Athabasca University



# THE HISTORIC ROOTS OF THE INSTITUTIONALIZATION OF THE ELDERLY IN ONTARIO

By

RENEE LEHNEN

Integrated Studies Final Project Essay (MAIS 700)

submitted to Dr. Angela Specht

in partial fulfillment of the requirements for the degree of

Master of Arts – Integrated Studies

Athabasca, Alberta

13 April 2018

# ABSTRACT

In Ontario, approximately 77, 500 frail elderly people currently reside in provincially-funded, long-term care homes. They are the only members of Ontario society who are institutionalized routinely. The mass institutionalization of elderly people is a social welfare phenomenon with origins in previous programs of institutionalization, from the industrializing Victorian era to the post-industrial millennium. Historic forms of institutionalization have included orphanages, asylums, houses of industry and refuge, and residential schools for Indigenous children and disabled people. This essay surveys the intertwining demographic, epidemiological, philosophical, social, and economic dynamics of institutionalization from the mid-nineteenth century to the present in Ontario. In addition, the possibility of deinstitutionalization and transition to alternative housing and care arrangements for elderly people is discussed briefly.

Notes on Language: Many of the terms used to describe people in the nineteenth and twentieth centuries are considered offensive today. However, for historical accuracy, terminology contemporary to each historical era is used in this essay. This essay discusses the institutionalization of people in mass housing facilities for social welfare or education rather than punitive purposes.

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**The Historic Roots of the Institutionalization of the Elderly in Ontario**

Often, elderly people with physical and cognitive disabilities are housed together in nursing homes. Currently, approximately 77,500 people, almost all of them elderly, live in Ontario's 627 government-funded, long-term care homes and 32,000 more elderly people are waiting for spaces in these facilities (Ontario Long Term Care Association (OLTCA), 2016). The mass institutionalization of many of Ontario's oldest citizens began in the mid-twentieth century and continues to evolve. Although long-term care comprises 7.9 percent of the Ontario government's health care budget, current policy reflects the alignment of the Ministry of Health and Long-Term Care (MOHLTC) to historically-driven trends of institutionalization rather than carefully planned social welfare policy (OLTCA, 2016; Daly, 2015).

Institutional care exclusively for old people arose recently, but institutionalization of marginalized people as a response to real or perceived need has roots in the industrializing Victorian era. In the mid and late nineteenth century, the Ontario government built lunatic asylums for the mentally ill, funded county-run houses of refuge for the poor, and facilitated the establishment of public, private, and Christian orphanages for Canadian-born and immigrant children. In the late nineteen and early twentieth century, patterns of institutionalization changed. Thousands of Indigenous children were forced into residential schools and parents of disabled children were encouraged to place their sons and daughters in institutional care. Most of these facilities were closed by the 1990s.

In this millennium, the only members of Canadian society who are institutionalized routinely are old people. The custodial care of elderly people in large facilities is a complex social welfare phenomenon of post-industrial Ontario with origins in programs of mass institutionalization of

members of other marginalized groups over the preceding century and a half. Examining this phenomenon in the context of historic demographic, epidemiological, philosophical, social, and economic change offers an opportunity to reflect on how Ontario's vulnerable elderly are housed and to consider alternative provisions for care.

## Definition of Institutionalization

Institutionalization is the act of placing people into residential facilities. Institutionalization for social welfare or educational purposes rather than punitive purposes is discussed in this essay.

## Historical Survey of Institutionalization, circa 1850 to Present in Ontario

Houses of charity date back to the middle ages in Europe, but large, professionally staffed, publicly-funded institutions first arose in Europe in the late eighteenth and early nineteenth centuries (Brown & Radford, 2015). In Ontario, governments and community organizations constructed facilities such as orphanages, asylums, houses of refuge, residential school institutions, and homes for the aged in response to the perceived care needs of distinct groups of people beginning in the mid-nineteenth century. The following historical survey of target populations, organized chronologically, describes the phenomenon of institutionalization in Ontario and how it has evolved, from the 1850s to the present. A collection of photographs of historic institutions appears in Appendix A.

***Parentless Children:***

In the mid-1800s, thousands of people immigrated from Britain, Ireland, and Europe to Ontario. Some parents, impoverished and disconnected from traditional sources of support such as extended family, were forced to place their children in orphanages (Brown & Radford, 2015). Other children were orphaned due to the deaths of their parents. Many children, including 70,000 British Home Children, immigrated to Ontario unaccompanied (Family and Children's Services of Guelph and Wellington County, 2018).

The first large facilities specifically for orphans were opened in Kinston, Toronto, London, and Ottawa in the 1850s under Dickensian banners such as the "Toronto Boys' Home for Vagabonds" and the "Ottawa Protestant Orphans' Home for Destitute Children." Usually sponsored by women's benevolent societies and churches, the goals of the orphanages included clearing the streets of homeless children, child protection, and education and training of children for work (Rooke & Schnell, 1982). After the passage of the *Charity Act* of 1874 and the *Act for the Prevention of Cruelty to and Better Protection of Children* of 1893, every town over 10,000 people was obligated to open an orphanage (Family and Children's Services of Guelph and Wellington County, 2018).

In the twentieth century, foster care became the preferred way to house vulnerable children. Because the general health of Ontarians improved, fewer children found themselves parentless. Almost all orphanages closed by the end of the Second World War (Rooke & Schnell, 1982).

***Mentally Ill People:***

Victorian mental health care was centred on the mass hospitalization of the ill. The "Provincial Lunatic Asylum" opened in Toronto in 1850, replacing a smaller, prison-like building that had been constructed following the 1839 *Act to Authorize the Erection of an*

*Asylum for the Reception of Insane and/or Lunatic Persons*. By the 1870s, the Ontario government was operating asylums in London, Kingston, and Hamilton as well as smaller satellite asylums (Reaume, 2006). These facilities consumed 16.5 percent of the total provincial budget in 1870, rising to 19 percent in 1880, more than prisons, hospitals, houses of refuge, and orphanages combined (Miron, 2006). There were six large provincial asylums by 1911 (Carter Park & Wood, 1992).

Asylums were massive buildings housing hundreds of people on sprawling campuses. Unable to offer effective medications and other therapies, practitioners prescribed patients hard work, a heathy diet, and routine in the secure environment of the asylum (Reaume, 2006). With the development of efficacious pharmacotherapy and better psychiatric care, rates of hospitalization of mentally ill patients declined in the latter half of the twentieth century. Today, few patients are hospitalized with psychiatric illness; most are treated in clinic and community settings (Sealy & Whitehead, 2004).

***Impoverished People:***

In mid-nineteenth century Ontario, homeless people frequently stayed in jails. Benevolent societies and religious charities recognized the need for alternative arrangements and by the 1870s, facilities such as the Salvation Army "Haven for Friendless and Fallen Women" in Toronto were offering shelter and employment training (Brown & Radford, 2015). The 1890 *House of Refuges Act* and the 1903 *Act Respecting Municipal Houses of Refuge* mandated that each county in Ontario open a facility for the poor. By 1912, 31 county-run houses and 27 charity-run houses were sheltering people who were elderly, ill, infirm, or unmarried with children (O'Connor, 2014). By 1914, 71 houses were serving approximately 8,000 destitute people (Wheatley, 2013b). A decline in unemployment with the Second World War and

conversion to payment-based social welfare systems saw the closure or conversion of the houses of refuge and industry into nursing homes for elderly people by the mid-twentieth century (Tyler, 2009; Weber, 2013).

***Disabled People:***

In Victorian Ontario, mentally disabled children were frequently housed in institutions for provision of care and training and, following puberty, prevention of pregnancy. Ontario's eugenics programs mostly relied on sex segregation rather than sterilization (Brown & Radford, 2015). In the 1870s, the "Orillia Asylum for Idiots" began admitting children and the "London Asylum for Adult Idiots" opened, the province's first facilities constructed for the therapeutic care of mentally disabled people, then classified by level of intelligence and function as "idiots, imbeciles, epileptics, morons, and the feeble-minded" (Wheatley, 2013a).

As medical care improved after the turn of the century, more disabled children survived infancy. Physicians advised parents to place their children in institutions to receive specialized education although most children languished in these settings. By mid-century, there were approximately twenty "Ontario Hospital Schools" housing thousands of children and adults who had grown up in institutional care. For example, in 1961, the Orillia facility was home to 2,800 residents and the Smiths Falls facility had 2,650 residents. By 1970, the province was keeping approximately 10,000 mentally disabled people in residential care (Brown & Radford, 2015).

In response to parents' advocacy groups such as the Ontario Association for Retarded Children, formed in 1953, the provincial government commissioned lawyer, Walter Williston, to investigate facilities. Williston's findings of inhumane conditions along with the 1973 Welch Report, which recommended deinstitutionalization, spurred the government to close the Ontario Hospital Schools during the 1990s and move residents to group homes and other community

living arrangements. The last three schools, including the Orillia facility, closed in 2009 (Brown & Radford, 2015).

***Indigenous Children:***

Federal rather than provincial law governed the forced confinement of indigenous children into residential schools. The residential school system was created in 1884 by amendments to the 1876 *Indian Act.* The Canadian government, in concert with the Anglican, Catholic, Presbyterian, and Methodist/United churches, ran 17 residential schools in Ontario from the 1870s to the 1990s for children from age 4 to 16 years of age. Unlike other programs of institutionalization, there was no basis in need. The purpose of the Indian residential school system was to erase Aboriginal cultures, ways of life, and languages from Canada, and fully assimilate Indigenous people into English and French-based settler societies. When the last school closed in 1996, approximately 150,000 children had been subjected to the residential school system (Union of Ontario Indians, 2016).

***Elderly People:***

Prior to the construction of homes for the aged, frail elderly people without family support were housed in jails, and later, houses of refuge and asylums. As more people survived into old age and fewer young people required shelter in the mid-twentieth century, many houses of refuge were converted into nursing homes for the elderly (Carter Park & Wood, 1992). Charities and municipalities operated nursing homes, but in a departure from previous practice, privately owned nursing homes proliferated as well. Over the decades, reports of elder abuse and neglect prompted the provincial government to set standards of care and funding through the *Ontario Nursing Homes Act* in 1966, the “Extended Care Funding Plan” in 1972, and the *Long-Term Care Homes Act* in 2007 (Daly, 2015). The long-term care system is Ontario’s largest program

of institutionalization to date and it is continuing to grow. As stated, about 77,500 people reside in the province's 627 publicly-funded long-term care homes (OLTCA, 2016).

## Factors Acting on the Phenomenon of Institutionalization

Running through institutionalization in all its manifestations are common threads, or factors, which have given the phenomenon pattern and shape over the decades. These factors can be organized into demographic and epidemiological, philosophical, social, and economic categories, and each perpetuates institutionalization in its current form, long-term care. A graphic representation of these factors and how they drive the phenomenon of institutionalization appears in Appendix B.

### *Demographic and Epidemiological Factors:*

In each era beginning in the Victorian era, institutionalization has been a response to prevailing demographic conditions and epidemiological demands. Except for residential schools for Indigenous children, the primary motivation behind institutionalization was and is human need. Appendix C contains graphs and tables that show census data including trends in immigration, fertility, population growth, and life expectancy in Canada and Ontario since the 1850s.

In the 1800s and early 1900s, accidents, infectious diseases, and high rates of maternal mortality left many children without their parents. In 1926, 4.1 percent of Canadian children aged 15 years or under were parentless and, in 1901, 55,000 children had a "non-parental custodian" (Statistics Canada, 2015a). Many of the children in these decades lived in orphanages. At the same time, medical care was improving, birth rates were high compared to today, and more children were surviving infancy (Statistics Canada, 2015c). As a result, the numbers of

disabled children rose. Ontario's medical and social welfare officials responded to the aspirations of parents that their disabled children be educated by building hospital schools for custodial care and training (Brown & Radford, 2015). In parallel, the hospitalization of mentally ill people in asylums was seen as a humane solution to the problem of homelessness and the demand on families that this patient population presented in an era without effective psychotropic drugs and other treatments (Reaume, 2006).

Just as orphanages, asylums, and houses or refuge housed thousands of people with common care needs in the preceding two centuries, long-term care has become a pillar of elder care in Ontario today, in part, because of demographic and epidemiological demand. Life expectancy in Ontario is currently 82.4 years (Statistics Canada, 2018). On the other hand, the average number of births per women has been below population replacement level since the 1970s and currently sits at approximately 1.5 children per woman in Ontario (Statistics Canada, 2017b, c). Of Ontario's approximately 14 million people, 16.7 percent are 65 years of age or older and 16.6 percent are under 15 years of age (Statistics Canada, 2017a). The oldest members of the baby boom generation are entering their eighth decade of life now, and in 15 years, the number of Canadians aged 75 years and older is projected to double (Gibbard, 2017).

Policy makers in health care have attempted to reduce morbidity among the elderly through public and primary health campaigns to reduce the need for institutional care. However, rates of lengthy chronic and acute illness and disability remain stubbornly high in these cohorts (Hirdes, Mitchell, Maxwell & White, 2011). Currently only the sickest and most disabled people are entering long-term care in Ontario but demand for beds exceeds supply. Ninety percent of long-term care residents are cognitively impaired, 58 percent are wheelchair bound, 97 percent have two or more chronic diseases, 97 percent require extensive assistance with activities of daily

living, and 61 percent take ten or more prescription medications (OLTCA, 2016). The mass institutionalization of elderly people is a response to unprecedented demographic and epidemiological conditions in Ontario.

***Philosophical Factors:***

Institutionalization is a phenomenon of modernity, industrialism, post-industrialism, humanitarianism, and scientific hubris. The rise of social welfare institutions such as asylums, houses of refuge, and orphanages mirrored the growth of universities and other institutions of education. In the preceding century and a half, groups who have been institutionalized have tended to dwell in society's margins and been perceived as inefficient or worse, threatening to orderly, law-abiding society and robust economies. Institutionalization for expert remedial training or custodial care was regarded as the rational, scientific, and humanitarian response to social problems such as lunacy, pauperism, indolence, criminality, and non-conformity (Brown & Radford, 2015).

Today, long-term care is an unexamined response to the inefficiency and inconvenience of advanced age and infirmity in a society which places high value on economic growth through nimble participation in the capitalist system. Policy-makers seldom question the philosophical underpinnings of institutionalization. Rather, institutionalization has been accepted as inevitable and necessary as target groups shift (Brown & Radford, 2015).

***Social Factors:***

Before confederation, Ontario already welcomed thousands of immigrants every year. In addition, the province was establishing efficient networks of rail and road infrastructure and a reliable postal network by the mid-1800s, enabling the province to industrialize and urbanize rapidly in the latter half of the nineteenth and in the twentieth centuries (Stelter & Artibise,

2006). Immigration, a mobile labour force, industrialization, and urbanization brought prosperity but also loosened community and family bonds and left groups such as orphans, mentally-ill, and disabled people on the social margins. Institutionalization was a partial solution to social problems such as homelessness, vagrancy, prostitution, and criminal behaviour that were blamed on orphans, paupers, lunatics, the feeble-minded, and wayward women. Furthermore, institutions were regarded as an efficient way to deliver care, housing, and education to people in need (Brown & Radford, 2015).

In contrast, the purpose of the residential school system for Indigenous children was to destroy aboriginal societies by assimilating the children into settler cultures, including through abusive measures. In 1920, the Deputy Minister of Indian Affairs, Duncan Campbell Scott, stated,

> "I want to get rid of the Indian problem. I do not think as a matter of fact, that the country ought to continuously protect a class of people who are able to stand alone. Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question, and no Indian Department" (Union of Ontario Indians, 2016).

Although the residential school program was a sinister manifestation of institutionalization, it was conceived as a solution to the "problem" of non-conformity of Indigenous communities and their resistance to assimilation into settler societies.

As a manifestation of the phenomenon of institutionalization, nursing homes for the aged have more in common with houses or refuge, asylums, and hospital schools than with residential schools in how they function within Ontario society. The illness and disability that often accompany advanced age can make living in community settings isolating or dangerous for old people and place stress on family caregivers. Long-term care has become an important part of the twenty-first century social safety net.

However, long-term care has medicalized, professionalized, and bureaucratized elder care resulting in the creation of a self-perpetuating system. Referring to social welfare, Swedish sociologist, Mikael Holqvist (2012) writes, “institutionalization is characterized by formalization, routinization, refinement, and habituation making the organization more and more enduring and taken for granted” (p.5). Long-term care homes are staffed by administrators and health care professionals such as nurses, dieticians, therapists, and personal support workers who operate on procedural systems and protocols governing everything from resident feeding and toileting to fire drills. Family members may become disempowered bystanders and residents may become passive recipients of specialized care because they may feel uncomfortable participating in an increasingly professionalized long-term care system (Baines & Armstrong, 2016).

Furthermore, long-term care personnel must adhere to rigid rules and regulations and demonstrate compliance with MOHLTC standards that are enforced by regular audits by ministry officials. For administrators and staff, maintaining the bureaucratic apparatus and systems of long-term care can take primacy of attention over residents. Institutional scaffolding is supported from within by personnel who conform to facility norms and rules and it is further bolstered by policy makers who draft the rules and by officials who enforce them. The complexity and size of the long-term care system casts the illusion that the mass institutionalization of Ontario’s elderly people is rational, intentional, inevitable, and necessary.

***Economic Factors:***

In industrial and post-industrial Ontario, the institutionalization of marginalized people has supported economic growth by: freeing family members and communities from unpaid caregiving thus enabling more people to participate in the paid labour force; stimulating the economy through large capital projects and payment of wages for workers in institutions; and

facilitating the pooling of resources such as money from taxes and charitable contributions for efficient spending on institutional care.

In Victorian to pre-Second World War Ontario, orphans received basic education and training in practical skills while in institutional care and many adolescents were discharged from orphanages into service, apprenticeships, farm work, or other employment that contributed to Ontario's economy (Rooke & Schnell, 1982). The inmates of asylums, houses of refuge and industry, and residential schools grew food on the grounds of their institutions and performed labour such as washing laundry and construction (Reaume, 2006; Weber, 2013; Union of Ontario Indians, 2016). Thus, in early manifestations of institutionalization, marginalized people frequently participated in the province's labour force.

Mentally disabled children and adults worked only in sheltered settings, but their institutionalization relieved family members, usually their mothers, from daily caregiving (Brown & Radford, 2015). Long-term care facilities fulfill a similar role today. Caregivers of elderly people are disproportionately women, and many are in the prime of their careers. Currently, eight million Canadians, or 28 percent of the adult population over age 15, support elderly family and friends in a caregiving capacity (Dobbins, 2016). Provision for elder care in institutions relieves caregivers to participate in other forms of paid and unpaid labour.

Furthermore, institutionalization has poured money into the Ontario economy through capital and operational spending and employment from the beginning. In 2016, the MOHLTC spent 4.07 billion dollars on the long-term care system, 7.9 percent of the provincial healthcare budget (OLTCA, 2016). Wages cost approximately 2.5 billion dollars for health care workers and 3.4 billion dollars for administration and support, employing approximately 62,300 people full-time.

General operations cost about 1.4 billion dollars (Canadian Institute for Health Information (CIHI), 2015).

Currently, each long-term care bed costs 94.37 dollars per day, and each resident contributes between 58.99 dollars per day for their care in a basic bed. For-profit companies own 57 percent of the province's 627 long-term care homes and non-profit corporations, charitable groups and municipalities own 43 percent. Private companies are being enriched by the province's 77,500 publicly subsidized, long-term care beds (OLTCA, 2016).

The long-term care sector is projected to grow. The Conference Board of Canada recommends that Canada nearly double its number of long-term care beds by 2035, pointing out that 123,000 jobs would be created, gross domestic product would rise by 235 billion dollars, and the government would recoup 71 billion dollars in taxes (Gibbard, 2017). The economic importance of long-term care to families, communities, governments, and the private sector perpetuates the phenomenon of institutionalization in its current elder care form.

## Discussion of Institutionalization as an Evolving Social Welfare Phenomenon in Ontario

The phenomenon of institutionalization has appeared in several manifestations in Ontario since the 1850s. However, social welfare institutions arose in Europe decades earlier, during the early Industrial Revolution, as a rational, humanitarian response to human suffering in the context of urbanization, population growth, and wide-spread poverty. European settlement of Ontario dates to the founding of Upper Canada in 1791, but fertile conditions for the birth of institutions including established towns and cities, government and community leadership, and sufficient capital for the construction of infrastructure, were not in place until the mid-nineteenth century in the province.

Long-term care facilities constitute the largest manifestation of institutionalization to date in Ontario, and the institutionalization of the frail elderly is expanding year by year in response to the rising numbers of people who require care. Yet, members of this demographic group are the only people who are routinely placed in facilities for custodial care today. A retrospective analysis of manifestations of institutionalization over the last century and a half reveals that, in general, each institutional form begins with an identified humanitarian or educational need among a marginalized population, gathers strength with the construction of facilities and the administration of policies that place people in the prevailing institutional form, and ebbs as the need for the institutional form subsides. The phenomenon can be visualized as overlapping arcs through history beginning in the Victorian era and culminating in the great, upward arc of long-term care today. A graphic representation of the phenomenon of institutionalization since the 1850s in Ontario appears in Appendix B.

To review, although prisons were in place earlier in the province's history, Ontario's first non-punitive, social welfare institutions were asylums for lunatics who were deemed dangerous to themselves or others, and in need of a therapeutic environment and a health-promoting routine. Asylums morphed into acute care, mental health hospitals with extensive out-patient care programs in the late twentieth century and the age of the asylum ended. Following a similar historical arc were orphanages for parentless children. From the mid-nineteenth century to the Depression of the 1930s, these institutions housed thousand of children. By the Second World War, orphans were comparatively fewer in number and foster care replaced orphanages.

Following close behind orphanages and asylums were residential school facilities for Indigenous and disabled children and custodial care facilities for mentally disabled adults, first opened in the 1870s and 1880s. Purportedly established to educate and train these marginalized

groups, residential school institutions provided housing and care that was largely inadequate. Furthermore, they were generally unsuccessful in their therapeutic and educational mandates. Unfortunately, their arc of existence spanned more than a century, and they were not closed until around the millennium. In contrast, houses of refuge and industry for paupers also arose in the mid-Victorian era, but they disappeared by the Second World War or transitioned into nursing homes for elderly people because their former inmates were able to find work or collect welfare funding.

In the mid-twentieth century, nursing homes for old people arose and evolved from earlier forms of institutionalization, especially houses of refuge that had sheltered elderly paupers. In fact, several municipally-owned long-term care homes sit on the sites of county houses of refuge (Weber, 2013). Long-term care is a manifestation of institutionalization that arose with scant planning by government policy makers. Rather, the establishment and expansion of institutional care for the elderly appears to have been a pragmatic, reflexive policy response to a social welfare need.

As with all other manifestations of institutionalization, the long-term care system has been moulded and perpetuated by demographic, epidemiological, philosophical, social, and economic factors evolving within its span of time in Ontario’s history. People are living longer than in previous generations, but often suffer from sickness and infirmity at the ends of their lives. Families are usually small and often mobile, and traditional caregivers, overwhelmingly women, frequently work outside the home. There is a prevalent belief among policy makers and society at large that professional care is superior to family-based care, especially when elderly people have dementia, disabilities, or complex illnesses. In the mid-twentieth century, long-term care was regarded as an economical way to care for the elderly and it is has become a significant

contributor to gross domestic product, a large employer, and a profit-making venture for private businesses. The long-term care system has flourished within a dynamic post-war society, a prosperous capitalist economy, and the underlying, unexamined philosophical assumption, prevalent within and outside of government, that medicalized, institutional care is efficient and superior to other models of care. These intertwining factors within the momentum of a powerful historical phenomenon give the illusion that long-term care is the only way to house and care for thousands of frail elderly people.

However, history suggests that the future of Ontario's long-term care system is not guaranteed. All other programs of institutionalization for social welfare purposes have ended, whether through diminished need as occurred in orphanages and houses of refuge, or through intentional policies such as the closure of residential schools. Successful, intentional deinstitutionalization depends on the provision of alternative services for people leaving care. For example, when asylum beds closed five decades ago, acute psychiatric beds were maintained in hospitals for people in crisis and community mental health services expanded to keep patients out of hospital (Sealy & Whitehead, 2004). In the 1990s, mentally disabled people moved into group homes and other supportive housing arrangements. Researchers Lynn Martin and Melody Ashworth (2010) write, "deinstitutionalization (of mentally disabled adults) results in significant improvements in quality of life and functioning for those persons who move to the community…and these findings have in fact sustained government policies and commitment to deinstitutionalization" (p. 167).

As numbers of frail elderly people have risen, the MOHLTC has been struggling to administer custodial housing and care efficiently, fairly, and humanely. Although deinstitutionalization of Ontario's elderly seems unlikely given the size and continual expansion

of the long-term care system, it is not impossible. In fact, deinstitutionalization may be beneficial for elderly people as shown by the experiences of Indigenous children following the termination of the residential school system and disabled people after large custodial care facilities closed a mere two decades ago.

**Alternatives to the Institutionalization of Ontario's Elderly People**

Ideally, the decision to enter an institution should be a choice rather than a necessity for elderly people regardless of their care requirements. Reflecting on lessons learned from programs of deinstitutionalization of mentally ill and disabled people in the recent past can aid in formulating effective policies for the care of elderly people. Changes to the current system of mass institutionalization of Ontario's seniors could include: thoughtful alterations in how nursing homes are structured and care is performed; the construction of other forms of assisted living; and rethinking how health care, home care, and social welfare are delivered.

First, the care within long-term care facilities should align with what the facilities are: homes. As sociologists Donna Baines and Pat Armstrong (2016) write, "the goal (should be) to promote more life into days rather than extending the days of life" (p.50). Simple, revenue-neutral changes could include permitting staff to wear ordinary clothes rather than uniforms, adjusting medication administration and daily routines to residents' preferences, and encouraging residents to perform household tasks such as setting tables, gardening, and folding laundry if they enjoy it. Quality of life rather than adherence to safety-focused regulations should be the central consideration in how long-term care homes are managed (Baines & Armstrong, 2016).

Second, long-term care homes could include public amenities such as child care centres, libraries, pools, gyms, and event spaces and be located within wheel-chair accessible, pedestrian-

friendly neighbourhoods. Germany has clustered homes for eight to twelve residents with common recreational areas (Doetter & Schmid, 2018). Nova Scotia has experimented with dividing large institutions into small, apartment-like pods in which the residents have their common living spaces arranged the way they wish (Baines & Armstrong, 2016). Denmark and the Netherlands house young people with seniors, and similar programs are appearing in North America as well (Canadian Association of Retired Persons (CARP), 2012).

In autumn 2017, upper level students enrolled in Western University's music program began living, rent free, in the Oakcrossing Retirement Residence in London, Ontario in exchange for engaging musically with their elderly cohabitants. The joint Oakcrossing-Western University pilot project is patterned on a successful program in Cleveland, Ohio. Heather Gingerich, a manager at Oakcrossing, says the program is a "win-win" which has brought "the arts and the vibrancy" of youth to the home while offering students elder "mentors and friends who support them" (Ghonaim, 2017). Intergenerational co-housing programs could be adapted to a range of housing types, from long-term care homes to assisted and independent living spaces. Such innovative projects promote community integration, connect young and old in mutual benefit, and do not necessarily cost more than current mass housing arrangements.

Family and friends usually assume the responsibility for maintaining elderly people in living arrangements outside of institutional care, but these unpaid caregivers are prone to high levels of stress, overwork, and burnout (Dobbins, 2016). Programming such as reliable, affordable personal care, respite care, and adult day care should be available to elderly people who live alone, with their families, or in other community-based settings. A key lesson from Ontario's programs of deinstitutionalization in the late twentieth century is that supportive programming must be in place before community-based housing can replace institutional housing.

## Conclusion

Ontario's long-term care system has evolved from historical trends arising prior to Canada's confederation. Ever-present and ever-changing since the 1850s, institutionalization is a complex phenomenon that has been influenced by intertwining demographic, epidemiological, philosophical, social, and economic forces. The nursing homes of today house thousands of the province's oldest, frailest citizens in the same way orphanages, asylums, and houses of refuge sheltered vulnerable people over a century ago. Residential institutions have provided essential care to marginalized groups in need, but they have also been places of profound suffering, especially for Indigenous children and mentally disabled people in custodial care. At present, the long-term care system is a crucial pillar in Ontario's elder care strategy. In the coming decades, institutional elder care will absorb thousands of baby boomers as this cohort enters old age. Ontario's future elderly citizens may demand alternative programming such as co-housing, supportive community housing, and other initiatives outside of institutional care as well as transformation in how nursing homes are structured and operated. As in the past, the phenomenon of mass institutionalization will be shaped by forces and conditions unique to new times, perhaps with the intentional, policy-driven deinstitutionalization of elderly people.

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Appendix A: Photographs of Historic Ontario Institutions

*Figure 1:* St. Patrick's Orphanage and Asylum, Ottawa, Ontario, opened 1865. (British Home Children Advocacy and Research Association).

*Figure 2:* The Provincial Lunatic Asylum, Toronto, Ontario, 1884.
(Toronto Public Library).

*Figure 3:* The Orillia Asylum for Idiots and the Feeble Minded, Orillia, Ontario, late nineteenth century. (Wheatley 2013a).

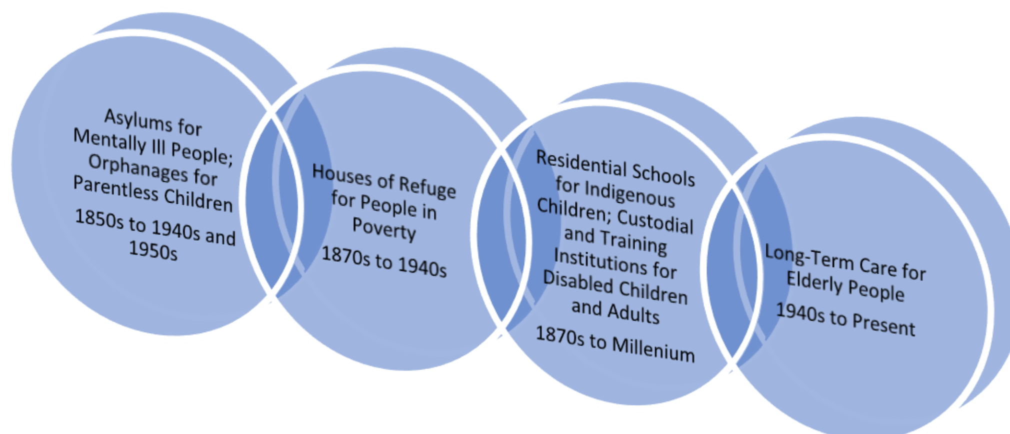
*Figure 4:* Perth County and Stratford House of Refuge, Stratford, Ontario, built in 1896. Spruce Lodge Home for the Aged stands on the former site of the House of Refuge. (St. Marys Museum).

*Figure 5:* Mohawk Residential School, Brantford, Ontario. Enrollment was approximately 150 children in the 1930s. (Anglican Church of Canada).

Appendix B: Graphic Representations of the Phenomenon of Institutionalization

*Figure 6:* Graphic Chart of Interwoven Factors Driving Institutionalization

*Figure 7:* Graphic Chart of Institutional Forms in Ontario, 1850 to Present



Appendix C: Demographic Data of Ontario and Canada, 1850 to Present

**Population of Ontario, 1840 to 2016**

1840: 432,000
1851: 952,000
1861: 1,396,000
1871: 1,621,000
1881: 1,927,000
1891: 2,114,000
1901: 2,183,000
1911: 2,527,000
1921: 2,934,000
1931: 3,432,000
1941: 3,788,000
1951: 4,598,000
1961: 6,236,000
1971: 7,703,000
1981: 8,625,000
1991: 10,085,000
2001: 11,410,000
2011: 12,851,000
2016: 13,976,000

*Figure 8:* Population of Ontario, 1840 to 2016. (Statistics Canada, 2014).

**Immigration to Canada, by Decade 1851 to 2001**

1851-1861: 352,000
1861-1871: 260,000
1871-1881: 350,000
1881-1891: 680,000
1891-1901: 250,000
1900-1911: 1,550,000
1911-1921: 1,400,000
1921-1931: 1,200,000
1931-1941: 149,000
1941-1951: 548,000
1951-1961: 1,543,000
1961-1971: 1,429,000
1971-1981: 1,824,000
1981-1991: 1,842,000
1991-2001: 2,335,000

Note: In some decades of the 1800s and early 1900s, emigration to the United States and other countries exceeded immigration. The population was highly mobile.

*Figure 9:* Immigration to Canada, 1851 to 2001. (Statistics Canada, 2014).

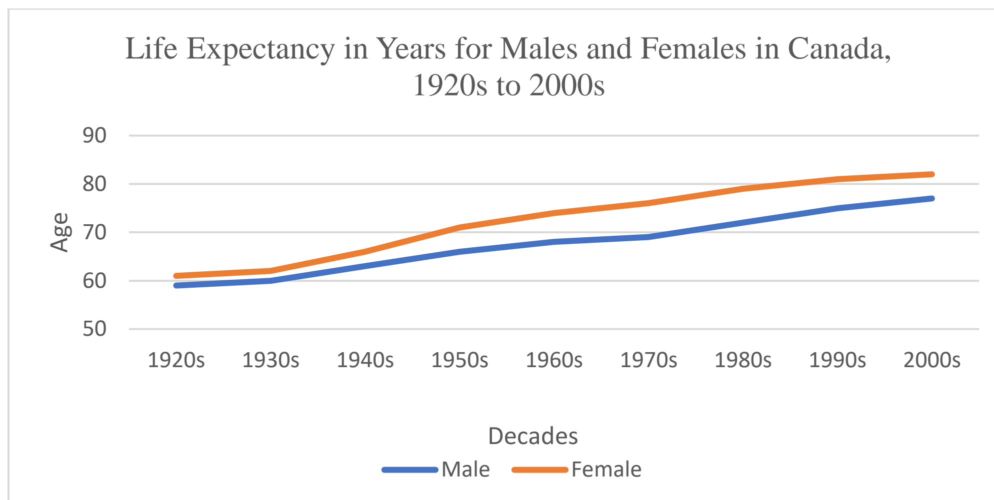



*Figure 10:* Life Expectancy in Canada, 1920 to 2000. (Statistics Canada, 2015b).

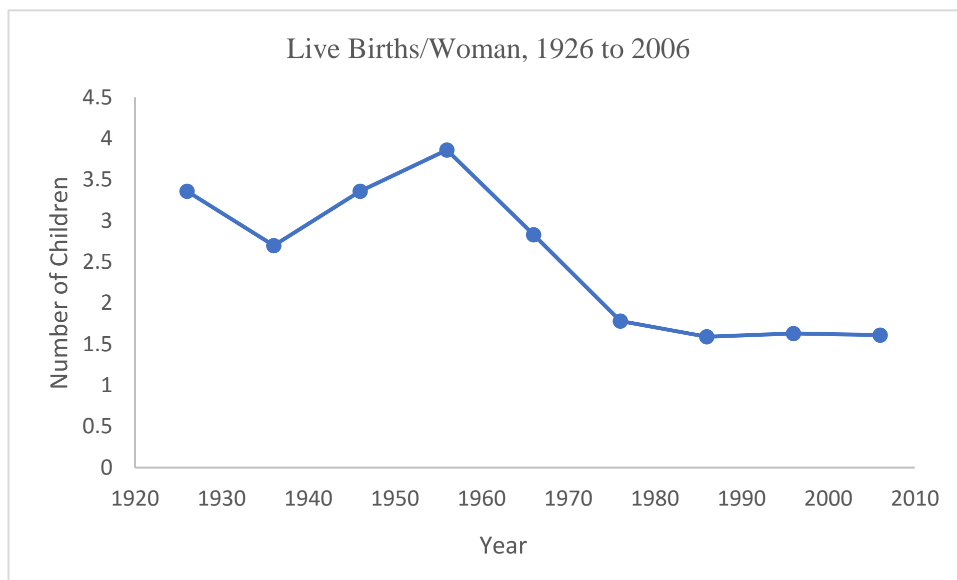



*Figure 11:* Fertility Rate of Canadian Women, 1926 to 2006. (Statistics Canada, 2015d).