A HISTORY OF MENTAL HEALTH CARE IN MANITOBA:
A LOCAL MANIFESTATION OF AN INTERNATIONAL
SOCIAL MOVEMENT

By
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A HISTORY OF MENTAL HEALTH CARE IN MANITOBA:
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the University of Manitoba in partial fulfillment of the requirements
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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 governments 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 document 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 hopelessly 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

\(^1\) 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 cure 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


\(^3\) "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 Higgens' 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

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 antithetical to moral treatment. 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. 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. 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 Scull, 
Ibid.

Jones, 
History of Mental Health, pp. 66-86. Scull, 
Ibid.
introduce legislation which would provide a competent inspection 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 physicians' demands that the bills be defeated. Temporarily, at least, the physicians retained their professional pre-eminance 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 insanity 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.


\(^11\)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


¹³Scull, 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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{16} The information gathered by these Commissioners during their routine

\textsuperscript{14}Jones, \textit{History of Mental Health}, p. 132.


\textsuperscript{16}Jones, \textit{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, extended their appointments into full-time employment as investigators 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 counterparts 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 Dix18 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


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." 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

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 domain 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

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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him. She was successful in convincing him that a lunacy commission should be appointed for Scotland. From there she went to the Channel Islands and remained there until a committee 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 second 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 insanity 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 claiming care within the boundaries of New Brunswick.\footnote{Hurd, The Institutional Care of the Insane in the United States and Canada, Vol. 4, (Baltimore: The Johns Hopkins Press, 1916-1917) p. 482-497.}

In Nova Scotia she found \textbf{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 \textbf{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 protection 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 patient...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 maniacal or idiotic, some piercing the heavy poisonous air of their filthy cells with loud cries, rending their clothes, or uttering low meaningless babblings or idiocy.\footnote{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.

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 tenant of contemporary psychiatric thought.

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 securing 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 procrastination.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 appropriate way to care for the mentally ill.

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

26Ibid.
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 incarcerated in jails or the strong rooms of county almshouses. As long as custody, rather than cure had been the primary purpose 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 Superintendent, no longer a

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 treatment was forgotten, and the "cure" (if any) came to be expected 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 professionals 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. In his book, The Curability of Insanity published in 1887, he discussed the misuse of statistics made by earlier doctors to justify the building of more asylums. Another attack on the medical superintendents was launched by the neurologists who had risen to prominence after the American Civil War. They criticized


30Ibid., 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 overuse 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 establishing the mechanisms of government and the departments necessary to keep that government functioning smoothly. Accordingly, Adams Archibald and Alexander Morris, the first Lieutenant Governors, organized and ran the provincial government 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 necessary for the Lieutenant Governor to intercede with the federal government from time to time to head off bankruptcy.³

²Ibid., p. 159.
³Ibid.
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." 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.

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

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

5 L. G. Morris to Secretary of State, October 31, 1876, I/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. 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." 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. He was allowed to continue his roaming although some concern was expressed about him. Eventually the jail became routinely used for holding these misfits.

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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. 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. 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 presence 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 consequence. 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.

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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 custody.13

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

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

Lieutenant-Governor. For the next eight years, the mentally ill were to be confined to the basement of the federal penitentiary at provincial expense.

Commitment procedures were clarified in 1876 when a law was passed to provide for the dangerously insane. 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.


The Custody of Insane Persons Act of 1877 provided a way of appealing the commitment. 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.

\[\text{C.M.S.: 23: Victoria 40: Custody of Insane Persons, 1877.}\]
All the physicians who have attended this penitentiary 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 partially are fewer than would happen under more favourable circumstances. So far as their wants and comforts 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 railway 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

19 W. Adshead, report to the Department of Justice, June 15, 1882, Microfilm, Ws4 D6-1, Samuel Bedson Letterbook, Manitoba Provincial Archives.

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—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 century.21

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and the Manitoba Free Press 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. 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...
being much delay in finishing the asylum.\textsuperscript{26}

The provincial government acquiesced and made plans to move the lunatics into temporary quarters at Lower Fort Garry.\textsuperscript{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 Superintendent 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

\textsuperscript{26}J. W. Moylaw, report to the Department of Justice, Government of Canada, October 11, 1884, Microfilm Ng4 D6-1

\textsuperscript{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, confident that he could help these people through the use of moral treatment.

28S. 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 superintendent 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 smallpox 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 formalized 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.

\(^1\)"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. 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 skillful 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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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 commenced 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.

3David 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. 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 construction in a spiraling fashion for as long as money was forthcoming. "No state in the American Union, no Province

4Province 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." 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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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 reformatory 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 reformatory. 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

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


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, reported 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.\(^11\)
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."\textsuperscript{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 \textit{Manitoba Free Press} reported a "terrible scene."\textsuperscript{13} "Some of the poor demented creatures

\textsuperscript{12}Province of Manitoba, \textit{Sessional Papers}, 1908.

\textsuperscript{13}"Brandon Asylum, Home of Six Hundred Persons, Burned Down", \textit{The Manitoba Free Press}, November 5, 1910.
went docilely 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\textsuperscript{14} assured the citizens of Manitoba that these persons were not dangerous. 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 temporary 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.\textsuperscript{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

\textsuperscript{14}"One Lost as Result of Fire," \textit{Manitoba Free Press} November 7, 1910.

\textsuperscript{15}Province of Manitoba, \textit{Sessional Papers}, 1913, p. 491.
and buildings were expanded in a futile attempt to accommodate the growing number of patients. In 1904 the last addition to the Selkirk Asylum was finished, and the building was complete as originally designed. Brandon Asylum continued 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 accommodated. Dr. Young sought some answer to the apparent failure 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 essentially 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 officially 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

16Province 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 home-front, 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.

17Province 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 effective 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 population. Despite all these innovations, mental illness remained. The years between World War I and World War II became a period 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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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. 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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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 worldwide 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, a book which had been reprinted twenty-five times when he died in 1943.

A Mind that Found Itself created a profound impression 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 knowledge 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


5Ibid 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.  

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. 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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6Quoted in Deutsch, *The Mentally Ill*, p. 315.

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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The Liberal party under the leadership of Premier T. C. Norris was engaged in expanding welfare legislation. 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 interference, 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. The

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10Clarence 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." There was not the "slightest regard to the demands of modern science"—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 dments 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. 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. The Winnipeg Psychopathic Hospital was

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 diagnostic 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

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. A training program for psychiatric nurses was established at both hospitals by 1921 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

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.

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. At Brandon a one and one-half story building for "senile dement" was built about a mile distant from the main complex of buildings 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. 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 admissions 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

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

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

turned toward the families who sent relatives to the hospitals accusing them of a "decreasing sense of individual, family and community responsibility." 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 follow-up studies never substantiated the confidence placed in the new treatment.

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

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

\[\text{23} \text{Ibid., Deutsch, The Mentally Ill, p. 500.}\]
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. 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. 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..." 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

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

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

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

27Manitoba, Sessional Papers, 1940, p. 149
28Manitoba, Sessional Papers, 1940, pp. 159-160.
29Manitoba, 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.\(^{31}\)


clinics were held in Killarney and Carberry. No outpatient 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. Within 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 consultation service was developed at Brandon as early as 1938.32 General practitioners were asked to participate in the assessment of patients whom they referred to the out-patient department. In this way general practitioners were instructed 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. However the large waiting list at the Psychopathic Hospital "disappeared" by 1942,33 and Dr. T. A. Pincock, who replaced

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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. Evidently 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." 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

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, nationally, 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 hospital within a much larger mental health system, for as one of the planners pointed out:

...there is continuity of service between outpatient 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. Hospitalization 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 disparagingly


³Ibid., 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


for a given geographical area; coordinated so that hospitals, clinics, and other centres would provide care without gaps and overlaps in service, and characterized by a continuity of care 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. 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." 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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6Ibid., pp. 38-45.

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—the talking treatment made famous by Sigmund Freud. The psychotherapist listened to topics initiated by the patient and through a process of questioning, focusing, clarifying, reflecting, and interpreting, helped the patient resolve conflicts which were causing mental suffering. The therapist sought to lead the patient towards the vague state of mental health, a concept which varied according to the definition of the individual therapist 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," 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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9Ibid., s.v. "The Concept of Mental Health" by Morris S. Schwartz and Charlotte Green Schwartz.

who bought books on these subjects or even sought the services 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 Mental 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.\(^\text{11}\) 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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\(^{11}\text{CMHA, Manitoba Division, Annual Report, 1956. The 1957 Board of Directors included the Provincial Psychiatrist, Dr. J. C. Pincock, and psychiatrists from both provincial mental hospitals. The institutional psychiatrists were active in establishing an organization which would function as a link between the hospital and the community.}\)
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. 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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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 produced a profit of $3,481 after all expenses were paid, and 321 patients received allowances from these profits.  

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 changing needs". "Activities in the hospitals were fewer and our activities at CMHA Social Rehabilitation Centres and elsewhere in the community were more numerous." (Italics Miss Desjardin's.) At this time the organization was extending 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 question 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".\textsuperscript{15} Dr. Pincock, then medical superintendent 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 institution 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.\textsuperscript{15}

The value of the plan was indisputable from an economic point of view.

The present capital investment at this institution, 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.\textsuperscript{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

\textsuperscript{15}Province of Manitoba, \textit{Sessional Papers}, pp. 94-95.

\textsuperscript{16}\textit{Ibid.}
"amply demonstrated." In 1944, Ivan Schultz, Minister of Health and Public Welfare, addressed the Legislature 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 clinical 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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17Province of Manitoba, Department of Health and Public Welfare, Annual Reports, 1944.
18Ivan 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* 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

of the staff effected the clinical course of the patient. More widely quoted was Erving Goffman's book, *Asylums* 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 irreparable 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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mentally ill. Under the premises of labeling theory, 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, a psychiatrist, incorporated labeling theory into his attack upon institutional psychiatry. 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 linguistic rules, such as homosexuals, alcoholics, and criminals were labeled "mentally ill" and subjected to treatment.


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." 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.

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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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 196527 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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the general population.\textsuperscript{28}

Scholars also investigated the socio-economic status of the mentally ill and found that the poor were far more likely to be hospitalized.\textsuperscript{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 depersonalized 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


dangerous to themselves or others in the community. The patients were perceived as victims; institutional psychiatrists 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 community. 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

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

Source: From Andrew Scull, Decarceration, p. 68.
TABLE II
RESIDENT POPULATION OF MENTAL HOSPITALS
IN ENGLAND AND WALES, 1951-1970

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

Source: From Andrew Scull, Decarceration, p. 70.
### TABLE III

RESIDENT POPULATION OF MENTAL HOSPITALS IN MANITOBA, 1938-1978

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

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. 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

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 personal hygiene was not acceptable.\footnote{Skills, Unlimited, Minutes of Advisory Board Meeting, Nov. 1, 1962.} He was prepared for living in the community by a series of programs of occupational 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 participating in work or the CMHA social center.

To help the former patients feel "more comfortable and more secure with other individuals", CMHA staff established special social rehabilitation programs. Classes in etiquette, grooming, physical fitness, clothing repair, and
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. 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. By 1964 the need for an additional sheltered workshop in Metropolitan

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

34Ibid.
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. 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.

\[^{35}\text{Ibid.}, \text{Feb. 14, 1964.}\]
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.


37Scull, Decarceration, pp. 79-89.
TABLE IV

TOTAL NUMBER OF PATIENTS IN MENTAL HOSPITALS AND RATE/100,000 PEOPLE IN MANITOBA
1951-1976

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Patients</th>
<th>Rate/100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>2,692</td>
<td>346</td>
</tr>
<tr>
<td>1956</td>
<td>2,824</td>
<td>332</td>
</tr>
<tr>
<td>1961</td>
<td>2,935</td>
<td>318</td>
</tr>
<tr>
<td>1966</td>
<td>2,245</td>
<td>233</td>
</tr>
<tr>
<td>1971</td>
<td>1,546</td>
<td>156</td>
</tr>
<tr>
<td>1976</td>
<td>946</td>
<td>93</td>
</tr>
</tbody>
</table>
The dramatic reductions in rate of mental hospitalization which occurred after 1961 were preceded by a period of gradual decline during which psychiatrists were experimenting with shock therapy, psychosurgery and occasional foster home placement as ways of decreasing the hospital population. 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.\textsuperscript{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."\textsuperscript{39} Because of the drugs, the "disturbed 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


\textsuperscript{39}\textit{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 solution to the problem of the care of the chronic patient, for
<table>
<thead>
<tr>
<th>Drug</th>
<th>Service</th>
<th>1958 Cases</th>
<th>Much Improved</th>
<th>Improved</th>
<th>Controlled</th>
<th>Unimproved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Largactil</td>
<td>P.I.</td>
<td>167</td>
<td>18%</td>
<td>26%</td>
<td>-</td>
<td>56%</td>
</tr>
<tr>
<td></td>
<td>Cont. Serv.</td>
<td>354</td>
<td>4.5%</td>
<td>23.5%</td>
<td>47.7%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Risperpine</td>
<td>P.I.</td>
<td>11</td>
<td>-</td>
<td>36%</td>
<td>-</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>Cont. Serv.</td>
<td>131</td>
<td>-</td>
<td>14%</td>
<td>60%</td>
<td>16%</td>
</tr>
<tr>
<td>Trilafon</td>
<td>P.I.</td>
<td>59</td>
<td>12%</td>
<td>24%</td>
<td>-</td>
<td>64%</td>
</tr>
<tr>
<td></td>
<td>Cont. Serv.</td>
<td>127</td>
<td>1.6%</td>
<td>31%</td>
<td>38.4%</td>
<td>29%</td>
</tr>
<tr>
<td>Nozinan</td>
<td>P.I.</td>
<td>43</td>
<td>25.6%</td>
<td>25.6%</td>
<td>-</td>
<td>48.8%</td>
</tr>
<tr>
<td></td>
<td>Cont. Serv.</td>
<td>145</td>
<td>11.7%</td>
<td>35.8%</td>
<td>-</td>
<td>52.5%</td>
</tr>
<tr>
<td>Stelazine</td>
<td>P.I.</td>
<td>34</td>
<td>26.5%</td>
<td>23.5%</td>
<td>-</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td>Cont. Serv.</td>
<td>39</td>
<td>13%</td>
<td>28%</td>
<td>-</td>
<td>59%</td>
</tr>
<tr>
<td>Marsilid</td>
<td>P.I.</td>
<td>33</td>
<td>15%</td>
<td>24%</td>
<td>-</td>
<td>61%</td>
</tr>
<tr>
<td></td>
<td>Cont. Serv.</td>
<td>20</td>
<td>5%</td>
<td>25%</td>
<td>-</td>
<td>70%</td>
</tr>
<tr>
<td>Other</td>
<td>P.I.</td>
<td>31</td>
<td>13%</td>
<td>13%</td>
<td>-</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td>Cont. Serv.</td>
<td>33</td>
<td>-</td>
<td>12%</td>
<td>-</td>
<td>88%</td>
</tr>
</tbody>
</table>

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 condition. 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 Attendant 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 exception 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 description 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

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


During the following years the hospitals were reorganized 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 tyrannical patterns of the traditional mental hospital. 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 potentially therapeutic for the patient, and therefore all staff shared the responsibility of providing therapy, both structured 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 educational authority for the psychiatric nursing education.

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program. 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 architecturally were undertaken. Through new construction and remodeling 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 comfortable and attractive furniture. Wards in the older Reception 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 increasingly 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.

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. After World War II, the staff from Selkirk Mental Hospital also adopted this pattern of community

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6See above, p. 74.
service and began to hold clinics in the nearby towns of Selkirk, Beausejour, Stonewall, and Gimli. 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 individual in the community, supervised him if he were admitted to the hospital, and provided after-care in his own community 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. The publication of Dr. Clarkson's findings, Mental Health and Retardation Services in Manitoba provided a survey of the resources in existence and a plan for incorporating these resources into a comprehensive, provincial mental health system.

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


9J. C. Clarkson, Mental Health and Retardation Services 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 geographic 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 continue to provide in-patient facilities for Parkland and West Manitoba regions; Selkirk Mental Hospital, in-patient


¹¹Clarkson, Mental Health, p. 82-85.
facilities for the East Manitoba and Interlake regions.\textsuperscript{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.\textsuperscript{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 subdivided into five catchment areas with one of the psychiatric 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 governmental 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

\textsuperscript{12}Ibid., pp. 81-82.

\textsuperscript{13}Ibid.
inefficient use of resources although many individuals and agencies produced excellent programs.\textsuperscript{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.\textsuperscript{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

\textsuperscript{14}Ibid., pp. 37-50.

\textsuperscript{15}Province of Manitoba, \textit{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 initiated 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 services 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. 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. 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


18Ibid., 1973, p. 34.
1974--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 difficulties 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 services and less on the redeployment of human and physical resources to community based programs." The Interlake teams from Selkirk regretted that "the previous plan to redeploy five mental health workers has not materialized." 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. 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 relationship with the services of private psychiatrists and

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19 Ibid., p. 68.
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


24Ibid.
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.\textsuperscript{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.\textsuperscript{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

\textsuperscript{25}CMHA, \textit{Annual Report}, 1976.

\textsuperscript{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 facilities for the aged. The patients who have recently come into psychiatric care in wards of hospitals and mental health centres usually have not experienced prolonged hospitalization 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

27See 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 processed 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 institutionalized 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 approximately 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, 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

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 live 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
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 institutionalization. Decarceration could be implemented for humanitarian reasons.

At this time the psychotropic drugs were introduced into the mental hospitals. They quieted the florid symptoms 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.

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 it 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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