More for the Mind and Its Legacy

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ABSTRACT

More For the Mind was published by the Canadian Mental Health Association in 1963. It reviewed the state of mental health services in Canada and called for transforming the delivery of mental health services from a neglected asylum-based system to a community-focused system where people could access services in general hospitals and the community. The article reviews the history of mental health services in Canada, the legacy of More for the Mind and the prospects for the reforms outlined in Changing Directions, Changing Lives.

Keywords: mental health services, history, reforms

RÉSUMÉ

More For the Mind a été publié par l’Association canadienne de santé mentale en 1963. Ce rapport a examiné l’état des services de santé mentale au Canada. Il a recommandé de transformer les services de santé mentale organisés traditionnellement autour des asiles qui étaient négligés et a proposé d’organiser un système communautaire qui donnerait l’accès aux services dans des hôpitaux généraux et dans la communauté. Cet article donne une vue d’ensemble de l’histoire des services de santé mentale au Canada, de l’héritage de More For the Mind et sur l’avenir des réformes décrites dans Changer les orientations, changer des vies.

Mots clés : services de santé mentale, histoire, réformes

In no other field except perhaps leprosy has there been as much confusion, misdirection and discrimination against the patient, as in mental illness. Control of the mentally ill has been regarded as the responsibility of the priests, the judges, the physicians, the philosophers, private charity and the state. Mentally ill patients have been lodged in jails, poor houses, hospitals, monasteries and pest houses. Mental illness, even today

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is all too often considered a crime to be punished, a sin to be expiated, a possessing demon to be exorcised, a disgrace to be hushed up, a personality weakness to be deplored or a welfare problem to be handled as cheaply as possible. (Griffin, Tyhurst et al., 1963, p. 1)

The Canadian Mental Health Association published the “cri de coeur” cited above in 1963 in a landmark report called More for the Mind that documented generations of failure to assign equal priority to the development of mental health services compared to physical health services in Canada. In 2012, almost 60 years later, the Mental Health Commission of Canada (MHCC) published Changing Directions, Changing Lives, (Mental Health Commission of Canada, 2012) Canada’s first ever national mental health strategy, which, like its predecessor report, proposes to transform Canada’s mental health services and remedy generations of neglect by government.

This article examines the legacy of More For the Mind as well as its influence on the MHCC mental health strategy. The findings and recommendations of More for the Mind are reviewed and compared with the analysis and recommendations found in Changing Directions, Changing Lives. In 1984, one of the authors of this article published a review of More for the Mind and prospects for reform (Lurie, 1984). We will draw on this analysis to track the progress of reform over time and reflect on the challenges and opportunities posed by Changing Directions, Changing Lives to transform Canada’s mental health system.

A BRIEF HISTORY OF MENTAL HEALTH SERVICES IN CANADA

In Canada during the 19th and early 20th centuries, the state and private charity assumed major responsibilities for the mentally ill. The state developed institutions that eventually shifted their focus from custodial care to medical or psychiatric care.

Griffin states that provincial authorities were at first concerned only with the segregation of the insane and the protection of society and property (Griffin et al., 1963). Canada’s first mental hospital was a pest house (a quarantine-like facility) in St. John, New Brunswick, originally built to care for immigrants with cholera. The conversion from pest house to mental hospital occurred in 1836. A new facility, the Provincial Hospital for the Insane, was opened in 1848, which resulted in the abandonment of the original pest house mental hospital.

The ideas of Dorothea Dix and Thomas Kirkbride, American crusaders for the development of institutions to care for the mentally ill, influenced the development of provincial asylums throughout Canada in the second half of the 19th century. By the time the British North America Act was passed in 1867, resulting in the creation of the Dominion of Canada, care of the mentally ill was recognized as a distinct provincial responsibility and the running of asylums consumed a significant percentage of provinces’ budgets. Professor Harvey Simmons claimed that asylums accounted for 75% of Ontario’s government spending at the beginning of the 20th century (S. Lurie, personal communication, 1990).

While the intent of provincial officials might have been to provide humane custodial care for the inmates of these asylums, the early history of Woodlands in British Columbia, now a provincial facility for people with intellectual disability, indicates that the opposite often occurred. (It should be noted that Canada’s early asylums also housed people with developmental disabilities. The first institution for people with developmental disabilities was built in 1919 [Wolfensberger, 1980]).
Woodlands (or the Public Hospital for the Insane) was built next to a jail in 1878.

The building was very gloomy and austere. The windows were tiny and so high in the walls that residents had to stand on tables in order to see outside. As a result, standing on tables became one of the few, common and institutionalized pastimes of residents, dramatically underlining how psychotic appearing behaviour can be induced to people by the environment and the keepers… The institution was overcrowded no sooner than it was completed. Within a year, five of the 36 residents had died and soon all sorts of other atrocities came to light. Apparently this included several killings with some residents’ bodies never being accounted for… Restraints were widely used, some of which resulted in death, as with one resident who died while squeezed into a closet. (Wolfensberger, 1980, p. 21)

Throughout the late 1800s and early 1900s, the populations of provincial asylums increased dramatically, and conditions continued to deteriorate. Dr. Clarence Hincks founded the Canadian Mental Health Association in 1918 and spent the next ten years investigating and reporting on the conditions of asylums in every Canadian province. (Lurie, 1984)

Dr. Hincks gave the following account of his investigation into conditions of provincial asylums in the Province of Manitoba. The asylum in Brandon had nine hundred patients and one doctor.

There was not one trained nurse in the entire institution. The male attendants were the roughest looking crew of men I have ever seen and because of the number of black eyes among the patients, it was evident that they used strong-arm methods for control. Over many of the beds was a heavy iron grating, and the patients beneath presented the appearance of caged wild animals. (CMHA, 1965)

Most patients were sent from the jails even though they had committed no offences, transported to the hospital tied down and fettered with “all the paraphernalia for restraint, manacles and chains” (CMHA, 1965). Dr. Hincks visited a place in Portage la Prairie that was worse than the Brandon asylum.

There was no medical man at all. At the end of one dark ward I saw a cupboard. I asked the Superintendent what the cupboard was used for… there on a hardwood floor was a naked woman with skin as white as snow and with a little square of towel. She placed it over her eyes because apparently she was unaccustomed to the light. And I asked the Superintendent. “How long has this lady been in this cupboard?” He said, “Two years.” I said, “Has she been taken out?” He said, “Only once for less than ten minutes, she was restless!” And so he returned her to the cupboard. (CMHA, 1965)

Hincks conducted surveys and made recommendations on facilities, programs and staffing in every Canadian province. Over the next 20 years, his organization was indirectly responsible for the expenditure of millions of dollars in the mental health field. Hincks advocated small regional mental hospitals associated closely with departments of psychiatry of university medical facilities and the establishment of psychiatric units in general hospitals (Griffin et al., 1963).

MORE FOR THE MIND

More for the Mind recounts the development of Canadian psychiatric services between 1939 and 1963. The development of services in this period reflected a shift from legal and administrative concerns to the provision of medical and therapeutic care. By 1939, there was a renewed interest in psychological and social treatment methods, as well as the medical procedures involving the administration of insulin as well as psychosurgery. However, during World War II, the services in mental hospitals deteriorated (Lurie, 1984).
In 1948, the federal government awarded mental health grants to all Canadian provinces resulting in the upgrading of institutional facilities, programs and staff by 1959.

In the decade 1949 to 1959 the bed capacity in Canadian mental hospitals rose by nearly 18,000. The number of patients on the books of mental institutions rose by over 18,000. Administrative staff doubled, professional personnel increased by three to four times, and the nursing staff became half as large again. Psychiatric services outside the mental hospital were greatly expanded, including the development of psychiatric treatment services in general hospitals, in outpatient and community clinics. (Griffin et al., 1963, p. 14)

While the number of beds did increase, the bed capacity per 100,000 population actually decreased between 1945 and 1963. Overcrowding was still a problem and the changes represented frantic attempts to meet a deficiency rather than implementation of a well planned program (Lurie, 1984).

In 1955, the National Scientific Planning Council of the Canadian Mental Health Association appointed the Committee on Psychiatric Services, chaired by Dr. J. S. Tyhurst, Professor of Psychiatry, University of British Columbia. It was given a mandate to

1. examine the existing mental health services in Canada, to explore and describe the existing patterns of care and the reasons why these patterns had developed the way they had; and especially, to find and expose the gaps in existing services.
2. devise fundamental new and more adequate patterns of diagnosis, treatment, care and prevention and to initiate a trend if possible towards changes in mental health services such innovations would create. (Griffin et al., 1963, p. 15)

The committee was composed entirely of psychiatrists, assisted by a group of consultants reflecting the disciplines of psychology, social work, nursing, occupational therapy, teaching and pastoral care. Over the next eight years, it reviewed previous studies, and commissioned briefs and papers by other professionals, culminating in the publication of More for the Mind in 1963, a report that was hailed as a blueprint for the development of mental health services in Canada.

FINDINGS AND RECOMMENDATIONS OF MORE FOR THE MIND

The Committee on Psychiatric Services reviewed the previous studies of provincial mental health services financed by the federal government and found that, in general, there had been a failure to act on the recommendations proposed. A number of reasons for this failure were identified as follows (Griffin et al., 1963):

- economic reasons, including the lack of money as well as the method of allocating and administering funds;
- tensions existing among psychiatric facilities services, lay organizations, governments, etc.;
- a lack of clearly defined principles for the development of psychiatric services;
- organizational problems in government health departments which attached a low priority to the development of mental health services;
- public attitudes did not support a rapid expansion of mental health services;
- the supply of trained personnel caused delays in implementing changes.
Besides documenting reasons for the failure to act, the report describes existing treatment services—a system dominated by the provincial mental hospital. *More for the Mind* goes on to identify shortcomings of existing psychiatric services, including:

- isolated and oversized mental hospitals “attempting to care for 1,000 to 5,000 or more patients often in buildings that are obsolete and inadequate even by minimum health standards” (Griffin et al., 1963, p. 26);
- the lack of integration between the psychiatric hospital and other medical services;
- centralized government control of provincial mental hospitals which makes local communities less inclined to show the same interest, concern and responsibility for mental health problems as they normally display towards physical health needs;
- exclusion of mental health services from public and private medical insurance plans; and
- complexity of certification and committal procedures.

Concern was also expressed that mental health services needed to be expanded for Canada’s aged population. There was also recognition that the medical treatment for the mentally ill was not the panacea to control mental illness. A strong commitment to psycho-social rehabilitation services would be required.

The central theme of *More for the Mind* was that “mental illness should be dealt with in precisely the same organizational, administrative framework as physical illness” (Griffin et al., 1963, p. 38). The report proposed

- Integration of psychiatric services with all other forms of medical care in order to reduce the stigma of segregation, raise the standards of care, and increase the acceptance of psychiatric illness by the medical profession.
- Regionalization of psychiatric services recognizing that “treatment should be provided as early as possible with as little dislocation and as much social restoration as possible” (Griffin et al., 1963, p. 40). The authors state that “a wide range of psychiatric services at the local level is necessary… Inpatient hospital services are seen as only one aspect of community mental health programs. Many patients may go through the complete illness episode without admission to hospital” (Griffin et al., 1963, p. 41)
- Decentralization that would place mental hospitals under local boards of directors.
- Continuity of care requiring “the closest possible co-operation and integration between the various services and professional staff” (Griffin et al., 1963, p. 44).
- Co-ordination of services in hospitals, clinics and other centres through the development of local mental health councils.

The subsequent 57 recommendations, which followed the theme and the five major proposals, covered a wide array of issues, including alcoholism and addiction services, the development of mental health services in industry, assessment, and treatment centres for children with emotional problems, development of psychogeriatric services, psychiatric consultation services and the establishment of domiciliary care facilities for people who do not require further clinical psychiatric treatment (Griffin et al., 1963).
A recurrent theme throughout the report was the development of community-based services resulting in a shift in emphasis from “inpatient services to community psychiatric services where a large proportion of psychological disorder can be treated without hospitalization” (Griffin et al., 1963, p. 15).

More for the Mind made a number of general comments related to the development of community-based rehabilitation services and continuity of care. Perhaps the most significant is the suggestion that “the discharged patient should actually have a continuous personal relationship with some person in a particular agency” (Griffin et al., 1963, p. 75) in other words, a case manager.

PROGRESS SINCE MORE FOR THE MIND

Examining the findings and recommendations in 2014 suggests that while there has been some progress, major issues are still unresolved. Funding is still an issue. While there have been major investments in health care, particularly since 2004, the mental health share of health spending has continued to decline. For example, the mental health share of overall health spending in Ontario was 11.3% in 1979, 10 years after the majority of psychiatric beds were closed or transferred in the era of de-institutionalization. It has now declined to less than 7% of provincial health spending. Canada’s spending on mental health is 7.2% of provincial health spending (WHO, 2011) and disproportionate to the burden of illness on individuals, families, and the economy.

As was the case in 1963, there is still considerable debate about planning principles for mental health systems, although the past 25 years have seen an increase in rhetoric in policy documents about recovery, patient or consumer-centred care, family involvement and shifting toward more of a community-focused system.

The stigma and discrimination identified in More for the Mind is still a problem. In 2006, the Senate Standing Committee on Social Affairs, Science and Technology issued its comprehensive report on mental illness in Canada, entitled Out of the Shadows at Last. Among its many recommendations—including a principal one that Canada needed to have a national mental health commission—it proposed that Canada develop an anti-stigma campaign similar to efforts in other countries and this has emerged as a key priority for the MHCC. Dr. Heather Stuart and colleagues have suggested that structural stigma contributes to underfunding of mental health systems, (Stuart, Alboreda-Florez, & Sartorious, 2012) a finding eerily similar to More for the Mind’s finding that public attitudes did not support expansion of mental health services.

The problem of large overcrowded mental asylums was largely resolved, although with unintended consequences in the absence of adequate community care. In 1963, the rated psychiatric bed capacity was 3.7 per 1,000 general population in Canada. By 1977, this had declined to 1.0 beds per 1,000. Patients in psychiatric institutional care declined from 79,707 to 24,362 in 1977, a three-fold decrease (Lurie, 1984).

However the shift toward a community-focused mental health system is still an elusive goal. In an audio recording just before his death in 1964, Hincks proposed:

All we need is leadership by people who recognize the fact that we are in the ox-cart stage of development. In Amsterdam they haven’t built a mental hospital in years because their mental health workers are working in the community, where they should be working… We could in the next few years open every mental
institution in the country, bar none. We could divide the staff fifty-fifty between the institutions that are open and work in the community, where the real job’s to be done. (CMHA, 1965)

For example, in 1993 the Ontario government proposed shifting the balance in mental health spending from 80% hospital-based and 20% community-based to 60% community-based and 40% hospital-based by 2003. This has yet to occur. Between 1987 and 2011, the community-based share of mental health spending in Ontario, as a reflection of overall health spending, did increase from 0.45% to 1.31% (Lurie, 2014) but there are still huge gaps in community care and waitlists for community mental health services and supportive housing. The same is true in all provinces and territories. While there are many examples of evidence-based community mental health services across the country, we do not have accessible community mental health systems in place as *More for the Mind* and Hincks proposed more than 50 years ago.

In *Changing Directions, Changing Lives*, the MHCC challenges the notion that deinstitutionalization, considered in isolation, is a public policy failure. The failure is the lack of investment in community services (Lurie, 2014).

Hospitals continue to be a major component of psychiatric care. An analysis of data from the Canadian Institute for Health Information (CIHI, 2014a) shows that general hospital discharges grew from 166,553 in 2003 to 182,655 in 2011, while psychiatric or specialty hospital separations declined slightly from 26,009 to 24,896 in the same period. CIHI data also shows that 1 in 10 people hospitalised for mental illness had repeat hospital stays and that rates increased in most communities across Canada between 2008 and 2011, (CIHI, 2014b) despite 30 years of research evidence showing the effectiveness of community-based supports such as case management, supportive housing, and assertive community treatment.

The Service Enhancement Evaluation Initiative (SEEI) studies in Ontario, which monitored the effects of enhanced funding for community mental health programs from 2004–2006, found that while there was increased capacity in some programs, “the newly enhanced community mental health system still does not have the capacity to serve all those in need. Demand increased in hospital emergency rooms even as early return rates to emergency rooms decreased” (CAMH, 2009).

Direct government control of psychiatric hospitals has been replaced by regionalization and, in some cases, changes in status to one similar to other public hospitals with local boards of directors. While psychiatric services are managed by the same authority responsible for general health care, mental health services do not receive the priority accorded to physical health care. For example, Ontario LHINS’ (regional health authorities) spending on hospitals averaged over 60 cents on the health dollar while community mental health spending averaged 2.52 cents in 2010 (Province of Ontario Public Accounts, 2010).

Few jurisdictions in Canada have developed comprehensive mental health human resource strategies, although there has been an expansion of multidisciplinary teams for people with complex conditions (Assertive Community Treatment) and early psychosis. While there has been an expansion of general hospital psychiatry programs, there has been limited integration of mental health services with primary health care. Implementation of shared care, which has occurred over 20 years in Hamilton, Ontario, is an anomaly despite evidence of the benefits to family practice, and the challenges in chronic disease management for people living with long-term mental illnesses, which shows a premature mortality of 25–30 years compared to the general population.
During the 1980s and 1990s, many international jurisdictions developed policies and strategies to reform their mental health systems. The United Kingdom, Australia and New Zealand developed strategies to transform their mental health systems and increase funding for mental health services. The themes of recovery, stigma reduction, developing services for particular clinical populations, use of new technology, workforce training, improved performance measurement and research are common across jurisdictions. The role of government as funder, regulator and catalyst for regional or local system development, rather than service provider, is also common.

Many of Canada’s provinces reviewed their mental health systems during this period and developed strategies for change. But by 2006, Canada remained the only member country of the Organisation for Economic Co-operation and Development without a national mental health strategy. Following their review of Canada’s health system, the Senate Standing Committee on Social Affairs, Science and Technology took on a review of mental health services in Canada. Their report, *Out of the Shadows At Last*, published in 2006 (Government of Canada, 2006), echoed many of the themes of *More for the Mind* and also found that federal government performance was lagging in areas of their constitutional jurisdiction, such as services for immigrants and refugees, First Nations, Inuit and Metis peoples, as well as people incarcerated in the federal corrections system. The Senate Committee proposed the establishment of a mental health commission to act as a catalyst for reform and the creation of a $5.3 billion mental health transition fund to accelerate the transformation towards community-based mental health care. The Mental Health Commission was established in 2007 and one of its key deliverables was the development of a mental health strategy for Canada.

**THE DEVELOPMENT OF A MENTAL HEALTH STRATEGY FOR CANADA**

The approach taken to developing a mental health strategy was deliberate and consultative. It drew on both existing national strategies in other jurisdictions as well as the experience and expertise from diverse groups of Canadians, including people with lived experience of mental health problems and illnesses, family caregivers, health professionals, and others. More formally, this process reflected a commitment to “civil society engagement,” as described in detail in a recent publication by individuals directly involved in creating the national strategy (Mulvale et al., 2014). In summary, the development of the national strategy involved a four-year process divided into two parts. The first part focused on the ultimate goals of a national strategy, since it was important to establish the destination before designing the means of getting there. This led to the publication of an interim report in 2009 entitled *Toward Recovery and Well-Being: A Framework for a Mental Health Strategy* (Mental Health Commission of Canada, 2009). This framework document established seven goals:

1. People of all ages living with mental health problems and illnesses are actively engaged and supported in their journey of recovery and well-being.
2. Mental health is promoted, and mental health problems and illnesses are prevented wherever possible.
3. The mental health system responds to the diverse needs of all people in Canada.
4. The role of families in promoting well-being and providing care is recognized, and their needs are supported.
5. People have equitable and timely access to appropriate and effective programs, treatments, services and supports that are seamlessly integrated around their needs.

6. Actions are informed by the best evidence based on multiple sources of knowledge, outcomes are measured, and research is advanced.

7. People living with mental health problems and illnesses are fully included as valued members of Canadian society.

It concluded with a call to arms, asking for the entire mental health community to work together in creating a social movement to engage all citizens and advocate for change.

This interim report—which some provinces immediately began to use in developing their own mental health strategies—reflected enormous input from Canadians from coast to coast to coast, in the thousands, through in-person and online exchanges. Special efforts were made to insure that the voices of people with lived experience of mental illness and family caregivers were heard, in addition to other advocates and experts.

The visionary founder and leader of the MHCC, Michael Kirby, felt that complete consensus on priorities and actions was an unachievable and even undesirable goal—that if everyone were happy, that was a sure sign nothing was being done. Rather, he advocated for endorsement of much, but not all, of the strategy by everyone, recognizing the diversity and divergence of views rendered unanimity elusive.

**CHANGING DIRECTIONS, CHANGING LIVES**

As expected, the framework document provoked a range of responses from high criticism to high praise, and the feedback was used to revise and re-shape the content into the second phase, *Changing Directions, Changing Lives* that contained more specific actions and indicators associated with six strategic directions:

1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.

2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses, and uphold their rights.

3. Provide access to the right combination of services, treatments and supports, when and where people need them.

4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.

5. Work with First Nations, Inuit and Metis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.

6. Mobilize leadership, improve knowledge, and foster collaboration at all levels.

It also recognized historic funding declines, and called for an increase in the proportion of health spending that is devoted to mental health from 7 to 9% over 10 years, as well as a 2% increase from current levels in the percentage of social spending that is devoted to mental health. Acknowledging the need for efficiency and priority, it also recommended re-allocation of existing mental health spending to achieve better
outcomes. Finally, it called on the private and philanthropic sectors to contribute resources to mental health (Mental Health Commission of Canada, 2012).

LEGACY AND CHALLENGES

Three years after its release, the national strategy’s recommendations have yet to transform the landscape of mental health and mental illness in Canada. That is hardly surprising given the size of the problems and the scope of the change that is needed. Further, the MHCC recognized that the preliminary indicators embedded in the strategy would not be sufficient to measure change in the mental health system, and it has since funded a systems performance initiative to produce a meaningful menu of change measures. While some of the recommendations of the MHCC strategy require changing mindsets to implement more effective programs, such as the anti-stigma campaign Opening Minds, many of the actions for provincial and regional mental health systems will require substantial financial investments and an increase in the mental health share of health and social spending. The MHCC strategy does provide a catalyst for reform, but it remains to be seen whether there is sufficient political and bureaucratic will to make the investments required, especially with the looming reduction in federal health transfers to provincial and territorial governments beyond 2016.

However, unlike the situation for the equally laudable goals of the More for the Mind report, there is more opportunity now to follow up and follow through. First, Canadian society is more aware of, and more responsive to, the need to do a better job addressing mental illness and mental health in this country. People are more aware of the prevalence, impact, and cost. Inroads are being made against stigma and discrimination that serve as a barrier to both funding resources and accessing them. Political parties of every stripe and at every level are more openly acknowledging mental health as a priority. Second, the MHCC has established itself as a trusted adviser at the levels of federal, provincial and territorial governments, as well as a partner to other organizations and communities across the complex mental health landscape. It has demonstrated a capacity to deliver innovative initiatives, such as the ground breaking national study on homelessness and mental illness, At Home/Chez Soi, as well as the world’s first national standards on psychological health and safety in the workplace.

More for the Mind offered 57 recommendations. In its Epilogue, it acknowledged that these reflected “the opinions of a group of psychiatrists rather than the joint and corporate views of representatives of the several different professional disciplines interested in the broad perspective of mental health.” The MHCC strategy included not only such voices but also those of people with lived experience of mental illness and family caregivers. It conceded the need for more multi-disciplinary follow-up to the report, but offered no equivalent to the MHCC to oversee and to catalyze needed reform, despite the valuable role that the Canadian Mental Health Association plays across the country.

If major opportunities for reform arise once per century, then in the 19th century it was the creation of an asylum system across Canada to provide custodial care for people with mental illness. In the 20th century, in the transition out of asylums as the focal point of mental health care, More for the Mind generated noble, worthwhile goals for system transformation—developed by traditional and now-narrow expert consensus and implemented to varying degrees. In the 21st century, the opportunity has risen anew with Changing Directions, Changing Lives, as well as with the existence of the MHCC, to try again to “get it right”—or at
least “get it better,” leveraging unprecedented public and political awareness and will to improve the lives of Canadians affected by mental health problems and illnesses. We cannot wait for the 22nd century.

REFERENCES


