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**Mental Health Service Delivery in Ontario, Canada:
How Do Policy Legacies Shape Prospects for Reform?**

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Abstract

Mental health policy-making in Ontario has a long history of frustrated attempts to move from a hospital and physician-based tradition to a coordinated system with greater emphasis on community-based mental health care.

This study examines policy legacies associated with the introduction of psychiatric hospitals in the 1850s and the introduction of public health insurance (medicare) in the 1960s in Ontario; and their effect on subsequent mental health reform initiatives using a qualitative case study approach. Following Pierson (1993) we capture the resource/incentive and interpretive effects of prior policies on three groups of actors: government elites, interests and mass publics. Data is drawn from academic and policy literature, and key informant interviews.

The findings suggest that psychiatric hospital policy resulted in important policy legacies which were reinforced by medicare. These legacies explain the traditional difficulty in achieving mental health reform, but are less helpful in explaining recent promising developments that support community-based care. Current reform of the Ontario health system features the introduction of regionalized service delivery and new models of interdisciplinary team-based primary care delivery and presents an opportunity to overcome several of these legacies. The analysis suggests a pressing need to link these two initiatives to overcome system fragmentation.

Introduction

Until very recently, the history of mental health policy in Ontario, Canada has been marked by frustrated attempts to move from a path of policy development rooted in a hospital and physician-based tradition to one which places a significantly greater emphasis on community-based mental health care¹. Over the years, numerous government studies have recommended reforms consistent with these policy goals (Health Services Restructuring Commission, 1999, pp. 174-175; Ministry of Health and Long-Term Care, 1993, , 1999a, , 1999b, , 2000a; Provincial Forum, 2002):

- (i) move care from psychiatric hospitals to community mental health services;
- (ii) reduce the ratio of mental health spending for institutional vs. community-based services;
and
- (iii) create a seamless transition among the various services and settings (Canadian Mental Health Association, 2004; Ministry of Health and Long-Term Care, 1993).

Some change has been achieved since the mid-1960s. Seven of 10 provincially-owned psychiatric hospitals (PPHs) have been divested, spending on a number of community-based programs (Ministry of Health and Long-Term Care, 2004b) has increased substantially, and Assertive Community Treatment² (ACT) teams (Ministry of Health and Long-Term Care, 2004a) and Community Treatment Orders³ (CTOs) (Government of Ontario Press Releases, 2000) have been introduced. However, the proportion of spending on institutional vs. community-based mental health care still has not reached the earlier policy target of 40:60 set in 1993 despite recent increases to community-based spending (Ministry of Health and Long Term Care, 2004) and the system remains highly fragmented and difficult for consumers to navigate (Dewa, Rogers, Kates, & Goering, 2000; Health Services Restructuring Commission, 1999; Kirby, 2004b; Ministry of Health and Long-Term Care, 1993, , 1999b). Moreover, the

comprehensive recommendations of nine regional mental health implementation task forces have not been implemented.

The challenges to achieving mental health reform in the province of Ontario are by no means unique (The President's New Freedom Commission on Mental Health, 2003). Other countries such as the U.K. and New Zealand have established national bodies to oversee long-term planning and promote mental health reform efforts (Kirby, 2004a, , 2005b). A Canadian Senate Standing Committee⁴ (hereafter referred to as the Kirby Committee) report recommended the creation of a National Mental Health Commission following its review of the Canadian mental health system (Kirby, 2005b) and funding for the commission was announced in a recent federal budget (Government of Canada, 2007). The commission could have a profound impact on the mental health reform agenda, but for it or any other initiative to be successful, the dampening effect that past policies have had on mental health reform efforts must also be considered (Altenstetter & Busse, 2005; Hacker, 1998; Pierson, 1993).

The historical institutionalism literature suggests that during critical junctures, where there is significant policy change (such as the establishment of a publicly-financed health care system), decisions will be taken whose effects will result in policy legacies that can have a fundamental impact on subsequent political development (Pierson, 1993). It is important, therefore, to examine the policy-making process within its historical context because the sequence of events can influence political outcomes (Hacker, 1998).

In this paper, we examine how the legacies of two prior policies, (i) the introduction of psychiatric hospitals (then referred to as asylums) in the mid 1800s, and (ii) the introduction of medicare to the province in the late 1950s and 1960s, have influenced repeated efforts in Ontario to develop a coordinated, consumer-centred mental health system and achieve a significant rebalancing of spending from institutional to community-based care (Health Services Restructuring Commission, 1999; Ministry of Health and Long-Term Care, 1993, , 1999a, , 1999b, , 2000a; Provincial Forum, 2002) through until at least the 1990s. In light of our analysis

of policy legacies, we assess current prospects for achieving stated mental health reform objectives in Ontario.

Methodology

Case Study Approach

We use a qualitative case study approach (Yin, 2003) and define the case as “the legacies of psychiatric hospital and medicare policy and their implications for mental health reform in Ontario”. We focus on the province of Ontario because of its history of largely failed attempts to achieve widespread mental health reform and because the province is currently presented with new opportunities as part of general health system reform. We examine how well the theory explains the case and what it tells us about current reform prospects.

Conceptual Framework

Pierson’s (1993) policy analytic conceptual framework was used to guide data collection and analysis and to promote analytical rigor (Harrison, 2001). Prior policy is seen as exerting two kinds of effects – *resource/incentive* and *interpretive effects* – of prior policy on three groups of policy actors: government elites (senior politicians and bureaucrats) , interests (interest groups, professional associations, lobbyists) and mass publics (the voting public) (Pierson, 1993). Pierson suggests these effects can become self-reinforcing and become ‘policy legacies’ that affect subsequent policy-making.

The first category of resource/incentive effects refers to how policies influence the financial resources and political influence of each group of policy actors. For government elites, policy decisions determine the funds allocated to different administrative departments and the areas of expertise developed by bureaucrats, which in turn can affect their capacity to promote different types of reform initiatives. For interests, policies can confer initial privileges such as

financial benefits and access to authority or can create a strong incentive for like-minded interests to come together through an “organizing niche” such as the formation of a medical association for fee negotiations in a publicly-financed system. Initial privileges can strengthen particular interests who will lobby to defend their position when reform initiatives are considered. For the public, some policies can influence major life decisions such as where to live, or what kind of job to take. Attempts to reverse a policy upon which such decisions have been made are likely to arouse substantial protest from the public.

Interpretive or policy learning effects refer to the ways in which policies can shape the worldview of political actors and their responses to subsequent policy development. Government elites and interest groups often respond to emerging policy issues with solutions that were successful in the past. Mass publics may consistently vote for particular parties whose ideologies tend to support policies they have come to depend on.

Data Sources

We use multiple data sources (academic literature, policy documents and key informant interviews) to search for the convergence of themes, and to assess the continuing relevance of policy legacies described in historical accounts with more recent sources (Hodder, 2000). The academic literature provided insight into the history of psychiatry as a profession, the asylum experience in Ontario and mental health policy making over the period 1850 to 1988⁵. Policy documents provided more recent data on mental health policy-making in the province, especially since the release of the Graham report⁶ (Graham, 1988), which set the tone for subsequent mental health reform in Ontario⁷.

Key informant interviews were conducted with representatives of each group of policy actors identified in the Pierson model: government elites (3 informants), interests (11 informants) and the public (3 informants). Participants were selected through purposive

sampling; some were identified through the document review and the remainder through snowball sampling during the interview discussions. Key informants are coded as 'GOV n', 'INT n' and 'PUB n' for the categories government, interests and public, respectively; where 'n' identifies the respondent within the category.

The government informants had collective experience with mental health reform in the Ministries of Health and Long-Term Care, Housing, Labour, Child and Youth Services and Corrections pertaining to mental health reform issues. The provider interest key informants⁸ (psychiatry, family medicine, nursing, psychology and social work) had worked in five settings of service delivery (psychiatric hospital inpatient and outpatient, general hospital, primary care, and community mental health agency) in numerous roles (e.g. provider, manager, or policy advocate). A specific key informant was identified who could provide excellent insight to represent the public's view, and also the interests of mental health consumers and their family members, based on an extensive knowledge of the history of mental health policy in Ontario⁹. Additional insight for the public, family member and consumer interests was obtained from two government key informants who had experience working for mental health consumer organizations and from written documents.

The interviews were carried out between July 2004 and November 2005. Participants were contacted by phone or email to inform them of the project and to determine their willingness to participate. One semi-structured interview guide was developed for each group of policy actors based on the Pierson framework. Each guide asked about policy effects and probed to determine whether or not these became policy legacies over time. Disconfirming evidence for the Pierson framework was sought during the interviews. The interviews typically lasted from 45 minutes to one and a half hours. Responses were confidential and the interviews were audio-tape recorded and transcribed by a professional transcriber who signed a confidentiality agreement. Ethics approval was obtained from the McMaster Research Ethics Board.

Data Analytic Procedures

The transcripts were read through in their entirety by the primary author for an overall impression of the findings, and then reread and searched for common themes. Some themes were directly related to the interview questions and others emerged from the interviews. The 53 themes that emerged were grouped into broader categories and compared against the key elements of the Pierson framework (see Appendix). A number of health system effects that were not captured by Pierson's framework were also identified. Evidence for or against findings identified by a single source was then sought in the literature, policy documents, Hansard or press releases. We included data as an effect if it was discussed in at least two different sources. Relevant sections and quotes were presented to the key informants to check for accuracy.

Findings

The First Legacy Effects: Early Mental Health Policy and the Effects of Psychiatric Hospitals

Mental health policy in Ontario can be traced back to 1850 when Upper Canada's first insane asylum was built in Toronto (Wright, 2004). This marked the beginning of Ontario's institutionalization era¹⁰, which continued until the early 1960's (Kirby, 2004b). Prior to this, individuals with mental illness may have received custodial care from families or religious institutions, but otherwise were left untreated and frequently ended up in jail or a poorhouse (Wright, Moran, & Gouglas, 2003). The asylums were intended as a place of respite and 'moral treatment' (Kirby, 2004b), which included occupational therapy, recreation and social activities in self-contained settings often removed from large busy centres. The British North America Act of 1867 gave jurisdiction over hospitals, asylums and charitable institutions to the provinces (Leeson, 2002)..This was more broadly interpreted as health care in the early-mid 20th century

in a series of legal decisions (Choudry, 2002; Leeson, 2002). By 1891, there were four principal asylums in Ontario, located in Toronto, Kingston, London and Hamilton (Wright, Moran, & Gouglas, 2003). During this era individuals who didn't fit into the community were commonly sent to an institution (e.g. reform schools for delinquent youth, institutions for the mentally retarded, jails and other detention centres) [GOV 1].

Effects on Government Elites

The introduction of insane asylums had resource/incentive and interpretive effects on government elites. First, the sheer size of the investment in psychiatric hospitals required a large bureaucracy to support them. Across the country, more was spent on asylums over the period 1845-1902 than on prisons and other hospitals (Wright, Moran, & Gouglas, 2003).

“At the beginning of the twentieth century...75% of provincial government expenditures in Ontario were on the asylums - this was a huge amount.” [PUB 1].

Governments focused on managing the construction and operation of very large in-patient facilities to house the mentally ill over the long-term rather than on clinical aspects of policy-making, which was left to the asylum superintendents (Simmons, 1989) in each location. An important legacy was that governments developed limited capacity for strategic mental health policy making and for many years, relied heavily on advice from the psychiatric profession.

“I think psychiatrists have always had a strong role in mental health policy...there were times they had a direct influence because the Ministry operated the 10 psychiatric hospitals. Inside the hospital and the branch level there were always psychiatrists working full-time...” [GOV 3]

Asylum policy also meant mental health policy decisions were divided across government departments, such as health and public works, with often competing objectives. A legacy of these past policies has been that clinical mental health policy came to be seen as a

relatively low priority for governments and an institutional focus for mental health policy also became entrenched.

“Until the late 1950s, the mental health bureaucracy had little influence over the location, size or design of the mental institutions. Thus they took over institutions which many of them felt were unsuited to the needs of mentally ill people or to the objectives of the mental health system. Yet, because the system had functioned this way since the middle of the nineteenth century, the mental health authorities had to accept the institutions as they were and to try to tailor their policies to fit the structures.” (Simmons, 1989, p. 109).

Over time, the psychiatric hospitals came to be used as a tool for regional development and were located in underdeveloped areas which would benefit from the injection of government funds and jobs into the community. Politicians learned that the choice of where to locate asylums could be a powerful tool for generating votes (Simmons, 1989). It was easy to choose politically expedient locations because the public did not develop meaningful involvement with local psychiatric hospitals in the same way as they did for general hospitals (Abelson, 2001, p787).

“Nobody wanted them...The psychiatric hospitals were like prisons...they weren't located to be 'the community's institution'. [Instead,] they were put where it was politically attractive for any particular government usually.” [GOV 1]

Effects on Interests

The asylums had important resource/incentive effects on professional interests. First, they directly lead – “led,” not “lead” -- to the development of psychiatry as a profession, which did not exist before the end of the 18th century (Shorter, 1997). As Wright (2004) stated in a speech on the history of mental health policy of Ontario ... “The asylum created the profession”.

“Psychiatry claimed guild status on the grounds that running an asylum in a therapeutic manner was as intricate a science as chemistry or anatomy (Shorter, 1997).

Second, public ownership gave substantial power and authority to psychiatrists in policy-making in Ontario. The superintendent was in charge of each asylum and reported directly to the Ontario Department of Health (Simmons, 1989). Not only did psychiatrists have direct power

in decision-making, the geographic remoteness meant the public was generally not aware of what went on in the asylums (Simmons, 1989, p. 218):

“...what happened in the mental hospitals and in the psychiatric profession in general was determined almost exclusively by a small circle of decision-makers: psychiatrists, the superintendents of the asylums, and those few government officials concerned with mental health policy. ... on the whole the daily life of mental patients in asylums passed in isolation from the media and certainly in isolation from the political realm.”

For consumers and family members, the asylums contributed to the stigma of mental illness by removing individuals with mental illness from the community (Arboleda-Florez, 2003). Patients residing in a distant asylum, away from the support of family and friends were unable to come together to develop an effective lobby and the stigma of having a mentally ill family member kept families from forming a lobby on behalf of patients [PUB 1]. This meant that from the early days, no consumer- or family-based mental health interest group developed among the general public.

“...that doesn't mean that families weren't concerned about the level of care at these places, but the situation was such that it was difficult for them...there was no citizen's movement for them to be part of ...” [PUB 1]

The difficulty faced by family members continued over time. Families have tended to lobby for greater treatment. They have protested hospital bed closures, pushed for community treatment orders and for community support services.

“...as family members in the mental health movement...they feel quite left out in Canada...they feel they will have the family member on their hands again with very little community support to help them ... and they're right because they haven't had the kind of respite care or the kind of support care that is now beginning to be available with the ACT team.” [GOV 1]

The Canadian National Committee for Mental Hygiene¹¹ was a professionally-based interest that lobbied on behalf of the rights of the mentally ill. Founded by a psychiatrist (Dr. Clarence Hinks), it comprised of a small number of psychiatrists, physicians and a few nurses (Canadian Mental Health Association) (CMHA), but did not have the support of the majority of the profession.

“... the CMHA up until the 1960s was not a citizens’ movement. It was a voluntary organization, but professionally-led with a corporate board...even Clare Hincks had difficulty getting the attention of psychiatrists and the medical profession on a lot of issues, including prevention.... [PUB 1]

Other interests emerged over time, and became important whenever there was discussion of closing psychiatric hospitals. These included the communities affected, which would lobby to keep the institutions and associated jobs in the communities; and the Ontario Public Service Employees Union (OPSEU), which lobbied on behalf of its members (Simmons, 1989) advocating for the rights of the mentally ill and the need for greater spending on mental health care (National Union of Public and General Employees, 2002; Ontario Public Service Employees Union, 1998a, , 1998b, , 2002).

“Many of those interviewed mentioned that one of the principal reasons for the government’s reluctance to contemplate closing the psychiatric hospitals was fear of the political backlash that would result from the damage inflicted on local economies and of resistance from the more than 7,000 staff members who belonged to the Ontario Public Service Employee’s Union” (Simmons, 1989 p. 249).

Effects on Mass Publics

The asylums ‘took the problem away’ from citizens in the community and relieved a major burden for family members who had struggled with caring for someone with mental illness.

“The public were so fearful and rejecting of the fact that mental illness was a common illness that to the general public, getting people out of the community was quite acceptable... It was all part of the era, if you can’t figure it out and you think it’s a bit dangerous - remove it and send it someplace else.” [PUB 2]

The needs of the mentally ill in far away asylums were much less visible to the public than other local needs.

“The public other than the public that are immediately concerned, the family members and so on are likely going to say well we’ve got better things to do with our money, let’s fix the road...these people, nobody seems to know how to fix them anyway...” [PUB 2]

There were also important interpretive effects for the general public. Since only those with more severe disorders were sent away to asylums, the public came to recognize mental

illness only at its most extreme. Although those with more moderate illness remained in the community, they were not necessarily recognized as having a mental illness.

“People didn’t think they had the mentally ill around them - one out of five of them. They would have imagined, I’m sure, that the relative who was around them and slightly depressed wasn’t even slightly like the person who was wild and wooly and out of their mind and in the psychiatric hospital...” [PUB 1].

Over time, lack of familiarity meant the public became less comfortable around people with mental illness (Arboleda-Florez, 2003). This prevented mental health from developing “the same sort of base of public consumer support” [INT 3] needed to support reform that would bring treatment of the mentally ill back into community settings.

Failed Reform Efforts and Psychiatric Hospital Legacies

Over time the provincial psychiatric hospitals became increasingly overcrowded and the original intent of providing moral treatment was lost (Kirby, 2004b; Simmons, 1989). Several attempts were made to adopt a community-based public health approach to preventing and treating mental illness, but these had limited success (Simmons, 1989). For example, in 1930, mobile mental health units in the community were introduced, but they were under-funded and soon overwhelmed by the demand and discontinued. Again, in 1946, the Deputy Minister of Health (McGhee) tried unsuccessfully to put forward a comprehensive community care plan that would create ambulatory mental health care in community public health units.

The difficulty of moving to community-based care can be understood in light of the policy legacies of psychiatric hospitals. First, government elites had developed considerable bureaucratic capacity and expertise in running large institutions and had far less experience in community-based programming. The Ministry had become dependent on the psychiatric community in policy-making and without a consumer- or family-based mental health interest group, the psychiatric profession was clearly the dominant interest. Most psychiatrists were reluctant to switch to an unproven, less prestigious and potentially less-lucrative community-

based system (Simmons, 1989). Further, from a political perspective, there was more to be gained in continuing to build large institutions in remote areas, than to have much smaller investments in community-based programs spread across many municipalities. There was also a risk that if the community-based programs did not adequately support the mentally ill in the community, there would be considerable backlash from the public, who were no longer accustomed to interacting with the mentally ill. In light of these legacies, it was not surprising that community-based care reforms enjoyed only limited success.

A Second Legacy and its Effects: The Introduction of Medicare

Soon after McGhee's attempt at widespread reform, the federal government introduced a series of incentives in support of a public health insurance system. In 1948, the federal government introduced the Dominion Health Grants to assist the provinces in developing and extending health facilities in specific areas. In the case of mental health, \$5 million of federal funding could be matched with provincial funds to support the development of general hospital psychiatric units (Hastings, 1999). This was followed by the Hospital Insurance and Diagnostic Services (HIDS) Act in 1957 and the Medical Care Act in 1966 (Health Canada, 2004) which offered federal cost-sharing for provinces and territories that operated a universal insurance program for hospital and physician services respectively. In response to this federal offer, the province of Ontario enacted public hospital insurance in 1959 and medical care insurance for physician services in 1969. The combined health insurance program in the province came to be known as the Ontario Health Insurance Program (OHIP).

During the federal-provincial negotiations which preceded the introduction of HIDS, (Taylor, 1978, p. 135) the Ontario government pushed "...to remove, as far as possible, any artificial financial or administrative distinctions between acute, convalescent, or chronic care, or care for mental illness and tuberculosis"; however, the federal government indicated that its

“contribution would not be made in respect of care in mental hospitals or tuberculosis sanatoria” because patients in the psychiatric hospitals were already covered by provincial general revenues (Kirby, 2004b; Simmons, 1989). The discovery in the late 1950s of new medications that showed promise in the treatment of mental illness increased acceptance of the idea of community rather than long-term psychiatric hospital care (Kirby, 2004b), but at the same time, reinforced the importance of physicians and general hospitals as modes for the delivery of community treatment, rather than broader community support programs.

Effects on Government Elites

The matched federal funding for general hospital psychiatric units under the Dominion Mental Health Grants and OHIP encouraged provincial governments to move care from psychiatric hospitals to general hospital psychiatric units (Simmons, 1989).

“The Dominion mental health grants started the shift away from the old asylums, but it wasn’t done for therapeutic reasons, as much as for fiscal reasons...these were 50 cent dollars. If you set up a psychiatric unit in a general hospital, you could get up to 50% of your cost paid...” [PUB 1]

Not only did inpatient units expand, but medicare encouraged the development of many community-based services in general hospital psychiatric outpatient clinics, which might otherwise have been offered in local public health units or community agencies. This reinforced the Ministry’s traditional institutional focus for mental health care (Rochefort & Portz, 1993, pp. 68-69).

“This policy led to rapid expansion of general hospital psychiatric units, as well as the promotion of community-based services under the organizational umbrella of general hospitals...In Ontario the decision was made to give general hospital psychiatric units a pivotal role in the deinstitutionalization process by making them the center of both short-term inpatient care and outpatient services”.

Since provincial psychiatric hospitals were excluded from OHIP, there was split responsibility within the Ministry of Health for policies pertaining to psychiatric and general

hospitals. Separate bureaucratic structures posed a challenge to coherent policy-making (Rocheffort & Portz, 1993; Simmons, 1989).

“This administrative intricacy can be explained, at least in part, by the long history of public mental health care in Canada, which had already developed a distinct array of provincial services and facilities before Medicare arrived.” (Rocheffort & Portz, p. 75).

Separate funding streams for general and psychiatric hospitals meant publicly owned psychiatric hospitals were subject to government cost control measures during periods of fiscal restraint that did not apply to the general hospitals. Without a publicly-based mental health lobby, governments learned that it was easier to cut mental health spending than general health care spending which reinforced a lower priority given to mental health policy.

“Because they were part of the government system, the government would put constraints on itself, in terms of employment spending freezes, etc. that would apply to the PPHs because they were part of the Ministry. Those policies were never put in place for the broader public sector, like the public [general] hospitals, so ...the [general] hospitals were always better funded, better staffed, in terms of equipment, and in terms of physician upgrades because they weren't under the Ministry....The government would be giving 8% increases to [general] hospitals that never applied to PPHs.” [GOV 2]

Even within hospitals, funds intended for psychiatric units would frequently end up being allocated to acute care services because:

“... the hospitals didn't get a lot of reward out of dealing with seriously mentally ill people...they may have been in for the 14th time and not doing so well... money targeted for mental health ... would end up being deployed for more surgeries or something...”[GOV 1]

Effects on Interests

OHIP covered hospital services regardless of provider type, and physician services regardless of delivery setting. This divided the mental health professional interest and privileged physicians over other mental health providers. For psychiatrists, OHIP offered the prospect of open-ended fee-for-service billing and professional autonomy in private practice rather than salaried employment in a government-run institution or community-based mental health organization. It

placed few restrictions on the type or amount of mental health care that could be provided (Goering, Wasylenki, & Durbin, 2000).

“unlike the psychiatric hospitals where they were employed exclusively on a salaried basis, individual psychiatrists in general hospitals could combine private practice with hospital work, as well as work in a more congenial, prestigious and professionally exciting atmosphere than in the psychiatric institutions” (Simmons, 1989, p. 130).

Physicians became a powerful force in health policy-making through the Ontario Medical Association’s interaction with government during the OHIP fee negotiation process (Hutchison, Abelson, & Lavis, 2001; Tuohy, 1999). Physicians became direct participants in health policy-making through joint management committees (Hutchison, Abelson, & Lavis, 2001).

“the majority of physician services are covered under Medicare, and because the government has a huge financial investment in those services, to a large extent the role that the medical profession might play in the development of public policy is ... in proportion to the government’s investment ... so without a doubt physicians are typically at most forums....” [INT 3]

Other mental health providers did not have the same access to policy-makers, which was a major problem during times of fiscal restraint. Psychologists were hit particularly hard during periods of hospital budget cuts. Unlike physicians, whose services were paid for by OHIP, psychologists’ salaries were paid from the hospital budget [INT 3, INT 4, INT 8, INT 11]. They were typically the first group to be let go from the hospital sector. OHIP coverage for psychotherapy delivered by family physicians, but not by psychologists (who typically had more extensive training in these techniques), was a point of conflict between the mental health professions [INT 3].

“Mental health professions such as psychology, social work and occupational therapy, unlike nursing and medicine, do not have equal and effective access to the highest levels of decision making...This lack of voice results in policy decisions being taken at the highest levels that ignore or do not effectively take into consideration psychological health, mental health, mental illness and addictions. The consequences can be severe in terms of inclusion or exclusion in short- and long-term planning, resource allocation, and so on” (Canadian Psychological Association, 2003, p. 16) .

Medicare produced powerful interpretive effects for the various mental health provider interests. Physicians learned to protect the OHIP funds from encroachment by other provider groups [INT 1] and to lobby against any reforms that might reduce existing privileges. Psychologists learned to operate in private practice [INT 2, INT 3] outside the public system.

“Physicians, the OMA, Ontario Medical Association, as a union for the physicians is extremely powerful as a group - anything that encroaches on the fee-for-service pot ... they’re very much against. And any other profession that may want to go fee-for-service, they’re very much against because ... they see that they’ll end up ... encroaching on their own pot... I think that’s in part why you don’t have these other professions being able to bill OHIP.” [INT1]

Without a unified interest across professions, the mental health system became more fragmented. Physicians focused on hospital and primary mental health care in private practice and had less interaction with public health units or community-based services.

Effects on Mass Publics

First dollar coverage under medicare gave the public a strong financial incentive to see their family physician for mental health problems rather than pay out of pocket to see a psychologist or social worker in the private setting. The public put up strong resistance to attempts to move away from this policy, including proposals to de-list family physician psychotherapy (Rochefort & Portz, 1993).

“People come and talk to their doctor about what to do about anything... When they [the government] tried to limit GP psychotherapy, they were personally attacked.” [INT 4]

Medicare also led to a two-tier system of psychiatry, as the public found general hospital care to be less stigmatizing than care in a psychiatric hospital. This led to increased general hospital utilization by individuals with less serious mental illness, some of whom might never have used a psychiatric hospital (Simmons, 1989).

“... general hospital psychiatric units tended to be used on a voluntary basis by middle and upper income individuals who were referred to them by private psychiatrists, while psychiatric institutions continued to provide services to poorer

individuals and to those who had been admitted involuntarily. This, in effect, created a two-tiered system of mental health care: the general hospitals and psychiatric institutions served groups of patients that rarely overlapped” (Kirby, 2004b, p. 141).

Later, with downsizing of psychiatric hospitals and shortages of psychiatrists, those with the most serious mental illness primarily used those community-based services that were available (Kirby, 2004b; Simmons, 1989).

Community Care since the Introduction of Medicare

As discussed, the introduction of medicare meant a shifting of services to the general hospital setting and to physicians in primary care. During the 1960s and early 1970s, many chronic patients were also shifted from psychiatric hospitals to other long-term care facilities. Without community support services, many were discharged to the community and suffered frequent relapse and readmission to psychiatric units in the general hospitals, and some ended up homeless or in jail. By the late 1980s there were increasing calls for greater spending on community services and some incremental change was achieved. By the early 1980s about 400 community-based services had been developed in Ontario which were a mixture of services of small non-profit agencies and others organized under the Canadian Mental Health Association (CMHA) (Graham, 1988) that offered residential services, vocational rehabilitation, income support, and case management programs to coordinate services and provide support and rehabilitation to individuals and their families (Kirby, 2004b). However, only three percent of provincial mental health budgets in Canada were allocated to community supports by 1990 (Goering, Wasylenki, & Durbin, 2000).

System Fragmentation and the Graham Report

In 1988, the release of the Graham Report (Graham, 1988) was seen as marking a new phase in mental health policy development in Ontario. The Graham report was unique compared to

earlier reviews of the Ontario mental health system because of its widespread consultation with mental health interests throughout the province, which for the first time included consumers and family members. Like earlier reform efforts, it called for a rebalancing of services with much greater emphasis on community supports, but also focused on the need to develop an integrated, coordinated mental health system. The report pointed to lack of coordination in the development of community-based and hospital-based programs (Graham, 1988) and a need for psychiatrists to become involved in the community sector to help bridge the gap between the two systems.

It pointed to the fact that community and hospital based programs and primary mental health care services tend to serve different groups of patients and involve different groups of providers. Patients with serious mental illness are typically treated in either the provincial psychiatric hospitals or to a lesser, but more recently growing extent in community-based services, while those with more moderate mental illness are typically treated in primary care (Dewa, Rochefort, Rogers, & Goering, 2003) Physicians work largely in private practice or the hospital setting, psychologists work largely in private practice, and social workers and nurses typically work in hospital and community settings. For patients and their families, confusion over where to access needed services and lack of coordination have made navigating the system one of several important barriers to access reported in the literature (Kirby, 2005a).

Following the Graham report, in 1991, the Ontario government made “a significant funding commitment to consumer groups” (Goering et al., 2000, p.354) by allocating over \$3 million to the Consumer Survivor Development Initiative. A consumer-based interest developed, and spending on community mental health programs increased. Until recently, however, spending on community mental health has not kept pace with overall mental health spending (Goering, Wasylenki, & Durbin, 2000; Kirby, 2004b; Rochefort & Portz, 1993; Simmons, 1989). The bulk of care is still hospital-based rather than the community and the system remains highly fragmented (Swenson & Bradwejn, 2002).

A subsequent report, entitled “Putting People First” stressed the need to overcome system fragmentation:

“The mental health system in Ontario is not really a ‘system’. It is a collection of different services, developed at different times and managed in different ways. Although this is gradually changing, there is little coordination among the different services: the provincial psychiatric hospitals, the general and specialty hospital, the community mental health programs and OHIP-funded services. In fact, these services have been described as the four solitudes of mental health.” (Ministry of Health and Long Term Care, 1993, p. 5).

Despite subsequent policy documents including nine regional mental health implementation task forces, (Ministry of Health and Long-Term Care, 1998, , 1999a, , 1999b, , 2000b) all calling for a pressing need to act, and with general agreement on what actions to take, the challenge, as reflected in the title of one government report, was to ‘make it happen’ (Ministry of Health and Long-Term Care, 1999a).

Discussion

Our analysis suggests that psychiatric hospital policy resulted in three legacies that have prohibited action toward widespread mental health reform: (i) it set the treatment of mental illness ‘apart’ from the treatment of physical illness and gave it a generally lower priority in policy-making; (ii) it entrenched a hospital-based focus for mental health treatment; and (iii) it gave psychiatrists a privileged position in clinical decision-making and mental health policy.

Medicare reinforced separate treatment and lower priority for mental health policy by excluding psychiatric hospitals from the public insurance scheme. It split decision-making across administrative units within governments which weakened the capacity of mental health administrators to press for sweeping reform (Rochefort & Portz, 1993). Medicare also continued the emphasis on hospital rather than community care, by offering coverage exclusively for hospital and physician services. Finally, medicare continued to privilege psychiatrists and physicians more generally over other mental health providers, by giving physicians clinical

autonomy, guaranteed public payment for services provided and special access to government during fee negotiations which strengthened their voice in policy-making (Simmons, 1989). Physicians were therefore unlikely to support any movement toward community-based services which would threaten their existing privileges. There was no broadly-based consumer or family lobby in the province until the 1980s, and the general public and union voices were much louder when it came to decisions about closing psychiatric hospitals than about promoting community-based service delivery approaches. These effects have served to sustain the fragmented mental health care system that exists in the province.

Incremental Changes Below the Surface and Recent Developments

The Pierson framework helps to explain the enduring nature of mental health care policy in the province and the failure to achieve a widespread shift toward community-based care; however, it does not account for the incremental movement toward community-based care within a system that continues to be dominated by hospital and physician services. Recently, historical institutionalism frameworks have been praised for their usefulness in explaining the enduring nature of policies, and at the same time, the emphasis on widespread change during critical junctures has been criticized for ignoring incremental change during the path-dependent periods, (Oliver & Mossialos, 2005; Peters, Pierre, & King, 2005; Schlesinger, 2005) and for masking the “dissensus that may exist beneath the surface of a program... that may act as a force for change” (Peters, Pierre, & King, 2005) (p. 1275

While sweeping reform has not been achieved and the proportion of spending on community-based services remains below the earlier target set in 1993 in Ontario, there have been important changes that may set the stage for new efforts at reform (Peters, Pierre, & King, 2005). These include the development of a stronger base of public support for mental health reform and the introduction of intensive community treatment approaches, such as ACT teams

and CTOs since 2000. In their critique of historical institutionalism, Peters and colleagues suggest that institutions embody prevailing ideas and that changes in ideas may be sufficient motivation for incremental change to occur (2005). A theme which arose in the interviews was that there has been a fundamental shift in ideas about the mentally ill over the last 10 years, which has lessened stigma and promoted acceptance of mental illness among the general public [PUB 1, GOV 1, GOV 3]. This is attributed in part to an expanded consumer movement, but more directly, to the willingness of a number of key public figures to speak out about personal experience of mental illness. This growing public acceptance may have been a key enabler of the reforms that have been achieved.

Policy Implications in Light of Current Opportunities

There are a number of signs of an emerging opportunity for comprehensive mental health reform in Ontario. Recent commitments to increase community mental health funding were a prerequisite for further bed transfers or reductions from the psychiatric hospitals (Ministry of Health and Long Term Care, 1999). Federal Accord dollars have been channeled into community mental health program expansion and Service Enhancement payments are targeted for those with mental illness and legal involvement. Further, the province is currently undergoing overall health system reform including the introduction of Local Health Integration Networks (LHINs) and Family Health Teams (FHTs). LHINs will mean regionalized service delivery and local coordination of care, which is an important theme in mental health reform recommendations (Ministry of Health and Long-Term Care, 1993, , 1999a, , 1999b, , 2000a; Provincial Forum, 2002) and has been shown to be a successful approach to shifting care from psychiatric hospitals to community based services in some regions (Health Systems Research Unit Clarke Institute of Psychiatry, 1997; Kirby, 2006). FHTs offer opportunities to develop multidisciplinary teams of primary health care providers which integrate non-physician mental

health specialists into the primary care team. What do policy legacies tell us about the opportunity to advance more widespread mental health reform in light of these initiatives?

First, the introduction of LHINs may help to overcome the legacy of fragmented mental health policy-making across different central government departments that weakened the capacity to press for reform. Moving operational policy decisions to the local level may allow for greater coordination of mental and physical health policy in each LHIN.

Second, a regionalized approach may engage the public in local decision-making and help to overcome the legacy of limited public interest in mental health policy. With greater public interest and a regionalized approach, local decision-makers may have better success in reallocating resources from institutional to community-based care in a manner that is politically acceptable to the public.

Third, FHTs are being introduced in a way that respects the traditional clinical autonomy and the dominant role of physicians while simultaneously offering a way to include non-physician providers within a publicly-financed primary care system that features different approaches to physician remuneration such as blended capitation. Moving some physicians away from fee-for-service remuneration may reduce their concern with protecting these funds and promote willingness to work together with other mental health provider groups. This may help to overcome the legacy of a divided provider interest and promote overall system integration.

Despite these positive attributes, policy legacies also suggest several challenges to developing a coordinated mental health system through current reforms. First, the legacy of separate treatment and lower priority for mental health care may continue within the LHINs. Community-based mental health programs are diverse and traditionally have had low priority in mental health policy-making. Their success will depend critically on the ability to engage the interest of the local public. If local public support does not materialize, it may be necessary to institute separate authorities to ensure mental health issues remain on the agenda and to find

ways to “ring-fence” funding for community-based programs to ensure it is not lost within overall local health care system spending (Kirby, 2004a).

Second, LHIN policy and primary care policy have been developing quite separately with little administrative coordination within government for planning, funding flows and service delivery. This may be a legacy of and reinforce the separation of primary care from the rest of the health care system and impede efforts to break down the four solitudes (the provincial psychiatric hospitals, the general and specialty hospitals, the community mental health programs and OHIP-funded services) of mental health delivery. At best, three of the four traditional settings of mental health service delivery will be integrated (psychiatric hospital, general hospital and community-based care within the LHINs), and there may be greater collaboration across provider groups within primary care through the FHTs. However, the division between primary care and community/hospital care will likely remain in the transformed system, with moderate mental illness treated in primary care and more serious mental illness in institutions and/or community-based care¹². It remains unclear how physicians will be attracted to work in conjunction with community-based services.

Past experience suggests that separate administrative structures in government may be reflected in separate silos of health care delivery. This would be a major impediment to developing a coordinated system that can be easily navigated by the patient and over time funding for one service delivery area may outstrip another. Early attention needs to be given to integrating the FHT and LHIN reform initiatives, both from a policy development and from a delivery standpoint. There is a need for a primary care/LHIN coordination function within the Ministry and a way to ensure funding flows are appropriately balanced between the various parts of the system. At the delivery level, there is a need for each delivery site to link into a central LHIN coordination function to direct patients to available services and manage the inventory of diverse mental health services within each LHIN to support the development of a consumer-centred coordinated mental health care system.

Conclusion

Policy legacies can prevent widespread change from occurring when policy windows open. Nonetheless, changing ideas can lead to incremental change which can support reform at a later critical juncture. Our examination of policy legacies suggests four important legacies of psychiatric and medicare policy: (i) the separation of mental and physical health policy-making in government and the lower priority given to mental health policy-making; (ii) the entrenched emphasis placed on hospital and physician-based mental health care; (iii) the relative strength of voice of physicians in policy-making compared with other mental health providers; and (iv) the lack of public interest in mental health policy and service delivery. Together these have resulted in the current fragmented delivery system and the difficulty in shifting the proportions of spending from hospital and physician toward more community-based care.

While widespread reform has proved elusive to date, below-the-surface changes have occurred, supported by changing public attitudes, that may support mental health reform as part of ongoing general health system reform in the province of Ontario. It will be important to monitor whether the implementation of a regionalized system further promotes public interest in mental health policy. If this shift in public interest does not occur, a mechanism to ring-fence funding for mental health services in each region will be required. It will also be critical to coordinate funding flows for LHINs and primary care delivery to achieve a balanced mix of mental health services and to coordinate mental health service delivery across settings. This suggests a need for integrated LHIN/FHT planning at the provincial level, and a mental health system liaison function within each LHIN and delivery site. Paying attention to these issues now will help promote the long-sought rebalancing of institutional and community care in Ontario and the development of a more integrated mental health system in each region of the province. Failure to do so will reinforce policy legacies dating back to the 1850s and 1950s that have kept mental health reform “beneath the radar screen” of policy-makers (Rochefort, 1999) and once

again thwart the development of a coordinated, consumer-centred and rebalanced mental health system in Ontario.

Appendix

Legacies of Provincial Psychiatric Hospitals and Medicare Policy on Mental Health Service Delivery

Part A: Psychiatric Hospital Legacies

Effect/Group	Government Elites	Interests	Mass Publics	Health System
Resource and Incentive Effects	<ul style="list-style-type: none"> • administration develops operational focus, less capacity for strategic mental health policy making (Simmons, 1990, GOV 3) • A large but divided bureaucratic Infrastructure developed around psychiatric hospital system (Simmons, 1990, p. 244, PUB 1) • Divided policy objectives across government departments (Simmons, 1990, GOV 2, GOV 3) • Psychiatric hospitals used as tool for regional development (Simmons, p. 244, GOV 1) 	<ul style="list-style-type: none"> • Psychiatry developed as a separate profession (Wright, 2004, Shorter, 1997) • Psychiatry dominant in mental health policy and delivery (Shorter, p. 65 Simmons p. 218, INT 7, INT 8, GOV 3) 	<ul style="list-style-type: none"> • Asylums removed 'problem' in the community [GOV 2] • Communities came to depend on large psychiatric institutions for funding and employment. [Hansard35-1/1254a, (OPSEU, 1998), Simmons, p. 182, 249] 	<ul style="list-style-type: none"> • Community infrastructure did not develop (Simmons, 1990, PUB 1, Kirby, 2004) • Overcrowding develops (Simmons, 1990, PUB 1, Kirby, 2004)
Interpretive Effects	<ul style="list-style-type: none"> • Government has minor role in clinical aspects of mental health policy [(Simmons, p. 218, 219), Wright et al., Sussman, INT 6] • Ministry of Health develops institutional focus [(Simmons, p. 174-175, Hansard36-1/1208b)] • Mental health policy recognized as a Low priority for the public [INT 3, GOV 2, (Rocheffort, 1999), (Simmons, p. 202, p. 233, 252), (Kirby:1, p. 51-52), (OPSEU, 2002, p. 16)] 	<ul style="list-style-type: none"> • Policy decided in a 'closed system' involving government and psychiatric profession, problems not recognized by public (Simmons, 1990, GOV 1). • No populist mental health interest develops [PUB 1, GOV 2] • Professional group advocates for consumer interest, but does not have support of the profession as a whole. [PUB 1, GOV 1] • families, unions, communities resist psychiatric hospital closures [(Hansard, 36-11254.a),(OPSEU, 1998), (OPSEU, 2002, App.2,) (Simmons, p. 182, 249)] 	<ul style="list-style-type: none"> • Separate Treatment Fosters Stigma, lack of understanding (Arboleda-Florez, 2003, INT 3) • Public not interested in mental health policy [GOV 2, PUB 1] 	<ul style="list-style-type: none"> • Treatment of mental health problems is separate from treatment of physical health problems (Sussman, 1998, Kirby, 2004).

Part B: Medicare Policy Legacies

Effect/Group	Government Elites	Interests	Mass Publics	Health System
Resource and Incentive	<ul style="list-style-type: none"> • Separation of psychiatric hospitals from the rest of the health care system [INT 7, (Rocheftort, 1993, p. 75 (Simmons, p.250), Sussman, 1998, Taylor, 1978)] • Incentive to expand psychiatric units in general hospitals to benefit from federal funding; general hospitals and physicians key role in service delivery with deinstitutionalization [(Kirby:1, p. 139,p. 197), (Rocheftort & Portz, p. 68,69), Simmons, 1989, PUB 1)] • Divided bureaucratic structures(Simmons,1989; Rocheftort & Portz, 1993) 	<ul style="list-style-type: none"> • Financial and political power to physician groups. - FFS attractive to physicians [INT 1, INT 3 , INT 4, (Simmons, p. 130, INT 8, INT 11)] - Access to authority through fee negotiations and joint management committees [INT 1, INT 3, INT 4, INT 8, CPA, 2003, p.16, Hutchison, 2001, Tuohy, 1999] - Clinical autonomy (Goering, 2000, Simmons, 1989) • Expanded mental health role for family physician, emergence of GP psychotherapy emerges (Rocheftort, 1993, p.76, CPA, 2001, p.11 brief check which, INT 9) • Lack of voice in policy-making for non-physician mental health providers (CPA, 2003, INT 3, INT 4) 	<ul style="list-style-type: none"> • Insurance encourages public to see GP and general hospitals as primary providers of mental health care (Rocheftort, 1993); [INT 1, INT 8, INT 9, INT 11] 	<ul style="list-style-type: none"> • Psychiatric in-patient and out-patient care expands in general hospitals. (Simmons, 1990, Kirby, 2004, GOV 1, GOV 2] • Different rules for different providers in different settings [INT 1, INT 2, INT3, INT 7, INT 8, GOV 2 Rocheftort, 1993] • Emergence of two-tier psychiatry: serious mental illness treated in psychiatric hospital or community-based system [Kirby:1, 2004, p. 141), (Simmons, 1989 p. 203), INT 8] • Exodus of Psychologists to the Private Sector [INT 2, INT 3, INT 11, (Kirby:1, p. 161), (CPA, 2003, p. 9 – 11), (CPA 2001, p. 9), (OPA, 2002), (OPA, 2003), (Rocheftort, 1993)] • Under funding of psychiatric vs. general hospitals (GOV 2, GOV 1)
Interpretive Effects	<ul style="list-style-type: none"> • Ministry retains institutional focus (Hansard, Simmons) • Easier to cut mental health than general health funding. [Simmons, p. 116, GOV 1, GOV 2, INT 4, INT 5, INT 6, INT 11, (OPSEU, 2002, p.63)] 	<ul style="list-style-type: none"> • Divided professional interest (CPA, 2003, INT 7) • Physicians protect fee-for-service funds [INT 1, INT 6, INT 7, INT 10] • Psychologists learn to operate outside public system [INT 2, INT 3, INT 10] 	<ul style="list-style-type: none"> • Public support for GP psychotherapy [INT 4, Hansard] 	<ul style="list-style-type: none"> • Different categories of patients use psychiatric vs. general hospitals [Simmons, 1989, p.74, 203, Kirby:1, p. 141] • GP and general hospital are identified as first line of treatment (Dewa, 2000, INT 4) • Fragmented system {Kirby, 2004, Rocheftort, 1993}

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¹ Depending on local needs, community mental health care may include a variety of programs and services, such as subsidized and supportive housing, case management, treatment through hospital outpatient and assertive community treatment (ACT) teams, peer support and self-help programs, crisis services, employment and court diversion programs. It is typically provided by medical and non-medical providers whose combined expertise can address the wide range of needs of individuals with serious mental illness and in doing so, provides many of the services that were traditionally offered in the psychiatric hospital setting.

² Assertive Community Treatment Teams serve persons with the most serious mental illnesses; feature multidisciplinary staffing with at least one peer specialist; low staff-to-client ratios and client-centred individualized intensive services offered on a 24-hour on call basis. (Ministry of Health and Long-Term Care (2004).

³ A CTO may be issued by a certified physician to require a person who suffers from serious mental disorders with a history of repeated hospitalizations to follow community-based treatment or care and supervision that is less restrictive to the person than being detained in a hospital environment. (Ministry of Health and Long-Term Care, 2000).

⁴ The Senate Standing Committee on Social Affairs, Science and Technology chaired by the Honourable Michael J. Kirby (the Kirby Commission).

⁵ We searched Ingenta search using keywords such as 'mental health policy,' 'health care policy' 'Ontario mental health policy', 'historical institutionalism', 'policy legacies', 'history of psychiatry', 'insane asylums', 'history of asylums', 'psychiatric hospital policy', etc.

⁶ Entitled "Building Community Support for People: A Mental Health Plan for Ontario."

⁷ Publicly-available mental health policy documents since the Graham Report were reviewed, including nine provincial mental health reform implementation task forces, submissions to recent national health and mental health commissions in Canada (the Romanow and Kirby Commission websites) were searched for submissions by important interests such as the Ontario Medical Association (OMA), Canadian Medical Association (CMA), Canadian Psychiatric Association (CPA), the College of Family

Physicians of Canada (CFPC), the Canadian Psychological Association (CPA) and the Canadian Mental Health Association (CMHA), national and Ontario divisions. Other policy submissions, research reports and press releases were drawn from the websites of these organizations.

- ⁸ Provider interviews were carried out in conjunction with another study that explored the potential for interdisciplinary collaboration in mental health delivery in Ontario. For a list of the characteristics of the key informants in terms of their professional disciplines or occupations, their work settings, and their work roles and if relevant, their role in policy advocacy and/or development see Chapter 2 in Mulvale, G. (2007) "Mental Health Policy and Service Delivery in Canada", Doctoral Dissertation in Clinical Health Sciences - Health Research Methods, McMaster University, Hamilton, Ontario.
- ⁹ For mass publics, in addition to the public key informant interview, indirect evidence was gathered from comments by providers and government key informants about the public's reaction.
- ¹⁰ The categories 'institutionalization era' and 'deinstitutionalization era' and the three phases of deinstitutionalization were drawn from the historical overview of mental health policy contained in Kirby, 2004b, p. 136-143.
- ¹¹ The precursor to the Canadian Mental Health Association (CMHA).
- ¹² Note that recent incentives for physicians to treat individuals with serious mental illness have been introduced in the province which may help to encourage their treatment within primary care.