A HISTORY OF MENTAL HEALTH CARE IN MANITOBA:

A LOCAL MANIFESTATION OF AN INTERNATIONAL

SOCIAL MOVEMENT

By

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FOR MARGARET:

Concerned Critic
Faithful Supporter
Favorite daughter-child

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ABSTRACT

Two hundred years ago reformers began to suggest
that a group of people called lunatics, who were kept in
deplorable conditions in asylums and private mad houses,
were actually "ill" and amenable to treatment. A social
movement gathered force in England, first to improve the
quality of asylum care and then to expand the number of
these institutions so that all who needed treatment could
be cured. Lunacy reform was introduced into Canada during
the middle years of the nineteenth century by Dorthea Dix
who crusaded throughout North America to persuade govern-
ments to provide asylum care for the mentally ill.

Although the history of the mental hospital has
received considerable attention in both the United States
and Britain, the historical literature of the development
of the asylum in Canada has been fragmentary. The present
study has been undertaken to examine the history of the
mental health system in one province and thereby to docu-
ment a portion of the Canadian experience more fully. The
development of a mental health system in Manitoba was seen
as consistent in most respects with the history of early
asylums elsewhere in North America. At first lunatics
were handled spontaneously by the members of the frontier

community, but very soon the penitentiary became the accepted place for holding such misfits. The provision of an asylum under the direction of a physician was seen as an important step in providing the kind of care which would cure these people. However, by the time of World War I, it was evident that asylum treatment alone could not cure mental illness. Psychiatrists began to look beyond the asylum for more effective treatments, but none of the treatments developed--neither psychopathic hospital, nor psychotherapy, nor shock treatments--were effective in controlling the spiraling asylum population. Finally the medical superintendents in Manitoba, like their counterparts in all of North America, began to send long-term patients back to the community, and the asylum was reorganized to provide only short term care.

Historical analysis of the asylum generally has been focused upon the development of the early asylum. This study includes not only the early development but the subsequent implementation of social policies in response to changing psychiatric solutions. It includes the disenchantment with the asylum and its replacement with plans for a community mental health system. It records attempts to place patients in the community as early as 1934 and the development of the decarceration movement which signaled an end to the old custodial hospital. Unfortunately mental illness remains uncured, and the problem of suitable care for many people handicapped by these conditions remain unresolved.

CHAPTER I

LUNACY REFORM: THE BEGINNINGS OF THE MENTAL

HEALTH MOVEMENT

As long as mental illness was explained in terms of
evil spirits, demonic possession, or magical influence, its
amelioration was not attempted. Lunatics, considered hope-
lessly afflicted and sub-human, often as not were subjected
to outright brutality--chained partially naked and treated
in most respects like animals.[1] At the beginning of the
nineteenth century new explanations of mental illness were
being considered which resulted in new approaches to their
care. Loss of reason was less likely to be seen as brutish
and animal-like, but rather the condition of a human being
lacking in self-restraint, but nonetheless, a human being.
Such people needed treatment and protection, and social
reformers sought to assure humane care through legislation.
The first attempts to introduce legislation to provide for
the regulation of asylums were defeated by the House of
Lords in England, but when a treatment was introduced which

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[1]Andrew T. Scull, _Museums of Madness_ (London: Allen
Lane, 1979) pp. 64-65, suggests that what divided reformers
from their opponents was "two mutually contradictory
paradigms of the essence of insanity." The "unenlightened"
considered the lunatic devoid of his humanity, thus bestial.

promised to <u>cure</u> the mentally ill and return them to productive living, opposition to lunacy reform gradually abated. Seemingly unresponsive to cruelty and neglect of a vulnerable group of people, the Lords were finally willing to support lunacy reform when a new system of treatment, called moral treatment, gained prominence and when a new profession, that of psychiatry, claimed special expertise in providing treatment.

The first of the English nineteenth century social reformers, primarily magistrates and upper middle-class philanthropists, sought to improve the lot of the lunatic through a series of investigations by select committees of Parliament. These groups published lurid descriptions of the neglect of the mentally ill and used their exposes as a basis for demanding legislation. The first such committee was struck in 1807 to inquire into the state of criminal and pauper lunatics in England. They found that most of these people were kept in conditions "revolting to humanity".[2] The report recommended that an asylum be built in each county to receive both pauper and criminal lunatics. An act was piloted through both Commons and Lords which recommended construction and maintenance of county asylums,[3] but since there were no funds made available for these institutions, only nine counties actually constructed asylums within the

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[2] Kathleen Jones, <u>A History of the Mental Health Services</u> (London: Routledge & Keegan Paul, 1972) pp. 57-63.

[3] "The County Asylum Act, 1808". 48 Geo 3, Ch. 96.

twenty years which followed this legislation. Pauper lunatics continued to remain for the most part in jails and poorhouses.

Subsequent events heightened the demand for lunacy reform. A magistrate named Godfrey Higgens uncovered a series of abuses at York Asylum and published a report on the conditions there.[4] The asylum staff resorted to burning part of the institution in order to destroy the buildings which contained the evidences of neglect, but they were unable to destroy the outrage with which reformers responded to Higgins' reports. Eventually the entire staff of the asylum was forced to resign. Another notable case of abuse was the discovery of William Norris who had been kept in an iron collar for nine years, feet manacled and arms pinioned to his sides.[5] Six members of parliament visited him and found him quite rational although badly wasted by tuberculosis. Scandals such as these led to the formation of another select committee in 1815 to renew the investigations of the facilities for the mentally ill. This committee attempted for the first time to provide a comprehensive survey of the care of the mentally ill in England, and the questions which were asked concerning the classification of patients, the staff, the use of mechanical restraint and the

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[4]Jones, History of Mental Health pp. 64-75.

[5]Ibid., p. 64.

amenities provided for the patients, indicated a changing criteria for evaluation. The reformers not only sought to investigate standards of physical care given in the institutions which they visited, but also sought to find out if a special humane care commonly known as moral treatment, was being practiced at the institution.

The lunacy reform movement had recently been given a new sense of direction by the development of this treatment which promised to cure the mentally ill and return them to normalcy. In 1792 an English tea merchant, William Tuke, had proposed to the quarterly meeting of the York Friends Society the establishment of a "retired habitation for those of deranged mind." The Quakers raised funds for the York Retreat within a period of two years, and in 1796 the small, private asylum was opened to the care of thirty people. The rationale of treatment there was based upon Christianity and common sense as opposed to ignorance and brutality. The individual was given a refuge from the stresses which were seen to have caused his condition and kindly guidance by these gentle people. These Quakers were successful in helping many of their charges to recover. The York Retreat became a model institution for those interested in the care of the mentally ill, and professionals and philanthropists alike made pilgrimages to inspect it.

Moral treatment at the retreat in England was a development of reformer concern rather than a product of

medical expertise. The medical men who practiced in the mental institutions of the time, the physicians, the surgeons, and the apothecaries, generally subscribed to medical procedures which were antithecal to moral treatment.[6] They attributed the basic causes of mental illness to vague humours and biles, and their "treatments" emphasized purges, vomits, bleedings and blisterings--all of which were deplored by the reformers. When moral treatment was first introduced, these doctors attempted to discredit the reformers and the treatment they advocated and to reassert medical dominance over the care and treatment of the mentally ill.

Andrew Scull has traced the struggle between early nineteenth century mad-doctors and the lunacy reformers for control of the mental health movement.[7] When the select committee of 1815 was struck to investigate the care of the mentally ill, physicians were in charge of most asylums and private madhouses where the committee found flagrant abuses.[8] Commissioners reported instances of filthy cells with a bedding of loose straw, bodies caked with excrement, abusive keepers, and questionable practices in certifying individuals as insane. Chairman Charles Williams-Wynn attempted to

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[6]Scull, _Museums of Madness_, pp. 125-129.

[7]Ibid., pp. 164-185.

[8]Jones, _History of Mental Health_, pp. 66-86. Scull, _Ibid._

introduce legislation which would provide a competent inspec-
tion system. Bills designed to set up an inspectorate were
steered through the Commons in 1816, 1817, and 1819[9] but
were defeated in the House of Lords. The physicians opposed
these reform bills on the basis that amateurs should not be
allowed to "pretend to decide" on the treatment of patients,
and the "high Tories", traditionally disposed to reject on
principle any type of social reform, supported the physici-
ans' demands that the bills be defeated. Temporarily, at
least, the physicians retained their professional pre-
eminence over the field of lunacy.

However, their victory was a fragile one, for the
findings of the committee had been highly publicised and were
available to provide fuel for a wider reform movement which
was gathering force. The doctors attempted to maintain their
advantage by issuing books and articles asserting that in-
sanity was a medical problem.[10] The proponents of the
reformer-developed moral treatment, on the other hand, did
not seek to produce a literature on moral treatment nor to
train a group of experts in the skills of humane care.[11]
Other than a brief history of the Retreat written by Samuel

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[9]These bills would have empowered boards of laymen
to inquire into the treatment and management of patients, to
direct discontinuances of practices they considered cruel,
and to order any patient discharged who had been restored to
sanity.

[10]Scull, Museums of Madness, pp. 148-154.

[11]Ibid. pp. 141-145.

Tuke,[12] a grandson of the founder of the institution, the Quakers made no claim to special expertise in this area. The physicians exploited this reticence of the reformers to maintain control over the practice of moral treatment. By claiming lunacy as a medical problem and establishing the profession of psychiatry to treat this condition, they gained ascendancy over the field of mental health. Some outside regulation and inspection of asylums became inevitable when another select committee investigated the state of pauper lunatics from the metropolitan parishes in 1827 and verified that patients were still being abused. The doctors sought to assume control over the appointment of the proposed inspection system,[13] and under the 1828 Madhouse Act they succeeded in obtaining for the medical profession five of the fifteen positions on the Metropolitan Commissioners body, an agency designed to inspect and license asylums, both private and public. Furthermore these physicians, and not their fellow Commissioners, were to receive payment. A battle to oust reformers from the Commission continued to be fought over the years to come with laymen such as Lord Ashley suggesting that "a man of common sense could give as good an opinion as any medical man" about such questions as

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[12]Samuel Tuke, A Description of the Retreat, reprinted in Charles E. Goshen (ed.) Documentary History of Psychiatry (London, Vision Press, Ltd., 1967).

[13]Scull, Museums of Madness, p. 152.

diet and exercise while doctors declared the reformers as "incompetent" to sit in judgement of cases of mental derangement. Despite the internal struggles, the Commissioners appointed under the Mad House Act worked diligently and were credited with eliminating the abuses which so incensed the reformers.[14]

The lunacy reform movement of the early nineteenth century involved a group of dedicated people in seeking to abolish abuse of the mentally ill, and they succeeded in making progress toward their goals through the establishment of the Commission to investigate the care of the mentally ill in the metropolitan area. Social reform movements tend to flourish and then fade unless the leaders are able to consolidate their gains by establishing an organizational structure which will assure the continuance of the movement.[15] The Commission provided such a structure. In 1842 the Commission was expanded to twenty members, and a national system of inspection and supervision was established.[16] The information gathered by these Commissioners during their routine

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[14]Jones, History of Mental Health, p. 132.

[15]John P. Roche and Stephen Sachs, "The Bureaucrat and the Enthusiast: An exploration of the Leadership of Social Movements" in Barry McLaughlin (ed.) Studies in Social Movements: A Social Psychological Perspective (New York: The Free Press, 1969) pp. 207-222.

[16]Jones, A History of Mental Health, pp. 132-133.

visits to the institutions provided the bases for further
policy recommendations. Eventually the Commissioners, at
first appointed in a part-time, volunteer capacity, extend-
ed their appointments into full time employment as investiga-
tors and as policy planners.

At the same time the reformers were shifting
their activities from sporadic investigations to regular
participation on increasingly bureaucratized licensing
bodies, the asylum doctors began to organize as specialists
within the field of medicine. In 1841, the English asylum
doctors organized as The Association of Medical Officers of
Asylums and Hospitals for the Insane; their American counter-
parts organized into the Association of Medical Superintendants
of Institutions For the Insane three years later. Having
established their claim to expertise in the diagnosis and
treatment of mental illness, these early psychiatrists were
recognized as the appropriate professionals to legally label
an individual as mentally ill. They became the opinion leaders
in the mental health movement, and increasingly reformers
began to look to them for leadership. The reformer was no
longer in conflict with the asylum doctor but his helpmate
in seeking to develop mental health care under his direction.

When the American reformer, Dorthea Dix, launched
a determined, personal campaign to better conditions for the
mentally-ill, her tactics were derived from those of the

British lunacy reformers, but her goals and rationale came from the asylum doctors. She visited the mentally ill in state after state and described the grim conditions in which she found them. She assaulted American consciences with descriptions of their neglect and then provided legislators with a solution for the problem--the construction of more asylums for all mentally ill irrespective of their financial situation. She echoed the "curability craze" which dominated the mental health field at mid-century. The mentally deranged person, given asylum treatment, could be cured! Mental illness could be eliminated through making asylum treatment available to all who needed it.[17]

Dorthea Dix[18] was catapulted into her career as a reformer when she visited the East Cambridge Jail to teach a Bible class. She found insane persons there confined without heat and was assured by the jailer that these people did not need heat, for it was common folk-knowledge at the time that the mentally ill could not feel heat or cold. She took the matter to court, and heat was provided. From there she

[17]See Albert Deutsch, The Mentally Ill in America: A History of Their Care and Treatment (New York: Columbia University Press, 1949) for a discussion of the history of what Deutsch calls "the cult of curability", pp. 132-157.

[18]For Biographies of Dorthea Dix see: Helen E. Marshall, Dorthea Dix, Forgotten Samaritan (New York: Russell & Russell, 1937); Gladys Brooks, Three Wise Virgins, (New York): E. P. Dutton & Co., Inc., 1957) pp. 3-80. Francis Tiffany, Life of Dorthea Lynde Dix, (Boston: Houghton, Mifflin and Co., 1890).

embarked on a tour of inspection of every jail and almshouse where the insane were kept in Massachusetts. For two years she recorded the details of neglect she discovered, and then she returned to Boston to compile her observations into a Memorial to be presented to the Legislature of Massachusetts. She went to her Unitarian co-religionist, Samuel Gridley Howe, to guide the bill through the legislature. "So profound (was) the sensation throughout the Commonwealth awakened by the frightful details and empassioned eloquence of the Memorial that the obstructions and delays of politicians were swept away before a steadily rising tide of public indignation."[19] A resolution was introduced to erect additional buildings to house 200 patients at the existing McLean Asylum at Worcester. It was Dix' first legislative victory, and her appetite was whetted for more. She was determined to extend her investigations to other states in order to awaken popular consciousness to the deplorable conditions in which the mentally ill were being kept and to demand that proper asylums be built for their care.

During her career as reformer, she was directly responsible for the founding or enlarging of thirty-two mental hospitals in the United States and in the Maritime colonies. Her style of leadership was individualistic and charismatic. She chose to lead the leaders. She made no

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[19]Tiffany, Life of Dorthea, p. 311.

addresses and gathered no large meetings but preferred, instead, to contact leading humanitarian elites "to deliver her burden as from the Lord to them, and let it work on their sensibility and reason."[20] Her reputation for success assured her of a warm reception from reformers and professionals wherever she went. Each of her successes was built upon long hours of arduous investigation, thousands of miles of travel by steamboat and stagecoach, and careful preparation of the politicians she selected to introduce her legislation.

In 1848 she sought to insure asylum treatment for any person needing such care in the United States by asking Congress to set aside a part of the public domaine to finance the care of the indigent insane. Already over 100,000,000 acres of the uninhabited interior had been given away to finance the establishment of education and for other philanthropic programs. Dorthea Dix proposed that 5,000,000 acres be reserved "to assure the greatest benefits to all (who suffered from) the sorest afflictions with which humanity can be visited." She prepared her campaign--carefully choosing the senator to introduce the bill and overseeing the appointment of members for the Select Committee to whom the bill would be sent for approval. The bill was deferred, and again she prepared the way--this time gathering more support from the churches and from the medical superintendents of the institutions. Again Congress adjourned without acting on

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[20] Ibid., p. 92.

the bill, and again the bill was allowed to die. Finally in 1854 the legislation was passed only to be vetoed by President Franklin Pierce who commented:

> If congress had power to make provision for the indigent insane without the limits of this district, it is the same power to provide the indigent who are not insane and thus transfer to the federal government the charge of all the poor in the states.[21]

Dix' six years of endeavor had foundered upon the issue of states' rights, and she had suffered her first defeat.

Her disappointment was profound. However, she sought to recover from this reversal through a European tour, and because she started her tour at the famous York Retreat, she was immediately re-involved in lunacy reform. Through Dr. Hack Tuke, the third member of the Tuke family to be in charge of the Retreat, she learned that conditions of the mentally ill in Scotland were deplorable. There was no lunacy Commission to investigate the asylums and private madhouses there, and these institutions were similar to the British ones prior to the reform movement. Dix visited Edinburgh and decided to stay to investigate the facilities for the insane there. Her visits to local asylums took the Scotch by surprise, and the asylum doctors resented her intrusions. She decided to take the matter of lunacy reform for Scotland to the Home Secretary in London because he was the only one who would have the authority to appoint such a commission. She arrived at his office and demanded to see

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[21]Deutsch, The Mentally Ill, p. 178.

him. She was successful in convincing him that a lunacy com-
mission should be appointed for Scotland. From there she
went to the Channel Islands and remained there until a com-
mittee of sixteen passed a resolution to build an asylum.
She rested in Switzerland and then went on to Italy. In
Rome she met with Pope Pius IX and chastised him for the
conditions of the mentally ill in Rome. The Pope made an
unannounced visit to the insane asylum there and in a sec-
ond audience, assured Miss Dix that he would undertake
reforms on behalf of those "cruelly-entreated members of
(his) flock." She visited mental hospitals in Austria,
Russia, Sweden, Norway, Denmark, Holland, Belgium, and
Germany and consulted with the "ablest authorities on in-
sanity in each country."

Dix came to Canada on a number of occasions to speak
for the cause of asylum construction. In 1850 in a Memorial
to the Legislative Assembly of Nova Scotia, she described
the existing institutions in the Maritimes:

> In Prince Edward Island, near Charlottetown, I found
> a small establishment for the reception of the insane,
> but wholly destitute, through want of funds, of all
> the comforts and arrangements deemed requisite for
> advancing the cure of the patients.
>
> In Newfoundland is the nucleus for an institution
> which the humanity of the citizens will nurture
> into a creditable curative hospital, it is believed.
>
> In New Brunswick is a hospital in the vicinity of
> St. John, for the establishment and support of
> which that government has made what, under the
> circumstances, must be considered very liberal
> appropriations. This hospital, however, cannot
> extend its care to citizens of another province

without excluding, in consequence, patients claim-
ing care within the boundaries of New Brunswick.[22]

In Nova Scotia she found _forty-four_ (her italics) insane
men and women "suffering under different forms of the malady
which placed them in a most helpless condition" in the
Halifax poorhouse; an additional _forty-six_ were found in
the county of Pictou alone. Concerning the Canadas which
she visited in 1843 and 1844, there was progress toward
infant institutions. She described the conditions she had
witnessed during her inspection just a few years previously:

> I found the jail at Toronto thronged with insane
> patients, held in detention for their own pro-
> tection and the public safety. In the jail at
> Montreal were above 70 of the most suffering and
> mismanaged patients I have ever seen; in the jail
> at Quebec I found about 50 in various conditions
> but in every respect more judiciously and humanely
> cared for than in Montreal...Many insane in the
> Canadas were intrusted to the care of religious
> communities; in the districts of Three Rivers,
> Montreal, and Quebec, the government paid yearly
> the sum of £32 10s for the support of each pat-
> ient...They are confined in separate cells,
> debarred all intercourse with each other or with
> society abroad; left to pine in dreary solitude,
> without recreation or employment; without fire
> for warmth in winter, and imperfectly defended
> from the cold by scanty apparel, they became mani-
> acal or idiotic, some piercing the heavy poisonous
> air of their filthy cells with loud cries, rend-
> ing their clothes, or uttering low meaningless
> babblings or idiocy.[23]

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[22]Dorthea L. Dix; "Memorial to the Honorable the
Legislative Assembly of the Province of Nova Scotia and its
Dependencies." in Henry M. Hurd, (ed), _The Institutional
Care of the Insane in the United States and Canada_, Vol. 4,
(Baltimore: The Johns Hopkins Press, 1916-1917) p. 482-497.

[23]_Ibid._, p. 485-486.

She acknowledged the efforts of those who protested against "these foul receptacles for the treatment of the wretched inmates," and gave special recognition "to the honored name of Sir Charles Metcalfe" whom she had contacted personally and in writing concerning these conditions. As a result a temporary hospital was constructed at Beauport about two and a half miles from Quebec. In September 1848, 87 insane from "the dismal cells of the jail in Montreal, the convent at Quebec, and the nunnery at Three Rivers" were transferred to this new facility. She described the transportation of these patients from their "dark, damp cells" to the new asylum:[24]

> They were removed in open carriages and cabs. They offered no resistance; on the contrary, they were delighted with the ride; and the view of the city, the river, the trees, the beautiful sky, and the passers-by, excited the most pleasurable emotions. On their arrival they were placed at a table at breakfast, and it was most interesting to witness their amazement and their delight. All traces of ferocity, turbulence and disorder had vanished; they found themselves again in the world, treated like rational beings, and endeavored to behave as such.[25]

Acting as spokesman for the reformers in Nova Scotia, Dorthea Dix was successful in having legislation introduced into the legislative assembly which would authorize the construction of an asylum. Part of her argument stressed the urgency of early and immediate asylum treatment which was a major tennant of contemporary psychiatric thought.

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[24]Ibid., pp. 486-487.

[25]Ibid.

> The malady of insanity when brought under early
> efficient treatment, is, except there be organic
> disease, equally manageable and curable as
> fever or a cold. The mischiefs of delay in secur-
> ing hospital care cannot be too strongly insisted
> on. Hundreds and thousands of incurable cases,
> within the range of my own observation alone,
> attest the inhumanity and cruelty of procrastina-
> tion.[26]

This tremendous confidence in asylum treatment was founded upon misuse of statistical data, especially in the American asylums.[27] Medical Superintendants made exhorbitant claims based upon calculating the percentage of cures, not on the basis of the total number of patients _admitted_ during the year, but on the total number _discharged_. Moreover the classification of patients as "recovered" was very slippery. It was possible that one person could account for as many as six "recoveries" in one year, for each time this person was discharged, he was discharged as "recovered" even though he might be readmitted at some later date during that year. Using such statistical methods, early psychiatrists were able to claim recovery rates of over 90 percent. Dorthea Dix used this material in her determined campaigns to convince the public that the asylum was the only effective and appropri-ate way to care for the mentally ill.

In reality the asylum failed to fulfill the expecta-tions which had been claimed for it. The post-1850 institu-tions, far from being family-like facilities, were so large

[26]Ibid.
[27]Deutsch, _The Mentally Ill_, pp. 132-157.

that individualized moral treatment was an impossibility.
They had become overcrowded, regimented institutions. This
situation resulted in part from the admission of ever larger
numbers of pauper lunatics who had previously been incarcer-
ated in jails or the strong rooms of county almshouses. As
long as custody, rather than cure had been the primary pur-
pose for institutionalizing the insane, these people were
cared for in the most economical manner. Since asylum care
was more expensive than almshouse confinement, very few
pauper patients were in the asylums. Dorthea Dix' campaign
to obtain asylum care for all mentally ill used fiscal
reasoning to bring about social reform. The pauper lunatics
could be cured in the asylum and the public purse would be
relieved of the expense of their care. Increasingly county
officials were inclined to send their lunatics to the state
asylum. Unfortunately, the medical superintendants had over-
sold their capabilities. A backlog of chronic patients
accumulated in all the new asylums. The American Medical
Superintendants, who had recommended that mental hospitals
should have no more than 250 patients, had to accommodate
ever-increasing patient populations. For example, by 1870
Utica Asylum in New York accommodated 629; the New Jersey
Asylum 648; the New York City Lunatic Asylum on Blackwell's
Island, 1,252.[28] The Medical Superintendant, no longer a

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[28]Gerald Grob, Mental Institutions in America: Social
Policy to 1875 (New York: The Free Press, 1973) p. 190.

paternal figure closely involved with each of his patients,
now supervised a staff of untrained, overworked, and usually
underpaid attendants in a regimen of organized and efficient
routines. As the years passed, the concept of moral treat-
ment was forgotten, and the "cure" (if any) came to be expec-
ted from asylum confinement alone.

Dorthea Dix had her own individualistic style of
working for lunacy reform. She developed no organization to
perpetuate reform but sought, instead, to inspire the pro-
fessionals who cared for the mentally ill with the "holiness
of their cause." During the last decades of the nineteenth
century many professionals recognized that the claims of
curability had been highly inflated and that a residue of
incurable patients inevitably accumulated in every asylum.
Foremost of these critics was Dr. Pliny Earle, an earlier
enthusiast of the asylum, but a man who began to question
the successes which reformers and Medical Superintendents
alike claimed for the institution.[29] In his book, The Cura-
bility of Insanity published in 1887, he discussed the misuse
of statistics made by earlier doctors to justify the build-
ing of more asylums. Another attack on the medical super-
intendents was launched by the neurologists who had risen to
prominence after the American Civil War.[30] They criticized

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[29]Deutsch, The Mentally Ill, pp. 155-157.

[30]Ibid., pp. 276-277.

the alienists, as the early Medical Superintendents were called, for their mismanagement of the asylums--the absence of recreational facilities, the monotony of diet, the over-use of mechanical restraint, and above all, the isolation from normal life circumstances. Despite these criticisms, the public and the governmental policy makers remained convinced by the Dix propaganda that asylum care was essential for the treatment of the mentally ill. Thus, although many professionals were questioning the efficacy of asylum care, the mental health movement was launched seemingly irrevocably in the direction of asylum containment, for popular confidence in the asylum persisted despite all criticisms.

Increasingly the asylum became accepted as the facility for storing strange and difficult people suffering from a variety of "manias" and "dementias". The professionals assured the relatives and friends who committed patients to these facilities that they were acting in the best interests of the patient. By the time Manitoba became a province, the great lunacy reformers were no longer active. Development of mental health care became the responsibility of the bureaucrats. Informal care in the community existed for short periods on the frontier, but as soon as governmental processes were established, arrangements were made for incarcerating the mentally ill.

CHAPTER II

LUNATICS AS PRISONERS: MENTAL HEALTH CARE IN MANITOBA

1870-1885

When Manitoba became a province precipitously in
1870, funds were lacking for the construction of an asylum,
and the population of 11,000 was too small to warrant the
construction of one. The people of the new "postage stamp"
province had not even the most elementary experience with
governmental processes, and it was necessary for the first
Lieutenant Governors to aid the local populace in establish-
ing the mechanisms of government and the departments neces-
sary to keep that government functioning smoothly. Accord-
ingly, Adams Archibald and Alexander Morris, the first
Lieutenant Governors, organized and ran the provincial gov-
ernment as paternal despots.[1] They faced the impossible
task of creating a full-fledged provincial administration on
a yearly grant of less than $70,000.[2] During the entire
period from 1870 to 1885 Manitoba was little more than a
financial ward of the federal government, and it was neces-
sary for the Lieutenant Governor to intercede with the
federal government from time to time to head off bankruptcy.[3]

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[1] M. S. Donnelly, The Government of Manitoba (Toronto:
University of Toronto Press, 1963), pp. 108-119.

[2] Ibid., p. 159.

[3] Ibid.

Ottawa, having created the new province prematurely, was morally bound to prevent its financial collapse. Therefore, even though care of lunatics was a provincial responsibility under the terms of the British North American Act, the reality of the financial relationship between the governments, dictated that care of lunatics would have to be negotiated between the two levels of government.

Initially, the individual lunatic was sent out of province whenever possible. Thus a man named Kennedy was returned to friends in Ontario in 1876 "since there is no facility for his proper treatment in Manitoba."[4] A similar statement from Lieutenant-Governor Morris accompanied a Mrs. U., the widow of a Northwest Territory Official.

> ...the Council found themselves obliged to send her down (to Ontario) in the care of proper guardians, and I am glad to be able to state that two of the Sisters of Charity of St. Boniface volunteered to take care of her...The Council are deeply sensible of the devotedness of the Sisters and the wideness of their sympathies as manifested in this case, a feeling which I am persuaded the Privy Council will share.[5]

The letter explained that her husband could not be regarded as a resident of Manitoba, and, therefore, the Privy Council would be expected to reimburse the province for the cost of the expenses of Mrs. U's trip. Others similarly afflicted

[4]L. G. Morris to "Whom it May Concern", December 12, 1876, L/B M, No. 66, Morris Papers, Provincial Archives of Manitoba.

[5]L. G. Morris to Secretary of State, October 31, 1876, L/B H, No. 65, Morris Papers Provincial Archives of Manitoba.

remained in Manitoba and were cared for in the community in a variety of ways. A suicidal man was taken to a surveyor's camp on the outside of the city of Winnipeg where a strict watch was kept over him by his friends.[6] Another man who did not know his name was arrested for entering the Presbyterian Church, lighting it up, and holding a service of his own. The Manitoba Free Press noted that, "The prisoner is a crazy man who has been around for some time and the Mayor, in the absence of any accommodation for unfortunates of this class was obliged to send him up for a month."[7] Another lunatic provoked concern because he wandered through St. James Parish. He refused offers of clothing on two occasions, wore long matted hair and was dirty in his person and habits.[8] He was allowed to continue his roaming although some concern was expressed about him. Eventually the jail became routinely used for holding these misfits.[9]

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[6]"Suicidal Mania", Manitoba Free Press, May 4, 1883.

[7]"City Police Court", Manitoba Free Press, July 28, 1874.

[8]Lieutenant-Governor Morris to Whom it May Concern, December 12, 1876, LB - M, No. 66, Papers of Lieutenant-Governor Morris, Provincial Archives of Manitoba.

[9]During the nineteenth century jails were used as holding institutions for a variety of deviants. They housed debtors, vagrants, and insane along with those accused of a crime or misdemeanor. David J. Rothman, The Discovery of Asylum (Boston: Little Brown and Co., 1971) analyses the prison, the asylum, and the poorhouse in the United States during this period of time. Richard B. Splane, Social Welfare in Ontario 1791-1893: A Study of Public Welfare Administration (Toronto: University of Toronto Press, 1965) pp. 117-193 discusses the multiple use of jails in Ontario during the same period.

In 1870 the lockup facilities in Winnipeg were limited
to a small log building just outside the wall of Upper
Fort Garry. This building combined the courthouse and the
jail and was altogether inadequate for keeping prisoners
secure.[10] When the federal troops left Lower Fort Garry
vacant in April 1871, the northern portion of the fort was
fenced off with a high palisade which enclosed an old stone
warehouse and converted it into a prison.[11] Samuel Lawrence
Bedson, a former British soldier, was selected as warden of
the institution and he imposed strict, military discipline
upon his staff and the inmates. The presense of lunatics
disturbed the orderly routine of the institution. As early
as 1874 Warden Bedson protested the presence of lunatics in
his prison:

> On the eighteenth of December my head turnkey was
> violently assaulted by a lunatic named Robinson
> while in the act of locking him up for the night.
> The officer was very badly hurt before the other
> officers had time to reach him and was unable to
> attend to his duties for several days in consequ-
> ence. I had made several applications to the local
> government during the year for a sum of money to
> put up a small building inside the walls of the
> prison where all lunatics could be kept, but they
> did not comply with my request until after the
> above occurrence took place.[12]

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[10]Alexander Begg and Walter Nursery, Ten Years in
Winnipeg: 1870-1879. (Winnipeg: Times Printing and Publish-
ing House, 1879) pp. 7, 35.

[11]Phillip Goldring, "Lower Fort Garry", The Beaver,
Outfit 301 (Summer 1970) pp. 34-55. The Manitoba Penitentiary
and Asylum, 1871-1886. National Historic Sites Service
Reports no. 28, 1970.

[12]Dominion of Canada, Sessional Papers, 1876,
pp. 138-140.

The Executive Council of Manitoba sought a solution to the care of the mentally ill by petitioning the Secretary of State to make some arrangement for them in a federal institution. They hoped to have a part of the new Manitoba penitentiary set aside for the care of lunatics--"the only practicable solution for a difficult question." A spate of letters traveled between Ottawa and Winnipeg in an attempt to arrange a federal facility for these people. In early spring 1875 the Lieutenant-Governor wrote the Secretary of State three times concerning care for the mentally ill. Finally, in November 1875, the Under Secretary of State replied:

> I am directed to inform you that it has now, for the first time been brought to the notice of the Government that lunatics are placed in the Penitentiary in Manitoba. It is represented that this is the cause of an increased expenditure, and that owing to the limited accommodation in that institution, very great inconvenience and annoyance is created and further that lunatics interfere much with the discipline of the institution--some of them being very boisterous and requiring additional guards on duty, whilst they at the same time destroy bedding and other property which may be within their reach.
>
> The features of the case are brought under your notice as showing the impossibility of continuing to keep these lunatics in the building and this view as distinct from the impropriety of lunatics being confined in what is legally a penitentiary.
>
> I'm requesting you to call the attention of your government to the above facts. I am further to ask you to urge upon them the necessity of making provision for the removal within a reasonable time (probably two weeks would suffice) of the lunatics to some other place of custory.[13]

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[13]L. G. Nirrus to Edward E. Langevin, Nov. 19, 1875 Morris Papers, Provincial Archives of Manitoba.

Lieutenant-Governor Morris in his reply reminded the Secretary of State of the previous communications concerning the lunatics and reiterated the request that a portion of the new penitentiary should be set apart for the reception of lunatics.

> The lunatics now in the penitentiary were sent there because there was no other place available for their reception. They were in the common jail on criminal charges and were transferred to penitentiary on an order issued by me...It will be impossible to remove the lunatics to the common jail. There are confined in it now seven persons charged with murder--three of them being sent from the territories by the Dominion Government, and the introduction of lunatics would render the jail entirely insecure.[14]

He suggested that a small temporary asylum could be erected within the walls of the stockade, but he would need longer than two weeks in which to make this change. A small wooden building was subsequently constructed, and Warden Bedson agreed to supervise the residents of this annex to the penitentiary. When the new penitentiary building was completed at Stony Mountain in February 1877, one lunatic was still in the Lower Fort Garry compound, and she accompanied the thirteen male prisoners who were transferred to the new institution.[15] Soon after six other lunatics who had been committed to the jail as insane and dangerous to be at large, were one by one removed to the penitentiary on the direction of the

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[14]L. G. Morris to Secretary of State, November 30, 1875, Letter #150, Morris Papers, Provincial Archives of Manitoba.

[15]R. R. Mills, The Story of Stony Mountain and District (Winnipeg: De Montford Press, 1960) p. 52.

Lieutenant-Governor.[16] For the next eight years, the mentally
ill were to be confined to the basement of the federal peni-
tentiary at provincial expense.

Commitment procedures were clarified in 1876 when a
law was passed to provide for the dangerously insane.[17] The
law stated that a person considered too dangerous to be at
large should be brought before a Justice of the Peace who
could commit him to the common jail pending a lunacy hearing
which was to be held within three days. Evidence concerning
his sanity was to be assessed, and if the unfortunate person
was judged insane and dangerous, he was to be committed to
the common jail until arrangements could be made for him.
The Lieutenant-Governor was directed to return the person to
relatives or friends, if the medical practitioners felt it
conducive to his recovery, or, on the written recommendation
of two medical practitioners, he might be sent to an asylum.
The law required that the family of the lunatic contribute
towards his expenses while in the asylum and directed the
Lieutenant-Governor-in-Council to recover the amount owed.

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[16]L. G. Morris to Royal, May 5, 1877, Letter #1425,
May 22, 1877 Letter #1476, June 20, 1877, Letter #1489,
July 25, 1877, Letter #1521, August 20, 1877, Letter #
Morris Papers, Provincial Archives of Manitoba.

[17]C.M.S.; 22: Victoria 38: Custody of Insane
Persons, 1876.

The Custody of Insane Persons Act of 1877 provided a way of appealing the commitment.[18]   If anyone wished to contest the original decision of lunacy,he might do so in a trial of travers, the court costs to be paid for by the party presenting the petition. The care of the estate of the insane person was put under the direction of a committee appointed to handle the insane person's accounts. Court approval was required for any sale or lease of property belonging to him.

The community did not protest the housing of lunatics in the basement of the penitentiary; there was no Dorthea Dix to rally the forces of reform against the mishandling of the mentally ill. The penitentiary had been built with an improper drainage system. A number of cases of typhoid were attributed to this situation, and even the warden became ill for a period of time. Physicians hesitated to send a lunatic to the penitentiary, but it was the Inspector of Prisons who raised a vehement protest against housing the mentally ill in this institution.

> There are fourteen male and three female lunatics confined here under special arrangements made between the Provincial Government and the Department when Mr. Blake was Minister of Justice.
>
> The place is utterly unsuited for these unfortunate people. There is no other accommodation for them than what can be provided in the basement. This portion is unfit for occupation on account of the defective drainage already referred to.

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[18]C.M.S.: 23: Victoria 40: Custody of Insane Persons, 1877.

All the physicians who have attended this peniten-
tiary for the past five years agree in expressing
their surprise that sickness and mortality have not
been at a much higher rate than the actual figures
show. Owing to the absence of cheerful and pleasant
surroundings the want of exercise grounds, and the
experienced nursing afforded in regular insane
asylums, instances of recovery wholly or even par-
tially are fewer than would happen under more favour-
able circumstances. So far as their wants and com-
forts are concerned everything is done under the
direction of the Warden and Surgeon to meet and
secure the one to the other.

Should it be the intention of the Government to
continue the custody and care of the lunatics at
Stony Mountain, I would earnestly recommend the
erection of a building which would be better adapted
in all essential requirements than this for the
proper treatment of the insane.[19]

The construction of a provincial asylum became more

feasible during the 1880's when the province of Manitoba

forged new agreements with the federal government. Wheat

and plowed fields had transformed the former fur trading

frontier into pioneer communities of stable farmers. The

population after a decade of booming settlement totaled

65,954,[20] and these new Manitobans began to challenge the

federal government upon such issues as disallowance of rail-

way charters and the control of the public domain. Although

the federal government did not yield any power to the province

either to grant railway charters or to dispose of its own

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[19] W. Adshead, report to the Department of Justice,
June 15, 1882, Microfilm, Mg4 D6-1, Samuel Bedson Letter-
book, Manitoba Provincial Archives.

[20] W. L. Morton, Manitoba: A History (Toronto:
University of Toronto Press, 1961) p. 177.

public lands, it did concede to demands for increased financial aid to the province. In 1881 Ottawa doubled the previous subsidy from $105,650 to $286,730 and again in 1885 the subsidy was increased to $441,000[21]--thus funding the province to expand governmental services for an ever growing population.

In 1883 the Manitoba Legislative Assembly passed an act authorizing the construction of an asylum to be known as the Manitoba Lunatic Asylum.[22] The Manitoba Free Press acknowledged this event with remarkable disinterest in the humanitarian concern for the mentally ill:

> We are pleased to note that at last steps are
> being taken to provide suitable accommodation
> of those poor unfortunate beings who happen to be
> unable to take care of themselves on account of
> total or partial insanity. Hitherto accommodation
> for insane persons has had to be found at the
> Provincial Penitentiary, this causing a great deal
> of inconvenience and extra labor on the part of
> the officials of the various departments of the
> institution.[23]

The editorial concluded with a suggestion that the asylum be built large enough to house juvenile boys currently confined in the jail until such time as a separate reformatory could be built. The well-ordered institution was seen as a solution to a number of social problems during the nineteenth

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[21]Donnelly, The Government of Manitoba, p. 160.

[22]C.M.S.: 15: Victoria 46: An Act Respecting Lunatics.

[23]"The Provincial Lunatic Asylum", Manitoba Free Press, June 19, 1883.

century,[24] and the <u>Manitoba</u> <u>Free</u> <u>Press</u> reflected a desire to acquire a full range of institutions such as existed in the eastern provinces and in the United States.

In 1883 the contract was let for the new asylum. It would have three stories and accommodate fifty-four beds. It was designed as the left wing of the main building, and provisions were made by the architect for additions as needed so that the completed building would be five times the size of the first construction.[25] In 1884 the Inspector of Prisons demanded that immediate action be taken for more humane care of the lunatics confined at the penitentiary. In his annual report he described the conditions in which the lunatics were kept.

> ...the warden owing to the growing number of convicts finds great difficulty in providing accommodation for the insane. They are lodged in the basement, the attic, and some females in the dungeon cells when these are not occupied by convicts under punishment. There is no proper ward or day room for the lunatics of either sex for recreation and exercise. The comparatively narrow passages have to answer for this purpose. A number of them have to sleep on the floor of the attic passages and there are cells near the tank room badly ventilated and lighted and too cold for winter occupancy. In a word the place is utterly unsuited for the hapless creatures who suffer from so dreadful an affliction. This is so much the case that I feel it my imperative duty to recommend that the local government be notified to provide accommodation for the insane elsewhere in the event of their

[24]Rothman in, <u>Discovery of the Asylum</u> analyses the development of such institutions as the penitentiaries for the criminal, asylums for the insane, almshouses for the poor, orphan asylums for homeless children and reformatories for delinquents and concluded that none of these were "steps in the progress of humanity" but a nineteenth century response to a rapidly industrializing world.

[25]Province of Manitoba, <u>Sessional Papers</u>, 1885, pp.64-66.

being much delay in finishing the asylum.[26]

The provincial government acquiesced and made plans to move the lunatics into temporary quarters at Lower Fort Garry.[27] The former penitentiary building was converted into a Men's Ward, and the Women's Ward was fashioned out of the building which once served as the canteen and hospital for the Northwest Mounted Police. A small wooden building next to the Men's Ward served as dispensary and administrative building. The stockade which encircled the area kept the patients from entering the Company's store. The lunatics were moved by special train to the new premises on February 20, 1885--"in truth a happy change for the better for them and equally a relief to the overstrained energies of the penitentiary staff." The report for the year of 1885 written by Samuel Bedson, Inspector, and David Young, Medical Superintendant reflected their Dixian optimism in the curative powers of the asylum:

> Now that much interest is being taken in the question of insanity and that it is discussed freely in public and private--that the old superstitions and prejudices against asylums are gradually disappearing in consequence of the improved administration of these institutions, in respect to more modern methods of treatment, better accommodation and publicity; it becomes the bounden and honorable duty of every member of the (community) to use his or her

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[26] J. W. Moylaw, report to the Department of Justice, Government of Canada, October 11, 1884, Microfilm Mg4 D6-1 Samuel Bedson Letterbook, Manitoba Provincial Archives.

[27] Phillip Golding, "Lower Fort Garry" and Manitoba Penitentiary and Asylum.

influence to induce relatives or dear friends
to waive for a time the strong ties of blood-
relationship and affection and cheerfully permit
the sufferers instant removal to the asylum on the
first symptoms of mental aberration making their
appearance. The change cannot be made too soon,
better for prevention than a tardy cure. If the
patient can be cured, let him or her, by all means,
be placed at once in the asylum where the process of
rehumanization may be commenced immediately under
the care and treatment of a physician skilled in the
diseases of the mind.[28]

Custody of the mentally ill was now in the hands of
a provincial physician instead of a prison warden. Dr.
David Young undertook the care of the mentally ill, con-
fident that he could help these people through the use of
moral treatment.

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[28] S. L. Bedson, report to Attorney General, Sessional
Papers, 1886, p. 34-37.

CHAPTER III

THE EXPANSION OF THE ASYLUM

The man selected to be the first medical superinten-
dent of the Manitoba Lunatic Asylum, David Young, had come
from Ontario in 1872 and had pursued an adventurous career on
the Manitoba frontier.[1] He served as medical officer to the
newly organized Northwest Mounted Police and as an Indian
Agent and Medical Officer in the Northwest Territories. In
1867, he attended the Icelandic immigrants during the small-
pox epidemic--finally becoming ill with smallpox himself.
When the Manitoba Asylum was under construction, he was
appointed medical superintendent. Any physician who wished
to practice psychiatry at this time learned the specialty
from other medical superintendents since there were no formal-
ized professional training programs. Dr. Young visited
asylums in eastern Canada and the United States in order to
learn the art of asylum management. Quite obviously he became
familiar with the precepts of moral treatment during this
period, for when he moved his first patients from Stony
Mountain to Lower Fort Garry, he implemented moral treatment
for a brief period of time.

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[1] "First Superintendent - Manitoba Hospital" Newspaper
article in family scrapbook of Barbara Sparling.

Treatment of insanity at the end of the nineteenth century relied upon three approaches--the hygenic, the moral, and the medical.[2] The removal of the patient from his home was considered hygenic inasmuch as it removed him from the causes of his disease. The medicinal treatments both "curative and palliative" included such drugs as tartrate of antimony, opium, purgatives, and tonics. Bleeding and leeching were still listed but "not recommended." Medical "interference" was deemed necessary in the acute and violent forms of mania and melancholy, but once the more florid symptoms had subsided, the patient might be treated by "moral means." Moral treatment demanded that the physician treat the patient with authoritarian firmness tempered by never-failing kindness, gentleness and sympathy. Above all, treatment was to be individualized. Under watchful and skill-ful management, the patient was encouraged to assume control of his behavior.

Dr. Young kept a journal for the first six months during which he was medical superintendent. In his daily entries he demonstrated a personal interest in his patients and a humane concern:

> February 19 -- twenty-seven men and eight female
> patients arrived by train from the penitentiary.
> Mr. Bedson accompanied them. Tea was served at
> 5:30, and all with the exception of three ate

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[2]Bucknill, John Charles and Tuke, Daniel H. A Manual of Psychological Medicine, facsimile of 1885 Edition with introduction by Francil J. Braceland, (New York: Hafner Publishing Company, 1968) pp. 444-506.

well. All went to bed quietly and orderly at
7:30 p.m.[3]

Later in February he began to write about a very
special patient, Annie S. He recounted her violent episodes
and her gradual recovery. He handled her outbursts with
understanding and firmness and demonstrated his mastery of
moral treatment. The week after the patients moved into
the Fort, Annie came to his attention because she hit the
matron, Miss McBride, with a mop and threatened to bite her.
A few days later she took off a slipper and struck another
patient. Dr. Young asked her what was the matter, and she
told him that she had "hydrophobia". She ran to her room
and threw her chamber pot at the door, smashing it into
pieces. He walked into her room, recovered the broken
pieces of crockery--all the time talking to her. She com-
menced to cry and gradually quieted down. On the following
day she grew excited again--threw her shoes in the fire,
tried to bite the attendant and to pull the dishes off the
table. Dr. Young did not use a restraining device, but he
did lock her into her room. She jumped on her bed until the
screws loosened, and one side of the bed collapsed. The
Medical superintendent had the bed removed and left Annie to
spend the night on the floor. In March the doctor began to
treat her excited spells with a glass of strong whiskey.

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[3]David Young Journal, February through September
1885, In possession of Hume Young.

Then on May 18 he gave her a sedative which she reported produced "the strangest feeling". After her experience with this drug, she began to change. She helped in the kitchen. She slept well, gained weight, and became concerned with her personal appearance. By June, Dr. Young proudly pronounced her ready to return home, and then he alternately encouraged and consoled her until August when her husband finally arrived to take her home.

The patience and concern which Dr. Young employed in helping Annie demanded time and dedication on the part of the medical superintendent. Soon David Young was unable to devote such energy to helping individual patients but was forced to expend it upon the many details of asylum administration. As the construction of the new asylum in Selkirk neared completion, he was absent from the Fort for periods of time while he attended to details of locks and landscaping, ornamental guards on the windows and fencing. His entries in his journal became sporadic and terse. Increasingly he relied on medical treatments such as purgatives and drugs, for more and more of his time was absorbed by administrative duties. Moral treatment was impractical in large institutions and remained so until the social psychiatrists of the 1950's developed ways of adapting this type of treatment to small ward groups under the rubric of the therapeutic community. (see page 98) It is not surprising, then, that when the patients were moved from Lower Fort Garry to

the new asylum on May 25, 1886 that moral treatment had
already been abandoned.

Although there was no effective treatment in the
asylums, medical superintendents continued to be agreed
upon the necessity of bringing the mentally ill person into
the institution upon the first signs of illness. They
sought to impress upon the general population the need for
early treatment. In response to this propaganda, more
people sought to commit difficult relatives and friends to
the asylum in the belief that this was the appropriate
facility. The new Manitoba Lunatic Asylum was an elegant
structure located in the country outside the town of
Selkirk. It was designed on a plan similar to one submitted
to the State of Pennsylvania by a commission composed of
medical superintendents.[4] This design allowed for expansion
of the facilities as the patient population increased. The
1886 structure at Selkirk, initially intended for fifty-four
patients was planned as the left wing of the main front of
a building which would be five times the size of the original
structure when it was completed. Previous experience with
asylum planning in the United States and England had been
one of increase in population followed by additional con-
struction in a spiraling fashion for as long as money was
forthcoming. "No state in the American Union, no Province

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[4]Province of Manitoba, Sessional Papers, 1884,
pp, 64-66.

in the British Colonies has ever built a new asylum until there has been waiting to enter at least three times as many lunatics as would fill it."[5] Thus observed Joseph Workman, esteemed medical superintendent at Toronto Asylum in 1866. The establishment of the Manitoba Lunatic Asylum was no exception to Dr. Workman's rule. The fifty-nine patients who were transferred from the makeshift asylum at Lower Fort Garry occupied a facility at Selkirk originally planned for fifty-four patients. Additional facilities were needed immediately, and room for the ever increasing numbers of patients eventually was found by increasing the size of the asylum and by transferring patients to other facilities as they were opened.

Two years after the opening of the asylum at Selkirk, an addition was already under construction, and Dr. Young protested that even this addition would not meet the growing need. In a letter to Thomas Greenaway, newly elected premier, he explained,

April 23, 1888

Sir!

In my letter of the 25th there is no reference to the necessity for increased accommodations in this new wing. I neglected to point out that the dining room used for the acute patients is too small for the number of patients we now have and that when the wing is completed, it will be necessary to use the dining room on the third flat.

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[5]Province of Canada, Sessional Papers 1867, Vol. VIII, p. 93.

> This room is now occupied as an associate dormitory
> and has twelve beds in it. These twelve patients
> will have to be removed to the new wing...only
> leaving accommodations for twenty-four (24) new
> patients. Beside these, five patients are now
> sleeping on the floor on the corridors, and they
> should certainly be provided with beds as soon
> as there are any.[6]

Some additional room was made for Manitoba patients

by returning thirteen men and eight women to the penitentiary

at Stony Mountain that year. These patients, originally

from Keewatin and the Northwest Territories, had been cared

for at Selkirk through an arrangement with the Dominion

Government.[7] A second asylum was established at Brandon in

1891.[8] This institution was originally built as a reforma-

tory for boys, but only one nine year old sentenced to five

years for stealing a letter from Her Majesty's Mail lived in

the building for the six months it functioned as a reforma-

tory. In July 1891, the institution became Brandon Asylum

and twenty-four patients were transferred to this facility

from Selkirk, the Eastern Judicial Jail, and the Brandon

Jail. An additional eleven patients were transferred from

the Home for the Incurables at Portage la Prairie. This

institution which accepted patients from the Northwest

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[6]D. Young to T. Greenway, April 23, 1888 Provincial
Archives of Manitoba.

[7]Manitoba, Sessional Papers, 1910, p. 153.

[8]T. A. Pincock, "A Half Century of Psychiatry in
Manitoba, Canada's Mental Health, Vol. XVIII, No. 3 (May-
Aug. 1970), p. 4.

Territories on contract with the federal government as well
as Manitoba patients was soon "fully taxed".

Other mental patients were deported as insane aliens.
In 1906 one of these "undesirables" was returned to the
United States and one to England; in 1909 ten people were
deported to Russia, France, Austria, and Romania from the
Selkirk Asylum, and twelve were deported from Brandon.[9]
During World War I, aliens were held at the asylums until
the end of the war. German and Austrian insane were deported
immediately after the war.[10] Deportations continued until
1935 when Provincial Psychiatrist, Dr. A. T. Mathers, repor-
ted that deportations had just about reached the vanishing
point.

David Young realized that every year admissions to
the Manitoba asylums included a certain number of patients
who would never recover and who would have to look on the
asylum "as their home for the balance of their lives", and
that each year additional space would be needed. In 1904,
he reported:

> Although our population has only increased by 37,
> yet the building seems already pretty well filled,
> so many who were formerly sleeping in the corridors
> being now in the dormitories. At present there are
> vacancies for about 16 women and 30 men. From the
> experiences of 1903 it may be taken for granted that
> these will be claimed in 1904.[11]

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[9]Province of Manitoba, Sessional Papers, 1910, pp.153.

[10]Ibid.

[11]Province of Manitoba, Sessional Papers, 1904 p. 443.

The patients were encouraged to work as soon as they recovered from the acute stage of their illness as the activity "diverts his mind, promotes sleep, aids in digestion, and makes him feel he is doing something useful."[12] The reports from the asylum farms attested to the productivity of patient labor. The farm manager listed pages of produce raised on the asylum farm which was, no doubt, useful in convincing the legislators of the frugal management of the establishment. An average of sixty to one hundred patients per day were involved in cultivating the crops. The women worked in the kitchen, in the laundry, and in the sewing rooms. They made nearly all the uniforms for the patients in the institution and mended stockings, clothing and bedding. The asylum provided a routine existence to the patient at minimum public expense.

The tedium of asylum routine was interrupted at Brandon Asylum on November 4, 1910 by a fire which broke out at supper time. Six hundred thirty-nine people were removed from the building in eight minutes, and the staff had sufficient time to rescue clothing and bedding before the building burned to the ground. The Manitoba Free Press reported a "terrible scene."[13] "Some of the poor demented creatures

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[12]Province of Manitoba, Sessional Papers, 1908.

[13]"Brandon Asylum, Home of Six Hundred Persons, Burned Down", The Manitoba Free Press, November 5, 1910.

went dociley to places of safety to which they were directed
while others screamed and danced with delight as they watched
the furious flames shoot upwards." The recapture of many
patients who were dispersed over the countryside occupied
the community for a weekend. Three days after the fire only
three men were still missing, and the Free Press[14] assured
the citizens of Manitoba that these persons were not danger-
ous. The "maniacs or dangerous patients" had been confined
in the jail, and the remainder were being made comfortable
at the Winter Fair Building. One woman died of exposure
when she wandered off from the crowd. Ladies Aid groups
from the Brandon churches volunteered to cook and to care
for the patients during the emergency, and the staff worked
around the clock to settle the patients into their new
quarters. The Winter Fair Building was converted into a tem-
porary asylum by partitioning off areas for dormitories and
kitchens, and very soon a temporary asylum was improvised.
The patients remained in this building for two years until
a new asylum was constructed.[15]

During the thirty years following the opening of the
asylum at Selkirk, the medical superintendents maintained a
confidence that asylum confinement was the very best manner
of caring for the mentally ill person. Populations increased

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[14]"One Lost as Result of Fire," Manitoba Free Press
November 7, 1910.

[15]Province of Manitoba, Sessional Papers, 1913, p.
491.

and buildings were expanded in a futile attempt to accommo-
date the growing number of patients. In 1904 the last addi-
tion to the Selkirk Asylum was finished, and the building
was complete as originally designed. Brandon Asylum con-
tinued to accommodate patients from the territories on a
contractual basis between the province and the federal
government until the time of the fire, but when the Brandon
Asylum was reoccupied, only Manitoba patients were accom-
modated. Dr. Young sought some answer to the apparent fail-
ure of the asylum to return more patients to normalcy. He
suggested that the name of the institution was at fault.

> The term asylum as used to designate institutions
> of this kind, has been, and is strongly objected
> to by not only a large number of the profession
> who consider it as implying mere care and custody,
> without bringing into view the curative measures
> usually associated with the word, hospital, but
> also the patients and their friends from sentimental
> reasons. In the United States, the great majority
> of asylums are known as 'hospitals for the insane.'
> ...For the acute, curable cases, they are essential-
> ly hospitals, and in the interest of this class
> there can be no serious objection to a change in
> the Act by which in the future they would be offici-
> ally and popularly known as 'hospitals for the
> insane' in this province.[16]

Again he repeated the belief that "the earlier the mentally
ill are withdrawn from the surroundings amongst which their
affliction started, the better the chance for recovery."
He was certain that relabelling the institution would dispel
the "unmerited aversion" individuals had towards the asylum

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[16]Province of Manitoba, Sessional Papers, 1906,
p. 530.

and would encourage them to come into the institution earlier. His confidence in the asylum had not diminished. To Young, the inability to cure these patients lay not in the asylum but in the unwillingness of relatives to commit the patient early enough in the course of the illness.

The growth of the asylums was checked briefly by the outbreak of World War I. Admissions decreased. War had a significant effect upon the mental health of the civilian population. H. E. Hicks, medical superintendent at Brandon in 1917 was confident that the decrease in admissions was due to the decrease in the consumption of alcoholic beverages "and the consequent decrease in poverty and unhappiness of the population."[17] The explanation was probably rooted in the economy also, for the unusual labor shortage caused by the war led to the employment of marginal people. A combination of wartime morale and useful employment, helped to decrease the number of people beset by mental illness. However, if mental illness declined on the homefront, it had devastating effects upon the troops subjected to prolonged bombardment. The unexpectedly large number of cases of "shell shock" demonstrated that everyone had a breaking point, and once more, people became interested in the causes of mental illness and the care of mental patients. In Manitoba this resulted in a questioning of existing mental health practices and a search for more effective ways of caring for the mentally ill.

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[17] Province of Manitoba, Sessional Papers, 1917, p. 69.

CHAPTER IV

THE SEARCH FOR TREATMENT ALTERNATIVES

Initially critics of the asylum were ignored by asylum personnel and the general public alike, for the reformers had presented the case for asylum-care with such certainty that alternative opinions were scarcely heard. Late in the nineteenth century a group of neurologists began to question this institution and eventually the ever increasing backlog of uncured patients still in care gave rise to a reassessment during which attempts were made to improve the asylum system. Thus new buildings were built-- some large and handsome and some smaller and designated as "cottages". Lunacy laws were rewritten, and lunacy was renamed mental illness. Doctors trained in psychiatry replaced general practitioners at these institutions, and trained nurses replaced the corps of attendants and matrons. All these measures were taken to make the asylum more effec- tive as a healer of the mentally ill. As before, some patients responded to the asylum experience, but many remained in the hospital to swell increasing patient popula- tion. Despite all these innovations, mental illness remained. The years between World War I and World War II became a per- iod of gradual disenchantment with the asylum. Despite all the changes, the mental hospital, as it was now called,

failed to help a significant number of people sent there for treatment.

The neurologists who had challenged the authority of the medical superintendents had sought the causes of mental disorder in the anatomy and physiology of the brain, and many asylums added a pathologist to the staff to dissect cadavers and to investigate lesions in the brain. Dr. Adolph Meyer, a Swiss pathologist, extended his investigations to the social causes of mental illness. He abandoned his bottles which contained brain specimens and began to look for the causes of mental illness in the childhood experiences of his patients. "One of the most important lessons of modern psychiatry," he concluded, "is the absolute necessity of going beyond the asylum walls and of working where things have their beginnings."[1] Accordingly he sent his new bride to visit the families of his patients to assess the reasons for the mental breakdown. The information obtained from these visits was not only important in understanding the individual patient, it was helpful in understanding the situation to which the patient would be discharged. Thus the importance of the relationship of the patient to the community was acknowledged.

The team of psychiatrist and social worker was initiated from the Meyers' studies, and from this partnership

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[1] Adolf Meyer, Public Lecture in Alfred Lief (ed.) The Commonsense Psychiatry of Dr. Adolf Meyer, (New York: Arno Press, 1973) p. 293.

the after-care movement emerged early in the twentieth century. The after-care teams sought to provide financial, medical, and moral assistance to patients discharged from the mental hospitals in an effort to avoid the relapses which often brought the patient back to the hospital. The first teams were organized in January 1906 at a joint meeting of the Medical Superintendents of the New York asylums and the officers of the Charities Aid Association. A plan for a state wide after-care system under the auspices of the State Charities Aid Association was drawn up, and a series of after-care committees were designated to implement the plan.

Concurrent with the after-care movement was the development of the Psychopathic Hospital.[2] This type of institution was developed in Germany, to provide examination, observation, and short-term, intensive treatment. The first such facility was established in North America at Bellevue Hospital in New York in 1879 for the accommodation and observation of people who might otherwise be sent to a jail. While the movement for psychopathic hospitals grew out of a need for decent accommodations for doubtful cases of mental disorder pending commitment proceedings, it later expanded its services to provide care for patients suffering from acute conditions. It became a center for research and

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[2]Albert Deutsch, The Mentally Ill in America: A History of Their Care and Treatment (New York: Columbia University Press, 1949) pp. 291-299.

study of nervous and mental disorders. In the 1920's some of these units began to offer out-patient clinics where individuals could receive psychiatric care without confinement in a mental hospital.

The most stunning criticism of the asylum came from a patient. Clifford Whittingham Beers had lived a very ordinary life, growing up in a middle class family, graduating from Yale, and entering a business career according to family expectations. Then on one day in 1897 he threw himself from the window of his third floor bedroom in an attempt to commit suicide. He was obsessed with the belief that he was becoming epileptic. He survived the fall with only broken bones, but his mind was "stormed by a train of delusions alternating from those of persecution to those of grandeur which ruled over his thought for the next three years."[3] His family sent him to three different institutions, the first a private asylum run for profit, the second a private non-profitmaking institution, and the third a state hospital. He was beaten, choked, spat upon and reviled by attendants, restrained by a straitjacket for as long as twenty-one consecutive nights, and imprisoned for periods in a dark, padded cell. His indignation at the treatment meted out to him evolved into a plan for starting a world-wide movement for the protection of the insane. When he recovered, he returned to his business career, but the idea

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[3]Ibid., p. 303.

of creating an organization in behalf of the mentally ill
remained in his thoughts. Eventually he decided to write
of his experiences. The result was his autobiography,
A Mind that Found Itself,[4] a book which had been reprinted
twenty-five times when he died in 1943.

A Mind that Found Itself created a profound impres-
sion upon those who read it. "It was not conceived as an
end in itself, but rather as the beginning--the first step--
of a movement calculated to organize public opinion,
scientific knowledge and a humane application of that know-
ledge into a unified force." Despite the reforms of the past
century, mental patients were still being mistreated, and
Beers was determined to insure that mentally ill persons
would be treated humanely and given every opportunity for
recovery. He chose to develop an organization, "a powerful
instrument of social progress," and sought the expertise of
influential professionals to give direction to his project.
William James, the famous psychologist, was first to lend
his name and financial support to the new organization and
to introduce Beers to other leaders in the mental health
field. Dr. Adolph Meyers recognized in Beers a potential
ally, "a fascinating personality, direct and sensible, and
promising to become an excellent champion for a great cause."[5]

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[4]Clifford Whittingham Beers, A Mind that Found It-
self, 25th Anniversary Edition, (New York: Doubleday, Doran
& Co., Inc., 1945).

[5]Ibid p. 382.

Preliminary organizational meetings were held in the home of Dr. Meyer. It was decided to start a local group first, and in March 1908 the Connecticut Society for Mental Hygiene was founded using thirty prestigious members of the community as an honorary committee. The National Committee for Mental Hygiene grew out of this endeavor in 1909. Its objectives were:

> To work for the protection of the mental health of the public; to help raise the standard of care of those in danger of developing mental disorder or actually insane; to promote the study of mental disorders in all their forms and relations and to disseminate knowledge concerning their causes, treatment and prevention; to obtain from every source reliable data regarding conditions and methods of dealing with mental disorders; to enlist the aid of the Federal Government so far as may seem desirable; to coordinate existing agencies and help organize in each State in the Union an allied, but independent Society for Mental Hygiene similar to the existing Connecticut Society for Mental Hygiene.[6]

The prevention of mental disorder was the cornerstone of this movement; the protection of the mentally ill, as Clifford Beers had advocated, became secondary.

The Canadian National Committee for Mental Hygiene was organized by Dr. Clarence Hincks in 1917.[7] As Medical Inspector for schools in West Toronto, he had become concerned with children's emotional problems. He learned the new techniques of administering Binet-Simon intelligence

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[6] Quoted in Deutsch, The Mentally Ill, p. 315.

[7] Canadian Mental Health Association, Clarence Meredith Hincks, 1885-1964, recording, 1965.

tests and became well known in the Toronto area for his work in mental testing. Dr. C. K. Clarke, renowned Professor of Psychiatry at the University of Toronto and Dean of the Faculty of Medicine there, induced Hincks to join him in establishing a psychopathic clinic in Toronto. From this experience Dr. Hincks became aware of the magnitude of the mental health problem in Toronto, and he developed a concern about such problems in the rest of Canada. He consulted with Clifford Beers in New York, and with Beers' blessings he began his campaign to establish a Canadian organization. At McGill University, where he met with the medical faculty, he was offered their support. He then went to the Governor-General who agreed to allow his name to be used. From there he contacted twenty outstanding Canadians and secured pledges of $1,000 each for the following three years. From these funds the national Canadian organization was launched. Very soon thereafter they received a request from the Public Welfare Commission of Manitoba to come to the province to study "conditions in Manitoba particularly in reference to the hospitals for the insane and other institutions where mental defectives were housed."[8]

Reform was in the air in Manitoba at this time.

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[8] C. K. Clarke and C. M. Hincks, "Report to Manitoba Public Welfare Commission, 1918" (typescript), Provincial Archives of Manitoba.

The Liberal party under the leadership of Premier T. C. Norris was engaged in expanding welfare legislation.[9] Within a few years, compulsory school attendance, women's suffrage, civil service reform, prohibition, workmen's compensation, mothers' allowances, and child welfare legislation had been enacted. Dr. Hincks and Dr. Clarke were asked to study all parts of the system which cared for the "mentally afflicted" and to make recommendations for improvement. They were allowed to investigate wherever they wished without interferrence, and accordingly, they visited the asylums, the jails, the children's homes, the hospitals, and the homes for unwed mothers, in short, any institution where such deviant individuals were kept. They found seriously mentally ill individuals under restraint in jails as well as "incorrigible" children as young as nine years of age. They identified a number of "morons" in the jails and maternity homes. Clearly many mentally handicapped people were not even recognized much less treated.

Concerning the mental hospitals, Dr. Hincks and his associate were impressed with the cleanliness and the minimal use of restraint. However, other conditions in these institutions appalled them. At Brandon Insane Hospital there were nine hundred patients and one doctor.[10] The

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[9] W. L. Morton, The Progressive Party in Canada (Toronto: University of Toronto Press, 1950), p. 33.

[10] Clarence Hincks, recording.

medical superintendent was "so busy overlooking the details of the asylum farm and signing death certificates that he had no time for the treatment of patients." There were no trained nurses on the staff, and the male attendants were a rough group. "It was evident from the number of black eyes of the patients, that they used strong-arm methods of control.[11] There was not the "slightest regard to the demands of modern science"[12]--neither the staff nor the equipment to give the patients the kinds of treatment which they needed. Conditions at Selkirk Insane Hospital were similar. Dr. Hincks and Dr. Clarke condemned the practice of "taking care of so many hopeless dements at the cheapest rate possible" because this policy resulted in a fine herd of Holsteins and a collection of fat hogs while the patients themselves were minimally fed.[13] They recommended changes in the mental hospital system which would provide patients with modern, progressive care. Following the visit of these consultants a number of changes were implemented, and Manitoba became the pride of the Canadian Committee for Mental Hygiene.

First and foremost was the construction of a psychopathic hospital.[14] The Winnipeg Psychopathic Hospital was

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[11]Ibid.

[12]Clarke and Hincks, "Report, 1918".

[13]Ibid.

[14]H. C. Hendri and J. Varsamis, "The Winnipeg Psychopathic Hospital 1919-1969: An Experiment in Community Psychiatry".

opened for thirty-two patients (Hincks and Clarke recommended
one hundred) on October 22, 1919. Dr. A. T. Mathers, a
graduate of the University of Manitoba and a member of the
staff of the Boston Psychopathic Hospital was selected to
head the Unit and to coordinate its activities with the other
mental hospitals in Manitoba. The facility offered diagnos-
tic services, short-term care for acute conditions, and
after-care services from a staff of qualified personnel.
Most significantly, it was located adjacent to the Winnipeg
General Hospital--not in an isolated part of Manitoba.
Idyllic countryside seclusion was scrapped in favor of a
location where out-patients and after-care services would
be more accessible. It was a first, tentative step in the
direction of treating the patient in the community.

An issue which was of great concern to humanitarians
interested in protecting the mentally ill was the conditions
of commitment. The "Custody of Insane Persons Act of 1876"
specified that a person considered insane could be committed
to the common jail pending a lunacy hearing.[15] Hincks and
Clarke in their report called the incarceration of mental
patients in jails "inhuman" and suggested that immediate
steps be taken to change the law so that the mentally ill
person could be taken directly to a psychiatric facility for
examination. In March 1919 legislation was passed which

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[15]C.M.S.: George V, 9: "Mental Disease Act,
1919".

allowed individuals in need of treatment or their relatives or friends to make application for admission to the psychopathic ward or to a mental hospital without recourse to a court hearing. Thereafter every effort was made to keep mental patients out of the jails.

In accordance with the consultants' report measures were taken also to improve the quality of care at Brandon and Selkirk Hospitals for Mental Diseases.[16] A training program for psychiatric nurses was established at both hospitals by 1921[17] for the purpose of professionalizing the keepers of the mentally ill. This training program was basically an apprenticeship with some classes in psychiatry, surgery, obstetrics, and "Materia Medica" which included "drugs, solutions, and pharmacology". After the first graduating classes in 1923, experienced staff replaced the casual labor heretofore hired to keep order in the wards. An ambitious building program was also undertaken at this time. The construction of new buildings was more practical than additions to wings on huge buildings already standing, and the new construction at the Manitoba facilities provided a cluster of separate buildings. A reception unit was built at both

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[16]The name of the hospitals was changed by the "Mental Diseases Act of 1919" from the Brandon (or Selkirk) Insane Hospital to The Brandon (or Selkirk) Hospital for Mental Diseases. It was the second name change in a period of six years.

[17]Registered Psychiatric Nurses Association of Manitoba, "A Brief on Psychiatric Nursing in Manitoba," 1977, p. 4.

Brandon and Selkirk to house returning soldiers. These
were the most modern units in all of Canada and were
equipped with laboratories, hydrotherapeutic equipment,
and space for occupational therapy programs.[18] At Brandon
a one and one-half story building for "senile dements" was
built about a mile distant from the main complex of build-
ings to house 83 people. Once again the facilities were
adequate for the number of patients needing care.

The years immediately following these reforms were
marked with enthusiasm, particularly in regard to the
Winnipeg Psychopathic Hospital.[19] During its first year of
operation, the daily average population was 31.67 indicating
maximum usage of the thirty-two bed facility. Only thirty-
three or 7.4 percent of the admissions were on a police
magistrate's warrant, and only 126 or 31.6 percent of the
patients were transferred on to a mental hospital for long
term care. The Medical Superintendent at Selkirk Hospital
for Mental Diseases commented upon the decrease in admis-
sions to the hospital and attributed this encouraging change
to the opening of the Psychopathic Hospital and the evidence
that both patients and their friends were showing a sensible

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[18]Manitoba, Sessional Papers, 1920, p. 51.

[19]Hendri and Varsamis, " The Winnipeg Psychopathic
Hospital." pp. 5-7.

desire to start treatment early. He credited early treatment at the Psychopathic Hospital with helping many individuals to return to their "former position in society" without recourse to the use of a hospital for mental disease such as Selkirk.

The early spirit of undiluted optimism was replaced very quickly by scepticism. The population began to increase once more at both Selkirk and Brandon, and once more the mental hospitals were crowded and unable to admit new patients. Transfers from the Psychopathic Hospital to the mental hospitals came to a standstill because of lack of accommodation at these hospitals. Dr. Mathers reported:

> The admission rate (at the Psychopathic Hospital) was actually lower this year. This could not be said to be due to fewer demands for accommodation but to the fact that overcrowding having reached a point beyond which no one with a scrap of humanity could carry it, admissions had to be refused or delayed for a considerable number for whom it was sought.[20]

The inability to get treatment for individuals suffering from severe mental conditions produced great difficulties in the families who were frightened at keeping a mentally deranged person in the home. They often called the police who brought the person into the Psychopathic Hospital on a magistrate's warrant. By 1930 fifty-four percent of the cases were admitted in this way.[21] Dr. Mather's anger

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[20]Manitoba, Sessional Papers, Department of Health and Public Welfare, 1931, p. 4.

[21]Hendrie and Varsamis, "The Winnipeg Psychopathic Hospital," Canadian Psychiatric Assn. Journal Vol. 16, April 1971, pp. 185-186.

turned toward the families who sent relatives to the hospitals accusing them of a "decreasing sense of individual, family and community responsibility."[22] The family which had been exhorted to bring the mentally ill relative into the hospital for early treatment was now being castigated for shirking its responsibility for its difficult member. It was becoming plainly evident that asylum care, whether in the psychopathic ward or the hospital for mental diseases, was not effective for a substantial number of patients. After 1930 medical superintendents sought new treatments for mental illness which might be useful in increasing hospital discharges. A flutter of optimism stirred in the psychiatric establishment from time to time as new treatments were introduced first at Brandon Hospital for Mental Diseases and later at the Psychopathic Hospital and Selkirk. The first statements were cautiously optimistic, but the followup studies never substantiated the confidence placed in the new treatment.

Insulin shock therapy was developed by a Vienese, Dr. Manfred Sakel, in 1933. Dr. Sakal made extravagant claims for this treatment and suggested that an eighty percent improvement in acute cases could be expected from its use.[23] Using injections of insulin, a condition of

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[22]Manitoba, Sessional Papers, Department of Health and Public Works, 1931, p. 5.

[23]Ibid., Deutsch, The Mentally Ill, p. 500.

hypoglycemia was induced until the patient lapsed into a coma. The coma was terminated after a period of hours by the administration of a neutralizing sugar solution. Insulin shock therapy was first used at Brandon Mental Hospital in 1937. In 1939 the results of administering shock therapy to 215 patients were evaluated.[24] Insulin therapy was used for a group of schizophrenic patients. Metrazol, another drug which produces epileptic convulsions was used for manic-depressive patients. Certain of those who did not respond to the initial therapy were given the alternate shock treatment. Of the 215 patients treated, 135 or 63 percent of these patients were able to leave the hospital. The patient population ceased its upward spiral and dipped slightly from 2,342 patients resident in the provincial hospitals on December 31, 1938 to 2,334 on December 31, 1939.[25] The Provincial Psychiatrist in a guarded statement suggested that "one is inclined to believe that the comparative favourable balance of the past two years is directly related to the introduction of newer methods of treatment..."[26] However, by 1940 Dr. Mathers reported that many of the patients "cured by shock are returning to the hospital", and in 1941 the continued rise in

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[24]Manitoba, Sessional Papers, Reports, 1939, pp. 41-42.

[25]See below Table I, p. 83.

[26]Manitoba, Sessional Papers, 1939, p. 31.

patient population attested to the suspicion that "the initial results of the treatment were viewed too optimistically."[27]

In July 1942 electric shock was introduced to replace the use of Metrazol shock. Its advantages were its economy and simplicity of use, (it could be used on an out-patient basis), absence of fear reaction, reduction of post-seizure symptoms—such as gastric upset and mental confusion, and reduction of complications such as fractures which might occur during seizures.[28] Shock therapy was now "in the forefront" of psychiatric treatment in Manitoba. It offered "definite advantages" in an increased recovery and discharge rate, decreases in the duration of hospital stay, and a "general rise in the behavioral level of the service as a whole."

During the same year two leucotomies were performed at Brandon and in the following year, twenty-one.[29] Those exhibiting extreme panic, destructiveness and rage reactions were selected for the operation. Previously "violent and extremely untidy in their personal habits and clothing", after the operation, over half of these people showed a "marked improvement in behavior". It was not possible to secure all the necessary personnel and equipment to open a

[27]Manitoba, Sessional Papers, 1940, p. 149

[28]Manitoba, Sessional Papers, 1940, pp. 159-160.

[29]Manitoba, Sessional Papers, 1944, p. 177.

"leucotomy service" at Selkirk. However, arrangements were made through the Psychopathic Hospital for patients to have the leucotomy performed at Winnipeg General Hospital in 1949. Shortly thereafter, through money obtained from federal Mental Health grants, the equipment for leucotomy operations was purchased for Selkirk. Until 1954, 261 patients from Brandon and 258 patients from Selkirk had received leucotomies.[30] At this time criteria for psychosurgery was extended to include recent acute cases which had not responded to other treatments. In April 1954 the drug, Largactil, was introduced at Brandon Hospital for Mental Diseases, and although the leucotomy was still considered a "therapeutic agent", its use diminished until 1958 when leucotomies were discontinued. The era of psychosurgery yielded before the introduction of psychoactive drugs.

The growth of psychoanalysis which was accelerated when many of these specialists emigrated to the United States from Germany just prior to World War II, demonstrated that many mental and emotional ills could be treated without stigmatizing asylum incarceration. Out-patient services where the individual could receive help and still live at home increased in importance during the 1930's. In Manitoba the staff of Brandon Hospital for Mental Diseases fielded traveling clinics in Minnedosa, Russell, Virden, Dauphin and Souris as early as 1931.[31] The following year additional

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[30]Province of Manitoba, Sessional Papers, 1955, p. 180.

[31]Province of Manitoba, Sessional Papers, 1930, p. 45.

clinics were held in Killarney and Carberry. No out-
patient facilities were developed at the Selkirk facility,
no doubt because regular clinics were held on a part time
basis at the nearby Psychopathic Hospital in Winnipeg.
Almost a third of the patients seen at these clinics were
children brought in by their parents for assessment. With-
in a decade two separate Child Guidance programs were
established to care for children. One, the traveling clinic
at Brandon Mental Hospital, and the other a visiting teacher
program under the sponsorship of the Winnipeg School Board.
The demand for adult services continued to increase from
year to year, and as Out Patient Departments were expanded,
many patients were treated without confinement. A consulta-
tion service was developed at Brandon as early as 1938.[32]
General practitioners were asked to participate in the assess-
ment of patients whom they referred to the out-patient
department. In this way general practitioners were instruc-
ted about psychiatric conditions and could contribute to
helping the patient during after-care.

Development of programs was slowed by World War II
and the departure of many staff for military service. How-
ever the large waiting list at the Psychopathic Hospital
"disappeared" by 1942,[33] and Dr. T. A. Pincock, who replaced

[32]Province of Manitoba, Sessional Papers, 1939,
p. 42-43.

[33]Province of Manitoba, Sessional Papers, 1942,
p. 366.

Dr. Mathers as Provincial Psychiatrist, attributed this decrease to the improved employment situation caused by the war. This diminished need for psychiatric beds was similar to, yet different from, the one which occurred during World War I. (See page 45) The World War I decrease was registered at mental hospitals; the World War II decrease was seen _only_ at the Psychopathic Hospital. Evidentally wartime morale did not effect the more chronic patients of the mental hospitals in the same way it did the patients seeking care at the Psychopathic Hospital. Although the number of patients seeking admission to the Psychopathic Hospital decreased, the number of long stay patients at the mental hospitals continued its upward climb. World War II, like World War I, again kindled interest in the psychiatric problems of troops. Dr. Pincock used this opportunity to call upon the government "to set in motion adequate machinery to meet both present and future demands for a well planned psychiatric service."[34] A well planned psychiatric service no longer needed to be limited to institutional care, for the experience of the interwar years had alerted policy planners to the potentials of treating patients in the community.

The period between World War I and World War II was one of asylum reform, of tinkering with parts of its systems

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[34]Province of Manitoba, _Sessional Papers_, 1943, p. 147.

in order to make it more capable of helping the mentally ill. The Psychopathic Hospital was established to provide people with the individualized care which was not possible in the large mental hospitals; the staff of the mental hospitals was enlarged and professionalized. Still a sizeable number of seemingly incurable patients were left in the mental hospitals, and neither shock treatments nor psychosurgery provided the anticipated cure for their condition. They accumulated as constant reminders of psychiatry's failure to cure. At the end of World War II, the limitations of the asylum had been acknowledged by psychiatrists. A debate concerning its future was impending.

CHAPTER V

NEW DIRECTIONS

Planning became the cornerstone for mental health
policy during the next three decades, and elaborate systems
of "service delivery" were proposed internationally, nation-
ally, and provincially. The architects of these ambitious
plans called for "fundamental new and more adequate patterns
of diagnosis, treatment, care and prevention." The mental
hospital was condemned for its depersonalization and its
geographic isolation; the community, idealized. In the new
plans hospitalization was defined as only one of many
resources available to the patient, and then to be used only
as a last resort. Prevention, treatment, and rehabilitation
services would be located convenient to every community and
accessible to all who wished to receive help. The plans of
the community psychiatrists were often utopian, but they led
to an exploration of a new relationship for the mental hos-
pital within a much larger mental health system, for as one
of the planners pointed out:

> ...there is continuity of service between out-
> patient and in-patient care which is related to
> the way in which the patient moves through his
> illness, i.e. from breakdown to hospitalization,
> to improvement and rehabilitation. Hospitaliza-
> tion is an episode in treatment and not the

entire treatment process.[1]

The deliberations of the Expert Committee on Mental Health of the World Health Organization, which were published in 1953,[2] provided a basis for discussion about new approaches to caring for the mentally ill. Although this report was designed to help countries beginning to develop a mental health program, it described a series of services which were considered necessary for establishing a comprehensive mental health system. It advocated the establishment of a number of in-patient and out-patient services and combinations of the two. Patients might be able to work during the day and attend hospital programs at night, or conversely, attend the hospital during the day and return home in the evening. Aftercare would be provided in out-patient clinics; special social clubs would provide diversion and social activities. The report suggested that one bed per 1,000 population be maintained "for the custodial treatment and care of those most flagrant cases of psychiatric disorder."[3] Above all, programs were to be flexible and creative in contrast to what became desparagingly

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[1]Ruth I. Knee quoted in CMHA, More for the Mind: A Study of Psychiatric Services in Canada (Toronto, 1963, p. 58.

[2]World Health Organization, The Community Mental Hospital, Third Report of the Expert Committee on Mental Health, Technical Report Series, No. 73 (Geneva, Switzerland, 1953).

[3]Ibid., p. 5.

referred to as "brick-and-mortar" asylum care.

During the following decade American and Canadian proposals for the extension of mental health services into the community were published. The American report entitled Action for Mental Health[4] contained a summary of current research in the field and recommendations for federal financing of continued research as well as training for mental health workers. It recommended the expansion of community treatment programs in such facilities as mental health clinics and general hospitals, and at the same time, the reduction in size of mental hospitals to no more than 1,000 patients. More for the Mind,[5] the Canadian report, was shorter and more focused. It sought to delineate a "radical new concept in treatment," and stressed that the patient suffering from mental illness should receive the same excellence of medical and ancillary health services "as quickly, easily, and efficiently" as the patient suffering from physical illness. Services were to be medically integrated so that mental health care would be available in the same types of settings as physical treatment such as doctor's offices, clinics, and general hospitals; regionalized so that treatment would be available in centres of population

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[4]Joint Commission on Mental Illness and Health, Action for Mental Health (New York: Basic Books, 1961).

[5]Canadian Mental Health, More For The Mind: A Study of Psychiatric Services in Canada (Toronto, 1963).

for a given geographical area; <u>coordinated</u> so that hospitals, clinics, and other centres would provide care without gaps and overlaps in service, and characterized by a <u>continuity of care</u> from discovery of illness, through out-patient, in-patient, rehabilitation, and aftercare.

These two plans contained similar recommendations for community treatment of patients and differed only slightly concerning the size of the mental hospital for long-stay patients.[6] The American report recommended institutions as large as 1,000 for these patients; the Canadian report suggested small regional facilities with a capacity of approximately 300 beds. In so doing the authors recognized the resistance of many patients to any of the therapies yet devised, and put forth plans which relied upon custodial care of the "failures". Historian, Gerald Grob has accused psychiatrists of engaging in a "vast holding operation by confining mentally ill patients until the distant day when specific cures for specific disease entities would become available."[7] However as employment opportunities increased when new community mental health programs opened, career opportunities for psychiatrists was no longer limited to the mental hospitals. As a result

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[6]Ibid., pp. 38-45.

[7]Gerald Grob, <u>Mental Institutions in America: Social Policy to 1875</u> (New York: The Free Press, 1973) pp. 356-57.

custodial care of chronic patients became a burden which
fewer psychiatrists were willing to assume. They were
becoming predisposed to dissolving their "holding operations".

Psychiatrists practicing in the community increasingly
relied on psychotherapy[8]--the talking treatment made famous
by Sigmund Freud. The psychotherapist listened to topics
initiated by the patient and through a process of question-
ing, focusing, clarifying, reflecting, and interpreting,
helped the patient resolve conflicts which were causing men-
tal suffering. The therapist sought to lead the patient
towards the vague state of mental health,[9] a concept which
varied according to the definition of the individual thera-
pist but usually included abilities to make independent
decisions, to perceive one's own interactions realistically,
and to experience oneself as a unique entity. The general
populace at this time was receptive to the concepts of
psychiatry and, was becoming "psychologically vocabularized,"[10]
terms such as "disturbed" and "neurotic" came into common
usage. Topics concerning psychiatry and mental health
attracted the interest of increasing numbers of individuals

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[8]Encyclopedia of the Social Sciences, 1968 ed., s.v.
"Treatment of Mental Disorders" by Kenneth M. Colby.

[9]Ibid., s.v. "The Concept of Mental Health" by
Morris S. Schwartz and Charlotte Green Schwartz.

[10]Harry Silverstein, The Social Control of Mental
Illness (New York: Thomas Y. Crowell Co., 1968), p. 2.

who bought books on these subjects or even sought the ser-
vices of a therapist. A climate of interest in mental health
and mental illness prevailed, and the planners of mental
health policy were able to tap this concern to facilitate
the changes that were considered necessary.

At this time the Canadian National Committee for Men-
tal Hygiene was reorganized into the Canadian Mental Health
Association, and a provincial branch of this organization
was established in Manitoba in 1955 to provide volunteer
services in the mental hospitals and to educate the public
about mental illness.[11] A grant of $2000 from the Winnipeg
Foundation enabled CMHA to hire an executive director.
With office equipment loaned by Wilson Stationery Company,
$2,560 in contingency funds from the Community Chest and
a Mental Health Grant from both provincial and federal
governments totaling $5,000, the new director, Patricia
Desjardins, began to develop programs at Selkirk Hospital
for Mental Diseases. The volunteers held monthly dances
and distributed candies, cigarettes, and magazines.
They collected Christmas gifts, gramaphone records and
books for the patients. A year later CMHA established
an activity and recreation centre in Winnipeg
where discharged mental patients could spend their

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[11]CMHA, Manitoba Division, Annual Report, 1956. The
1957 Board of Directors included the Provincial Psychiatrist,
Dr. J. C. Pincock, and psychiatrists from both provincial
mental hospitals. The institutional psychiatrists were
active in establishing an organization which would function
as a link between the hospital and the community.

time. A branch of the organization was established in Brandon for the purpose of providing visitors to the patients at the Brandon Hospital for Mental Diseases and for planning a social rehabilitation centre similar to the Outdoor Club in Winnipeg.

Miss Desjardins visited the small communities of Manitoba to lecture, and within ten years there were groups of CMHA in twenty-five Manitoba communities. Branches were established at Brandon, Flin Flon, Winnipeg, and Selkirk; committees at Altona, Beausejour, Bisset, Dugald-Oak Bank, Elie, Emerson-Dominion City, Gimli, Gladstone, Lac Du Bonnet, Morden, Morris-Lettellier, Minnedosa, Neepawa, Russell, Starbuck, Steinback, Teulon and Treherne-Rathwell. The programs of the small, rural communities focused upon fund raising and donations to the annual Christmas gift drive. The Winnipeg and Brandon branches undertook an ever enlarging range of programs including social action and education as well as services to the mentally ill and post mentally ill.

In 1959 the first patients were brought into Winnipeg from the Selkirk Mental Hospital to spend an evening at the CMHA Open Door Club.[12] The first six guests were "carefully selected" patients--three men and three women. They attended a dinner and meeting of the club. Later, as the program

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[12] CMHA, Annual Report, 1959.

developed in size, the patients were expected to ride the
bus without supervision. They were met by volunteers at the
bus stop and accompanied on a shopping tour of the larger
department stores before supper at the Open Door Club.
CMHA volunteers from Brandon also established a social
rehabilitation center similar to the Open Door Clubs. These
volunteers became involved in the industrial therapy program
at the hospital and received an invitation to participate
on an Industrial Therapy Committee. This committee sought
to employ the patients in financially profitable ventures,
and during its first year of operation in 1961, three
patient operated canteens and a scrap metal industry pro-
duced a profit of $3,481 after all expenses were paid, and
321 patients received allowances from these profits.[13]
At the end of the first decade of its existence, Executive
Director Desjardins recognized that the organization was
modifying its program due to "changing conditions and chang-
ing needs". "Activities _in_ the _hospitals_ were _fewer_ and
our _activities_ _at_ _CMHA_ _Social_ _Rehabilitation_ _Centres_ _and_
elsewhere _in_ _the_ _community_ _were_ _more_ _numerous_."[14] (Italics
Miss Desjardin's.) At this time the organization was extend-
ing a new service to the mental hospitals of Manitoba.
It was helping to find foster homes for the large number
of patients which were being returned to the community.

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[13]_Ibid._, 1962.

[14]_Ibid._, 1965.

Foster home placement had been contemplated since
the depression when psychiatrists were beginning to ques-
tion about appropriate care for chronic patients. In 1934
the first patient from Brandon Hospital for Mental Diseases
was placed in a boarding home, and by 1938 there were eight
patients in five "legalized homes".[15] Dr. Pincock, then
medical superintendant of the hospital, listed the reasons
for the slow growth of the boarding out plan:

> First it (the plan) has been in the nature of an
> expedient. Second, the timidity of friends to
> consent to have their relatives leave the instit-
> ution proper...Third it was considered advisable
> to be conservative in order not to discredit the
> plan in the minds of the public who might be
> antagonized and alarmed by the publicity.[15]

The value of the plan was indisputable from an economic

point of view.

> The present capital investment at this institu-
> tion, including auxiliary services is $2,350 per
> bed; therefore eight patients so placed represents
> a capital outlay of $8,800 which at 4% interest
> means a savings of $752.00 per annum. Per diem
> costs for boarded out patients is .75¢ while the per
> diem cost at the institution are in the neighborhood
> of .83¢. This represents a considerable saving,
> reduces over-crowding, and provides a more nearly
> normal social existence for the patient.[16]

Community placement from Brandon Hospital for Mental Diseases

continued on a small scale during World War II during which

the "benefits" of this type of "therapeutic care" were

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[15]Province of Manitoba, Sessional Papers, pp. 94-95.

[16]Ibid.

"amply demonstrated."[17] In 1944, Ivan Schultz, Minister of
Health and Public Welfare, addressed the Legislature[18] and
outlined a plan to provide mental health services throughout
the province by establishing mental clinics at Brandon,
Portage la Prairie, Selkirk, the Psychopathic Hospital in
Winnipeg, and perhaps Dauphin. In addition to their clini-
cal responsibilities these clinicians would be responsible
for finding boarding-homes in the community where patients
from the institution might be placed and for supervising
the placements. The plan for extending foster home care did
not flourish. The severe housing shortage following World
War II limited the number of extra rooms in homes, and the
program was abandoned because of the lack of boarding homes.
It was revived in 1960 as part of a campaign to return
chronic patients to the community "in the shortest number of
hospitalization days." This time the psychiatrists were
successful in sending the chronic patients who overcrowded
the mental hospitals into foster homes so that the hospitals
could be reserved for patients requiring care on a short term
basis only.

For a period of time the psychiatrists had been aware
that the hospital affected some patients adversely. These

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[17]Province of Manitoba, Department of Health and
Public Welfare, Annual Reports, 1944.

[18]Ivan Schultz, Address to Legislative Session,
1944, pp. 6-7.

patients, usually diagnosed as schizophrenic, and suffering from disturbances in thinking processes, bizarre emotional responsivity, delusional ideas, and, perhaps hallucinations, often developed additional symptoms from the environmental pressures of the mental hospital. However, it was the social scientists who analysed the social situations which existed in these institutions, and provided the explanation of why institutions had such detrimental effects upon many patients. From these studies developed the rationale for returning the chronic patients to the community.

The first of the pioneering sociological studies of the asylum, The Mental Hospital[19] was written by a psychiatrist and a sociologist and published in 1954. These authors analysed the hospital as a social system composed of a number of social sub-systems, and they described the various interactional processes and institutional patterns which effected both the patient's behavior and his therapeutic course while in the hospital. The book was important, not so much because of the uniqueness of the authors' observations, for these had been known for a number of years, but rather because the authors were able to integrate these ideas into a coherent framework which explained how the social structure of the hospital and the personal interactions

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[19]A. H. Stanton and M. S. Schuartz, The Mental Hospital (New York: Basic Books, 1954).

of the staff effected the clinical course of the patient.[20]

More widely quoted was Erving Goffman's book, Asylums[21] in which Goffman presented his analysis of the total institution. Into this category he placed homes for the blind, the aged, orphans, tuberculosis sanitoria, mental hospitals, abbeys, and a number of other institutions where one group, the residents slept, played, and worked under the supervision of a smaller group, the staff. Goffman worked as an athletic director at St. Elizabeths Hospital in Washington, D.C., and used his observations made as a participant observer in the hospital to analyse the deficiencies inherent in the mental hospital system. The flaws he found were so fundamental and irremediable as to suggest that the mental hospital was fundamentally anti-therapeutic. Patients were coerced into placing themselves entirely in the staff's hands and to follow their program of indoctrination called medical treatment. This "self-alienating moral servitude" crushed many patients.

Other scholars focused upon the process by which an individual was identified, categorized, and treated as

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[20]Arthur J. Ransom, An Introduction to Social Psychiatry (Middlesex, England: Penguin Books, 1971), p. 116.

[21]Erving Goffman, Asylums (New York: Doubleday-Anchor, 1961).

mentally ill. Under the premises of labeling theory,[22] the

gradual recognition that a person was mentally ill began

with close associates and was later confirmed by psychiatric

diagnosis. The consequences of this diagnosis were far

reaching. The individual was treated as mentally ill...often

confined in an institution. When the patient came to accept

this label as his reality, he was unable to sustain any

alternative definition of himself. He became the type of

person implied by the label of mental illness and behaved

accordingly. Thomas Szasz,[23] a psychiatrist, incorporated

labeling theory into his attack upon institutional psychia-

try. Those who deviated from the societal norms were labeled

by the majority as sick, bad, stupid or wrong so that the

majority could enjoy being healthy, good, wise, or right by

comparison. Psychiatry had increased the number of mental

patients by designating whole groups of people as "sick".

Those who violated society's basic interpersonal and ling-

uistic rules, such as homosexuals, alcoholics, and criminals

were labeled "mentally ill" and subjected to treatment.

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[22]For a history of the development of the concept of
labeling theory see Cornelia Johnson, "The Family as a Con-
trol Agent in the Labeling of the Handicapped Child",
unpublished thesis, University of Manitoba, 1977. For a
discussion of labeling theory as it relates to mental illness
see Thomas J. Scheff, Labeling Madness (Englewood Cliffs,
N.J.: Prentice Hall, 1975).

[23]Thomas S. Szasz, The Manufacture of Madness
(New York: Dell Publishing Co., 1970) p. xxvi.

R. D. Laing, a Scottish psychiatrist, suggested that the person labeled schizophrenic was "employing a special strategy...in order to live in an unlivable situation."[24] The process of labeling this person schizophrenic was a political event, a conspiracy of family, General Practitioner, mental health worker, psychiatrist, nurses, social workers, and even fellow patients. The person so labeled was:

> degraded from full existential and legal status
> as (a) human agent and responsible person, no
> longer in possession of his own possessions,
> precluded from the exercise of his discretion as
> to whom he meets, what he does. His time is no
> longer his own and the space he occupies is no
> longer of his choosing. After being subjected
> to a degradation ceremonial known as psychiatric
> examination he is bereft of his civil liberties
> in being imprisoned in a total institution
> known as a 'mental' hospital.[25]

A psychologist, R. L. Rosenham explored the consequences of being labeled schizophrenic. Eight people without any psychiatric history were admitted to a psychiatric ward. These pseudo-patients reported hearing voices which were "empty" and "hollow". Beyond alleging these symptoms and providing false information concerning name, vocation, and employment, no other alterations were made. Once the person was admitted to the ward, he behaved normally. Hospital

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[24]R. D. Laing, The Politics of Experience (London: Penguin Books, 1967) pp. 84-119.

[25]Ibid. pp. 100-101.

reports described these patients as "friendly", "cooperative" and exhibiting "no abnormal indications", but no report recognized them as sane. They were discharged as schizophrenic in remission. Dr. Rosenham commented:

> The data speak to the massive role of labeling
> in psychiatric assessment. Having once been
> labeled schizophrenic, there is nothing the
> pseudopatient can do to overcome the tag.
> The tag profoundly colors others' perceptions
> of him and his behavior.[26]

Other researchers investigated the ability of psychiatrists to predict which patients were likely to be dangerous. Because of persistent, widespread public belief that the mentally ill were violence-prone, many patients had been detained in mental hospitals. A panel of the American Psychiatric Association reviewed the research on this topic in 1965[27] and concluded that violent behavior was a function of both personal characteristics and characteristics of the situation. Since it was impossible to anticipate with accuracy the social situations the released mental patient might encounter, it was impossible to predict with any accuracy which patients would become violent. Furthermore the incidence of violence among ex-hospitalized mental patients was actually far less than in

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[26]R. L. Rosenham, "On Being Sane in Insane Places", Science, Vol. 179, (1973) pp. 250-258.

[27]Jonas R. Rappeport (ed.) The Clinical Evaluation of The Dangerousness of the Mentally Ill, (Springfield, Ill.: Charles C. Thomas, 1967).

the general population.[28]

Scholars also investigated the socio-economic status
of the mentally ill and found that the poor were far more
likely to be hospitalized.[29] August Hollingshead and
Fredrick Redlich investigated the relationship between
social class and mental illness and found that where people
take their "troubles" depends upon the social class of the
individual. The upper or middle class person tended to
seek private psychiatric help at the behest of family or
friends; the lower class person came into care upon referral
from the courts, social agencies, or clinic physicians.
The middle or upper class person was more often treated
without recourse to institutional confinement; the lower
class patient, confined in a state mental hospital.

The failures of the asylum were irrefutable. The
condition of many patients deteriorated under the deperson-
alized routines imposed upon them. It was the poor and the
powerless who were most vulnerable to commitment to one of
the large mental hospitals, and furthermore, those committed
were often pathetic and inadequate rather than violent and

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[28] Jonas R. Rappeport, George Lassen, Nancy B. Hay,
"A Review of the Literature on the Dangerousness of the
Mentally Ill" in Rappeport, Clinical Evaluation, p. 74.

[29] August B. Hollingshead and Fredrick C. Redlich,
Social Class and Mental Illness (New York: John Wiley and
Sons, Inc., 1958). A follow-up study Jerome K. Myers, A
Decade Later: A Follow-up of Social Class and Mental Ill-
ness (John Wiley & Sons, Inc., 1968) has added to this
dimension of the study of the sociology of mental illness.

dangerous to themselves or others in the community. The
patients were perceived as victims; institutional psychia-
trists as the oppressors who labeled these people as
mentally ill because of their disturbing behavior and then
imprisoned them in an institution where their original
craziness was reinforced. The asylum appeared to be an
expensive mistake.

The response to this censure of the asylum was
decarceration[30]--the disgorging of patients into the com-
munity. Beginning in the mid-1950's both in the United
States and Britain, the number of patients resident in
mental hospitals in each country decreased. (Tables I and
II.) A similar decrease was begun in Manitoba in 1960.
(Table III.) There emerged in all three countries an
explicit commitment to a policy of returning patients to
the community. In Manitoba the chronic, long-stay patients
were given "remotivation therapy" to teach them to function
outside of the mental hospital and then sent to live in
foster homes. New patients were kept for only short periods
then returned to the community to live independently, or if
necessary, in a boarding home. Foster care for mental
patients was no longer a timidly administrated plan, but an

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[30]See Andrew Scull, Decarceration: Community Treatment
and the Deviant--A Radical View (Englewood Cliffs, N. J.:
Prentice-Hall, Inc., 1973). Scull discusses developments
in decarcerating asylums and prisons during the past two
decades.

TABLE I

RESIDENT POPULATION IN STATE AND COUNTY MENTAL HOSPITALS

IN THE U.S.A., 1950-1974

Year	Number Resident	Year	Number Resident
1950	512,500	1963	504,600
1951	520,300	1964	490,400
1952	532,000	1965	475,200
1953	545,000	1966	452,100
1954	554,000	1967	426,000
1955	558,900	1968	400,700
1956	551,400	1969	370,000
1957	548,600	1970	339,000
1958	545,200	1971	309,000
1959	541,900	1972	276,000
1960	535,500	1973	255,000
1961	527,500	1974	215,600
1962	515,600		

Source: From Andrew Scull, Decarceration, p. 68.

TABLE II

RESIDENT POPULATION OF MENTAL HOSPITALS

IN ENGLAND AND WALES, 1951-1970

Year	Number Resident	Year	Number Resident
1951	143,200	1961	135,400
1952	144,600	1962	133,800
1953	146,600	1963	127,600
1954	148,100	1964	126,500
1955	146,900	1965	123,600
1956	145,600	1966	121,600
1957	143,200	1967	118,900
1958	142,800	1968	116,400
1959	139,100	1969	105,600
1960	136,200	1970	103,300

Source: From Andrew Scull, Decarceration, p. 70.

TABLE III

RESIDENT POPULATION OF MENTAL HOSPITALS IN MANITOBA, 1938-1978

Year	Number Resident	Year	Number Resident	Year	Number Resident
1938	2,342	1951	2,692	1964	2,433
1939	2,334	1952	2,735	1965	2,341
1940	2,341	1953	2,795	1966	2,245
1941	2,371	1954	2,844	1967	1,921
1942	2,569	1955	2,852	1968	1,829
1943	2,463	1956	2,824	1969	1,743
1944	2,530	1957	2,865	1970	1,689
1945	2,578	1958	2,831	1971	1,546
1946	2,626	1959	2,908	1972	1,236
1947	2,638	1960	3,112	1973	1,006
1948	2,652	1961	2,935	1974	971
1949	2,666	1962	2,779	1975	929
1950	2,668	1963	2,613	1976	946
				1977	937
				1978	951

Source: Province of Manitoba, Annual Reports, 1938-1978.

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aggressive policy. Community placement was far less expensive than hospital care; it freed the services of skilled psychiatrists to treat patients suffering from acute conditions rather than for routine supervision of chronic and unresponsive patients, and it promised to decrease the incidence of institutionalization which developed in patients who became so accustomed to hospital routines.

In Manitoba the vehicle which was chosen for the development of the expanded foster home program was the Canadian Mental Health Association. In 1962 Patricia Desjardins mounted a lively campaign in the press, television, and radio for people to open their homes to mental patients from Selkirk Mental Hospital.[31] A Foster Home Committee was formed, and both staff and volunteers cooperated in the process of recruiting and selecting homes for twenty chronic patients. The Provincial Department of Welfare agreed to allow $65.00 per month for room and board, $5.00 for clothing, and $7.00 for incidentals. Of the forty-one families which offered a home for a mental patient, thirty-five were judged "suitable". Some would have to wait, for the hospital was unable to supply patients for all the homes wanting them. At the end of the year, 82 patients were in foster homes in Metropolitan Winnipeg; a similar program was being implemented in

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[31]CMHA, Manitoba Division, Annual Report, 1962.

Brandon, and there were plans to expand the program for a
total of 200 Selkirk patients.

The patients chosen for placement were described as
over forty-five years of age, with no saleable skills, no
financial resources, no family resources, and who, after
an average of nine years in the hospital, did not know the
date or even minimal social graces. Furthermore his per-
sonal hygiene was not acceptable.[32] He was prepared for
living in the community by a series of programs of occupa-
tional therapy, physical exercise and classes in grooming
and personal hygiene. After a year of this program, the
patient's "general fund of information" was generally
adequate and his appearance neat. He was then ready to be
enrolled in group psychotherapy and to be assigned a social
worker who would arrange his placement in the community.
Some would be referred for work assessment at a sheltered
workshop; others would be expected to participate in the
CMHA Open Door program. The patient was promised a more
normal life in the community, living in a family and parti-
cipating in work or the CMHA social center.

To help the former patients feel "more comfortable
and more secure with other individuals", CMHA staff estab-
lished special social rehabilitation programs. Classes in
etiquette, grooming, physical fitness, clothing repair, and

[32]Skills, Unlimited, Minutes of Advisory Board
Meeting, Nov. 1, 1962.

dancing were introduced. The hours of the Open Door Club were extended to include evenings and Saturdays so that individuals receiving training at Skills Unlimited could participate in the programs. Similar classes were held in Brandon and Flin Flon. In addition, special events such as theatre parties, field trips, swimming outings, and trips to hockey games were scheduled.

A sheltered workshop for mental patients opened its doors in 1962 at 322 Manitoba Avenue, within walking distance of the Selkirk Hospital.[33] Like the programs of CMHA, the programs of this workshop were launched upon the combined efforts of community volunteers, provincial funding, and psychiatric guidance. Mr. Sam Sair provided the building and donated $5,500 to the project. The province granted an additional $2,500, and Walter Boyd, Provincial Coordinator of Rehabilitative Services assisted in planning an industrial program in cooperation with volunteers and mental health professionals. On November 2, Dr. Kovaks, psychiatrist at Selkirk Mental Health Centre, assessed the results from the first five months of workshop operation. Clients had received $2,539 in wages, and seven clients had "graduated" into community employment.[34] By 1964 the need for an additional sheltered workshop in Metropolitan

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[33]Skills, Unlimited, Minutes of Advisory Board Meeting, Nov. 1, 1962.

[34]Ibid.

Winnipeg was apparent because over 150 ex-patients were living in foster homes in the area, many of whom were capable of undertaking workshop training.

In consultation with representatives from other sheltered workshops in the area, two vocational centers were planned for Winnipeg.[35] One workshop would provide work assessment, work training, and remunerative sheltered employment for post-mentally ill adults; the other would provide the same services for mentally retarded adults. Thus Skills Unlimited, a private non-profit agency was formed. Mr. Sair agreed to act as manager at no remuneration, and a staff of work superintendent, clerks, salesman, and vocational counselor was hired. Only one workshop was opened to serve both mentally retarded and mentally ill clients--a situation which eventually limited the effectiveness of the workshop in its work with the post-mentally ill person.

The remarkable rate at which mental patients were returned to the community has been attributed solely to the introduction of psychotropic drugs. These major tranquilizing drugs, of which chlorpormazine has become best known, were introduced initially to control nausea and vomiting, but when their effectiveness in controlling the symptoms of psychotic patients was discovered, they were highly publicised by the pharmaceutical companies which marketed them

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[35]Ibid., Feb. 14, 1964.

for this purpose. A direct cause and effect relationship between drug introduction and reduction in mental hospital population has been commonly accepted. An alternative explanation was put forward by Gerald Klerman who suggested that the reduction of asylum population was not directly related to drugs alone but that the drugs acted to accelerate already existing trends towards earlier release.[36] Andrew Scull traced the history of the introduction, marketing, and evaluation of these drugs and concluded that the psychotropic drugs contributed to the policy of early discharge by "reducing the incidence of florid symptoms among at least some of the disturbed", but added that it was "highly implausible" that drugs alone were responsible for the change in policy which led to decarceration.[37]

Although the number of patients had been increasing every year in Manitoba (Table III), the ratio of patients in the mental hospital to general population had been decreasing since 1941 (Table IV). The 1941 rate of 349 patients per 100,000 Manitobans dropped to 346/100,000 in 1951 and still further to 332/100,000 five years later in 1956.

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[36]Gerald L. Klerman, "Historical Behavior for the Evaluation of Maintenance and Drug Therapy of Discharged Psychiatric Patients" in Milton Greenblat, Daniel J. Levinson, Gerald L. Klerman, Jack Ewalt, Mental Patients in Transition (Springfield, Mo.: Charles C. Thomas, 1961).

[37]Scull, Decarceration, pp. 79-89.

TABLE IV

TOTAL NUMBER OF PATIENTS IN MENTAL HOSPITALS AND RATE/

100,000 PEOPLE IN MANITOBA

1951-1976

Year	Number of Patients	Rate/100,000
1951	2,692	346
1956	2,824	332
1961	2,935	318
1966	2,245	233
1971	1,546	156
1976	946	93

The dramatic reductions in rate of mental hospitalization
which occurred after 1961 were preceded by a period of
gradual decline during which psychiatrists were experiment-
ing with shock therapy, psychosurgery and occasional foster
home placement as ways of decreasing the hospital popula-
tion. When 154 patients were selected to receive Largactil,
a psychotropic drug in April, 1954, at Brandon Mental
Hospital, its introduction was given only routine notice.[38]
The personnel of the hospital were busy catching up on a
backlog of "candidates for the leucotomy service" and were
coping with the recent decision to discontinue mechanical
restraint -- retraining of staff so that they could handle
disturbed and violent patients on one hand and stimulate
apathetic and untidy ones on the other, was of prime concern.
A year later, the value of the drugs was perceived as one
of helping seriously disturbed patients to lead "a much
happier hospital life."[39] Because of the drugs, the "dis-
turbed wings" of the hospital had been opened and the
patients incorporated into the general activities on the
wards. A total of nine patients "who would otherwise have
had to remain under direct hospital care" were probated
from the hospital that year and owed their release to the

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[38]Province of Manitoba, Department of Health and
Public Welfare, Annual Report, 1955, pp. 171-172.

[39]Ibid., p. 200.

use of the new drugs. A 1958 report on the results of the
use of these drugs at Brandon Hospital for Mental Diseases
would not have justified the zeal with which decarceration
was implemented in the next decade. Over fifty percent of
the patients who received the drugs remained unimproved
except in the cases of Continuing Service patients who were
judged Improved or Controlled with the use of Largactil,
Reserpine, or Trilafon. (Table V.) The immediate benefits
from the introduction of psychotropic drugs were seen as
assisting patients to become "more amenable to extensive
and intensive psychotherapies." Although initially these
drugs were not perceived by Manitoba psychiatrists as
remarkably effective in treating mental patients, by 1960
these physicians had begun to move the chronic patients
out of the mental hospitals of Manitoba. In so doing,
they were following the lead of American psychiatrists who
had been successful in expelling patients from the crowded
mental hospital wards and sending them back to the community.
The psychotropic drugs were the means of implementing a
policy of foster home placement for long-stay patients, a
program which had been introduced unsuccessfully over
twenty years earlier. The rationale for the change in
policy evolved from recent social research and as a result
of the development of the concept of community psychiatry.

Since World War I, psychiatrists had sought a solu-
tion to the problem of the care of the chronic patient, for

TABLE   V

EVALUATION OF THE USE OF PSYCHOTROPIC DRUGS,

BRANDON MENTAL HEALTH CENTRE

1958

| | | | New Drugs | | | |
Drug:	Service	1958 Cases	Much Improved	Improved	Controlled	Unimproved
Largactil	P.I.	167	18%	26%	-	56%
	Cont. Serv.	354	4.5%	23.5%	47.7%	24.3%
Resperpine	P.I.	11	-	36%	-	64%
	Cont. Serv.	131	-	14%	60%	16%
Trilafon	P.I.	59	12%	24%	-	64%
	Cont. Serv.	127	1.6%	31%	38.4%	29%
Nozinan	P.I.	43	25.6%	25.6%	-	48.8%
	Cont. Serv.	145	11.7%	35.8%	-	52.5%
Stelazine	P.I.	34	26.5%	23.5%	-	50%
	Cont. Serv.	39	13%	28%	-	59%
Marsilid	P.I.	33	15%	24%	-	61%
	Cont. Serv.	20	5%	25%	-	70%
Other	P.I.	31	13%	13%	-	74%
	Cont. Serv.	33	-	12%	-	88%

Source: Province of Manitoba, Sessional Papers, 1958.

it was evident that providing life long care to these people
was a very costly policy. For a period of time during the
interwar years, emphasis was placed upon improving treatment
available at the mental hospitals so that the hospital
could be more effective in curing people. After World War
II, the psychiatric community began to acknowledge that
they did not know how to cure these people, and furthermore,
that the hospital experience was reinforcing their condi-
tion. Innovative plans were proposed for treating the acute
patient in a number of new community facilities, but the
question of disposition of the chronic patients remained
unresolved. Finally chronic patients from all over North
America were sent back to their communities to live. In
Manitoba the process of decarceration was a well planned and
well executed manoeuvre using volunteer and hospital
resources. In the long run, the social worker became
responsible for the long term planning for these people,
and the psychiatrists were freed to reorganize the mental
hospitals into mental health centres which would provide
only short term care.

CHAPTER VI

COMMUNITY CARE

Reorganization occurred both within and without
the mental hospitals of Manitoba during the next two
decades. The forerunner of these changes occurred in 1953
at Brandon Mental Hospital when mechanical restraint was
abolished. Locked wards were hesitantly opened, and the
volunteers from CMHA were allowed to come in to visit.
Still changes were very slow in developing. In 1959 a
group of concerned attendants petitioned the Chief Atten-
dant about conditions on the wards. They protested:

1. We do not see why the patients have to
    have porridge 365 days every year. We
    feel confident that none of us have
    porridge every day for breakfast. The
    breakfast diet here is monotonous and
    always the same. Occasionally a little
    syrup and jam is added. With the excep-
    tion of the T.B. Wards no other ward has
    any eggs. The Unit on occasion has eggs
    in the morning. We believe that eggs are
    given to the patients twice a year in the
    main building.

    We are not arguing against the adequate
    number of calories received by each patient
    for breakfast, but against the monotony of
    the meal.

2. In the Colony the porridge is served on
    flat plates. There are not enough bowls
    to go around and consequently at lunch

or supper on occasions when soup is served,
the soup is served on flat plates.[1]

Separate kitchens prepared food for each of the groups.
The doctors' dining room always received the best food; the
patients the plainest. The patients were allowed meat only
twice a week because it was feared that more meat might make
them difficult to control.[2] These attendants also criticized
the state of the nursing arts at the institution. Although
they received training in psychiatric therapies, they were
expected to scrub walls, wash floors, and supervise the
cleanliness of the wards. More graphic was their descrip-
tion of the bathing procedures:

> The water is either changed after every few
> patients, or it is made to run over. This is
> highly unfair. On ward two (sic.) as an example
> the water runs over. The bath-tub takes too
> long to drain--that is the excuse given.
>
> On ward eight and ward six there aren't
> enough towels for the patients. When washing
> the very regressed patients on ward eight one
> might have a bit of luck--5 towels for twenty
> patients.
>
> ...The conditions of bathing are highly unfair
> to the patients who work out especially on the
> farm and the piggery. On ward two where most
> of the farm patients are found, they are still
> only washed once a week. Normally we could
> hope that they would get a bath every night.[3]

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[1] Letter from L. H. Henderson with enclosures to
Mr. Russell, Chief Attendant, July 20, 1959, Brandon Mental
Health Centre Archives.

[2] L. H. Henderson, Interview, Brandon Mental Health
Centre, September 1979.

[3] Ibid. Letter L. H. Henderson to Russell, 1959.

During the following years the hospitals were reorgan-
ized using the approach developed by Maxwell Jones in
England. Dr. Jones experimented with new methods of hospital
administration where he sought to develop settings which
would be equalitarian, democratic, permissive and communal
as opposed to the rigid, hierarchial, stereotyped and even
tyranical patterns of the traditional mental hospital.[4]
Implementation of the therapeutic community, as he called
his model, required the social restructuring of the entire
institution so that more spontaneous relationships would
develop between and among patients and staff. Therapy was
no longer considered the experience the patient had during
appointments with his doctor but rather the entire series
of experiences he had with all of the staff and even the
patients. All relationships in the hospital were potenti-
ally therapeutic for the patient, and therefore all staff
shared the responsibility of providing therapy, both struc-
tured and impromptu.

The professionalization of the psychiatric nurse was
an important step toward the development of a therapeutic
community. In 1960 two acts were passed in the Legislature
of Manitoba which officially established psychiatric nursing
as a separate professional entity and established the educa-
tional authority for the psychiatric nursing education

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[4]Maxwell Jones, The Therapeutic Community (New York:
Basic Books, 1953).

program.[5] In the same year the psychiatric nurses of Manitoba
joined the Canadian Council on Psychiatric Nursing which
sought to promote standards in nursing as well as to improve
conditions for the nursing staffs of the mental hospitals.
The role of the psychiatric nurse was changing to one of
co-therapist.

As the institutions were emptied of their chronic
patients, plans to remodel the mental hospitals architec-
tually were undertaken. Through new construction and remodel-
ing of existing buildings, residences were provided which
were less stark and institutional. At Selkirk, where no new
buildings had been constructed during the depression and
war years, a modern building of brick and glass, Selkirk
Psychiatric Institute, was built and provided with comfor-
table and attractive furniture. Wards in the older Recep-
tion Unit were redecorated in 1968 and 1969 with brilliant
colors and unconventionally shaped lounges and chairs. The
amenities of carpeting and color were attempts to provide
an ambiance of hospitality and comfort. In 1965 the farms
of the hospitals began to close. Long the source of such
staples as turnips, milk, and butter, they became increas-
ingly mechanized after World War II, and patient labor was
not suited to the new methods of farming. The fields were
replanted with grass which provided sweeping lawns and a
parklike landscape.

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[5]"A Century of Psychiatric Nursing", Canadian Psy-
chiatric Nursing, Vol. XX, No. 4, pp. 5-8.

Once again asylums were renamed. This time they were to be "mental health centres." In 1963 Congress had passed the Community Mental Health Centers Act in the United States. This legislation provided federal funding for the construction of centers which were to include in-patient and out-patient facilities, day and night care services, halfway houses and foster home placement services, 24-hour emergency services and consultation and educational programs. The legislation was promoted in Congress on the basis of economic reasoning. If community services could be developed, it might be possible to eliminate the mental hospital system altogether. Many patients could be treated in these centers without hospitalization or with only short term stays, and the incidence, duration, and degree of disability due to mental disorder could be decreased. These services were not new, but the plan to coordinate the entire continuum of services under one roof was. Both mental hospitals in Manitoba were reorganized similar to the mental health center model.

Community programs had been in existence in Manitoba since the 1930's when the first traveling teams from Brandon Hospital for Mental Diseases held clinics in the towns of western Manitoba.[6] After World War II, the staff from Selkirk Mental Hospital also adopted this pattern of community

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[6]See above, p. 74.

service and began to hold clinics in the nearby towns of
Selkirk, Beausejour, Stonewall, and Gimli.[7] In 1966 the
traveling clinics at Brandon Hospital were reorganized to
provide a continuity of service on a geographical basis.
The same team members assessed the condition of the indivi-
dual in the community, supervised him if he were admitted
to the hospital, and provided after-care in his own com-
munity when he was released. In 1971 the consultant firm
of Dr. J. Graham Clarkson was asked to undertake a study
of mental health and mental retardation services in
Manitoba and to make recommendations for "a first class
mental health and mental retardation program". This request
was part of the newly elected New Democratic Party's plan
to establish an integrated and regionalized system for the
provision of all health and social services throughout the
entire province.[8] The publication of Dr. Clarkson's findings,
Mental Health and Retardation Services in Manitoba[9] provided
a survey of the resources in existence and a plan for incor-
porating these resources into a comprehensive, provincial
mental health system.

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[7]Province of Manitoba, Annual Reports, Department of
Health, 1963, p. 53.

[8]Province of Manitoba, Guidelines for the Seventies,
3 Vols. 1973.

[9]J. C. Clarkson, Mental Health and Retardation Ser-
vices in Manitoba (Winnipeg: Province of Manitoba, 1973).

Fundamental to Clarkson's recommendations for re-
organization of mental health services was the development
of "catchment areas".[10] The term involved more than geo-
graphic boundaries; it included the people and the unique
social and economic problems the people in the catchment
area faced. The regionalization of Manitoba psychiatric
services into catchment areas was complicated by the inter-
dependence of rural and Winnipeg regions. Winnipeg mental
health workers used the facilities of Selkirk Mental Hospital
for patients needing long term care, and the hospital mental
health workers looked to Winnipeg for homes and employment
resources for patients being discharged. Ideally catchment
areas provided a full continuum of services to the residents
of the area without recourse to external resources. It was
suggested that through reorganizing services in Winnipeg,
the pattern of sending the most difficult Winnipeg cases to
the hospital at Selkirk could be interrupted, and aftercare
of former Selkirk patients already resident in Winnipeg
secured.[11]

Clarkson suggested that Brandon Hospital should con-
tinue to provide in-patient facilities for Parkland and West
Manitoba regions; Selkirk Mental Hospital, in-patient

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[10]Jack Zusman, "The Catchment Area Concept" in Allan
Geigu and Alan I. Levesson, The Community Mental Health
Centre (New York: Basic Books, Inc., 1972).

[11]Clarkson, Mental Health, p. 82-85.

facilities for the East Manitoba and Interlake regions.[12]
The Northern region would be designated as an experimental
area where residential care would be available at hostels
and the wards of general hospitals.[13] The mental health
resources for all areas would be administered from offices
outside of the hospital by Regional Co-ordinators of Mental
Health so that programs would be community based rather
than hospital based. The Winnipeg region would be sub-
divided into five catchment areas with one of the psychia-
tric wards in the five general hospitals functioning as the
central mental health facility for the catchment area.

Essential to this scheme was the "redeployment of
resources and personnel" from the large institutions.
Mental health workers would be expected to live in the areas
in which they worked. They would "deal with mental health
problems in the early stages right in the community" thus
decreasing the use of high cost mental hospital services.
Although the mental health services which existed in the
rural areas were meager, these services were under govern-
mental control. Workers were employed and deployed in
accordance with provincial policy. In Winnipeg, a sizeable,
entrenched private mental health sector existed. The result,
according to Clarkson, was a poorly co-ordinated and

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[12]Ibid., pp. 81-82.

[13]Ibid.

inefficient use of resources although many individuals and agencies produced excellent programs.[14] Psychiatry had expanded in Winnipeg in the 1950's. In 1957 Dr. T. A. Pincock, then Provincial Psychiatrist, reported with pride that there were twenty-five certified psychiatrists in the province, eighteen of whom were working full time in the institutions or in public services or teaching.[15] By 1970 the total number of psychiatrists had doubled, but other than those practicing at the provincial institutions, all were located in Winnipeg. They were on the staffs of five Winnipeg general hospitals, employed as consultants to the courts and community agencies, involved in teaching, and engaged in private practice. The private practitioner was an anathema to Clarkson, for he did not fit into the scheme of community planning. This physician maintained a commitment to his patients rather than to a catchment area; he used an individual rather than a team approach to treatment, and he tended to treat the less seriously ill person. Moreover his income came from fees for professional services so he was independent of governmental planning.

The changes recommended by Clarkson were radical. He sought to relocate the center of service delivery from the mental hospital to the community through the introduction

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[14]Ibid., pp. 37-50.

[15]Province of Manitoba, Annual Report, Department of Public Welfare, 1957, p. 150.

of a new layer of administrators responsible for the co-
ordination of mental health services in each region.
Workers presently employed at one of the mental hospitals
would be asked to consider relocating in rural areas
throughout the province, and private practitioners in
Winnipeg would be encouraged to become part of the provin-
cial government system by establishing a practice at one of
the general hospitals and by becoming involved in the mental
health needs of its specific catchment area.

The policy statement issued in 1975 by the Department
of Health and Social Development attempted to delineate
more concrete goals for the next five years.[16] Two hundred
trained mental health workers, living in the communities
they served would be the foundation of a community mental
health system. Psychiatric nurses, social workers,
psychiatrists, and psychologists would contribute to
team endeavors including screening and assessment, crisis
intervention, consultation, and out-patient treatment.
Small residences for ten patients or less would be developed
as an alternative to expensive hospitalization for some and
as transitional facilities for others who needed a temporary

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[16]Province of Manitoba, Department of Health and
Social Development, Policy Paper No. 2. "Mental Health
Programs in Manitoba", July, 1975.

place when released from the hospital. Other residences
for not over fifty patients would be developed to care for
those not capable of independent living. Also in this
"spectrum of service" would be 720 foster homes run by well
trained and supervised foster parents. A number of personal
development programs would be innitiated such as life skills
and vocational rehabilitation programs. This category of
service would also include vocational training centres and
sheltered workshops. With the realization of these ser-
vices in-patient care at the mental health facilities would
be reduced to 200 psychiatric beds for the entire province.

Initially Brandon Mental Health Centre Staff launched
into the new era of regionalization with considerable success.
In 1974 the first mental health workers from the staff
established residences in the communities of Dauphin, Saint
Rose, Virden, Hamiota, Reston and Melita.[17] In addition
community mental health workers in consultation with general
practitioners arranged 1,026 psychiatric admissions to
general hospitals in the Parklands and Westman areas, thus
diverting these people from the mental hospital experience.[18]
Teams from Selkirk Mental Health Centre were less prompt in
relocating in the rural districts. Although four community
mental health workers were resident in the Norman Region in

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[17]Province of Manitoba, Department of Health and
Social Development, Annual Report, 1974, p. 67.

[18]Ibid., 1973, p. 34.

1974[19]--two in Thompson and one each in Flin Flon and The
Pas, other teams continued to work from the hospital. Two
itinerant interdisciplinary teams worked in the Eastman
area and two in the Interlake area. By 1976 the difficul-
ties in recruiting staff to live in rural areas was
acknowledged. Brandon staff began to concentrate on the
"consolidation of existing in-patient and out-patient ser-
vices and less on the redeployment of human and physical
resources to community based programs."[20] The Interlake
teams from Selkirk regretted that "the previous plan to
redeploy five mental health workers has not materialized."[21]
By 1977 redeployment had ceased to be a central issue.

In 1975 seventeen field staff from Selkirk Mental
Health Centre were redeployed to Winnipeg to follow up
1,200 patients from the hospital who were living there.[22]
In 1977 attempts to make the services of this new team
"available to the community" were thwarted by the unit's
"limited relationship with the practitioners and agencies
already existing in Winnipeg." However, in 1978 a hopeful
note was registered that "a definition of the teams relation-
ship with the services of private psychiatrists and

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[19]Ibid., p. 68.

[20]Manitoba, Annual Report, 1976, p. 47.

[21]Ibid.,p. 49.

[22]Ibid.

psychiatric units in the general hospitals is becoming clearer."[23] Still, in 1978 Selkirk Mental Health Centre continued to admit patients from the Winnipeg area.[24] Sufficient resources for severely mentally ill patients had not been developed in the Winnipeg region.

The ambitious plans for community psychiatry in Manitoba which promised the eventual control of mental illness through a new system of regionalized, preventative programs, produced much debate during the seventies but limited implementation. A fringe, rather than a force, of mental health workers moved to reside in the rural towns. No additional hostels or half-way houses or residences were built to provide interim care for those incapable of independent living. Moreover the existing services for the post mentally ill began to deteriorate.

Beginning in 1970, CMHA had begun to phase out its services to patients in the mental hospitals. Volunteers no longer visited in the hospitals, and patients from the hospitals no longer visited the CMHA Open Door Clubs. The clubs continued to offer programs such as crafts, discussion groups, field trips and dances, but two kinds of patients were attending these programs...the decarcerated chronic and the patient discharged from the new mental health centre program. The same program was not appropriate for both types

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[23]Manitoba, Annual Report, 1978.

[24]Ibid.

of patient, and CMHA responded by an attempt to provide a
social center for the decarcerated patient and a social
rehabilitation center for the recently discharged patient.
In 1975 a program was initiated in Winnipeg which grouped
the members by functional levels. Attendance at club
activities dropped drastically, and the program was
returned to its earlier format of social club activities,
then discontinued at the end of the year.[25]

Skills Unlimited continued to provide vocational
assessment services for former mental patients, but the
facilities of the sheltered workshop came to be used more
by the mentally retarded than by the post mentally-ill. As
the proportion of mentally retarded using the shop increased,
the mental patients withdrew, not wanting to associate with
the retarded workers. In April 1977 the sheltered workshop
at Selkirk was closed. In 1979 only forty percent of the
workers at Skills in Winnipeg were post mentally ill; the
rest were retarded.[26]

Of even more consequence was the decline in quantity
and quality of foster homes. The cost of housing meant that
very few families would have a spare bedroom available for
care of boarders, and those rooms which were available would
be in great demand. Other governmental agencies sought

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[25]CMHA, Annual Report, 1976.

[26]Interview, W. B. Friesen, Director, Skills Inc.,
November, 1979.

home care as opposed to more expensive institutional care
for various types of dependent people--the retarded, the
aged, and the children who had been removed from their own
homes. The mental health workers had to compete for these
homes. Furthermore women were joining the labor market,
they preferred to take jobs rather than care for dependent
people at welfare rates. In 1979 The Winnipeg Free Press
reported on the homes where the old, the retarded and the
mentally ill were placed. Vulnerable people were existing
in sub-standard conditions where diet, hygiene, and health
care were "below acceptable standards". Medication was
often not properly supervised, and the helpless boarders
were forced to "live in squalor".[27]

The decarcerated patient population has aged, and
many have moved out of the mental health system into facili-
ties for the aged. The patients who have recently come into
psychiatric care in wards of hospitals and mental health
centres usually have not experienced prolongued hospitaliza-
tion and have not become institutionalized to the hospital.
The mental hospital which previously provided long term
care has now been transformed from a human warehouse to a

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[27]See June 13, 1979 "Sick, Aged Sent To Live in
Squalor"; June 19, 1979 "Poor Food, Care Cited at Local
Guest Homes."

"revolving door institution". Patients arrive, are proces-
sed and released hopefully before there is a possibility of
learning the role of mental patient. The question then
raised is how these people can be spared an institutionali-
zed existence in the community since many of the discharged
patients will be handicapped in some degree.

Readmission rates vary according to the type of
patient, but for schizophrenics who represent the major
group who use the "revolving door", one third will return
within the first year of release, and another third will
return at some other time during their life. Only approx-
imately a quarter of them can expect to "recover". The rest
will probably live in the community with mild to substantial
handicaps ranging from a plodding, perhaps unsociable lack
of initiative to complete withdrawal into contemplation of
private experiences. Shirley Angrist and Simon Dinitz,[28]
both sociologists, have reviewed some of the research on
community placement and have noted that patients returning
to live with a spouse performed better than those going to
a parental home. Those living alone tended to perform
least well. Additional variables which determined the
patient's success when released were his socio-economic
status, his intellectual endowment, and the stressful

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[28]Shirley Angrist and Simon Dinitz, "Home Care For
Psychiatric Disorders: Assessment of Effectiveness", in
Paul M. Roman and Harrison M. Trice, Sociological Perspec-
tives on Community Mental Health (Philadelphia: F. A.
Davis and Co., 1974) pp. 233-247.

circumstances he encountered when he returned. The mildly handicapped person can be expected to live a "normalized" existence in the community but may regress if placed in an unstimulating environment. Conversely, severely handicapped schizophrenics may perform at a more satisfactory level if enrolled in special work training and social programs.

The promise of community care has been that fewer people would suffer the secondary effects of institutionalization if they were allowed to live a more normal life in the community. However the patient who cannot cope with his family or has no family to which he can return has limited alternatives in Manitoba. The foster home program is in disarray; none of the alternative residences called for in the 1975 policy statement on mental health have been constructed, and sheltered workshops and social clubs are all but non-existent. There is no doubt that many ex-patients are lapsing into institutionalized lives in the community without the provision of adequate diet, proper hygiene, supervision of drugs or diversion of any sort. The implementation of community care, while helpful to some, has actually worsened the quality of life for a number of discharged patients.

CHAPTER VII

ONE HUNDRED YEARS LATER

During the nineteenth and twentieth century a number of health crusades were mounted. Some, such as the March of Dimes campaign against polio and the Tuberculosis Association fight to conquer tuberculosis resulted in a medical "cure" or vaccine. The analogy taken from the fund raisers using battle terminology was an apt one. A health condition was identified, and organizations were founded to "fight" for care of those afflicted by the disease and to search for a cure or prevention of the condition. The mental health movement has been one such crusade. The first battles were fought by asylum reformers who sought to bring humane care to people afflicted with mental illness and to convince the general populace that these people were ill and in need of treatment. Governments responded by providing asylums where these people could retreat from the stresses of living and recover their health. However, many who retreated never fully recovered, and these people accumulated in the institutions. Subsequent campaigns to improve conditions of the mental hospitals occurred from time to time, and new treatments such as shock treatments, psychotherapy, and psychosurgery were introduced, but the population of the mental hospitals continued to spiral.

In Manitoba, the provincial psychiatrists attempted a new solution to the problem of ever-climbing patient populations in 1934 when they experimented with a foster home placement program. Ten years later the Minister of Health and Public Welfare announced a policy of releasing mental patients to foster homes, but the program was used only for a relatively few patients and then discontinued because of the post World War II housing shortage. A decade later in 1954 the decarceration movement was begun in the United States, and by 1960 a decarceration plan was in operation in Manitoba. Patients long stored in the wards of the mental hospitals were sent to live in foster homes.

The question then arises why a quarter of a century elapsed between the time the first patients were sent to live in foster homes and the time when the policy of decarceration was finally implemented. Why was the foster home program held in abeyance during those years, and, why, after so many years, was foster home placement revived to provide places where decarcerated mental patients might live. It is quite evident from provincial reports that after World War I, the right of patients to life long institutional care was being questioned. However until a humanitarian rationale, which would allow for their release was developed, these people continued to live at public expense in mental

hospitals.[1] During the 1950's social scientists and
psychiatrists analysed the mental hospitals and concluded
that such institutions were generally destructive to the
patients who were confined in them. Patients who became
institutionalized to the regimented routines of the mental
hospitals often suffered severe secondary disabilities from
the experience. These observations provided the reasons for
removing patients from the hospital. Patients in the
community would be spared the destructive process of insti-
tutionalization. Decarceration could be implemented for
humanitarian reasons.

At this time the psychotropic drugs were introduced
into the mental hospitals. They quieted the florid symp-
toms of patients and made them more suitable candidates for
foster home care. Through behavior modification therapy,
patients in Manitoba were prepared for placement, and after
placement, efforts were made to integrate them into the
community through participation in sheltered workshops and
social clubs specifically designed for the ex-patient.

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[1]These findings substantiate those of Andrew Scull
in Decarceration (Englewood Cliffs, New Jersey, 1977) P. 152:
"In the circumstances, it is scarcely surprising to learn
that decarceration in practice has displayed remarkable
little resemblance to liberal rhetoric on the subject.
Indeed, the primary value (though far from its authors'
intent) seems to have been its usefulness as ideological
camouflage, allowing economy to masquerade as benevolence
and neglect as tolerance."

Eventually the quality of foster home care and many of the community services, such as the social clubs, were allowed to deteriorate.

The mental health crusade has not terminated in victory. For the most part the major task of restoring seriously mentally ill persons to social competence has not been accomplished. The tremendous confidence in asylum care was unfounded. Psychotherapy has helped many suffering from mental and emotional distress, but it has never been demonstrated that is is effective in preventing major mental illness. Psychotropic drugs have controlled the symptoms of these illnesses, but they have not cured them. Although intermittent campaigns have been waged to assure humane care for mental patients, many are still sent to live in wretched conditions. Goals first articulated by the early reformers remain unattained after a century of endeavor. In Manitoba, as elsewhere in North America, the mental health movement has achieved little more than modest success in its war to eliminate mental illness and to provide care and protection for its victims.

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