. 1455-1463.

[42] See: note 56.

[43] Julia Jones, "Mental health care reforms in Britain and Italy since 1950: a cross-national comparative study," *Health and Place* 6 (2000), pp. 171-187.

mental health services that were insufficiently developed to compensate for the decrease in capacity of centralized institutions. These mirror the same issues faced by British Columbia and elsewhere and demonstrate that it was not unique in its attempts and struggles in decentralizing mental health services.[44]

Conclusions

Criticism of care provided in centralized mental hospitals combined with shifts in thought about ways to treat mental illness led to pressures to deinstitutionalize mental health care in the Western world. In Canada, the report *More for the Mind* prepared by the Canadian Mental Health Association in 1964 served as a key document that outlined Canada's approach to deinstitutionalization and subsequently influenced decentralization attempts in British Columbia. A central driving objective of the *More for the Mind* report was the *McNeel Ideal* which placed emphasis on the importance of individuals to have the ability to receive mental health services while living in and being part of their community. The following decades in British Columbia saw the development of a number of reports evaluating the state of mental health services in the province, as well as made recommendations to move towards the goal of downsizing the provincial mental hospital, Riverview Hospital, and shifting the provision of mental health care from this centralized institution to regional and community-based services.

One of the first official plans that outlined explicit steps to take in order to replace Riverview Hospital was the *Mental Health Consultation Report* in 1987 followed by the *Strategic Mental Health Plan*s of the 1990s. In the period of initial attempts to transition patients from Riverview Hospital to the communities, complications developed and multiple barriers were encountered in the process. This resulted in significant temporal lags in progression, unanticipated by the early mental health service planning reports. Both the *1987 Mental Health Consultation Report* and *1992 and 1993 Strategic Mental Health Plans* had initially proposed five-year plans for the downsizing and eventual closure of Riverview Hospital. Although decreases in the population of

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[44] See: note 56; Marijke Gijswijt-Hofstra and Harry Oosterhuis, "Comparing National Cultures of Psychiatry," in: *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches*, eds. Marijke Gijswijt-Hofstra, Harry Oosterhuis, Joost Vijselaar, and Hugh Freeman (Amsterdam: Amsterdam University Press, 2005), pp. 9-32.

institutionalized patients and closure of some buildings have taken place at Riverview, these were the results of superficial efforts such as the creation of more exclusive admission criteria and stringent rules for patient transfers. As a result, the insufficiently equipped regional general hospitals and community-based services were overwhelmed and unable to compensate for the decreased capacity of Riverview Hospital. Combined with issues such as lack of committed funding for the transition process, fragmentation of existing mental health services, and lack of legislative commitment, successful attempts at transitioning care for patients form Riverview to the communities saw many ongoing barriers. However, this was not a unique situation, as a comparison, deinstitutionalization processes in England and Italy echo similar ongoing struggles. Jone's study identifies similar barriers faced by the cities of Sheffield and Verona during their respective periods of mental health reform resulting in a temporal lag in the implementation of policies.[45]

Cultural, financial, social, and political factors acted in combination to influence the development and progression of Riverview Hospital's downsizing. Cultural influences on Riverview downsizing came in the form of negative media attention on the transition into community based care increased public attention and advocacy for mental health issues. The increased public activism brought to the forefront the need to make mental health care a priority in the province and placed pressure on the provincial government to better consider the consequences of Riverview downsizing plans in the early 1990s. The creation of a patient charter of rights at Riverview hospital and the commitment of the hospital to providing multidisciplinary care that extended beyond medication came as additional outcomes of increased patient advocacy. Financial issues had a significant influence on the progression of Riverview downsizing from the outset of deinstitutionalization plans. The inability to secure committed funding to support development of community-based mental health services in order to compensate for decreased services at Riverview hospital had a significant impact in overburdening of regional services at the time in the 1990s. The lack of social support for Riverview patients being transitioned to communities also added to the already overburdened care services. In addition, negative reactions of communities and reluctance in accepting patients into their communities furthered the stigma of mental illness. Last of all, fluctuation of political support for the deinstitutionalization process resulted in ongoing changes in policy and

[45] See: note 94.

multiple reports that reiterate similar issues in mental health services in the province.

Examination of the role of Riverview Hospital and the deinstitutionalization process in British Columbia demonstrates the complexities in the transition from institutional to community-based mental health service provision. Underestimated complexities in downsizing Riverview Hospital by the early mental health care reform plans in the late 1970s and 1980s resulted in stunted progress and the need for ongoing re-evaluations until the end of the twentieth century. Although some positives were achieved in the attempts to deinstitutionalize, examination of the process and the role of Riverview within it demonstrate that no easy solutions exist. In line with recommendations made by several reports at the end of the twentieth century, if the deinstitutionalization process is to be successful, it will require sustained political will, legislative and financial commitment, a greater consideration of the social and environmental health determinants, and careful and calculated implementation.