CONCEPTIONS OF INSANITY AND THEIR IMPACT ON THE SASKATCHEWAN HOSPITAL, NORTH BATTLEFORD

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CONCEPTIONS OF INSANITY AND THEIR IMPACT ON THE SASKATCHEWAN HOSPITAL, NORTH BATTLEFORD

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Legal, medical, and social conceptions of insanity influenced the perceived role of the insane institution and contributed to institutional commitment's dual function of treatment and detainment. This thesis examines the legal, medical, and Mental Hygiene conceptions and their impact on Saskatchewan Hospital, North Battleford between the years 1914 and 1945. Emphasis is placed on the manner in which the institution attempted to accommodate the changing conceptions and the way it came to be criticized as a failure. In order to ascertain the changing conceptions of insanity and their impact, information has been derived from a variety of sources with particular emphasis placed on the primary sources available to the public. The historical analysis of primary material provided the basis for understanding the changing conceptions and institutional role. It also illustrated the subjective nature of insanity definition and the inherent difficulty of managing the insane.
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Chapter 1

CONCEPTIONS AND MANAGEMENT

Language, whether scientific, legal, or social in nature, reflects various social perceptions. Images and thought are expressed through language and provide the means of communicating a reality. However, language is more than a means of communicating and expressing society’s assumptions, values, and behaviour models. Language provides a conceptual framework for human relations. The ability of language to express or limit societal conceptions is especially apparent when examining the issue of insanity and insanity historiography.

The expansion of insanity conceptions from visible behaviour to invisible threat, from an individual problem to a social danger underscores two components of insanity perception. Essentially insanity is alien and incomprehensible unless made understandable through society’s reaction and definition. This thesis recognizes that the first component of insanity perception is that the concept of insanity has a subjective nature and is as much an expression of a social or medical concern as it is a means to ensure a particular societal stability. The lack of consensus regarding the nature of insanity, of its cause, or of the means to intervene, creates the second component of insanity perception, in that various agencies defined insanity and perceived a particular institutional role. While insanity historiography examines both the subjective nature and expansive quality of the concept of insanity, the institution has been perceived as a failure in treating the insane. This thesis also recognizes the failure of institutional treatment. However, it is not viewed as inherent to institutionalizing the individual, but
as a result of the various conceptions of insanity and the various perceptions of management. Like James Thurber's "The Unicorn in the Garden" in which insanity is a myth capable of isolating the individual, the conception of treatment may be a myth which has isolated the institution. Insane institutions have been subject to changing external pressures to control and manage insanity and in such a manner, the concept of insanity and the perception of the institution have become a panacea.

Insanity historiography has examined the nature of insanity and the causes ascribed by society. Insanity has been conceptualized as an affliction imposed by a supernatural being, as the consequence of chronic brain disease, as the result of genetic inheritance, or as the manifestation of social stress. These conceptualizations link insanity to particular phenomena, and in turn provide historians the basis for examining change over time.

The constructs of insanity changed from a religious basis to a scientific or societal perception. Yet, while the reality of insanity causation has been subject to changing conceptions, historiography has often limited its approach to change:

Almost without exception the approach of these studies is chronological and biographic rather than thematic, with no attempt to synthesize or create a larger conceptual framework. Insanity historiography has linked change to medical or scientific concepts. To this end changes in ideas, or medical approaches are examined through the role of key individuals. However, insanity can not be expressed solely through individual logic or initiative, nor through internal professional theory. For the reality of insanity is that it exists within society:

Every society recognizes certain forms of aberrant behaviour as mental derangement or insanity. In other words, along the range of human behaviour, from that which a society considers normal to that which it regards as abnormal, there is some point or section at which a social judgement is made and an individual comes to be regarded as mad. Thus, changing insanity conceptions reflect social assumptions and become a means of understanding society.
The changing nature of insanity terminology also expresses the conceptions of insanity. Terms such as "lunatic", "mad", or "mentally diseased" convey particular perceptions. To be a lunatic conveyed a sense of powerlessness, to be susceptible to outside influences such as the moon. To be mad suggested an unreasonableness, to be explained through individual physiology. While to be diseased implied an impaired condition to be intervened upon by medical personnel. While these are not the only terms ascribed to insane individuals, nor the only perceptual consequence, they do serve as a basis for accessing the conceptual framework of insanity.

The reality of insanity, based upon changing social perceptions, is also reflected in the changing means of intervention. Insanity historiography often cites the changing relationship between sane and insane as a sign of progress. Therefore, the history of intervention from the ignored, wandering lunatic to the cared and treated institutionalized patient implies a sense of humanitarian progress. However, the reality of insanity is not solely based upon humanitarian intervention. For within the scope of interventive methods, the relationship between society and insanity exists. The relationship had a changing interventive consequence, direction, and impact, but the relationship was always divisive.

Legal and medical practitioners and their associations, as well as reform associations act as agencies of social perception. They also act as agents of intervention. Laws codified societal conceptions of insanity. They offered a means of defining the insane individual and afforded a way of intervening on behalf of society. Medical practices also defined the constructs of insanity and through procedures or treatment offered a means of intervention. Reform associations, through their advocacy platforms also provided an insanity definition, while at the same time ensuring the continuation of intervention. Thus, the history of insanity becomes related to the methods of intervention. And, in this relationship of intervention, the act of defining and managing insanity reflects directly upon society. For intervention provides a
means of understanding how others were treated while at the same time reflecting how society views itself.

The reality of insanity lies in its ability to cause a societal reaction. Laws which liberated the insane in revolutionary France competed with ordinances linking insanity to beastial destruction. For the most part the modern conceptualization of insanity as irrational, violent or hallucinating behaviour created a conception of insanity as dangerous. The reaction to this conception resulted in management techniques:

...violence met by violence, hyperactivity was met by restraint, wakefulness was dealt with by hypnotics.

Thus, the history of insanity encompasses aspects of action and reaction.

Yet, to express insanity solely as action and reaction limits insanity conception. The concepts of insanity expanded from those based upon overt bad behaviour to include covert perceptual beliefs. Insanity as expressed by the raving lunatic of the eighteenth century grew to encompass the dangerous crowd in the nineteenth century. Twentieth century events such as World War I “shell-shock”, or immigration provided an opportunity for insanity to include the trauma induced by environmental stress. At the same point insanity became perceived as a social problem, the root of political turmoil and the basis for social instability and maladjustment. In such a manner, the concept of insanity acted as a panacea for both real and imagined social concerns.

This expansion of insanity from visible behaviour to invisible threat allowed the perception to flourish that the insane, besides being dangerous, threatened societal progress:

Experience, however, proves that the educated classes, the busy, strenuous men of affairs who propel forward at such a rapid pace the great industrial, commercial and social forces in the world, do not figure prominently in our asylum statistics. It is abundantly proven that the mass of the registered insane come from the uneducated lower stratum of the people, the raw material as it were of society - the class whose brains are not developed by intellectual effort.
While this concept of insanity as a curtailment to progress had been formulated from nineteenth century social Darwinism, it also shows how the methods of intervention may be perceived not solely as reactive. Instead, the methods may be viewed as a means of domination, a way by which one group is made to yield to the authority of another.

Some historians of insanity have examined the means by which the concept of insanity came to be used as an instrument of domination. Klaus Doerner has examined the eighteenth century relationship of insanity and society as the manifestation of the visible poor lunatic. Thus, insanity was represented by, and representative of, society’s outcasts. The unreason of the insane being related to social rationality. This aspect of insanity as a challenge to rationality has led Michel Foucault to conclude that the concept of insanity was created by civilization. The insane were perceived as idle, poor, unable to contribute economically and unable to integrate within the group. Thereby confinement came to manifest a social conception of the insane as being a non-being.

The psychiatrist Thomas Szasz also agrees that insanity was created. But unlike Foucault, Szasz does not see the creation as a means to silence a particular group. Instead the concept of insanity came to serve a functional purpose similar to witchcraft. Insanity thus becomes a means of societal delineation and allows for permissive methods of intervention:

...the victims are harassed by the majority not because they engage in overtly aggressive or destructive acts, like theft or murder, but because their conduct or appearance offends a group intolerant to and threatened by human differences.

Therefore, the means of intervention were not based solely upon humanitarian principles of helping or healing. Instead, intervention became a means of controlling behaviour and disseminating societal values.

The ability of insanity conceptions to both define and to exclude the individual provides an insight into how society controls the uncontrollable. The legal approach has primarily focused on ways to contain the social
transgressor. Individuals who challenged social stability, who committed acts of violence, were dealt with through the legal system. The transgressor could be executed, banished, humiliated, or confined. In instances of confinement, a holding cell with or without restraining mechanisms or a jail built primarily to confine became the means of legal intervention. The loss of liberty associated with legal commitment was justified by the legal intent to protect society.

Similarly, the legal intent and intervention techniques have been applied to the insane individual. The treatment afforded the insane varied little from the social transgressor. Although insanity history attempts to forge a historical link between insanity and a humanitarian hospitalization, the reality of the legal approach to insanity has rested upon the containment or confinement of the individual. To this end, the insane and criminal were confined together and perceived to be the same.

The social conception of the insane as “dangerous”, “wild”, or “beast-like” was developed and reinforced through the legal means of intervention. Confined in cells or cages, the insane were exhibited and taunted into displays of aggression. Chained to the wall or floor, they were observed to be powerless. Thus, a conception of the insane as dangerous to society and in need of forceful, authoritarian restraint emerged and expanded.

To a certain extent these conceptions of dangerous and in need of authoritarian force have persisted. In Saskatchewan, the method of commitment and the means of confinement as exemplified in The Insanity Act of 1906 reflect this concept. A warrant would be issued to confine the individual deemed to be dangerous in the safe custody of a jail while awaiting a judicial hearing. Although subsequent Saskatchewan statutes would delete the term “dangerous”, the perception persisted that the insane were transgressors. Thereby, the law continued to recognize the insane as stepping beyond societal standards. Through societal comparison, the legal system is able to control or manage insanity.
As an agent of intervention, medicine has played a key role in defining the concept of insanity, as well as providing a basis of conceptual expansion. The medical interest in the insane centers upon the desire to find the underlying causation factor. At the same time, the medical discovery of causation would lead to conceptualizations of insanity, thereby offering a means of control.

Unlike law with its emphasis upon the individual transgressor, medicine sought to define the laws of general human health or illness. To this end, the individual was examined with respect to physiology, subtle signs were explored, and the body's external formation prodded in an attempt to understand physiology and functioning. Accumulated information contributed to the explanation of "normal" and "abnormal", to a system of diagnosis and prescribed solutions, and eventually to a concept of disease etiology.25

The medical approach to disease theory revolved around recognition of a symptom or syndrome and the discovery of an underlying biological cause.26 In the area of insanity, a similar approach was employed.27 By the seventeenth century abstracted signs and symptoms were accumulated by Thomas Sydenham and coordinated through empirical methodology. His book, Epistolary Dissertation on the Hysterical Affections, described the nature and cause of hysteria, but more importantly provided a concept of "disease" as an entity in itself.28

The concept of disease ushered in scientific empiricism and essentially ended the theological conception of insanity.29 Insanity was no longer the manifestation of demon possession, nor divine intervention. Instead, the cause of insanity became linked to physiology. Spinoza's tenet of the mind and body being inseparable was employed by eighteenth century physicians. The brain was explored for evidence of destroyed matter and autopsies were performed on deceased insane for evidence of brain lesions. When evidence of destroyed matter could not be found, the explanation given was the lack of medical technology.30
The conception of insanity as a physical or somatic disease also allowed for a variety of treatment procedures. The body was bled or purged to lessen bodily tension, baths were employed to reduce fevers, and fevers brought on to purge the body of the disease. The physicality of treatment methods complied with the perception of the insane as being immune, as being physically impaired. Medical intervention sought to bring about an equilibrium and thereby restore sanity. However, the same method of intervention to bring about equilibrium complied with a conceptual belief that the insane were not balanced, not equal, and in need of medical intervention to restore the balance.

This medical perception of the insane as not equal and in need of physical treatment resulted in various management techniques. In order to manage the constructs of insanity, physicians worked towards a more refined system of classification. By the eighteenth century terms such as “melancholia”, “mania”, or “madness” came to signify stages:

Mania usually referred to violent behaviour.... When they were calm, these patients might be placed in another grouping, such as ‘monomania’ if their characteristic symptom was mental derangement on one or a few subjects. If they reverted to violence, they were again considered maniacal. Cases in which sadness and depressed feeling predominated would be classed as ‘melancholic’; a patient suffering from melancholia might, if he became active and forceful, be called a maniac.

This classification of insanity provided a means by which the physician could understand the concept of insanity. It afforded a means to define a behaviour and offered a way, at least psychologically, to control the phenomena of insanity and make the uncontrollable, dangerous lunatic harmless.

The classification of insanity into separate somatic diseases also expanded the method of treatment. The physicality of treatment, the confinement of the insane in holding cells and the resulting neglect challenged social sensibilities. In Britain, a Yorkshire magistrate described his visit to a series of cells finding them to be:

...in a very horrid and filthy condition...the walls were daubed with
excrement; the airholes, of which there was one in each cell, were partly filled with it. I then went upstairs... into a room... twelve feet by seven feet ten inches, in which there were thirteen women who... had all come out of those cells that morning... I became very sick, and could not remain any longer in the room. I vomited.34

Crowded, neglected conditions of confinement had been afforded the insane. The pauper lunatic, unable to pay for private home care was most often the recipient of the neglected holding cell.35

Medical concepts regarding classification did little to dispell the harsh, forced treatment imposed upon the lunatic. Nor did classification have an impact upon the societal perception of the insane as less than human. However, confinement conditions and the social status of insane individuals began to alter the intervention technique of overt authoritarian force.

In Britain, the mental breakdown of George III in 1788 and the inability of attending physicians to treat the disease36 ushered in both a new conception of insanity and a new method of intervention. Dr. Francis Willis, a clergyman, physician, and private asylum owner, was called in to treat the king. Willis attributed the breakdown to strain and ordered isolation.37 The treatment of isolation, breaking of the will through the threat and employment of physical restraint effectively brought about a recovery.

Willis' method of breaking the will power and thereby controlling the patient expanded the perception of insanity. It showed that technique held the means of effecting a cure. The physician was in a position of absolute power, even above a king.38 Willis' technique also showed that the insane could be appealed to, that reason and reasonable force was an applicable managerial tool. His directive of isolation focused treatment on the individual, and his assessment of "strain" provided a functional explanation for insanity causation.39

The concept of insanity as functional led to the investigation of various predisposing conditions such as family history, upbringing, and lifestyle. At
the same time, Britain's emerging industrial society began to focus attention on the dignity of man and the dignity of work. The animal or beast-like quality of insanity was replaced with the perception of the insane being sensitive, especially to external conditions and personal experiences. Due to changing social conceptions and the success of Willis' management technique, it became apparent that the insane could be transformed.

Insanity historiography has termed this changing conception and mode of treatment as “moral treatment”:

...instead of merely resting content with controlling those who were no longer quite human, which had been the dominant concern of traditional responses to the mad, moral treatment actively sought to transform the lunatic, to remodel him into something approximating the bourgeois ideal of the rational individual.

The means of remodeling and the method of treating was in opposition to past displays of physical restraint and crowded, neglected conditions.

In Britain, William Tuke convinced his Quaker community to establish their own madhouse. Tuke's York Retreat opened in 1796 and operated on principles meant to lessen the perception that the insane were to be confined. The Retreat offered an aesthetically pleasing location and construction. Those at the Retreat were not to be idle, but encouraged into activity so that mind and bodily health could be restored. The Retreat acted as a therapeutic community creating a psychological, social, and physical environment in which Tuke acted as both administrator and father figure in guiding the insane back to sanity.

The Retreat provided a model for managing insanity. Restraining mechanisms were replaced by internal self induced restraint. The insane individual was to submit to the father figure who had his best interests at heart. A type of family authority combined with religious principles resulted in techniques of gentle persuasion in which the individual became responsible for his own restoration or for his own punishment. This conception of individual responsibility had as its basis the societal perception
that individuals had great powers of self-control and self improvement. As well, individual powers of self restraint created and complied with a perception that insanity could be mastered. Ironically, the insane individual perceived as socially irresponsible was considered to be responsible for his own transformation to sanity.

Moral treatment as exemplified by the Retreat provided a societal perception as to the nature of insanity and the means of intervention. The location of the Retreat, isolated in a rural setting, complied with a conception of insanity being caused by chaotic social progress. It offered, as its name suggests, a place to escape. Its influence extended to France, the United States and Canada where increasingly the technique of moral treatment came to be viewed as a means of curing insanity. By being able to return the insane individual to the social community, moral treatment eroded the perception that only medicine had the means of curing. Instead, the technique of authoritarian power could be applied by physician and layman alike.

Moral treatment provided the perception that location and management could cure or restore sanity. In 1811 Dr. T.R. Beck of New York expressed the ideas of managing insanity:

This consists in removing patients from their residence to some proper asylum; and for this purpose, a calm retreat in the country is to be preferred; for it is found that continuance at home aggravates the disease, as the improper association of ideas cannot be destroyed. A system of humane vigilance is adopted. The rules most proper to be observed are the following: Convince the lunatics that the power of the physician and keeper is absolute; have humane attendants, who shall act as servants to them; never threaten but execute; offer no indignities to them, as they have a high sense of honour; punish disobedience peremptorily, in the presence of the other maniacs; if unruly, forbid them the company of others, use the strait waistcoat, confine them in a dark and quiet room, order spare diet, and...tolerate noisy ejaculations; strictly exclude visitors, let their fears and resentments be soothed without unnecessary opposition; adopt a system of regularity:...When convalescing, allow limited liberty; introduce entertaining books and conversation, exhilarating music, employment of body in agricultural pursuits,...and admit friends under proper restrictions....Forbid their returning home too soon. By thus acting, the patient will 'minister to himself'.

\[51\]
The optimism inherent in moral treatment, its seeming ability to cure, was dependent upon location and the power of the authoritarian figure. However, these two factors were a source of concern. The place of escape, as well as the method of treatment needed to be justified to society.

The idea of committing a family member to an insane institution was not popular, nor was the institution considered to be the ideal place to treat the insane. However, the proliferation of professional associations as well as the concept of "professional" helped alter public opinion.

The concept of professional care for the insane was essentially and effectively challenged by Tuke's presence at the York Retreat. Yet by the 1830s the public mental hospitals in Britain had resident medical directors and by 1845 were required by law to have medical records of treatment for each resident. The re-emergence of the medical practitioner into the field of insanity care has been examined by the sociologist Andrew Scull. By promoting the moral treatment technique as an "art", by citing the home environment as nurturing insanity, and by perceiving insanity as a "disease" and not a condition, Scull contends the medical practitioner was again perceived as the person best suited to provide care. Even though medical practices such as bleeding and cathartics were either useless or harmful, terms such as "patient", "treatment", "hospital" and "cure" conveyed a sense of caring medical knowledge and expertise. The medical practitioner was perceived as a professional and through association and published journals able to continue the perception. That practitioners had little training in insanity did not seem to be a concern.

Reasons for a lack of social concern regarding the guardianship of the insane in the nineteenth century are attributable to several factors. The optimism of a cure created by the technique of moral treatment carried over into the field of medicine. Dr. Willis' contention that he was able to cure nine out of ten patients created an overblown optimism. By 1843 the "cult of
curability” reached its pinnacle in the United States when Dr. William Awl of the Ohio State Lunatic Hospital claimed a recovery rate of 100 per cent.⁵⁶ Although curability was later challenged for abusing the term “recovered”, and being unable to actually provide a cure in light of statistics showing institutional growth,⁵⁷ the layman’s claim to the expertise of moral management had been eroded. Increasingly the influx of incurables, such as the chronic or old, represented a large proportion of those being confined at the institution.

While Tuke’s Retreat had initially relied upon community generously, subsequent institutions were not so fortunate. Institutional reports which essentially acted as brochures,⁵⁸ and careful consideration to institutional architecture could not sustain paying families nor large government subsidies in light of their inability to cure. Increasingly the family environment exemplified by the Retreat gave way for reasons of economy to large, regimented institutions in which the routine became custodial care. By the mid-nineteenth century “moral treatment” meant little more than efficient management.⁵⁹

Insane institutions which originated in opposition to the neglect and confinement of the jail, became isolated entities. Superintendents were chastised for their inability to delve into the causes of insanity and for their inability to see beyond their own walls:

The cloistral lives you lead give rise, we think, to certain mental peculiarities. I could tell you how to mend them; I shall by and by. You hold to and teach certain opinions which we have long learned to lose. One is the superstition (almost is it that) to the effect that an asylum is in itself curative. You bear the regret in every report that patients are not sent soon enough, as if you had ways of curing which we have not. Upon my word, I think asylum life is deadly to the insane. Poverty, risk, fear, send you of true need many patients; many more are sent by people quite able to have their friends treated outside. They are placed in asylums because of the wide-spread belief you have so long, and, as we think, so unreasonably, fostered to the effect that there is some mysterious therapeutic influence to be found behind you walls and locked doors. We hold the reverse opinion, and think your hospitals are never to be used save as the last resource.⁶⁰
The mediating role in which superintendents found themselves was criticized. Their position as medical superintendent and political appointee was precarious and dependent upon favourable visitations and efficient management. Annual reports and institutional statistics were suspect:

That you depend for sympathy, intelligent help, and even your livelihood, on the continued good-will of bodies thus made up is a grave evil. It leads to this need to manage the manager, to want of decision, to rose-colored reports, to deference to potent trustees as to your minor appointments; Although insane institutions and institutional superintendents adopted the language of medicine, the institution was not perceived as a hospital.

The concept of insanity would always be a separate entity for medicine. Although a medical practitioner would define insanity as a disease and through classification become perceived as manageable, the subjective nature of defining as well as the relationship between medicine and society ensured that insanity would continue to be perceived as divisive and an impediment to progress.

The perception of insanity involved a judgement that could be stretched to almost infinite proportions. However, in order to justify intervention, society was dependent upon scientific laws. In the early nineteenth century, the social appeal of phrenology lay in its seeming ability to solve the problem of insanity causation. Although later discredited, for among other reasons, its inability to explain autopsies which showed no physical damage, its influence extended beyond scientific inquiry. In phrenology, existing social beliefs were able to be codified into scientific laws.

Just as phrenology acted a societal legitimizer, so too did the subsequent study of eugenics. Mendelian laws of dominant and recessive genes appeared to explain the problem of feeblemindedness and insanity. Family studies undertaken in the early twentieth century linked social problems to mental degeneration. The eugenic solution was to encourage the biologically and socially acceptable individual and discourage the inferior and subnormal. In Canada, the province of Alberta enacted a sterilization bill entailing
family consent and governed by an appointed government board. As in the case of phrenology, scientific laws provided the rationalization for societal concerns and intervention.

Science explored the relationship of insanity to alcohol, to fevers, and to microbes such as syphilis. The body's arteries were examined for their effect on the brain, and the subtle changes of old age explored. Physicians were told to study the endocrine system and chronic infections, or germ-plasm and injury inflection as a means of ascertaining the nature of insanity. However, increasingly medicine and society began to employ the concept of Darwinian heredity as a factor for insanity causation.

Darwin's laws of hereditary inheritance helped explain some of the problems associated with insanity and appeared to offer an explanation. Heredity became perceived as both a means of preventing disease and a way to promote health. Problems in providing an institutional cure were explained by superintendents to be the result of inheritance. In Saskatchewan, Dr. J. MacNeill, medical superintendent of North Battleford asylum and former provincial legislative member for Hanley, stated the problem of heredity as an institutional and social concern:

It is unfortunate that in the past insane people have been shunned and despised because insane; today our sympathy is extended to them as never before, because we realise that to a great extent our patients are as they are because of what their ancestors were. The curse is only being visited on this the second, third, fourth or later generation, and shows itself in the physical and mental shipwrecks we care for in hospitals for the insane, and tolerate at large, not because they are ineligible for such institutions but because the wise step appears so drastic. The day is coming when the misfits at large will be so restrained that it will be impossible for them to continue deceiving an unsuspicious public, a crime doubly black because of the whitened-sepulchred face these misfits commonly present.

This concept of hereditary insanity as representative of society's "misfits" and acting as agents of deception allowed for two methods of intervention. Society could legally intervene as it did in Alberta to prevent further degeneration, and it could put into place practices which further decreased
the possibility of transmission. To this end, studies were undertaken to show a correlation of insanity with a particular ethnic group. Although these studies could not substantiate restrictive immigration on the basis of ethnic insanity alone, they did serve to propel the issue of nationality and insanity into a socially legitimizing concern. As well, the concept of hereditary "misfits" provided the institution with a reasonable excuse for its inability to cure. Therefore, instead of questioning its own ability, the institution proceeded to view itself as the place suited for adapting the insane.

Occupation or work "therapy" cited in institutional reports conveyed a perception that the insane were employable and that the institution had the means of transforming:

The work-cure does away with the idleness which used to be the bane of the mental hospital, permitting patients to deteriorate and to become involved in all sorts of useless or harmful activities.

More importantly, the work therapy offered a visible means of showing improvement. It mattered little what form the therapy was to take. What became important was that the institutional treatment was perceived to be curing. Insanity historiography has examined the role of occupation as an institutional therapy. As a method of therapeutic intervention it has been found lacking. However, as a method of internal, efficient management and as a means of exemplifying submission to authority, the work therapy program was successful:

One lesson which can be derived from the history of institutional care of the mentally ill is that human beings are molded by whatever authority they respect and that ideas about human beings of authoritative origin eventually influence human behavior in a direction which confirms the authoritative idea.

In an era of decreasing funds occupational therapy offered an economic solution. As well, it verified the authority of the superintendent and the role of the institution as a controlling force.

The history of insanity, of intervention, and of insane institutions is often that of rationalization. Yet it is a rationalization of opposition. Insanity historiography applauds the role of medicine in classifying and categorizing
insanity. This "medical model" approach to insanity cites the expansion of insanity constructs from observable behaviour to invisible threat as a progression of human understanding. Although it cites past attempts at medical intervention as barbaric, the question remains as to the assessment of current therapeutics. Does hydrotherapy represent improvement from the canvas muff? Does the inducement of a coma imply a progression from the narcotic? Proponents of a "societal reaction model" would reply in the negative. Their studies would point out that intervention serves only one purpose - to control. Therefore, the only purpose in the concept of insanity is its rationalization to divide. The stigma associated with being perceived as insane ensures societal conformation and essentially becomes a means of social verification.

The two approaches to insanity, its existence as an entity or its creation as a submissive tool represent two polar extremes. Perhaps the concept of insanity should be somewhere in the middle. Insanity represents something that is incomprehensible, that challenges individual reason. Therefore, the way to understand it is through a study of the intervention agencies of law, medicine, and society. Each agency has defined insanity and incorporated it into its own perception.

The reality of insanity lies in its subjective nature. Yet, it is this fluid structure that allows "insanity" to mean what it does. Insanity conveys different concepts at different times. The release from being perceived as insane is also subjective and the conception of "cure" or institutional "discharge" will also show changes over time.81

While the history of insanity shows changing societal conceptions, the history of insane institutions has remained constant.82 The insane institution has been chastised for its inability to cure and for its belief in itself as a means to cure. Perhaps the condemnation of insane institutions is that it produces a lifestyle foreign or alien to societal expectations. The terms
"institutionalism" or "disculturalization" have entered the language of insanity and essentially act in opposition to a social conception of "liberty".

Perhaps institutional condemnation lies in the physical presence of the building. Built of brick and steel the edifices seem unpenetrable. They convey a sense of permanence, of belonging to a social history. Perhaps the condemnation lies in their location. Unlike institutional construction in the 1950s and 1960s which emphasized community location, the historical institution tended to be geographically isolated. Perhaps the inability of the institutions to provide a cure rests in their internal structure. A structure which while amenable to supervision and management was not conducive to the resident. Or, perhaps the condemnation of the institution lies in a societal conception that the institution can do more than confine, that it can cure. If this is the case then, like the concept of insanity, the institution has become a panacea, attempting to be all for those social agencies who have used it.

A history of insanity can examine these and other questions. It can provide an insight into how insanity was perceived and thereby how society viewed itself. The history of insanity can explore ways in which society is divisive and ways it is in agreement. It provides a means of ascertaining not what insanity and society should be, but what it has been.

This thesis attempts to examine the conceptions of insanity over a particular period of time. It will examine the ways in which law, medicine, and society viewed the insane individual and also explore the manner in which the institution complied or digressed from these views. To this end, the thesis will examine various conceptions and controlling techniques in practice between 1914 and 1945 at Saskatchewan Hospital, North Battleford.

Although a time frame of thirty-one years would in itself show change, the time frame was initially selected for specific reasons not related to change. In the first instance, Dr. MacNeill was the only superintendent at North
Battleford from its opening in 1914 to his retirement in June, 1945. His work on behalf of the insane, and his efforts to provide institutional care was recognized as commendable. Institutional surveys undertaken during Dr. MacNeill’s tenure as superintendent and Mental Hygiene Commissioner consistently cite his services:

Under the leadership of the Mental Hygiene Commissioner who has recently retired, great advances were made in abolishing physical restraint, barred windows and objectionable airing courts; in strengthening arrangements for occupational therapy, hydrotherapy, recreational therapy, shock therapy and neurosurgery; in providing excellent arrangements for tubercular patients; and in creating a hospital atmosphere conducive to recovery.83

In order to ascertain institutional practices, Dr. MacNeill’s annual reports were a valuable source of information. As the sole author between 1914 and 1945, these reports show a changing tone and content. Early reports which explained the nature of insanity, institutional means of intervention, and essentially lectured the provincial government as to their responsibility, gave way to curt reports citing the need for more space and essentially begging the government’s indulgence.

A second factor in choosing the time frame 1914 to 1945 was the need to ascertain the changing management techniques. Although legal conceptions regarding insanity existed prior to 1914, they changed significantly in the 1940s by citing insanity treatment as an “entitlement”. As well, the medical conceptions of insanity and management underwent significant changes. A factor which contributed to legal and medical changes was the Mental Hygiene movement. Their proposals for “mental health” and their surveys of institutional practices placed pressures upon the institution to conform and comply with Mental Hygiene principles. Their Saskatchewan surveys conducted in 1920, 1929, and 1945 would shape a societal, governmental, and institutional perception of insanity and management.

In order to examine insanity conceptions and their impact on North Battleford, this thesis has used a variety of source material. Legal statutes
and medical text books and journals have been utilized. As well, newspaper accounts and periodicals have been consulted as a means of examining how conceptions of insanity and management were conveyed to the provincial resident. Government reports, when available, have been employed as well as various secondary source material. Institutional case-books have not been used. The scope of this thesis does not warrant an examination of individual case histories, nor is it meant to be an expose of institutional abuse directed toward the individual. The scope of this thesis is an examination of insanity conceptions and their impact, on an institution and on public perceptions of insanity. To this end, material which would be available to the public has been utilized.

An insanity history has inherent difficulties. In the first instance, medical terminology and conceptions regarding etiology are often beyond the knowledge of the non-medically trained. To this end, a variety of sources often need to be consulted. This thesis has employed a variety of medical sources in an attempt to examine insanity conceptions at a particular time. As well, interviews with medical personnel and those currently working with the insane were undertaken. A second difficulty experienced was in the area of government reports. Individuals from the Saskatchewan Archives were helpful and supportive in attempts to locate original material. However, some original reports cited by secondary sources could not be found. A memo sent by Battleford residents to Premier Scott could not be found by the archivist, nor was a search of newspapers helpful. Also, recommendations made by Dr. Low in February, 1907 as to institutional construction were not found. However, portions of Dr. Low's recommendations appear in a newspaper account of Battleford's institutional construction in December, 1911. Despite the best efforts by the archivists, the unavailability of these reports has necessitated their insertion as a footnote. A third difficulty experienced in this thesis was the publication of institutional statistics. Statistics, by nature are fraught with pitfalls, and institutional statistics are no exception. Yearly reports did not consistently cite the same material, and
the nature of cited material would alter. In the case of foreign admissions, institutional statistics showed a change from equating the concept of "foreign" as an origin of birth, to equating it to the nationality of the resident.

The difficulties experienced in examining insanity conceptions are not unique to the area of insanity, nor should they dissuade. There have been problems encountered in the writing of this thesis. However as a means of understanding societal change, insanity history like the concept of insanity and perception of insane institutions expresses a panorama of societal judgements, concerns, and values.
FOOTNOTES

1. The traditional and revisionist interpretations of insanity historiography have assessed the institutions as containing flaws and imperfections and have characterized the institutions as failing to achieve their purpose of treatment (Gerald Grob, "Rediscovering Asylums: The Unhistorical History of the Mental Hospital," in The Therapeutic Revolution Morris Vogel and Charles Rosenberg, eds., [Boston: The University of Pennsylvania Press, 1979], p. 138).

2. Thurber’s short story is of a man who told his wife about seeing a unicorn in the garden. Knowing the unicorn to be mythical, the wife then phoned the authorities to remove her husband to an insane institution. When they arrived, she told them what her husband had said. The authorities too recognized the unicorn as a mythical beast and when the husband concurred that the unicorn was a mythical creature, the authorities removed the wife. Thurber’s short story first appeared in The New Yorker magazine and is reprinted in Thomas Szasz, The Age of Madness (New York: Jason Aronson, 1974), pp. 278-279.


4. The emphasis placed on key individuals as a means to explain changing conceptions and ideas has resulted in the history of medicine being related to intellectual history and the history of science (Gerald Grob, “The Social History of Medicine and Disease in America: Problems and Possibilities,” Journal of Social History X, [June, 1977], p. 394).


6. In Tudor England, wandering vagrants and beggars were the “Abram-men” or “Toms o’Bedlam”. These were individuals, sometimes not entirely recovered, who were discharged from Bethlehem Hospital and were licensed to beg. By 1675 this license to beg was revoked due, in part, to the large number of imposters (Rosen, Madness in Society, p. 153). In the early twentieth century, reports often cited the institutionalized individuals as “inmates” (J.W. MacNeill, “Mental Hygiene in Saskatchewan,” The Bulletin IV, [November, 1929], p. 3).
7. This concept of therapeutic change as indicative of progress has as its corollary, the emergence of the medical profession. The relationship of belief and behaviour between physician and layman can be found in Charles Rosenberg, "Medicine, Meaning and Social Change in Nineteenth Century America," in The Therapeutic Revolution, Morris Vogel and Charles Rosenberg, eds., (Boston: The University of Pennsylvania Press, 1979), pp. 3-25.


9. In France, Article 3 of the ordinances issued between August 16 and 24, 1790 made communal administrations responsible for damages or harmful incidents caused by released insane. The same provision also applied to stray, destructive and dangerous animals (Klaus Doerner, Madmen and the Bourgeoise [Oxford: Basil Blackwell, Publishers Limited, 1981], p. 121).


19. Szasz states that he agrees with Sigerist in that psychiatry developed as the persecution of witches declined. However, he does not see this as a result of heretics gradually being found to be insane. Instead, Szasz views the development of psychiatry as a transformation:

   I say it happened because of the transformation of a religious ideology into a scientific one: medicine replaced theology; the alienist, the inquisitor; and the insane, the witch. The result was the substitution of a medical mass-movement for a religious one, the persecution of mental patients replacing the persecution of heretics.


21. In *The Mind of Man*, Bromberg has assessed insanity treatment as a type of universal truth in which "mental healing started as a self curative process, moving by extension to others whose difficulties were recognized as familiar" (Bromberg, *The Mind of Man*, p. 7).

22. In the preface of *World History of Psychiatry* mental hospitals have been cited as a means of treating insanity since the eighth century. The preface then goes on to show medical hospitalization of the insane in various world regions from the eighth to thirteenth century (Howells, *World History of Psychiatry*, p. xiii). However, in *Madness in Society* the role of the early hospital has been equated to a facilitator of social order, a place to house the sick and needy (Rosen, *Madness in Society*, p. 159).

23. In the 1700s the curious could still by a ticket to visit the wards of Bethlehem Hospital and observe the antics of the insane.

25. In the late eighteenth century, the Baconian conviction that scientific laws could be derived from the collection and analysis of information influenced medical procedures. It was felt that diseases could be classified in much the same manner as plants, that is through genera and species. The classification, dependent upon similar characteristics, was felt to provide a clear and precise definition. In turn, a precise definition would lead possibly to the identification of factors which contributed to health or to illness. When unable to find the inner cause of the disease, physicians then examined external symptoms in order to assess causation (Grob, “Rediscovering Asylums:,” in The Therapeutic Revolution, pp. 140-141). This premise is reiterated in Gerald Grob, “The Social History,” Journal of Social History X, pp. 402-403).


27. In Egypt the female hysterical was perceived to be hysterical due to the malposition of the uterus, means were employed to coax the uterus back to a natural position (Alexander and Selesnick, The History of Psychiatry, p. 21). In Elizabethan England, incidents of melancholy were ascribed to be the result of black bile produced by the spleen (Vieda Skultans, English Madness: Ideas on Insanity, 1580-1890 [London: Routledge & Kegan Paul, 1979], p. 20).


29. The theological conception of insanity as demon possession led to practices of exorcism or torture to drive out the demon. This theological conception and treatment of insanity has been cited as giving rise to the fanaticism experienced in European witch hunts in the seventeenth century (Benjamin Braginsky, et. al. Methods of Madness [New York: Holt, Rinehart and Winston, Inc., 1969], p. 178).

30. In the beginning decades of the nineteenth century, the perception existed that insanity was the result of a diseased brain. If autopsies showed no actual physical changes in the brain, then it was cited that skills were still too crude to ensure accurate results (David Rothman, The Discovery of the Asylum [Boston: Little, Brown and Company, 1971], p. 110).

31. Somatic diseases are those in which an abnormal brain condition produces psychological symptoms. The etiology might be organic or functional but the pathology was somatic (Norman Dain, Concepts of Insanity in the United States, 1789-1865 [New Brunswick New Jersey: Rutgers University Press, 1964], p.16).

32. Dain, Concepts of Insanity, pp. 6-7.
33. The desire to control the unknown or harmful aspects of nature has been characterized as a fundamental component of scientific laws. Thereby scientific laws allow nature to be harnessed and harmless (Doerner, Madmen, p. 4).


35. Scull, Museums of Madness, p. 53.

36. His insanity may have been the result of a rare metabolic disorder called porphyria (Skultans, English Madness, p. 10).

37. It has been speculated that the acute form of his attack may have already run its course when Dr. Willis arrived (Doerner, Madmen, p. 74).


39. The concept of “functional” was used in cases where organic brain lesions could not be found. This explanation was more readily adopted in the nineteenth century.

40. By the eighteenth century, the belief that emotions represented the animal instincts and were therefore to be extinguished, had become reassessed. This change in perception regarding “passion” has been attributed, in part, to an intellectual change from the Stoics conception of “tranquility” to the Aristotelian conception of passion as the promoter of action and genius (Skultans, English Madness, p. 52).

41. Scull, Museums of Madness, p. 69.


43. Activity or work provided an intrinsic benefit as well as providing the institution with the labour needed to operate. Work also acted as a “constraining power”, allowing the insane individual to be judged on the basis of contribution (Foucault, Madness, p. 247).

44. The “community” as exemplified by the Retreat has been likened to a milieu therapy program (Dain, Concepts of Insanity, p. 13).

46. Work and recreational activities, such as a tea party, were also a means by which the behaviour of the insane would be observed and judged in accordance to societal standards of behaviour (Foucault, *Madness*, p. 249).

47. The conceptual link between irrationality and insanity were seen to be as a result of the separation of man from nature. This then was seen to result in a deranged sensibility (George Rosen, *Madness in Society*, p. 170).

48. While the Retreat acted as an escape from industrial society, the cause of insanity was not perceived to be the result of social changes but due to individual character faults in that the person could not adapt (Doerner, *Madmen*, p. 81).


50. In the United States, proponents of moral treatment viewed it as a technique of common sense and sympathy and thereby not solely within the field of the medical practitioner. The first American institutions practicing moral treatment tended to provide their services mainly to the wealthy (Dain, *Concepts of Insanity*, p. 51). In Canada the technique of moral treatment was employed at various institutions during the 1840s and 1850s.


52. The optimism inherent in “moral treatment” was that it implied technique was able to bring about a transformation, that the individual had powers to combat insanity. Within society, the perception existed that the individual could make his own way and overcome adversity (Skultan, *English Madness*, p. 65).


55. Associations and association journals provide a valuable means of understanding both the profession and society (Shortt, “Antiquarians,” p. 7).

56. The phenomena of curability in the United States began around the second quarter of the nineteenth century. The phrase “cult of curability” was developed by Albert Deutsch in his classic study of insanity. For a discussion of the phenomena of curability see Albert Deutsch, *The Mentally Ill*, chapter VIII.
57. Dr. Awl, often referred to as Dr. "Cure-Awl", based his statistical ratios on discharged patients, not on admissions (Deutsch, The Mentally Ill, p. 153). A patient was counted as "recovered" whenever discharged. This meant that the individual could be admitted numerous times throughout the year and be counted as "cured" for each discharge (Deutsch, The Mentally Ill, p. 156).

58. Institutional reports of the nineteenth century promoted the institution as a treatment center and in such a manner acted as a brochure to attract and inform the reader (Nancy Tomes, "A Generous Confidence: Thomas Story Kirkbride's Philosophy of Asylum Construction and Management," in Madhouses Scull, ed., p. 125).


61. Institutional visitations were described by Mitchell as a charade in which everyone played out their expectant role (Mitchell, "Address," p. 420).


63. Mitchell chastised the institutions for citing themselves as hospitals and pointed out that among other things the institutional physicians did not go through the wards with resident students (Mitchell, "Address", p. 414).

64. Although insanity would adopt the concept of "disease" as a causation factor, the field of insanity would continue to be set apart from that of medicine. Several factors, such as regulatory associations, medical training, and method of treatment, contributed to this isolation. As well, insanity terminology such as "alienist" bore the implication that insanity was alien or foreign from the rest of medicine (MacDermot, One Hundred Years, p. 188).

65. Current general classifications of insanity indicate the severity and nature of insanity. Under the International Classification of Diseases (I.C.D.), there are two types of psychiatric disorders. The term psychoses which includes such conditions as schizophrenic, paranoid, manic and depressive. The second type, the neuroses are represented by less severe conditions such as depressive, obsessional, hysterical, phobic, or anxiety (Wing, Reasoning about Madness, pp. 44-45).
66. The relationship between physicians and society has been cited to reflect prevalent social values and expectations, to lag behind the social values and represent past values, or to combine forces within society which lead to modification of values or expectations (Thomas Szasz, William Knoff, and Marc Hollender, "The Doctor-Patient Relationship and Its Historical Context," *The American Journal of Psychiatry* 115, [December, 1958], p. 528).

67. For an examination of phrenology as a societal legitimizer of beliefs and value judgements see Roger Cooter, "Phrenology and British Alienists, ca. 1825-1845," in *Madhouses* Scull, ed., pp. 58-104.

68. In order to explain autopsies showing no physical brain damage, phrenology would cite that the brain was "disordered" (Cooter, "Phrenology," p. 83).

69. This ability of phrenology to "shelter" existing beliefs and encompasses them into a quasi-scientific law was an important factor in its appeal (Cooter, "Phrenology," p. 78).


74. Dr. James Walter MacNeill was born and educated in Prince Edward Island. He studied medicine at McGill university and after a few years of medical practice in New Brunswick he left to settle in Hanley Saskatchewan in 1908. He was elected to the provincial legislature as the liberal member for Hanley. Dr. MacNeill was appointed superintendent of the North Battleford institution in 1913. He continued in this position until his retirement in June, 1945. He died at Saskatoon in July, 1945 following an operative procedure. Dr. MacNeill was the first Saskatchewan Commissioner of Mental Health Services, and he was also a grand master of Saskatchewan for the Masonic order.

76. Although studies undertaken by Professor Smith for the Mental Hygiene movement would cite the need for regulation and selection due to economic motives, the studies also pointed out that particular ethnic groups could not assimilate or hampered the economic prosperity of the Canadian worker. Thus, although economic prosperity was the rallying point for regulation, the implication became that of ethnic inferiority.


80. For an overview of drug therapy in the 1800s see Hall, One Hundred Years. Medical studies in the 1930s concerning the inhalation of carbon dioxide cited various levels at which the individual would succumb into a coma. Although some died as a result of the procedure, it was felt that the inducement of a coma was a valuable therapeutic procedure able to “change the mental activity and the conduct of certain patients very promptly.” (H.C. Solomon, M.R. Kaufman, and F. D'Elseaux “Some Effects of the Inhalation of Carbon Dioxide and Oxygen, and of Intravenous Sodium Amytal on certain Neuropsychiatric Conditions,” American Journal of Psychiatry X, [March, 1931], p. 765).

81. The institutional statistics regarding discharged as “cured”, “recovered”, or “improved” warrant examination in light of the institution's economic condition and its level of overcrowding. As well the pressures exerted upon the institution to be a treatment center, and its own internal belief as able to provide treatment may contribute to increased incidences of institutional discharges.

82. Insanity historiography whether stated as “medical model” optimism or “societal reaction” cynicism, is in agreement that institutions have failed as treatment centers (Grob, “Rediscovering Asylums,” p. 138).

83. C.M Hincks, Province of Saskatchewan Mental Hygiene Survey, 1945, pp. 9-10.
84. Saskatchewan efforts to confine the insane at provincial institutions and community centers is outlined in F.H. Kahan, *Brains and Bricks* (Regina: White Cross Publications, 1965). The author uses a variety of sources including primary reports and personal interviews. However, there is not one footnote in the whole book. In the case of Low's report or the North Battleford memo, dates are given. However, this was not helpful at the Saskatchewan archives. Although the book contains interesting interviews, there is also the premise that the past was "bad" and the present situation of community centers "good". These value judgements are also implicit within the book's discussion of institutional construction at North Battleford.
Chapter 2
CARE AND MANAGEMENT

The nineteenth century perception and treatment of the insane in Canada paralleled British and American developments. In Canada, the insane were cared for by family or friends, housed in private institutions, left to wander or, if considered dangerous placed in jails.

Just as Britain had sought relief from the social and economic problems caused by vagrant paupers and lunatics through legislation, so too did Canada. A 1759 statute established a workhouse in Halifax, and although it cited no special accommodation for the insane, it did allow consideration to be made for the retarded or physically incapacitated lunatic.

It was not until 1835 that Canada established an institution solely for the insane or retarded. An existing St. John hospital, which originally housed cholera patients, was converted to an insane asylum and by 1836 housed fourteen lunatics. However, the institution could not house all the insane. Dangerous lunatics were confined in jails and if need be chained. Elderly, chronic, or pauper lunatics were at times auctioned to individuals in the community. In Quebec, such auctions led to the “farming-out” system in which those caring for the insane were paid per annum per head.

The system of confining the insane at a specified “asylum” resulted in the specific supervision of the insane in a specific place. As with the American and British institutions, Canadian asylums carried on the practice of social isolation. Early Canadian asylums also suffered economically. The result was neglect and overcrowding.
Just as in Britain and the United States, the Canadian response to asylum excess was the technique of “moral treatment”. Medical superintendents such as Dr. James Douglas at Beauport Quebec cited “the quieting effect of fresh air and beauty” of the institution. Dr. Joseph Workman of the Toronto Asylum believed that patient freedom was an important component of insanity therapy. At the London asylum, Dr. Richard Bucke, practised the technique of moral treatment through non-restraint, the abolition of alcohol as a sedative, and the provision for occupation as a form of therapy. Within the institution's strictly controlled environment, Canadian medical superintendents felt insanity could be cured through technique and an appeal to the individual to affect transformation.

Social perception accepted both the optimism of cure and the validity of the asylum as the place suited to the needs of the insane. Yet, asylum isolation, medical treatment techniques, and the custodial form of institutional control or management continued to foster the social belief that the insane were different and dangerous. While superintendents were charged with the management of the insane, the government was responsible for the asylum. The Act of Union placed the government in control of public welfare institutions such as the penitentiary, reformatory prisons, and insane asylums. This grouping of government responsibility did nothing to dispell the social belief that the insane were dangerous.

The scope of government responsibility toward the insane continued to be carefully outlined. In Upper Canada the government provided a maintenance payment for those insane housed in county jails and subsequently asylums. Government subsidies in Lower Canada extended to private institutions caring for the insane. This system of “farming-out” governmental control resulted in “overcrowding, insufficient supplies and attendance” to the needs of the asylum. Although an attempt to operate an asylum through state care was begun in 1861 at St. Johns, Quebec, it soon failed due to “motives of economy as well as humanity”. Unlike most
provinces after Confederation, Quebec continued to rely upon private institutions or religious charities to provide the facilities for the management of the insane.

In 1867 the British North America Act delineated dominion and provincial responsibility. Section 92 of the Act recognized sixteen areas in which provincial governments had exclusive control. Within the scope of provincial responsibility fell the areas of public lands, public works, prisons, charitable institutions and hospitals. The province was responsible for:

The establishment, maintenance and management of hospitals, asylums, charities, eleemosynary institutions in and for the province other than marine hospitals.

However, lands immediately west of Ontario formed part of the old Hudson's Bay Company territory and did not immediately come under the Act until their subsequent acquisition by the dominion government.

Although insanity existed in the sparsely populated west, little has been written about the nature of insanity and treatment methods. The Hudson's Bay Company made no provision for the care or treatment of insanity. Instead, harmless insane were allowed to wander, while those deemed socially dangerous were jailed. The small numbers of jailed insane were treated as criminals, and with the exception of female insane, no special provision was made to separately confine. The influx of settlers after the creation of Manitoba in 1870 led to the creation of an easily administered, centralized location to house the insane. Between 1871 and 1877 the stone store house of the old Hudson's Bay station at Lower Fort Garry was used to confine both the criminal and insane.

In 1877 a new penitentary was established and the criminal and insane were transferred to Stony Mountain Penitentary. Again, little consideration was given to separating the insane and criminal at the new institution until 1879 when an order in council called for a separate portion of the penitentary to be set aside to house the insane. The same order also made provision for
Stony Mountain Penitentiary to admit insanity cases from Manitoba and the North-West Territories. Gradual overcrowding of the area set aside for the insane resulted, and in 1883 the provincial government authorized the building of an asylum. Twenty-seven men and eight women were removed to Lower Fort Garry until the 1886 completion of the Selkirk Asylum.

The brick institution at Selkirk with its initial capacity of 167 became overcrowded within two years. By 1890 construction began on a second provincial asylum at Brandon. Despite further additions to the two asylums the problem of overcrowding persisted. Additional beds were crowded into dormitories, halls, and landings as superintendents sought to cope with the institutional population. When on November 4, 1910 the entire Brandon Asylum was destroyed by fire, the response was to remove the insane to the Winter Fair building. Here the insane remained until December 1912 when the new Brandon Asylum opened with a capacity of one thousand residents.

Confinement of North-West Territorial insane residents in the Manitoba asylums was made possible through an agreement with the Dominion government. In exchange for providing the facilities, the Manitoba asylums received one dollar per head per day to house the out-of-province insane. With the creation of Saskatchewan and Alberta in September 1905, the new provincial governments enacted legislation citing provincial responsibility for the insane and the need to provide provincial asylums. In 1906 Saskatchewan passed its legislation and in the following year Alberta enacted legislation for the establishment of a provincial asylum. Yet, despite the early legislation, the insane in Manitoba were not removed to their respective provinces immediately. It was not until 1911 that Alberta opened its provincial asylum at Ponoka, and not until 1914 could the Saskatchewan insane be transported from the Brandon Asylum to the provincial asylum at North Battleford.

Saskatchewan legislation recognized the Attorney-General's department
as responsible for the overall operation of places of confinement. Among the cited institutions were prisons, correctional houses, and asylums.\textsuperscript{22} Those sent to confinement institutions continued to be perceived as dangerous to society, of needing special attention. Although insanity was recognized as a special need warranting a separate institution, the perception persisted of combining insanity and criminality. The implement of confinement institutions, the construction and future direction was the responsibility of the Department of Public Works.\textsuperscript{23} Confinement and construction was the government's response for those deemed dangerous. However, the legal definition of insanity, and the obligations of government needed to be clearly specified.

In 1898 the existing North-West Territorial government had enacted legislation calling for the apprehension of a suspected insane individual to be brought before a justice of the peace and examined as to whether insanity existed.\textsuperscript{24} The following year \textit{An Ordinance respecting Insane Persons} was amended to have the individual remain in safe custody while awaiting both the examination and the outcome of the insanity hearing.\textsuperscript{25} On May 26, 1906 the Saskatchewan legislature repealed these existing ordinances and legally defined the government's responsibility toward the insane. The twenty-seven regulations of \textit{The Insanity Act} sought to clarify the process of declaring an individual insane, the means of confinement, and the method of maintaining confinement. It provided the regulations and forms for admission, discharge, and apprehension, and outlined the legal process of defining insanity.\textsuperscript{26}

The responsibility for deeming an individual insane was assigned to the judicial system and the medical process. Saskatchewan residents were asked for their assistance in bringing to the attention of the courts, an individual "suspected and believed" to be insane and "dangerous to be at large".\textsuperscript{27} Information regarding possible insanity was to be duly noted in a standardized form sworn and signed before a justice of the peace.\textsuperscript{28} The sworn information, once signed by a justice of the peace then became the
basis for issuing a warrant of apprehension. Residents who provided information and charged an individual with insanity were protected from recrimination if they had "acted in good faith and with reasonable care". It would seem then that citizen protection was uppermost in the legislation, not the rights of the person charged with insanity, but protection of the individual who reported in good faith and thereby helped the province in detaining the dangerous lunatic.

The legal system took control after the charges of possible insanity had been laid. Warrants of apprehension were issued and the accused brought before a justice of the peace who presided over the inquiry. The inquiry could summon public and medical witnesses, and adjourn from time to time for a period of no more than three days. During the course of the inquiry, the background of the accused would be examined with respect to the possible danger of being at large, previous residence, occupation, family members, and means of support. At the conclusion of the inquiry, the justice of the peace could find the individual not insane and release him from custody, or if found insane under section 4, the individual would remain in custody until removal to an asylum. From the time of apprehension, to the conclusion of the inquiry, the accused individual remained in custody. Although provision was given for a set period of adjournment, the time from apprehension to inquiry was never specified. Once in custody, the individual's status remained to be defined through the legal and medical views of insanity. The limits of "to be dangerous at large" were never clearly defined. Instead it was left to an individual complaint to define dangerous and thereby insanity.

_The Insanity Act_ codified the responsibility for defining insanity and the response that the government would make in order to ensure public safety. A third major component of the Act was directed toward the insane individual and the family members. If a relative or friend believed and could supply evidence that commital was unwarranted, a notice made before removal could be issued by a magistrate. However, the application for the appeal
needed to be made to a provincial Supreme Court judge within four days of the committal warrant.34 The costs of such an appeal were to be bourne by the person initiating the appeal. Thus, time and money were often necessary for a successful appeal.35 If there was not an appeal, the committed individual would be removed to an asylum by a constable or peace officer or by a competent relative or friend.36 Despite the provincial responsibility for public safety and the confinement of those deemed dangerous, the insane individual was found to be responsible for his own confinement. The province had gone to great lengths to prove or disprove the allegations of insanity, and in the end, the individual had to bear the expense:

When any person is committed for safe custody to any goal or asylum under the provisions of this Act on account of being insane all the expenses incurred in connection with the apprehension, examination, committal to gaol, medical examination, custody, transportation, care and maintenance of said person unless...otherwise provided by relatives or friends shall be bourne by the said insane person if possessed of sufficient means to pay for his care and maintenance...or being without such means that he has relatives or other persons belonging to or connected with him legally liable to provide and capable of providing for his care or maintenance,...37

Provincial legislation provided the government with powers to recover expenses through claims on the estate, to sue the estate for expenses, and to have claims on any subsequent possession of property which could be used towards the maintenance of the insane individual.38 Exempt from this provincial claim on estates were the indigent whose maintenance costs would be defrayed by the province, and Indians who would:

...not be removed to an asylum unless the expense of their maintenance and other charges are guaranteed by the superintendent general of Indian affairs.39

An individual deemed insane was responsible for his care and maintenance at the asylum. The paradox of the insane as socially irresponsible but institutionally responsible for the financial costs of confinement existed. Another paradox also existed in Saskatchewan. The government defined its social responsibility to commit and confine, but, while the method of committing existed, the means of confinement were left elsewhere.
The Saskatchewan government continued to use the existing facilities in Brandon, Manitoba to confine their residents found to be insane. Unable to utilize an existing building which would be large enough to house the insane, the Saskatchewan government sought the advice of medical personnel and institutional architects as to the construction of the provincial asylum. Dr. David Low, the provincial Health Officer was charged with investigating existing facilities and providing a direction as to the form the asylum was to take. In order to understand the current treatment methods, Dr. Low made inquiries at two New York institutions and at one Canadian asylum.

The Manhattan State Hospital at Ward's Island, New York had existed since 1868 when the Department of Immigration, which controlled the island, allowed for the construction of an asylum capable of housing 500 insane. By 1871, the insane males previously confined on Blackwell's Island were transferred to the new facility. Despite expansion, overcrowding continued at Ward's Island. Between 1900 and 1905 the female and male insane were segregated and housed in Manhattan State Hospital West or East respectively. Ward's Island also contained the State Pathological Institute which undertook autopsies and laboratory research into the causes of insanity. In 1902, with the appointment of Dr. Adolf Meyer, the Institute expanded its operation to include clinical observation. At the time of Dr. Low's 1907 inquiry, Manhattan State Hospital housed nearly 4,000 cases of insanity and was staffed by trained nurses and selected attendants. At the asylum, the insane were observed and clinically studied, general medical needs were treated, various therapies utilized, and parole to family or friends as well as liberty on the island was provided.

A second institution chosen by Dr. Low was the St. Lawrence State Hospital at Ogdenburg, New York. This institution, with frontage on the St. Lawrence River, was originally planned in 1888 to provide an administrative and hospital building for 300 acute insane with outlying groups of buildings to house 1,200 more cases of insanity. After opening in 1890, it expanded to
include a training school for nurses, accommodation for employees, and a recreational building and library. By 1898 a farm cottage building was completed to house those individuals who worked on the asylum's farm.\textsuperscript{43} By the time of Dr. Low's inquiry the institution had expanded and numerous buildings were operating to care for the insane as well as tubercular patients.\textsuperscript{44}

The third institution examined by Dr. Low was the Protestant Hospital at Verdun Quebec. The establishment of the Verdun asylum was due to the existing system of “farming-out” and the care and treatment given by religious orders and charities. By 1875 a Protestant Montreal citizen began to examine the feasibility of establishing a Protestant asylum. In 1881 Mr. Alfred Perry succeeded with the passage of \textit{An Act to Incorporate the Protestant Hospital for the Insane}.\textsuperscript{45} The Act ensured that the Protestant insane could be treated in a Protestant institution, and that monies raised would be expended upon the institution and its individuals. By 1887 a site selection committee concluded that 110 acres known as the “Hadley Farm” situated at the foot of the Lachine Rapids was a suitable location. Despite local opposition, the land was purchased and construction of an asylum to house 250 insane began.\textsuperscript{46} From its completion in 1890, the asylum relied upon government payments and private contribution to expand its facilities. Farm buildings, a pathology laboratory, and separate buildings for male and female insane and for the violent insane were constructed.\textsuperscript{47}

After examining the three institutions, Dr. Low produced a series of recommendations which he presented in a report.\textsuperscript{48} All three institutions relied upon a treatment procedure of non-restraint.\textsuperscript{49} Instead, they employed treatment techniques such as hydrotherapy and occupational therapy. The institutions employed medical personnel to administer general medical or dental needs, and provided facilities for the medical care of the insane. At the time of his 1907 inquiry, two institutions contained pathology laboratories which provided autopsies and insanity causation research
through the examination of changes in tissue and bodily fluid structure. At Manhattan State Hospital the importance of clinical observation and environmental causes was stressed. Thus, at all the institutions he studied, Dr. Low commended the medical procedure as well as the medical treatment afforded the insane.50

Despite medical treatment and causation research, all three institutions had to contend with overcrowding. At Verdun, the problem was alleviated through construction as the need arose and also through the expansion of the asylum controlled lands. In New York expansion of wards and separate buildings was also necessary. The three institutions relied upon government grants or private donations to carry out the necessary expansion. Although the construction and maintenance of asylums was a government responsibility, the daily operation was in the hands of the medical superintendant.

Through his inquiry, Dr. Low found that although the asylums operated as “hospitals”, and sought to cope with a growing number of “patients”, their physical location continued to promote insanity as a special kind of disease. The three institutions were not located in cities or towns, and although close to urban centers still remained socially and physically isolated. Their physical location near to water and railways ensured adequate transportation of materials and individuals. Equally important was a ready source of water able to supply the basic institutional needs of heating, washing, and cleaning as well as the treatment method of hydrotherapy.51 Although Dr. Low viewed institutions which provided specialized buildings such as barns and cottages, their initial construction relied upon a sturdily built centralized building. All three institutions affixed the term “hospital” to their designation and provided trained medical and nursing personnel. However, the needs of the institution and the insane could not be met through this group alone. Attendants were employed and the institution contributed to the local region by providing a source of employment.
Dr. Low's report cited the necessity of a pleasant yet serviceable location, which could be expanded on to provide for the needs of the province. It outlined the means of medical and internal operation, and how the asylum could possibly contribute to the region. He also provided recommendations concerning the construction of the asylum.

The function of asylum design had been a topic of American discussion since the middle of the nineteenth century. The importance attached to asylum design reflected a perception that architectural order would help facilitate a cure and allowed for a means by which asylum superintendents could legitimize their role as managers of the insane.52 In 1851, the American Medico-Psychological Association adopted a guide as to the location and structure of insane institutions. Dr. Thomas Kirkbride elaborated the recommended asylum structure in his 1854 publication On the Construction and Organization of Hospitals for the Insane. He advocated a linear projection of wings from a central administrative section which would accommodate a maximum of 250 individuals. Wings were not to be close enough to allow undesirable mixing and should contain separate wards with their own access to asylum grounds and central administration.53 Kirkbride's concern for asylum structure extended to all areas of the physical design. He outlined the construction and placement of doors, windows, and faucets as well as the organizational operation of the asylum. In part, Kirkbride's plan provided for the security and safety of the individual placed in an asylum. However, it also provided a guide for the appearance of the institution to those outside. He promoted particular building materials for their durability to weather as well as cleaning, and cited the need to incline floors to help facilitate washing.54 The Kirkbride plan, with its careful eye on detail, sought to promote the perception that the asylum would be a place of insulation, a hospital, where the needs of the insane were met with kind and competent care.55 Yet, the growth in population and the concomitant rise in the number of insane brought the crowding and expansion of asylums.
In order to deal with a growing asylum population, the concept of a "cottage system" came into being. This system, based upon grouping small detached buildings around a centralized administration building offered a greater degree of privacy and a better means of grouping insane according to classification. It also altered an asylum and treatment principle of congregation. Instead of grouping the insane and providing treatment through congregation, the cottage system allowed for smaller units and the principle of segregation to emerge. While the cottage system may reflect a greater concern for effective patient treatment, it also provided a means to decrease the initial cost of asylum construction.

Each of the two methods of asylum construction were advocated by various institutional superintendents. Although the cottage system was held as the ideal, economic constraints often meant that the larger, congregated institution built along a modified Kirkbride plan was initiated. In Saskatchewan there were those such as Dr. Low who advocated an asylum design based at least in part on the cottage system. However, the final decisions about design were in the hands of the Saskatchewan legislature and the architectural firm of Messrs. Storey and Van Egmond of Regina.

After consultation with an eastern architectural firm, the Regina architects submitted a pavilion design for the provincial asylum. The design, although initially costly, was felt to be more suitable to Saskatchewan's climate. Unlike the cottage system, it was felt the pavilion style provided ammenities for institutional residents:

...the plan approved here is to have all the units joined so that food may not have to be taken outside at all, an yet joined in such a way that there will be no possibility of patients in any one unit seeing or hearing anything of those in another.

In material as well as design, the Saskatchewan asylum resembled the existing institutions of Manitoba and eastern Canada. The main building composed of two stories was bisected by an administration unit of three stories. Projecting north and south from each unit were the dormitories.
Concerned with serviceability as well as security, the architects selected menominee brick and Bedford stone. Internal materials were also selected for their security and maintenance. Male and female insane units were divided by the central administration building. As with the Kirkbride plan, the Regina architects provided wings which were used to house various classifications of insanity:

The housing of classified patients in their divers units is well arranged for. The units in each wing, of which there are four, viz.: acute, observation, chronic, are complete in their entirety; each having dining-rooms, exercise rooms, bath rooms and dirty rooms in the basement. The dormitories, dayrooms and single rooms are on the ground and first floor. The units are divided by fireproof communicating doors with through corridors. The disturbed units lead from the main corridors of the chronic unit and are well arranged ensuring a quietude to patients in other wards.

The main entrance which lead to the male or female wings also lead to the administration unit. This single unit of three stories contained the basement which housed the employee dining-room, vaults, the main kitchen, bakeshop and refrigerator plant. On the ground floor was the general office, the medical superintendent's office, the assistant superintendent's and matron's offices, and the dispensary. Also situated on this level was an assembly hall used for church services and entertainments such as movies. The second floor provided the quarters for the medical officers and the matron while the top story housed a separate male and female medical ward with an operating room.

Although the institution contained six dining rooms there was only one centrally located kitchen. Kitchen supplies were sent to service rooms:

...which are fitted with steam table and urns; this ensuring an efficient method of preparing meals. Also there are installed dumb waiter elevators to diet kitchens in wards above. The food for sick patients not sufficiently convalescent to eat in the general dining-rooms is therefrom provided.

The overall effect of selected construction materials and design was one of efficiency and pleasing appearance. It also may have contributed to a feeling both to administrators and the general public that the insane individuals were safe and secure.
The treatment of insanity was evident through the segregation of the various types. Acute, chronic, disturbed and observation were each housed in self-contained units in their respective wings. Closest to the central portion of the building were the acute units in which the non-violent insane were housed. Next to the acute units were the observation units in which the new patients were admitted for observation and assessment. The chronic unit, in the wing furthest from the center of the building, connected by means of a passage way to the disturbed unit:

It is in this portion of the building that the continuous flowing baths are fitted: there being one large room containing three of these, and two smaller rooms containing one each. The wings being in duplicate, there are five such baths in each. There is also established an arrangement for Hydro-Therapeutic and Electro-Therapeutic treatments, these departments being fitted with the latest apparatus for curative methods. Contained in the basement of the disturbed unit were the mortuary rooms and the pathological laboratories. While all the wards had an intercommunicating system of house telephones, only the disturbed unit was connected by means of a special electric alarm to the physicians' unit.

The design plan devised by Messrs. Storey and Van Egmond reflected prevalent beliefs as to asylum construction and materials. Just as Dr. Low's examination of eastern asylums had resulted in recommendations regarding asylum construction and insanity treatment, so too had the architect's inquiries. Left to implement the design plans and direction of the asylum was the provincial legislature. The provincial responsibility for committment and confinement could not be realized until construction began.

While recommendations and design plans were being formulated, the future asylum site still needed to be chosen. Despite The Insanity Act which enabled the province to provide an asylum, the actual selection of a site and the acquiring of land received little discussion in the provincial legislature. Unlike the problems encountered by the site selection committee of the Protestant Hospital in Quebec, there appeared to be little if any negative response to site selection. Perhaps the physical as well as social isolation
the asylum contributed in part to this response. Also the realization of potential community employment, the housing of insane residents closer to home, and the erecting of a model institution may have been factors in encouraging a particular site. North Battleford residents, possibly still reacting to the community's loss of the territorial capital and the failure to get the provincial university, requested the provincial government to consider their community as a suitable location. Unlike the flat, dry southern regions, North Battleford stated that their region was environmentally pleasing with its river, valley, scenery and trees. The request was not that the Asylum be centrally located, but that the area offered an environment conducive for returning sanity. Citing that insanity occurred due to the hardships of rural isolation, the North Battleford request argued for the location of the asylum at the frontier of settlement. The request also cited the conveniences of the community, the water and rail lines available, and above all, the availability of a large parcel of land accessible to towns and districts yet isolated from an urban center.

In August 1911 the first sod was turned beginning the actual construction of the asylum. The government purchased 2,480 acres of land two and a half miles from Battleford and three miles from North Battleford. The location of the asylum with its elevated view of the Battle and Saskatchewan Rivers, and its water frontage provided a scenic view in which it was felt to be "a suitable situation for the efficient care and hospital treatment of the mentally deranged." During the autumn of 1911 approximately one hundred men worked on constructing the institution until November, when:

The whole of the building was shut in and the roof slab poured in before the arrival of cold weather, and thus by providing temporary heat inside, the heating, plumbing and ventilating contractors were enabled to carry on throughout the whole of the winter, materially advancing work generally. Carpenters, too, were at work or every available day during the winter, framing the roof, in itself quite an undertaking, when the fact is considered that this building is over seven hundred feet in length.

The construction of the asylum's power house began early in 1913. Heating and plumbing fixtures were installed, engines and boilers were positioned,
and preparation was made for the institution to be operational by the winter of 1913.

Although the Provincial Hospital for the Insane received its first residents in February 1914, construction and expansion continued. Among the problems cited by Superintendent Dr. J.W. MacNeill in a June, 1914 report were the difficulties of organizing asylum service as:

many workmen have been busy, and necessarily conflicted greatly with the hospital routine and regulations... 

By May 1914 it was noted by the Department of Public Works that the asylum capacity of 500 would need to be expanded as “there is no doubt further accommodation will have to be provided in the near future.” The following year an additional unit and warehouse were already under construction and it seemed as if continuous expansion would be needed. Plans were prepared for six cottages to house medical personnel, new dining rooms were provided, and access roads graded. By 1916 two new units were completed to house 180 insane males and 44 male staff, new dining rooms were complete and raised the total to sixteen dining areas, and the six cottages occupied. Despite a provincial plan for financial restraint due to World War I, construction at the asylum continued to be needed. Land was broken to accommodate the asylum’s crops, livestock expanded, and barns built. By 1920 the insane population had outstripped the available space. Again, cottages were called for to provide housing for the married staff who lived on the premises. Tubercular residents had their own accommodation as did single nurses.

The end result of the government’s responsibility to confine had been the constructing of an asylum based upon provincial need and research into treatment methods. However, the government’s responsibility to construct extended throughout the early operational years due to asylum population growth and inherent problems. Reports in the first six years constantly cite the need for expansion in providing the insane with the needed bed space.
The institutional crops were subject to drought, and the asylum's vegetable garden choked by weeds. River water which supplied both the institution's heating and treatment systems was corroding the pipes, and the asylum's drinking water, furnished by a well, was fully extended. Even the scenic location was an object of concern as river floods threatened to erode the bank. The asylum's physical location often made family visitation difficult and was viewed by Superintendent MacNeill as contributing to institutional crowding:

We find a constantly present difficulty in paroling patients whose condition is so far improved that it is advisable to put them in an environment other than that of the Hospital for the Insane. Several patients are here whose residence is being prolonged by the wilful negligence of relatives and by the length and cost of the railway journey, making relatives unable to come to the Hospital to see or to parole those in whom they are interested.

Financially, the government would expend a large portion of its budget on institutional maintenance and expansion. In turn, the institution would be held accountable for its expenditures both in its daily and yearly operations. Beginning in the annual report of 1915-1916, the Department of Public Works submitted comparative tables citing the maintenance costs of the various institutions under its control. Citing the need to reduce expenditures during World War I, the Department of Public Works implemented conservation regulations for their various institutions. In North Battleford, institutional departments such as the kitchen and power plant complied with government conservation regulations by using substitute products. Taken in total, the decreasing Departmental expenditures, the demonstrated ability of the institution to conserve, and the publication of comparative tables impelled the institution to show both financial and managerial responsibility. The promotion of "occupational therapy" solely as a treatment method during this same period is suspect in light of the economic conditions faced by the institution.

The accountability of financial expenditures tied both the institution and the government with bonds of responsibility. The institution would supply the method of treatment and the government the means of treating.
However, provisional to this joint venture of responsibility was the manner of commitment. Since 1906, the manner of declaring insanity had rested between an individual's sworn information and the court's inquiry. In a very real sense one was thought to be insane until proven otherwise. But on May 1, 1919 the judicial response to defining insanity and the manner of committing altered. *The Lunacy Act* which came into effect still relied upon resident information and the court procedure to define insanity, however until being defined as insane under section 6, the individual was deemed to be an "alleged lunatic". A second major departure from *The Insanity Act* of 1906 was the method of trial. It was no longer an inquiry, but a trial with either an open or closed court and the right of the alleged individual to elect a trial by jury:

An alleged lunatic shall be entitled to demand, by notice in writing to be given to the person applying for the declaration of his lunacy, and also to be filed in the proper office of the court, at least ten days before the first day of the sittings at which the issue is directed to be tried, that any issue directed to determine the question of his lunacy shall be tried with a jury, and, unless he withdraws such demand before the trial, or the court is satisfied by personal examination of the lunatic that he is not mentally competent to form and express a wish for a trial by jury and so declares by order, the issue shall be tried by a jury.

Insanity, defined through the judicial and medical process, was also recognized to exist through peer definition.

The provincial government recognized the financial obligations of the insane. Personal debts, and expenses incurred for maintenance of the insane or of the family needed to be addressed. To ensure financial responsibility in both the payment of debt and the maintenance of the individual and family, and as a means of centralizing the financial control, the provincial government had in 1914 enacted legislation creating the Administrator of Lunatics' Estates. The Administrator's duties included the managing and handling of real or personal property belonging to an insane individual. The Administrator was to act as a court appointed guardian:

...of any lunatic who has no other guardian and who is detained in a public asylum in the Province of Saskatchewan, under the provision of The Insanity Act...
If the Administrator found the estate to be insufficient for the maintenance of the insane individual or of the family, he was then able to sell or mortgage the property. Transactions carried out by the Administrator were duly recorded and submitted to the government in annual reports.

Mr. A.T. Spohn was appointed Administrator and in his submitted report of 1917 outlined the activities of his office:

Upon the patient being committed to the hospital, the papers are forwarded to me for perusal before being sent to the hospital. In this way I am usually able to locate any property, and get information with regard to the relatives of the patient. Where no relatives are mentioned on the papers, every effort is made to locate them, and in a great many instances we have succeeded in locating friends and relatives in foreign countries.88

Once an inventory of property was made,89 the estate was under the Administrator’s control regardless of the length of institutional confinement. If the estate property was a farm, arrangements were made, usually with a neighbour, to continue agricultural operations. However, as Spohn reported, the absence of the individual often led to problems:

It is very unfortunate that in some localities it is found that the people in the neighbourhood have taken advantage of the absence of the unfortunate patients to trespass, and to steal personal property. I have prosecuted two cases, and obtained convictions for both; the magistrates in each case inflicting severe penalties.90

During the confinement of the insane individual, the Administrator would provide assistance as needed to family members. Farm land could be leased in order to provide maintenance for the individual and dependents, or property sold to cover costs.91 However, the Administrator was to attempt to keep the real and personal property of the confined individual intact until discharged from the asylum.

The Lunacy Act of 1919 continued to recognize the duty of the Administrator as a guardian of estates.92 But, administrative responsibility was extended to include administration on the death of a lunatic:

The administrator may thereupon apply to the proper surrogate court for letters of administration or letters of administration with the will annexed,...he shall be entitled to such letters in priority to the next of kin of the deceased or any other person interested in the deceased’s estate;...93
The consolidation of provincial powers concerning the management of estates was further extended in 1922 with the establishment of *The Administrator of Estates of the Mentally Incompetent.* As with the 1914 Act, the Administrator could sell, mortgage or transfer estate property without petitioning the court. However, the 1922 Act intensified government management by disregarding family concerns:

> Notwithstanding anything in *The Homesteads Act,* in case the wife of a mentally incompetent person refuses to sign a transfer, agreement of sale, lease, mortgage or other instrument intended to transfer or charge the homestead of such mentally incompetent person or any interest therein, the administrator may apply to a judge of the Court of King’s Bench in chambers and the judge may thereupon make an order dispensing with the signature of the wife of the mentally incompetent person, or such other order and upon such terms and conditions as he may deem advisable.

Therefore, by 1922 the government’s recognition of insanity management had extended from financial obligations incurred by the insane to encompass family management.

Increasingly the insane and their dependents were socially, economically and politically isolated as the means of managing personal affairs was removed from their control and centralized in the government agency. Guardians already appointed by an insane individual could be legally removed by the government Administrator. Contractual agreements entered upon by the Administrator while the individual was confined continued to be binding even upon discharge from the institution. As well, it appears the only means of removing the Administrator was with institutional discharge of the insane individual, or if the Administrator deemed further guardianship as unnecessary.

Between 1905 and 1922 the government’s response to insanity rested upon the construction and expansion of the asylum, and the implementation and extension of management. Within the judicial response, the scope of insanity had also expanded. Any person affected by the court’s declaration of insanity continued to have the right to appeal. However, in 1919 this right to appeal was extended to the “alleged lunatic.” As well, the declaration of lunacy was open to re-examination:
Upon application at any time after the expiration of one year from the date of the order by which a person has been declared a lunatic, or sooner by leave of the court, the court, if satisfied that such person has become of sound mind and capable of managing his own affairs, may make an order so declaring.98

Thus, the legal conception of insanity recognized a fluid or temporary nature in which insanity no longer seemed to be a permanent condition. The concept of temporary insanity and the ability to regain sanity became the basis for the institution to grant parole and provisions were made for the institutional superintendent to remove the individual and place him in the custody of friends.99

The change in insanity conception also extended to judicial treatment. By 1922 the judgment of committal did not include custody in jail. The individual deemed insane was instead placed in the custody of a relative or friend prior to removal to the asylum or discharge by law.100 While the legal definition continued to reside upon the hearing of evidence, the medical component of inquiry evidence had altered.

In 1917 The Insanity Act was amended to include a signed medical certificate,101 stating the grounds upon which the opinion of insanity was based. A qualified physician continued to provide inquiry evidence, but by 1919 provision was made for insanity assessment by one or more physicians. By 1922, the scope of medical assessment had expanded. While a physician continued to supply inquiry evidence, it was now possible for the courts to detain and convey an individual to the asylum on the basis of two medical reports and certificates.102 The basis of asylum confinement further expanded with the 1922 provision of “voluntary admission”.103

By 1922 the provincial government had met its social responsibility toward the insane through social management and by committing and confining in the Battleford institution. The legal response to insanity also altered to encompass a changing awareness of insanity. No longer were the insane confined in jail as a criminal, nor was commitment solely based upon
a court inquiry. In 1922 the terms “hospital” and “disease” replaced the legal concept of “asylum” and “dangerous lunatic”.

Between the opening of Battleford in 1914 and the inception of The Mental Diseases Act of 1922 the perception of “insanity”, “treatment” and “institution” altered. The individual who signed the voluntary admission form did so upon the medical assessment that “he is a reasonably hopeful subject for treatment with a view to effecting a cure of his malady”. This perspective of the institution as the place suited to care and treat insanity correlated with the judicial and government response to insanity. However, the institution would increasingly be placed under a strain in order to justify itself as the treatment center. Medical research and treatment procedures which promised results would be expected to provide results.

This belief that the institution could provide the “cure” was the outcome of a changing social perception of insanity. The Mental Hygiene movement, with its conception of “mental health” promoted insanity as a social concern. The experiences of World War I and the returning “shell shock” soldiers led to a change in the perception of insanity - it no longer affected a few “unfortunates”. It could affect anyone. However, a major pressure placed on institutions to provide the “cure” was the result of medical conceptions. For within the scope of medicine the treatment of “disease” was possible. Thus, by legally defining insanity as a disease process, pressure was placed upon the institution to both manage and cure.
FOOTNOTES


2. The treatment of the insane in Canada does not appear to differ markedly from the treatment of the insane in other countries during the same period (J.J. Heagerty, The Romance of Medicine in Canada [Toronto: The Ryerson Press, 1940], p.68).


4. Francis, "The Development of the Lunatic Asylum," p. 93. The asylum's first superintendent was George Mathew who had previously acted as an overseer of the poor. This converted building was abandoned in 1848 and the 90 insane individuals were transported to the new provincial asylum (Howells, ed., World History of Psychiatry, pp. 420-421).

5. Maude Abbott, History of Medicine in the Province of Quebec (Montreal: McGill University, 1931), p. 77. The eighteenth century pauper auctions were the result of people's unwillingness to take in paupers and the community's inability to purchase a place to hold them. At the auction, an individual would bid on an annual basis for the yearly maintenance of the pauper, with the money being paid in advance. The chronic or old paupers deemed to have little economic value were taken by "marginal" people for a small profit (Greenhous, "Paupers and Poorhouses," p. 107).

6. Abbott, History of Medicine, pp. 77-78. Although Abbott is careful to point out that those accepting the insane in nineteenth and twentieth century Quebec often did so as an act of Christian charity, the overall effect of the "farming-out system" was neglect or hardship as charities and institutions sought to balance a set budget. Thus, the auctions and Quebec system point to ways in which government responded to a pressure for responsibility or action on a problem. Yet, the two methods also illuminate the perception that paupers and lunatics were alike, and that their maintenance or care deserved only a cursory response.

7. While Douglas commended the quieting effect of fresh air and beauty at Beauport, the institution eventually suffered from neglect and over crowding and was condemned in a survey conducted by Dr. Hack Tuke in 1887 (Abbott, History of Medicine, p. 78).
8. MacDermot, One Hundred Years, p. 37. Dr. Workman (1805-1894) was appointed as the superintendent of the Toronto Asylum in 1854.

9. MacDermot, One Hundred Years, p. 37. Dr. Bucke (1837-1902) graduated from McGill in 1862.

10. Payments for maintenance were established by 1830. In 1839 the government of Upper Canada voted to provide the money to erect a building to replace the old Toronto jail which had been converted to an asylum (Margaret Strong, Public Welfare Administration in Canada [Chicago: The University of Chicago Press, 1930], p. 40).

11. Abbott, History of Medicine, p. 75.

12. An old courthouse was converted to the Quebec Provincial Asylum at St. Johns Quebec in an attempt to relieve the crowded conditions at Beauport. It closed in 1875 (Abbott, History of Medicine, p. 78).


16. Hurd, The Institutional Care of the Insane, IV, p. 27. At this time only the dangerous insane were confined. Since the number was relatively small, the insane and criminal were housed together. Only the female insane had separate provision.

17. The Selkirk asylum opened May 25, 1886 and initially housed 44 men and 15 women. However, the subsequent population growth of Manitoba and the Northwest Territories necessitated expansion of the asylum system.
18. The Brandon asylum was similar to Selkirk in external building material. However, internal division walls and ceilings of studding, lath and plaster were inferior and not fireproof.

19. For an overview of the Selkirk and Brandon institution see Hurd, The Institutional Care of the Insane, IV, pp. 28-34.

20. For newspaper accounts of the Brandon fire see “Brandon Asylum, Home of Six Hundred Insane Persons, Burned Down,” Manitoba Free Press, 5 November 1910, pp. 1, 20. For a Saskatchewan synopsis of the fire see “Fire Destroys the Brandon Insane Asylum,” The Morning Leader, 5 November 1910, p. 1. The new Brandon asylum was constructed of fireproof material throughout. Brick, stone walls, metal roofs, iron staircases and a power plant apart from the main building were some of its features (Hurd, The Institutional Care of the Insane, IV, p. 34). A study of the Brandon asylum between 1891-1948 was conducted by S. Schultz and A. Henderson. Portions of this study appeared in a subsequent study by S. Schultz, A. Henderson, E. Clarke and J. Fisher conducted for and published by the Department of National Health and Welfare. See Department of National Health and Welfare, Mental Health Division, Report Series Memorandum No. 3. An Evaluation of Treatment: The Brandon Hospital for Mental Diseases, Brandon Manitoba (Ottawa, August, 1957).


22. Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 7, section 3.

23. The Department of Public Works allocated a large percentage of its annual budget toward the construction of the Battleford institution. In the annual report for 1912-1913, the total amount voted for Public Works was 2 906 351 dollars. The Department spent over 385 000 dollars for roads, ditches, and surveys and over 370 000 dollars for the asylum construction. The third largest expenditure went toward legislative and departmental buildings and grounds (Annual Report of the Department of Public Works, Regina, Sask., 1912-1913, p.10.).

24. The procedure of filing information, issuing a warrant of apprehension, and ascertaining insanity through the use of a court hearing was also provided in 1898 in An Ordinance respecting Insane Persons. However, the 1898 ordinance did not state the attendance of a medical practitioner, nor did it make any provision for committal other than a jail (The Consolidated Ordinances of the North-West Territories, 1898, chpt. 90).
25. An Ordinance respecting Insane Persons was amended in 1899. The Lieutenant Governor was to receive the original inquiry report, and provision was made for committal to jail or other place of safe custody (The Consolidated Ordinances of the North-West Territories, 1899, chpt. 24).

26. On April 10, 1906, during the first legislative assembly, Mr. John Henderson Lamont of Prince Albert introduced Bill no. 12, An Act respecting Insane Persons. This act received third reading on May 10, and when assented on May 26 became cited as The Insanity Act.

27. The information or complaint regarding insanity suspicion was recorded in a form which listed the names and residences of the individuals involved. This information was taken to and sworn before a justice of the peace (Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, section 2).

28. The apprehended individual could then be brought to the issuing justice of the peace or to another justice of the peace.

29. Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, section 22.

30. During an adjournment, the accused individual was to be remanded to jail or in some manner placed under safe custody (Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, section 3).

31. The Insanity Act outlined forty-four areas in which information was to be elicited by the justice of the peace. The information was to be gathered from witnesses and was to include the evidence provided by a legally qualified medical practitioner. Inquiry information was to be compiled in a report which identified the accused individual, relatives or dependents, the occupation and religious background as well as the origin of birth. The report was also to show the individual's means of support, the ownership of property, and who was to bear the cost of transferance to a former residence on recovery. Witnesses were also asked to provide information regarding the length of insanity, the duration of the present attack, possible causes of insanity, signs of avatism, and also the individual's habits with respect to temperance, industry, and general conduct (Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, pp. 112-113).

32. The committal of the individual was covered in section 4:

If upon hearing the evidence adduced the justice is satisfied that the person so brought before him is insane and dangerous to be at large such justice shall commit him by warrant in form D in the schedule to this Act to the nearest gaol... there to await the order of the Attorney-General for
removal to an asylum in this or some other province of Canada or until discharged by law;...

Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, section 4.

33. The constructs of the medical examination were not specified in the 1906 Act. Although the inquiry's submitted report was to contain evidence provided by the medical practitioner, the questions as to the nature, duration or cause or insanity often required a subjective response. The subjective nature of defining insanity was clearly shown in the Illinois inquiry regarding the sanity of Mrs. Elizabeth Packard in the 1860s. At her inquiry, the medical practitioner, Dr. J. Brown, cited the reasons why he found her to be insane. Among the cited reasons was her dislike of being called insane, and her pronouncement of him as a "copperhead" without proof (Szasz, ed., *The Age of Madness*, p. 66).

34. Upon application, a judge would examine the individual and evidence relating to committal as well as hear further evidence. If the individual was then found to not be insane or, if insane not dangerous, the judge could then issue a form which among other things, stated the individual was not fit for an asylum (Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, section 10).

35. Section 10 clearly states an application for discharge to be filed within four days after the inquiry's notification of committal. Although the actual costs could not be found, one may speculate that they would in most instances be prohibitive.

36. Female insane could be transported to the asylum by a family member such as a father, mother, brother, sister, or husband. If not transported by a family member, she was then to be accompanied by and in charge of a female (Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, section 12).

37. Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, section 14. Initially the costs for apprehension, examination, and committal were paid by the department of the Attorney-General.

38. Statutes of the Province of Saskatchewan, Regina, Sask., 1906, chapter 22, section 16. The policy regarding the government's initial expenditure and its financial recovery through suing the estate was carried over in *The Mental Diseases Act* of 1922 (Statutes of the Province of Saskatchewan, Regina, Sask., 1922, chapter 75, sections 24, 25, 26).

40. For an overview of Manhattan State Hospital, its early history and attending medical personnel see Hurd, The Institutional Care of the Insane, III, pp. 201-214.

41. In 1902, Dr. Adolf Meyer became director of the Pathological Institute of the New York State Hospitals. This Institute, originally in New York City, moved to Ward's Island shortly after Meyer's appointment (Deutsch, The Mentally Ill, p. 286). While employed by the Institute, Meyer organized a clinical department. He believed that in order to understand the nature of insanity all components affecting the individual such as heredity, environment, or physical and social settings needed to be studied. His case histories investigated the interaction between physical and psychological components of insanity. He termed his investigation a "psychobiological" approach in which:

psychobiology starts not from a mind and a body or from its elements, but from the fact that we deal with biologically organized units and groups and their functioning. It occupies itself with those entities and relations that form, or pertain to the he's or she's of our experience - the bodies we find in action, as far as we have to note them in the behavior and functioning of the 'he' or 'she'...It is behavior, overt, and internal or implicit, that concerns us, so far as it works as the 'he' or 'she'.

Deutsch, The Mentally Ill, p. 504.

42. Hurd, The Institutional Care of the Insane, III, p. 194.

43. The institution also operated a butter factory (Hurd, The Institutional Care of the Insane, III, p. 196).

44. The tubercular were housed in a pavilion named "Inwood". This pavilion was located on the southern edge and was built to accommodate 100 individuals. By 1910, "Eastwood" was constructed to house the employees caring for the tubercular. Shortly after that time, the state authorities began to oppose institutional expansion due to the cost of construction and the belief that the district assigned to the institution was unable to fill the wards (Hurd, The Institutional Care of the Insane, III, pp. 196-197).

45. Abbott, History of Medicine, p. 76. For an overview of the events leading up to the establishment of the Protestant Hospital see Hurd, The Institutional Care of the Insane, IV, pp. 293-326.

46. For a discussion regarding the local opposition to institutional construction see Hurd, The Institutional Care of the Insane, IV, pp. 307-308.
47. The Protestant Hospital was able to carry on its expansion due to subscription fees, government grants, and private donation. In 1907 Dr. James Douglas of New York donated $42,000 to the institution in memory of his father, the former superintendent of Beauport. This donation was used to purchase an additional 60 acres. In 1911 Dr. Douglas donated $65,000 toward the construction of a resident amusement hall, and in 1915 he contributed $75,000 to the construction of a nurses' home (Abbott, History of Medicine, p. 79).


49. While restraint measures such as padded cells or straight-jackets were replaced by physical freedom or measures such as baths and sedatives, it does not mean that restraint mechanisms were non-existant. Dr. Low's contention that "the modern idea was to remove all evidence of restraint in the management of the insane" (Kahan, Brains and Bricks, p. 13) illustrates a belief that restraint is mechanical in nature and to be modern is to remove the evidence of mechanics.

50. Dr. Low was reportedly struck with the system in New York which required a medical examination first, a judicial hearing and then transport to an asylum if insane. Dr. Low found this approach favorable as the insane individual "is not at any time confined in a gaol except in the case of criminals who become insane while undergoing sentence" (Kahan, Brains and Bricks, p. 15).

51. While a water source such as a river provided a scenic setting, it was also thought by nineteenth century superintendents to be able to have a soothing effect upon the nervous insane (Francis, "The Development of the Lunatic Asylum," p. 102).

52. The concern regarding institutional architecture reflects a belief that the settling of technical matters would lead to the solving of insanity (Rothman, The Discovery of the Asylum, pp. 134-135). Also, the formulation of a method for asylum design and construction would provide a way of legitimizing the asylum at a time when medical superintendents were suffering from low self-esteem (Tomes, "A Generous Confidence," in Madhouse, Scull, ed, p. 122). By adopting a guide for construction, a public perception of continuity and expertise could be developed.


55. Kirkbride's plan sought to mask security measures so as not to be perceived as a prison. While the asylum's outfittings, its
architecture, and landscaping would bring about a perception of "solidness" or "security", it also was an important source of the public's first impression. Kirkbride also outlined employee demeanor and offered an organizational plan in which the superintendent had complete authority (Tomes, "A Generous Confidence," pp. 134-138).

56. Dr. Low recommended the cottage system due to its ability to meet current needs and expand as needed. He was also familiar with European centers such as those of Germany ("Saskatchewan's New Hospital for the Insane," The Morning Leader, 23 December 1911, p. 11).

57. The "blame" for the pavilion construction has been placed on an eastern architectural firm who consulted "with a Dr. Clarke" (Kahan, Brains and Bricks, pp. 15-16). In this instance, the "blame" expressed is in light of the Izumi planned insane community units built in Saskatchewan during the early 1960s. The "blame" also underscores a particular western attitude and nullifies any consultive ability of Dr. Charles Clarke. The actual architectural plans were submitted by the Regina firm which had consulted with eastern representatives.

58. For a discussion of the merits of the pavilion design as reported to the newspapers see "Saskatchewan's New Hospital for the Insane" The Morning Leader, 23 December 1911, p. 11.

59. The Battleford institution contained brick walls, concrete floors and beams, slate and iron stairways, and metal roofs.


62. Hurd, The Institutional Care of the Insane, IV, p. 222. The top floor operating room would have initially performed standard medical procedures. As well, the arriving individuals were given a medical examination:

We have made it a routine practice to do a urinalysis for each patient admitted, and in addition a considerable quantity of laboratory work as indicated. Our physical and mental examinations and the laboratory reports are all carefully preserved.

Annual Report of the Department of Public Works. Regina, Sask., 1914-1915, p. 63. MacNeill's report then indicates the type of laboratory work performed such as blood and cerebrospinal fluid examinations, sputum and urethral and vaginal


64. The acute, chronic and observation units had attendant rooms on the ground and first floors as well as a linen room and diet kitchen. The basement of each unit provided space for occupational rooms, dining rooms, and bathrooms. As well, rooms in the basement were set aside for unclean patients (Hurd, The Institutional Care of the Insane, IV, p. 222).


66. Sessional papers prior to 1911 make no mention of debate regarding asylum construction. There appears to be no opposition to building a provincial asylum. In part, this may be the result of Saskatchewan residents wishing to have insane family members cared for in the province. Another aspect which may have contributed to the acceptance of a provincial asylum was the government's and the architectural firm's survey of existing facilities. Their surveys were reported by the Regina newspaper as bringing about “the finest institution of its kind in Canada” (“Saskatchewan’s New Hospital for the Insane at Battleford” Morning Leader, 23 December 1911, p. 11).

67. A committee of North Battleford residents requested consideration for their community as a suitable asylum location (Kahan, Brains and Bricks, p. 18).

68. The belief in scenic environment as conducive for restoring sanity had also been cited in the late eighteenth century by William Tuke of the York Retreat. This belief underscores a perception of the insane as being sensitive and therefore the nature of the asylum was to be aesthetically pleasing (Scull, Museums of Madness, pp. 104-105).

69. The resolution sent to Premier Scott and members of the Executive Council reportedly stated:

...a great number of those who become mentally deranged are from the outskirts of settlement, owing no doubt to the trials and vicissitudes which always beset the new, inexperienced settler; and therefore for a great number of years to come an Asylum would be conveniently located, as far as regards the majority of the inmates, within easy reach of the frontiers of settlement. The older settled portions of the Province, while less subject to mental diseases, are to some extent already accommodated by the Brandon Asylum, and moreover, if convenience of location is essential we should not lose sight of the fact that at the present time the
greatest development is taking place in the Northern portions of the Province, through which the Grand Trunk Pacific, the Canadian Pacific and the Canadian Northern Railway systems are penetrating with their main and branch lines. The centre of population will follow the greatest development that is taking place along these lines of railway. This fact should be borne in mind if convenience is to be a determining factor in locating the Asylum.

Kahan, Brains and Bricks, p. 17. Ironically rural isolation seen as a cause of insanity would also be promoted as a cure.

70. Through reports investigating similar institutions, the government realized the necessity of having enough land in order to expand. Also, investigation of the three eastern institutions showed the economic benefit to be derived from the institution's agricultural self-sufficiency. While the ability to expand and be self sufficient conveys a future planning and economic concern, the asylum location insulated from a neighboring community conveys a social concern with respect to the “dangerous” or “alien” aspect of insanity perception.

71. The purchased land consisted of 2,400 acres set aside for the institution's farm. The first inspection report stated that 300 acres were cultivated and planted primarily with barley and oats (Annual Report of the Department of Public Works. Regina, Sask., 1914-1915, p. 84).


74. The plans for the power house were designed by Messrs. Storey and Van Egmond of Regina. It was constructed of brick and stone similar to that of the institution, and was reported to have “a very attractive appearance”(Annual Report of the Department of Public Works. Regina, Sask., 1912-1913, p. 87). The power house contained the boilers which were used to power generator engines needed to supply the institution's light and water supplies. Low pressure steam, needed for heat and in the kitchen and medical rooms, as well as water heaters for for bathing and domestic purposes was supplied to the institution from the power house.


77. The Department of Public Works viewed the rate of admissions as a concern and felt that if the present rate continued, the Department would need to make provision for annual additions of 100 to 150 beds (Annual Report of the Department of Public Works. Regina, Sask., 1914-1915, p. 8).


79. By 1916 the institutional farm had increased the area under cultivation and had realized an increase of farm animals such as chickens, hogs, cattle and horses. Farm work such as sowing and butchering was performed by a hired employee assisted by five residents (Annual Report of the Department of Public Works. Regina, Sask., 1915-1916, p. 48).

80. A Regina firm was awarded a 245 540 dollar contract to supply and install the materials needed for heating, plumbing and lighting. The workmanship and materials became a source of concern. The institution found the plumbing material to be inferior and a source of breaks (Annual Report of the Department of Public Works. Regina, Sask., 1914-1915, p. 75). The steam needed for water heaters and kitchen preparation constituted a large institutional expenditure due to the loss of heat through condensation. And the well, which produced over 15 000 gallons of water daily was seen to be reaching its capacity by 1916.


82. The following table cites the capital slated for the Department of Public Works, and the amount of capital spent by the Department toward the expansion and/or maintenance of the Battleford Institution. Fiscal restraint during World War I is shown both in the drop of Departmental capital and in the amount allotted for the institution. Battleford experienced a second drop in capital during the construction of the Weyburn institution.
### Accountant's Branch, Department of Public Works

<table>
<thead>
<tr>
<th></th>
<th>Total Capital</th>
<th>Battleford Per. Cent. for Asylum</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1912-1913</strong></td>
<td>2 906 351</td>
<td>370 223.02</td>
</tr>
<tr>
<td><strong>1913-1914</strong></td>
<td>2 668 289.14</td>
<td>621 682.49</td>
</tr>
<tr>
<td><strong>1914-1915</strong></td>
<td>1 886 507</td>
<td>304 640.18</td>
</tr>
<tr>
<td><strong>1915-1916</strong></td>
<td>1 577 811</td>
<td>257 494.89</td>
</tr>
<tr>
<td><strong>1916-1917</strong></td>
<td>1 145 773.50</td>
<td>21 449.08</td>
</tr>
<tr>
<td><strong>1917-1918</strong></td>
<td>1 106 095</td>
<td>48 754.21</td>
</tr>
<tr>
<td><strong>1918-1919</strong></td>
<td>1 058 778</td>
<td>56 118.22</td>
</tr>
<tr>
<td><strong>1919-1920</strong></td>
<td>2 263 592</td>
<td>244 968.05</td>
</tr>
<tr>
<td><strong>1920-1921</strong></td>
<td>3 991 342</td>
<td>24 012.81</td>
</tr>
<tr>
<td><strong>1921-1922</strong></td>
<td>5 099 400</td>
<td>*</td>
</tr>
</tbody>
</table>

* no expenditure given. In 1921 the Department provided Weyburn with 1 186 016.55 dollars, and in 1922 spent over 1 180 000 for the construction and maintenance of the Weyburn institution.


83. During World War I the institution's annual reports reflect their effort to help the war. The institution purchased war bonds, and many employees were released in order to serve overseas. Food conservation became a factor of institutional management, and the kitchen did its part by complying through the use of substitution even when substitute foodstuffs were found to be more expensive (Annual Report of the Department of Public Works. Regina, Sask., 1917-1918, p. 47). The power plant also attempted to lessen expenditures by using lignite as a substitute for coal (Annual Report of the Department of Public Works. Regina, Sask., 1917-1918, p. 49).

84. While it is questionable as to whether the term "alleged" would remove the social stigma associated with insanity, the incorporation of the term at least implied innocence until proven otherwise. However, the term "lunatic" was still used and legally defined in *The Lunacy Act* to be an idiot or a person of unsound mind (Statutes of the Province of Saskatchewan, 1918-1919, chapter 58, section 2).

85. Statutes of the Province of Saskatchewan, 1918-1919, chapter 58, section 8.

86. Statutes of the Province of Saskatchewan, 1914, chapter 10. Prior to *An Act to appoint an Administrator of Lunatics' Estates*, the estates of the confined were administered by various Trust Companies throughout the province.
87. Statutes of the Province of Saskatchewan, 1914, chapter 10, section 3.


89. It would appear from Mr. Spohn's report that police assistance was at times necessary in order to access the inventory and to regain the lost property (Annual Report of the Department of Public Works. Regina, Sask., 1916-1917, p. 18).


91. In the fiscal year ending April 30, 1917, the Administrator was actively supervising 158 estates, of which 68 farms were leased on a crop share rental. During the year, 6 farms had been sold due to their lack of revenue producing potential. In 1919 the duty of the Administrator continued to be the ability to sell estate property. However, the notice of sale was to be published in the community newspaper for a period of two weeks prior to sale. As well, notification was to be published in The Saskatchewan Gazette no less than seven days before the sale (Statutes of the Province of Saskatchewan, 1918-1919, chapter 59, section 8).

92. The number of estates under government control continued to expand from 206 estates in 1918 to 352 estates in 1922. Within the same time frame the assets also grew as did payments made to the institution for the maintenance of the individual. The following table shows the financial increase from 1917 until the opening of the Weyburn institution in 1922.

<table>
<thead>
<tr>
<th></th>
<th>Total Assets</th>
<th>Institutional Sustenance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1917-1918</td>
<td>269 425.00</td>
<td>27 236.00</td>
</tr>
<tr>
<td>1918-1919</td>
<td>471 976.79</td>
<td>37 156.97</td>
</tr>
<tr>
<td>1919-1920</td>
<td>603 649.00</td>
<td>37 608.00</td>
</tr>
<tr>
<td>1920-1921</td>
<td>745 678.27</td>
<td>42 544.92</td>
</tr>
</tbody>
</table>


93. Statutes of the Province of Saskatchewan, 1918-1919, chapter 59, section 17.
94. In 1922 An Act to appoint an Administrator of Estates of the Mentally Incompetent replaced The Administrator of Lunatics' Estates Act (Statutes of the Province of Saskatchewan, 1922, chapter 65).

95. Statutes of the Province of Saskatchewan, 1922, chapter 65, section 9.

96. Statutes of the Province of Saskatchewan, 1922, chapter 65, section 8, 12, 14.

97. Statutes of the Province of Saskatchewan, 1918-1919, chapter 58, section 6. It appears that the right of the alleged to appeal an insanity declaration was repealed in 1922.

98. Statutes of the Province of Saskatchewan, 1918-1919, chapter 58, section 10.

99. The constructs of parole as outlined in The Mental Diseases Act of 1922 (Statutes of the Province of Saskatchewan, 1922, chapter 75, section 22) placed the granting of parole within the sphere of the superintendent's duties. This provision for the superintendent to grant parole had existed since 1909, prior to the establishment of a provincial asylum. However, it appears that the 1909 judicial concern regarding parole was not directed toward responsibility of supervision, but concerned instead with the method of apprehending an individual who when paroled is again deemed dangerous (Revised Statutes of the Province of Saskatchewan, 1909, chapter 138, section 21).

100. Statutes of the Province of Saskatchewan, 1922, chapter 75, section 10.

101. Statutes of the Province of Saskatchewan, 1917, chapter 44, section 3. The inquiry regarding insanity required a certificate stating that the physician had examined the individual separately from any other medical practitioner.

102. The medical report was a separate entity from an inquiry report, however areas of the inquiry report could be incorporated in the medical report. The medical certificate signed by the examining physician and signed by two witnesses, attested to a personal examination and basis for finding the individual insane as well as the gathering of insanity information from other sources. The medical certificate stated that the attending physician found the individual to be "mentally diseased" and "dangerous at large" (Statutes of the Province of Saskatchewan, 1922, chapter 75, section 15). Thus, it would appear that medical conceptions continued to tie insanity and the "dangerous lunatic".
103. Statutes of the Province of Saskatchewan, 1922, chapter 75, section 36. The annual reports submitted by the Battleford institution only show total admissions or re-admissions. The records do not break down admissions with respect to the three methods of commitment. It was not until 1932 that the method of admission was compiled and publically published by the Dominion Bureau of Statistics.

104. Statutes of the Province of Saskatchewan, 1922, chapter 75, form J.
Chapter 3
TREATMENT AND MANAGEMENT

Legislation with respect to insanity brought to light the ethical principle of social responsibility toward those not able to care for themselves and the administrative principle of providing an institution for their care. Legislation and commitment procedures provided, at least outwardly, a system of checks and balances in which caution was given that only after careful examination could the individual be deemed insane. A possible fear by family members or the community if the insane were allowed to be at large was alleviated through the commitment to the institution. The legal approach to insanity also attempted to alleviate a fear that one could be wrongfully confined to an insane institution while at the same time ensuring that the province would be economically responsible for those in need. Yet, while legislation implied an ethical or administrative responsibility it also allowed the perception to exist that the institution was the place best suited to provide the necessary help.

The political and legal response to insanity rested upon the construction of institutions and the implementation of laws. However, laws of commitment and institutions of confinement were, to a large extent, dependent upon the views of the medical profession. Throughout Canada, provincial governments had enacted legislation expanding the means of institutional admission. By 1922, a Saskatchewan resident could voluntarily seek commitment or be committed by a Lieutenant-Governor’s warrant, a judicial inquiry, or on the basis of two medical certificates. Through direct medical certification the cost of a trial and the stigma of being tried as insane were lessened. While
certification lessened or abolished the indignities of a court trial, it also allowed the perception to flourish that the medical practitioner was the individual best suited to define and treat insanity.

This perception of the institution and the medical approach as the instruments best suited to providing insanity care was a recent development. For much of the nineteenth century, the role of the institution was that of custodian. It provided a place which protected both the insane and the community. Medical superintendents at these institutions were often equated as jailers and chided by other medical disciplines for their lack of scientific inquiry. However, when combined, both the language of medical theory and the language of institutional operations conveyed a message of expertise. The institution was an asylum, a building of protection from society as well as a solace to society. Those working in the asylum were attendents and able to provide care and treatment for the patients. Through medical journals insanity could be understood in terms of biological and psychological dysfunction. Yet, while the language of institutional life and therapy implied medical care and treatment, the language also conveyed a sense of isolation. The term alienist, used to describe those who were in charge of insane institutions, implied an expertise with respect to insanity as well as expressing a message that insanity was alien or foreign.

By the early twentieth century, the importance of institutional language could no longer be ignored. In his second report to the provincial government, the superintendent of North Battleford wrote:

In submitting the second annual report for the Hospital for the Insane, or the Asylum, Battleford, I would like to point out that the above names are not received with favour throughout the country. I receive many letters, and have one to-day, where a patient whose mental condition, from the report which I receive from his people, needs treatment and who would be willing to have treatment, if he were being sent to any place but the Asylum or the Hospital for the Insane as this place is called, is stoutly refusing to be sent to, or to submit to treatment in an Asylum. Superintendent MacNeill also requested that the province consider eliminating the terms insane and lunatic from the provincial Act. In part,
these requests were made to eliminate prejudice against the institution and to instill confidence in the ability of medicine to provide treatment. Throughout the early reports, MacNeill continued to request the change in name.

MacNeill's request for change eventually occurred. In his eighth report to the provincial government in 1922, MacNeill acknowledged his gratitude. Battleford was now designated as a Mental Hospital, and changes had been made to the legislation which equated insanity to a mental illness. Yet, while the legal and medical profession defined insanity as an illness or disease process and thus implied at least the possibility of treatment or cure, the correlation of insanity, criminality and custody persisted.

Since the opening of the institution at North Battleford, the provincial jails had transferred the insane criminal to the provincial asylum. The 346 individuals transferred in 1914 by private train from Brandon to North Battleford were joined by individuals from the Regina, Prince Albert, and Moosomin jails. In turn, the insanity hearing necessary to send an individual to North Battleford also fostered a correlation between insanity and criminality.

The constant overcrowding at North Battleford and the housing of the criminal insane at the asylum was a situation Superintendent MacNeill addressed:

| It has been the custom of the Department of Justice to send their criminally insane to the mental hospitals. To my mind, this is wrong; and it is a very great detriment to the patient who is here for treatment, and who has always been a good citizen and a respectable member of the community. He very naturally asks, and he does ask, why he should be domiciled and have to associate with the criminal - that he never committed any crime and that he is being insulted by being asked to live and associate with the murderer, the burglar and the horse thief. He cautioned the provincial government to remember that criminal confinement was a dominion responsibility and that the asylum was not suitable to care for criminal cases and had not been built to provide custody. |
This request to eliminate the criminal insane from the Battleford Mental Hospital was an important issue. By housing the insane and criminal insane together, the institution could be perceived as providing a custodial role. MacNeill realized that the ability of the institution to instill public confidence was dependent upon the perception that the institution was a hospital, a place where one could be treated. Equally important was the concept that the individual deemed insane felt that the institution could offer treatment. The ability of the institution to operate as a hospital and to be seen as a treatment center would help erode the perception of a custodial role. In turn, if the concept of custody could be dismissed, the medical personnel would not be equated with jailers.

Superintendent MacNeill’s concern with the legal description of insanity, the designation of the institution, and the type of resident it housed illustrates a major concern of the medical profession and institutional personnel. In order to be perceived as a profession suited to care and treat insanity, medical personnel needed to disassociate the institution from a jail, the individual from the criminal, and therapy from custody. The institution was not solely a place of legal confinement, nor its personnel solely custodians. Medicine sought to be above the legal solutions of commitment and confinement, and instead sought to diagnose, treat, and possibly cure the disease. Essentially the designation as “hospital” conveyed a message of hope. Despite a system which allowed a patient to be paroled and despite a 1929 report in which MacNeill described the initial residents from Brandon as “inmates”, it was imperative for medicine to be seen as having the expertise in defining and treating insanity. Such expertise would ensure the continuation of the medical prestige both in the community and in the institution.

The ability to define and provide treatment was integral to the role of physician. Medical training emphasized symptomatology, diagnostic procedures, and the body’s physiological attributes. The processes and
phenomena of organs, cells, and tissues were examined as a means of identification. Often standard medical diagnosis and procedures were applied as a means for treating insanity. As a means of dissemination, medical journals such as The Canadian Practitioner published articles dealing with the relationship of insanity and medical procedures. In 1908, Vancouver physician Ernest Hall submitted a study of insanity cases that had come under his care. Hall’s article, “Gynecological Treatment in the Insane”, cited patient number 137, age 27, who had developed puerperal mania. Upon examination Hall recommended a procedure in which:

Amputation of cervix, curettage, posterior vaginal section, removal of tubes and puncture of ovarian follicles was done under morphine-hyoscine anesthesia with a few drops of chloroform added.

The outcome of the surgical procedure was provided by the patient’s father who stated:

She is not quite so noisy, much less troublesome, knows her baby and at times talks reasonably.

The physician’s ability to observe or define a problem and provide a correctional procedure was not always the case. In some instances the general physician became part of a team approach. Nova Scotia’s Provincial Health Officer, Dr. W.H. Hattie, published in 1919 an article entitled “The Physician’s Part in Preventing Mental Disorder”. Hattie identified the general physician as having:

...the great advantage of being witness to the earlier manifestations of mental disorder, and is thus in a position to acquire data which may be of great service in the ultimate estimation of the relative importance of various causal factors.

The importance of early intervention and prevention were not to be lost on the physician. To Hattie, the outcome of insanity affected all:

All the members of the family of the victim of mental disorder are subjected to distresses, anxieties and disablements which not only prevent the full enjoyment of life but which may seriously interfere with their normal activities reducing earning power and lessening productiveness.

Hattie cautioned the physician to be aware of the economic costs to the public of providing institutions and to see insanity as being a problem of both national efficiency and progress.
Unlike Hall's article with its emphasis on biological observation, Hattie’s article concentrated on genetic conditions as an etiological factor. He cautioned the physician to be aware of the individual’s heredity:

Despite the fact that the evidence that heredity is prominently concerned in the causation of insanity is still largely circumstantial, it is impossible for one who has followed out the family history of many cases to dispossess himself of the belief that it is a potent factor in predisposing to and even in determining mental breakdown.21

Hattie realized that the general physician often had an opportunity to advise a mode of lifestyle to the patient. Therefore, he advised the physician to be aware of the nervous patient’s reaction to stresses of competition and the “absurdities of many of our social customs”.22 He also cautioned that a lifestyle which included alcohol or the chance of acquiring venereal disease could be “disastrous to those whose inheritance respecting mental and nervous conditions is not of the best”.23 Geographical location as well as certain periods of the lifecycle were also cited as factors which could contribute to the onset of insanity. Above all else, the physician was to be aware of the warning signs of insanity whether biological, psychological, or social in origin. The importance of the physician understanding or preventing insanity within the individual was equated with the ability of the individual and society to adapt. Thus, the onus was on the physician to heal the person and thereby the nation.24 The omnipotence of the medical profession in prescribing and healing seemed unlimited.

Despite a perception and acceptance that insanity treatment was primarily a medical concern, the emphasis upon insanity instruction varied among medical schools. American medical schools in the mid nineteenth century often ignored insanity instruction.25 Students or physicians interested in the study of insanity relied upon medical publications, specialized books, and specialized lectures.26 The graduating student who wished to study or specialize in insanity could work under an individual or for an institution, but often this specialization necessitated travel.

The lack of specially trained physicians in the area of insanity became an
important issue by the late nineteenth century. At the fiftieth annual meeting of the American Medico-Psychological Association, the keynote speaker was the neurologist S. Weir Mitchell.\textsuperscript{27} He chided the gathered medical superintendents for their isolation from medical and scientific developments.\textsuperscript{28} Institutional reports were chastised for their lack of scientific study:

We commonly get as your contributions to science, odd little statements, reports of a case or two, a few useless pages of isolated post-mortem records, and these are sandwiched among incomprehensible statistics and farm balance-sheets; and this is too often your sole answer.\textsuperscript{29}

The existing program that allowed medical residents to be sent to an institution for a three month training period was characterized by Mitchell as a "useless and thoughtless way" of providing insanity instruction.\textsuperscript{30} Instead, Mitchell advised the superintendents to:

Insist on hospital training, knowledge of psychology, of neuropathology, and then demand of your people original reports or product of some kind.\textsuperscript{31}

Medical superintendents, firmly entrenched in the ideology of nineteenth century institutional treatment reacted to Mitchell's address. Livingston Hinckley from the Essex County Hospital for the Insane at Newark New Jersey cited the political and economic restraints that superintendents faced.\textsuperscript{32} He acknowledged the need to understand insanity and equated it to the need to know a "vast unexplored continent".\textsuperscript{33} However, it was the issue of scientific unproductiveness which Hinckley found objectionable:

In most all of our colleges little or no attention is given to the subject of insanity. To the chair of 'nervous diseases' is incidentally appended a few cursory lectures on insanity. These lectures are almost invariably delivered in empty halls to vacant seats; for the lecturer manifests so little interest and enthusiasm in the subject of his discourses that students are impressed with the belief that such lectures are only thrown in to fill up space and are wholly irrelevant. In the final college examination, questions on mental diseases are exceedingly rare.\textsuperscript{34}

The lack of scientific contribution cited by Mitchell and the lack of adequate medical education cited by Hinckley point to the problems of nineteenth century insanity study.\textsuperscript{35}
At Canadian medical schools a similar situation existed. Graduating students who wished to specialize in insanity were forced to look beyond Canadian medical schools. Upon his graduation from the Toronto School of Medicine, Dr. Daniel Clark travelled to European centers. He later returned to Canada and by 1875 became the medical superintendent of the Toronto Asylum for the Insane. Although Dr. Clark spent many years as an extramural professor of mental diseases at the University of Toronto, he is best remembered for a series of twelve lectures delivered in 1894 to the graduating medical class. A synopsis of these lectures was published in 1895 under the title *Mental Diseases*[^36]. Dr. Clark defined such terms as delusion, hallucination and illusion. He described the circulatory and nervous system's affect on the brain and the necessity of understanding the relationship:

> The brain is very simple in its construction. This is necessary when we considered its many-sided work. Were it specialized as machines are it would of necessity be limited in its operations. It is virtually a loose structure composed of cells, nerve fibres, connective tissues and blood vessels, yet it is the seat of sensation, ideation, volition, consciousness and all the phenomena which are seen in the sensori-motor and ideo-motor operations. No wonder it is the centre of so much speculation and investigation.[^37]

Unlike physicians who viewed insanity as strictly a phenomena localized within the brain, Dr. Clark felt that other factors could contribute.[^38] In instances of puerperal insanity, which he assessed as a common form afflicting child-bearing women, Clark outlined the role of physical and emotional stress and how it appeared to affect a particular social group:

> Puerperal insanity is more prevalent among the rich or well-to-do than among the poor. The artificial living, the less vigorous organism, the neurotic diathesis so prevalent in the higher stratum of society, the flabby organization for want of proper exercise, the overfeeding, late hours and the unnatural life of fashionable society and such like, all tend to physically and mentally unfit such to face the trials of maternity. The introduction of healthy mothers from the humbler classes saves the race from extinction as the well-known laws of heredity show.[^39]

The overall effect of cursory lectures provided to Canadian medical students was both to disseminate the existing medical knowledge regarding insanity causation and treatment, and to supplement medical textbooks. For, despite instruction in the field of psychiatry and psychology in twentieth

[^36]: Mental Diseases
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century medical schools, the emphasis placed upon undergraduate instruction varied. First and second year medical students received little, if any, instruction in psychology or psychiatry. At McGill and Toronto, the courses in psychology and psychiatry were offered to upper year students and varied in length from 12 to 60 hours. Medical schools in western Canada provided instruction ranging from 14 to 28 hours to upper year students only. Although medical schools offering psychology or psychiatry courses made provision for written and oral examination, the emphasis placed on insanity instruction varied. In part, the varying hours of study reflected a medical conception of insanity and psychiatry. Those schools offering minimal instructional hours tended to view insanity as a specialty warranting graduate instruction, while schools offering more hours of instruction viewed psychiatry as diffused knowledge of which general medical physicians should be aware.

The dilemma regarding the emphasis to be placed on insanity instruction carried over in the medical textbooks. Dr. Charles Mercier wrote in the preface of his 1902 edition:

> Year by year the students to whom I lecture ask me what book on insanity they ought to study, and year by year I have to recommend books which I know to be excellent in themselves, but which I feel are of such bulk and volume as to be out of proportion to the time which students can profitably give to an outlying subject, and to the vast mass of other material which they have to assimilate during their brief curriculum.

A revised and expanded edition published in 1914 continued to be offered as a student's guide of this outlying subject:

> ...to give them a general notion of the subject without going much into detail, and incidentally to be of use to them in examinations.

Mercier's book was not intended for those seeking advanced study, and he cautioned the novice student:

> ...if he is reading merely for the purpose of preparing for a qualifying examination, there is much that he will be well-advised to omit. It is never advantageous to an examinee to know more than his examiners about his subject.

The undergraduate medical student relied upon classroom instruction and medical textbooks or journals in order to gain an understanding of insanity.
Upon graduation, Canadian physicians in the early twentieth century who wished to further their education with respect to insanity often worked under a noted specialist or travelled outside Canada to complete graduate work.

Despite a medical curriculum which sought to define and understand disease processes through a biological approach, the area of insanity continued to be an enigma. While physicians such as Hall treated lesions, others equated insanity to heredity and social Darwinism. In 1902 the physician James Russell who was also the asylum superintendent at Hamilton wrote of the natural laws which governed both physical and mental health. Among the causes of mental alienation, Russell cited the restless spirit of the age, and sexual or moral practices. But, above all else, Russell stated heredity as the chief cause of insanity:

It cannot be denied that a large percentage of the human family is born into the world so weakly endowed mentally as to be wholly unfit for anything but the most primitive form of citizenship.

In order to remedy the situation, Russell cautioned that "laws in the breeding of the human race" and "perverted modes of living" should not be ignored. Although a specific medicine could not be used to cure insanity, Russell reiterated an aspect of the medical approach:

A diseased brain expresses itself in diseased thought, will and action, which is insanity. All rational methods of treatment must consist in discovering the causes which have contributed to that disordered condition and must be followed by a complete reversal of the mode of living which has provoked it. The patient must be placed in a new environment where discipline is enforced and with a complete surveillance of the habit of life.

This reversal of a living style and the discipline of a new environment was to be provided by the provincially funded and medically staffed asylum. At such an institution, residents would receive treatment from the medical profession. But, the type of treatment offered was often based upon medical training or the needs of the institution. Medical students receiving their training at affiliated hospitals most often adhered to an observable and biological approach when studying disease processes. However,
specialization in insanity necessitated a move to an isolated institution in which various factors were considered to be contributory to the processes of insanity. Tissue culture examination did not seem to explain the incidences of insanity. Therefore, medical superintendents, although trained in the biological approach, often sought causation answers through the examination of social causes.  

Superintendent MacNeill wrote that the Saskatchewan asylum received most of its resident population from the rural districts. In light of the province’s agrarian economy and the large proportion of farm families, MacNeill did not find this ratio unexplainable. Yet, MacNeill equated the higher percentage of institutional rural residents as being a result of rural isolation:

...it is painful to see the large number coming in suffering from the different forms of mental depression and mental confusion due to isolation... Their insanity is usually traceable to some apparently unimportant circumstance, but is sufficient to unbalance a nervous system already weakened by long isolation from the tonic stimulant of social intercourse.

Unlike Dr. Ernest Hall whose cases of puerperal insanity were linked to observable phenomena, MacNeill viewed isolation as a contributory factor:

...I have not the least doubt that the dread prospect of passing through this ordeal, without the assurance of proper medical care, or being nursed properly, tends to bring them to such a state of nervous exhaustion as to render them victims to the mental shocks they are compelled to pass through.

MacNeill’s departure from a medically trained biological approach was an attempt to explain the various factors that could contribute to insanity. In a later report he stated how all factors needed to be considered if the individual was to contribute:

Man has a psychic side and a spiritual side, if you will, and he is not entirely made up of material cells which can be invaded by bacteria. The proper adjustment of this side is what means dollars and cents to a material state.

This economic contribution to the family, community and nation was carried over to the institution. A major part of treatment hinged upon the benefits of “occupational therapy”, both to the patient and to the asylum.
The work-cure provided a means of combatting the idleness or deterioration associated with insane institutions. Products which were serviceable or saleable provided a means of judging the insane as employable or re-trainable. Yet, it was this aspect of productiveness which continued to foster a belief in institutional therapeutics while at the same time maintaining the institution.

At North Battleford, a need to employ residents became apparent during its first year of operation. In the kitchen three employees prepared institutional meals with the help of patient labour. Patients were also employed in the dining rooms, wards, laundry and sewing rooms, as well as in outdoor programs. In the bakeshop, a baker assisted by three patient -helpers provided the pies, cakes and approximately 850 pounds of bread daily consumed by the institution in 1917. In the same year, three employees and thirty residents weekly laundered nearly 10 800 articles, while one employee and two residents repaired fifty to sixty mattresses every month as well as providing new mattresses, blankets, and bath hammocks or covers for the institution. The sewing room provided sheets, cushions, table cloths, curtains and such articles needed by the institution. In the sewing room, one employee and eighteen residents made or mended nursing and attendant uniforms and the garments used by the residents.

The utilitarian value of occupational therapy was recognized by asylum administrators. Patients were taught by instructors to make the clothing, mattresses, brooms, mats, and other products needed by the institution. The daily routine work at the institution was carried out by able-bodied patients. While occupational therapy became cited as a treatment method, it was also a means by which the institution itself could operate. Financial considerations with respect to daily operations often necessitated that those confined at the institution were expected to contribute. Physical work provided the means of contribution.
The economic and utilitarian value of occupational therapy was an integral component of Superintendent MacNeill's program:

The idea of constructing buildings for the housing of these people, and not providing a means to employ them, is expensive from every standpoint.64

Through employment he felt that "enthusiasm and correct habit of thought"65 could be achieved. The value of employment either contributing to the institution's operations or as a means for one to spend a day was cited by MacNeill as providing an economic contribution as well as an advantage to a patient:

Let it be understood, however, that employment alone is not sufficient: they should be kept 'busy', and there should be sufficient variety to appeal to, and interest, every variety of patient.66

As a work oriented society, employment or busy work was both a means of spending time and a means for being perceived as useful. Work also broke down individual isolation and provided a means for those confined to develop social relations.67

The occupational program at Saskatchewan emerged during 1916. Indoor classes were offered to female patients in the areas of fancy work such as crocheting, needlework, rug weaving and the making of clothes and linens.68

These products were exhibited at the Regina Exhibition and in November a bazaar was held at the institution's auditorium. The money realized from the sale was used to purchase materials and reported to have "considerably added to the Christmas cheer of our patients".69

In the summer months the male patients were involved in outdoor activities. Land was cleared, trees planted, and fences built with the help of resident labour. Yet, in the winter months, the problem of occupational therapy was more acute. In 1917, MacNeill outlined the problem to the provincial government:

In the summer months we are able to find employment for our male patients, but in the winter we do not find it so easy; if we had the space for a workshop we could employ them to their own advantage and to the benefit of the hospital in many ways.70
The problem of overcrowding constantly affected the institution. Various institutional departments such as the sewing room, mattress maker's shop, and shoemaker's shop were limited in providing employment due to the lack of space. However, with the opening of a second provincial asylum at Weyburn in December of 1921, the problems of crowding and space allocation at North Battleford were lessened.71

The expansion of employment and occupational therapy contributed to the institution's daily operations, and also provided a means of institutional income. The sale of female fancy work in 1916 which had netted 500 dollars expanded to include various craft work which realized sales of 3 500 dollars in 1920.72 In the basement of ward 7a, forty to fifty women daily engaged in the therapeutic work of crocheting, knitting or braiding rugs. Male residents were engaged in basket-making, wood work, and toy-making in another room. Completed products from the industrial and occupational classes continued to be exhibited and sold at provincial exhibitions and institutional bazaars.73 While the institution attempted to produce saleable articles, the submitted reports to the provincial government stressed the intrinsic value of the occupational program:

To interest a patient who has lost his hold and grip of himself, and thereby give him an interest and sense of usefulness to again take his place as a citizen of the province, is our aim and wish.74

The occupational program at North Battleford was cited for its success at rehabilitating and retraining patients.75 Institutional reports to the Saskatchewan government even attributed cures entirely to the work undertaken in the occupational and industrial classes.76 From classes which initially produced a limited amount of saleable goods, the therapy program expanded by 1930 to over two hundred different varieties of products.77 Some products such as nurses' caps, tablecloths and bath covers were used at the institution, while candy baskets, toys, doilies, and tea wagons were some of the saleable articles. The monies realized from sales were used to restock depleted supplies and provided the institution with articles such as pianos, gramaphones, gramaphone records, and recreational materials.78
The success of the occupational program in realizing an institutional income, in providing work for the "idle and listless", and in implementing a means of developing social relationships was not without its drawbacks. While the institutional practice was to employ as many residents as possible, the reports complained that some employed residents were "often paroled soon after becoming accomplished in some work". Although attempts were made to provide some type of occupation for all the patients, a lack of available work space, and the inability of some residents such as the chronic to perform various work functions necessitated that other forms of treatment be provided.

The expansion of occupational therapy in the decade of 1920 resulted in an expanded institutional income. However, an expanded income was dependent upon an expanded market:

We are, of course, handicapped in not having a large enough field to sell what articles we make. If we could find some people who would interest themselves in the sale of our work we could do much better. Provincial exhibitions and institutional bazaars could not provide the expanded market needed to sell the increasing variety of products. Organizations such as the Department of Soldiers' Civil Re-Establishment of Regina, the Local Council of Women or the I.O.D.E. of Saskatoon, the Women's Missionary Society of Sovereign Saskatchewan, and various individuals from outside Saskatchewan helped promote the sale of institutional products.

Occupational and industrial programs, besides providing a benefit to the institution and resident, also provided a means of lessening institutional isolation. Superintendent MacNeill believed that the programs provided a therapy whereby the patient experienced a "building up of will" and therefore an ability to "adjust to society when discharged". Exhibition displays and institutional bazaars became a means of dispelling prejudices regarding the capabilities of the insane and the benefits of institutionalization. Perceptions of the insane as being unfit to work, idle, and in need of restraint were lessened through the products of occupational and industrial therapy.
Annual bazaars held in the auditorium afforded the community an opportunity to enter the institution. Product market expansion helped dispell the foreign or alien aspects of insanity and institutions. MacNeill was thankful for the “interest and sympathy” which the community and province displayed to the institution. He equated this support to a lessening of prejudices:

These are encouraging signs and show that that prejudice which has existed, and of course still exists, in the minds of the people generally, is becoming less, and that a more sensible and scientific attitude towards the patients suffering from a psychoses is taking possession of everyone everywhere;... However, an aspect which helped dispell prejudices and that was at least partially responsible for changing attitudes was the ability of the institution to provide saleable products and be perceived as being productive.

Institutional products and productiveness were a means to show the public that those residing at the institution were on the road to recovery. The quantity of work and the quality of workmanship became a means for the public to assess insanity:

Some of the patients do beautiful work, and many who see the finished product say: “Surely, anyone who can do such beautiful work cannot be ill.” Whether one saw insanity causation as biological, psychological or social in origin, the institution’s ability to provide saleable articles promoted a public perception that the institution was the place suited to provide insanity treatment. In turn, the institution benefitted from public interest and sympathy.

The institution gained economically through the expansion and promotion of saleable goods. Articles could be purchased which at least outwardly alleviated a perception that an institution could only provide custodial care. Recreation and recreational equipment promoted both a public perception of recovery and an institutional perception that the asylum provided more than custody. Sports days were held and prizes awarded to “patients who are able to take an interest in out of door sports”. The drill and calisthenic exercises
were adopted. Institutional reports cited that residents who “had difficulty in co-ordinating and co-operating”91 improved physically and attitudinally because of the drill. The success of calisthenic drill as a treatment procedure was reported by MacNeill to the provincial government:

Our method is to take the patients who are vegetating and drill them with other patients who can assist. In that way we have reclaimed female patients who have done nothing for years and have turned them into productive channels.92

The ability to turn patients into productive residents correlated with the ability of the institution to be seen as the primary productive instrument. As well, the implementation of a drill correlated with institutional operations dependent upon routine and regimentation. Those involved in occupational therapy and drill could be perceived as productive and compliant, able to take orders, and able to be controlled. Therefore, a measure of institutional success was its ability to be perceived as having the means to control the insane. Throughout the 1920s, reports submitted from North Battleford to the provincial Department of Public Works emphasized the therapeutic benefits to be derived from physical work and recreation. The weekly dance and picture show mentioned during the previous decade93 was replaced by an emphasis on physical and re-education forms of treatment.94

Although occupational and industrial classes were cited in institutional reports as a valuable therapeutic tool providing an intrinsic benefit to the resident, the daily institutional operations necessitated an expansion of patient labour. The Saskatchewan government, beset with constant requests for institutional expansion, maintenance or repair, found that a large percentage of its annual budget went toward the maintenance and care of the institution. Just as institutionalization created an economic cost for the individual and family95, so too did it result in an economic cost to the province. Buildings needed to be constructed and serviced, equipment maintained, salaries paid, and the essential aspects of food, clothing and shelter provided. The Department of Public Works, charged with the
construction and maintenance of the governmental buildings, saw a large percentage of its operational budget allocated to the North Battleford institution. Despite smaller departmental budgets over subsequent years, the expansion and maintenance of the insane institution continued to garner a large part of available capital. Increasingly Dr. MacNeill, and those charged with institutional operations found it imperative to manage efficiently and maintain the institution. Decreasing or levelling budgets, coupled with an increase of institutional residents contributed to the development and expansion of work as a form of therapy.

The ability of Dr. MacNeill to efficiently manage the "unfortunate inmates" was commended by Gerhard Ens the government appointed Inspector of Public Institutions. In the inspection report of 1917, Mr. Ens commented upon the use of resident labour:

A great deal of the work in connection with preparing and serving the food is done by the patients themselves under the supervision of capable attendants.

He also commented upon the institution's farm which comprised 2 400 acres:

...I would recommend that some more horses and cattle be secured so that more land might be brought under cultivation, which to my mind would help considerably towards the upkeep of the institution.

This institutional upkeep implied a sense of self reliance. To facilitate economic constraints, the farm was expanded to meet the ever growing institutional needs and to comply with a governmental policy of reducing the cost of maintenance. At North Battleford, the farm attempted to comply with the government directive, to operate successfully and utilize the available residents. While government reports commended the residents for their reliable work, it is apparent that the perception of the institution as an authority in insanity treatment was also dependent upon the institution's self reliance and ability to reduce cost.

In the eyes of government inspection reports, the institution was assumed to be self reliant. Institutional farms and institutional operations could run efficiently and were expected to run efficiently "especially with the labour
question solved." As the number of residents at North Battleford increased, so too did the number of residents employed. Asylum residents assisted in building the cottages used to house the institution's personnel. They assisted in the planting of the trees and shrubs used in the asylum's grounds and along the roads. They hauled away earth, repaired and laid down the institution's roads. They repaired the shoes and slippers required by the institution. The routine work of the institution was carried out by the resident when an employee was absent. Daily operations and institution expansion was dependent upon the ability of the resident to solve the labour problem.

Resident labour, whether termed employment or therapy helped promote the institution as the provider of more than confinement or custody. Internal operations, the institution's external expansion to meet its needs, and the government policy of self-reliance depended upon resident labour. MacNeill's ability to efficiently manage hinged upon the ability of the institution to operate effectively. Although the value of occupational therapy or employment was consistently stressed for its intrinsic value, the value of resident labour to the province and community was also cited. Institutional goods were a means of judging residents while the farm and grounds became a means of judging the success of the institution:

...we hope in a short time to have one of the beauty spots of Saskatchewan at this hospital; a spot that will be a pleasure to the inhabitants of the province, to the visitors to our province, and a joy and benefit to our own patients for whom, and by whom, the effort is made.

Employment and occupational therapy was more than a treatment method or a "means of re-educating the patient." It was more than a way of regaining physical and mental health. It implied that the resident could build up his individual will, could be remodeled or retrained, did not have to be idle or listless, and could contribute to national efficiency and national progress. The foreign or alien aspects of insanity and asylums could be dispelled through resident products and productiveness. Yet, this ability of
the resident to produce or contribute and to be perceived as trainable
continued the maintenance of the institution as a treatment center and the
perception that medical institutions had the means of treatment.

The implication of employment or occupational therapy was that the
individual could adapt, that in most cases insanity was adopted by the
individual as a reaction. However, the ability of employment or occupational
therapy to provide the treatment cure to insanity did not materialize.
Although it continued to be cited as a treatment method, institutional growth
contributed to a perception of insanity as inevitable and unable to be treated
by the institution.

Institutional growth became correlated with provincial population growth
and described as a “history of all civilised communities”.[111] While not giving
up the policy of recreation and employment, MacNeill looked elsewhere for
ways to alleviate institutional growth:

While treatment in hospital of mental diseases is important, it is,
evertheless, true that more attention should be paid to the prevention, to
the early recognition of those individuals whose reactions to their
environment are such as to make it almost certain that they will, if not
looked after, have to be taken care of at a mental hospital.[112]

If the individuals were responsible for their insanity because of their
reactions to the environment, then the medical approach and institutional
policy needed to shift.

The language of the institution moved from the concept of cure to that of
adaptation, while the language of the medical superintendent moved to the
concept of prevention. However, the instrument of prevention was not to be
found within political laws or medical institutions. It formed outside these
agencies and seemed to offer hope to the inevitability of insanity in society.
Although its consequences would bear directly upon government policy and
institutional practices, the development of the Mental Hygiene movement
helped shift the onus of insanity from the individual to society. Thus,
everyone stood to gain if mental disease or mental illness could be replaced
with mental health.
FOOTNOTES

1. Social and ethical obligations and administrative principles in Britain regarding the insane can be found in Jones, Mental Health and Social Policy, 1845-1959.

2. The fear of wrongful confinement was popularized in newspapers and popular expose books during the nineteenth century (P. McCandless, “Liberty and Lunacy: The Victorians and Wrongful Confinement” in Madhouses, Scull, ed., pp. 339-362). In the United States, Mrs. Elizabeth Packard was confined at the State Insane Asylum in Jacksonville Illinois between 1860 and 1863 at the request of her husband. Upon her release she wrote several exposes and succeeded in 1867 in getting the Illinois legislature to pass a law providing safeguards for those accused of insanity. For a discussion of her case see “Madness and Marriage” in The Age of Madness, Szasz, ed., pp.53-76. At the North Battleford institution there were few reported instances of an individual being sent to the asylum and there diagnosed and reported as not insane (Department of Public Health Annual Report, 1930, p. 71).

3. The following table shows the means of institutionalizing in 1926.

<table>
<thead>
<tr>
<th>BASIS</th>
<th>NS</th>
<th>PEI</th>
<th>NB</th>
<th>QUE</th>
<th>ONT</th>
<th>MAN</th>
<th>SK</th>
<th>AB</th>
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<td>Yes(2)</td>
<td>Yes(2)</td>
<td>Yes(*)</td>
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<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<td>Yes</td>
<td>Yes</td>
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<td>Yes</td>
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<td>No</td>
<td>Yes(!)</td>
<td>No</td>
<td>Yes(*)</td>
<td>No</td>
</tr>
</tbody>
</table>

* refers to admission through the Minister of Health; ! refers to admission to a Psychopathic Hospital.


5. This distrust between medical superintendents and the other areas of medicine came to a head in the late nineteenth century (Deutsch, The Mentally Ill, chpt. XIV).

7. Superintendent MacNeill felt the individual needed to be able to enter the institution with confidence in its ability to treat and that this would be possible if the public prejudice toward the institution could be dispelled. Terms which denigrated the individual or institution were to be altered with generic terms such as hospital or illness. While these terms may have lessened the stigma associated with insanity, they also convey the association of insanity as a field of study for those in the medical profession.

8. On February 9, 1922 the existing Act was amended and became An Act respecting the Care and Treatment of Mentally Diseased Persons. This act designated the Battleford institution as a hospital. In 1947 an amendment to The Mental Hygiene Act of 1936 stipulated that mental institutions established in the province were to be known as The Saskatchewan Hospital followed by the name of the city or location of the hospital (Statutes of the Province of Saskatchewan, 1947, chapter 80, section 2).

9. Although the prison doctors were requested to examine cases of insanity, not all examined cases were transferred to the provincial asylum. The following table shows the yearly transfers from provincial jails to North Battleford between 1914 to 1921.

<table>
<thead>
<tr>
<th>Year</th>
<th>Regina</th>
<th>Moosomin</th>
<th>Prince Albert</th>
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</thead>
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<tr>
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<td>26</td>
<td>4</td>
<td>9</td>
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<tr>
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<td>6</td>
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<td>1918-19</td>
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<td>14</td>
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<td>1919-20</td>
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<td>*</td>
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</tr>
<tr>
<td>1920-21</td>
<td>49</td>
<td>*</td>
<td>21</td>
</tr>
</tbody>
</table>

*reports regarding transfers from Moosomin jail were not given.


11. MacNeill continued to lobby for the disassociation of the conceptual link between criminality and insanity by arguing that the criminal insane were under the jurisdiction of the dominion Department of Justice (“The Care of the Insane
Criminal" Bulletin 2, (February, 1926), p. 3). However, the issue of criminal insanity was more than an argument over jurisdiction. To house this type of resident would require a change in institutional management. MacNeill felt it would also mean a continuation of the perception of insanity and the institution as a process of criminal prosecution and not of medical intervention:

The criminal is a different patient to take care of, while on the other hand, the average mental patient, who is not anti-social, can be kept, with proper observation, in any ordinary hospital.


12. This concept of separation has as its basis the need for the medical profession to establish itself as a unique body of trained personnel. Therefore, the separation concept also ties in with the rise of the medical profession as providing services distinctly different than other groups of individuals interested in the care of the insane. An example of the rise of medical expertise in the field of insanity care and treatment can be found in Scull, Museums of Madness. For an overview of the American medical experience, the social response to medicine, and the rise of united professions see “The Consolidation of Professional Authority, 1850-1930” in Paul Starr, The Social Transformation of American Medicine (New York: Basic Books, Inc., Publishers, 1982) pp. 79-144.


17. A study concerning this team approach of general physicians and psychiatrists was undertaken in Saskatoon Saskatchewan in 1961 by Drs. Smith and McKerracher. Although the study did not advocate the replacement of the psychiatrist by a family physician, it did acknowledge the physician as having a closer bond with a patient and that this bond often superseded the necessity of referring the patient to a psychiatrist. The study commended the program of community psychiatric care and the benefit to be derived from the physician’s increased psychiatric skills (Colin Smith and D.G. McKerracher “The Family Doctor in a Programme of Comprehensive Psychiatric Care” in New Aspects of the Mental Health Services Hugh Freeman and James Farndale, eds., [London: Pergamon Press, 1967], pp. 237-245).


22. Hattie, “The Physician’s Part,” p. 120.

23. Hattie, “The Physician’s Part,” p. 120.

24. The physician’s obligation was perceived as humane and national:

   Canada is today faced with a situation not less perilous than that involved in accepting the challenge of the Hun. We have entered upon a period of competition such as was never before dreamed of. Our place among the nations depends upon our ability to meet this competition, and this in turn depends upon the physical, mental and moral qualities of our people. Material progress is essentially dependent upon adaptation to the opportunities with which nature surrounds us.


25. The emphasis on hospitalizing the insane in isolated institutions meant that physicians often had little contact with the insane. In the mid nineteenth century, American physicians were becoming aware of psychiatric theories, but were largely unconcerned with insanity (Dain, Concepts of Insanity, pp. 148-151).

26. In 1853 British asylum doctors founded the Asylum Journal. It was renamed in 1862 to the Journal of Mental Science (K. Jones, Mental Health and Social Policy, 1845-1959, p. 12). In the United States the American Journal of Insanity was founded in 1844 for asylum doctors and the Journal of Nervous and Mental Diseases was founded in 1874 by neurologists (Howells, ed., World History of Psychiatry, p. 349).

27. Dr. Mitchell addressed the annual meeting of asylum superintendents (Mitchell, “Address,” pp. 413-437). Dr. S. Weir Mitchell was a neurologist who believed in the therapeutic benefits of a rest cure. In cases of fatigue, he advised that “Dr. Diet and Dr. Quiet” be called in. Thus, his method was undertreatment not overtreatment (Bromberg, The Mind of Man, p.154).
28. The assembled superintendents were condemned for their lack of scientific advancement:

You look back with just pride as alienists on the merciful changes made for the better in the management of the chronic insane. It is to be feared that you also have cause to recall the fact that as compared with the splendid advance in surgery, in the medicine of the eye and the steady approach to precision all along our ardent line, the alienist has won in proportion little. This is partly due to the nature of the maladies with which you have to deal; but there are many other causes at work to retard the wholesome progress.


35. The lack of insanity education may in part be the result of the newness of the field and its initial inability to provide a pool of standardized scientific data. Also, the asylum’s daily operations often meant that the medical superintendents were too exhausted to engage in scientific works (Deutsch, The Mentally Ill, pp. 272-273).


37. Clark, Mental Diseases p. 16.

38. The melancholic patient was described as being indifferent and absorbed in misery:

If a patient appears afflicted with melancholy, and declares that he is on the brink of ruin of character, that his wife has deserted him or is unfaithful to him, that he is a wicked and dishonest man, that he is liable to arrest, that financial ruin is staring him in the face, it is necessary to be cautious in regarding his statements as unfounded. It may be they are true, and that his feelings of misery are only the natural outcome which such circumstances ought to excite in a normal mind.

Clark, Mental Diseases p. 115.

40. The following chart shows the hours and year of medical instruction in psychiatry and psychology at various Canadian medical schools in 1925.

<table>
<thead>
<tr>
<th>TRAINING</th>
<th>McGill</th>
<th>Toronto</th>
<th>Toronto</th>
<th>Western</th>
<th>Manitoba</th>
<th>Alberta</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatric Option</td>
<td>General Course</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Normal Psychology</td>
<td>Yr. 1</td>
<td>Yr. 2,3</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Yr. 4</td>
</tr>
<tr>
<td></td>
<td>15 Hrs.</td>
<td>60 Hrs.</td>
<td></td>
<td></td>
<td></td>
<td>28 Hrs.</td>
</tr>
<tr>
<td>Abnormal Psychology</td>
<td>Yr. 3</td>
<td>Yr. 4</td>
<td>Yr. 4</td>
<td>None</td>
<td>None</td>
<td>Yr. 5</td>
</tr>
<tr>
<td></td>
<td>30 Hrs.</td>
<td>60 Hrs.</td>
<td>12 Hrs.</td>
<td></td>
<td></td>
<td>28 Hrs.</td>
</tr>
<tr>
<td>Didactic Psychiatry</td>
<td>Yr. 4</td>
<td>Yr. 5,6</td>
<td>Yr. 5,6</td>
<td>Yr. 6</td>
<td>None</td>
<td>Yr. 6</td>
</tr>
<tr>
<td></td>
<td>30 Hrs.</td>
<td>20 Hrs.</td>
<td>20 Hrs.</td>
<td>25 Hrs.</td>
<td></td>
<td>14 Hrs.</td>
</tr>
<tr>
<td>Clinical Psychiatry</td>
<td>Yr. 5</td>
<td>Yr. 5</td>
<td>Yr. 6</td>
<td>Yr. 6</td>
<td>Yr. 4</td>
<td>Yr. 6</td>
</tr>
<tr>
<td></td>
<td>15 Hrs.</td>
<td>60 Hrs.</td>
<td>10 Hrs.</td>
<td>50 Hrs.</td>
<td>25 Hrs.</td>
<td>14 Hrs.</td>
</tr>
<tr>
<td>Required Examination and Oral Psychology</td>
<td>Written</td>
<td>Written</td>
<td>Written</td>
<td>Written</td>
<td>Written</td>
<td>Written</td>
</tr>
</tbody>
</table>

* refers to instruction in a psychopathic ward

A survey of medical school instruction was carried out by the Canadian National Committee for Mental Hygiene and published in *Bulletin 2*, (February, 1926), p. 2.

41. The emphasis to be placed on psychiatric training is still an area of concern. For the most part, physicians continue to be trained in physical and biological methods but few receive training in behavioural concepts (R. Bruce Sloane, “Psychiatry in Undergraduate Education,” *Canadian Medical Association Journal* 90, (April 14, 1964), pp. 845-850).

42. Charles Mercier, *A Text-Book of Insanity and other Mental Diseases* (London: George Allen and Unwin, Ltd., 1914), p. vii. Dr. Mercier was the author of various psychology books and a lecturer on insanity at the medical schools of Westminster Hospital, Charing Cross Hospital, and Royal Free Hospital.


45. Dr. Clarence Hincks (1883-1964), who was instrumental in the Canadian Mental Hygiene movement, was influenced by Dr. Charles K. Clarke (1857-1924) of the Toronto Psychiatric Hospital. In turn, Dr. Clarke had been influenced by Dr. Joseph Workman (1805-1894).
46. Although Canadian medical schools provided psychiatry and psychology instruction, graduate work was usually undertaken in the United States or Europe (Strong, Public Welfare Administration in Canada, p. 180).


50. Russell read his report before the Canadian Conference of Charities and Corrections. Unlike Dr. Mitchell's regime of diet and quiet, Russell advocated a treatment method of labor, recreation, rest, and plenty of fresh air in order to tire the patient and restore the desire to eat. One wonders what he was implying when he ended his address with a quote from "Julius Caesar":

Let me have men about me that are fat, Sleek-headed men and such as sleep o' nights, Yon' Cassius has a lean and hungry look, He thinks too much; such men are dangerous.


51. Unlike neurologists with their emphasis on physiological examination, asylum superintendents continued to see social causes as more important than lesions in explaining the incidences of insanity (David Rothman, Conscience and Convenience: The Asylum and its Alternatives in Progressive America [Toronto: Little, Brown and Company, 1980], p. 303).

52. Table of Saskatchewan Population

<table>
<thead>
<tr>
<th>Census Year</th>
<th>Total</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>1901</td>
<td>91 279</td>
<td>77 013</td>
<td>14 266</td>
</tr>
<tr>
<td>1906</td>
<td>257 763</td>
<td>209 301</td>
<td>48 462</td>
</tr>
<tr>
<td>1911</td>
<td>492 432</td>
<td>361 037</td>
<td>131 395</td>
</tr>
<tr>
<td>1916</td>
<td>647 835</td>
<td>471 538</td>
<td>176 297</td>
</tr>
<tr>
<td>1921</td>
<td>757 510</td>
<td>538 552</td>
<td>218 958</td>
</tr>
<tr>
<td>1926</td>
<td>820 738</td>
<td>578 206</td>
<td>242 532</td>
</tr>
</tbody>
</table>

Department of Natural Resources, Report of the Saskatchewan Royal Commission on Immigration and Settlement (Regina: Kings's Printer, 1930), p. 68.
53. The belief in rural isolation as contributory to insanity was often countered by the belief in urban stress and mechanization as contributing factors. Ironically, MacNeill's statement concerning the impact of rural isolation was not tied into the isolation of the asylum from the community. Instead, institutional isolation was looked upon as being therapeutic.


57. Farrar, "Mental Diseases in Canada," p. 3.

58. At North Battleford's institution, the products made by the residents were used by both residents and staff. The link between therapeutics and maintenance can be found in products such as clothing and nurses' uniforms which were both serviceable to institutional needs and made possible through the adoption of a program of occupational therapy. Also, the occupational program at North Battleford initially assisted Weyburn by providing over three thousand sheets and towels and pillow slips for the new institution (Annual Report of the Department of Public Works. Regina, Sask., 1920-1921, p. 34).

59. An indication of the amount of foodstuffs prepared by the kitchen can be found in the institution's 1914-1915 report. In that first year of operation, the kitchen would handle during one month:

   Beef, pork and mutton, 8,000 lbs. each, fish 700lbs.,
   potatoes, 20,000 lbs., eggs, 300 doz., milk, 13,500 lbs.,
   oatmeal and cornmeal, 1,200 lbs., rice, sago, tapioca, 900 lbs.


60. Although the types of stated employment would vary as institutional needs arose, the institution consistently sought to employ as many residents as possible. Institutional reports in the first year of operation provide an indication of the types of work available:
FEMALE PATIENTS EMPLOYED

<table>
<thead>
<tr>
<th>Department</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laundry</td>
<td>26</td>
</tr>
<tr>
<td>Officers' dining room</td>
<td>4</td>
</tr>
<tr>
<td>Employees' dining room</td>
<td>5</td>
</tr>
<tr>
<td>Patients' dining room</td>
<td>36</td>
</tr>
<tr>
<td>Ward work</td>
<td>52</td>
</tr>
<tr>
<td>Sewing room</td>
<td>12</td>
</tr>
<tr>
<td>Fancy work</td>
<td>4</td>
</tr>
<tr>
<td>Employees' quarters</td>
<td>7</td>
</tr>
</tbody>
</table>

MALE PATIENTS EMPLOYED

<table>
<thead>
<tr>
<th>Department</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ward work</td>
<td>126</td>
</tr>
<tr>
<td>Dining rooms</td>
<td>31</td>
</tr>
<tr>
<td>Grade work</td>
<td>22</td>
</tr>
<tr>
<td>Garden</td>
<td>29</td>
</tr>
<tr>
<td>Laundry</td>
<td>13</td>
</tr>
<tr>
<td>Basement</td>
<td>7</td>
</tr>
<tr>
<td>Baker</td>
<td>2</td>
</tr>
<tr>
<td>Power house</td>
<td>7</td>
</tr>
<tr>
<td>Kitchen</td>
<td>9</td>
</tr>
<tr>
<td>Tailor</td>
<td>3</td>
</tr>
<tr>
<td>Farm</td>
<td>3</td>
</tr>
<tr>
<td>Barn</td>
<td>4</td>
</tr>
<tr>
<td>Carpenter</td>
<td>1</td>
</tr>
<tr>
<td>Mattress maker</td>
<td>1</td>
</tr>
<tr>
<td>Store</td>
<td>4</td>
</tr>
</tbody>
</table>

Also submitted by the institution to the government was the corresponding percentage of residents employed. According to their report, 70 per cent of the women and 73 per cent of the men were employed at the institution (Annual Report of the Department of Public Works. Regina, Sask., 1914-1915. pp.67-68).


63. In the sewing room, one employee and eighteen female residents made institutional articles such as sheets and pillow slips as well as resident clothing such as dresses, chemises, night dresses, men's top shirts, and men's flannelette underwear (Annual Report of the Department of Public Works. Regina, Sask.,
Although patients could bring their own clothing, it appears that few female residents had their personal effects:

Of the two hundred and sixteen female patients eighty are supplied with clothing by their friends or relatives and of the four hundred and sixty men, one hundred are supplied with clothing from the Institution. We send for private patient’s clothing about twice a year.


65. Annual Report of the Department of Public Works. Regina, Sask., 1919-1920, p. 21. It appears that “enthusiasm and correct habit of thought” would correlate with a conception of the insane as idle and yet able to be transformed.


71. Beginning in November 1921, approximately 80 residents per week were placed in rail cars and transferred from North Battleford to Weyburn. Eventually 460 residents and 45 employees were moved to Weyburn (Annual Report of the Department of Public Works. Regina, Sask., 1921-1922. pp. 8, 57). In January 1934, 75 residents from Battleford were removed to Weyburn (Annual Report of the Department of Public Health, 1933-1934, p. 68).

72. The sale of occupational therapy products continued to be a source of income for the institution. Between 1920 and 1924, the articles produced resulted in yearly sales of thousands of dollars. After 1924, the institution’s yearly reports did not cite the amount realized from the sale of articles.

73. The residents produced a variety of products and often the supply exceeded the demand. In 1923 the occupational products realized sales of approximately seven thousand dollars. The same year saw the various work divided into four distinct categories. The basket shop produced twenty-eight different
products, the most being framed pictures and hanging baskets. In the copper work department bowls and napkin rings comprised the majority of articles. The toy shop produced forty-five articles, the majority being animal and bird toys. In the largest department, the women produced fifty-nine article varieties, the majority being doilies and woven rugs (Annual Report of the Department of Public Works. Regina, Sask., 1922-1923, pp. 70-72).


75. At the tenth annual meeting of the Canadian National Committee for Mental Hygiene, held in Toronto on February 15 and 16, the Committee’s Medical Director, Dr. Clarence Hincks called upon Dr. MacNeill to explain the value of occupational therapy. Dr. Hincks stated:

Might I just state that Dr. MacNeill has been very reticent in making any reference to his own hospital. It is unique on the North American continent in regard to occupational therapy; ninety per cent of the patients are occupied, with the exception of those who are bed-ridden.


77. The various departments produced a wide range of products. Among the cited products are candy baskets, paper flowers, pillow slips, ladies aprons, doilies, hand towels, tea bags, toy rabbits, chickens and frogs, scrub and polishing brushes, flower baskets, cribbage boards and foot stools (Annual Report of the Department of Public Works. Regina, Sask., 1929-1930, pp. 66-68). Due to the wide variety of products made by the resident and cited under the heading “occupational therapy”, it appears that saleable goods and institutional necessities were considered by 1930 to be the same.


81. Submitted reports continued to stress the value of work on the patient. Yet, clearly the work benefitted the institution:

For some the work prescribed is cleaning, dusting, weeding, road working, shelling peas, or even keeping themselves tidy, while others are given work which requires more initiative and sociability.

Annual report of the Department of Public Works. Regina, Sask. 1924-1925. p. 70.


83. Besides thanking the mentioned organizations, Mrs. Van Koughnet, the honorary superintendent of the Soldiers' Comforts Branch of the Soldiers Civil Re-establishment in Toronto, was also thanked for her interest and resulting sale of occupational products (Annual Report of the Department of Public Works. Regina, Sask., 1922-1923. p. 70).


85. The institutional bazaars were a means by which community members could come into contact with the personnel as well as some of the patient population of the institution. Newspapers such as The Battleford Times cited these bazaars and sports days. Their files show numerous pictures of outdoor events such as agricultural displays and, along with reports submitted to the Department of Public Works, there are also pictures of the interior of the institution.


89. The institution's isolation from the community was lessened through concerts and plays provided by outside agencies. Individuals and organizations were often cited for their interest and entertainment provided to the residents:

In closing I would say that we are thankful to Mr. D.W. Vaughan for quantities of magazines and papers sent to the patients, to the Elliott Family Orchestra for a concert, to the Union Choir of North Battleford for the 'Hymn of Praise,' and to the Masonic Lodge of Battleford for their sketch 'Lend Me Five Shillings.' Members of our own staff have also taken part in concerts and a play which have given the patients enjoyment.


93. The mention of the weekly show and dance occurred in the Annual Report of 1917-1918. Later reports stated other recreational occupations such as tennis and golf which both the staff and patients participated.

94. An indication of the institution's recreation program came from the following report:

For recreation, in addition to walks, we have two picture shows a week, a dance once a week, church every Sunday afternoon, Mass every Monday morning, and physical drill and games every Saturday afternoon for the women. Our tennis courts are also now in good form and are used by the patients with good results. The women's garden this year is larger and better than formerly. We have a Sports day for both men and women, when races are run, games played, refreshments supplied and prizes awarded.


95. The loss of working years and earning power when an individual is institutionalized was equated to the loss of society's productiveness (Benjamin Malzberg, "Mental Illness and the Economic Value of Man," Mental Hygiene XXXIV, [October, 1950], pp. 582-591).

96. In 1912-1913 the budget of the Department of Public Works was $2,906,351 of which the institution's construction was allocated over $370,000. The following year the Department's budget was similar, however, over $620,000 was spent for the provincial asylum with the next highest expenditure of $293,151 allocated for the Regina gaol. The following table shows the average number of patients per day and the total maintenance cost. The total cost covers such areas as clothing, the maintenance and operation of the power house and building, the operating costs of the farm, salaries paid, and the costs of transportation and deportation. The table shows a steady increase in the number of residents, with the exception of 1922-1923 when the residents had been transferred to Weyburn. The following chart shows that despite institutional growth, the total cost appears to have
levelled even when the institution was accommodating over a thousand patients per day.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>Av. Number of Patients Per Day</th>
<th>TOTAL COST</th>
</tr>
</thead>
<tbody>
<tr>
<td>1919-20</td>
<td>822.90</td>
<td>360,094.12</td>
</tr>
<tr>
<td>1920-21</td>
<td>889.90</td>
<td>461,153.57</td>
</tr>
<tr>
<td>1921-22</td>
<td>883.40</td>
<td>443,928.26</td>
</tr>
<tr>
<td>1922-23</td>
<td>614.30</td>
<td>370,697.21</td>
</tr>
<tr>
<td>1923-24</td>
<td>658.55</td>
<td>286,155.82</td>
</tr>
<tr>
<td>1924-25</td>
<td>714.68</td>
<td>296,515.72</td>
</tr>
<tr>
<td>1925-26</td>
<td>789.77</td>
<td>319,619.28</td>
</tr>
<tr>
<td>1926-27</td>
<td>850.30</td>
<td>336,883.86</td>
</tr>
<tr>
<td>1927-28</td>
<td>901.97</td>
<td>338,795.28</td>
</tr>
<tr>
<td>1928-29</td>
<td>931.95</td>
<td>370,665.86</td>
</tr>
<tr>
<td>1929-30</td>
<td>989.88</td>
<td>435,992.44</td>
</tr>
<tr>
<td>1930-31</td>
<td>1030.94</td>
<td>441,394.85</td>
</tr>
</tbody>
</table>

The above compilation is from the accountant's branch of the Department of Public Works, Annual Report of the Department of Public Works, 1919-1931.


98. Although the implementation of work therapy was not new to the twentieth century it was fully utilized as a method of treatment during this time, and helped the institution to run efficiently. That cures were ascribed to the implementation of work therapy was disputed by Dr. Amariah Brigham (1798-1849) who wrote in the American Journal of Insanity in 1847 that while manual labour may be useful, the 'large majority of patients that recover are restored without it...' (Bockoven, "Moral Treatment in American Psychiatry," p. 302).


105. In the summer of 1924, 6,000 square yards of a crushed rock road were laid at the north and east sides of the institution. In the same reporting year, 9,000 cubic feet of earth was hauled and a graded road lowered by ten feet on a road leading to North Battleford. This work project appears to have had the assistance of fifty male residents (Annual Report of the Department of Public Works. Regina, Sask., 1924-1925, pp. 68, 74).

106. The institution found it more convenient and profitable to do its own repairing of shoes:

   When we sent the repairs to town, they were sometimes weeks before they were returned, whereas here, it is only a matter of two or three days.


107. The mattress maker was given a three month leave of absence in order to visit England. During this time a patient took over the routine work (Annual Report of the Department of Public Works. Regina, Sask., 1924-1925, p. 69).

108. The institution's policy was stated by MacNeill:

   We have continued our policy of having as many patients as possible employed on the farm and in the Gardens and Grounds and always with marked benefit to their physical and mental health.


Chapter 4

SOCIETY AND MANAGEMENT

Throughout the history of insanity the role of the individual or group to bring change has been heralded. William Tuke and Philippe Pinel are consistently cited for their impact on changing asylum conditions in the eighteenth century. The drama of removing the chains or the appearance of a family environment caught the public's attention. By the nineteenth century individual American reformers such as Dorothea Dix and Elizabeth Packard gained the public ear. Dix's crusade on behalf of improving institutional conditions gained her world-wide renown.\(^1\) She investigated the conditions of institutional life, the treatment afforded the insane, and lobbied state legislatures for improved care.\(^2\) In the latter part of the century Packard came to the public's attention. Her commitment and subsequent dismissal from the State Insane Asylum at Jacksonville, Illinois served as the basis for her written exposes. Besides describing the conditions of institutional life, her exposes brought to the foreground the possibility of illegal accusations and commitment. Through her efforts state legislation was enacted to provide a safeguard to wrongful confinement.

Various individuals wrote exposes of particular asylums, of the abuses contained within, and of the horror of wrongful confinement. Such exposes rarely resulted in permanent gains or improvements however, they did bring out a public interest. The public interest aroused by reformers such as Tuke or Dix was harnessed into associations. At times these associations formed out of a fear of insanity. In Britain the Alleged Lunatics' Friend Society founded in 1845 by John Perceval\(^3\) and composed of members such as Luke James Hansard stated their objective as:
...the protection of the British subject from unjust confinement on the grounds of mental derangement, and from the redress of persons so confined.  

In London, the Society for Improving the Conditions of the Insane was organized in 1842 by Lord Shaftesbury. This association saw its role as a bridge in diffusing the knowledge between medical personnel and an interested lay public. By 1879 a meeting in New York to discuss the problems of lunacy reform resulted in the later establishment of The National Association for the Protection of the Insane and the Prevention of Insanity. Association members composed of social workers, psychiatrists, and socially-minded laymen sought to educate the public in the nature of insanity and improve the methods of management.

Asylum reformers or associations often viewed the insane as victims, but this victimization was seen as the result of institutional mismanagement or inadequate attendant training. For the most part, exposes and reform movements addressed the concerns of institutionalized individuals and offered means by which institutional conditions could be improved. However, lack of sustained public response meant that reform could not be sustained. The economic conditions which created and maintained institutions wavered. Tax dollars and government budgets would not indefinitely support the institution.

The public response to these individuals and associations varied. Gestures and chartered objectives were unable to sustain a public interest. The Alleged Lunatics’ Friend Society ceased operation by the 1860s, the Society for Improving the Conditions of the Insane saw its influence decline and membership merge with the Lunacy Law Reform Society of London. The National Association was effectively defunct by 1886. However, despite the nature or time of demise, the reform associations had managed to enact at least limiting reforms at various institutions as well as keeping the issue of insanity alive in the public sphere.
In the early twentieth century the public perceived insanity causation to be the result of heredity. Physicians detailed the concept of heredity and showed how the child inherited the features of brain and mind from the opposite parent. Psychiatrists and psychologists examined the relationship of mind and behaviour and used case histories as a means to access avatism. Hereditarian laws described insanity as a recessive or degenerative condition in which future generations could suffer.

While the concept of heredity provided a causation model and pointed to the potential growth of a mental taint in society, it also provided an explanation for the institution's inability to cure, and offered a means by which science and society could unite. The insane individual could still be perceived as a victim. But, unlike beliefs in institutional abuse as the principle cause of victimization, the concept of heredity viewed society as a victim due to genetic inheritance contributing to increased numbers of insane. The individual with a perceived inherited mental taint was not solely responsible for her or his condition, but would have to learn to adapt due to the disadvantaged inheritance. The institution would continue to be promoted as a treatment center, but increasingly the treatment prescribed was one of adaptation not of cure.

Science and medicine employed hereditarian laws as a means of explaining insanity and as a way of understanding mental illness. Yet within the concept of heredity a social and scientific problem emerged. If the individual was restricted due to a limited inheritance and such an inheritance could expand in society, what could science and society do? The fatalistic assumption contained within the concept of heredity shifted the onus of control from the individual to that of society. Social service organizations examined the economic or social conditions which impeded health and happiness. Individual lifestyle, heredity, or hereditarian tendencies were examined for their ability to prevent illness and promote health. The concept of a “brother's keeper” gained ground in light of the hereditarian model.
The problem of avatism or hereditary illness could be broached in two ways. The first was to educate the public to avatism and the ways in which illness could be prevented. The second approach was to provide a program in which the insane individual could be helped in adapting to society and, at least in a limited way, contribute to social health. Conditions such as insanity could be lessened, if not eradicated, through a system of adaptation and education. Into this arena of prevention of illness and promotion of health emerged an organization willing to promote the discoveries - the Mental Hygiene movement.

The Mental Hygiene movement was similar to previous reform associations in that it undertook a program that would bridge scientific knowledge and an interested lay public. It examined institutional conditions and lobbied for improved care. At the same time, it undertook social condition surveys and implemented programs which were meant to benefit the insane institution and society. Its membership was composed of interested lay individuals, physicians, superintendents, psychologists and psychiatrists, as well as social service workers. Like earlier movements, it received its impetus from the experiences of an individual confined to an insane institution and the subsequent publishing of an expose.

In 1900 the Yale graduate Clifford Whittingham Beers found himself in a state of mental collapse. A suicide attempt in June 1900 left him hospitalized with broken feet. While hospitalized the feelings of persecution came to the fore and over the next three years, Beers found himself confined to various types of insane institutions in the state of Connecticut. Throughout the first two years of confinement Beers' feelings of persecution persisted. He felt watched either by detectives or society and felt guilt as if he had committed some crime. By 1902 these feelings of depression altered to feelings of elation. Beers described this insight into his mental condition as a sensation in which "my mind seemed to have found itself". Beers then began an active letter writing campaign to the Connecticut Governor, and
various officials outlining the abuses he had experienced or witnessed at the institutions and the need for reform. In July 1903 he was granted an unlimited parole and in September given a discharge. Upon his discharge Beers felt the stigma of being perceived as a former mental patient often limited the occupations available and gave the individual an undeserved social taint. Despite a short voluntary commitment to a private institution in January 1905, Beers was able to resume his business career. But his resolve to reform institutional conditions and social perceptions persisted. By 1907 he quit his business career and undertook the writing of his autobiography which sketched his family life, detailed the experiences at the institutions, and outlined his proposals of reform.

Unlike previous exposes which denied the individual’s insanity, Beers perceived his insane condition as real:

Psychiatrists inform me that it is not unusual for those suffering as I did to retain accurate impressions of their experiences while ill. Thus, both the condition of insanity and the experiences he described were to be believed by the reading public. Although Beers chastised institutional treatment procedures and condemned the mechanical or chemical restraints employed, he believed that the institutions were needed and when well managed would help the individual regain sanity.

Beers sent his manuscript to William James, a Harvard psychologist. Later Dr. Adolf Meyer sent a supporting letter to Beers and suggested the term “mental hygiene.” By 1907 the concept of an organized auxiliary movement for improved care and treatment and for the prevention of insanity was beginning to form. In the following year, Beers’ autobiography, A Mind That Found Itself was published, and in May, 1908 the Connecticut Society for Mental Hygiene was founded. The success of the book provided the impetus for further expansion of the Mental Hygiene movement.

In February 1909 the National Committee for Mental Hygiene was founded with Beers acting as secretary. The purpose of the National
Committee was to take up the issue of after-care or rehabilitation, and to educate the public about insanity. Funded by the Rockefeller Foundation, the National Committee undertook surveys of existing facilities and examined schools and correctional facilities for evidence of mental deficiency. By promoting the principle of prevention, the Mental Hygiene movement was able to increase its membership and expand its financial base. Within ten years, seventeen state societies existed, and by 1936, thirty countries had their own national societies. At the First International Congress on Mental Hygiene held in Washington in 1930 more than 3000 attended. Throughout the growth and expansion of the Mental Hygiene movement, Beers continued to play an active role in the organization. He travelled, lectured, and, in the case of Canada, helped form the societies. His three year commitment turned to a lifetime commitment of promotion and prevention in which he believed he had a “distinct mission in life” to promote the laws of mental health.

The Mental Hygiene movement went beyond institutional conditions and undertook an ambitious program of mental health in which the goal was to effect a reduction of insanity. In such a way it promoted the positive concept of prevention and charted a course for future social intervention. It sought to go beyond the public’s perception of viewing insanity as incurable or a disgrace and instead focused public attention to the problem of eliminating preventable insanity. The Mental Hygiene movement broke away from the fatalism of hereditarian law by promoting individual rehabilitation. Beers ability to go beyond insanity became a source of hope for the movement and society in general. Unlike associations which chided science and institutional procedures, the Mental Hygiene movement elicited their input. Membership was drawn from those working directly with or interested in the area of insanity. Although institutions were chastised for abusive treatment methods the movement never sought to abolish the institution. Instead, Mental Hygiene examined conditions in light of their ability to promote efficient living.
The appeal of Mental Hygiene lay in its ability to define a problem and offer a solution. The effects of mental inheritance and the social environment were examined as a means of understanding the various factors which contributed to the development of the individual. Social problems were identified and placed in the sphere of scientific solutions:

...how many of our practitioners in Canada today realize that approximately 75 per cent. of the inmates of our jails, about 50 per cent. of our juvenile offenders, from 75 to 80 per cent. of our prostitutes, and a goodly percentage of our cases of pauperism, non-employment, illegitimacy and intemperance are really cases for our medical men, rather than for our judges and their courts?

Instead of attacking the outward conditions, the Mental Hygiene movement attempted to identify and treat the internal mental or social factors. It sought to co-ordinate medical, psychiatric and social service efforts and thereby improve the health of the individual and the health of society. Insanity, in the Mental Hygiene schema, was a condition which affected individual and social efficiency and contributed to individual and social problems. Yet, the Mental Hygiene movement went beyond the identification of problems by offering a program of solutions in which the goal became one of public good:

Mental hygiene, therefore, as aiming to promote and preserve the mental determinants of right and efficient living, must consider and promote...good mental endowment...good development of the mental capacities, and...good use of them and...the factors and conditions that are favorable to them. Promotion of the good involves prevention of the harmful.

The Mental Hygiene movement, conceived by Beers and supported by science, encompassed aspects of scientific facts and principles and transferred them to principles of living. It was more than an agency of reform and education, it became a means of assessing the individual and society.

The Mental Hygiene mandate of restoration, promotion, and prevention appealed to the public. Organizations and individuals such as parents, teachers, employers and judges were encouraged to understand and apply mental hygiene principles. Pamphlets, newspaper articles and specialized journals promoted the movement’s viewpoint and goal, and offered a program of activity in which society could take part.
In February 1918, Beers accepted an invitation to attend a meeting at the Toronto home of Mrs. D. Dunlap. Dr. Charles Clarke chaired the meeting in which the gathered individuals were convinced of the need for a Canadian Mental Hygiene association. At this meeting a tentative Canadian program was outlined and an organizing committee appointed. On April 28 the Canadian National Committee for Mental Hygiene was formally launched in Ottawa. The Committee adopted a provisional constitution similar to that of its American counterpart. Office bearers were elected from the approximately 125 members. Dr. Charles Martin of McGill University was elected President, Dr. Charles Clarke from the University of Toronto became the Medical Director, and Dr. Clarence Hincks of Toronto was elected Associate Medical Director and Secretary. Other Committee positions were elected from the membership which was to consist of one third medical men, one third non-medical, and one third unspecified.

At the Ottawa meeting, the Canadian National Committee stated its objective to assist existing agencies:

It was established because of the belief that a group of professional and lay citizens could materially strengthen the hands of these agencies by impartially surveying the problems of mental abnormalities in Canada; by evaluating the effectiveness of the institutions actually in operation; by discovering the points at which efforts were being impeded by public apathy and indifference; by studying the medical, educational, social and legal results of mental abnormalities; by envisaging, in collaboration with the proper officials, federal, provincial, and local programmes for sound and stable progress in the scientific and humane treatment of the mentally afflicted; and by educating the public to such measures as might be feasible or requisite.

In order to carry out its mandate, the Committee solicited the involvement of government officials and prominent individuals. University presidents and college deans and professors of medical schools were approached as a means of initiating public education. In turn, mental hygiene concepts were passed on to teachers, nurses, social workers and lastly the public. The concept that insanity could be prevented was heralded, and the Mental Hygiene movement promoted this discovery as a means by which everyone could profit:
To-day the psychologist to whom mental hygiene makes no appeal is as the old man who, unable to keep pace with the rapid current of medical science, creeps up on the bank and silently watches the stream of progress flow by him and beyond.\textsuperscript{42}

To supplement the education program, the Committee initiated medical school prizes\textsuperscript{43} and fellowships to encourage further education.\textsuperscript{44} The impact of the Committee's membership and its activities influenced the government response. Advice, service, and suggestions were offered to provincial and dominion agencies as a means of implementing and ensuring legislation based on mental hygiene principles.

The financing for the Canadian Mental Hygiene activities came from various sources. Initially private subscription was used as a way to obtain the projected yearly budget of 25,000 dollars.\textsuperscript{45} In 1919 the dominion government provided the Committee with a grant of 10,000 dollars. However, varying dominion grants\textsuperscript{46} and the expansion of Committee activities necessitated further financing. Prominent individuals donated money or name in an effort to finance mental hygiene work,\textsuperscript{47} and American foundations came to the financial aid of the Canadian Committee. In June 1924 the Rockefeller Foundation provided a grant of 75,000 dollars to be used over a five year period for research in the application of mental hygiene to school age children. Subsequent financing from the Laura Spelman Rockefeller Memorial and the Metropolitan Life Insurance Company initiated the Canadian Committee's research into child development.\textsuperscript{48} A second Rockefeller Foundation grant in 1931 encouraged the Canadian Committee to initiate and operate a post-graduate centre for psychiatric training.\textsuperscript{49}

The Canadian National Committee began the publication of a journal as a means to promote objectives and activities.\textsuperscript{50} Although the Committee's executive office was headquartered in Toronto, the journal's editorial office was situated in Montreal. Dr. Gordon Mundie became the editor of the \textit{Canadian Journal of Mental Hygiene} which first appeared as a quarterly publication in May, 1919.\textsuperscript{51} Despite the costs incurred by the Committee in
its publishing of journals and pamphlets, the printed works did disseminate objectives and beliefs. Interested individuals could subscribe or request the publications. The journal articles reflected the wide range of Committee activities and in tone as well as title reflected the scope and emphasis of the Committee. By 1931 the journal became supplemented with another form of public education. Weekly newspapers were supplied with short articles. This service provided by the Committee was used on a regular basis by 166 newspapers.

Like its American counterpart, the initial activities undertaken by the Canadian National Committee for Mental Hygiene centered upon the compilation of existing data regarding institutional conditions and insanity causation. The outbreak of World War I and the resulting war casualties provided a situation in which both perceptions of insanity, and the types of treatment offered began to change. Cases of psychoneuroses or “shell shock” clearly showed that everyone, even those deemed physically and emotionally stable, had a breaking point.

The concept of social stress being related to the onset of insanity was not entirely new. For the most part, the impact of social stress had been in conjunction with its effect on an already weak individual:

When a human organism breaks down under the stress of life, in a way that the majority of men do not break down, it is because either the person who fails is weaker than his fellows, or the stress brought to bear on him is greater.

However, the large number of “shell shock” cases provided a situation in which physical explanations alone could not adequately explain. Recruitment procedures which attempted to identify physical or emotional problems seemed to have failed as incidences of neuroses rose among the military. The victims of “shell shock” provided psychiatrists and psychologists with a vast living laboratory in which to study insanity causation. Various explanations regarding causation were offered:

It is easy to understand that complex adaptations required of the soldier, who is recruited more or less suddenly from civilian life, will tend to
produce mental conflicts, the reaction to which in many may be some anomalous convulsive attack which requires special care and knowledge.\textsuperscript{58} While war psychiatry broadened the area of insanity causation, the necessity of returning the soldier to his battalion altered the predominant treatment method of rest.

Until the spring of 1915, soldiers showing signs of insanity had been removed from the front lines or sent to general military hospitals in England. However, the increasing numbers of hospitalized and the escalation of the war necessitated a change. Each army area operated a “shell shock” hospital in conjunction with a clearing hospital.\textsuperscript{59} At these centers soldiers were interviewed, diagnosed and classified by trained medical staff, and treatment procedures begun to return the soldier to active duty. At times groups of soldiers were convened and appeals made for them to return to their unit. In other instances, the denial of privileges and the performance of demeaning work was used as a means of treatment.\textsuperscript{60} Suggestion, medical mystification, and arguments were used to encourage a return to the battalion:

The intellectual status of the patient was not without its effect. The relatively ignorant soldier was usually softer clay in the physician’s hands than was the one in whom learning and training had sharpened the habit of questioning, scrutinizing, and weighing in the balance.\textsuperscript{61}

The ability of the front-line medical staff to return the soldier to active duty was crucial to the war effort and to the prestige of science to effect a cure. Statistics compiled showed a high recovery rate during a short period of time.\textsuperscript{62} For proponents of Mental Hygiene, the success of front-line cures further intensified their belief that sanity could be restored. Early identification and early intervention in treatment allowed the soldier to return to duty. Thus, to a certain extent the restoration and productiveness of war psychiatry became a means to measure the abilities of the civilian insane institution.

Despite the productive success of war psychiatry to return the soldier to his battalion, not all incidences of neuroses were so quickly cured. Those soldiers whose recovery was less favorable were evacuated to the base or to
England. If the Canadian soldier was not deemed fit within six months he would be sent to Canada for further treatment and discharge. Upon his arrival at the ports of Quebec, St. John, or Halifax, the soldier was examined by a medical board and his needs determined. The board's classification of immediately dischargable, in need of treatment, or permanently disabled signified the available treatment.\textsuperscript{63} Initially the Canadian response to care for the injured soldier centered upon the convalescence of the physical cripple and the hospitalization of the very sick. The dominion government had, in the early years of the war, established a civilian Military Hospitals Commission headed by Senator James Lougheed. The Commission, charged with overseeing the management of sanatoria and hospitals, felt that a period of rest would benefit the returning soldier. A desire to help the war effort and provide a restful environment proved disastrous:

Wealthy people in the Dominion turned over magnificent residences where the men could loll in luxury and ease. Women with more zeal than judgment lionized the first detachments of returned heroes and vied with each other in the entertainment and attention to the first cripples. The soldiers who, themselves, thought they had done their simple duty were told so often that the government could never repay them for their services that they came to believe it. All these artificial conditions were ill adapted for the rehabilitation of nerve-racked men.\textsuperscript{64}

It was soon discovered that the deterioration of morale and listlessness was the result of such hospitality. The majority of the returning soldiers were not physical cripples and could be expected to enter industry or business.\textsuperscript{65} To this end, the Commission planned and built convalescent homes and sanatoria.

The sanatoria and convalescent homes offered vocational training and efforts were made to find an area of interest. Although such training was to be secondary to the soldier's medical needs, the emphasis placed upon successful vocational training underlied the belief in the "gospel of the busy life" and "salvation through honest work".\textsuperscript{66} Commission members saw vocational training as a means of returning the soldier to civilian life and as a way of ensuring social stability:

...Canada is determined to have no crop of 'carpet-baggers', pension
mongers, and government alms takers with the consequent commonplace filching of national funds and degeneration of civic honesty.\textsuperscript{67}

Yet, despite the intention of the Military Hospitals Commission to facilitate the re-entry of the soldier into civilian life, the number of soldiers returning to Canada and in need of medical intervention increased.

Provisions were made to transport disabled soldiers to the district convalescent homes.\textsuperscript{68} Special provisions were offered to surgical cases, the tubercular, and to the insane who were transferred to provincial institutions.\textsuperscript{69} Problems which had plagued the civilian Military Hospitals Commission were further intensified with troop demobilization.\textsuperscript{70} In 1918 the civilian Commission was replaced by the newly created Soldiers' Civil Re-establishment Department.

The Department, charged to provide the means by which returning soldiers could re-enter civilian life, undertook various studies to access existing facilities. Although the Central Hospital for Nervous Diseases at Cobourg, Ontario housed the severe cases of returning insane soldiers,\textsuperscript{71} it was apparent by 1918 that provincial institutions would also be housing the military insane. Dr. Colin Russel, Montreal neurologist and member of the Executive Committee of Mental Hygiene, undertook a survey of existing institutions for the Soldiers' Civil Re-establishment Department. In comparison to the Department's Cobourg institution\textsuperscript{72} the provincial institutions surveyed by Dr. Russel were found to be unsatisfactory to the needs of the soldier and to the goal of Mental Hygiene. When approached by the Manitoba provincial government, Dr. Russel suggested the services of the Canadian National Committee for Mental Hygiene would help identify institutional problems and provide recommendations for improvement. In October 1918, Dr. Hincks and the social worker Marjorie Keys initiated a survey of Manitoba's facilities on behalf of the Canadian National Committee. This survey of Manitoba's insane institutions was soon followed by similar requests from British Columbia, New Brunswick, Nova Scotia, Prince Edward Island, Alberta, and Saskatchewan.
The recommendations made by Hincks reflected the Mental Hygiene conception of insanity and correlated with the mandate of the Soldiers’ Civil Re-establishment Department. Restoration of sanity was possible. The example of Beers and the experiences of war psychiatry exemplified that principle. Restoration to a useful and productive life was feasible. The example of Beers’ motivation and the success of war psychiatry’s rehabilitation provided the example of productiveness.

In order for the institution to restore and rehabilitate, the nature of the soldier needed to be understood. Dr. Edward Bott, a member of the Canadian National Committee for Mental Hygiene, described the nature of the soldier as being similar to the civilian. Like the civilian, the soldier was used to being part of a group. He was seen to respond favorably to routine and commands, which might be applied to the civilian insane. Thereby, institutional treatment should center not so much on what was done, but on how it was done:

...the aim throughout is to combat the attitude of invalidism by setting precise tasks, not minimizing difficulties, and appealing to the strong motives of mastery, of self-competition and group competition.73

Ironically the stress of tasks and competition, which may have contributed to war neuroses, became the means of restoration and rehabilitation cited by proponents of Mental Hygiene. Occupation as a treatment method, espoused by Mental Hygiene and readily accepted by institutions, correlated with the social and economic concerns of idleness and unproductiveness. In such a manner, the ability to restore and rehabilitate became the yardstick by which governments and society could measure the success of the institution and the principles of Mental Hygiene.

The conception of restoring and rehabilitating the insane was not the only activity undertaken by the Mental Hygiene movement. Mental Hygiene surveys of institutional practices were just one means of combatting insanity. Within society various factors needed to be examined if insanity was to be eradicated. Chief among those factors was the impact of immigration.
The Canadian immigration policy, based in part upon the needs of settlement and labour, was subject to parallel agreement between provincial and dominion governments. Although the policy encouraged immigration, it was not until 1901 that the rate of immigration exceeded the rate of emigration.\textsuperscript{74}

The Immigration Act of 1910 required the immigrant to have a degree of literacy and to be mentally and physically sound. Medical personnel hired by the Department of Immigration and Colonization assessed the soundness of the applicant and implemented procedures for admission or rejection. With the exception of the Asiatic who had to meet special terms of entry, the request to enter was denied for few specific reasons. Among the cited reasons for denial were health, criminal offences, prostitution, and insanity if it was felt the individual would become a public charge.\textsuperscript{75}

Canadian immigration policy encouraged settlement as a way of ensuring economic prosperity both to the province and nation. It encouraged immigration of the British, Americans and northern Europeans for their seeming ability to assimilate to Canadian standards. During the first decade of the twentieth century approximately 40% of the immigrants came from the United Kingdom and 32% were from the United States.\textsuperscript{76} Although these two groups continued to compromise the majority of admissions and rejections in the subsequent decade, problems of immigration and assimilation emerged.

The influx of immigrants created disproportionate settlement patterns. While provinces such as Ontario had a foreign-born population of less than 6%, the western provinces such as Saskatchewan had over 33% foreign-born inhabitants and a total population in which 50% was British-born or foreign-born immigrant.\textsuperscript{77} Although prairie agriculture continued to absorb the farming or labouring immigrant, the pressure on urban centers to absorb the growing number of immigrants grew as the number of homesteads decreased:

This great influx into the life of Canadian cities with their congested areas, lack of housing facilities, costs of areal expansion, has done much to
change the whole economic situation, multiplied the agencies necessary for charity or benevolence, increased the growth of the slum, swelled the ranks of labour, and produced a task of assimilation by the State and the Church which is yet a long way off from completion.\textsuperscript{78}

The problems of urban centers, disproportionate settlement patterns, and the influx of immigrants caused both real and imagined national concerns with respect to assimilation and economic prosperity.

The resulting influx of immigrants between 1901 and 1931 was attributable, in part, to an open immigration policy and a changing government conception of a “desirable” candidate.\textsuperscript{79} In Saskatchewan, the concerns regarding the percentage of foreigners was further exacerbated by agreements such as the “Railway Agreement” of 1925 which encouraged immigration of the eastern European. Committees such as The Saskatchewan Command of the Canadian Legion called for the end of the “Railway Agreement” and for the encouragement of increased British immigration.\textsuperscript{80} The need of immigrant assimilation was also echoed by the Royal Commission report of 1930. This Saskatchewan Commission, after hearing briefs from various organizations\textsuperscript{81} recommended that immigration be controlled and based upon the ability to assimilate. Their report, while viewing immigration as eroding a national standard, also cited uncontrolled immigration as an economic hardship.

The belief that uncontrolled immigration constituted an economic hardship developed, in part, through studies undertaken by Mental Hygiene. In Canada the National Committee undertook a series of studies examining the role of immigration and insanity. These studies under the direction of W.G. Smith, professor of psychology at the University of Toronto and member of the National Committee, examined the cause and reasoning behind a restrictive immigration policy. Professor Smith’s articles attempted to explain the social response to immigration. Unlike American studies which equated nationality and insanity,\textsuperscript{82} the Canadian studies of 1919 equated the problem of immigration as an economic concern. In a study of oriental
immigration, Smith found the social objection as being primarily based upon economic grounds:

For in the final analysis the objection to the Oriental is not racial, nor social, nor religious, but economic. The Asiatic is accustomed to long hours of labour, small wages, and a low standard of living. The whole trend of Western Industrial Labour, on the other hand, has been toward shorter hours of labour, larger wages and a higher standard of living. These two industrial conditions are incompatible and in occupations where the Oriental prevails, the Canadian labourer moves out.  

Smith's studies provided statistics to show that the Immigration department did restrict the entry of undesirables. His studies outlined the large immigrant influx, the costs incurred in promoting immigration, and the necessity of more regulation and selection in order to safeguard the economic concerns of the nation.

The economic hardship cited by Mental Hygiene had also been a concern of insane institutions. Annual reports submitted from North Battleford showed that foreign admissions comprised nearly two-thirds of yearly admissions. Superintendent MacNeill viewed the foreign admission as an economic and maintenance hardship placed on provincial governments due to inadequate dominion measures to identify or deport the insane immigrant:

...it is only reasonable when the Dominion of Canada recognizes its duties in trying to sort out the immigrants and in providing laws whereby these undesirables may be returned to their native country within a given period of time that we should expect to receive the whole-hearted co-operation of the Immigration department, the country's machinery for this work. We are forced however to state that it has often appeared to us to be necessary to use considerable pressure before some deportations are brought about, and many deportations legal so far as we can interpret our country's laws are not brought about.

Institutional reports citing admissions and deportations of the foreign insane brought to the foreground the correlation of insanity and immigration. In turn, insanity which had been viewed as a factor in criminality and social problems began to be combined with immigration. An article entitled "One Phase of the Foreign Invasion of Canada" published in the Canadian Journal of Mental Hygiene sought to show that illiteracy and immigration contributed to a large proportion of Manitoba's criminal cases.
Studies undertaken at prisons in the United States by Mental Hygiene members cited a large percentage of insanity among the prisoners. Therefore, through a process of implication, insanity was the root of criminality which in turn had its basis in inadequate immigration policies and procedures.

Institutional concerns regarding foreign admissions were addressed by Mental Hygiene. Major J.D. Page, chief medical advisor for the Quebec port and member of the Executive Committee of the Canadian National Committee for Mental Hygiene, described the problem of immigration selection:

The Immigration Medical Service being only a side line for the port inspectors who live chiefly from their private practice, it is nothing but natural that they take very little or no interest in it outside the inspection rooms. They go to the ships according to a system of rotation which cannot always be adhered to on account of their being engaged somewhere else when wanted, so that occasionally four or five of them have to be called before you can get the number required. You will agree with me that under such conditions no earnest training for this very special and difficult work of necessarily rapid inspection can be obtained.89

Institutional concerns regarding deportation were also addressed by Mental Hygiene. Although the 1910 Immigration Act had established a three year probationary period in which immigrants convicted of a criminal offence, charged in prostitution related offences, or in various ways becoming a public charge could be deported, the Mental Hygiene Committee called for a longer probationary period. As well as extending the period in order to access assimilation and ensure the immigration of the desirable, the proponents of Mental Hygiene called for the expansion of trained medical personnel involved in the process of selection.

The immigration policy which promoted settlement and labour was chastised by Mental Hygiene for its inability to ascertain the desirable immigrant, the ones who would assimilate and make an economic contribution to the national prosperity. Their arguments for strict regulations and expanded medical selection addressed concerns expressed by government, provincial institutions, and organized groups.
The call by the supporters of Mental Hygiene for regulation in order to ensure national and individual well-being appeared to have the nation's best interests at heart. In the Mental Hygiene schema, immigration regulation was not racially motivated, nor directed to a particular ethnic group. Instead, selection was cited for its ability to foster economic prosperity and ensure social stability. Yet, these studies undertaken by Mental Hygiene only addressed part of the concerns. Prosperity, while dependent upon labour, was also dependent upon a domestic and world market. Assimilation, while based upon a Canadian standard, was also affected by the perception of not appearing to be foreign. And the idea of social stability, while affected by those who became public charges, was based upon the absorption of immigrants and the creation of a Canadian mosaic.

Institutional concerns with respect to foreign insanity admissions or deportations correlated with societal concerns of immigration. Statistics showing foreign admissions were never compared with statistics showing the composition of the provincial population. Concerns regarding the economic or maintenance hardship of institutionalizing the foreign insane appear to have had little bearing to the small number of actual deportations. Although the nationality of admissions and deportations submitted in annual reports would continue to show a majority as "foreign", the possibility exists that a large percentage of the foreign insane were legally considered Canadian citizens. Therefore, the issue of insanity and immigration may reflect a social perception, a belief that limited the reality of the situation. It is possible that foreign insanity and immigration were fused together in a conceptual framework due to the immigrant and the insane being perceived as "alien" or "foreign". If this is the case, the Mental Hygiene call for increased selection underscores a belief that national prosperity was dependent upon the selection of the right individual. Their recommendations for adequately trained individuals involved in the selection process, and their studies regarding suitable immigration became the attempt by the movement to define the "desirable" immigrant in light of Mental Hygiene principles.
The initial activities undertaken by Mental Hygiene pointed out areas where problems existed, and offered programs for solutions. Their involvement in war psychiatry and institutional surveys helped promote a perception of expertise in the care and treatment of insanity. Their studies concerning the consequences of open immigration promoted the perception of an organization concerned with individual and national well-being. Their research in the area of child development promoted the perception of attainable individual health based upon the organization's principles. The public was encouraged to expand its conception of insanity and to be aware of the physical, environmental, and developmental components of insanity causation. Institutions were encouraged to alter conditions and procedures and to implement programs of productive rehabilitation. Provincial and dominion governments were encouraged to financially support the institutions and to expand their support to other measures of restoring and maintaining sanity.

The movement's goal of preventing illness and promoting health, and its activities directed toward individual and national betterment did not challenge governmental, institutional or social goals. Its activities in the area of insanity causation and prevention encouraged research into other areas such as criminality, delinquency, and child guidance.93 Its principles of betterment and efficiency seemed to be applicable to all areas of human activity:

If I understand mental hygiene correctly, it does not consist simply in preventing damage to the brain and in avoiding disorders of the mind, but concerns itself more particularly with the most difficult and complex problem of progress - namely, attaining and maintaining a sound mind. The ultimate object of health is a positive quality that must encompass the whole man, which includes his physical, mental, and spiritual make-up. The ultimate in mental hygiene means mental poise, calm judgment, and an understanding of leadership and fellowship - in other words, cooperation, with an attitude that tempers justice with mercy and humility. The sum total of all these qualities is ordinarily called common sense, which is the quintessence of mental health.... With a community enjoying mental health, civilization would advance with a firmer step.94

Through the combining of insanity, restoration, rehabilitation, prevention, and social problems, the principles of Mental Hygiene acted as a panacea.
Members of the Canadian National Committee for Mental Hygiene defined the problems and offered solutions. Although research data and scientific theory was promoted, the problems and solutions proposed reflected their value judgments. The initial composition of membership reflected a Protestant base of individuals who had succeeded economically, politically, and socially. The solutions of efficiency and the ability to combat insanity were based unconsciously upon these values:

Mental health may be defined as the adjustment of individuals to themselves and the world at large with a maximum of effectiveness, satisfaction, cheerfulness, and socially considerate behavior, and the ability to face and accept the realities of life. Thus vague terms such as “effectiveness”, “security”, and “happiness” came to be defined as “mental health”.

The movement's use of terms under the guise of science was criticized:

The ethical meaning of ‘normal’ is further borne out by the fact that when specific advice is given concerning life problems, the conduct prescribed is ordinarily such as would conform to our ideals, not to the statistical average. The mental hygienist tends to justify such advice, however, not on moral but on rational or ‘scientific’ grounds. One can best secure mental health, best satisfy one's needs, by conforming. But, the ability to propose standards to an entire society readjusted the perception of insanity, the treatment made available, and garnered optimistic support.

The Mental Hygiene's 1920 survey of Saskatchewan elicited a favourable response from MacNeill:

We were visited by the Mental Hygiene Committee of Canada, of which Doctor Clark is the chairman, which committee was making a mental survey of the province. We enjoyed their visit very much, and we hope to benefit by the suggestions which we received - and I think the province will benefit by the suggestions which Doctor Clark has to make. I find that having people of that kind visit us is a real stimulus towards the better performance of work of this kind. I am inclined to think that if we had visits from people frequently, who are qualified to know how an institution of this kind should be run, it would be better for everybody concerned. It is certainly a great advantage to an institution of this kind to get suggestions from people who have had wide experience in this kind of work. A subsequent Saskatchewan survey in 1929 led by Dr. Hincks and assisted by Dr. S. Laycock and Dr. O. Rothwell provided the government with a
series of recommendations. The government supported the proposals regarding prevention and treatment and in February 1931 Dr. F. Munroe, Minister of Health, announced a provincial plan to establish training schools for the defective, to provide instruction for nurses and attendants, and to provide psychiatric evaluations at provincial institutions. The structure of the Department of Health was altered to incorporate the area of insanity, and Dr. MacNeill was appointed Commissioner for Mental Health in order to co-ordinate all activities of prevention and treatment.

The experiences of World War I psychiatry and various forms of causation research altered the constructs of the term insanity. Insanity could no longer be viewed as strictly biological, nor could it be solely judged as bad behaviour. The reforms and research initiated by Mental Hygiene contributed directly to an expanded perception of insanity and the need for social intervention. Insanity could arise inAnyone for various reasons. Thus, society was to be aware of factors or else risk the consequence of social problems.

Statistics supplied by Mental Hygiene equated institutional growth to the success of their education program. Institutional growth meant that a program of detection and intervention was being successfully employed to find the cases of insanity. Statistics concerning institutional growth placed pressure upon the government and institution to adopt Mental Hygiene principles of combating insanity. Governments were supplied statistics showing the financial cost of maintaining the insane. Thus, while recognizing a responsibility toward the institution's maintenance, provincial governments began to look elsewhere for other methods of efficiently treating and detecting insanity.

Governments were encouraged to support Mental Hygiene measures which removed both the stigma and treatment from the isolated institution. To this end, the Mental Hygiene movement lobbied for interventive care and the establishment of psychopathic wards at general hospitals. The shift in
government focus, the statistics of growing insanity, and the expanded perception of insanity placed both a direct and indirect pressure on the insane institution.

Increasingly the institution found itself in the position of re-evaluating its existence in light of Mental Hygiene policy. The institutional goal of adaption through occupation, while serving its needs, could not compare to the Mental Hygiene's belief in restoration and eradication. Therefore, treatment procedures which directly affected the individual were promoted as a means of restoring sanity. The institution's measure of success through a lower percentage of confinement\textsuperscript{105} contrasted with the Mental Hygiene belief that institutional increase meant a better system of detection. Therefore, crowded conditions could be viewed as a reminder of the need for programs of mental health. The perception of the institution as the place best suited to care and treat insanity contrasted with the Mental Hygiene perception of intervention and restoration. Their aggitation for other avenues of treatment resulted in the perception that the insane institution was the place of last resort.
FOOTNOTES


2. Dix believed that the insane were "wards of the nation" (Deutsch, The Mentally Ill, p.177).


4. Jones, Mental Health and Social Policy, 1845-1959, p. 11. By 1851 the Alleged Lunatics' Friend Society had no acting President, however ten Members of Parliament acted as Vice-Presidents.

5. The objectives of the society were to diffuse knowledge with respect to the causes, nature and treatment of insanity, to correspond and promote essays on the treatment and management of hospitals and asylums, and to advance the moral, intellectual, and professional education of attendants (Deutsch, The Mentally Ill, p.311).

6. For an overview of the National Association see Deutsch, The Mentally Ill, pp. 311-314, or see Hall, ed., One Hundred Years, p. 340.

7. Thomas Szasz cautions that the problem with institutional or insanity exposes is that while concentrating upon exposing "abuse", they imply that the institution also had desirable qualities (Szasz, The Manufacture, p. xxiv).


11. The differences between heredity and temperament or instinct are outlined by Clouston, The Hygiene of Mind, chapter V. In this chapter Clouston showed the conflicting approaches of the day by using the problem of alcohol as an example. Some viewed the craving for alcohol as an instinctive and special inborn character while others viewed it as a specific habit.
12. In 1894 Beers' brother had been diagnosed as epileptic. He died in 1900 and although the postmortem showed a brain tumor, Beers feared that he too was epileptic.

13. Beers was initially confined to a privately owned asylum which he left in March 1901. He then went to a private non-profit asylum between June and November, 1901. His last institution was a state run asylum where he was confined from November 8, 1901 to July, 1903.


15. Beers described mechanical restraints such as the canvas muff, how nose and throat tubes were used to give medication, and how often requests such as the sending of a birthday card were denied. Dr. Charles Mercier described letters written by the insane as incoherent, relating perceived persecution, and sent to newsworthy people unknown by the insane individual. He described letter writing as characteristic of those individuals having general paralysis, paranoia, or sub-acute mania (Charles Mercier, A Text-Book, pp. 345-346).

16. Beers, A Mind That Found Itself, p. 34.

17. Beers book was accepted by those specializing in the field of insanity as well as the general reading public. Previous exposes, failed because of warped outlook, a suspicious lack of coherence, inadequate literary ability on the author's part, or some other defect(Deutsch, The Mentally Ill, p. 306). However, it is plausible that the approach Beers used by having leading psychologists proof read and endorse his book ensured the success of his manuscript.

18. The fatalistic aspect of heredity in that it viewed disease as a fixed entity was not conducive to Beers' schema in which diseases such as insanity were curable and preventable. Essentially Beers viewed insanity as an enemy to be conquered by self will. To a request for employment help, Beers replied that the former patient should get his own job. Two of Beers' brothers entered an asylum upon his advice. They both committed suicide while in the asylum (Porter, A Social History, p. 195-196).

19. Dr. Meyer believed in the value of case histories and he attempted to go out from the confined individual and examine the wider society where insanity was bred. In such a manner the possibility of preventing insanity would be realized (Rothman, Conscience and Convenience, pp. 302-307 and Howells, ed., World History of Psychiatry, p. 459).
20. The term "mental hygiene" first appeared in the United States when Dr. William Sweetser (1797-1875) published the book Mental Hygiene in 1843 (Hall, ed., One Hundred Years, p. 325).

21. The introduction for Beers’ book was written by William James and letters by Adolf Meyer were included. Twenty-two editions of the autobiography had been published within twenty-five years.


23. The National Committee received funding from the Rockefeller Foundation and in 1911, Mr. Henry Phipps donated 50,000 dollars. In 1928 the American Foundation for Mental Hygiene was founded. Beers acted as Secretary in this organization whose primary purpose was to act as a financing agent. In his revised autobiography Beers described “the perfect gift” in which the donor gives his personal salary for a ten year period (Beers, A Mind That Found Itself, p. 308).

24. The background leading up to the conference and the reports presented were published in book form by the National Committee. Excerpts regarding the conference appeared in the April and June 1930 editions of Mental Hygiene Bulletin.


26. Beers, A Mind That Found Itself, p. 204. Ironically his latter years were not dissimilar to 1900. In his sixties, Beers entered Butler Hospital suffering from depression. He died in 1943 believing his doctors were impersonators (Porter, A Social History, p. 198).

27. While Beers wrote and lectured about insanity it appears that he attempted to disassociate the insane experience and instead concentrated on the hope and improvement of his mission of reform and education. In his autobiography he described his experience as “My past is a thing apart…” (Beers, A Mind That Found Itself, p. 204).

28. At a meeting of the American Psychiatric Association, Dr. Abbot stated:

    ...mental hygiene must also consider...ways of helping the handicapped individual to compensate for the impairment, in order to promote the most efficient living of which he is capable. This must include ...the care of the handicapped, in
order that the environment may be as positively favorable
and as little handicapping as possible.

E. Stanley Abbot, "What is Mental Hygiene?" American Journal
of Psychiatry vol. IV (July, 1924), p. 263.


30. Evelyn Molson Russel, "The Origin, Organization and Scope of
the Canadian National Committee for Mental Hygiene,"
Mrs. Russel was a founding member of the National Committee,
his husband Dr. Colin Russel was a Montreal neurologist and a
member of the Executive Committee of the Canadian Mental
Hygiene movement. It was through the suggestion of Dr. Russel
that the Mental Hygiene Committee undertook their initial
activity of provincial surveys.

31. While the view expressed by Mrs. Russel serves to place social
corns in the field of medicine, it also implies that the insane
constitute a reserve of "bad blood" which manifests itself as
social problems. Therefore, at the root of every problem lies the
impact of insanity. The problem of past reforms had been in
their method:

...there has been the realization that they are pruning the
dead branches only, when the trouble really lies at the root,
that a thoughtful protective care of the roots would soon
result in a great improvement in the general health of the
wide-spreading branches of our social life.


32. Abbot, "What is Mental Hygiene?" pp. 262-263. Abbot has used
the term "good" in a biological sense and does not use it as an
ethical or religious sense. However, after explaining his
conception of the term, he then goes on to state that "in human
affairs the biologically good is usually also the morally good".

33. The ability of the individual to continually adjust with self-
directed activities to the outside environment became the means
to ascertain whether the individual had successfully adapted
and was able to carry on a lifestyle of efficient living(Abbot,
"What is Mental Hygiene?" p. 262).

34. Abbot equated the serviceability of mental hygiene principles to
various individuals and organizations. Among those cited was
industry:

...to secure good health conditions, harmonious relations
between management and employees and among employees,
work and workers fitted to each other, understanding for
and consideration of the misfit.

Abbot, "What is Mental Hygiene?", p. 280. The ability of mental
hygiene principles to be used as a means of guiding and improving the management of human relation problems was espoused by mental hygiene proponents such as Dr. C. Hincks (See “Mental Hygiene a Modern Need,” Mental Hygiene Bulletin IX, [December, 1931], pp. 1, 4). For the most part, the inability of the individual to adapt was viewed as the factor in problematic relations. However, individuals such as Trigant Burrow viewed insanity as a social problem and a direct result of an insane society (T. Eliot, “The Social Philosophy of Trigant Burrow,” Mental Hygiene XII, [July, 1928], pp. 530-548 and Trigant Burrow, “Insanity a Social Problem,” The American Journal of Sociology XXXII, [July, 1926], pp. 80-87).

35. The Canadian National Committee for Mental Hygiene published their research and findings in book and article form. A list of their publications regarding such areas as child development or juvenile delinquency can be found in a 1932 survey made of the Committee by the Canadian Medical Association (The Canadian Medical Association, Report of a Survey made of the Organization in 1932 [Ottawa: The Metropolitan Life Insurance Company, 1932], pp. 62-69).

36. The program was intitially formulated to cover the psychiatric examination of recruits and the care of returning insane soldiers, the examination of immigrants to ensure better selection, the establishment of facilities to diagnose and treat insanity, to promote the care of the mentally deficient, and to provide education in the prevention of insanity and deficiency (The Canadian Medical Association, Report of a Survey, p. 9).

37. In 1950 the name of the organization was changed to the Canadian Mental Health Association. Information regarding the formation of the Mental Hygiene movement in Canada can be found in Russel, “The Origin, Organization and Scope,” and in C.F. Martin, “The Mental Hygiene Movement in Canada” Canadian Journal of Medicine and Surgery 63, (June, 1928), pp. 167-173. A valuable article regarding the Ottawa meeting, the Committee members, offices and initial operational activities is “The Canadian National Committee for Mental Hygiene,” Mental Hygiene II, (July, 1918), pp. 469-472.

38. The patron of the Canadian National Committee was the Duke of Devonshire who was the Governor-General of Canada. The majority of executive postitions were filled by members from Toronto and Montreal (“The Canadian National Committee for Mental Hygiene”, pp. 471-472).

39. The non-medical third were to consist of business men, individuals involved in education or social work, and the philanthropist (Russel, “The Origin, Organization and Scope,” p. 541).

41. W.E. Murray, President of the University of Saskatchewan and the Hon. W.M. Martin, Premier of Saskatchewan were among the group of founding members of the Canadian National Committee. Also included among the founding membership was Senator Sir James Lougheed of Calagary who headed both the Military Hospitals Commission and the Department of Soldiers' Civil Re-establishment.


43. In 1918 a prize of fifty dollars was awarded to a Queen’s University medical student for attaining the highest standing in psychiatry (*The Canadian Medical Association, Report of a Survey*, p. 12).

44. The Committee also initiated fellowships to encourage graduate students to further their education abroad (Martin, “The Mental Hygiene Movement in Canada”, p. 171).

45. Initially the Committee sought to receive seventy-five thousand dollars. According to Russel, fifty thousand had already been subscribed (Russel, “The Origin, Organization and Scope,” p. 541).

46. Between 1920 and 1927 the dominion government provided grants of ten thousand dollars, and in 1928 the grant was increased to twenty thousand dollars. But, in the years of 1923 and 1932 the dominion grant decreased to five thousand and nine thousand dollars respectively. Outside grants by American Foundations while often allocated toward a specific research program, were also contingent upon the Canadian Committee's ability to secure a percentage of the total in Canada (*The Canadian Medical Association, Report of a Survey*, pp. 50-51).

47. In 1920 Lady Eaton provided the Committee with a donation to research educational and industrial systems and the feasibility of industrial training methods for children who leave school. This research was under the direction of Professor Edward A. Bott. In 1924 the Governor-General's wife lent her name to the establishment of “The Lady Byng of Vimy Fund for Mental Hygiene”, and in 1928 “The Lady Willingdon Fund for Mental Hygiene” was initiated through the patronage of Viscountess Willingdon.

48. The Spelman Memorial of fifty thousand dollars was to be paid over a five year period and was targeted to the establishment of nursery schools in which child development could be studied. The Metropolitan donation was to be used to initiate a program of parent training in the concepts of mental hygiene (*The Canadian Medical Association, Report of a Survey*, p. 15).
49. The Toronto Psychiatric Hospital was selected to serve the conditions of the 1931 grant. It was to provide the training and make positions available to the promising graduate students from the universities of Alberta, Saskatchewan, Toronto, and McGill (The Canadian Medical Association, Report of a Survey, p. 20).

50. Articles concerning Committee research and findings were published in such journals as the Journal of Experimental Psychology, the Ontario Journal of Neuro-Psychiatry, Parents' Magazine, Modern Hospital, and the Canadian Medical Association Journal.

51. The Mental Hygiene movement promoted its research and principles through various Committee sponsored publications. It is often a maze of alterations. In 1921 the Canadian Journal of Mental Hygiene merged with the American publication, Mental Hygiene. In its place the Toronto offices produced The Mental Hygiene Bulletin. In turn, this publication became The Bulletin and was published every other month. In January 1931 the Canadian journal was renamed Mental Health and published as a monthly journal until December 1932 when due to a lack of money it ceased publication. In November 1935 Mental Health reappeared. In the United States the New York offices published the Mental Hygiene Bulletin. This publication consisted of ten issues a year with a yearly subscription fee of one dollar. The November–December issue in 1932 announced its demise.

52. The journal Mental Health had a mailing list of over 3,000 (The Canadian Medical Association, Report of a Survey, p. 19).


57. Mercier, *A Text-Book*, p. 3.

58. C. Stanford Read, “A Survey of War Neuro-Psychiatry,” *Mental Hygiene* II (July, 1918), p. 368. Dr. Read was the officer in charge of “D” block at the Royal Victoria Hospital at Netley. His article cites various studies undertaken by such personnel as Mott, Jones, MacCurdy and others concerning war neuroses.

59. F.H. Sexton, “Vocational Rehabilitation of Soldiers Suffering from Nervous Diseases,” *Mental Hygiene* II (April, 1918), p. 266. Mr. Sexton was the Vocational Officer for the Military Hospitals Commission of Canada.

60. Edward Strecker, “Military Psychiatry: World War I 1917-1918,” in *One Hundred Years*, Hall, ed., p. 394. Strecker was involved in the American Psychiatric force headed by Dr. Salmon. In France he was a divisional psychiatrist and involved in the Aisne-Marne operation.


62. Often the disabled soldier returned to battle within a month. In some instances centers reported a 91% recovery (Sexton, “Vocational Rehabilitation,” p. 266). American studies of 400 war neuroses reported a 65% recovery rate, and an average treatment period of four days (Strecker, “Military Psychiatry,” p. 396). However, studies regarding recurrences were found to be inconclusive.

63. William Russell, “The Returned Disabled Soldiers of Canada,” *Mental Hygiene* II (April, 1918), p. 246. Dr. Russell was the medical superintendent of Bloomingdale Hospital in White Plains New York and chairman of the Executive Committee of the National Committee for Mental Hygiene. He spent a week in Canada visiting and obtaining information regarding the needs of the returning soldier. The soldiers classified as immediate discharge were found unfit for overseas duty but capable of returning to their previous civilian occupation. The cases deemed treatment were sent to hospitals, and those deemed permanently disabled in which further treatment would be useless were given a pension and training in an occupation if necessary (Russell, “The Returned Disabled,” p. 246).

65. The first 25,000 disabled soldiers who returned to Canada were found not to be hopelessly crippled. Only 3% had suffered amputations, 1,500 were tuberculous and 34 had lost their sight (Sexton, “Vocational Rehabilitation,” p.271).


68. The disabled were transported from the landing ports to the necessary hospitals in ordinary sleeping cars. Those unable to be transported in that manner were moved in specially equipped hospital cars which operated in pairs. In one car were the medical and nurses quarters and cots for eight patients, and in the other car was accommodation for fourteen patients. These hospital cars could be attached to the passenger train or be used on their own as a special train. The disabled were transported to one of the fifty convalescent hospitals in operation at the time. These hospitals varied in size but in total could accommodate approximately 8,000 patients (Russell, “The Returned Disabled,” pp.247-248).

69. The Saskatchewan government enacted provisions for the apprehension and detention of the military insane in The Mental Diseases Act of 1922 (Statutes of the Province of Saskatchewan, 1922, chapter 75, section 33). However, the confinement of the military insane had begun earlier. The confinement of the military insane at North Battleford was first reported in the annual report of 1916-1917. In that year the institute received 20 men, among which were 7 who had been sent overseas. The report of 1916-1917 is the only one which mentioned whether the men had been overseas. For the most part, the men were single. The Soldiers’ Civil Re-establishment Department helped with the cost of maintenance. The Department also supplied the institution with recreational equipment such as golf clubs and tennis racquets for the tennis court. Insanity diagnosis for the military insane was primarily “Dementia Praecox”.

<table>
<thead>
<tr>
<th>Military Insane at North Battleford</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Military Admissions</strong></td>
</tr>
<tr>
<td>1916-19</td>
</tr>
<tr>
<td>1919-22</td>
</tr>
<tr>
<td>1922-25</td>
</tr>
<tr>
<td>1925-29</td>
</tr>
</tbody>
</table>

*Five admitted prior to April 30, 1925 but not known to be military.*

70. The soldiers objected to receiving orders from civilians and it was felt a hospital run on a more fixed military routine would be of benefit (Russell, "The Returned Disabled," p. 249).

71. Those deemed insane or suffering "shell shock", nervous instability and Dementia Praecox were the majority of residents at Cobourg. The institution provided the prevalent therapies of hydrotherapy and electrotherapy, and offered occupational classes. Unlike the convalescent hospitals, the program at Cobourg did not encourage serious industrial and vocational re-education (Sexton, "Vocational Rehabilitation," pp. 267-269).

72. Cobourg was considered a psychopathic hospital. The patients were not restrained, however, it appears that the ability to be quiet acted as the means of accessing success (Elizabeth Mills, "Mental Excitement in a Psychopathic Hospital: Its Prevention and Care" Canadian Journal of Mental Hygiene I [July, 1919], pp. 318-322).

73. E.A. Bott, "The Mentality of Convalescence" Canadian Journal of Mental Hygiene I (January, 1920), p. 311. At this time Dr. Bott was associated with the Military School of Orthopaedic Surgery and Physiotherapy in Toronto. He was later involved in the Committee's research regarding child development.

74. Table of Canada's population (in thousands)

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>NATURAL INCREASE</th>
<th>IMMIGRATION</th>
<th>EMIGRATION</th>
<th>NET MIGRATION</th>
<th>POPULATION (DECADE END)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1889-1901</td>
<td>719</td>
<td>326</td>
<td>507</td>
<td>-181</td>
<td>5,371</td>
</tr>
<tr>
<td>1901-1911</td>
<td>1,120</td>
<td>1,782</td>
<td>1,066</td>
<td>715</td>
<td>7,207</td>
</tr>
<tr>
<td>1911-1921</td>
<td>1,349</td>
<td>1,592</td>
<td>1,300</td>
<td>233</td>
<td>8,788</td>
</tr>
<tr>
<td>1921-1931</td>
<td>1,486</td>
<td>1,198</td>
<td>1,095</td>
<td>103</td>
<td>10,377</td>
</tr>
<tr>
<td>1931-1941</td>
<td>1,242</td>
<td>149</td>
<td>262</td>
<td>-112</td>
<td>11,507</td>
</tr>
</tbody>
</table>


75. In Canada the idiot, insane, feeble-minded, deaf and dumb, blind, and infirm were denied entry unless the individual belonged to an accompanying family or a family already entered who would guarantee permanent support (W.G. Smith "Immigration, Past and Future," Canadian Journal of Mental Hygiene I [July, 1919], p. 130). For an overview of Canadian immigration policy to 1915 see Hurd, The Institutional Care I, pp. 472-477.
76. Over 73% of deportations were to the United Kingdom and over 4% to the United States (Smith, “Immigration, Past and Future”, pp.134-135).


79. Clifford Sifton encouraged the immigration of the American, British, and European farmer. When Frank Oliver assumed Sifton’s position in 1905, the immigration policy became more restrictive and although agriculturists were preferred, Oliver also encouraged the immigration of British subjects.


81. This Commission chaired by Dr. Swanson was vice-chaired by Mr. P.H. Skelton. The Commission heard briefs presented by various groups such as The German-Canadian Association of Saskatchewan, the Provincial Grand Orange Lodge of Saskatchewan, the Ku Klux Klan, the Native Sons of Canada, the American Federation of Labour, the Canadian Legion, and the United Farmers of Canada. A summary of their submissions appears in Department of Natural Resources, Report of the Saskatchewan Royal Commission of Immigration and Settlement.

82. In the United States, published works also equated foreign insanity as an economic concern:

    ...it is equally true that the tremendous increase in mental defects here is to be attributed in no small degree to immigration. This constitutes a problem of social and economic importance which is worthy of serious consideration.

James May, Mental Diseases (1922) reprint by (New York: Arno Press, 1980), p. 155. However, the same author also discussed immigration and mental diseases and related particular types of insanity to a particular ethnic group (May, Mental Diseases, pp. 162-163).


84. Smith's statistics showed that from 1900 to 1919 the number of immigrants desiring entry was over 3 million. Of this number, he found that over 168 000 were rejected and over 12 000 were deported. He then showed that the rate of deportation was 1 to
18. He found that the number of British nationals rejected at Canadian ports of entry was relatively low, however the amount of subsequent deportations was high. In contrast, he found the rejection of foreigners at Canadian entry ports high and subsequent deportations low (Smith, "Immigration, Past and Future," p. 138). In light of his findings, Smith called not for restriction, but for select regulation and careful examination at the ports of entry.

85. In light of the composition of Saskatchewan's population, it is not surprising that institutional reports citing admissions would show a larger proportion of foreign nationalities.

### Yearly Admissions to Battleford Institution

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Total Admissions</th>
<th>Canadian Admissions</th>
<th>Foreign Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1914-1915</td>
<td>501</td>
<td>165</td>
<td>336</td>
</tr>
<tr>
<td>1915-1916</td>
<td>250</td>
<td>80</td>
<td>170</td>
</tr>
<tr>
<td>1916-1917</td>
<td>268</td>
<td>67</td>
<td>201</td>
</tr>
<tr>
<td>1917-1918</td>
<td>290</td>
<td>87</td>
<td>203</td>
</tr>
<tr>
<td>1918-1919</td>
<td>318</td>
<td>105</td>
<td>213</td>
</tr>
<tr>
<td>1919-1920</td>
<td>296</td>
<td>93</td>
<td>203</td>
</tr>
<tr>
<td>1920-1921</td>
<td>302</td>
<td>102</td>
<td>200</td>
</tr>
</tbody>
</table>


87. Dr. Charles Clarke outlined some of the problems facing institutions due to foreign insanity:

...51 per cent of all cases of mental abnormality examined have come to us from countries outside Canada. This fact alone demonstrates that no adequate means have been adopted at our ports of entry to prevent the feeble-minded and insane from entering the Dominion.


88. J. Halpenny, "One Phase of the Foreign Invasion of Canada," Canadian Journal of Mental Hygiene I, (October, 1919), pp. 224-226. Halpenny examined the cases brought before six assize courts of Manitoba during the spring of 1919. He found that cases against "desirable" and literate immigrants tended to be dismissed by the courts and the individual found innocent. In contrast, areas of foreign settlement where illiteracy was high and interpreters necessary were found to have a larger number of court cases. The implication then became that of
foreign immigration and illiteracy as contributory factors in an increased court docket.


90. The Saskatchewan region experienced an upsurge in immigration from 4,713 in 1901 to 19,297 in 1906 (Census of Northwest Territories, 1906, p. 102). The foreign-born continued to comprise a large amount of the population.

<table>
<thead>
<tr>
<th>Total Population</th>
<th>Canadian born</th>
<th>British born</th>
<th>Foreign born</th>
</tr>
</thead>
<tbody>
<tr>
<td>1916</td>
<td>647,835</td>
<td>352,920</td>
<td>93,712</td>
</tr>
<tr>
<td>1921</td>
<td>757,510</td>
<td>457,833</td>
<td>100,355</td>
</tr>
</tbody>
</table>

Saskatchewan Command of the Canadian Legion, Committee on Immigration Report, p. 8.

91. In the first year of operation, the institution deported over 20 individuals primarily to the United States or British Isles. During World War I, deportations occurred only to the United States. At the end of the War, deportations gradually increased until they again reached over 20 per annum by 1928. In the latter part of the 1920s the majority being deported were of eastern European descent. Foreign admissions have been calculated as nationalities non-Canadian.

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Foreign Admissions</th>
<th>Deportations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1914-1919</td>
<td>1,123</td>
<td>57</td>
</tr>
<tr>
<td>1919-1925</td>
<td>1,010</td>
<td>39</td>
</tr>
<tr>
<td>1925-1931</td>
<td>1,118</td>
<td>116 *</td>
</tr>
</tbody>
</table>

* 1930-1931 reported in the Annual Report of the Department of Public Health, pp. 70, 73.


92. The correlation of immigration and insanity may not be as it first appears. It is reported that more foreign-born Saskatchewan residents sought citizenship than in any other province (Department of National Resources, Report of the Saskatchewan Royal Commission on Immigration and Settlement, p. 84). As well, the number of foreign insane as compared to the provincial distribution shows that a small number were institutionalized. Since both institutional
admissions and government statistics stated the “nationality” of the individual, it would appear that arguments for regulated admission were based upon concepts of ethnic insanity. Thereby, the issue is not the birth place of the insane individual, but the nationality. In such a manner, the statistics supplied by the institution could be used as a basis for citing the need for regulation and selection not solely upon the basis of assimilation or economic contribution, but also on the basis of nationality.

93. In the United States the research and interest in child development was characterized as the “infantilization of adults” (Bromberg, The Mind of Man, p. 247).

94. M.J. Rosenau “Mental Hygiene and Public Health” Mental Hygiene XIX (January, 1935), p. 9. Therefore, the goal of public health was linked to social welfare.

95. “Problems of Mental Health,” Mental Hygiene Bulletin IX, (January-February, 1931), p. 1. In a radio address, concepts of “mental health” and “morale” were equated to “efficiency” and “happiness” (Pratt, “Morale and Unemployment,” p. 4).

96. Kingsley Davis, “Mental Hygiene and the Class Structure” Psychiatry I, (February, 1938), p. 59

97. Annual Report of the Department of Public Works, Regina, Sask., 1919-1920, p. 22. The survey was carried out by Dr. Charles Clarke.

98. Dr. Laycock was associated with the Department of Educational Psychology at the University of Saskatchewan and acted as a consulting psychologist to the Saskatoon school board. Dr. Rothwell had acted as the medical surgeon for the Regina jail. He was a practising psychiatrist and later became director of the psychopathic ward at Regina Hospital.


100. The Superintendent now provided annual reports to the Department of Public Works and statistical reports to the Department of Public Health.

101. The Commissioner also acted as a liason in the community and would address meetings and send out literature to district nurses (A.E. Grauer, Public Health, p. 114).

102. In a comparative study between Massachusetts and Canada, the Canadian National Committee found the incidences of insanity and deficiency higher in Massachusetts and the rate of discharge higher in Canada. They then inferred that more people in need of care were receiving it in Massachusetts and
that the state was able to find additional accommodation without an added expense (H.B. Spaulding, "Mental Hospital Population Increases less in 1931 than in 1930" Mental Health VII, [September-October, 1932], p.44).

103. The Canadian National Committee calculated yearly further capital expenditures over three million dollars and an annual maintainence cost of 330 dollars per institutionalized resident ("More People in Mental Hospitals Than in Kingston or Kitchener" The Bulletin V, [July, 1930], p. 1).

104. Saskatchewan's first psychopathic ward opened December 20, 1930. The ward, composed of 20 beds, was part of the Regina General Hospital and leased by the provincial government for a five year period. They were initiated to lessen institutional growth and the expenses of continual enlargement, and considered a better means of providing an opportunity for a cure (Annual Report of the Department of Public Health, Regina, Sask., 1930, p. 8).

105. Superintendent MacNeill described the institutional growth as gratifying:

   The population of the hospital continues to increase in proportion as the population of the province increases, but it is gratifying to note that we have the smallest percentage of insane of any province in Canada:...

Insanity historiography has been described as a polarization of beliefs in which the fundamental question has centered upon the concept of insanity and the institution’s role:

Those who accepted the definition of insanity as illness saw hospitals in therapeutic terms. The fact that such institutions were unable to provide therapy, they insisted, was due to a shortage of competent staff, inadequate facilities, and a lack of material resources... the critics who denied the existence of mental diseases maintained that hospitals were repressive institutions which violated basic civil liberties and destroyed individual dignity.\(^1\)

In such a manner, the history of insanity has concentrated upon the ability of the institution to treat or detain the insane individual. In each instance, either as a treatment center or penal center, the assessment has been that of institutional failure.

The criticisms levelled at institutions have come from a variety of sources and cover a variety of issues. The institution has been criticized for having "encompassing tendencies"\(^2\) for providing something of an isolated world for its residents. Institutional group dynamics examined by John and Elaine Cumming, show how affective symbols, the gestures or tones of voice not necessarily realized, are used to control the social dimensions of the group. The individual committed to an institution may orient toward the behaviour accepted by the institutional personnel, or to that of the resident society.\(^3\) Those individuals not a member of either group become the isolated, mute, resident transferred into the chronic ward.\(^4\) The symptoms of institutional care, the passivity of residents, and the reliance upon the institution to provide basic physical needs has been examined by Robert Sommer and
Humphry Osmond. Through their study of Weyburn residents, they found that the resident lost contact with the outside and became isolated, forgotten by friends and family.5

The structure of internal relationships existing at the institution and the reliance upon the institution for basic needs has led to the conception that individual adaptation results in the phenomena of "institutionalism." This concept of institutionalism, while explaining resident passivity, reliance, and adoption of behaviour patterns, has been described as the result of institutional commitment and confinement.6 Therefore, the institution has been condemned for developing a behaviour foreign or alien to that of society, and of impeding the recovery or rehabilitation of the insane individual. However, a factor often ignored in the concept of institutionalism has been the role the resident plays in determining the institutional practices and social organization.

The internal and external construction of the institution has been criticized for impeding insanity recovery. The belief that institutional architecture acts as a conduit for insanity treatment was again promoted. Tuke's Retreat, Kirkbride's institutional guidelines, and S. Weir Mitchell's 1894 conception of an ideal institution7 were historically resurrected to underscore a belief that architecture could contribute to, or hamper, insanity recovery.

Institutions such as North Battleford were criticized for their inability to segregate8 and architectural symposiums chastized institutions for their design, organization, and standards seen to reflect "traditional views and attitudes."9 Criticized by the World Health Organization as cost ineffective due to wasteage,10 the institution was likened to a holding center unable to contribute to new treatment methods.

Unlike the custodial care and social isolation offered by institutional commitment, insanity architecture in the 1950s would reflect a medically and
socially integrated approach. During the 1950s the Regina architectural firm of Kiyo Izumi would work in conjunction with Saskatchewan psychiatrists to develop a “Saskatchewan Plan” for small, cottage type buildings, attached to regional hospitals, and integrated within the community. Defined in opposition to traditional large institutions which were seen to promote resident enumeration and easy surveillance, these community centers were promoted as providing a relaxed atmosphere suitable to individual needs and expression:

The mental patient then must have a little privacy; must be able to express a little individuality; find entertainment for himself; socialize with others; ... Since most of his contacts in a hospital will be with other patients whose problems are as bad or as worse than his own, the design of the hospital must make it easier for the personnel of the hospital and people from the outside to have contact with the individual patient.

The principle of individualized treatment allowed for a greater interaction between personnel and residents, and was felt to dissuade the development of institutionalism. Yet, although these centers appear to differ radically from institutions such as North Battleford, the premise of insanity management remained virtually the same. Insanity control hinged upon socialization, in which the success of treatment was judged and observed by others.

Institutional commitment has been criticized as an impediment to rehabilitation and socialization and as a perpetrator of the isolation of the insane and the foreignness of insanity. Yet institutional commitment needs to be examined in light of the function it served. The institution was perceived both as a place to detain and as a treatment center, and would be utilized by the various agencies of intervention to serve their particular interests. Perceived by law, medicine, and Mental Hygiene, as a place to control insanity, North Battleford would adopt various procedures meant to enhance the perception of treatment and management. However, the outcome of institutional commitment often differed from intention. Increasingly, the institution became as isolated as its residents.

Legal provisions attested to the viability of institutional commitment and
treatment. The Mental Diseases Act of 1922 which had designated the institution as a “hospital”, and expanded the means of admission, also described the North Battleford institution as a place of “detention” where the individual would remain until “sufficiently recovered”. This legal perception of the institution as the primary place of detention and treatment was elaborated upon in The Mental Hygiene Act of 1936.

The Mental Hygiene Act allowed for institutional admission on the basis of a judicial inquiry, a deputy minister’s warrant, two medical certificates, or by voluntary commitment. With the exception of voluntary commitment, the period of confinement was an institutional decision based in part upon the resident’s recovery and the availability of suitable supervision:

No person shall be discharged unless, upon investigation, the superintendent is satisfied that the conditions in, and environment of, the home of such person are suitable for his return thereto.

In cases of voluntary commitment, institutional discharge was through written notification.

Although The Mental Hygiene Act allowed for discretionary discharge, it also made provision for continual detention. Regardless of the method of admission, the institutional resident could continue to be detained:

...upon the certificates of two physicians accompanied by the prescribed history record and financial statement, and notification to and the issue of warrant for detention by the deputy minister.

As well as citing the means of institutional commitment or detention, The Mental Hygiene Act also recognized psychopathic wards as alternative treatment centers. However, commitment to a psychopathic ward was of limited duration. Therefore, within The Mental Hygiene Act, provision was made for an individual’s removal from a psychopathic ward to an institution if it was believed further treatment would not prove to be beneficial.

The institution, legally perceived as a center to treat or manage the insane whose prognosis of recovery elsewhere was deemed inadvisable, found itself reacting to the changing legal conceptions of insanity. Insanity was not
solely a social transgressor deemed to be a dangerous lunatic. Nor was institutional commitment a financial cost to be borne by the individual or family. In 1944, institutional commitment was deemed a provincial responsibility\textsuperscript{23} and an individual's entitlement:

...all persons who are residents and have been residents of Saskatchewan for a period of at least twelve months immediately prior to admission to an institution shall be entitled to care and maintenance at the expense of the province.\textsuperscript{24}

The financial care and maintenance of the insane by the province placed added pressure upon North Battleford to provide cost-effective treatment. National comparative statistics, which had begun in 1932,\textsuperscript{25} were compiled and published by the Dominion Bureau of Statistics. These comparative institutional statistics showed a steady population increase and a steady increase in operational costs.\textsuperscript{26} Implicit within these statistics was the perception that alternative treatment centers such as the psychopathic ward were better able to treat the insane and were less costly than institutional commitment.

The Rowell-Sirois commission, convened to examine dominion and provincial economic concerns, was presented with a brief by Mr. A. Grauer outlining the scope of public health concerns. Grauer's submission outlined the problem of institutional growth and his tables of provincial expenditures showed that some provinces, such as Saskatchewan, consistently paid more per capita to institutionalize than the national average.\textsuperscript{27} Citing Mental Hygiene goals of treatment and prevention, Grauer promoted clinics as an alternative to institutionalization:

Such a system should keep many people out of institutions and hospitals and by early diagnosis should cut down the length of institutionalization of others. Accordingly these clinics should pay for themselves from the onset.\textsuperscript{28}

The desire for cost-effective treatment shifted the concept of insanity management from that offered by the institution to that available in the community. Criticism of institutional commitment and management as
costly worked in conjunction with the Mental Hygiene concept of the institution as inadequate.

The first Saskatchewan survey conducted by Mental Hygiene members Dr. C. Hincks and Dr. C.K. Clarke in 1920 was an assessment of existing facilities. They visited six schools in Regina, Moose Jaw, and Saskatoon, the insane institution at North Battleford, the Home for Mental Defectives in Regina, the Boys Detention Home in Regina, and the jails at Regina and Prince Albert. Their report released in January 1921 commended the provincial government for various policies. The Committee found Dr. MacNeill and his assistants capable and enthusiastic and commended their efforts in developing occupational therapy:

An institution with its patients fully occupied is one that is easy to manage and a happy home for its inmates. However, the survey did find that North Battleford offered less than the ideal. The institution’s airing court was described as an eyesore, justifiable only for “the convenience of the lazy among the employees”, and by its existence “smack too much of jail methods”. Paradoxically, these airing courts reminiscent of jails were not discussed in relation to the survey’s conception of the insane as inmates.

The second Mental Hygiene survey in 1929, placed the concept of insanity treatment within the community’s medical facilities. Psychopathic wards were recommended for their ability to treat individuals who would benefit from direct medical intervention and mental health clinics were promoted as a means to combat and eradicate insanity.

Mental Hygiene’s criticisms of institutional operations which appeared to be custodial in nature, and its recommendations for integrative medical intervention challenged the perception that the institution could manage insanity. North Battleford adopted procedures meant to enhance the perception of medical care and treatment, and increasingly saw its personnel reflect the medical approach. While medical physicians cited air, water,
exercise, and work as conducive to mental health, superintendents such as Dr. MacNeill cited mental health as an extension of institutional duties:

We have endeavoured to extend our work by means of lectures on mental hygiene given by members of our staff to different groups, such as teachers' conventions, women's organizations, service clubs, public health nurses and nurses in training throughout the province.

The outcome of this shift in focus from "illness" to "health" was to retain, at least psychologically, the perception of institutional treatment. However, it also afforded an opportunity to point out the inadequacy in perceiving the institution as a hospital.

Superintendent MacNeill, appointed in 1931 to the newly created position of Commissioner of Mental Hygiene for the Department of Public Health, attempted to implement programs which would raise institutional standards to that of a hospital. In comparison with other provinces containing similar numbers of institutionalized residents, the two Saskatchewan institutions were found to be lacking adequately trained medical personnel. A comparative table published in 1932 by the Dominion Bureau of Statistics showed that Saskatchewan's 2,561 institutionalized residents could expect the services of 8 physicians, 4 occupational therapists, 7 graduate nurses, 92 nurses, 170 attendents, and a total staff of 403 individuals.

In the 1930s various programs were begun to provide adequate trained personnel. At the Weyburn General Hospital, a program of lectures and training for nurses was begun in conjunction with institutional training programs. In 1933 North Battleford reported that twenty-seven members of its staff had completed training and successfully passed an examination for a diploma in mental nursing. In conjunction with medical training, Superintendent MacNeill encouraged programs of institutional experience. Medical students were employed during the summer in order to gain experience in insanity treatment and to provide medical relief for the institution's vacationing personnel. However, training programs meant to enhance the perception of medical treatment were only moderately successful.
Programs to enhance the professional medical treatment were found to be lacking in the third Mental Hygiene survey of Saskatchewan conducted by Dr. Hincks in 1945. Although cognisant of a reduction in medical personnel due to World War II, Dr. Hincks criticized North Battleford operations for their lack of medical professionals. He found the existing ratio of 1 physician for 343 residents unacceptable and recommended the appointment of two additional physicians. Using the twenty standards adopted by the American Psychiatric Association as a guide, the recommendations provided both a means of judging conformity and a way of elaborating institutional inadequacy.

The 1945 survey, which commended personnel for their service, also pointed out areas of improvement. Dr. Hincks recommended sufficient psychiatrists to effect a ratio of 1 psychiatrist for 200 residents, and the addition of one physician for every hundred admissions. Although the ratio of nurses and attendents complied with set standards, Dr. Hincks found that during the war period the majority of staff had inadequate academic training. While recommendations were made supposedly to improve insanity treatment or care, they also reflected a perception that institutional treatment was lacking, and that institutional operations, personnel, and residents required a specialized approach or assessment.

North Battleford was criticized for its lack of trained personnel, dentists, and programs which would utilize social service workers. In response, North Battleford increased the medical personnel, implemented operational procedures such as a Social Service Department, and attempted to secure adequately trained personnel. These internal operations meant to enhance the perception of hospitalization and ideal treatment were unable to provide a cure. By the time of the third Mental Hygiene survey, the hope of a cure no longer rested in institutional treatment. Instead, mental hygiene was promoted as the ideal treatment approach:

...because of the contribution it can make in assisting individuals to attain higher levels of mental health; social usefulness; and effective,
satisfying, wholesome living. All sections of the population can benefit from a comprehensive mental hygiene program—parents and children in the home, teachers and pupils in school, workers in industry and, of course, those who are definitely handicapped because of the burden of personal maladjustment.42

Despite the criticisms of institutional operations and despite the availability of alternative treatment centers, North Battleford experienced conditions of institutional growth. The real and imagined shortcomings of institutional commitment did not hamper growth. Society continued to utilize the institution as both a place of treatment and of detainment.

The dual function of institutional commitment, to detain and treat, and the legal provisions to ease institutional admission further exacerbated the conditions of crowding. From its inception, the institution had faced conditions of overcrowding. However, by the 1930s North Battleford’s institutional reports cited being 50% overcrowded43 and hampered in ability to maintain adequate care or provide treatment:

It is impossible, in this crowded condition, to give the patients the medical care and nursing which they should have, and the admissions, as you will observe, have been increasing rapidly from year to year, and I would urge upon the government the necessity of finding some means of relieving the congestion at the hospital.44

Institutional reports from North Battleford between 1931 and 1945 showed that approximately 370 individuals were admitted to the institution every year.45 Although the majority of reported admissions were cited as “first admissions”, approximately one-third of those being committed were cited as “readmissions”.

Although North Battleford’s submitted annual reports did not cite the method of commitment, an indication of the method can be found in the comparative statistics compiled by the Dominion Bureau of Statistics. Despite the legal provisions for voluntary commitment, the legal and medical professions continued to define insanity and provide the means of institutionalizing the individual.
Throughout the 1930s, individuals from Saskatchewan continued to be committed as first admissions on the basis of a judicial warrant. It was not until the latter part of the 1930s that medical certification as a method of commitment was used by approximately one-half of the individuals being admitted for the first time. By 1940, medical certification for female first admission showed a significant increase as compared to judicial warrant. This trend of medical certification for first admission continued throughout the 1940s and by 1945 both males and females were being admitted through the medical process. A similar process existed for those individuals being readmitted to the institution. Throughout the 1930s, readmission was the result of a judicial warrant. It was not until the latter 1930s that females were readmitted on the basis of medical certification. Seldom was voluntary commitment employed as a method of first admission or readmission.46

In order to alleviate crowded conditions, and to relieve societal doubts as to the viability of institutional treatment, North Battleford enacted various procedures meant to enhance the perception of treatment. Gone were the earlier reports citing the therapeutic benefits of work47 The practice of "occupational therapy" which had been the basis of judging the success of institutional treatment, was replaced by the institutional "discharge".

The perception that discharge should be the means of assessing institutional success of treatment had been cited by Superintendent MacNeill in 1923:

Our percentage of paroles as compared with admissions has, on the whole been very satisfactory, and this should be, after all, the standard by which to judge any hospital.48

Discharge acted as a verification of institutional treatment, that a cure or recovery was possible. Institutional reports in the 1920s which showed a 41% or 57% rate of institutional parole, became replaced in the 1930s with submitted reports showing parole as comprising approximately 60% of admissions. By 1945, the submitted report from North Battleford recorded institutional discharge as comprising over 66% of admissions.49
Discharges implied that institutional commitment could bring about a recovery, that insanity treatment was not hopeless. Yet, while the high percentages of institutional paroles implied success in treating, the method used to formulate the percentage is suspect. By comparing yearly paroles to yearly admissions, the institutional reports provided a rule of thumb statistic in which the outcome was a forgone conclusion. Discharge statistics were not compared to the total institutional population, nor did they take into account the individuals being readmitted. Although discharge statistics implied a recovery, the benefit may have rested with the institution and not the individual. For discharge statistics obscured the outcome of commitment on the chronic or hard to treat:

For patients hospitalized for more than two years, leaving hospital by death is more likely than discharge.

North Battleford’s statistics regarding discharge could not dispell the inherent hopelessness of institutional statistics showing increased growth.

While institutional growth implied a better system of detection, it also eroded the perception of treatment. This inability to cure was perceived by institutional superintendents not as an institutional problem, nor a treatment problem. Instead, it was viewed as a resident problem:

... many of the patients admitted to a mental hospital are not hopeful prospects of recovery because of the fact that their psychoses are due in many cases to old age or have been of very long duration, and have become fixed.

This view which shifted the onus of responsibility of treatment or curability from the institution to the individual resident, also expresses the manner in which insanity was socially perceived and the way in which the institution was utilized.

For the most part, the individuals committed to North Battleford tended to be the elderly and hard to treat cases. This is especially apparent in the 1930s and 1940s when short-term alternative centers such as psychopathic wards were operational. The majority of institutional admissions were individuals classified as senile psychoses, psychoses with cerebral arteriosclerosis, and dementia praecox.
The commitment of the elderly at North Battleford contributed, in part, to the crowded conditions, to the phenomena of institutionalism, and to the perception that the institution could not cure. Susceptible to physical decay, the elderly often neglected personal hygiene and engaged in various behaviours. As medical patients, the elderly could be unpleasant and difficult to treat:

... moreover, the conditions and types of diseases from which they suffer are apt to be therapeutically hopeless or at best to lend themselves only to symptomatic relief.

The commitment of the elderly, of individuals deemed senile or having symptoms of senility, contributed to and fostered the perception that the institution's role was to care and maintain. However, the commitment of this group also points out a particular lack of social interest in the aged.

In the national comparative tables published in 1945 an indication of this lack of social interest in institutionalized residents classified as senile or cerebral arteriosclerosis can be found. Each group was usually committed for less than a year before discharge, and upon discharge ranged in age from 64 to 77 years. Although most were married at the time of admission, both the institutionalized males and females were cited as having marginal or dependent economic conditions. The cerebral arteriosclerosis and senile resident who died at the institution ranged in age from 70 to 78 years and had spent on average 1 to 3 years at the institution.

While the commitment of the elderly poor to the institution expresses an economic disinterest in alternative centers, it also expresses the subjective nature in the concept of insanity:

... the aged are unpleasant, even repulsive, from the aesthetic standpoint, the degree being determined both by the condition of the patient and the aesthetic state and capacities of the observer.

Another group, those classified as suffering from dementia praecox represented the expansive concept of insanity.

The term "dementia praecox", conceptualized in 1899 by Emil Kraepelin,
had been applied to individuals showing apathy, a lack of drive and believed to have irreversible intellectual deterioration. In symptomology it was likened to dementia:

Dementia is the lowest form of insane intellectuality. In short, it is mental decay because of brain degeneration. It effects every mental faculty, and is stamped upon and is patient in the intellect, disposition, habits, manners, temper and general character of the individual. It is mental deprivation and is contra-distinguished from the mental exaltation of mania.

However in dementia praecox, the onset was found to occur at an earlier age.

The concept of dementia praecox encompassed a wide variety of behaviours and symptoms. But, its encompassing ability was criticized:

To strain a classification to such an extent that 40 per cent. of the admissions of a hospital for the insane can be included under the heading “dementia praecox” is certainly adding little to science, but rather tending to befuddle the whole subject.

As a term for insanity it offered no known origin, nor solution.

In order to clarify the concept of dementia praecox, Eugen Bleuler proposed in 1911 the term schizophrenia:

The name dementia praecox, which neither leads to dementia nor is precocious in its origin, necessarily, gave rise to many misunderstandings, ... it would appear that schizophrenia is not a disease in the narrower sense but a group of diseases somewhat analogous to the organic group, which includes paralysis, the senile form, etc.... It is characterized by a specific type of alteration in thinking, feeling and relation to the outer world.

Bleuler's assertion that schizophrenia was indicative of unstable idea associations would not prevent the term being used interchangeably with institutional reports citing the diagnosis as dementia praecox.

In North Battleford, annual reports cited dementia praecox as contributing to admissions and institutional growth. By 1945 comparative tables showed that dementia praecox comprised a significant number of discharges and readmissions in Saskatchewan institutions. Unlike elderly residents, those residents categorized as dementia praecox tended to be in their early thirties when discharged. Although a discharge for the dementia
praecox individual occurred approximately one year after admission, the majority of dementia praecox patients required longer periods of commitment. Those who died at the institution were on average between 52 and 55 years old, and had spent over 15 years at the institution. As a categorization for a wide variety of behaviours or perceptual beliefs, those classified as dementia praecox also became the means for a variety of experimental medical solutions.

Dementia praecox was perceived as a change in brain tissue exhibited through outward behaviour. Therefore, institutional residents provided a medical laboratory in which to test various procedures to arrest the changes believed to occur in the brain. In Vienna, Manfred Sakel’s insulin treatment for morphine addicts with withdrawal symptoms appeared to benefit their idea association. Applied to schizophrenic individuals in 1933, Sakel’s method of insulin shock to change the brain’s chemical structure appeared to bring about mental clarity and end the delusional aspects of schizophrenia. As a treatment procedure insulin shock was used on recent and long-term schizophrenic cases. The method of bringing on a state of hypoglycemia through insulin dosages was described by Drs. Cameron and Hoskins in 1937:

The earliest symptoms of hypoglycemia usually set in within half an hour and consist in a slight drowsiness which may increase to actual sleep. About this time or a little later some sweating appears, which later may become copious. This, together with the fact that the heat regulating mechanism appears to become impaired sometimes results in low body temperatures.... At the end of from one to three hours the drowsiness begins to pass over into increasing wakefulness, which may again, after one-half hour or so, pass over into drowsiness, which in turn leads directly into coma. This is usually achieved by the third to fifth hour after treatment is commenced.... Just prior to the commencement of coma, twitching and jerking of the face and of the limbs are common. Occasionally this jerking may become increasingly severe and lead on to convulsions.... We usually consider somewhat arbitrarily that coma is present when the patient can no longer swallow... The pulse, which tends to increase in frequency up to the time of coma, begins to fall somewhat as coma progresses... The same is true of the blood pressure. Coma may be prolonged for varying periods from ten minutes up to about one and one-half hours,... Treatment can readily be terminated by the giving of carbohydrate.
The alternating states of coma and muscular activity were not to last longer than 5 hours due to the danger of irreversible brain damage. As a method of curing, insulin shock appeared to be promising, however, the duration and nature of the treatment often resulted in emergency situations.

Various shock therapies developed throughout the 1930s in an effort to jar the brain to sanity. Metrazol, injected into the blood stream, produced convulsions and was felt to alleviate conditions of depression, agitation, and excitement. Electric convulsive shock treatment produced convulsions, but unlike insulin shock, required a shorter period of duration and less medical intervention. Also, the period of amnesia prior to convulsion produced by electric shock was viewed favourably as the anxiety associated with an oncoming seizure would be lessened.

North Battleford's annual reports in the 1930s and 1940s show that various shock therapies were utilized in conjunction with the existing treatment of hydrotherapy. The therapies utilized for specific categories or for specific reasons were often overrated. But, in an effort to provide current treatment methods and in order to be perceived as a treatment center the institution employed methods which it often doubted. In the case of various shock therapies, the utility was questioned by Superintendent MacNeill, however the outcome was a belief in the new therapeutics:

The shock therapy has now been carried on for a sufficient length of time in all three hospitals for us to be able to form some estimate of the value of this particular therapy, and, while it does not measure up to the claims of the early advocates of insulin and metrazol, it is, in our opinion, a worthwhile method of treatment, and one which has given an added impetus to the advancement of psychiatric care and treatment.

Institutional practices such as hydrotherapy and shock therapy were employed in an attempt to combat the insanity and recover the individual. Although the long-term effect of shock therapy continued to be suspect, its utilization did point out to what extent the institution would go to provide the cure and eradicate insanity. Yet the outcome of institutional therapeutics differed from the original intention of curability. Shock
therapies represented a divisiveness, for unlike the sane individual, the thetherapeutics applied to the insane appeared alien, foreign, and unlimited.

The history of insanity and insane institutions has been characterized by change and expansion. Medical classifications such as “dementia praecox” used in 1920 to describe reticent, unadaptable behaviour74 came to be viewed by 1950 as a perceptual problem in which the individual experienced a different reality:

It is possible that the schizophrenic is a special type of ‘person,’... It may represent a special way of experiencing a totality of events which some of us are unable to define in the light of our present personal knowledge and experiences.75

The legal conceptions of insanity underwent similar changes. Insane individuals were not deemed to be dangerous transgressors in need of confinement. Instead, the individual was described as having a medical condition and entitled to care and management.

While insanity conceptions altered, the basic premise underlying the reality of insanity has remained constant. Insanity becomes defined not solely by law, medicine, or Mental Hygiene, but through societal judgements that vary in time and place76 It is a concept both subjective and dependent upon another’s perception. And, it is a definition characterized by a judgement such as that experienced by the seventeenth century playwright Nathaniel Lee:

They called me mad, and I called them mad, and damn them, they outvoted me.77

The concept of insanity acts in opposition to that of socialization, and isolates the individual from the family and community. A controlled study undertaken in Saskatchewan in 1951 showed that although a six month education program was provided concerning the clinical nature of insanity, the community attitude toward the insane remained virtually the same.78 The community tended to tolerate a wide variety of behaviour. It was only when the behaviour appeared abnormal and unpredictable that the
individual was perceived as insane.\textsuperscript{79} Similarly, within the family unit it appears that insane behaviour was often ignored or accommodated. Institutional commitment became contemplated only when the family's toleration threshold was reached and the individual became perceived as insane.\textsuperscript{80}

The societal perception of insanity as abnormal and unpredictable created two social responses. In the first instance, the insane were viewed as a curiosity albeit in need of isolation. Individuals transported from Brandon to North Battleford in February, 1914 experienced the isolation and public curiosity. Boarding the twelve coaches which comprised their special train, they travelled a continuous private journey until the morning of February 4, when the train reached the special spur tracks built at North Battleford's institution. Their transferance had been without problems, although the train's switch to Canadian National Rail lines at Regina's Union depot had resulted in the gathering of a large crowd "anxious to see if there would be any excitement."\textsuperscript{81} In the second instance, the social response toward the insane was that of isolated verification. Insanity became a behaviour or belief pattern contrary to societal expectations. Judged by law or medicine to be insane, the individual was removed from the community and isolated in the institution. In this manner, the concept of insanity was verified through institutional commitment for institutional treatment was in itself a signal of insanity.\textsuperscript{82}

The social response toward insanity, the isolated curiosity and verification, have to a certain extent, contributed to the perceived role of the institution. The institution could be viewed as a place of detainment for the abnormal and unpredictable. Institutional procedures to recover or rehabilitate appeared foreign or alien and were judged as confirming the alien or foreign perception of insanity. Despite institutional operations and practices meant to enhance medical treatment, institutional personnel and psychiatrists were not perceived as physicians.\textsuperscript{83} Thus, North Battleford was an enigma, being neither solely custodial or medical.
North Battleford's existence was dependent upon its ability to encompass and manage the various conceptions of insanity. As with the concept of insanity, the attributes ascribed to institutional commitment seemed unlimited. It could re-socialize some, but it would fail with others. It could provide a world for the abandoned chronic, but it would be seen to encompass others. Its isolated presence could remove the individual from societal sanctions, but the isolation would be viewed as fostering the stigma of insanity.

The subjective and encompassing conceptions of insanity which isolated the individual, also isolated North Battleford. For within the concept of insanity there is a belief in an “ideal”. A perception that an ideal system of defining, an ideal means of intervention will transform the individual. Socially, geographically, and medically isolated, North Battleford's institution was seen to reflect less than the ideal.

The institution's physical presence and utilization challenged the perception of preventable insanity. Its crowded conditions eroded a faith in cures. Like the societal definition of insanity, the institution was judged by others and found to be foreign or alien. Compared with alternative treatment centers, the institution was not modern. Unlike integrated centers, its visible presence could not hide the insane, nor could its chronic and hard to treat residents hide the subjective nature of insanity definition. In an era of preventative medicine, the necessity of an institution pointed to the inevitability of insanity. However, the failure of institutional treatment of insanity may not lie in the institution's structure, nor in its means of operation. Instead the failure may be inherent in the various conceptions and in the premise that an ideal technique, method, or structure could bring about an ideal cure.
Footnotes


2. The study undertaken by Erving Goffman at St. Elizabeth’s Hospital in Washington D.C. pointed to the ability of the institution to foster a dependence. As well, the dual nature of the institution as a resident community and as a center of formal organization contributed to the ability to act as a total entity able to supply various needs (Erving Goffman, Asylums [Garden City New York: Anchor Books, 1961], p. 4).

3. If the committed individual successfully adopted staff approved methods of behaviour, he would be deemed a social recovery. However, if he adopted resident methods he could be deemed “institutionalized”. As an institutionalized resident he would be tolerated by the staff and institutional community, able to work he would also continue the behaviour for which he was initially committed (John Cumming and Elaine Cumming, “Affective Symbolism, Social Norms, and Mental Illness,” Psychiatry XIX, [February, 1956], p. 85).


5. Their study identified various phenomena associated with long-term commitment. They found that individuals became less self-assertive, developed a reliance upon the institution, suffered feelings of stigma upon discharge, were estranged from developments in the outside world, were stimulus deprived, and isolated. The committed individual seldom received letters after being committed longer than a year and was seldom visited by family or friends (Robert Sommer and Humphry Osmond, “Symptoms of Institutional Care,” Social Problems 8, [Winter, 1960-61], pp. 255-257).

6. The assessment of “institutionalism” has been that the individual acquires values and attitudes unsuited to his previous community but suitable to those of the institution (Sommer and Osmond, “Symptoms of Institutional Care.” p. 256).

7. Dr. Mitchell perceived the “ideal” building to be situated near to a city and close to a railway. He described the grounds as well treed and shrubbed with vine covered railings and a wide open gate. Upon entering, the individual would be taken to a side door, similar to a home, and be met cheerfully by a head nurse. The new resident would be assigned a cottage containing ten to twelve residents and be allowed to use the building’s recreational facilities, engage in work activities, and thereby come to be treated and cured (Mitchell, “Address,” pp. 433-434).
8. The Mental Hygiene survey of 1945 criticized the crowded conditions at North Battleford for preventing the segregation of residents and the provision of individualized treatment. The survey recommended that the construction of the Saskatoon mental hospital be planned along the cottage model and segregate the resident in a small group according to type (C.M. Hincks, Province of Saskatchewan Mental Hygiene Survey, 1945, pp. 9, 11).

9. Tyhurst, et. al. More for the Mind, p. 83. This view was expressed by the Mental Hospital Service of the American Psychiatric Association.

10. In 1953 the World Health Organization released a technical report that said that insane institutions had been modeled both as a general hospital and as a prison. This report also found that 250 to 400 beds were cost effective. After 800 beds the wastage on the part of too large a staff and unnecessary buying became inevitable (F.S. Lawson, “Mental Hospitals: Their Size and Function,” Canadian Journal of Public Health 49, [May, 1958], p. 188).

11. Built in the 1960s these centers replaced the concept of isolated institutional treatment. Architecturally they took into account the relationship between color, texture, space, and space relations among residents. Some general sources outlining the development and conceptions behind the “Saskatchewan Plan” are Charles Goshen, Psychiatric Architecture (Washington: The American Psychiatric Association, 1959); Kahan, Brains and Bricks; K. Izumi, “An Analysis for the Design of Hospital Quarters for the Neuropsychiatric Patient,” Mental Hospitals 8, (April, 1957); and F.S. Lawson, “The Saskatchewan Plan,” Mental Hospitals 8, (March, 1957). The reasonings for these or similar plans can also be found in Lawson, “Mental Hospitals”; and Humphry Osmond, “Function as the Basis of Psychiatric Ward Design,” Mental Hospitals 8, (April, 1957).

12. Insanity historiography has assessed the internal construction of institutions as indicative of a theory of insanity which made for easy surveillance. As well, institutional wards have been condemned as allowing for institutional enumeration in which names and faces were often unrecognized by institutional staff (Jones, Mental Health and Social Policy, 1845-1959, p. 95).


16. The deputy minister's warrant would be issued if it was felt that the individual should be admitted even though the proceedings for admission had not been completed. The institution would then be instructed to detain the person for a limited period of fourteen days unless the warrant for admission was issued during the period (Statutes of the Province of Saskatchewan. Regina, Sask., 1936, chapter 91, section 10).

17. Voluntary commitment was based upon a written application attested by a physician. The process of voluntary commitment could not be applied to the aged or the mental defective as separate provisions for their care and commitment to alternative institutions existed.

18. Statutes of the Province of Saskatchewan. Regina, Sask., 1936, chapter 91, section 30. The individual could also be discharged to suitable family or friends on a trial basis. If however, the individual appeared to be in need of institutional readmission within six months, a warrant for his apprehension and return to the institution would be issued (Statutes of the Province of Saskatchewan. Regina, Sask., 1936, chapter 91, section 31).

19. Upon the written notification of a desire to leave, the individual could not be detained longer than five days (Statutes of the Province of Saskatchewan. Regina, Sask., 1936, chapter 91, section 11).


21. *The Mental Hygiene Act* cited the basis of admission to a psychopathic ward:

   Any person who is or is believed to be in need of observation, care, and treatment in a psychopathic ward may be admitted thereto and kept therein, with the permission of the director, on the certificate of a physician, other than the director, ... provided no person shall be kept in a psychopathic ward for a period longer than three months without the authority of the deputy minister on the recommendation of the director.

Statutes of the Province of Saskatchewan. Regina, Sask., 1936, chapter 91, section 41.
22. Statutes of the Province of Saskatchewan. Regina, Sask., 1936, chapter 91, section 43. In 1947 The Mental Hygiene Act was amended to provide for the discharge of a person in a psychopathic ward even against the advice of the director, if the application for discharge was made by a responsible relative (Statutes of the Province of Saskatchewan. Regina, Sask., 1947, chapter 80, section 11).

23. If the institutionalized resident died, the cost incurred for commitment and maintenance would be paid through the estate. However, unlike previous statutes, the ability of the province to recover costs through the estate was not applicable if the estate was a direct inheritance or if dependents were deemed to be in need of the estate for support (Statutes of the Province of Saskatchewan. Regina, Sask., 1944, chapter 47, section 2).

24. Statutes of the Province of Saskatchewan. Regina, Sask., 1944, chapter 47, section 2. At this time, T.C. Douglas was Minister of Public Health. As a young graduate student of Brandon college, Mr. Douglas had examined the conditions at Weyburn for his Masters thesis.

25. Questionnaires were prepared and sent by the Dominion Bureau of Statistics. It was stated that Mr. Coats and his staff cooperated with the Mental Hygiene Committee (H.B. Spaulding, "Mental Hygiene Population Increases Less in 1931 than in 1930," Mental Health VII, [September-October, 1932], p. 41).

26. In 1933, receipts at Canadian institutions totaled $11,395,085.05. This amount was comprised of provincial grants of over 7 million dollars. In 1933, Saskatchewan receipts were reported to be $763,639.95 of which the provincial grants to the institutions totaled $680,359.52. In addition to government grants, the two Saskatchewan institutions received over $80,000 from the 2,689 institutionalized residents (Mental Health VIII, [November, 1935], p. 6).

27. The following table shows the total provincial expenditures of the 9 provinces in thousands of dollars as well as total per capita expenditures which include maintenance costs. Only Quebec, Nova Scotia and New Brunswick paid considerably less per capita than the national average in 1936. The highest per capita cost in 1936 was experienced by Prince Edward Island ($1.12) followed by Saskatchewan and Manitoba ($ .95).
### Institutional Expenditures

<table>
<thead>
<tr>
<th>Year</th>
<th>National Total</th>
<th>Per Capita</th>
<th>Saskatchewan Total</th>
<th>Per Capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>1913</td>
<td>2,337</td>
<td>$0.31</td>
<td>191</td>
<td>$0.34</td>
</tr>
<tr>
<td>1926</td>
<td>5,485</td>
<td>$0.58</td>
<td>513</td>
<td>$0.62</td>
</tr>
<tr>
<td>1929</td>
<td>6,977</td>
<td>$0.70</td>
<td>746</td>
<td>$0.84</td>
</tr>
<tr>
<td>1931</td>
<td>7,422</td>
<td>$0.72</td>
<td>702</td>
<td>$0.76</td>
</tr>
<tr>
<td>1933</td>
<td>6,694</td>
<td>$0.63</td>
<td>700</td>
<td>$0.75</td>
</tr>
<tr>
<td>1935</td>
<td>6,768</td>
<td>$0.62</td>
<td>765</td>
<td>$0.82</td>
</tr>
<tr>
<td>1936</td>
<td>7,445</td>
<td>$0.68</td>
<td>941</td>
<td>$1.01</td>
</tr>
</tbody>
</table>


29. The 1920 survey commended the facilities at Westmore School in Regina for their ability to instill the immigrant child with “Canadian ideals” and foster a “growing loyalty to the British flag.” The Boy’s Detention Home was commended for its lack of bars and bolts and its reliance upon kindly methods of discipline. The survey of mental defective school children and prisoners resulted in recommendations for the Provincial Department of Education to implement special classes and teacher instruction, and for the prison system to provide psychiatric examination and suitable care as a means to combat recidivism (“Treatment Given Defectives in Saskatchewan is Praised by Mental Hygiene Committee,” *The Leader*, 22 January 1921, p. 15).


32. Various factors contributing to mental health were elaborated in a chapter entitled “General Principles, Essentials and Ideals of Mental Hygiene” by Dr. Clouston (Clouston, *The Hygiene of Mind*, pp. 43-52).

34. The following chart outlines the scope of personnel employed in Saskatchewan institutions and comparable institutions in 1932.

Institutional Services

<table>
<thead>
<tr>
<th></th>
<th>Sask.</th>
<th>Man.</th>
<th>B.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients</td>
<td>2,561</td>
<td>2,329</td>
<td>2,778</td>
</tr>
<tr>
<td>Institutions</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Physicians</td>
<td>8</td>
<td>15</td>
<td>12</td>
</tr>
<tr>
<td>Dentists</td>
<td>0</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Occ. Therapists</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Grad. Nurses</td>
<td>7</td>
<td>54</td>
<td>21</td>
</tr>
<tr>
<td>Nurses</td>
<td>92</td>
<td>107</td>
<td>111</td>
</tr>
<tr>
<td>Attendants</td>
<td>170</td>
<td>159</td>
<td>183</td>
</tr>
<tr>
<td>Total Staff</td>
<td>403</td>
<td>526</td>
<td>507</td>
</tr>
</tbody>
</table>


37. Beginning in 1933 the North Battleford institution was able to utilize the services of 12 medical students (Annual Report of the Department of Public Health. Regina, Sask., 1935, p. 68).

38. The twenty standards adopted by the American Psychiatric Association included such areas as having a qualified medical superintendent unhampered by political interference and in charge of a medically qualified staff, the utilization of well kept clinical records and statistical information, adequate medical facilities and medical library, the employment of restraint only under controlled conditions, and an adequate kitchen able to supply the institutional food (Hincks, Mental Hygiene Survey, pp. 29-31).

39. Standard 18 of the American Psychiatric Association guidelines called for an adequate nursing force able to carry out a 12 hour shift and able to effect a ratio of 1 to 8 of the total population. In instances of intensive care, the ratio became 1 to 4. Although Dr. Hincks found the total population ratio acceptable, he found that there was not a qualified instructor, nor arrangements made for student nurses to qualify for R.N. certification (Hincks, Mental Hygiene Survey, p. 31).

40. Dr. Hincks recommended the employment of 1 full-time dentist per 1000 residents, and the utilization of social service workers to provide case histories and to assist those being discharged (Hincks, Mental Hygiene Survey, p. 13).
41. The lack of trained personnel was alleviated to a certain extent at the end of the war when absent employees returned to the institution. In September, 1945 a full-time dentist was hired, and in August, 1945 the Social Service Department was formed. On August 1, 1945 an agreement with the United Civil Servants of Canada, Local No. 3 was brought into effect. The institution hired additional personnel to comply with this agreement which called for an eight hour work day for ward employees (Annual Report of the Department of Public Health. Regina, Sask., 1945, p. 117).

42. Hincks, Mental Hygiene Survey, p.1.


45. The following table shows a compilation of total admissions, "first admissions", and "readmissions" according to sex that occurred at North Battleford institution between 1931 and 1945.

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>First</th>
<th>Readmitted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>1931-1933</td>
<td>1095</td>
<td>534</td>
<td>304</td>
</tr>
<tr>
<td>1934-1936</td>
<td>1184</td>
<td>568</td>
<td>340</td>
</tr>
<tr>
<td>1937-1939</td>
<td>1151</td>
<td>531</td>
<td>346</td>
</tr>
<tr>
<td>1940-1942</td>
<td>1103</td>
<td>499</td>
<td>342</td>
</tr>
<tr>
<td>1943-1945</td>
<td>1120</td>
<td>456</td>
<td>399</td>
</tr>
</tbody>
</table>


46. Provincial methods of institutional admissions were provided by the Dominion Bureau of Statistics. The following table shows the method of commitment for male and female "first admission" and "readmission" in Saskatchewan over a period of time.
### Institutional Admissions in Saskatchewan

<table>
<thead>
<tr>
<th>Year</th>
<th>Voluntary</th>
<th>Medical</th>
<th>Warrant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>1932</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>first</td>
<td>3</td>
<td>3</td>
<td>67</td>
</tr>
<tr>
<td>readmit</td>
<td>3</td>
<td>2</td>
<td>21</td>
</tr>
<tr>
<td>1935</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>first</td>
<td>10</td>
<td>2</td>
<td>72</td>
</tr>
<tr>
<td>readmit</td>
<td>4</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>1940</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>first</td>
<td>7</td>
<td>9</td>
<td>159</td>
</tr>
<tr>
<td>readmit</td>
<td>3</td>
<td>3</td>
<td>29</td>
</tr>
<tr>
<td>1945</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>first</td>
<td>23</td>
<td>12</td>
<td>187</td>
</tr>
<tr>
<td>readmit</td>
<td>8</td>
<td>4</td>
<td>34</td>
</tr>
</tbody>
</table>


47. Although the institution continued to make goods which were both saleable and serviceable to the institution, the annual reports in the 1930s no longer listed the number of residents employed by the institution. However, an indication of resident labour as necessary to institutional maintenance can be found in the submitted report for 1938-1939. In this report, Superintendent MacNeill lists the various projects undertaken by the “Industrial Occupation Department”. This list includes such projects as building a concrete slab at the back of the main kitchen, building a carpenter’s shop and store room for lumber and supplies, building a curling rink, pulling down a root cellar, and providing alterations in the officers’ dining room and enlarging the dispensary (Annual Report of the Department of Public Health. Regina, Sask., 1938, p. 87).


49. Annual reports submitted from North Battleford showed various percentages of discharges to admissions. In the 1920s one of the lowest rates of discharge occurred in 1922 when paroles to admissions showed 41.43%. During the same decade, 1923 reported a parole to admission rate of 57.44%. In 1933 the discharge rate was 47.78% and by 1938 discharge was reported at 59.74%. This rate of discharge continued with 1943 showing a rate of 52.73% and 1945 showing a rate of 66.24%.
50. By using the institutional statistics for 1945, an indication of the employment of statistics for a particular purpose can be found. In 1945 the institution reported 397 admissions and total paroles of 263 for a discharge percentage of 66.24%. However, if paroles had been compared to the total institutional population of 1,715 the discharge percentage would have been slightly over 15%.

51. Discharges allowed the institution to lessen somewhat the conditions of crowding. The utilization of drug therapy would hasten this operational procedure of deinstitutionalization and has been characterized as a situation in which the institution would "begin to open their back doors" while also "closing the front doors" (Gronfein, "Psychotropic Drugs," p. 441).

52. Royal Commission on Health Services, Psychiatric Care in Canada: Extent and Results (Ottawa: Queen's Printer, 1966), p. 4.

53. G.H. Stevenson, "The Evolution of the Mental Hospital," The Canadian Hospital (June, 1930), p. 35. Dr. Stevenson was the medical superintendent at Ontario Hospital, Whitby Ontario.

54. Earlier reported admissions from North Battleford cited the categories of dementia praecox and manic depressive as contributing significantly to yearly admissions.

55. The following table shows North Battleford's total admissions and yearly admissions of males and females classified as senile, cerebral arteriosclerosis, and dementia praecox over various periods of time.

<table>
<thead>
<tr>
<th></th>
<th>Total Admissions</th>
<th>Senile M</th>
<th>Senile F</th>
<th>Arterio. M</th>
<th>Arterio. F</th>
<th>Dementia M</th>
<th>Dementia F</th>
</tr>
</thead>
<tbody>
<tr>
<td>1933</td>
<td>383</td>
<td>23</td>
<td>12</td>
<td>23</td>
<td>8</td>
<td>100</td>
<td>55</td>
</tr>
<tr>
<td>1938</td>
<td>390</td>
<td>14</td>
<td>12</td>
<td>41</td>
<td>9</td>
<td>80</td>
<td>49</td>
</tr>
<tr>
<td>1942</td>
<td>347</td>
<td>32</td>
<td>10</td>
<td>38</td>
<td>18</td>
<td>58</td>
<td>36</td>
</tr>
<tr>
<td>1945</td>
<td>397</td>
<td>12</td>
<td>16</td>
<td>33</td>
<td>21</td>
<td>50</td>
<td>51</td>
</tr>
</tbody>
</table>


56. The behaviours expressed by the aged are those such as peevishness, irritability, wilfulness, childishness, ill-temper, foolish obsession and suspicion, and prolonged conversation (Nolan Lewis, "Mental Hygiene of the Senium," Mental Hygiene XXIV, [July, 1940], p. 439).

58. In autopsies performed upon the elderly senile it was found that discolored deposits existed in the brain. These discolorations termed “senile plaques” were felt to exhibit the inevitability of decay in old age. Dr. Critchely disputed that such plaques were necessarily inevitable (Macdonald Critchely, “The Neurology of Old Age,” The Lancet 220, [May 23, 1931], p. 1124).

59. The following table shows national averages with respect to males and females categorized as senile and cerebral arteriosclerosis for 1945.

<table>
<thead>
<tr>
<th></th>
<th>Senile</th>
<th>Arterio.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>F</td>
</tr>
<tr>
<td>total discharges</td>
<td>94.0</td>
<td>86.0</td>
</tr>
<tr>
<td>av. age</td>
<td>77.1</td>
<td>73.8</td>
</tr>
<tr>
<td>av. stay (years)</td>
<td>0.6</td>
<td>0.9</td>
</tr>
<tr>
<td>av. age (death)</td>
<td>77.3</td>
<td>78.4</td>
</tr>
<tr>
<td>av. stay (years)</td>
<td>2.2</td>
<td>3.0</td>
</tr>
</tbody>
</table>


61. Wing, Reasoning About Madness, p. 100.

62. Clark, Mental Diseases, p. 69.


64. May, Mental Diseases, pp. 444-445.

65. In the 1933 annual report from North Battleford, the term schizophrenia was used on its own. In subsequent years the term dementia praecox was used with the term schizophrenia appearing in brackets.

66. In 1945 the greatest amount of readmissions at Saskatchewan institutions were for those termed dementia praecox, while manic depressive were the second largest category being readmitted. These two groups comprised over 200 institutional discharges (Dominion Bureau of Statistics: Mental Hygiene Statistics, 1945, pp. 51, 55).
67. The following table shows the national average of male and female dementia praecox residents who were discharged or died in 1945. The term dementia praecox had various subdivisions, however for ease of understanding and comparison, the various subdivisions have been utilized as a generic term.

Discharges and Deaths of Dementia Praecox at Canadian Institutions in 1945

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dementia Praecox</strong></td>
<td><strong>M</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td>total discharges</td>
<td>1009.0</td>
<td>688.0</td>
</tr>
<tr>
<td>av. age</td>
<td>32.7</td>
<td>34.1</td>
</tr>
<tr>
<td>av. stay (years)</td>
<td>1.5</td>
<td>1.2</td>
</tr>
<tr>
<td>av. age (death)</td>
<td>52.6</td>
<td>55.0</td>
</tr>
<tr>
<td>av. stay (years)</td>
<td>17.4</td>
<td>17.6</td>
</tr>
</tbody>
</table>


70. Hall, *One Hundred Years*, p. 319.

71. Although hydrotherapy had been utilized by North Battleford since its opening in 1914, it was only in the annual report of 1944 that the various forms of hydrotherapy and the various hours of treatment were stated. The following table shows the primary forms of hydrotherapy given to male and female residents. Other forms such as the ice mit, rain and needle spray, and douche are not cited although the annual report for 1944 shows their employment as a treatment procedure.
Hydrotherapy at North Battleford, 1944

Male Hydrotherapy

patients receiving hydrotherapy ............... 176
patients receiving prolonged baths ........... 188
patients receiving cold wet packs ............ 111

no. of prolonged bath treatments ............. 4 962
hours of prolonged bath treatments .......... 32 490
no. of cold wet pack treatments .............. 3 328
hours of cold wet pack treatments .......... 19 968

no. of neutral showers for cold wet packs .. 6 656

Female Hydrotherapy

patients receiving hydrotherapy ............... 151
patients receiving prolonged baths ........... 92
patients receiving cold wet packs ............ 66

no. of prolonged bath treatments ............. 3 461
hours of prolonged bath treatments .......... 23 116.25
no. of cold wet pack treatments .............. 1 896
hours of cold wet pack treatments .......... 10 142.25


73. In 1944 the institution's annual reports began to cite the number of residents receiving various shock therapies. The following table shows the types of shock therapies and the extent of their use on males and females as a treatment procedure in 1944 and 1945.
Shock Therapy at North Battleford, 1944 and 1945

<table>
<thead>
<tr>
<th></th>
<th>1944 M</th>
<th>1944 F</th>
<th>1945 M</th>
<th>1945 F</th>
</tr>
</thead>
<tbody>
<tr>
<td>INSULIN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>number of patients</td>
<td>4</td>
<td>8</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>number of treatments</td>
<td>159</td>
<td>81</td>
<td>833</td>
<td>692</td>
</tr>
<tr>
<td>METRAZOL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>number of patients</td>
<td>14</td>
<td>0</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>number of treatments</td>
<td>34</td>
<td>0</td>
<td>18</td>
<td>43</td>
</tr>
<tr>
<td>ELECTRO-SHOCK</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>number of patients</td>
<td>96</td>
<td>105</td>
<td>76</td>
<td>132</td>
</tr>
<tr>
<td>number of treatments</td>
<td>991</td>
<td>1340</td>
<td>991</td>
<td>1767</td>
</tr>
</tbody>
</table>


75. Lewis, “What do we know about Dementia Praecox,” p. 579.

76. “Problems of Mental Health,” p. 4.

77. Porter, A Social History, p. 3.

78. Elaine Cumming and John Cumming, Closed Ranks (Cambridge: Harvard University Press, 1957), p. 88. This study undertaken in 1951 pointed out that insanity was socially defined when it disrupted the predictability associated with social life. As well, the ignorance or fear associated with insanity is not based solely upon a lack of information but is as much derived and maintained by personal and community needs (Cumming, Closed Ranks, p. xi).

79. The Saskatchewan study found that the act of perceiving someone as insane is as much a reaction to a situation as it is a means to ensure particular societal conformation:

When an individual does exhibit a clear-cut break with the norms, certain things happen. Members of his subsociety and possibly all the members of society, will react against his unacceptable behavior. Indeed, they must, because the ordinary, everyday business of social life can only be accomplished if people by and large do what is expected of them and feel guilty and repentant if they fail.

Cumming, Closed Ranks, p. 116.
80. In a study undertaken in 1955, it was found that insane behaviour, while not readily understandable by family members, was ignored by the family and adaptations made to accommodate the behaviour. However, it was also found that once a threshold point is reached, the individual becomes perceived as having a psychiatric problem (M. Yarrow, C. Schwartz, H. Murphy and L. Deasy, “The Psychological Meaning of Mental Illness in the Family,” The Journal of Social Issues XI, [1955], pp. 15-16).


82. Cumming, Closed Ranks, p. 102.

83. In a questionnaire given to over 700 college educated individuals it was found that although this group tended to be more sympathetic toward the insane, the concept of what a psychiatrist does and what psychiatry does was often lacking:

The public has strong and often negative feelings about psychiatrists: they are often thought of as aggressive, unnecessarily curious, too much concerned with money, at times in possession of sinister power to read minds and influence fate, and quite often as abnormal as their patients.


84. A study of 2,166 chronic residents, those institutionalized for more than two consecutive years, found that over two-thirds of the male residents and over one-half of female residents had no living children. Although the majority of chronic residents had siblings, only approximately one-quarter had both parents living at the time of admission (Norman Morgan and Nelson Johnson, “Failures in Psychiatry: The Chronic Hospital Patient,” American Journal of Psychiatry 113, [March, 1957], pp. 826-827). The implication of this study was that the chronic lacked outside support systems and that social workers should work with this type of resident.

85. Institutional commitment fulfills an intended function by removing the individual from stress which may have precipitated the insane condition. As well, it allows for the protection of the individual from self-inflicted violence, or from societal abuse (Cumming, Closed Ranks, p. 132).

86. The family’s unwillingness to confine has been found to be related to how they will be perceived by relatives, co-workers, or the community if it is known that a member is institutionalized. These feelings of “stigma” among institutionalized relatives appear to be associated with the degree of bizarre behaviour, the social class of the family members, and their personality

87. The degree of faith in asylum care generally varies with the physical accessibility and age of the institution (Dain, Concepts of Insanity, p. 151).
Chapter 6
Conclusion

The changing legal, medical, and social conceptions of insanity between 1914 and 1945 influenced the role envisioned for Saskatchewan Hospital, North Battleford and provided a basis for societal perceptions of its function. Therefore, as with the conceptions of insanity, the institution has been subject to changing conceptions of its role and perceptions of its function, and like insanity has been subject to various historical assessments of its utility:

It carries different meanings according to the epoch, the society, and the social group involved, and according to the interests and preconceptions of the person who is using it.¹

In order to ascertain the initial response toward insanity in Saskatchewan, the legal and political provisions were examined. Procedures implemented for commitment and detainment, the provisions for court hearings, and the language employed in Saskatchewan statutes provided the basis for examining both the social and legal response toward the insane and the perceived role of the institution. The perception that the insane were dangerous, potentially violent, and unnatural can be gleaned through early provisions for commitment and detainment and through the legal language utilized such as “dangerous lunatic” or “inmate”. This linking of insanity and criminality can be found in the earlier history of insanity care and treatment. Yet, this linking of insanity with criminality is not solely a historical legacy, nor somehow inherent to architectural construction which provided an isolated residence to a category of socially troublesome people.²

The linking of insanity and criminality appears to be the result of a societal perception. Subsequent sociological studies which examined the
family and community response to insanity and the insane individual suggest that institutional commitment is considered when the individual is perceived as unnatural or a societal threat. In such a manner, the legal perception of the insane as a social transgressor may reflect the family's or community's response toward insanity. This, being the case, the perception of the insane institution was that of protector. Its role was to detain and its function to rehabilitate. The success of institutional commitment and treatment could be measured through both discharge and occupational employment and productiveness.

However, the role envisioned for the institution changed from rehabilitating the social transgressor to curing the patient. The twentieth century perception of insanity curability was in part a result of World War I shell shock cures and the ability of medicine to define and combat diseases such as yellow fever or syphilis. The second area of change concerning insanity conceptions occurred within the medical approach.

The medical treatment of the institutionalized insane can be traced from the nineteenth century onward. In the early twentieth century, the medical conceptions of insanity causation centered upon disease theory or social attribution. Insanity was medically perceived as similar disease processes in that it was judged through symptoms. But, unlike the practice of general medicine, insanity was described as either a disorder of conduct or a disorder of mind. Specialized training and terminology such as "neuroses", "psychoses" or specified categories such as "dementia praecox" differentiated insanity from other areas of medical research. In Saskatchewan insanity came to be legally defined as a disease. The legal provisions which attempted to differentiate the disorderly sane from the disorderly insane worked in conjunction with medical or scientific explanations which attempted to define the nature of insanity as a separate entity from other illnesses or other forms of deviant behaviour.
Institutional superintendents such as Dr. MacNeill, although politically appointed, were also medically trained. Through their writings an understanding of their's, if not the medical profession's, assessment of insanity causation and treatment can be found. At North Battleford, internal programs such as trained personnel, and procedures such as shock therapies were utilized to reflect a medical approach of professional, competent care or cure.

Although insanity was a separate medical entity, its link with medicine created a situation in which the success of institutional treatment centered upon its ability to possibly control or cure the insane individual. While the employment of shock therapy created a reaction which was felt to control or cure the insane, it also created a situation in which the insane could continue to be perceived as different and in need of specialized services. The development of physical therapies during the 1930s also show that the medical approach toward insanity treatment was to perceive the mind and body as the same.

The third area of change concerning insanity conceptions and the perceived role of the institution occurred within the broader social sphere. Although the genesis of the Mental Hygiene movement may be described as one man and one book, its policies and programs would have a tremendous affect upon the institution. The Canadian Mental Hygiene agenda which covered areas such as war work, immigration, statistical compilation, and child research touched a wide variety of social issues and concerns. Their perception that mental abnormality was at the root of social maladjustment underscored a belief that insanity weakened both the individual and society. Their influential membership promoted insanity as the cause for social problems in that:

Those regarded as insane are simply the cases whose capacity for adjustment to the requirements of organized society has failed to such degree that they have become a burden or a menace.

Their recommendations acted as a panacea for social problems and as a theory of human behaviour to better the individual and the society.
Mental Hygiene recommendations addressed a variety of concerns. Provincial governments were provided with alternative centers such as psychopathic wards. Social concerns regarding immigration were addressed through Mental Hygiene surveys which were scientific in methodology. However, as in the case of phrenology, the immigration surveys acted as a societal legitimizer in that the relationship between the perception of a social and economic problem and the collection and dissemination of the relevant data tended to be used to continue and promote the perceived problem regarding immigration.\(^6\)

However, it was at the institution that Mental Hygiene's goal of insanity eradication and its programs for betterment had the greatest impact. The changing nature of provincial surveys reflect the concept of ideal and the principle of adherance. Surveys which identified the "good" or the "bad" acted also as a means to provide conformity. These surveys in conjunction with alternative treatment centers created a situation in which the institution was financially managerial or businesslike in nature and also restorative or medical in function. Clearly by 1945, the onus was on the institution. It could adopt measures similar to that of a psychopathic ward and join with the Mental Hygiene movement, or it could become a back up place for the chronic or hard to treat cases and provide custody.\(^7\)

By the 1940s, the institution, like the insane, was perceived as uncontrollable, unmanageable and dangerous. Its procedures and structure found lacking, and open to criticism. Like the concept of insanity, the institution would be isolated. However, unlike the legal, medical or social conceptions of insanity, the perceived role and function of the institution would come to be defined as obsolete.
FOOTNOTES


2. The insane institution has been found to be similar to other institutions such as nursing homes, orphanages, and jails in that it provides a custodial function (Goffman, Asylums, p. 354).

3. At the twentieth annual meeting of the American Mental Hygiene movement, Dr. William Welch, Director of the Department of the History of Medicine at John Hopkins University, presided and in a tribute to Mr. Clifford Beers equated the history of Mental Hygiene as “one man and just one book” (“Twenty Years of Mental Hygiene,” The Bulletin IV, [November, 1929], p. 4).


6. While the collection and dissemination of ethnic data can promote or reinforce problems such as assimilation, it also becomes a means to show that discriminatory social or economic characteristics have not disappeared (Warren Kalbach and Wayne McVey, The Demographic Bases of Canadian Society [Toronto: McGraw-Hill Company of Canada Limited, 1971], p. 3).

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