

# Deinstitutionalization Reconsidered: Geographic and Demographic Changes in Mental Health Care in British Columbia and Alberta, 1950–1980

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*Using demographics on admission to, and discharge from, mental hospitals in Alberta and British Columbia, this paper analyzes the social process commonly framed as deinstitutionalization between 1950 and 1980. A focus on the two most western Canadian provinces permits an exploration of these changes in these regional contexts. Pressured by new funding arrangements, a shift towards community care, and growing criticism of the alleged oppressive nature of large institutions, the three main mental hospitals scaled down as of the 1950s. This trend did not mean, however, that the overall number of hospitalized patients decreased during this time period. The total number of hospitalizations, particularly short-term admissions, actually expanded, while trans-institutionalization also occurred. This case study mirrors larger trends of postwar mental health care, illustrating the social, political, and cultural challenges experienced in the reconstruction of institutional care.*

*Cet article analyse le processus social connu sous le terme de désinstitutionnalisation, entre 1950 et 1980 en Alberta et en Colombie-Britannique, à partir de données démographiques sur les admissions et les sorties des hôpitaux psychiatriques. Une étude de la situation dans les deux provinces les plus à l'ouest du Canada permet d'analyser ces changements dans ces contextes régionaux. À la suite de nouveaux mécanismes de financement, d'un recadrage des soins communautaires et d'une critique croissante de la nature prétendument écrasante des grands établissements, chacun des trois principaux hôpitaux a réduit son envergure au cours des années 1950. Néanmoins, cette tendance n'a pas entraîné, au cours de*

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*cette période, une diminution du nombre global des patients hospitalisés. De fait, le nombre total des hospitalisations, et plus particulièrement celles de courte durée, a augmenté au moment où se produisait un phénomène de trans-institutionnalisation. Cette étude de cas reflète les principales tendances des soins apportés aux maladies psychiatriques de l'après-guerre et illustre les défis – sur un plan social, politique et culturel – auxquels s'est heurtée la reconstruction des soins en établissements.*

### **Introduction**

In the second half of the twentieth century, the focus of mental health care shifted from care provided in large, often remote institutions towards community-oriented services and general hospital psychiatry centralized in urban areas, a process of change commonly depicted as one of deinstitutionalization. Pressured by new funding arrangements, by the shift towards community care, and by growing criticism of the alleged oppressive nature of large institutions, Canadian mental hospitals began to scale down as of the 1950s. This paper contributes to the historical analysis of this social change in the regional context of two western Canadian provinces, namely British Columbia and Alberta, between 1950 and 1980. Because health and welfare policy largely developed as a provincial responsibility within Canada's constitutional federalism, each province established its own provincial health care system within its own political and cultural context. However, these provinces also presented some significant similarities in their collective responses to the social, political, and cultural influences that transformed mental health care in the latter half of the twentieth century.<sup>1</sup> Multiple factors, including the establishment

1 On regional differences see Megan Davies, "Mapping 'Region' in Canadian Medical History: The Case of British Columbia," *Canadian Bulletin of Medical History*, no. 17, 2000, pp. 73–92. Davies notices, for example, differences in emphasis on public health and in medical school availability (BC did not have one until 1952). For a general history of British Columbia, see Jean Barman, *The West Beyond the West: A History of British Columbia* (Toronto: University of Toronto Press, 2007) and of Alberta see Howard Palmer, *Alberta, A New History* (Edmonton: Hurtig, 1990). Historical scholarship on mental health history in British Columbia, mostly of the period up until the 1940s, includes: Robert Menzies and Ted Palys, "Turbulent spirits: Aboriginal patients in the British Columbia psychiatric system," in *Mental Health and Canadian Society: Historical Perspectives* (eds.) James E. Moran and David Wright (Montreal: McGill-Queen's University Press, 2006), pp. 149–175; Robert Menzies, "Contesting criminal lunacy: Narratives of law and madness in west coast Canada, 1874–1950," *History of Psychiatry* no. 7, 2001, pp. 123–156; Megan Davies, "The Patient's World: British Columbia's Mental Health Facilities, 1920–1935 (MA Thesis, University of Waterloo, 1987); Megan J. Davies, *Into the House of Old: A History of Residential Care in British Columbia* (Montreal: McGill-Queen's University Press, 2003); Mary-Ellen Kelm, "The Only Place Likely to Do Her Any Good: The Admission of Women to British Columbia's Provincial Hospital for the Insane," *BC Studies*, no. 96, 1992–3, pp. 66–89; Mary-Ellen Kelm, "Women, Families and the Provincial Hospital for the Insane, British Columbia, 1905–1915," *Journal of Family History*, vol. 19, no. 2, 1994, pp. 177–193; Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–50* (Vancouver: University of British Columbia Press, 1998). An overview of governmental services in BC provides Robert H. Thompson, *A Summary of the Growth and Development of Mental Health Facilities and Services in British Columbia, 1850–1970*

of public funding for health services, the promise of new therapies and therapeutic approaches, the advent of psychotropic drugs, and the rise of a critical patient rights movement, among others, shaped this complex, transnational process of change, which generated contradictory effects and continued debate over the direction of mental health care in the second half of the twentieth century.<sup>2</sup>

### Background

The shift to community mental health care in the latter half of the twentieth century is beginning to receive scholarly analysis by Canadian historians.<sup>3</sup> Judith Fingard and John Rutherford have provided a comprehensive analysis of the politics of postwar mental health care in Nova Scotia, pointing out how the adoption of national health insurance, changes in medical treatment (such as profound optimism about the potential of new psychotropic drugs) and local circumstances shaped the shifting context of care.<sup>4</sup> Erika Dyck examined cultural, political, and professional implications as well as the ways that counterculture trends shaped psychiatric LSD research in Saskatchewan.<sup>5</sup> Several other scholars have begun to identify how broader institutional and cultural forces, including

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(BC Government Report, Mental Health Branch, Department of Health Services and Hospital Insurance, 1972). Examinations of mental health history in Alberta include: Ronald A. LaJeunesse, *Political Asylums* (Edmonton: Muttart Foundation, 2002), as well as my own work: Geertje Boschma, Olive Yonge and Lorraine Mychajlunow, "Gender and Professional Identity in Psychiatric Nursing Practice in Alberta, Canada, 1930–1975," *Nursing Inquiry*, vol. 12, no. 4, 2005, p. 243–255; Geertje Boschma, "A Family Point of View: Negotiating Asylum Care in Alberta, 1905–1930," *Canadian Bulletin of Medical history*, vol. 25, no. 2, 2008, p. 367–389.

2 Gerald Grob, one of the leading international scholars on mental health history, reviewed the most important trends shaping postwar mental health care in the US: Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: The Free Press, 1994); David Healy has examined the impact of pharmacology: David Healy, *The Creation of Psychopharmacology* (Cambridge: Harvard University Press, 2002); For Canadian trends see also: Edward Shorter, *A History of Psychiatry: From the Era of The Asylum to the Age of Prozac* (New York: John Wiley & Sons, 1997); Cyril Greenland, Jack Griffin, and Brian Hoffman, "Psychiatry in Canada from 1951–2000," in Quentin Rae-Grant, ed., *Psychiatry in Canada: 50 years, 1951–2001*, p. 1–16 (Ottawa: Canadian Psychiatric Association, 2001); Ian Hector, "Changing funding patterns and the effect on mental health care in Canada," in Quentin Rae-Grant, ed., *Psychiatry in Canada: 50 years, 1951–2001*, p. 59–76 (Ottawa: Canadian Psychiatric Association, 2001); Patricia Sealy & Paul C. Whitehead, "Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An empirical assessment," *Canadian Journal of Psychiatry*, no. 49, 2004, pp. 249–257; For an extensive review of relevant national and international scholarship on deinstitutionalization see also the introduction to this volume by Erika Dyck.

3 See James Moran and David Wright (eds.) *Mental Health and Canadian Society: Historical Perspectives* (Montreal: McGill-Queen's University Press, 2006), especially the introduction.

4 Judith Fingard and John Rutherford, "The Politics of Mental Health Care in Nova Scotia: The Case of the Halifax County Hospital, 1940–1976," *Acadiensis*, vol. 35, no. 1, 2005, pp. 24–49.

5 Erika Dyck, *Psychedelic Psychiatry: LSD from Clinic to Campus* (Baltimore: Johns Hopkins University Press, 2008).

the disappearance of patient work in asylums, changed the nature of institutions and, in so doing, generated contradictory results within a range of new therapeutic approaches and community-based services.<sup>6</sup>

Most Canadian historians of psychiatry have focused on the history of the asylum era during the nineteenth and early twentieth century. Their analyses of this time period have produced important insights upon which analysis of the shift to community mental health care can build. Recent studies examining the asylum in its broader community context and portraying the asylum as a place of negotiation and interaction between families and institutions have included James Moran's study of asylum care in Ontario and Quebec, André Cellard and Marie-Claude Thifault's work on the history of madness in Quebec, David Wright, James Moran and Sean Gouglas' study of admission demographics in Ontario, as well as my own study of family responses to the asylum in Alberta.<sup>7</sup> Moreover, several Canadian historians have examined the dynamics of asylum admission based on detailed analyses of patient records.<sup>8</sup> Analyses of what happened to people with mental illness prior to admission or upon discharge have furthered the insight that families interacted with the asylum in a variety of ways that were shaped by their economic, social, and unique family circumstances.<sup>9</sup> Within legal and

- 6 Harley Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905–1984* (Regina: Canadian Plains Research Centre, University of Regina, 1989); Boschma, Yonge & Mychajlunow, "Gender and Professional Identity;" Caroline Knowles, *Bedlam on the Streets* (London: Routledge, 2000); LaJeunesse, *Political Asylums*.
- 7 James E. Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal and Kingston: McGill-Queen's University Press, 2000); André Cellard, & Marie-Claude Thifault, "The Uses of Asylums: Resistance, Asylum Propaganda, and Institutionalization Strategies in Turn-of-the-Century Quebec," in: Moran, James and David Wright (eds). *Mental Health and Canadian Society: Historical Perspectives*, (Montreal: McGill-Queen's University Press, 2006), pp. 97–116; David Wright, James Moran, and Sean Gouglas, "The Confinement of the Insane in Victorian Canada: The Hamilton and Toronto Asylums, c. 1861–1891," in Roy Porter and David Wright (eds.), *The Confinement of the Insane* (Cambridge: Cambridge University Press, 2003), pp. 100–128; Boschma, "A Family Point of View."
- 8 Mary-Ellen Kelm, "The Only Place Likely to Do Her Any Good;" Cheryl L. Krasnick Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1833–1923* (Montreal and Kingston: McGill-Queen's University Press, 1989); Wendy Mitchinson, "Reasons for Committal to a Mid-Nineteenth-Century Ontario Insane Asylum: The Case of Toronto," in Wendy Mitchinson and Janice Dickin McGinnis, eds., *Essays in the History of Canadian Medicine* (Toronto: McClelland and Stewart, 1988), pp. 88–109; Patricia Prestwich, "Family Strategies and Medical Power: 'Voluntary' Committal in a Parisian Asylum, 1876–1914," *Journal of Social History*, vol. 27, no. 4, June 1994, pp. 797–816; Marie-Claude Thifault, "Hell in the Family: Married Women and Madness Before Institutionalization at St-Jean-de-Dieu Asylum, 1890–1921," *Nursing History Review*, no. 19, 2011, pp. 15–28.
- 9 Various terms have been used over time to refer to people with mental illness, including mad, insane, and mentally ill, and each must be understood in their historical context. Generally I will use the term people with mental illness. Similarly, the term developmental disability will be used to refer to people with such disabilities, although historically different terms have been used. Occasionally

medical constraints, families influenced negotiation over admission. Canadian trends paralleled international changes in mental health care.<sup>10</sup>

Another important influence on the history of psychiatry prior to the 1950s was the way in which eugenic ideas shaped perceptions and practices related to asylum admission. While eugenic ideas influenced all provinces, particularly during the Depression years, Alberta and British Columbia stand out for their apparent response to the eugenic movement compared to other provinces in that they passed sexual sterilization laws in 1928 and 1933, respectively.<sup>11</sup> Several scholars have analyzed how widespread class- and race-based fears of alleged human degeneration propelled the preoccupation with public mental hygiene, the prevention of mental illness, and the existence of related social problems, and how these factors enhanced support for eugenics programs in British Columbia and Alberta.<sup>12</sup> In the post-World War II era, such policies were increasingly discredited and pressured by broader changes in mental health care. Both provinces proceeded to repeal their sterilization legislation, although this did not occur in Alberta until after the defeat of the Social Credit government in 1972.<sup>13</sup>

The transformation of postwar mental health care has been profoundly shaped by the cultural influence of the civil rights movements and by the campaign for patient rights that these movements triggered.<sup>14</sup> Furthermore,

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I will use the term used in the context of the time, such as patient, as it was also a common term during the time period under study, although currently client or consumer is more accurate. Especially within the rising of the patient rights movement in this time period, people with mental illness increasingly used ex-patient/survivor/consumer as terms more adequately reflecting their perspective. I also use the term mental illness, although I am aware of its constructed nature.

10 Grob, *The Mad Among Us*; For a comparison of cultures of psychiatry and mental health care in various European countries, see: Marijke Gijswijt-Hofstra, Harry Oosterhuis, Joost Vijsselaar & Hugh Freeman, *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century* (Amsterdam: Amsterdam University Press, 2005); Julia Jones, "Mental Health Care Reforms in Britain and Italy Since 1950: A Cross-national Comparative Study," *Health & Place*, no. 6, 2000, pp. 171–187.

11 Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885–1945* (Toronto: McClelland and Stewart, 1990).

12 Ian R. Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880–1940*, (Ithaca: Cornell University Press, 1997); Jana 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; McLaren, *Our Own Master Race*; Deborah C. Park and John P. Radford, "From the Case Files: Reconstructing a History of Involuntary Sterilization," *Disability & Society*, vol. 13, no. 3, 1998, pp. 317–342. See also Boschma, "A Family Point of View."

13 Sterilization Acts were repealed in BC in 1953, and in AB in 1972, after the defeat of the Social Credit government. See McLaren, *Our Own Master Race*; For a discussion of the shifting ideas on prevention of mental illness see also Jack Griffin, *In Search of Sanity: A Chronicle of the Canadian Mental Health Association, 1918–1988* (London ONT: Third Eye Publications, 1989).

14 Nancy Tomes, "Merchants of Health: Medicine and Consumer Culture in the United States, 1900–1940," *Journal of American History*, no. 88, 2001, pp. 519–547; Nancy Tomes, "The Patient as a Policy

in the early 1960s, several influential works inspired a more critical, activist anti-psychiatric movement.<sup>15</sup> In France, Michel Foucault published his influential analysis of *Madness and Civilization*, while in the US, Erving Goffman's *Asylums* put forward a critical analysis of the asylum, describing it as a "total institution," an exemplary prototype of social control.<sup>16</sup> Concurrently, Ken Kesey's notorious novel *One Flew over the Cuckoo's Nest*, which was published in 1962 and made into a world-famous film in 1975, had an enormous impact on the public imagination, fuelling dissatisfaction with the contemporary state of mental hospitals and psychiatric treatment.<sup>17</sup> Several psychiatrists and other mental health professionals identified with the movement and critique as well, with the US psychiatrist Thomas Szasz and the British psychiatrist Ronald Laing being some of the best-known proponents. They each questioned the construction of mental illness as a disease, framing it instead as a myth.<sup>18</sup> These works stimulated a counterculture in psychiatry, whose followers resisted the dominance of the medical discourse and instilled activism among various groups dissatisfied with the system. People with mental illness and family members became active participants in a movement aiming to resolve disparities, enhance access to services, and remove social stigma. In Canada, Geoffrey Reaume analyzed the history of psychiatry from the perspective of patients and examined the lack of acknowledgement of patient work in the asylum.<sup>19</sup> Others exposed the fragile, contradictory, and fragmented nature of the postwar mental health experience from an academic, experiential, or family point of view, revealing the strong presence and participation of people with mental illness and their families in the

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Factor: A Historical Case Study of The Consumer/Survivor Movement in Mental Health," *Health Affairs*, 25, (2006): 720–9.

- 15 An international introduction to the history of the anti-psychiatric movement is provided by Gemma Blok, "The Moral Agenda of Anti-psychiatry in the Netherlands," in: Marijke Gijswilt-Hofstra, Harry Oosterhuis, Joost Vijsselaar & Hugh Freeman, *Psychiatric Cultures Compared (cited above)*, pp. 103–115.
- 16 Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason* (New York: Pantheon, 1965); Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Doubleday, 1961).
- 17 Ken Kesey, *One Flew over the Cuckoo's Nest* (New York: Viking Press, 1962); Laura Hirshbein and Sharmalie Sarvananda, "History, Power, and Electricity: American Popular Magazine Accounts of Electroconvulsive Therapy, 1940–2005," *Journal of the History of the Behavioral Sciences*, vol. 44, no. 1, 2008, pp. 1–18.
- 18 Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (New York: Harper Collins, 1974); Ronald D. Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Baltimore: Penguin Books, 1969).
- 19 Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870–1940* (Don Mills, Ontario: Oxford University Press, 2000); Geoffrey Reaume, "Patients at Work: Insane Asylum Inmates' Labour in Ontario, 1841–1900," in: James Moran and David Wright (eds), *Mental Health and Canadian Society: Historical Perspectives*, pp. 69–96 (Montreal: McGill-Queen's University Press, 2006).

construction of postwar mental health.<sup>20</sup> Health geographers also made important contributions to the analysis of community psychiatry, offering a critical perspective on the transfer of formerly hospitalized patients to communities with few resources.<sup>21</sup>

Considering these multiple and complex forces that shaped postwar mental health care, further study of the meaning of deinstitutionalization in the Canadian context seems timely. The purpose of this article is twofold. First, by means of a detailed examination of the demographics of admission to and discharge from mental hospitals in Alberta and British Columbia, I interrogate the notion of deinstitutionalization. Because of the nature of the aforementioned sources, this article primarily explores this transformation in relation to policy, to institutional and demographic change, and to the reorganization of care, including the rising influence of patient activism. More detailed analyses of the experiences of family members and of those who worked in mental health care during this process of transformation have been published elsewhere.<sup>22</sup> In the shift to community settings, I argue that new, more fluid but perhaps more complex institutional contexts were formed and that these suggest that the notion of deinstitutionalization may not adequately capture the important changes in question. My analysis reveals that the total number of hospitalizations of people with mental illness, particularly short-term admissions, actually expanded, and significant movement between institutions – or trans-institutionalization – took place as well.

Second, I explore the implications of these demographic changes for the development of community-based services. Large numbers of formerly hospitalized patients were transferred into the community, triggering the establishment of new boarding homes, mental health centres, and other community facilities, including psychiatric departments in general hospitals. Elderly patients with mental illness and developmentally disabled individuals were transferred into nursing homes and specialized

20 Everett, Barbara. *A Fragile Revolution: Consumers and Psychiatric Survivors Confront the Power of the Mental Health System* (Waterloo: Wilfrid Laurier University Press, 2000); Irit Shimrat, *Call Me Crazy: Stories from the Mad Movement* (Vancouver: Press Gang Publishers, 1997); Barbara Schneiders, "Mothers talk about their children with schizophrenia: A performance autoethnography," *Journal of Psychiatric and Mental Health Nursing*, no. 12, 2005, pp. 333–340; Barbara Schneiders, "Communication between people with schizophrenia and their medical professionals: A participatory research project," *Qualitative Health Research*, no. 14, 2004, pp. 562–577.

21 Jennifer Wolch and Chris Philo, "From distributions of deviance to definitions of difference: past and future mental health geographies," *Health & Place*, no. 6, 2000, pp. 137–157; Philip Yanos, "Beyond 'Landscapes of Despair': The need for new research on the urban environment, sprawl, and the community integration of persons with severe mental illness," *Health & Place*, no. 13, 2007, pp. 672–676.

22 Boschma, "Accommodation and resistance to the dominant cultural discourse on psychiatric mental health: Accounts of family members," *Nursing Inquiry*, vol. 14, no. 4, 2007, pp. 266–278; Geertje Boschma, "Community Mental Health Nursing in Alberta, Canada: An Oral History," *Nursing History Review* (in press; to appear in volume 20).

institutions. Altogether, these processes generated a new but equally complex and fragmented system. I also explore the emerging role of (ex)-patients in shaping these services and their involvement in creating community resources. A detailed analysis of provincial mental health reform policies in the 1980s reveals how participation by people with mental illness and their family members in shaping mental health services gave them an essential role in service development and provision.

### **Demographics and provincial mental health politics**

The primary source material for the demographic analysis presented in this paper consists of demographics on patient admission and discharge as presented in the provincial annual reports of mental health services in British Columbia and Alberta.<sup>23</sup> These provinces had three main provincial mental hospitals, namely the Alberta mental hospitals in Ponoka (AHP) (1911) and in Edmonton (AHE) (1923) and the Riverview Hospital in British Columbia. The original British Columbia provincial asylum had opened in New Westminster in 1878. In 1904, the government secured more land nearby for an expansion, and patients themselves helped clear the land.<sup>24</sup> The new site, across from the Fraser River in the City of Coquitlam, was called Essondale. The opening of the first unit in 1913 marked the beginning of a steady expansion in what would be renamed Riverview Hospital in 1966.

By the 1950s, these three institutions served as the admitting mental hospitals in the two provinces. Patients from these hospitals might be discharged, remain institutionalized, or be transferred to an expanding network of auxiliary hospitals and training schools for individuals with developmental disabilities. Alberta, for example, established a training school for what were then called mentally deficient children in Red Deer in the 1920s. During the 1930s, a system of mental hygiene clinics, or guidance clinics as they were later called, was established, and two other smaller auxiliary hospitals for elderly long-term mentally ill people opened in Raymond and Claresholm.<sup>25</sup> Continuous expansions and new buildings at British Columbia's mental hospital included Colony Farm

23 Annual Reports, Alberta Department of Public Health, Mental Health Division, 1940–1976, (hereafter cited as ABDPH, MHD); Annual Reports, Provincial Mental Health Services, British Columbia, 1950–1967 and the Provincial Mental Health Branch, BC, 1967–1974 (hereafter cited as BCPMH). After 1974 the BCPMH became part of the Department of Human Resources (1975–1976), and thereafter of the Ministry of Human Resources (1977–1985). The Alberta Mental Health Division became part of the Department of Health and Social Development in 1970.

24 Thompson, R. H., A Summary of the growth and development of mental health facilities in BC, 1850–1970, (BC Mental Health Branch, BC Government, 1972).

25 Report of Survey of Mental Institutions and of Mental Hygiene Clinics in the Province of Alberta submitted by The National Committee for Mental Hygiene (Canada) (no place: A. Shnitka, King's Printer, 1948).

(1920), an acute psychopathic unit (1924), a unit for female patients (1930), a veterans' unit (1934), a home for the aged, later called Valleyview (1936), the Crease Clinic for psychological medicine (1949), and a tuberculosis unit (1955). From 1919 until 1964, a home for the criminally insane, later called a forensic psychiatric hospital, operated in Colquitz on Vancouver Island. In 1950, the original mental hospital in New Westminster, still in use, was renamed Woodlands School and designated as a residential facility for developmentally disabled people.<sup>26</sup>

The main argument in this paper is that while the three large admitting mental hospitals became the primary target of deinstitutionalization policies in the 1960s and 1970s, which were characterized by increased discharge rates, these hospitals alone did not reflect the overall numbers of hospitalized patients in the provinces. Provincial government reports tended to emphasize the decline in the patient population in these three hospitals. These figures downplayed the changing matrix of institutional settings, which included the auxiliary hospitals and training schools as well as the new settings emerging in the 1950s such as nursing homes, community care centres, outpatient treatment clinics or mental health centres, and general hospital psychiatry, which served growing numbers of patients. Therefore, as my analysis will demonstrate, the numbers of people institutionalized increased rather than decreased in this 30-year period under study.<sup>27</sup>

The admission and discharge demographics underscore how institutional places must be understood as constructed spatial realities. Rather than a move away from institutions, the transformation brought about by deinstitutionalization shows how institutions and communities formed new connections, suggesting a process of reconstruction and reorganization of institutional care. Place, therefore, is a dynamically or symbolically constituted site with meaning beyond its mere physical appearance. As a geographic category of analysis, place is a useful concept for understanding the transition to community-based care and for exploring the changes in Canadian mental health geography after 1950.<sup>28</sup>

26 Thompson, "A Summary"; BC Mental Health & Addiction Services, "History: BC Mental Health Timeline, 2008," Retrieved from <http://www.bcmhas.ca/AboutUs/History.htm>.

27 The analysis of admission and discharge demographics is limited by the availability of those demographics published in the annual reports. These not necessarily reflect all people with mental illness in the province. Not all of these people may have sought either help or admission. Moreover, the numbers were not always kept consistently, and of some institutions, such as patients admitted to psychiatric departments in general hospitals, no numbers were kept. Therefore the Tables presented in the remainder of this section reflect available statistics from the annual reports, based on which only certain trends can be identified.

28 Erika Dyck and Christopher Fletcher (eds.), *Locating Health: Historical and Anthropological Investigations of Place and Health* (London: Pickering and Chatto Pubs, 2011). [http://www.pickeringchatto.com/monographs/locating\\_health](http://www.pickeringchatto.com/monographs/locating_health); B. Poland, P. Lehoux, D. Holmes, and G. Andrews, "How Place Matters: Unpacking Technology and Power in Health and Social Care,"

Prior to the 1950s, the people admitted to the mental hospitals included a wide range of age groups.<sup>29</sup> Developmentally disabled children were among those admitted, and they were often transferred to purpose-designed training schools for so-called mentally deficient children. Many demented elderly also spent the last years of their lives in asylums. Thus, the mental hospital population in both provinces was never static. Many patients left after relatively short stays. Some were admitted and died shortly thereafter, whereas others never left, gradually increasing the proportion of long-stay patients.<sup>30</sup> Demand for placement invariably exceeded available space and provincial estimates. Families were an integral part of placement requests, although they considered a range of solutions, with asylum admission being only one of them. Often, they cared for family members with mental illness for a long time before they considered admission.<sup>31</sup> In both provinces, relatively similar legal structures facilitated admission. Numbers of admissions to the provincial institutions always seemed to exceed estimates. During the first half of the twentieth century, both governments expanded institutional facilities in response to what seemed an ever-growing demand for placement of mentally ill individuals.<sup>32</sup> Despite these efforts, ongoing problems of overcrowding were compounded by the shortcomings of isolation, poor treatment, and, especially in the 1940s and 1950s, the lack of qualified staff.

In the early to mid-1950s the numbers in all three hospitals peaked, then declined, reflecting the trend toward decreasing the population in the provincial mental hospitals. In Alberta, total admissions at year-end peaked in 1956 at about 1,500 in AHP and AHE, the two admitting mental hospitals for the province (Table A). By 1950, the British Columbia government was determined to reverse the trend toward continued growth of the mental hospital population. The first annual report of the new amalgamated BC Provincial Mental Health Services firmly noted that future policy should

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*Health and Social Care in the Community*, no. 13, 2005, pp. 170–180. See also the classic work of Christopher J. Smith, *Mental Health and Geography* (Washington, D.C.: Association of American Geographers, 1977).

29 See also Boschma, “A family point of view.”

30 These patterns were not unique to the British Columbia and Alberta mental hospitals, but confirm similar patterns in mental hospitals in North-America and internationally, and which have received substantial historical analysis. See Gijswijt-Hofstra, et al., eds., *Psychiatric Cultures Compared*; For a discussion of similar trends during the nineteenth century see: Geertje Boschma, *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums, 1890–1920* (Amsterdam: Amsterdam University Press, 2003); Patricia D’Antonio, *Founding Friends: Families, Staff, and Patients at the Friends Asylum in Early Nineteenth-Century Philadelphia* (Bethlehem: Lehigh University Press, 2006).

31 Boschma, “A Family Point of View;” See also Prestwich, “Family Strategies and Medical Power.”

32 Val Adolph, *In the Context of Its Time: A History of Woodlands* (Richmond B.C.: Government of British Columbia, Ministry of Social Services, 1996); Boschma, “A Family Point of View;” LaJeunesse, *Political Asylums*.

TABLE A: Total number of patients reported at year end in the two main Alberta Mental Hospitals, 1946–1976

Year	AB Hospital Ponoka Total	AB Hospital Edmonton Total
1946	1,404	1,239
1956	1,521	1,512
1960	1,052	1,410
1965	1,087	1,345
1967	960	1,141
1969	818	916
1972	614	666
1976	479	662

Source: Sheila Abercrombie, *Alberta Hospital Edmonton, 1923–1983* (Edmonton: Alberta Hospital Edmonton, 1983), p. 38 (1946); Alberta Department of Health, Annual Reports, 1947, p. 117; 1956, p. 90; 1960, p. 131; 1965, p. 159; 1967, p. 118; 1969, p. 87; 1971–72, p. 29; 1975–76, p. 64.

be directed at “increased early active treatment to prevent patients entering into the long-term treatment mental hospital area,” and at “alleviating present overcrowding” in existing facilities.<sup>33</sup> As an immediate effect of this change, the report noted a peak in the total number of patients in their three main facilities in 1950 (Table B). A year later, the number had decreased (Tables A and B). However, it would be misleading to assume that the numbers in each province confirmed a trend towards deinstitutionalization, as the BC government was eager to claim. A focus on the numbers in the admitting mental hospitals alone does not sufficiently reflect the larger, complex transformation of postwar institutional places, as I will show in the remainder of this analysis.

### Deinstitutionalization?

To question simplistic understandings of deinstitutionalization, this section first explores the circumstances that prompted the shift toward deinstitutionalization in Alberta and British Columbia.<sup>34</sup> The changing nature of institutionalization is then examined based on the demographics of admission and discharge. It is argued that the institutional context of

<sup>33</sup> Annual Report, BCPMH, 1950–51, p. 20

<sup>34</sup> Various contemporary scholars have contributed to a beginning, more nuanced analysis of the asserted notion of deinstitutionalization, particularly as the problems and pressures of the alleged shift to community care mounted, and public debate over the inadequacy of mental health care continued into the 21<sup>st</sup> century: Grob, *The Mad Among Us*; Micheal J. L. Kirby, “Mental health reform for Canada in the 21st century;” Marina Morrow, “Mental Health Reform, Economic Globalization, And The Practice of Global Citizenship,” *Canadian Journal of Community Mental Health*, vol. 23, no. 2, 2004, pp. 39–50; Sealy & Whitehead, “Forty Years of Deinstitutionalization.”

TABLE B: Total number of patients at year end, 1922–1951 in New Westminster (Woodlands), Essondale, and Colquitz

Year	Total
1922	1,697
1931	2,550
1936	3,180
1941	3,836
1946	4,110
1950	4,602
1951	4,538

Source: Annual Report, BC Provincial Mental Health Services, 1951, pp. 90–91

mental health care was indeed transformed but did not disappear, despite the decline implied by numbers focusing only on the three main hospitals.

Several factors influenced the provincial governments' determination to change their mental health policies and reverse the trend toward mental hospital growth. Postwar optimism that health was a right to which all were entitled resonated within the mental health care community.<sup>35</sup> Changes in policy swept through the entire health care system, and mental health was no exception. The 1948 World Health Organization declaration of health as a state of complete physical, mental, and social well-being seemed at odds with a predominantly custodial structure of mental health care that was seen as contributing to mental health problems rather than solving them.<sup>36</sup> Not only had the institutional system become too costly – some estimated that 30%, others that 50% of Canadian hospital beds were within mental hospitals, absorbing a large proportion of provincial health budgets<sup>37</sup> – but the system itself seemed to be the culprit. A rapid reorientation toward community care spread. It seemed more beneficial to try to prevent long-term hospitalization, to treat people with mental illness within the context of their own communities, and to work towards normalization rather than isolation.<sup>38</sup> Social

35 Jack Griffin, *In Search of Sanity*.

36 Norman Howard-Jones, "The World Health Organization in Historical Perspective." *Perspectives in Biology and Medicine* vol. 24, no. 3, Spring 1981, pp. 467–482; Greenland, Griffin, and Hoffman, "Psychiatry in Canada."

37 Greenland, Griffin, and Hoffman, "Psychiatry in Canada"; Aleck Ostry, "The Foundations of National Public Hospital Insurance," *Canadian Bulletin of Medical History*, vol. 26, no. 2, 2009, pp. 261–282; David Wright, Shawn Day, Jessica Smith, and Nathan Flis, "A Janus-Like Asylum: The City and the Institutional Confinement of the Mentally Ill in Victorian Ontario," *Urban History Review*, vol. 36, no. 2, 2008, pp. 43–52.

38 Jack Griffin, *In Search of Sanity*; Grob, *The Mad Among Us*, pp. 191–220; Wolf Wolfensberger, *Principles of Normalization in Human Services* (Toronto: National Institute on Mental Retardation, 1972).

and political pressure to boost the numbers of qualified health care personnel, improve professional education, and expand services increased. In 1948, the federal Department of Health implemented a National Health Grants Program providing provinces with funding to expand professional education and services and improve mental hospitals, while also reducing their size.<sup>39</sup> The understanding of professional mental health practice itself also changed, with a greater emphasis on medical research and a closer alignment of mental health care with general medicine while new emerging professional fields expanded the domain and scope of professional psychiatric practice. The fields of psychology, psychotherapy, and social work emerged in mental health care, and new psychotherapeutic understandings of psychiatry and psychiatric nursing also grew as the emphasis on rehabilitation increased.<sup>40</sup>

To keep people in their communities and make services more accessible and open became important goals. A major factor supporting these goals was the introduction of psychotropic drugs for treatment of severe mental illness in the early 1950s, especially the advent of chlorpromazine. Although the side effects were not well understood, psychiatrists optimistically prescribed these drugs, which were believed to make patients more open to therapeutic management so they could maintain their lives outside of hospital walls.<sup>41</sup> Whereas some scholars framed this as the psychopharmacological revolution of post-World War II psychiatry, others underscored the inevitable cultural and gender implications of the rapidly increasing and widespread use of psychotropic drugs, whether within mental hospitals or society at large.<sup>42</sup>

Families, as well as reform-oriented professionals, began to resist the custodial orientation of large mental hospitals. Families advocated for more openness and better service for mentally ill family members. The Canadian Mental Health Association (CMHA), a revamped version of the commission on mental hygiene, became an important advocate for this group, seeking to reduce the stigma of hospitalization and create better alternatives. The CMHA began an active visiting and volunteer program in mental hospitals, promoting more interaction between institutions and the community while also actively employing people with mental illness.<sup>43</sup> Provincial divisions of the CMHA were established in British Columbia in 1952 and in Alberta in 1955. Increased public criticism

39 LaJeunesse, *Political Asylums*, pp. 125–150; Boschma, Yonge & Mychajlunow, “Gender and Professional Identity.”

40 Grob, *The Mad Among Us*, pp. 191–249; Erika Dyck, *Psychedelic Psychiatry*; Greenland, Griffin, and Hoffman, “Psychiatry in Canada”; Moran & Wright, *Mental Health and Canadian Society*.

41 David Healy, *The creation of psychopharmacology*.

42 Andrea Tone, *The Age of Anxiety: A History of America's Turbulent Affair with Tranquillizers* (New York: Basic Books, 2009); Erika Dyck, *Psychedelic Psychiatry*.

43 Griffin, *In Search of Sanity*; See also Jayne Whyte's essay in this collection.

over long-term institutionalization of people with mental illness further stirred debate. In Alberta, journalist Tori Salter faked schizophrenia to get herself admitted to AHE in 1968. Her resulting critical publication triggered controversy and public debate, reflective of wider anti-psychiatric trends.<sup>44</sup> The political pressure from the Liberal party in Alberta grew stronger in the 1960s as it rallied against the Social Credit government. The Liberals supported change in mental health care. A governmental report, known as the Blair Report, resulting from a provincial investigation into the state of mental health services in 1967, was critical of the conditions in large mental hospitals and promoted the development of community-based services.<sup>45</sup> Likewise, British Columbia underwent a major reorganization of its mental health services in the early 1970s.<sup>46</sup>

Another, and probably one of the most important influences shaping mental health services was the establishment of public health insurance in the 1950s and 1960s. With growing postwar demand for general hospital care and medical services as well as pressure to keep care affordable and accessible, the federal government approved a new public health insurance arrangement with the passage of the *Hospital and Diagnostic Services Act*, which came into effect in 1957, and the *Medical Services Act*, which was implemented in 1968.<sup>47</sup> The latter was originally established as a fifty/fifty cost sharing funding model between the federal and provincial governments.<sup>48</sup> While the 1948 federal training grant program had already fostered changes in mental health care, public health insurance further stimulated the trend within both provinces to adapt and change their mental health service systems in order to qualify for federal funding. The traditional provincial mental hospitals were not eligible for the new federal funding, and this generated pressure to move psychiatric treatment into the general hospital system. As a result, general hospital psychiatry departments rapidly expanded in number, becoming important places in community-based care and influencing the numbers of hospitalized patients with mental illness.<sup>49</sup>

44 LaJeunesse, *Political Asylums*, p. 156.

45 W.R.N Blair, *Mental Health in Alberta: A report on the Alberta Mental Health Study* Vol. I (1969) and Vol. II (1973) (Edmonton: Queen's Printer, 1973); LaJeunesse, *Political Asylums*, pp. 155–160.

46 1974 Annual Report of the BC Mental Health Branch; F. G. Tucker, "Mental Health Services in British Columbia," *Canada's Mental Health*, vol. 19, no. 6, 1971, pp. 7–12.

47 Aleck Ostry, "The Foundations of National Public Hospital Insurance," *Canadian Bulletin of Medical History*, vol. 26, no. 2, 2009, pp. 261–282; Robert Lampard, "The Hoadley Commission (1932–34) and Health Insurance in Alberta," *Canadian Bulletin of Medical History*, vol. 26, no. 2, 2009, pp. 429–452; Greenland, Griffin, and Hoffman, "Psychiatry in Canada."

48 Ostry, "The Foundations of National Public Hospital Insurance."

49 Hector, "Changing Funding Patterns;" Sealy and Whitehead, "Forty Years of Deinstitutionalization."

It was these influences and shifts in policy that led to the peak in the population in the large mental hospitals in both British Columbia and Alberta in the early 1950s, as shown in Tables A and B. A more detailed look at the demographics of admissions to the institutions in the provinces, however, shows that this change was neither as linear nor as positive as it seemed. The decrease in year-end numbers of patients in the three large mental hospitals gives only a partial perspective on the changes that occurred from the 1950s onward. Other important influences increased demand for mental health services. For one, in both provinces, the general population increased dramatically during the 1950s. Alberta's population increased between 1955 and 1965 by nearly 50%, from 1,066,000 to 1,451,000,<sup>50</sup> while the population of BC nearly doubled between 1951 and 1971, from 1,165,210 to 2,184,625.<sup>51</sup> These increases enlarged demand for mental health services.

More importantly, the wider range of institutional services established over these decades caused shifts in the patterns of hospitalization rather than an immediate decrease. Governments, as we saw, began to establish alternative facilities for elderly patients with mental illness and for developmentally-disabled individuals. The emergence of general hospital psychiatry had an important impact on the rate of hospitalization within the mental health system. Significantly, the total hospitalized population of people with mental illness and developmental disabilities in the provinces did not decrease substantially until the 1970s, even though health officials had begun making a sharper distinction between these categories. In order to understand the challenges that the provinces faced in redirecting services and changing hospitalization patterns, two important trends transforming the therapeutic landscape in postwar mental health care, namely trans-institutionalization and increased short-term admission, must be considered.

### **Trans-institutionalization**

In his analysis of changes in mental health care in the US, Gerald Grob used the notion of trans-institutionalization to describe how new federal funding for US Medicare and Medicaid in the 1960s – designed to provide medical care for the aged and poor – generated a transfer of large numbers of elderly patients from mental hospitals to nursing homes and resulted in a shift in the nature of the mental hospital populations.<sup>52</sup> A similar process occurred in Western Canada, and the notion of trans-institutionalization aptly describes the changes in Alberta and British Columbia. Sealy and Whitehead also emphasized this process in

50 Palmer, *Alberta. A New History*, p. 78; Annual Report, ABDPH, 1968, p. 102.

51 Barman, *The West Beyond the West*, p. 385.

52 Grob, *The Mad Among Us*, pp. 265–266.

TABLE C: Institutionalized mental hospital population in Alberta, per hospital, 1940–1972

Year	Total	Treatment Hospitals		Elderly		Mentally Disabled	
		AHP	AHE	Rosehaven	Claresholm Raymond	Red Deer	
						Tr.School	Deer Home
1940	2,783	1,596	766		205	216	
1952	3,791	1,543	1,342	249*	232	425	
1955	4,407	1,585	1,476	415	233	698	
1956	4,466	1,521	1,512	505	230	698	
1958	4,630	1,378	1,434	495	230	758	335**
1960	4,788	1,052	1,410	505	234	756	811
1965	5,381	1,087	1,345	497	440	861	1,134
1967	5,243	960	1,141	467	460	977	1,228
1970	4,354	693	846	335	466	800***	1,214
1972	4,117	641	666	344	446	813	1,195

\* newly opened in 1952; \*\* newly opened in 1958; \*\*\* in residence, on the books were 1,028, some of whom resided in a new pediatric unit opened at the Baker Memorial Sanatorium in Calgary in 1968.

Source: Alberta Department of Health, Annual Reports, 1940, pp. 90–91; 1953, p. 157; 1956, p. 90; 1957, p. 95; 1958, p. 112; 1960, p. 131; 1965, p. 159; 1967, p. 118; 1970, p. 94; 1971–72, p. 29

their analysis of deinstitutionalization trends in Canada.<sup>53</sup> Statistics on admission and discharge in Alberta show that while the provincial mental hospitals began downsizing in the 1950s, a series of new institutions was established to accommodate large groups of patients hitherto hospitalized in the mental hospitals (Table C).<sup>54</sup>

In 1952, Rosehaven, a facility for geriatric patients, opened in Alberta, while the elderly population in the auxiliary hospitals in Raymond and Claresholm also expanded, particularly after 1965. The existing Training School for the Mentally Deficient, located in Red Deer, was augmented with a whole new facility, Deer Home, for mentally disabled adults. By 1970, it housed over 1,200 individuals, most of whom had been transferred from the mental hospitals. This process of trans-institutionalization led to the transfer of the elderly with mental illness to other facilities, while institutional facilities for developmentally disabled residents also expanded.

The removal of people with long-term mental illness from the main mental hospitals became a central goal in both provinces, likely because

53 Sealy & Whitehead, "Forty Years of Deinstitutionalization."

54 Table C and E in this article also appeared in Geertje Boschma, "Community Mental Health Nursing In Alberta, Canada: An Oral History," *Nursing History Review* (in press; to appear in volume 20), and are reused with permission of Springer Publishing.

of economic and professional interest in aligning psychiatric care more closely with acute treatment. As a result, the mental hospitals were transformed into institutions for acute care and active treatment. (See Table C) The mental hospitals in Alberta became “active treatment centres” and downsized their chronic populations, while institutional care for the mentally ill elderly and developmentally disabled population expanded but shifted to other institutions. Annual reports in the 1950s noted the increase in admissions of older or ‘senile patients’ to the main mental hospitals, and the transfer of this group to other facilities might have partly resolved this problem.<sup>55</sup> A new *Mental Health Act* enhancing voluntary admission in 1964, as well as the 1964 *Nursing Home Act* making financial support available for placement in nursing homes, probably facilitated this process.<sup>56</sup> These numbers illustrate how community care and the release of long-term hospitalized people occurred against a backdrop of continued hospitalization of large numbers of people.

Numbers for the province of British Columbia show a similar trend. In 1950, the BC government implemented a number of significant changes and reorganized the province’s mental health services. BC government officials became increasingly concerned about the increase in admissions, which they had noticed during the immediate post-World War II years. In the first report of the new amalgamated mental health services, officials listed the forces driving a continued increase in admissions, and these factors provide a good reflection of the trends and thinking of the time. The report listed the following:

An increase in the population of the province (just over one million in 1951);  
 An increase in the aged population of the province and life expectancy;  
 Improved and increased facilities for care of the aged psychotic patient;  
 Improved community relationships and widening of the horizon of psychiatry, resulting in a greater number of voluntary admission; and the opening of the Crease Clinic [a new facility at Essondale for ‘psychological medicine,’ providing short-term treatment based on voluntary admission].<sup>57</sup>

The province began to build institutional facilities for particular groups, i.e. those over age 65 and under age 15. These groups allegedly had the poorest outlook for recovery or improvement. Accommodating them separately would address the goal of reducing the patient population in the main mental hospital.<sup>58</sup> Hence, during the early 1950s, BC expanded its

55 Mary F. McHugh Abt, “Adaptive Change and Leadership in a Psychiatric Hospital” (PhD Thesis, University of Alberta, Edmonton, Canada, 1992), pp. 161, 177.

56 Annual report, ABDPH, MHD, 1964, p. 6.

57 Annual report, BCMHS, 1950–51, p. 16.

58 Annual Report BCMHS, 1952–53, p. T24.

“Homes for the Aged” and “The School for Mental Defectives.” The latter started to accommodate direct admission, independent from Essondale.<sup>59</sup>

These developments in BC further illustrate the process of trans-institutionalization. Although the patient population of the provincial mental hospitals peaked in 1951 (at 4,602; Table B), the overall institutionalized population actually expanded from 1950 to 1970 due to transfers (see Table D). Whereas the total number of residents in the Essondale mental hospital decreased, the population in the Woodlands School, augmented with the Tranquille School in 1960, increased, as did the number of residents in the Homes for the Aged (Table D).

The existing Woodlands School was expanded with several new 100-bed units in the 1950s, enlarging its capacity by over 400 beds. In 1960, Tranquille, the former provincial tuberculosis sanatorium in Kamloops, was converted into a facility for developmentally disabled people, and a first group of 100 residents was transferred from Woodlands that same year.<sup>60</sup> Ten years later it housed over 650 residents. For elderly people with mental illness, facilities increased as of the late 1940s. In 1946, the first new building constructed on the Essondale grounds in twelve years was a new 100-bed unit for aged mentally ill patients. Another 100-bed unit opened a year later, in 1947. These homes eventually became administratively independent from Essondale and were renamed Valleyview Hospital for psychogeriatric patients. In 1952, this facility expanded with another 100-bed unit. In the late 1940s, two former military hospitals in Vernon and Terrace were also renovated into homes for elderly with mental illnesses, together accommodating a little over 500 residents by the early 1950s.<sup>61</sup>

The static nature of these statistics and list of facilities obscures the continued complex movement of people behind these numbers, which involved continuous transportation, new admissions, and adjustments for the people involved. Many of the large group of elderly patients died within years, if not months, of their admission, and a constant transfer of patients took place. Although the homes in Terrace and Vernon seemed to have a fairly stable population of around 500 patients, the details for 1965, a typical year, show that 75 new patients were admitted, 55 by direct new admission and 20 as transfers, while 72 “separated,” that is, five were discharged and 67 died. The picture at Essondale was even more complex: while the overall number of “in house” residents was reduced by 74 in 1965 – from 3,533 to 3,459 – there were 232 people already on probation and five had escaped but were still on the books. Admissions that year included 628 new admissions, 200 admissions from

59 Annual report, BCMHS, 1951, p. 15.

60 Annual report, BCMHS, 1959–60, p. 17; Thompson, “A Summary,” p. 18.

61 Thompson, “A Summary,” pp. 10–11.

TABLE D: Institutionalized mentally ill population in British Columbia, per facility, 1953–1968

Year	Total	Essondale		Elderly (geriatric)		Colquitz	Mentally Deficient Woodlands/Franquille
		Riverview	Crease	Valleyview	Terrace/Vernon		
1953	5,738	3,484	215	418	527	286	808
1955	6,331	3,419	267	535	509	288	1,208
1959	6,227	3,279	241	528	495	281	1,403 [109]*
1963	6,070	2,740	218	729	528	149	1,288
1965	6,053 (448)	2,689 (257)	229	759 (149)	523	[closed]	1,282 (36)
1968	5,856	2,683***		758	480		1,276

\* Tranquille opened in 1960, 109 patients transferred from Woodlands.

\*\* In 1965, boarding home placement started. Numbers in parentheses reflect boarding homes, and were available only for 1965.

\*\*\* For 1968 Riverview (formerly Essondale) includes the numbers for Crease Clinic.

Source: Annual reports, BC Mental Health Services, 1951–1968, tables showing patients in residence; (1952–53, p. T23; 1954–55, p. M20; 1958–59, p. J17; 1962–63, p. D7; 1963–64, p. F10; 1964–65, p. F8; 1965–66, p. G8; 1966–67, p. G10; 1967–68, p. L84).

other institutions, and 349 readmissions of former Essondale patients, while 82 patients transferred in for a total of 1,259 new patients. This means that, on average, about 100 patients were admitted every month. Patients who left that year included 959 who were discharged, 144 who died, 273 who were put on probation, two more who escaped, and 189 who transferred out for a total of 1,570 patients. Therefore, on average, 12 patients died and about 130 left the institution every month. Administrators and staff dealt with a constantly shifting population, so the vast numbers of individual moves became increasingly difficult to manage. The actual decline in total patients was minimal in the face of an ever-expanding number of people entering and leaving.

### **The staggering increase in short-term admissions**

Rather than showing a decrease in overall admissions, the time period under scrutiny actually showed an enormous increase in patient numbers, particularly in short-term admissions. New mental health policies emphasized community services as an alternative to hospitalization, but short-term admission became an integral part of such community care. By the late 1950s, the annual reports of the BC Mental Health Services noted that “there is no indication that mental hospitals will be entirely unnecessary, but there is every indication that the numbers of patients in mental hospitals can be greatly reduced, and, further, that the majority of future patients need not go to hospital if given early diagnosis and help in the community.”<sup>62</sup> To treat more people on an outpatient basis, BC Mental Health Services embarked on the establishment of new mental health centres, the first of which opened in Burnaby in 1957.<sup>63</sup> A reorganization of the Mental Health Services took place in 1962, resulting in a branch structure with four main divisions, namely one for mental hospitals, one for geriatric services, one for the then called mentally retarded persons, and one explicitly new division for community services. The new Community Services Division was responsible for diagnostic, consultative, and therapeutic services in the mental health centres throughout BC provided to patients who did not require hospital care.<sup>64</sup> Although this shift aligned with the effort to reduce hospitalization, it must also be noted that people with severe mental illness were still admitted to Essondale, while those who could be treated on an outpatient basis were often patients with less complex problems.

In his analysis of the US postwar shift to community care, Grob noted how new community mental health centres “serviced a quite different clientele,” not necessarily the people with severe and persistent mental

62 Annual Report 1957–58, BCMHS, L11.

63 Thompson, “A Summary,” p. 17.

64 Annual Report 1962–63, BCMHS, p. 7.

illness.<sup>65</sup> As the first numbers on the reduction of patients admitted to mental hospitals and the increased numbers served in the community became available, these more subtle shifts in services were not acknowledged in either the BC or Alberta annual mental health services reports. More and more patients were admitted, often multiple times, for relatively shorter periods of time. David Healy observed a similar pattern in his study of the demographics of mental health services in Wales, UK.<sup>66</sup> From the 1950s on, annual reports noted a rapid increase in the number of admissions over the course of a year, which is different than the total number of hospitalized patients in the hospital at year-end. In the mid-1950s, 60 percent of the patients who were discharged from AHP, for example, spent less than three months in the hospital, indicating a continuously changing patient population.<sup>67</sup> The increase of service provision in new departments of psychiatry in general hospitals exacerbated this complexity. As a result, the new type of community services that emerged did not evolve as a well-coordinated whole, but generated a rather complex structure that also had to accommodate an increasing number of admissions and discharges.

In 1967, the then newly appointed BC Deputy Minister of Mental Health F. G. Tucker set up a committee to review the organization of the Mental Health Branch. That branch ceased to exist in 1974 when it was amalgamated into the Department of Human Resources and the Department of Health. In 1971, Tucker optimistically and confidently noted that “the trend has been redirected to a decentralized and regionalized approach which stresses local involvement in all aspects of mental health programming.”<sup>68</sup>

As indicated, particularly due to new public funding arrangements, an expanding number of psychiatric departments in general hospitals was an essential component of this change. In Alberta, for example, the first general hospital departments were established in the late 1960s, and by 1988, 16 general hospitals in the province had a department of psychiatry.<sup>69</sup> These departments focused on short-term admission, with follow-up care in the community. In the meantime, mental hospitals also increased voluntary admission and developed outpatient treatment. To this end, in BC, the

65 Grob, *The Mad Among Us*, 265–6. See also Peter Nolan, *A History of Mental Health Nursing* (London: Chapman & Hall, 1993), pp. 161–63, discussing this issue for the UK.

66 David Healy, Margaret Harris, Pamela Micheal, Dinah Cattell, Marie Savage, Padmaja Chalasani, and David Hirst, “Service Utilization in 1896 and 1996: Morbidity and Mortality Data From North Wales,” *History of Psychiatry*, vol. 16, no. 1, 2005, pp. 27–41.

67 Abt, “Adaptive Change,” pp. 176–177.

68 F. G. Tucker, “Mental Health Services in British Columbia,” p. 7–8; Thompson, “A Summary,” p. 20.

69 Report Mental Health Services in Alberta (Edmonton: Albert Mental Health Services, 1988), p. 5; Grob observed that during the 1980s general hospitals in the US had become the most frequent site for hospitalizations for mental illness, particularly for individuals with severe and persistent mental illness. Grob, *The Mad Among Us*, p. 291.

Essondale mental hospital had been expanded by adding the Crease Clinic in 1951, a short-term admission unit for psychological medical treatment. When the opportunity arose, the medical staff worked in close cooperation with the Psychiatric Department of the new School of Medicine, which opened at the University of British Columbia in the early 1950s. Stronger links with medical science, research, and resident training were all part of this new development.<sup>70</sup> Initially the Crease clinic had about 250 inpatient beds; admission was voluntary, with patients staying for a maximum treatment period of about four months. It eventually became an outpatient clinic in the 1960s.

F.G. Tucker, who had started as a resident physician in Essondale in 1953, became director of the Crease Clinic in 1959 prior to taking on the position of Deputy Director of Mental Health Services in 1963. He was committed to redirecting services towards a stronger emphasis on community care. Showing decreasing admission numbers, while indicating in the annual reports how outpatient programs were rapidly expanding, reflected this strategy.<sup>71</sup> Tucker emphasized how the province focused on “the development of community-based psychiatric programs, facilities and service for [mentally retarded individuals], comprehensive programs for emotionally disturbed children, integrated services for the aged and mentally ill, and the provision of forensic services.”<sup>72</sup> By 1971, British Columbia counted 17 mental health clinics throughout the province providing direct services and focusing on prevention, while the province also expanded general hospital psychiatry.<sup>73</sup>

This change seems significant in light of the passage of federal Medicare legislation. Importantly, Tucker noted how joint planning by the Mental Health Branch and the British Columbia Hospital Insurance Service focused on “planning for psychiatric beds in acute care hospitals” financed by the local hospital district and expanding “extended care hospitals,” which could be financed under the BC Hospital Insurance Service and provide care for developmentally disabled people who also had physical disabilities. Furthermore, a boarding home program had been established and would be expanded throughout all regions “in order to clear more beds of patients in provincially operated institutions and return them to their community.”<sup>74</sup> This boarding home program, which had started in BC in 1965, was intended to prevent long-term hospitalization while still providing “some protective supervision.”<sup>75</sup>

70 Annual report, BCMHS 1961–62, p. I14; 1962–63, p. D15.

71 Thompson, “A Summary,” p. 20.

72 Tucker, “Mental Health Services,” p. 9, Thompson, “A Summary,” p. 17.

73 Tucker, “Mental Health Services”; Thompson, “A Summary,” p. 21.

74 Tucker, “Mental Health Services,” p. 11.

75 Annual report, BCMHS, 1964–65, p. F8.

Although these new facilities provided alternatives to traditional hospitalization, they also formed new institutional structures, places that maintained a certain level of control and dependency over those who used them. While accommodation for developmentally disabled and elderly individuals expanded, more patients also began to be accommodated on an outpatient basis, often following short-term admission. Each province passed a new *Mental Health Act* in 1964 to accommodate and enhance voluntary treatment.<sup>76</sup>

In Alberta, AHP and AHE both also developed outpatient departments, collaborating with the existing network of guidance clinics to coordinate discharge of patients and the follow-up care in the community.<sup>77</sup> In 1968, AHP had established outpatient services to facilitate the discharge and follow-up of patients, initially called 'after care.' In Calgary, the Guidance Clinic, for example, coordinated the placement of patients from AHP discharged to Calgary, and a new Inter-Agency Council of After Care was formed to help create and coordinate new community resources.<sup>78</sup> Over a hundred patients were discharged to foster homes and nursing homes in Calgary in 1967. In the subsequent three years, 1000 more patients, among them many elderly, were placed in foster and nursing homes. Within years, the Foothills General Hospital, newly established in Calgary in 1966, took over the Guidance Clinic's function as part of one of the province's first new psychiatric departments in general hospitals.<sup>79</sup> Psychiatrist and Department Head Keith Pearce led the initiative to establish outpatient community care while also accommodating a follow-up clinic for patients discharged from AHP, who had moved into foster or nursing homes or low rental apartments in Calgary. Soon the case-load of the new psychiatric department counted over 600 former AHP patients.<sup>80</sup>

Statistics for the mental hospitals in Alberta show how short-term admissions enormously expanded over this period (Table E<sup>81</sup>). Admissions and discharges at AHP doubled between 1956 and 1965, while at AHE, the numbers increased even more. It continued to take in over 2000 patients until the mid-1970s, creating a much more complex place of service (Table E).

76 Legislative changes resulted in a new *Mental Health Act* in BC in 1964. Alberta passed similar legislation in that same year. Annual report, ABDPH, MHD, 1964, p. 6.

77 Boschma, Yonge, and Mychajlunow, "Gender and Professional Identity." Boschma, "Community Mental Health Nursing In Alberta."

78 Abt, "Adaptive Change," p. 216; Boschma, "Community Mental Health Nursing In Alberta."

79 Boschma, "Community Mental Health Nursing In Alberta."

80 Keith I. Pearce, "A Comparison of Care Given by Family Practitioners and Psychiatrists in a Teaching Hospital Psychiatric Unit," *American Journal of Psychiatry*, vol. 127, no. 6, 1970, pp. 835-840.

81 See endnote 54.

TABLE E: Total number of patients, admissions, discharges in AHP and AHE, 1946–1976

Year	AHP			AHE		
	Total	Admission	Discharge	Total	Admission	Discharge
1946	1,404	≈600	≈500	1,239	103	112
1956	1,521	692	570	1,512	830	688
1960	1,052	893	746	1,410	1,243	1,038
1965	1,087	1,422	1,323	1,345	2,050	1,854
1967	960	1,301	1,266	1,141	2,281	2,338
1969	818	717	783	916	2,554	2,560
1972	614	642	629	666	2,168	2,219
1976	479	867	826	662	1,822	1,751

Source: Sheila Abercrombie, *Alberta Hospital Edmonton, 1923–1983* (Edmonton: Alberta Hospital Edmonton, 1983), p. 38 (1946); Alberta Department of Health, Annual Reports, 1947, p. 117; 1956, p. 90; 1960, p. 131; 1965, p. 159; 1967, p. 118; 1969, p. 87; 1971–72, p. 29; 1975–76, p. 64.

As indicated in Table E, while until the 1960s the number of admissions to AHP in one year was only half of the total patient population, this changed during the 1960s. While the total number of patients at year-end decreased in AHP, from the mid-1960s onwards the number of patients admitted and discharged during the year first equalled and then doubled the entire hospital population. There were over 1400 admissions to AHP in 1965 while the total hospital population at year end was just over 1000 patients. By 1976, the hospital's patient population had fallen to 479 but admissions and discharges that year involved over 800 individuals. This implied an ongoing high level of short-term admissions. In AHE, the numbers were even more dramatic. In 1967, admission numbers were double the entire hospital population, while ten years later, in 1976, admissions and discharges numbered about 1800 people, three times the hospital population of about 600 (See Table E). Many of those admitted were re-admissions, creating a steady stream of patients who went back and forth between community placements and the mental hospital. Such movement was increasingly referred to in the literature as the "revolving-door" phenomenon.<sup>82</sup> The demographics of admission and discharge show how the new geography of community care continued to be characterized by frequent and continued hospitalization of large numbers of patients. To accommodate these numbers, new institutional places within the community had to be created. General hospital departments of psychiatry played a key role in this process.

In British Columbia as in Alberta, the overall numbers of patients admitted to residential and outpatient facilities between 1950 to 1974

82 Grob, *The Mad Among Us*, p. 299.

TABLE F: Admissions to Residential Facilities\*\* of the Mental Health Branch, BC, 1945–1974

Year	Admissions
1945–46	834
1949–50	1,415
1951–52	2,175
1955–56	2,855
1958–59	2,993
1960–61	3,924
1962–63	4,248
1965–66	5,069
1967–68	4,179**
1970–71	3,870
1972–73	2,650
1973–74	2,823

\*\* After 1968 “Residential Facilities” (Institutional Provincial Mental Health Services, which include Riverview, Woodlands, Tranquille, Valleyview, and the hospitals in Vernon and Terrace) are contrasted with outpatient programs. After 1968, separate statistics are kept for “entries” to outpatient service.

Source: Annual Reports, BC Mental Health Services 1950–1968 (1951–52, p. Q17; 1958–59, p. I11; 1967–68, p. L84) and BC Mental Health Branch Report, 1972 (p. 85) and 1974 (p. 109).

showed an enormous increase. By 1968, there was a downward trend in the numbers in residential facilities, while outpatient programs had increased significantly (Tables F and G). It must be noted that neither province included statistics on patients admitted to the expanding number of general hospital psychiatric departments. Clearly, the overall high number of admissions was not easily reversed and contributed to the many new problems of community mental health.

By 1970, outpatient programs in BC accommodated almost 6000 “entries” altogether, a number that nearly doubled over the next four years (Table G). Most of these people were accommodated within new mental health centres. Community mental health services had expanded considerably as of the 1960s, with a further increase of another 15 centres in the early 1970s and the creation of the BC Youth Development Centre in Burnaby. Housing had to be established as a separate service, initially accomplished through a system of boarding homes. By 1974, the boarding home program that had started in 1965 was accommodating 1,700 people with mental illness in 280 homes, including many people with developmental disabilities.<sup>83</sup> Expansion of general hospital departments was included in the 1974 planning. One was established at

83 1974 Annual Report of the BC Mental Health Branch, p. 28.

TABLE G: Entries for all outpatient programs in British Columbia, 1970–1974

Year	1970	1971	1972	1973	1974
All outpatient programs	5,903	6,001	7,240	9,326	11,719
Mental Health Centres	4,725	4,958	6,363	8,120	9,610
(Number of centres)	(17)	(20)	(23)	(27)	(32)
Outpatient Department Riverview	481	385	406	557	492
Outpatient Department Woodland and Tranquille	–	–	96	149	115
Waiting list Woodland and Tranquille	158	124	99	104	70
BC Youth Development Centre	–	–	276	278	152
Community Care Teams	–	–	–	118	1,280
(Vancouver, number of teams)				(1)	(6)

Source: Annual Reports, BC Mental Health Branch, 1972 (p. 85) and 1974 (p. 109).

St. Vincent Hospital in Vancouver, while Vancouver General Hospital also had such a department, and others were planned for St. Paul's, St. Joseph, and Shaughnessy hospitals.<sup>84</sup>

Short-term admission and outpatient care became the dominant treatment pattern for acute mental illness in this period. In both provinces, the shifting nature of the ongoing admission and discharge of large numbers of patients, which formed the new pattern of service, generated many new challenges. Not only did the establishment of community services go hand in hand with an enormous expansion of patient admissions, but the ability to find staff to provide the planned services was continuously constrained by severe shortages of personnel and by complex governmental structures.

Recruitment of personnel, especially of psychiatrists, was an ongoing difficulty and all facilities experienced severe shortages. In 1974, staff turnover in BC mental health services was 30%.<sup>85</sup> Employed were 4,593 staff and 501 summer students. A designated department personnel officer spent four weeks in the UK to recruit nurses in 1974. In that year, Riverview hospital had eight vacant medical staff positions, while ten psychiatrists had been granted medical staff appointments and 13 resigned.<sup>86</sup> Alberta directors of the mental health division noted similar struggles in the annual reports of the mental health division, as did all Canadian provinces in this time period.<sup>87</sup> It is plausible that staff shortages formed one of the factors that stimulated, perhaps unintentionally, more family and patient initiatives, not only so they could create more services but also so they could take the organization of care into their own hands.

84 1974 Annual Report of the BC Mental Health Branch, pp. 17–19.

85 1974 Annual Report of the BC Mental Health Branch, p. 32.

86 1974 Annual Report of the BC Mental Health Branch, p. F82.

87 Sasha Mullally & David Wright, "La Grande Séduction?: The Immigration of Foreign-Trained Physicians to Canada, 1954–1976," *Journal of Canadian Studies*, vol. 41, no. 3, 2007, pp. 67–89.

### **New initiatives in community care**

To accommodate the growing number of people with mental illness in the community, the emerging community system of care was characterized by continuous reconstruction and expansion and new forms of service with close connections to existing institutional structures. In the 1970s, new initiatives explored alternatives to long-term hospitalization. In 1971, the BC Mental Health Services set up a pilot study of psychiatric home treatment to divert admission away from Riverview Hospital (formerly Essondale). The project showed limited success, in part because a strict either/or alternative did not seem to work. An option of partial hospitalization would probably have produced better results, the study noted.<sup>88</sup> The results indicate how finding the right mix and flexibility of services in the community was an ongoing, pressing question. Another innovative experiment in Vancouver in the early 1970s was the establishment of community care teams, introduced as a showcase demonstration project within the newly established Greater Vancouver Mental Health Services (GVMHS), which was part of Deputy Minister Tucker's policy to decentralize programs.<sup>89</sup>

The Vancouver project caught the eye of the federal Department of Health in 1982 as an example of approaches that the Mental Health Division was eager to promote, i.e. an urban community mental health service "designed specifically to care for the most difficult of client groups – the long-term psychiatric patient."<sup>90</sup> The GVMHS program had started in 1973, with the Metropolitan Board of Health of Greater Vancouver handling its administration. At the same time, the GVMHS had decided to "phase out the Outpatient Department of the Provincial Hospital and to transfer staff to a program designed to serve those patients in Greater Vancouver who needed acute care."<sup>91</sup> The proposed community teams were part of a larger "Vancouver Plan" for community-based mental health service, developed by the influential couple John Cumming and Elaine Cumming, who, as Kathleen Kendall shows in this issue, had conducted one of the first Canadian studies trying to improve a community's attitude toward mental illness; this study consisted of a mental health education experiment in a small Saskatchewan town conducted in the 1950s.<sup>92</sup> This same couple designed the "Vancouver Plan"

88 Annual Report, BCMHS, 1974, p. 24.

89 Greater Vancouver Mental Health Service (GVMHS): A Model of An Urban Community Mental Health Service (Ottawa: Mental Health Division of Health and Welfare Canada, 1982).

90 *Ibid.*, p. i.

91 *Ibid.*, p. ii.

92 John Cumming and Elaine Cumming, *Closed Ranks: An Experiment in Mental Health Education* (Cambridge MA: Harvard University Press, 1957); John Cumming, *Plan for Vancouver* (1972), UBC library collection, no place and publisher. See also paper presented by Kathleen Kendall, (University of Southampton) "Closed Ranks: The Weyburn Experiment," *Open Doors/Closed*

for the BC Provincial Mental Health Service that established community care teams specifically aimed at developing community-based services for people with severe mental illness who otherwise would likely have needed hospitalization. The GVMHS was operating nine teams in Vancouver and Richmond by 1974.<sup>93</sup> This was an attempt to respond to the challenges that had already surfaced during the 1960s when large numbers of patients were discharged after short hospitalizations. These challenges included services that operated independently of one another, shortages of hospital beds preventing private psychiatrists from admitting patients, inadequate public services (including overloaded emergency facilities), volunteer agencies often lacking psychiatric expertise, the pressure to find suitable housing for discharged patients rather than providing therapy, frequent encounters with the police and the courts, and earlier discharge from hospitals with most problems unresolved, resulting in the “typical revolving door situation,” the report noted.<sup>94</sup>

Those pressures generated a growing crisis to which the creation of community care teams was a response; each multidisciplinary team operated from a facility close to a transit route and provided walk-in and drop-in services, free coffee, and an opportunity for patients to chat with other patients. The focus of the service was to provide basic life skills support to counter the alleged reduction in basic social competence resulting from mental illness, to build life skills such as the ability to find and maintain an apartment, to develop recreational skills and to provide employment support. To meet the latter ends, teams worked together with existing agencies such as those providing vocational rehabilitative resources. GVMHS support for their clients in finding housing consisted of four “modes:” emergency short-term stay facilities, long-term boarding homes, independent group living, and private home living with homemaker services. Three short-stay emergency residences, Venture, a ten-bed emergency residence for males, Vista, a ten-bed rehabilitation residence for women, and an independent long-term living program for three women were operated by the GVMHS itself, while all other housing was arranged through other non-profit societies, primarily boarding home arrangements involving various levels of independence.

Professionals and policy makers were not alone in trying to respond to the emerging community care crisis. Ex-patients responded as well, leading a growing number of initiatives to create community resources for themselves. Reflecting this increased involvement of ex-patients in their own care, the Service worked with the Mental Patients’

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Ranks: *Locating Mental Health After The Asylum Workshop*, University of Saskatchewan, August 22–24, 2009, and her essay in this collection.

93 1974 Annual Report of the BC Mental Health Branch, p. 28.

94 GVMHS: *A Model of An Urban Community Mental Health Service*, p. 3.

Association of Vancouver (MPA), for example, which had established itself in 1971 as a self-help advocacy and activist group and ran five communal houses, funded jointly by the Ministries of Human Resources and Health. The MPA “runs its homes in an unorthodox manner,” the report noted, “with the insistence that half the staff in all of its programmes be mental patients.”<sup>95</sup> Particularly for allegedly “hard-to-house [people],” these homes were a good fit. These people probably had difficulty with the concept of “being housed” just as they had difficulty with “being diagnosed” and “being treated,” i.e. they were people who resisted a regimented structure laid upon them by “organized psychiatry.”<sup>96</sup> The MPA homes were to a large degree managed by ex-patients. Furthermore, GVMHS worked with the non-profit Coast Foundation, which had started as a federal government Local Initiative Programme, and managed several apartment buildings and “three-quarter” houses, with a day-time coordinator and a communal kitchen. GVMHS also negotiated a new subsidized independent living program (placing small groups of patients in a home under a rental agreement) with the BC Housing Management Commission and the Housing Department of the Greater Vancouver Regional District. Unique features of the GVMHS were an after-business hours emergency service and a suicide prevention program.<sup>97</sup>

This extended and detailed description of the new places for community-based service makes clear that the operation of community housing was strongly dependent on the political will to publicly fund such programs, on complex if not confusing cooperation between different government departments, and on skilful and diplomatic negotiations to arrange housing in a competitive market with soaring real estate prices. The crisis in community services (and housing) had in part emerged because many existing for-profit boarding homes had put their homes on the market when real estate prices soared in Vancouver in the seventies. The Coast Foundation, at the request of GVMHS, had purchased four such boarding homes, with this being made possible by interest-free loans from the Canada Mortgage and Housing Corporation.<sup>98</sup> This example illustrates how community services operated in a politically demanding and socially fragile and fragmented environment. Social stigma from communities not eager to welcome mental patients in their midst as well as political ambivalence about putting public funding into relatively expensive labour-intensive support programs could easily

95 GVMHS: A Model of An Urban Community Mental Health Service, p. 13.

96 Irit Shimrat, *Call Me Crazy: Stories from the Mad Movement* (Vancouver: Press Gang Publishers, 1997).

97 GVMHS: A Model of An Urban Community Mental Health Service, pp. 14–15.

98 GVMHS: A Model of An Urban Community Mental Health Service, p. 14.

disrupt a precarious set of services. This socio-political context, further constrained by soaring patient numbers, presented considerable challenges in community mental health.

### **Policy directions as of the 1980s: A shifting landscape of mental health care**

To give further direction to its mental health policy, the BC government undertook a series of evaluations and studies of mental health approaches and services during the 1980s when the initial fifty/fifty federal-provincial funding arrangement reverted into a block-funding system, once again leaving the provinces with the responsibility for a much larger portion of the health care budget. Similarly, in the early 1980s, Alberta Health undertook a review of its *Mental Health Act* and produced two evaluations of its mental health services to guide further planning and regionalization.<sup>99</sup> By the late 1980s, it articulated the new ideal that effective mental health services required a partnership among family, community and government to “enable individuals [with mental illness] to live full and productive lives.”<sup>100</sup> The report noted that the combined hospital population in AHP and AHE had been reduced to 1,072 individuals while a much stronger emphasis on community care had come into effect.<sup>101</sup> Expansion of institutional services came to a definite halt. The ongoing expansion of Woodlands in BC also came to an end by the late 1970s, and the Tranquille institution closed in 1985.<sup>102</sup>

Standards of care had shifted profoundly, not only due to the continued argument about health care costs, but also under the pressure of increased consumer involvement and continued questioning of the efficacy of institutional care. The first in a series of re-evaluations in BC took place in 1979. The *Mental Health Planning Survey* aimed to further shift care from centralized institutions to regionally- and community-based mental health services.<sup>103</sup> By that time, the hospital population of Riverview Hospital had been reduced to about 1,100 patients.<sup>104</sup> The survey revealed that too much centralization, difficulties in inter- and intra-hospital

99 Alberta Health, *Mental Health Services in Alberta*, p. 4. Planning reports included *The Challenge for Psychiatric Care in Edmonton and Northern Alberta – An Action Program for the 1980s* (McKinsey and Company, 1980), and *Southern Alberta Study of Psychiatric Needs and Provisions* (Clarke Institute of Psychiatry, 1983).

100 Alberta Health, *Mental Health Services in Alberta*, p. 3.

101 Alberta Health, *Mental Health Services in Alberta*, p. 8.

102 BC Mental Health & Addiction Services, “History.”

103 Mental Health Planning Survey Staff, *Report of the Mental Health Planning Survey*, (Victoria: Queen’s Printer for British Columbia, 1979). Ronquillo, C., & Boschma, G. (in press). Deinstitutionalization of mental health care in BC: A critical examination of the role of Riverview Hospital from 1950-2000. Conference Proceedings 2009 University of Calgary History of Medicine Days.

104 *Report of the Mental Health Planning Survey*, p. 57–58.

transfers, and problematic accounting and budgeting procedures continued to plague the system. In response, in the mid-1980s, a *Mental Health Consultation Report* served as a first official plan to further downsize and eventually replace Riverview Hospital.<sup>105</sup> A renewed ideal of rehabilitation shaped the new policy agenda, no longer just emphasizing availability of community-based services but also promoting the value of working with individuals with mental illness “to maximize their mental and behavioural potentials and maintain as normal a lifestyle as possible.”<sup>106</sup> The implementation of these plans would prove to be a prolonged process, however, fraught with political controversy as well as continued funding constraints that continued well into the 1990s.

By the 1980s, both provinces were moving towards a new rehabilitation-oriented model of mental health care, which had been strongly advocated by an increasingly vocal and organized family and emerging consumer movement. *Head on Into the Eighties*, documenting the history and philosophy of the Vancouver Mental Patients Association, founded in 1971, is indicative of a mental health system that had moved away from 1950s era approaches.<sup>107</sup> Under the leadership of ex-patient Lanny Beckman, among others, the organization had formed as a self-help group; Beckman noted how he had lost faith in organized mental health services as a patient in a day-care program when he noticed that staff were not available in the evenings and weekends when crises often began, and that patients were actually discouraged from having contact with one another outside the institution.<sup>108</sup> Following the suicides of two fellow patients on weekends, a patients’ phone list was circulated clandestinely, and out of this move grew a peer-support group. With the help of a sympathetic newspaper columnist, according to Beckman, they drew public attention to their cause. They were able to develop services for themselves with a house offered to them at low rent, which the group set up as a meeting place, crisis centre, and 10-bed residence and which was financed by donations initially and later by governmental and foundation support. Soon they ran several such houses.<sup>109</sup> In the broader context of deinstitutionalization, as more patients and families were forced to find resources, more self-help organizations emerged. Often frustrated with the lack of support or the stigma they experienced or with the nature of the

105 Ronquillo & Boschma, “Deinstitutionalization.”

106 BC Ministry of Health, *Mental Health Consultation Report: A Draft Plan to Replace Riverview Hospital* (Victoria, B.C.: Ministry of Health, 1987), quote on pp. 7–8; Ronquillo & Boschma, “Deinstitutionalization.”

107 Vancouver Mental Patients’ Association Society (MPA). (1983). *Head on Into the Eighties*. Vancouver: Carolina Publications.

108 An experience which may underscore the observation about staff shortages above.

109 MPA, *Head on*, p. 1. See also discussion above about the Greater Vancouver Mental Health Service and their collaboration with the MPA.

medical treatment itself, they considered themselves as survivors (of oppressive medical treatment) or consumers (rightful users of services) and formed an active ex-patient or consumer movement, creating their own resources in the process.<sup>110</sup> Family members also lobbied for better service and public education, founding in Alberta, for example, the Alberta Friends of Schizophrenics in 1983, later renamed the Schizophrenia Society of Alberta.<sup>111</sup>

As community care increased, residents and families became more actively involved in mental health politics, in part because the realities of community care were most often felt to be in sharp contrast with the ideals of community-based support and rehabilitation. People with mental illness living in the community experienced enormous challenges. The disappearance or reduced size of the mental hospital as a physical structure had not removed the inequities people with mental illness continued to face, while public funding for mental health services continued to be insufficient.<sup>112</sup> The system would and could no longer operate without the active involvement of consumers or survivors.<sup>113</sup> Continued inequities included a lack of affordable housing – with the supply of supportive housing facilities helping people with mental illness to live in the community never meeting the demand. Often communities resisted such facilities in their neighbourhoods. Not only did mental illness often profoundly affect individuals' education, volunteer work and employment opportunities, but continued stigma also affected their chances of obtaining permanent employment, despite the expansion of supportive employment services.<sup>114</sup>

Furthermore, the unpredictable nature of severe mental illness often caused people to experience multiple re-hospitalizations that disrupted their stability. Homelessness among people with severe mental illness increased due to the intertwined consequences of poverty, lack of resources, and fragmentation of services. Community-based mental health service providers found themselves with limited capacity to handle the increasing number and complexity of services required.<sup>115</sup>

110 Irit Shimrat, *Call Me Crazy*; Nancy Tomes, "The Patient as a Policy Factor."

111 LaJeunesse, *Political Asylums*, pp. 201–02.

112 See Knowles, *Bedlam on the Streets* for a study of community care in Montreal; Morrow, "Mental Health Reform, Economic Globalization;" Internationally, see M. J. Dear, & J. R. Wolch, *Landscapes of Despair: From Deinstitutionalization to Homelessness* (Princeton: Princeton University Press, 1987); Grob, *The Mad Among Us*.

113 Everett, *A fragile revolution: Consumers and psychiatric survivors*; Tomes, "The Patient as a Policy Factor."

114 Everett, *A fragile revolution: Consumers and psychiatric survivors*; Geertje Boschma, "Gender, work, and identity in community mental health care," Paper, presented at the International Perspectives in the History of Nursing Conference, London, UK, 14–16 September 2010.

115 Ronquillo & Boschma, "Deinstitutionalization."

Consumer advisory councils and the participation of consumers in service development increased in the broader context of a shift to community-based rehabilitation services.<sup>116</sup> Ambivalence over the culturally dominant medical discourse of mental illness persisted.<sup>117</sup> The realization surfaced that consumer participation was required to achieve change and to accommodate the ongoing large numbers of people in need of community mental health services within a politically challenging health care climate focused on cost containment – this was a novel idea when it arose within the community mental health movement. Although embraced with ambivalence, it became a persistent, much needed, and perhaps one of the most promising elements of mental health reform.

### Conclusion

This analysis of the demographics of admissions and exploration of new places of community care suggests that rather than deinstitutionalization, the intertwined processes of trans-institutionalization, expansion of acute and short-term admissions, formation of community-based services (including the expansion of general hospital psychiatry) and emergence of a consumer movement marked the transformation of mental health services between 1950 and 1980. Until the 1970s, the number of hospitalized individuals actually increased, and the overall numbers of people with mental illness in need of help continued to increase thereafter. While mental hospitals were gradually reduced in size, new connections between communities and institutions were forged. In the reconfigured system of care, institutional dynamics did not disappear. While most would argue that the new landscape of community care represented an improved, more humane system of service that provided more independence and support for people with mental illness, the challenges were no smaller. New, rehabilitative, community-based mental health services are best conceptualized as a transformation of institutional practices. People with mental illness obtained for themselves a more prominent place in community-based care, a stronger presence, and a political voice. The persistently large numbers of people in need of mental health services combined with the erratic and still poorly understood nature of mental illness continued to present a challenging context of care. It was not without foresight, therefore, that the 1982 federal report on the GVMHS service ended with the observation that “what is presented here is the image of an agency striving in an imperfect world to provide

116 Morrow, “Mental Health Reform; Kevin Borkes, “My Recovery: A Long and Winding Road,” *Peace of Mind – Bi-Annual Newsletter of the CMHS, Simon Fraser Branch*, no. 7, 2008, p. 11.

117 Richard Ingram. 2005. *Troubled being and being troubled: Subjectivity in the light of problems of the mind* (PhD dissertation, University of British Columbia. 2005); Boschma, “Accommodation and resistance to the dominant cultural discourse.”

the best possible help to a patient group which is often ignored, too often short-changed on services, and all too often, conveniently shut away from the rest of society.”<sup>118</sup>

118 GVMHS: A Model of An Urban Community Mental Health Service, p. 20.