

Introduction

Dismantling the Asylum and Charting New Pathways into the Community: Mental Health Care in Twentieth Century Canada

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IN 2007 Megan Davies at York University and I, then at the University of Alberta, secured a history of medicine grant from the Canadian Institutes of Health Research to launch a collaborative project called “Open Doors/Closed Ranks.” The project was inspired and supported by Bob Menzies and has since blossomed to include over twenty collaborators across the country, each of whom is developing new approaches to studying deinstitutionalization, or care in the community, in a Canadian region. Some of the results of those studies have been posted on our bilingual website www.historyofmadness.ca, which emphasizes the Canadian social history of this phenomenon and prioritizes patient and former patient perspectives above others. This special edition of *Histoire Sociale / Social History* represents the results of some of those studies and highlights the central idea of deinstitutionalization as an organizing principle for understanding more broad-based changes in Canadian twentieth century social history. Critical ideals about work, welfare, ability, health, gender, and human rights assumed new meanings, particularly in the second half of the twentieth century, and, as the following articles make clear, multifaceted changes to the mental health system have often underpinned these cultural transitions.

Deinstitutionalization in the most literal sense involved the massive depopulation of mental hospitals across the country. This maneuver,

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however, had a rippling effect across many sectors of society, including the economy, workforce, public health and education, human rights and, most obviously, mental health care treatment and facilities. Downsizing and eventually closing mental hospitals, formerly designed as asylums, was not simply an activity that was confined to the mental health system, nor did it exclusively affect former patients and their families. The changes wrought by deinstitutionalization were far-reaching for their impact on the Canadian economy and on human rights discourses, particularly those that hinged upon ideals of ability, disability, health and illness.

Indeed, these changes in the second half of twentieth century were perhaps as significant as those that had occurred during the previous century, amid state building campaigns, rapid industrialization, urbanization, and colonialization, all of which formed the backdrop to the rise of the asylum.² The twentieth-century context for the reversal of this trend involved a different set of ideological and cultural precedents, but contained remnants of some of these earlier influences. State building, for example, continued apace, but adopted new formats. Immediately after the Second World War, the federal government took on the task of reconstruction and reinforced or initiated a series of new programs, including family allowances, unemployment insurance and eventually health care. Collectively, these social programs contributed to what some have referred to as the 'welfare state.'³ By the 1980s, that goal had faded as neo-liberal policies were implemented in a growing number of countries. An era of Reaganomics took over in the United States, Britain faced Thatcher-style reforms, and Canada succumbed to a similar economic mantra as Brian Mulroney opened the Canadian border to freer trade and weakened the social services infrastructure that previous governments had developed. Under the new regimes of fiscal conservatism, the welfare state that had evolved out of the reconstruction period crumbled. A closer look at the details affected by these ideological shifts reveals the impact of such public policy on areas of child welfare, disability supports, and provincial programs for social services, health care and education more broadly.⁴ Primarily as scholars have pointed out already, the ideological shifts at the high political level created significant challenges, particularly for more

2 For a thorough historical examination, see: David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little Brown, 1971); Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England* (New York: St. Martin's Press, 1979); James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal: McGill-Queen's University Press, 2000).

3 See for example, Jim Struthers, *The Limits of Affluence: Welfare in Ontario, 1920–1970* (Toronto: University of Toronto Press, 1994).

4 See for example, Raymond Blake's *From Rights to Needs: A History of Family Allowances in Canada, 1929–1992* (Vancouver: University of British Columbia Press, 2009).

vulnerable members of society, including patients as well as under-employed staff associated with these institutions.⁵

Industrialization accelerated with the Second World War, and one of the goals of reconstruction was to maintain levels of production and employment in peacetime. Yet the emphasis on one's value in the workforce continued to frame discourses on categories of ability and disability, as they had during the rise of the asylum. A number of scholars moved beyond the rigid ability/disability dichotomy and offered more sophisticated studies that considered how human value has been medicalized and how ability itself has been understood in modern economies.⁶ Some scholars have even begun to turn the notion of ability on its head by pointing to the folly of assigning value to work while not providing remuneration for work conducted by institutionalized individuals when it can be written off as therapeutic. Geoffrey Reaume's pioneering scholarship in this field not only reminds us that the labels ability and disability are too simplistic, but also that the notion of work needs to be more carefully theorized in relation to human value, worth and dignity and the context in which it occurs.⁷ In the age of the asylum, work functioned as an essential component of therapy, allegedly teaching the moral virtues of industriousness, discipline, responsibility and skills. Conversely, as Reaume has pointed out, patient labour helped to ensure that large-scale psychiatric institutions were relatively self-sufficient as patients worked the gardens, ran the laundries, and performed most of the maintenance and cleaning on the hospital grounds.

In a post-asylum world, work became a means of survival, but too much work threatened to undermine social service provisions. The emergence of sheltered workshops, which contributors Fingard and Rutherford investigate in Nova Scotia, fill the role of asylum-based 'work therapy' in a quasi-remunerative environment, sheltered at times from direct labour competition, but subject to economic markets. The rise of these new working regimes rested upon the efforts, often, of volunteers who championed such a facility, along with subsidies from a variety of government and non-profit organizations. Although the institutional nature of work

5 See especially, Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: The Free Press, 1994).

6 For a comprehensive historical overview of this literature, see: Henri Stiker, *A History of Disability* (translated by William Sayers) (Ann Arbor: University of Michigan Press, 1999). For a further example in this genre that provides a closer study of specific programs that have been designed to challenge public perceptions of disability and that have confronted legal challenges, see: Sharon L. Snyder and David T. Mitchell, *Cultural Locations of Disability* (Chicago: University of Chicago Press, 2006).

7 Geoffrey Reaume, "Patients at Work: Insane Asylum Inmates' Labour in Ontario, 1841-1900," in James E. Moran and David Wright (eds), *Mental Health and Canadian Society: Historical Perspectives* (Montreal: McGill-Queen's University Press, 2006), pp. 69-116.

changed, the valuation of patient and former patient labour remains under appreciated and the relationship between therapy and employment continues to exist in murky territory.

By the second half of the twentieth century, urbanization included suburbanization, which contributed to the creation of new, often gendered, discourses on mental health, behaviour and illness, including, for example, what Betty Friedan called “the problem that has no name.”⁸ Meanwhile, psychiatrists, armed with medico-scientific labels, referred to similar behaviours as depressive or anxious and applied pharmaceutical remedies, including Miltown and later Valium.⁹ Some of these pharmaco-therapies replaced institutional care in an asylum setting but did not fundamentally replace the need for care and attention being focused on disordered, undesirable or unwanted behaviours—whether from the individual’s or the physician’s perspective. As scholars including Elaine Showalter, Wendy Mitchinson, Elizabeth Lunbeck and Cheryl Warsh have shown us, the gendering of mental disorders has a long history, and under asylum conditions, the gendered disorders also made for distinctions in accommodations and treatment options.¹⁰ Separate wards, separate treatments, and by extension a separate set of gendered expectations deepened the gender divide.

In the era after the asylum, the gendered distinctions remained firmly in place, even as the walls of the institutions dissolved from the picture. Acceptable displays of masculinity and femininity, often characteristics infused with ideals of sexuality, continued to shape the ways that mental disorders were understood and addressed.¹¹ Advertisements for pharmaceuticals revealed these lingering assumptions, with women portrayed as inherently more prone to depression and men to stress and anxiety. Even childhood mental disorders have shown these kinds of gendered

8 Betty Friedan, *The Feminine Mystique*, (New York: Norton, 1963), chapter 1.

9 For historical studies of the cultural and gendered implications of the psychopharmaceutical approach to ‘modern’ mental health, see: David Herzberg, *Happy Pills in America: From Miltown to Prozac* (Baltimore: Johns Hopkins University Press, 2008); Jonathan Metzl, *Prozac on the Couch: Prescribing Gender in the Era of Wonder Drugs* (Durham: Duke University Press, 2003); Andrea Tone and Elizabeth Siegel Watkins, *Medicating Modern America: Prescription Drugs in History* (New York: New York University Press, 2007); Andrea Tone, *The Age of Anxiety: A History of America’s Turbulent Affair with Tranquilizers* (New York: Basic Books, 2009); and Erika Dyck *Psychedelic Psychiatry: LSD from Clinic to Campus* (Baltimore: Johns Hopkins University Press, 2008).

10 See Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830–1980* (New York: Virago Press, 1987); Wendy Mitchinson, *The Nature of their Bodies: Women and Their Doctors in Victorian Canada* (Toronto: University of Toronto Press, 1991), especially chapter 10; and, Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* (Princeton, NJ: Princeton University Press, 1994).

11 Elise Chenier, *Strangers in Our Midst: Sexual Deviancy in Postwar Ontario* (Toronto: University of Toronto Press, 2008); and, David Herzberg, *Happy Pills in America: From Miltown to Prozac* (Baltimore: Johns Hopkins University Press, 2008).

assumptions about behaviour and ‘dysfunction.’ Matthew Smith has looked at western ideals of healthy children in contrast to the proliferation of attention deficit disorders and concluded that girls were more likely to be diagnosed with this label when they appeared listless or disengaged, emphasizing the deficit aspect of the disorder, whereas boys were more likely to be considered hyperactive and uncontrollable, leaning towards the attention feature.¹²

And while colonialism’s functioning was reshaped and ostensibly overturned in liberation struggles in the second half of the twentieth century, a different generation of race relations, power dynamics and ethnic conflicts rooted in colonial legacies took its place.¹³ In the first half of the twentieth century, biological explanations for mental ‘diseases’ had encouraged biological remedies. Within psychiatry, biological explanations supported the rise of somatic therapies, which included the introduction of sexual sterilizations, lobotomies, electro-convulsive (electro-shock) therapies, and other invasive bodily treatments. Within the field of mental health more broadly, which included areas of mental disability, or mental retardation, the unquenched thirst for biological explanations also resulted in eugenics programs throughout North America and parts of Europe in the early decades of the century. In Canada, support for eugenics was formally realized in programs in British Columbia and Alberta, where provincial governments authorized the sexual sterilization of nearly 200 and 3,000 individuals, respectively, based largely on theories of mental incompetence or deficiency. Alberta’s eugenics program continued into the early 1970s, the basis for its existence still rooted in a belief in biological explanations for human behaviour, intelligence, and, by extension, competence.

Biological explanations did not disappear from psychiatric discourse in the second half of the century, although their more overt expressions, such as those that manifested in eugenic programs, had almost all been abandoned.¹⁴ Biological conceptualizations of race, which often

12 Matthew Smith, “Putting Hyperactivity in its Place: Cold War Politics, the Brain Race and the Origins of Hyperactivity in the United States, 1957–68,” in Erika Dyck and Christopher Fletcher (eds), *Locating Health: Historical and Anthropological Investigations of Health and Place* (London: Pickering and Chatto, 2011), pp. 57–70.

13 For example, see Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (Boston: Beacon Press, 2009); Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness and Colonialism in Southwest Nigeria* (Berkeley: University of California Press, 1999); Waltraud Ernst, Matthew Gambino, “Mental Health and Ideals of Citizenship: Patient Care at St. Elizabeth’s Hospital in Washington, D.C., 1903–1962” (unpublished PhD dissertation, University of Illinois at Urbana-Champaign, 2010); and Waltraud Ernst, “Colonial policies, racial politics and the development of psychiatric institutions in early nineteenth-century British India,” in Waltraud Ernst and Bernard Harris (eds), *Race, Science and Medicine, 1700–1960* (London: Routledge Press, 1999), pp. 80–100.

14 See Paul Lombardo, *Three Generations No Imbeciles: Eugenics, the Supreme Court, and Buck v. Bell* (Baltimore: Johns Hopkins University Press, 2008); for Canadian literature on this subject, see: Jana

co-mingled with more political notions of citizenship, continued to affect the experience of illness, particularly as specific individuals negotiated medical services.¹⁵ As historian Edward Shorter had argued, biological assumptions also acquired new meaning with the growth of neuroscience and the rapid investment in new scientific methods and foci for generating a more sophisticated understanding of the relationship between biology and behaviour.¹⁶

Significant changes were also occurring within the professionalization of psychiatry during this period. After the Second World War, several fundamental developments reshaped this sub-discipline within medicine, including the development of psychotropic medications and the launching of what some scholars have called a psychopharmacological revolution.¹⁷ The same year that the first anti-psychotic medication became commercially available in Europe and in Canada, 1952, the American Psychiatric Association released its first comprehensive classification system for psychiatric disorders (The Diagnostics and Statistical Manual for Mental Disorders). These professional and structural developments in psychiatry coincided with new research directions within the discipline, which, as Edward Shorter has argued, resurrected biological psychiatry and forged a renewed connection with neuroscience after the devastations of the Second World War and a continued fascination with psychoanalytic, psychodynamic and Freudian-based theories of behaviour.¹⁸ The changes within the profession coincided with changes in the practice of institutional psychiatry. Increasingly, psychiatrists sought positions in private practices, and general practitioners assumed the burden of this shift as they began observing psychiatric symptoms in emergency rooms and family medicine encounters.

In spite of the structural changes initiated by the closure of long-stay hospitals, and the physical impact that destroying large-scale institutions

Grekul, Harvey Krahn and Dave Odynak, "Sterilizing the 'Feeble-minded': Eugenics in Alberta Canada, 1929–1972," *Journal of Historical Sociology* vol. 17, no. 4, 2004, pp. 358–384.

15 See Robert Menzies and Ted Palys, "Turbulent Spirits: Aboriginal Patients in the British Columbia Psychiatric System, 1879–1950," in James E. Moran and David Wright (eds), *Mental Health and Canadian Society: Historical Perspectives* (Montreal: McGill-Queen's University Press, 2006), pp. 149–175; and for a non-psychiatric perspective, see: Maureen Lux, "Care for the 'Racially Careless': Indian Hospitals in the Canadian West, 1920–1950s," *Canadian Historical Review*, vol. 91, no. 3, 2010, pp. 407–434.

16 See for example, Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons Inc., 1997) and for a historiographical critique of this 'biological turn' see: Daniel Lord Smail, *On Deep History and the Brain* (Berkeley: University of California Press, 2008).

17 See for example, David Healy, *The Anti-Depressant Era* (Cambridge: Harvard University Press, 1997).

18 Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley & Sons Inc., 1997).

had on the landscapes and economic outlook for many communities, these dramatic changes did not always bring about significant differences in the experience of alienation or vulnerability faced by many individuals who interacted with the mental health care system. Deinstitutionalization may have signalled the end of the age of the asylum and the dawn of a new kind of mental health accommodation, which included a precipitous decline in long-stay patient populations, the gradual closure of separate mental hospitals as psychiatric wards were folded into general hospitals, and the rise of an entirely new system for mental health, but it did not coincide with a decline in the numbers of individuals and families seeking assistance. Quite the opposite occurred. Where the asylum had ostensibly provided a set of services under one roof, problematic though they may have been, the post-asylum world involved a complicated matrix of services. These were not under the jurisdiction of any one governmental department and did not necessarily fit neatly into Canada's constitutional federalist framework. Medical services, housing and employment needs along with financial and family support services required a delicate degree of bureaucratic coordination in a Kafkaesque world of red tape.

For Canadians, the introduction of universal, publicly-funded health care distinguished us from Americans who continued (and for now still continue) to add another layer to this bureaucratic entanglement in the form of Health Maintenance Organizations (HMOs) and the health care insurance industry. But, medicare significantly affected the way that health care services were provided across Canada, and bringing psychiatric facilities into alignment with the general health system produced tensions running from community organizations to legislative assemblies. Greg Marchildon explores this feature of deinstitutionalization in his article in this volume, and successive health commissions have reinforced this perspective, outlining the awkward relationship that continues to challenge service providers in the mental health field. In his 2002 commission report *Building on Values: The Future of Health Care in Canada*, Roy Romanow described mental health as the "orphan child" of Canadian health care. He claimed that "today, mental health care is largely a home- and community-based service, but support for it has too frequently fallen short. It is time to take the long overdue step of ensuring that mental health home care services are included as medically necessary services under the *Canada Health Act*, and are available across the country."¹⁹

While such analyses tended to lament the fall of the asylum, or at least suggest that the new face of mental health had been sorely underfunded, under-resourced and overpopulated, other critics and analysts embraced,

19 Hon. Roy Romanow, *Building on Values: The Future of Healthcare in Canada* (2002), executive summary, p. xxxi.

and even demanded, an end to the incarceration of individuals deemed mentally disordered. This sentiment stemmed from a number of cultural movements that had gathered momentum in the midst of rights-based campaigns. Building on the strengths of civil rights, feminism and gay and lesbian rights movements, patients' began campaigning for their place in the human rights discourse. Disability rights activists engaged in aggressive campaigns for better access to services,²⁰ while psychiatric patients and their families began lobbying for anti-stigma campaigns, alongside demands for adequate housing, basic health services, voting rights and access to safe employment. Some of these campaigns were both fuelled by, and gave inspiration to, a set of intellectual critiques that questioned the ways mental disorders were understood and treated.

Some of those intellectuals, including Thomas Szasz, a psychiatrist based in California, pronounced that "mental illness was a myth," which had no basis in scientific or medical reasoning.²¹ The French philosopher Michel Foucault went well beyond blaming the psychiatric profession. He began his career with a trenchant critique of a modern world where psychiatrists wielded significant power to determine what was and was not acceptable behaviour.²² In a world where free will and individuality was leached away by modern aspirations of productivity, capital accumulation and moral authority, Foucault seemed to lament the opportunities that such a worldview created for individuals to police normalcy and to discipline members of society, including through the use of institutions. The evolution of an 'anti-psychiatry' perspective, which sometimes cross-fertilized with post-modernism, provided ample fodder for critiques of institutions. One contemporary scholar of Foucault and Szasz, Erving Goffman, focused his doctoral work specifically on the way in which the institution itself produced abnormal behaviours due to the disciplined existence within its walls, the rhythms of institutional life, and the reinforced identities that one is forced to adopt while 'playing a role' within the institution, such as those of patient, nurse, orderly, etc. Goffman introduced the term 'total institution' to describe the damaging effects that life in an asylum had, not only for the patients, for whom this fate was the worst, but also for the staff at all levels, whose versions of the outside world became perverted over time as they became more and more accustomed to the routines of the asylum.²³ Catherine Duprey picks up on these international

20 Geoffrey Hudson, "Regions and Disability Politics in Ontario, 1975–1985," paper presented at "Region Matters: Health and Place Conference," University of Alberta, Edmonton, 2007.

21 Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper Collins, 1974, first published in 1960).

22 Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Vintage Books, 1965).

23 Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and other Inmates* (Garden City, New York: Anchor Books, 1961).

and intellectual critiques in her study of Quebec psychiatry and institutionalization, suggesting that there may have been subtle differences in the ways Quebecers in the 1950s and 1960s responded to these challenges to institutional authority, particularly as these developments in Quebec coincided with broader political and cultural shifts enmeshed with the Quiet Revolution.

The history of deinstitutionalization is intertwined with contemporary socio-cultural transitions, political restructuring and economic conservatism. American historian Gerald Grob, one of the leading scholars on the history of mental health care policy in the United States, has argued that there were several distinct factors that culminated in what became a transnational phenomenon called ‘deinstitutionalization.’²⁴ He suggested that psychotropic medications and changes within the professional landscape of psychiatry (including a shift towards more private practice and an increased reliance on general practitioners), more federal funding for intensive research programs into mental disorders, a changing politico-economic climate that coincided with the dismantling of the welfare state, and the rise of human rights and humanitarian campaigns (including those levelling critiques at the plight of institutionalized individuals) were critical ingredients in the history of deinstitutionalization. This combination of medical, political, social and cultural changes swept across North America, leaving indelible marks on the contours of mental health care in the latter half of the twentieth century. Canadian institutions were not immune to these broader trends, and while there are many similarities, the Canadian context also reveals some important differences in this transnational phenomenon.

This multi-layered combination of factors, as Grob has suggested, undermines the argument that a single event, even one as significant as the introduction of psychopharmaceutical medications, triggered deinstitutionalization. Furthermore, given the diffuse nature of this process, it becomes apparent that deinstitutionalization did not occur uniformly across North America, nor did it achieve consistent results. While Grob has relied on a policy-based analysis of this process in the United States, the same kind of scholarship has not emerged in Canada. Historians here have focused on different aspects of this process, where they have paid attention to it at all. Clinical and social science researchers have

24 Gerald Grob, “American Psychiatry: From Hospital to Community in Modern America,” *Caduceus*, vol. 12, no. 3, 1996, pp. 49–54 see also: Grob, “Deinstitutionalization: the Illusion of Policy,” *Journal of Policy History*, vol. 9, no. 1, 1997, pp. 48–73; Grob, “The National Institute of Mental Health and Mental Health Policy, 1949–1965,” in *Biomedicine in the Twentieth Century: Practices, Policies and Politics* (ed) Caroline Hannaway (Amsterdam, IOM Press, 2008), pp. 59–94; Grob, *The Mad Among Us: A History of the Care of America’s Mentally Ill* (New York: The Free Press, 1994); and Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton, NJ: Princeton University Press, 1991).

also contributed to the discussion, often concluding that a national approach to deinstitutionalization in Canada is neither feasible nor desirable.²⁵ Canada's constitutional federalism, which for the most part places health and welfare concerns within the purview of provincial governments, sits in contrast to a national analysis, since most of the activities and programs have been developed on a provincial level. This situation has meant that deinstitutionalization in Canada assumed a distinctly regional character, with significant differences in the timing, scale, and impact of hospital closures on their respective communities.

In 2004, psychiatrists Sealy and Whitehead published a report in the *Canadian Journal of Psychiatry* suggesting not only that deinstitutionalization was still under way, but also that its greatest variability came in a province by province comparison. Moreover, they concluded that the term deinstitutionalization was misleading, with 'transinstitutionalization' being better suited to the reality faced by patients who left long-stay hospitals only to later be admitted, albeit in shorter stints, to a variety of public and private facilities, including nursing homes, emergency rooms, and for some, penitentiaries.²⁶

Harvey Simmons recognized the regional limitations in his study of community care in Ontario as he charted the rise and fall of the asylum and the corresponding shift from health care to welfare for individuals deemed mentally disabled.²⁷ These kinds of regional studies are essential for improving our understanding of the impact that deinstitutionalization has had on mental health services as well as for deepening our historical appreciation for illness narratives, patient activism, and post-World War II psychiatry. Moreover, as the previous discussion emphasizes, deinstitutionalization was not simply an event or set of reactions, but involved a process that represented a culmination of ideological and cultural changes in the latter half of the last century. For that reason, its study has significant importance for Canadian social history more broadly.

Deinstitutionalization in the *Canadian Medical Association Journal*

As the preceding discussion suggests, the process of moving patients out of long-stay hospitals was complicated and multi-faceted. The results have been equally complex and varied, but politicians and the medical community have invariably been blamed for failures and shortcomings caused by short-sightedness, the search for financial savings, or political expediency. In the discussion below, I provide background for the articles that follow

25 Sealy P, Whitehead, PC. "Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment," *Canadian Journal of Psychiatry*, vol. 49, no. 4, 2004, pp. 249–257.

26 *Ibid.*

27 Harvey G. Simmons, *From Asylum to Welfare* (Downsview, ON: National Institute on Mental Retardation, 1982).

by analysing editorial and peer-reviewed articles published in the *Canadian Medical Association Journal* from 1955 to 2008 that dealt with, or appeared to deal with, issues around deinstitutionalization, care in the community, or the closure of long-stay hospitals. It was over these years that the secondary literature identified the beginnings of deinstitutionalization, at least as an idea. However, tracing the discussions into the twenty-first century suggests that this process has continued. The debates are still raging as tensions over how best to finance such a system remain a running theme, both in the journal and in public discourse. And while medical specialization and the proliferation of corresponding journals might account for the reduction in articles dealing with treatment issues, the shift in conversation towards finances and service delivery underscores the complicated and bureaucratic nature of the current system. However, looking back at the escalation of these discussions also reveals the pressing need to move beyond the medical and political communities to better understand the impact that deinstitutionalization has had on Canadian society. While there are glimpses of evidence suggesting that physicians recognized some of the cumulative problems that deinstitutionalization might incur, such insights deserve further exploration and development by social historians to provide a more comprehensive picture of what amounts to a significant cultural change in the way that we conceptualize and accommodate mental health needs in our society.

The earliest editorials from my sample indicate that psychiatrists clearly recognized the importance of connecting individuals with the community in a meaningful way, whether they remained under institutional care or were preparing for life outside the institution. An editorial from December 1955 underscored this point when a Dr. C. Max commented on the importance of developing creative activities for people when they are home visiting or are interacting in the community. In the same editorial, psychiatrist Humphry Osmond stressed the importance of giving patients responsibilities in running their own affairs.²⁸ These kinds of comments suggest that while intellectuals may have picked up on these points in the 1960s, the ideas were already circulating within the medical community well in advance of the decisions to move patients out of long-stay facilities on a massive scale.

One reason for such insight came from the realities of institutional care at mid-century. Psychiatrists complained that after the Second World War, they witnessed an increase in the demand for institution-based services, which they attributed to a decrease in stigma and possibly a true increase in the number of people affected by mental illness, particularly noting the numbers of veterans requiring assistance.²⁹ Stigma proved to be a

28 Osmond, H. "Editorial Comment: The Changing Mental Hospital," *CMAJ*, no. 73, Dec. 1955, pp. 975–976.

29 Dewan, JG. "Editorial Comment: Overcrowding in Mental Hospitals," *CMAJ*, no. 76, 1957, pp. 413–414.

formidable subject that framed discussions over who practised psychiatry and whether hospitals should be separate psychiatric facilities or connected with general health facilities.

By the mid-1960s, these discussions intensified as considerations about the best institutional environment became inseparable from debates over funding arrangements for hospital construction. The *Hospital Insurance and Diagnostic Services Act* (1957) formalized the funding formula and prioritized small clinics and general hospitals over purpose-built, large-scale psychiatric facilities. The Act, in effect, ensured that, to qualify for the new federal funding, the number of beds in mental hospitals would decrease. And no further grants were made available for any new mental hospital with more than 300 beds.³⁰ As psychiatrists commented in the journal on the new funding realities, they took stock of their own situations, realizing that many of their colleagues had already made this transition informally by going into private practice and avoiding the psychiatric hospital altogether. Some even went further in embracing the recommendations of the Health Care Commission by suggesting that psychiatric wards should simply be added to the general hospitals to save costs and help to reduce stigma.³¹

By the mid-1960s authors in the *CMAJ* regularly referred to the changing nature of their practice as ‘community psychiatry,’ involving a combination of private practitioners, general physicians performing basic mental health care, and the increasing number of psychiatric wards in general hospitals. Some practitioners recognized this phase as a transition away from the asylum model, but not necessarily a stable solution.³²

These discussions seemed to pick up pace in the 1970s as various regions reported on the numbers of patients that had successfully moved out of the psychiatric hospitals and how this set of changes had created a decrease in the number of psychiatrists and psychologists required to staff a large area. These sentiments corresponded with the largest decreases in long-stay patient populations; the number of patients in mental hospitals across Canada peaked in 1960 at 59,308 but by 1971, that number had dropped by 43%, to 34,181.³³ During that period, the reasons for the changes were not lost on the medical community. Ontario-based psychiatrists boasted that the large numbers of patients were “moved out of mental hospitals owing to improvements in medication, changes in psychiatric

30 Department of Medical Economics. News and Views on the Economics of Medicine: Recommendations of the Royal Commission on Health Services. *CMAJ*, no. 82, 1964, pp. 1–24.

31 Jones, RO. “Special Article: Psychiatric Programs: Their Medical Integration,” *CMAJ*, no. 92, 1965, pp. 333–340. Though not everyone shared this view, see: Wallis, WG. “Letters to the Journal: Psychiatric Programs: Their Medical Integration,” *CMAJ*, no. 92, 1965, p. 885.

32 O’Reagan, JB. “A Psychiatric Service: A Preliminary Report,” *CMAJ*, no. 93, 1965, pp. 691–695.

33 Kedward HB, Eastwood MR, Allodi F, Duckworth GS, “The evaluation of chronic psychiatric care,” *CMAJ*, no. 110, 1974, pp. 519–523.

philosophy, awareness of the eroding effect of institutionalization, and [the] evolution of economic and other priorities in the health care system.”³⁴ In this instance, it appears that the medical community, or at least those writing to the *CMAJ*, were well aware of the critiques being levelled at the profession and that the system had adapted in response to such criticisms.

Indeed, authors readily supplied their own critiques of the crumbling system. Editorials lamented the creation of a ‘revolving door’ policy in which patients whose needs were not being met in the new era of community psychiatry were repeatedly readmitted to the hospital. Many of these patients, they believed, were chronic patients who had been living in institutions for most of their lives and/or who lacked necessary family and community supports.³⁵ Researchers reported that readmission rates had increased to such a degree, that in 1971, they represented 55% of all admissions across Canada.³⁶

While the number of articles on this topic fell dramatically during the 1980s and 1990s, perhaps due to publications elsewhere, by the 2000s, psychiatrists publishing in the *CMAJ* seemed resigned to the new realities of psychiatric services. Rather than discussing the changing context for responsibilities, creative activities, or the connections with communities, as had been raised in the 1950s, authors fifty years later complained of heavy work loads, increased spending and gaps in service delivery. An article in 2001 indicated that general practitioners were performing 76-84% of mental health services in Canada, while psychiatrists served another 8-9% of that patient population.³⁷ Meanwhile costs for these services had increased by 18% over the previous decade.

In 2008, six years after Roy Romanow had highlighted the weaknesses of mental health delivery, Senator Michael Kirby reported that Canada was the only country in the G8 that did not have a national mental health strategy.³⁸ Reiterating some of the historical themes of the pre-deinstitutionalization era, Kirby suggested that a national strategy needed to address the concerns of stigma and discrimination surrounding the experiences of people diagnosed with mental illnesses. Concerns of poverty, criminality and justice ran through these discussions and continued to

34 Sylph JA, Eastwood MR, Kedward HB. “Long-term psychiatric care in Ontario: the Homes for the Special Care Program,” *CMAJ*, no. 114, 1976, pp. 233–237.

35 Voineskos G. “Part-time hospitalization programs: the neglected field of community psychiatry,” *CMAJ*, no. 114, 1976, pp. 320–324.

36 Martin BA, Kedward HB, Eastwood MR, “Hospitalization for mental illness: evaluation of admission trends from 1941–71,” *CMAJ*, no. 115, 1976, pp. 322–323.

37 Arboleda-Florez J, Saraceno B, “Mental Health and primary care,” *CMAJ*, vol. 164, no. 7, 2001, p. 1013–1014.

38 Kirby, M. “Commentary: Public Health: Mental health in Canada: out of the shadows forever,” *CMAJ*, vol. 178, no. 10, 2008, pp. 1320–1322.

frame the debates over the appropriate kind of care required—be that health care, community care, welfare, or simply humanitarian care.

This brief window into the medical community's thoughts on this issue suggests that these concerns were part of medical discussions. Furthermore, even within the primary organ for the Canadian medical profession, the discussion quickly moved away from best practice or care for patients and instead focused on concerns around remuneration, workload and professionalization. These sentiments further underscore the need for social historians to look beneath the high-level discourse in an effort to more carefully articulate the lived experiences of former patients, families and communities. In a range of different ways, that is what the papers that follow seek to do.

The Volume

This special volume offers a range of historiographical approaches that collectively take a step towards enriching the limited Canadian literature on this topic. Using case studies from different areas of the country, the authors of the following articles confront the regional social histories behind deinstitutionalization and demonstrate that experiences varied across the country as widely as did the motivations behind this shift. They bring interdisciplinary perspectives and methods to this study as they consider how this multi-faceted process unfolded and affected diverse groups, including nurses, bureaucrats, families, communities, employers, and, of course, individuals diagnosed with mental disorders.

The volume begins with a study of one major Quebec institution, the Saint-Jean-de Dieu Asylum run by the Sisters of Providence. Authors Marie-Claude Thifault and Isabelle Perreault demonstrate that deinstitutionalization in Quebec was initiated within specific, individual hospitals rather than being a provincial scheme. This article encourages us to rethink the periodization of deinstitutionalization as well as to reconsider the role that families, nuns, and the Catholic Church historically played in the mental health system, particularly that which existed outside the walls of the asylum. These authors concentrate on the period between 1900 and 1950 in Quebec and analyse case records, institutional registers, annual reports of the asylum, legislation, and correspondence between family members and the medical superintendents to show how the practice of deinstitutionalization that came to pass in the 1960s and 1970s was rooted in a longer tradition of short stays or respite with family. Thifault and Perreault are critical of the historiographical assumption that deinstitutionalization emerged as a significant phenomenon in the wake of anti-psychotic medications and amid the looming social critiques of institutionalization. Rather, they show that the practice of community care, particularly that within the family, had already existed during the first half of the twentieth century.

Geertje Boschma brings her considerable expertise in psychiatric nursing history to the next article which analyses admission and discharge information for the three main mental hospitals in British Columbia and Alberta, along with a combination of archival and secondary sources to explore the new challenges faced by mental health workers and patients in those two western provinces. By looking closely at these two jurisdictions, Boschma shows how the numbers of people leaving the institution corresponded with rising rates of admissions to a new matrix of institutional settings, including nursing homes, community care centres, outpatient treatment clinics and general hospitals. She demonstrates that the numbers of people using this range of institutions actually increased between 1950 and 1980, rather than decreased, and argues that, rather than the misleading label of deinstitutionalization, this process should more appropriately be considered a form of transinstitutionalization.

Saskatchewan receives a thorough examination as four scholars examined different layers of its mental health history to show how different constituencies contributed to, and were affected by, the massive changes that occurred in that province alongside vicious debates over general health reforms. Kathy Kendall introduces Saskatchewan with a look at the public education campaign that preceded the movement of patients out of the hospitals but that also illuminated the deeply-held stigma that communities held towards individuals with mental illnesses. She ultimately explores how that stigma spread from individual to community by concentrating on the roles played by 'experts' John and Elaine Cumming. This couple had important international and political ties that both advanced their research but also perhaps impeded its reception by the local community. The researchers' attempts to provide clinical, educational and social science interpretations of the role that stigma played in releasing patients into communities raised alarm bells for locals.

In her historical study of the Ladies' Auxiliary visiting program, Jayne Whyte provides a unique look at the relationships between patients and visitors at the Saskatchewan Mental Hospital at Weyburn. Jayne spent time in this facility as a patient, and she offers readers a patient's perspective on this history through a combination of historical documents and personal interpretations showing that the issue of stigma was well known to the architects of deinstitutionalization. This article was originally produced for the Canadian Mental Health Association (Saskatchewan Division), with funding provided from Saskatchewan Parks and Recreation/Saskatchewan Lotteries.

The next two articles maintain the focus on Saskatchewan, addressing its historic legacy as the birthplace of Medicare and exploring how changes in health care provision affected mental health services. Greg Marchildon breathes life into the bureaucratic wrangling that unfolded while civil servants and members of the Canadian Mental Health Association's Saskatchewan chapter squared off over how best to bring psychiatric

care into alignment with the evolving principles of Medicare. Chris Dooley echoes some of those political debates through the perspectives of psychiatric nurses who, like patients, had often lived within the walls of the institution and were facing issues of stigma, work reassignment and life changes.

Catherine Duprey examines some of these themes in her study of changes in the mental health care system in Quebec in the 1950s that were precipitated by critiques of the asylum. Echoing the arguments of fellow contributor Boschma, Duprey shows that despite the goal of reintegrating patients into the community in Quebec (as elsewhere), the pressure to close or reduce stays in long-stay (asylum-style) institutions created new pressures elsewhere. In particular, the desire to reduce the risk of Goffman's 'total institutionalisation'³⁹ led to the creation of numerous other institutions, including outpatient clinics, the introduction of psychiatric units into general hospitals, sheltered workshops, and special schools for children considered mentally deficient. Duprey's article adds an important dimension to the Canadian studies by showing how Francophone and Anglophone psychiatrists in Quebec responded to the national changes in health care funding as well as to the international critiques of the asylum.

The final article by Judith Fingard and John Rutherford moves us into the Maritimes and into more contemporary challenges with a focus on sheltered employment services in Halifax. Picking up on the health care to welfare themes, they also suggest that these kinds of employment strategies are inherently idiosyncratic. They show that the operators relied on a combination of federal, provincial and municipal funds to carry out these kinds of quasi-remunerative employment opportunities. Rather than conform to a particular strategy or policy, work placements have had to rely on the good will and volunteerism of community partners who adjusted to fit into the mental health system.

Together, this collection represents the original work of Canadian scholars of diverse backgrounds who have been dedicated to deepening our understanding of the regional realities of mental health care in the community, the meanings of disorder and disability, and the social history of politico-economic ideologies. We want to encourage further research and conversation, and we hope that by placing mental health, patients, and services at the centre of our studies, we help readers better understand the diverse ways that mental health and illness have shaped our society historically and in the present.

39 Erving Goffman, *Asylums: Essays on the social situation of mental patients and other inmates* (Garden City, New York: Anchor Books, 1961), p. xiii.