PUBLIC PROMOTION AND MENTAL HEALTH POLICY IN SASKATCHEWAN, 1920-1975

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PUBLIC PROMOTION AND
MENTAL HEALTH POLICY
IN SASKATCHEWAN, 1920-1975

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by
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ABSTRACT

The Campaign to Create a Psychiatric Public in Saskatchewan.

Most policy literature, particularly much recent material on the sociology of psychiatry, tends to gloss over significant questions surrounding public opinion and public demand. Specifically, what are the origins of public support for social policy initiatives and how are publics introduced and habituated to new service forms that arise with changes to social policy? These questions are the object of an investigation into the role of the psychiatric professions in generating political support and consumptive demand for services attendant with the transformation of psychiatric services into its present community mental health modality. This transformation entailed the medicalization of psychiatric work and an externalization of the locus of service provision. Psychiatry, formerly an administrative specialty that was centered in custodial asylums, was converted into a range of community services based on a medical model that promised to deliver prevention of mental disorders. This transformation was a dual process that involved changes not only to service provision but also service consumption and thus required an overall social reconstitution of insanity into medical categories—termed collectively, mental illness. Evidence from approximately 600 articles reported in major Saskatchewan newspapers illustrates that the Canadian Mental Health Association functioned as a primary vehicle for the promotion of a psychiatric worldview in the public forum. It shows the important role these professions played in attempting to generate and shape public opinion to achieve their goals.
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CHAPTER 1

Literature Review and the Research Problem

1.1 Introduction

This work is a case study of some of the major dynamics in the historical development of those social policies directed towards dealing with mental disorders in the province of Saskatchewan, Canada. It broadly follows policy developments from when the area was first constituted as part of the NorthWest Territories up to the 1970s, a period in which the social management of the mentally disordered changed dramatically. Especially since World War II, policy across the West, including Saskatchewan, has been towards what is called 'community psychiatry' or 'community mental health'.

Community psychiatry essentially refers to the replacement of large, centralized mental hospitals, previously the major site for treatment of mental disorders, in favour of a variety of community-based programs that deliver a range of psychiatric services\(^1\). Community psychiatry indicates a radical change in treatment modalities, along with different objectives. Most significantly, it involves a number of intensive, short-term and ostensibly more preventative methods, administered where possible on an out-patient basis. This contrasts with the long-term, intramural, mostly custodial care that typified asylums.

Saskatchewan presents an unusually interesting opportunity in which to study this transformation, since it pioneered many of the policies and practices that were standardized into community psychiatry practised in other
regions. Although sociological analysis of these developments has been recently undertaken, significant gaps remain in the overall picture of this transformation as it occurred in this province. This work is intended to help fill in that picture. While many of the significant policy matters identified in the study may be unique to this particular topic and region, many are indicative of more general issues as well. To the extent that policy reflects common issues, this study is aimed at a more general understanding of social policy processes. The focus of the analysis, as will be introduced in this chapter, is on a particular aspect of mental health policy, the role of public promotion.

Since mental health will be considered here as a type of social policy, it is useful, if not essential, to clarify this concept. In the general policy literature, social policy is a "fairly elastic concept"\(^2\), subject to a variety of operational definitions linked to considerations such as theoretical perspective. One highly contentious issue revolves around the question of how policy is determined and the consequences of this determination. Indeed, a major concern of the present study is to examine what we contend is the important role of professional promotion in the determination of policy.

This chapter is divided into five major sections. The next section clarifies the concept of social policy; by way of a brief review culled from some of the welfare state policy literature. The increase in state welfare after the Second World War has generated considerable interest in the nature and role of the state in this regard. This concern can be observed not only in the general policy literature on the welfare state, but especially in the literature on the 'social control' aspects of policy. Since much of the most salient material concerning mental health derives from this literature, Section Three traces its relevant currents.

While much of the early social control work was based on a consensual view of policy, more critical work began to emerge in the 1960s. More recently, that trend has been continued in the 'revisionist histories' of pre-twentieth century control institutions such as mental hospitals. Revisionists have
demonstrated that the history of these institutions is more variegated than the simple progressive-evolutionary scheme typically reported.

The fourth section goes on to critically review three key works written in a revisionist vein that deal with the more contemporary issues surrounding the establishment of community psychiatry. The first two of those accounts, by Andrew Scull and Diana Ralph respectively, employ social control perspectives. The last, by Françoise Boudreau, utilizes a systems-conflict approach and is reviewed separately, at the end of the section.

1.2 The Concept of Social Policy

Policy can quite simply be defined as a "course or general plan of action", or roughly speaking a 'guide-line'. Public policy is a broad concept, usually defined as something like "authorized collective intervention". Social policy more narrowly refers to that part of public policy "which affects social life".

In demarcating the field of social policy, a number of writers distinguish broad from narrow definitions of the term. Yelaja's seminal survey article offers a comprehensive definition representative of the broad perspective. According to Yelaja,

Social policy is concerned with the public administration of welfare services, that is, the formulation, development and management of specific services at all levels, such as health education, income maintenance, and welfare services. Social policy is formulated not only by government, but also other institutions such as voluntary organizations, business, labour, industry, professional groups, public interest groups, and churches.

In this broad sense then, social policy most often refers to direct and indirect "human resource development". For instance, while mental health policy is
directly concerned with the conditions and principles under which services are provided, it indirectly overlaps with a host of other public issues that bear on psychic well-being.

In contrast, social policy more narrowly refers to what is usually called social welfare policy. In this sense, it is an "expression of the philosophy and programs concerning the poor, dependent handicapped and others who need economic, social or psychological support". For the purposes here, social policy, for the most part, will be used in the narrower sense.

Social policies then, are defined as the guide-lines around social welfare programs adopted by governments and other groups, and codified in law. Mental health policy, while part of a network of policies and practices, is mainly concerned with the definition and management of mental illness/health. Not that social welfare policies in Canada are a highly co-ordinated and completely coherent. On the contrary, the system is complex, with many overlapping, unrelated and even contradictory elements. This situation reflects the uneven history and residual character of many programs, that can only loosely be described as a 'system'.

The set of institutions that comprise the social welfare system entail both public and private provisioning of assistance. The term 'welfare state' denotes, in part, the generally observed trend towards greater state involvement in this realm among Western nations since World War II. In virtually all such societies, the state has displaced philanthropies, 'friendly societies' and private charities as the principal provider of social assistance. Thus, the various levels of the state have become major initiators and orchestrators of social policy interventions.

Welfare states actively intervene by providing various social service programs, and also through regulation of private activities. In Canada, there are presently two basic types of social welfare programs. First, there are state
supplied or organized income security plans involving income transfers. These include cash transfer programs, social insurance plans and tax credits. In addition, there are private schemes, usually employment related, along with private charities. Second, there is a range of non-income, personal and community services in health, education, housing, child welfare, corrections and other areas. Many of these services are either directly provided or funded, in part or whole, by various levels of government. A substantial portion are also provided by commercial or voluntary organizations. As noted, these are usually subject to some degree of state regulation through licensure or resource subsidies.

This description presents a basic profile of the social welfare interventions typical of modern states and would seem to be relatively uncontroversial. In fact, until quite recently, the bulk of material concerning social policy remained on this type of descriptive terrain. Of late, there is more concern with theoretical issues raised by welfare state interventions. One central set of debates revolves around the nature of the state in relation to its interventions. On the one hand, many writers seem to agree that the object of policy is "to shape the quality of life or level of well-being of individuals and groups in society". Ostensibly, this is felt to be based on a criterion of individual or group need.

In a more critical vein, on the other hand, authors such as Gough maintain that this common position, assumes "that the purpose of the welfare state is [primarily] the enhancement of human welfare". Gough's basic point is that modern capitalist societies, after all, are still capitalist and ultimately predicated on the production of profit before the satisfaction of human need.

Now, this point about the purpose of social policies highlights complex problems that resonate through much of the policy literature. The following section introduces some of these basic issues that are most pertinent to the present study. These are presented in the form of an outline of the major currents in 'social control' leading up to 'revisionism', since a good deal of the
most salient sociological material on mental health policy emanates from this body of literature.

1.3 Social Policy and Social Control

1.3.1 The History of Social Control

The notion of social control as first articulated by the classical theorists in the last century, notably Comte, Spencer, and Durkheim, concerned the problem of social order in the widest sense. That is, as originally used by these figures, social control referred to "macro-sociological questions of order, authority, power, and social organization" in relation to both coercion and consensus. In the decades immediately around the turn of the century, social control continued to be used as a central analytic concept concerned with social groups' capacities for self-regulation. It was widely used in this way in North America by writers such as E.A. Ross and G.H. Mead, and in work by the Chicago school. As well, it figured prominently in some European thought, for example, in Mannheim's writings.

By the 1940s, however, social control research had become progressively more restricted, so that it was almost entirely focused on social regulation and consensus. From the perspective of the 1940s control theorists, social control was largely seen as a problem of ensuring conformity, which was thought to be achieved in three basic ways. First and foremost, it was achieved through family socialization; second, by informal means, such as peer pressure, and last by formal mechanisms such as, courts and police. The emphasis from this perspective was clearly psychological, oriented primarily to the processes that elicit individual conformity through the internalization of norms.

In this still highly influential approach, deviant behavior, including mental disorder, is seen as a failure of social control. That is, it is seen primarily as a result of defective socialization. While this may in a sense be accurate, deviance is treated in isolation from the activities of formal agencies of control,
save as reparative mechanisms\textsuperscript{27}. Since such actions are considered remedial, they are regarded as benevolent for society as a whole. Despite such questionable assumptions, this sort of approach was widely adapted by neighboring sub-disciplines, notably 'progressivist' history. Progressivist or 'Whig' institutional histories are thus characterized by their benevolent portrayal of control institutions viewed as an inevitable outcome of the progress of modern society. One consequence of the dominance of this kind of perspective is that until recently, the sociology of psychiatry has been preoccupied with the etiology of mental disorders. This has circumscribed the field largely to problems delimited by social-psychological and psychiatric concerns\textsuperscript{28}. In short, the striking feature of the transmutation of social control is that until fairly recently, state and other institutional practices have been unequivocally taken as progressive and non-problematic.

However, a distinct breach with this tradition in sociology rose to prominence with labeling theory in the 1960s. Labeling theorists pin-pointed the active role of formal agencies "in shaping the very stuff [the definition and enforcement] of crime and deviance"\textsuperscript{29}. This proved to be a launching point for critical interest in the relationship between social control and social policy. Social control became an essential concept to explain the growth and effects of welfare state social policies. Control theories of policy were subsequently developed in a number of directions, for example, in Marxism, in work on the 'urban crisis', and in radical social work theory\textsuperscript{30}. In contrast to the previous position, this perspective highlighted crucial questions about the "legitimacy of state intervention, [relative to] the maintenance of order and the protection of individual freedom"\textsuperscript{31}. Generally speaking, the benefit of this approach was that social policy, especially state-initiated policy, was considered at least potentially problematic, and hence came under closer scrutiny. Yet, on the other hand, critical control theorists usually concluded, wholesale, that all social policy functioned as a form of social control.

It is the 'revisionist histories' of crime and mental disorder that have since most clearly focused some of the limitations of social control as an analytic concept. Although these works deal mostly with control institutions, they are
premised on the recognition that crime and mental illness are intimately related to wider policy issues, in fact, "these very categories are politically defined"32.

The common thread of revisionism is a basic skepticism towards the dominant progress model usually invoked to explain the historical changes in control institutions. As mentioned, the progress model assumes simply that such changes were the result of progressive, humanitarian reforms, tout court. While such an idea may be generally appealing, this view tends to obscure critical, yet important questions about the nature and history of control occupations, institutions, and policies. Rothman33, Foucault34, Ignatieff35, and Scull36 are the major figures who present a strikingly different portrait of the history of control agency policies up to the end of the nineteenth century. It must be added, however, that revisionism is not a unified school. In explaining the history of segregative institutions there are key differences in analytic perspective, as well as the region and timing with which each of the contributions deal. Yet, they all challenge the assumptions of the progress model, and in doing so, unavoidably raise questions of historical agency and purpose behind control practices.

1.3.2 Revisionism and Nineteenth Century Social Control

Rothman's treatment of the rise of the asylum in the United States during the Jacksonian era, stresses the major role of an assortment of reformers in utilizing and shaping general anxieties about the breakdown of colonial order37. In this context, crime and deviance were no longer interpreted to be just manifestations of individual wickedness, but as more globally symptomatic of a disordered society. Since insanity was a product of disorder, it was felt that it might be cured by placing sufferers in a sheltered, model environment.

Rothman skillfully shows that the reform ideology attached to the creation of the asylum system held deep symbolic significance which suggests the re-creation of some sense of order amid anomie. He thus illustrates how an
environmenatal theory of crime mutually reinforced an unbounded faith in the reformative effects of institutional isolation as the basis for powerful arguments for an asylum solution to mental disorder. This resulted in a system of public asylums which by the 1870s became increasingly custodial, but were nonetheless retained for lack of any real alternatives. Here, Rothman demonstrates that in spite of benevolent motives, organizational imperatives acted to distort original reform intentions. Rothman's work testifies to the persuasive value of the idea of progress, although it is a story "far more complicated than terms such as reform, benevolence and humanitarianism imply".

Foucault examines the foundations for the transition from open to segregative control in the case of France. His analysis is conducted in terms of policy changes to segregate the insane in conjunction with changes to the cultural images of insanity. Until the 'great confinement' of the mid-seventeenth century, the insane were unsequestered, usually left in the care of their families, or banished from cities. They often roamed the countryside in itinerant groups, or else were set adrift in 'ships of fools'. The popular and Renaissance literary image of madness (folly), symbolized "madness at the very heart of reason". Madness, claims Foucault, engaged in a dialogue with reason, in which reason could discover itself through its own negation.

The subsequent segregation of the insane and other marginal groups that lacked the capacity for productive work was accompanied by a shift away from the Renaissance image of madness. Thus, in the classical age, "reason banished madness", so that the faculty of reason defined humanness, while insanity was simply its absence. In this view, the insane were considered an 'alien race', a cultural image which Foucault insists was a precondition for their later segregative treatment. Thus, the moral treatment ideology that accompanied the reform movement of the early twentieth century was fundamentally a technique for the re-socialization of the alien into the realm of human reason.
Elsewhere, Foucault\textsuperscript{43} links political structures and forms of punishment in terms of the symbolic significance of these forms for sustaining political regimes. In absolutism, public punishments were the "symbolic displays of the highly personalized sovereignty of the king...[where] the ritualized dispatch of selected miscreants,...implied a loosely articulated political structure", which perforce tolerated a 'margin of illegality'\textsuperscript{44}.

Foucault argues that a new disciplinary mode, a new 'economy of power', arose with capitalism that manifested changes to the economic, political, and legal relations. He contends that henceforth the use of power was progressively rationalized\textsuperscript{45}. That is, power was thereafter used at the lowest economic and political cost in exchange for the most intensive and wide-reaching effects. This was the backdrop for the emergence of various specialties of control. The insane asylum was part of the 'carceral archipelago' established in the nineteenth century, that also included workhouses, prisons, and reformatories, and in which the management of the insane eventually became the preserve of medically-trained asylum directors.

Ignatieff, writing about English developments in this period\textsuperscript{46}, concurs with Foucault that the new disciplinary ideology was initially adopted by "reforming county magistrates and dissenting professional classes"\textsuperscript{47}. The catalyst for the materialization of the disciplinary ideology in segregative institutions was a perceived crisis of social order in the post-1815 period. But Ignatieff rejects the view that the new carceral forms were simply a conscious, class strategy of a unified ruling class foisted on a growing working class to divide and contain them. For although class fear among the ruling elites was undoubtedly a factor, Ignatieff insists that there was solid support for institutional solutions from the dominated classes themselves. This, at least in part, was because new formal sanctions were constructed over-top of pre-existing moral sanctions that were observed across class lines. The state thus "ratified a line of demarcation [of moral sanctions] already indigenous to the poor"\textsuperscript{48}. 
Scull\textsuperscript{49} locates the origins of the asylum for managing the insane in terms of the broad social changes wrought by the development of wage labour and the consequent proliferation of a dependent population. Writing of the appearance of the asylum system in nineteenth century England, he argues that the rise of wage labour dissolved the decentralized parish relief system founded on Elizabethan Poor Law. The institutional segregation of the poor developed as a more efficient means to sort out those who properly deserved aid, and to instil in them correct work habits, as well as to deter would-be malingerers. This entailed the development of specific institutions, eventually under public auspices, that distinguished the mad, the bad, and the sick from the general pauper population. Concentrating on the asylum, Scull describes this transition from the origins of a reform movement through to the monopolization of insanity as a concomitant to the professionalization of psychiatry.

In the eighteenth century, asylums were generally small, privately-owned affairs, run by medically-trained doctors, strictly for profit. This haphazard system, based on physicalist methods and the liberal use of body restraints, became the target of an alliance of Evangelical reformers around the turn of the nineteenth century\textsuperscript{50}. The reform ideology thus combined the humanistic paternalism of the former with the expertise and efficiency embodied in the latter in a way that was contrary to existing asylum practices.

The reformists believed that madness might be cured by (re)constituting discipline-of-the-self. Drawing on the example of the 'moral treatment' regimen devised by Tuke, Pinel and others, the reformers fought for the public provision and inspection of an asylum network. This was, in fact, achieved by the 1850s, yet medically-trained administrators dominated this system at virtually every level. Scull shows moreover, that asylums were designed as large as possible for economy of scale, but were still perennially overcrowded and understaffed, all of which violated the basic tenets of moral treatment.
For Scull, the asylum system itself was the key to the acquisition of a medical monopoly over the identification and management of the insane. When the reform movement gained wide support by the 1820s, its model of moral treatment was successfully co-opted by mad-doctors who emphasized their administrative skills in running asylums. In this struggle, asylums were a power resource in which the "institutional base in the asylum assured [psychiatry's] cognitive monopoly and guaranteed a captive market for its services". Despite neither a legitimation for medical control in the principles of moral treatment, nor a clear demonstration of a physical basis of most mental disorders, psychiatry emerged as the dominant profession in charge of madness by the 1850s. According to Scull, the complete medicalization of insanity was a foregone fact in the nineteenth century, and the profession consolidated and advanced its dominance into this century.

Each of the revisionists mentioned posits his own theory of control in accounting for these trends. Collectively, they add to our understanding of the history of control institutions and are an antidote to overly-simple policy histories, in part propagated by the control occupations themselves. But the initial wave of revisionism has also generated a number of counter-arguments and auto-critiques.

For example, Grob, perhaps the leading counter-revisionist, holds that social control accounts are largely mistaken in that the motives behind mental hospital reform were, in reality, overwhelmingly benevolent. Grob concedes that the public asylums of the Victorian era were less than ideal, and often downright dismal. He explains this situation mostly as the unintended consequences of ill-planned, incremental decisions taken by policy makers. Grob sees a "cruel dilemma" in the conflict between the concern for welfare versus the goal of maintaining order and administrative rationality in a complex institution in which the principles of moral philosophy were outgrown.
Grob's views have subsequently been criticized primarily for his over-emphasize on 'accidental' factors which "fail to come to terms with the multiple ways in which structural factors constrain, prompt and channel human activities in particular directions". In other words, Grob's analysis does show that unintended consequences may legitimately explain some of the negative results of policy implementations. However, because he explains any and all such consequences as accidental, his account lapses into apologism.

These debates highlight the limitations of functional arguments which characterize each of these authors to some degree. That is to say, they tend to explain policy primarily in terms of its function for reproducing various aspects of society. For Rothman, the asylum mirrors the needs of a functional, contradiction-free society. In Ignatieff, it is a reflection of an emerging class hierarchy in capitalism. For Scull, it is the functional control requirements resulting from capitalist production relations. Foucault too, sees it as part of the growth of a disciplinary world-view where law is a ruling class instrument. In essence, this is a mirror-image of the consensual functionalist versions, except that policy is presumed suspect, rather than benevolent, as in Grob's view.

If the purpose of policy is taken to be social control, then it follows, as many writers openly assert, that state and other policy makers and operatives are 'agents of social control'. The difficulty in such a presumption is to show precisely how psychiatry and other control policies and practices essentially contribute to the reproduction of specifically capitalist social forms. What is particularly noticeable in the absence of such explanation is that the policy process tends to take on a deus ex machina quality.

This and other difficulties has lead some revisionists to question the usefulness of social control as a concept adequate for historical investigation. Ignatieff, for instance, concedes that,
the social control model assumed that capitalist society was systematically incapable of reproducing itself without the constant interposition of agencies of state control and repression. This model essentially appropriated the social control models of American Progressivist sociology [and thus] carries on the assumption of society as a functionally efficient totality of institutions. [T]his implies that institutions 'work', whereas the prison [and asylum are] classic example[s] of institution[s] that work badly, but nonetheless survive in the face of recurrent skepticism as to [their] reformative capacities. [W]e ought to think of society in much more dynamic and historical terms, as being ordered by institutions like prisons which fail their constituencies and which limp along because no alternative can be found or because conflict over alternatives is too great to be mediated into a compromise.  

This suggests that it is questionable to reduce the relation between psychiatric practices and social reproduction to humanitarian, or state, or professional, or class interests alone. For to do so often results in a less than convincing account as will be shown in the following review of three recent studies that deal with mental health policies in this century. The first two of these works, Andrew Scull's Decarceration, and Diana Ralph's Work and Madness, demonstrate some of the limitations that mono-causal explanations impose on a satisfactory understanding of the policy process. These are juxtaposed with Françoise Boudreau's account "the Quebec Psychiatric System in Transition". Boudreau's work illustrates the necessity of analyzing policy formation in a more dynamic way if we are to adequately account for the form, content, and variations in community psychiatric policy, and by extension, social policy in general.

1.4 Community Control Policy and the Demise of the Asylum.

For many observers the overall trend towards community care policy and practices, especially apparent since the early 1960s, signals a reversal of the segregative controls established in the last century. Scull calls this process "decarceration", which he defines as the "state-sponsored policy of closing down asylums, prisons and reformatories". He argues, that in consequence,
these institutions have been severely de-populated through a policy of massive discharge, and more tightly restricted admissions. Since then, criminals, delinquents and, particularly the mentally ill, are increasingly relegated to care in community-based programs which are purported to be, not only more humane, but more effective and less costly. Scull contests, however, that these programs were "built on a foundation of sand", and that their alleged benefits are more rhetorical than real65. In Scull's view the intentions of policy makers are basically irrelevant, simply a mask for the undeclared needs of the system. He asserts that the new community psychiatric programs have largely been a myth all along and concludes that the demise of the asylum is tantamount to the "demise of state responsibility for the seriously mentally-ill"66. So for Scull, the reduction in the number of mental hospitals has not been met with real community programs. Rather, community psychiatry marks the start of a "new trade" in lunacy, strikingly reminiscent of the pre-reform practices of eighteenth century mad-doctors67.

To arrive at these conclusions, Scull critiques three types of "conventional explanations" usually proposed to account for the growth of community control programs--progressivism, technological innovation, and criticism of total institutions. He immediately rejects the progressivist argument, that community programs were primarily a consequence of humanitarian concerns. Here, Scull nothing humane in expelling helpless mental patients adrift where they "rot and decay" in broken-down welfare hotels in inner city ghettos68. He also dismisses the idea that drugs were the major cause of decarceration. He correctly points out that the trend toward accelerated discharge preceded the widespread use of drugs. At best, claims Scull, this "facilitated early discharge by reducing florid symptoms...easing management in the community...[and] persuading doctors of the feasibility of such a policy"69. Finally, he rejects the notion that critical social science studies such as Goffman's Asylums70 profoundly affected social policy. While such works uncovered the negative affects of total institutions says Scull, similar if not identical arguments existed in the last century.
In contrast, Scull argues that to truly grasp the "relationship between between deviance and social control...it is necessary to study [them] from a historically-informed, macro-sociological perspective". Thus, he contends that the timing of decarceration can only be explained in light of the emergence of the welfare state which provided functional (cost-effective) alternatives to mental hospitals. These alternatives were absent in nascent capitalism where labour discipline was instituted and maintained on the simple principle of 'less eligibility'. The evolution of the modern state, in part, transformed this principle into 'social capital investment' in the workforce. Following Gough, Scull claims that factors such as popular demand, the need for economic crisis management, and lack of competitive pressure in the state sector, resulted in a massive expansion of services and expenditures characteristic of the welfare state. Then drawing on O'Connor, he claims that state growth generated a burgeoning 'fiscal crisis', along with subsequent pressures to reduce its spending. The state has unerringly responded to the situation with appropriate cost-cutting measures.

In this context, deinstitutionalization was viewed as the only viable solution to the ensuing strain on state mental health budgets. State officials believed that substantial cost saving would accrue from canceling new construction and from reducing fixed costs by closing, where possible, existing mental hospitals. Moreover, since properly planned and implemented community services would cost even more than the facilities they were supposed to replace, it is ludicrous to suppose this would ever happen to the benefit of welfare patients. The pressure to reduce costs, argues Scull, is the real reason behind the policy of decarcerating mental patients, and with it, the dismal failure of community psychiatry.

A number of criticisms can be leveled at the assertions Scull makes in *Decarceration*. For instance, while he raises the significance of economic factors, he does not adequately specify a mechanism for how economic pressure is translated into policy. Here, it is difficult to see how state expenditures expanded because of the absence of the 'competitive market mechanism', and to understand, on the other hand, how decarceration was
caused by fiscal restraint. Since Scull glosses over the significance of the policy process as simply "a mask for the undeclared needs of the system"\textsuperscript{74}, he rejects out-of-hand the possibility that the perception of what constitutes economic necessity at a given point may be determined, at least in part, through the policy process.

Scull's reductionism leads him into difficulties in explaining variations in policy. Simply put, if economics straightforwardly determines policy, then all capitalist economies should have identical policies. Moreover, his simple cost-cutting argument leads him to portray community alternatives as essentially a sham. Empirically, this is simply inaccurate. Such services may be inadequate, but they do exist \textsuperscript{75}.

While similar to Scull's approach, Diana Ralph nevertheless argues that community psychiatry involved a tremendous expansion of services, and that this fact requires explanation\textsuperscript{76}. She writes "that although the fiscal crisis may help explain the move to decarcerate patients, it fails to explain why the state adopted such expensive psychiatric services for the unemployed"\textsuperscript{77}. To bridge this gap Ralph proposes a "labour theory of community psychiatry" which "treats community psychiatry as an example of the function and growth of social services"\textsuperscript{78}.

Ralph's basic contention is that the cause of this expansion lies in the greater social control requirements of modern capitalism in the face of the progressive alienation of its workforce. For Ralph, community psychiatry is a nationalized version and domestic counterpart to industrial psychology in the workplace. Thus, its purpose is to preempt worker militancy, and at the same time, to combat worker breakdown. Indeed, she sees community psychiatry as an offshoot of industrial psychology, and not of clinical psychiatry, as is commonly supposed. She argues that the techniques seen in industrial psychology, perfected in Mayo's experiments and the American military, provided the basic methods later adopted into community psychiatry. Ralph claims that an upsurge of labour unrest after World War II resulted in
demands from business, political and business leaders (the capitalist class) for the implementation of national mental health programs. These events set the scene, while industrial psychology provided a model, so that by the mid-1950s the organizational infrastructures for community psychiatry were established. The co-extensive advent of psychotropic drugs and behavior modification techniques which proved to be highly effective tools of pacification, assured the success and expansion of community psychiatry. Ralph contends that the recent crisis of Western Capitalism portends the intensification of these types of social control measures.

While Ralph provokes the question of the genealogy of community psychiatry, she does not adequately show how mental health policy bears a specific relation to labour unrest and continued capital accumulation. This makes it difficult from her account to fathom how the labour theory of community psychiatry confronts the fact that community psychiatry was first developed on a large scale in the province of Saskatchewan, during the reign of a social-democratic government.79

Scull's and Ralph's difficulties stem largely from their almost total reliance on functional explanations. Both, in effect, are critical antitheses to progressive approaches. As a result, both accounts suffer from the same sort of problems that plague orthodox functionalism. Most significantly, function is confused with cause. But the presumption that policy fulfils a particular function does not necessarily provide us with an adequate explanation of its origins, nor its persistence.80 So while functional approaches may deal neatly with the alleged functions of a policy, commonly there is a conspicuous lack of detail as to how these polices are developed, enacted, and implemented. One consequence of this is a tendency to reify policy, since it is analyzed in such a way that it appears disembodied from the human action that produced it.81 For example, in Scull's work, policy ultimately answers to least-cost imperatives, irrespective of policy-makers. This obscures factors which, as we said, are indispensable to an adequate grasp of historical and geographical variations in mental health policy and service delivery.
In order to avoid this type of shortcoming, policy must be viewed as the dynamic product of human action. Policy does not arise fully-formed from the 'head of Zeus', it is not automatic. Neither can it be assumed to be optimal for accumulation, nor is it necessarily the full articulation of a complete social consensus. For the purposes here, mental health policy is conceived as an often contradiction-laden outcome of social struggles which involve not only economic, but also political, occupational, ideological, and other factors.

In these respects, Boudreau's 1980 analysis of the transformation of psychiatric services in Quebec provides a more satisfactory portrait of the policy process than the previous writers. She clearly shows that ideological and political forces play an important role in policy formulation which help account for the unique policy variations manifested in Quebec. Here, the author describes the process of coalition formation among various interest groups that make up two basic camps, the "change producers" and the "change resistors". Over time, the "power budgets" of these coalitions shift due to internal and external factors. As a result, the policy scene is characterized by periods of relative stability, punctuated by thresholds of change. Change may take place in one of two basic ways, either by "insurgence", that is change from within a system, or else "invasion", or change from without. Rapid transformations occur when 'change producers' marshal enough power to overcome a system's 'dynamic conservatism', or the "property of a system to fight to remain the same"82. The emergent system, with a new set of dominant interests and power resources, subsequently becomes the status quo, and the process is then repeated.

Boudreau argues that in Quebec there have been two such transformations. The first was the transformation of the custodial asylum system based on religious principles which was prominent up to about 1961. That year marked the victory of the efforts of modern psychiatrists (insurgents) to establish a modern system based on psychiatric principles. This system was dominant from 1961 until 1970, whereupon a bureaucratic state elite (invaders) captured control of the psychiatric system and forcefully integrated it into a patchwork
of health and welfare services secured by "an invading government". This system, the author claims, is based on a public health rationality and has resulted in psychiatry becoming an "undifferentiated, devalued part" of the new, larger system.

However, while Boudreau's work is a notable attempt at a textured synthesis of the forces underpinning these changes, it is not without gaps and problems. For one thing, Boudreau uncritically adopts a rather vague systems model which she ostensibly uses as an analytical framework. Yet the actual study, in effect, is an interest group analysis in which the resulting evidence is never integrated with the theoretical model. Because of this, it is difficult to see the significance of her evidence with respect to her model which detracts from the overall coherence of the piece.

This aside, there are a number of noticeable silences in the analysis, such as the largely unexplained, sudden 'insurgence' of modern psychiatrists into the old asylum system. Incidentally, this can also be viewed as an 'invasion' because the intrusion of this group is said to result from the federal government's massive 1948 investment into psychiatric training. What was the reason behind this transfusion of resources? This is glossed over, as is the somewhat mysterious "migration into the system of other types of experts (psychologists, social workers, and others)" during the period of modern psychiatry's consolidation.

A similar absence is encountered when Boudreau goes on to argue that the ascendency of the technocratic state-elite was due to demands for rational planning and co-ordination due to several factors: (1) an increasing citizen consciousness and demand for participation, (2) the professionalization and syndicalization of occupational groups, and (3) an increasing attempt at government control manifest as movement towards compulsory, universal, and centralized health insurance. The author contends that the rising technocratic elite possessed the requisite skills which coincided with these demands and which enabled them to increase "their power budget by finding
their way as upper-level civil servants, advisers to government, consultants and members of commissions of inquiry." This group then used their access to legislative power to acquire control from the psychiatric profession which marked a second major transformation of the system.

Now these factors would seem to indicate the existence of important connections between the government, the relevant occupations and the appearance of popular demand. Indeed, one of the author's key explanatory factors is that groups seeking control over the existing system, do so by highlighting existing inadequacies thereby provoking a "popular demand for a new model of action." But this is insufficiently explored, particularly in relation to the second transformation. In the first transformation it is implied that competing forces used the media, especially the newspapers, to generate support for their respective positions. But in the second transformation, public demand seems to arrive on the scene, fully-formed.

Apparently, the technocratic elite acquired its policy-making dominance on the coat-tails of a publicly supported social-democratic ideology of state intervention that was 'in vogue' around then. The government was then used in an authoritarian way to regulate, standardize, and otherwise rationalize services against the interests of the entrenched liberal professions. This is interesting as far as it goes. But what was it about the character of public demand that effected a change in the role of the state from laissez-faire to interventionist? How is it that the professions could generate popular demand at one stage but not another? More generally, what is the place of public opinion and demand in the social policy process?

1.5 The Professions, the State, and the Public

Today, insanity is overwhelmingly regarded as a type of illness, and is not considered in itself a crime. In fact, mental illness may be a major exculpatory factor in criminal prosecutions. It is also noteworthy that it is psychiatry, by
legal mandate, that is the key specialty in the treatment of mental illness\textsuperscript{91}. How and when has this state of affairs come about? There is recent evidence that questions whether public psychiatrists actually achieved a professional monopoly until well into this century\textsuperscript{92}. That is, psychiatry is a medical sub-specialty that did not develop in the context of private practice as did organic medicine, but pre-dominantly as a state-sponsored, administrative specialty\textsuperscript{93}. So although superintendents were in complete charge within asylums, law courts ultimately controlled admissions and discharges for some time after the turn of the century. In the case of public asylums, rather than a professional monopoly, it seems more plausible that the state acted as a patron to offer the public provision of services on behalf of its, often reticent, clients\textsuperscript{94}.

Where a state-sponsored provision of services has been established, it would appear that the state mediates the occupational forms involved in a given type of service. As seen from the nineteenth century revisionist literature, there were similar sorts of occupational struggles occurring in different parts of Europe and North America over the definition and management of mental disorder. Scull\textsuperscript{95}, for instance, contends that asylum superintendents successfully co-opted the proponents of moral treatment, so that by the mid-nineteenth century they had a virtual monopoly over the public care of the insane. To the extent this is accurate, Scull shows that the state was a primary vehicle through which this degree of monopoly was first won and later sustained. This illustrates a key defining feature of states is their ability to pass and enforce laws and legislation—to legally confer in certain circumstances, a degree of occupational monopoly. In general terms, the form of public provision is constituted mostly by the nature and mix of the services that are offered. This can be seen largely as a result of the abilities of various competing occupations to mobilize political power to pressure the state to ratify in policy an occupation's legitimate place in the range of services provided\textsuperscript{96}.

One important implication of this view is hinted at by Grob who argues that American psychiatric leaders in the last century were bent upon favorably altering public and legislative attitudes to the asylum and mental illness,
thereby enhancing their own authority and status. In fact, it will be the contention here that the successful education of the public to create popular support and demand for its services was an indispensable element in the development of modern psychiatry's occupational dominance in the treatment of mental disorders. Thus, one key objective of this work is to examine how psychiatrists and their allies sought to create a supportive public and the role this played in the development of psychiatric policy in Saskatchewan.

To sum up, revisionist histories of control institutions highlight some of the current concerns about the overall adequacy of the social control perspective as is usually conceived. One such limitation has been demonstrated in Scull's and Ralph's work on community psychiatry, namely that this institution is viewed as a form of social control that is directly functional for the economy and that policy is somehow automatically given by economic requirements. This quite spuriously presupposes a simple unity between the professions and a dominant economic class. It results, inter alia, in an inability to explain variations in policy. Rather, it must be investigated how it is that economic factors may assume relative significance in policy determination in certain circumstances. This obviously requires concrete historical analysis of the policy process that does not assume simple unity of interests among policy actors. It must be added there is no way to provide irrefutable proof against economic reductionist arguments. However, such analysis may show that policy was not, in all cases, developed primarily on economic imperatives. This would provide supporting evidence for the position adopted here.

It is concluded, closer to Boudreau's portrayal, that mental health policy is an often contradiction-laden and negotiated outcome of social struggles which involve not only economic but political and other concerns. Policy formation will thus be analyzed as the mediation of three sets of intersecting interests--state, occupational, and public interests. The analytical focus of the work is on the role of publics and the mobilization of public support in policy development. Given the limitations that have been identified in the approaches reviewed above, the next chapter will introduce the framework and method that was developed for the study.
Notes to Chapter 1


11. Ibid.


25. Ibid.


32. Cohen and Scull, op. cit.


44. Ignatieff, op. cit.


48. Ibid., p. 90.

49. Scull, 1979, op. cit.

50. Ibid., p. 56.

51. Ibid., p. 258.


53. Ibid. pp. 95 and 130.

54. Ibid., p. 95.


62. Ralph, op. cit.

63. Boudreau, op. cit.


65. Ibid.

66. Ibid., p. 162.


69. Ibid., p. 89.


72. Gough, op. cit.


**Note that this work by Dr. Dickinson has been recently published under the title *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984*, (Regina: Canadian Plains Research Center, 1989). References throughout the present study are taken from the dissertation.
76. Ralph, op. cit.
77. Ibid., p. 42.
78. Ibid., p. 43.
83. Ibid., p. 132.
84. Ibid., p. 135.
85. Ibid., p. 126.
86. Ibid., p. 131.
87. Ibid., p. 132.
88. Ibid.
89. Ibid.
92. Dickinson, op. cit., Chapter 1.
95. Scull, 1979, op. cit.
96. Ingelby states that the "professions do need a mandate to operate, and that the savoir of the professions is used day to day to justify [their] practices". See Ingelby, 1985, op. cit., p. 178.
CHAPTER 2

The Framework and Data

2.1 Introduction

This chapter is comprised of two main sections, an exposition of the framework employed for the study and information about the data and method used. Following from the last chapter, which proscribed uni-causal analysis of policy and insisted on a dynamic view of the policy process, the first section examines the relevant literature for the purposes of developing a coherent framework designed to focus on the present research concerns. This review concludes that a type of modified interest group framework is most suitable for the present analysis while the remainder of the section goes on to detail the framework that is used. The second section indicates the data sources on which the study is based and shows how the data are relevant to the specified framework.

2.2 An Analytic Framework

For the reasons given, the last chapter rejected the direct application of a highly abstract framework to an empirical policy study. An obvious alternate starting point is to explore some existing policy studies from which to show there is no single, generally accepted perspective used to analyze policy developments^1, although policy studies generally employ some type of 'middle-range', interest group theory. Variants of this approach have been widely used, for instance, in the interactionist tradition in sociology, and in political analysis, both in political science and political sociology. A well-known
review article by Weller traces the major currents in political science approaches to health politics since the 1950s and serves as a useful introduction to this literature.

Weller contends that three kinds of analytic frameworks have emerged in political science research which have been utilized to address developments in health care systems in the West. The appearance of group, then modified group and finally holistic analyses mirrors an increasing public concern and state involvement with health issues. Weller stresses, however, that most political scientists and sociologists continue to use a simple, but overly narrow group approach to the health field and that this retards the study of health politics.

This approach is the 'classic' pressure group perspective which concentrates analysis on how certain groups, for example doctors, manoeuvre into positions that enable them to shape policy in a way that coincides with their interests. Among other drawbacks, Weller points out that this orientation tends to overlook the 'latent' influences of less visible groups. Additionally, it ignores the significance of state growth and influence, as well as fundamental shifts in the structure of health occupations.

Weller feels that modified group perspectives, exemplified in the work of Tuohy and Alford, are preferable since they are more sensitive to the increasingly pluralistic nature of the health care system. According to Weller, Alford sees "health as a field of pluralistic struggle among four groups, which he calls professional monopolists, corporate rationalizers,...diverse community populations, and [various levels of] government. Weller concludes that this kind of perspective still "does not identify anything approaching the full range of factors" in health politics.

Finally, Weller sees a recent trend towards "holistic" approaches, or what are essentially systems analyses applied to the health field. He groups these into
three major categories\textsuperscript{11}: (1) the standard approach which stresses
prevention\textsuperscript{12,13}, (2) the "health as ailing system" perspective which
emphasizes the dysfunctional consequences of the anarchic development of
the health system, and (3) a highly critical view of health as part of a medical-
industrial complex controlled by various elites\textsuperscript{14,15,16}. The holistic
perspectives Weller says positively "relate health systems to wider forces in
the general environment"\textsuperscript{17}. However, Weller charges that the central
concepts of most holistic studies are vague and the accounts themselves are
highly polemical. Weller's rather banal conclusion on methodology is that the
"future analysis of health policy processes should be eclectic"\textsuperscript{18}.

Now, aside from being unhelpful, Weller's inconclusiveness is problematic
since the three major perspectives he identifies differ in theoretical
assumptions, levels of analysis and related methodologies. A call for
eclecticism does not resolve the difficulty of which approach, if any, may be
more adequate to address policy issues. In fact, this appears to contradict the
basic thrust of his argument, which is that simple or modified group analyses
are too limited and hence should be abandoned. Let us re-examine some of
these issues to determine whether any of these types of perspectives might
form an adequate basis for empirical study.

One of the common criticisms leveled at 'simple' interest group perspectives is
that they are grounded, more or less explicitly, on pluralist assumptions.
Pluralist in the sense that they suppose "health care phenomena [are] due
simply to actions of...more or less equal power groups all seeking their own
interests\textsuperscript{19}. This position, closely related to pluralist political theory, usually
concludes that since no one group predominates in policy formation, no
particular set of interests dominates, or if they appear to, this is justly in the
'common interest'. This is of course, highly questionable, even where analysts
more thoughtfully attempt to focus on the power of elite groups. This sort of
naïve pluralism has been increasingly challenged by "recent evidence that
shows some elites matter more than others" and that elites themselves operate
within some kind of [unequal political and economic] framework\textsuperscript{20}. This
does not dispense with the notion that the policy process is a complex
mediation of interests, but rather suggests a situation of structured differences in the ability of various interest groups to influence policy.

On the other hand, as Weller correctly pointed out, holistic approaches tend to be pitched at high levels of abstraction. Since their conceptual terms are highly formal it is difficult to directly specify their empirical referents with any precision. One consequence of this is that such concepts often obscure or conflate phenomena that require differentiation. Indeed, it is this type of problem with which this investigation is basically concerned. The example here is Scull's extreme economic reductionism and hasty dismissal of ideological factors in the policy process. The object of this investigation is to empirically examine how additional determinants can shape the course of policy. In sum, both these kinds of perspectives would appear to be flawed for the present purposes.

This leaves the possibility of utilizing a type of modified group perspective. Weller's criticisms notwithstanding, the framework Alford employed in his 1975 study appears to provide an adequate basis for concepts which might be applied to an empirical study. Here, Alford's unorthodox pluralism allows a way to examine how the policy process is a mediation of interests, albeit in an unequal way. His basic scheme distinguishes "between the organized action of a group to represent its interests (an interest group), and those interests served or unserved by the way they fit into the basic logic and principles by which the institutions of a society operate". Alford identifies three distinct sets of interests which he terms dominant, challenging, and repressed interests.

Domestic structural interests are those served by their relationship to the overall social, economic and political institutions at any given point. Challenging interests are those that are created by the changing relationships in the overall structure of a society. Repressed interests are defined as "the opposite of dominant ones", although not necessarily always in conflict with them. Repressed interests, by definition, will not be served within their
location in a society's institutional matrix, "unless extraordinary political
ergories are mobilized" to represent them23.

Alford's example of dominant interests are professional monopolies, medicine
being the paradigmatic case. Changes to the organization of health care have
generated new, challenging interests based on bureaucratic interests. The
interests of this challenging group of 'corporate rationalizers' conflict, in
fundamental ways, with dominant interests. His example of challenging
interests are "hospital and medical school administration, public health and
planning agencies, and researchers". Yet, these groups, aside from their
specific, antagonistic interests, also share a common disposition "vis-a-vis
government regulatory and funding agencies"24. Alford claims that the
conflicts between monopolizers and rationalizers periodically explode in crisis
and calls for reform. However, reforms are usually channeled in a way that
does not fundamentally threaten the institutional roots on which the power of
structural interests are based. In other words, dominant and challenging
interest conflicts are contained within an institutional framework such that
the latter are prevented from generating enough social power to fully
reorganize the health system on fully bureaucratic-rational principles.

In this scenario, repressed interests are basically diffuse, negative interests
that are not organized and thus not systematically represented by existing
arrangements. Examples given here are the interests of various community
populations such as "white rural and urban poor, ghetto blacks, lower middle
class groups just above the medicaid income maximum" and other
disadvantaged groups25. Such interests are able to be mobilized, but mostly in
unusual circumstances, typically around single 'public' issues of short duration.
Alford stresses that dominant and repressed interests are not necessarily in
automatic opposition. Health insurance schemes, as an example, ensure
payment to doctors while they defray medical costs to the disadvantaged.

Also Included in Alford's scheme is an indication of the role of the state in
health care policy. "Government", he writes, "is not an independent power
standing above and beyond competing interest groups, but represents changing coalitions of elements drawn from various structural interests."\textsuperscript{26} This view is consistent with the thrust of recent state theory which sees Western states, in part, as organizers of hegemony in civil society to facilitate social reproduction\textsuperscript{27}. Urry, for instance, argues that the state operates "especially within those sites where individual subjects, popular forces and social classes struggle to control and transform their conditions of reproduction"\textsuperscript{28}. In this, the social reproductive interventions of the complex of institutions that make up states vary, but ultimately are based on the ability to pass and enforce regulations and laws. Additionally, in civil society there are various "classes-in-struggle", outside the fundamental class division\textsuperscript{29} which distinguishes capitalist society, namely capital and labour. One major fraction of this residual grouping is the 'new middle class' of service professionals that specialize in reproductive practices. So the broad position adopted here is that the state and the "new middle class" are contiguously located around social reproductive practices, such as mental health. In simple terms, professionals actually operate various social reproductive institutions, while the main directions of policy are passed into legislation through the state.

Such a position would seem to be consistent with the view that in concrete terms there is no single psychiatric community, "but clusters of psychiatric thinking and practice, with cluster formations shifting in terms of specific issues and problems"\textsuperscript{30}. From this perspective psychiatry is, among other things, a "work locale"--an occupational arena in which professionals representing different disciplines "manage to forge a division of labour" through on-going confrontation and negotiation\textsuperscript{31}. Given its central legislative powers, significant dimensions of these practices are negotiated through the state which mediates conflicting occupational interests. In the name of the public, the state mandates into policy the particular mix of competing interests, that is, which interests are to dominate and how these mesh with subordinate interests.
From these comments, Alford's scheme would seem to provide a starting point for an empirical study of psychiatric policy. It requires some modification given that it was applied to organic medicine during a period in which private medical practice had already assumed a position of clear dominance. This study is directed towards a somewhat longer time-frame, beginning at a point in which psychiatry had yet to achieve a similar sort of dominance enjoyed by medicine. Unlike Alford, we are concerned here with a situation in which a challenging group successfully transformed a dominant institutional form. But, as it stands, Alford's model is too static to address how a challenging group mobilized enough power to accomplish such a feat.

Like many other social policy investigators, Alford seems to completely miss a major aspect in the concentration of power that would seem necessary to explain in such a transformation. That factor is public promotion. This blind spot also highlights the largely unanswered question of how repressed public interests are in fact repressed, or how, on occasion they are mobilized. Here, Alford seems to treat community demands as completely independent and spontaneous but co-opted phenomena. Although he recognizes that "professional monopolists will [may?] seize upon the demands of community interests...to legitimate their efforts to establish another project or program," he seems to be oblivious to the possibility that such demands might be generated by and for other than 'community interests', that is, partly by professional groups themselves.

This point indexes that the notion of the 'general public interest' is in fact problematic, since in reality there are only concrete, specific publics. Although for expository purposes this study will use the term to refer to the gamut of lay groups outside the professions, it must be kept in mind that the term 'general public' is an abstraction. In sum, it is proposed here that the creation of public demand is a primary power resource utilized by dominant and/or challenging groups to mobilize power to sustain or advance their interests. Such groups, in other words, often engineer demand through public promotion. This would seem to suggest that interests outside these two major groups are not so much directly repressed, as they are not
systematically voiced because of their deficit structural location. By definition, repressed public interests are, in relation, unorganized, and to this extent are barred from access to more systematic representation.

One way to conceptualize the creation of demand with respect to psychiatry is to draw on the 'public process' model developed by Shatzman and Strauss. Briefly, this model pictures psychiatry as a focal set of practices which radiate outwards in continuous inter-relation to other equally complex worlds constituted by various other social practices, much like a series of concentric circles. Thus, at the model's centre are the various forms of psychiatric practice proper. Immediately coterminous to it "lies a relatively broad network of quasi-psychiatric persons" such as teachers, courts, clergy, guidance counsellors and so forth, who most usually interact with the psychiatric professions. Further removed still, from "the professional psychiatric province is a larger hinterland of laymen"34, with a wide variance of comprehension about psychiatry. In short, psychiatry operates within a larger environment in which large-scale, radical shifts in occupational practices would seem to require significant degrees of demand consensus, from within and outside the realm of psychiatry, especially to be represented in legislation.

This is not to say that social change cannot occur without total consensus, but that larger institutional changes typically involve the re-alignment of existing arrangements which require the build-up of social power on a sufficient scale to effect such changes. One way social groups often gain enough power to direct change to their benefit is to concentrate it through fusion, that is through coalition formation. This allows groups who have perceived similar interests, but that alone lack sufficient power to direct change, to aggregate more power than would otherwise be the case. Since large-scale change often appears to necessitate the aggregation of groups who do not, however, have identical interests, how is it possible to form such coalitions?
An answer to this is provided in a work by Gouldner, which claims that one of the key devices for cementing coalitions is ideology, defined for now as systematized beliefs for legitimating a course of action. Gouldner's argument is that with the demise of tradition-based, feudal society, Western culture underwent a fundamental change to its authority system. In feudal society public discourse regarding social practices were authorized mostly by tradition. However, the subsequent rise of industrial society, in part, entailed a new form of authority, characterized by rational discourse. In other terms, in the "old mode of discourse" grounded in an authority culture, assertions were justified by invoking the public authority of the speaker. In contrast, in the new mode of discourse, assertions were justified by invoking ostensibly rational reasons for assertions.

The new mode of public discourse, which rose to prominence over the late eighteenth and early nineteenth centuries, marked the start of what Gouldner terms the 'age of ideology'. He argues that the demise of traditional society unleashed massive social and technological changes that, in part, resulted in the development and expansion of a modern market for the services of a new sort of intelligentsia that dealt in the currency of rational discourse. This form of discourse remains part of our modern 'rational' culture and is a signal characteristic of both science and ideology.

Gouldner points out that it is difficult to make an absolute distinction between social science and ideology simply on a criteria of rationality. Both involve forms of rational-based, public discourse whose underlying structure contains 'report' as well as 'command' components. That is both contain a report of some allegedly existing state of affairs based on 'fact', along with 'command(s)' which direct the reader to some course of action in view of the report given in the discourse. Relative to ideologies, social science discourse characteristically suppresses its 'command' component, leaving it implicit. Conversely, ideologies typically emphasize their command component and are usually directed to activating a broader audience for large-scale public projects. Both, however, involve rational-based forms of discourse which tend to interpenetrate one another. That is, in many cases social science findings are
distilled and used to form the basis of the 'report' component of political or professional ideologies in which the latent command component that was embedded in the original work is amplified. On the other hand, since scientists operate within networks of professional communities located in modern 'rational' culture, they are not immune from the need to legitimize their practices through degrees of ideological promotion.

As Gouldner writes,

Ideologies are beliefs systematized [and made public] by a stratum of intellectuals separated from power and property from which they initially [sought] support and sponsorship. Unlegitimated by tradition or church, these new intellectuals authorized themselves in the rhetoric of science and through rational discourse.38

Thus, the producers of ideologies always reserve for themselves a key role in the discourse that is produced. From such a perspective, it would seem that the emergence of community psychiatry involved a significant degree of ideological promotion in which its proponents defined for themselves a leading role. In fact, the major focus of this study is to investigate the formulation and use of ideology as a coalition forming device to promote the goals of psychiatrists. It is also argued that this activity was an important factor in explaining the rise of community psychiatry.

We will now more precisely define ideology as it will be used and recount the most relevant points of Gouldner's extensive discussion that apply here. For the present purposes ideology is defined as "[rational-based] symbol systems that serve to justify and mobilize public projects of reconstruction". As noted, ideologies contain demands for social action authorized by reports of 'facts' based on alleged existing affairs. An ideology typically has a universal character in order to appeal to the range of groups which it is designed to coalesce. At the same time, this renders ideologies sufficiently general to mask often conflicting concrete interests among those groups. Since they are aimed at public mobilization, ideologies are public documents and must be communicated to publics. Unlike propaganda, however, ideologies are largely believed in by their purveyors. So while ideologies usually mobilize political
power on putative similarity of interests, they simultaneously suppress real differences among groups. As Boudreau noted, challenging ideologies often work by highlighting the hidden tensions in the ideologies of coalitions on which dominant institutions are based. These comments suggest that to the extent that the rise of community psychiatry was such a wide-ranging project, it is perhaps a prime example in the use of ideology as a coalition forming device.

From this lengthy discussion, it is our contention that the demise of mental hospital psychiatry can not be explained solely in terms of an abstract notion of economic pressure as Scull and Ralph hold. Rather, these pressures are partly mediated along with other factors in the policy process. It is contended that the mobilization of public support or demand for proposed policy was an important ingredient for a successful, although protracted challenge to the dominant mode of mental hospital psychiatry. This process would appear to have involved attempts to 'create a consumer public' who would demand certain services, and lend political support for policies that would result in the expansion of those services.

Efforts to create such publics were attempted through the spread of a mental hygiene ideology, disseminated through various public media, mostly through newspapers. Also, the public process model above would appear to suggest that a core consensus of demand for new practices had to be successfully negotiated first among different psychiatric occupations in order to generate sufficient momentum for demand to reach out to the lay public sector. On this basis, it will be argued that attempts at public demand creation emanated centrally from the psychiatric professions themselves, by successfully co-ordinating the creation of a core coalition of mental health occupations, allied with other important political and economic forces. The method and data used to 'test' these contentions are spelled out below.
2.3 Data Sources, Limitations and Management

Evidence for our contentions would be provided if the analysis showed that mental professions were instrumental in attempting to engineer support through ideological efforts, and if these attempts influenced the direction of policy in their interests, that is, to the advancement of their material and/or status benefits. A wide variety of historical data were utilized by means of text analysis combined with simple quantitative techniques described below. Two basic kinds of available data recorded this process and were used as evidence. These were—documents that recorded relations among occupations, and also between occupations and the state, along with various records of public ideological mobilization attempts, (recalling that ideologies are public documents).

These data were analyzed along two major dimensions: (1) public discourse, and (2) (relatively less public), organizational discourse. Data sources for the latter included government publications, such as annual reports from the Departments of Public Works and Health, as well as material from parliamentary and legislative debates and commissions. Additionally, professional journals and pamphlets, books and various archival materials from the Saskatchewan Archives Board (SAB) were used. The sources for public discourse data were articles drawn mostly from Saskatchewan daily newspapers—the Regina Leader and Leader-Post, the Saskatoon Star-Phoenix, the Prince Albert Herald, the Moose Jaw Times-Herald, along with a weekly paper, the Western-Producer.

As these were all secondary data, they were subject to cautious use and required some simplifying assumptions in keeping with the analytical framework and scope of the study. For example, it was assumed that "existing institutions function for all occupations, groups, organizations which had their interest signified by the classifying term", dominant, challenging and repressed. As well, it was assumed that the authors or spokesmen of any given discourse represented the collective views of the groups or organizations for which they spoke. That is, the views expressed in them were not unique or random
occurrences. With respect to newspapers materials in particular, it was recognized that media in effect 'mediate information'. Hence it was necessary to assume that newspaper accounts which involved journalists, and other authors in interviews, press releases, reports and other stories, were essentially accurate representations. Editorials were considered to be a good indice of a newspaper's position on an issue.

These same sorts of assumptions also applied to organizational texts. So while ideological representations were taken at face value, they were scrutinized for 'ideological effects', that is the occlusion of the full effects of concepts related to underlying discursive practices. A prime advantage of utilizing a wide range of data from the public forum, in apposition to the more cabalistic material from archival papers, was that the consistency of the discourse by organizations that operated in both realms could be gauged. Finally, it was not assumed that the members of an organization were necessarily cognizant of their interests, nor if so, could they always act to promote them.

### 2.3.1 Data Gathering and Limitations

While a wide range of data promised certain analytical advantages, it also introduced disadvantages--namely heavy commitments in time and energy, along with significant methodological hurdles. On the initial consideration of data sources, it was immediately apparent that resource limitations disallowed a total coverage of any and all public-forum communications that reported on mental health issues. For this reason radio and television coverage was rejected at the outset in favour of strictly print medium sources. Similarly, the possible use of local weekly newspapers in small centers was abandoned. Instead, major daily papers were selected as the major source because they were systematically stored on microfilm at a number of locations, which easily made them the most accessible and complete of the potential public data sources.
After this initial choice, it rapidly became apparent too that an exhaustive, page-by-page search for mental health articles by a lone researcher would take the project far beyond its allotted time. It was thus decided to draw on those articles from various newspaper indexes that listed these works by topic heading. These indexes, compiled by the SAB and Saskatoon Public Library, provided a locational reference for articles according to paper, date, page and title. All existing indexes were used. The Legislative Library Index, unfortunately discontinued in 1981, was employed to find the articles listed for all papers dating to 1947. The period before 1947 was fully covered for Regina papers back to 1883 in the indexes to the Regina Leader and Leader-Post. The Western Producer was essentially covered in full in the Index to Western Producer, dating to 1925, while the later material from this paper was covered in the first index mentioned above. Since 1981 the Star-Phoenix has been the only paper still indexed in any systematic fashion.

Initially, a list of articles was compiled by searching all indexes according to subject heading for any topic that might be conceivably be related to mental health. For instance, all relevant articles were included that began with the prefix 'mental'--as in mental health/illness, hospitals, hygiene, legislative Acts, patients, associations, and so on. Similarly, general hospital topics such as public health, medicine, hospitals, Battleford, Weyburn, etc., were also searched. In addition, occupational headings such as psychiatric nursing, psychiatrists, psychiatric services, psychiatric research, psychologists, and social workers were searched, and the articles listed under those headings were located. This procedure yielded a 'location list' of 809 articles published between 1895 and 1987 that were supposedly available for content analysis.

Next, using the references provided by the indexes, available newspaper microfilms were searched for all articles on the location list. All articles that could be located were then photocopied and catalogued for subsequent analysis. Of the 809 on the original list, 695 (85.9%) were actually located, photocopied and thus accessible for content analysis (see Tables 1A and 1B). Additionally, permission was obtained to examine the restricted access personal papers of past Ministers of Public Works and Health up to 1977, all of which were stored at
the SAB. These materials were subsequently tapped, along with unrestricted SAB files and stacked publications at the University of Saskatchewan and other libraries.

Table 1A. Newspaper Articles Listed and Located by Select Periods

<table>
<thead>
<tr>
<th>Period</th>
<th>Articles on List</th>
<th>Articles Located</th>
</tr>
</thead>
<tbody>
<tr>
<td>1893-1987</td>
<td>809</td>
<td>695</td>
</tr>
<tr>
<td>1883-1981</td>
<td>758</td>
<td>644</td>
</tr>
<tr>
<td>1883-1975</td>
<td>655</td>
<td>554</td>
</tr>
</tbody>
</table>

Table 1B. Articles Located by Newspaper for Select Periods

<table>
<thead>
<tr>
<th>Leader Post</th>
<th>Star Phoenix</th>
<th>Times Herald</th>
<th>P.A. Herald</th>
<th>Western Producer</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period</td>
<td>445</td>
<td>227</td>
<td>9</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td>1883-1987</td>
<td>(97%)</td>
<td>(97%)</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
</tr>
<tr>
<td></td>
<td>695 (86%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1883-1981</td>
<td>445</td>
<td>176</td>
<td>9</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>(97%)</td>
<td>(97%)</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
</tr>
<tr>
<td></td>
<td>644 (84%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1883-1975</td>
<td>411</td>
<td>135</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>(90%)</td>
<td>(96%)</td>
<td>(-)</td>
<td>(-)</td>
<td>(-)</td>
</tr>
<tr>
<td></td>
<td>554 (83%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1883-1950</td>
<td>61</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>(91%)</td>
<td>(100%)</td>
<td>(-)</td>
<td>(-)</td>
<td>(100%)</td>
</tr>
<tr>
<td></td>
<td>82</td>
<td></td>
<td></td>
<td></td>
<td>(77%)</td>
</tr>
</tbody>
</table>

* Figures in brackets are articles actually located expressed as a percentage of articles initially included on the location list. As an example, of all articles the Leader Post published from 1883 to 1981 which were included on the location list, about 97% were actually located and photocopied. For the same period, about 84% of all listed articles were located.
At this stage, it was apparent that there were a number of data limitations that needed to be addressed. For instance, there was little doubt that not every article relating to mental health was properly indexed or catalogued in the first place. For analysis to proceed, it was therefore necessary to assume that errors or omissions in indexing and location procedures were relatively constant over the entire period and among publications.

Another problem was that due to the irregular nature of indexing practices, fully comparable data for the original list of the five papers noted, was limited to the 1947-1981 period. Along with the fact that Ministerial papers were accessible only up to 1977, this meant that in the interests of accuracy, it was best to terminate the analysis in the mid-1970s. Also, pre-1947 newspaper material was slightly problematic, since only the Western Producer and Regina Leader-Post were indexed from 1947 back to their first issues. Nevertheless, combined and up to 1981, these papers constituted better than 62% of all listed articles. And more than half of all articles on the 'location list' were carried in the Leader-Post. Since it is located at Regina, the seat of provincial government, articles published by that paper certainly reflected major policy trends and issues. Hence, it was assumed that enough data were available from these two papers to develop a picture of pre-World War II promotional trends sufficiently accurate to serve as a backdrop for the focal period of this study, from the about 1950 to mid-1970s.

Other problems were encountered in trying to find articles stored on microfilm as indicated by indexes. In a number of cases, articles were not in their specified locations. A reasonable effort was made to find them by a page-by-page search of up to a month on either side of the specified date, which indeed turned up the majority. More problematic was that a block of articles was simply unavailable for content analysis because they could not be procured through inter-library loans. As shown in Tables 1A and 1B, this was the case with articles from the Prince Albert Herald, which were completely unavailable, and for most of the list from the Moose Jaw Times-Herald, which could only be obtained for the 1977-81 period. This was not felt to be fatal to the project since the procedures described yielded a subset of almost 85%
(644/758) of all articles taken from the indexes between 1883 and 1982, that were successfully photocopied and available for analysis. Furthermore, of these, three papers were well-represented over most of the entire era, especially the critical time between 1950 and 1970.

Articles actually located in two of these—the Leader-Post and the Star-Phoenix, papers published in the main urban centers of the province—comprised better than 83% of the original list of 809 on the location list. Together, they made up 81.1% of all articles listed up to the end of 1981. Irrespective of content, the 758 articles listed up to 1982 provided a good gross indicator of mobilizing activity derived from their frequency distribution by year.

To sum up these points, two sorts of public discourse data were used as evidence at different points in the analysis: (1) all articles selected from those listed in the indexes and included on the location list, and (2) a subset of all articles from that list which were actually located. Group one provided evidence for the overall distribution of public discourse activity, while content analysis was obviously limited to the second group. It was recognized that these samples were not totally exhaustive, nor were they random. But due to the nature and scope of the study, random samples were neither feasible nor particularly useful. While it would have been preferable to obtain the entire population of articles for content analysis, this was not possible. In all, it is claimed that these materials, though not completely exhaustive, certainly constitute an acceptable sample size. Furthermore, the data in them were representative enough of the major issues to have served as an excellent barometer of the opinion expressed in the public forum.

2.3.2 Method of Analysis

Once theoretical-empirical perspectives were selected and some preliminary data gathered, a method of organizing this information was needed. Based on the perspective adopted, and from the preliminary materials, the major
policymaking groups were identified. Concurrently, a variety of historical accounts were consulted to provide a chronology of institutional and other events, in and out of the province. This formed a basic interpretive framework. It was at this stage that data from the SAB were collected along with newspaper materials. The sheer mass of newspaper articles posed the greatest problems in data management and analysis.

Since my primary interest was in the shaping of public opinion relative to the formation of policy, it was essential to find out which groups were trying to shape opinion, how these people were attempting to do so, and on what occasions. First, all listed articles were initially catalogued by their date, the pages on which they appeared and the papers in which they were found. This provided an overall picture of the annual distribution of newspaper activity. The articles located were then categorized by their length and their origin (provincial, national or international). Each article was then painstakingly scrutinized to determine the major group that was cited in or who authored the particular piece. At the same time, each article was grouped by other variables. The form in which it appeared, for instance as an editorial, a news report or a testimonial; and by what occasioned the piece, for instance a government commission, or visiting dignitary; most importantly, all located articles were judged by their content to fall into either report or else prescriptive groupings.

'Report' articles were those whose text made little or no overt attempts to convince or convert readers to any ideological position. Examples of these were simple announcements of occupational appointments, proposed construction of facilities or new services, announcements of grants, and so forth. 'Prescriptive' or educational articles were those which attempted, actively and transparently, to shape the reader's opinion—to convince readers that he or she should adopt a particular attitude with respect to mental health. While in one sense all such accounts are educational in that they broadcast issues, this distinction was analytically necessary and valid in order to address the matter of ideological promotion. In the majority of cases, cataloguing articles by this variable was surprisingly clear-cut. Finally, a variable called
prescription was used to categorize what sorts of arguments were being employed wherever articles were deemed to be prescriptive.

The resulting data were analyzed by the author with the aid of a computer. Given the limitations of the data already noted, analysis was confined to the use of descriptive statistics such as calculations of raw frequencies, rates ratios and percentages. The resulting information was used as descriptive evidence to show the effects of changing social structural relations. In this, the computer-assisted results were synthesized with archival and other materials for a contextualized analysis which narrated the efforts of certain interest groups to shape opinion along with some of the effects this had on provincial policy. Qualitative evidence from all sources was given at the appropriate points in the text of the study, punctuated by summary descriptive materials presented in charts, graphs, and tables.

What follows then is a narrative which describes how dominant, challenging and repressed interests represented in professional, state and other agencies were mediated in the policy process in a way that gave rise to particular developments in Saskatchewan. Special attention is given to the role of occupations in seeking to mobilize public support in order to direct policy outcomes, particularly between 1950 and 1970, in which time community health emerged into full view.

The next chapter describes the course of developments up until about 1944. Its purpose is to provide essential background material to detail the trajectory of policy in the post-1944 period. The post-Second World War material is then analyzed in two separate chapters. The first deals with the period to about 1965, by which time medical control of insanity had been achieved. The second describes developments from that point into the early-to-mid 1970s. A final chapter reports conclusions and offers some possible directions for future research.
Notes to Chapter 2


3. Ibid., p. 444.


10. Ibid., p. 455.

11. Ibid., pp. 456-463.


18. Ibid.
20. Ibid.
23. Ibid.
24. Ibid., p. 15.
25. Ibid.
26. Ibid., p. 251.
29. Ibid., see Chap. 5, "The Practices of Civil Society", especially pp. 65-68.
31. Ibid., p. 130.
33. Ibid.
34. Shatzman and Strauss, op. cit., p. 135.
36. Ibid., p. 16.
37. Ibid., pp. 29-40.
38. Ibid., p. 208.
39. Ibid., p. 54.
40. Ibid., pp. 54-56.
41. Ibid.
42. Alford, op. cit., 1975, p. 15.
CHAPTER 3

The Establishment of Psychiatry in Saskatchewan: Custodial Care, the Mental Hygiene Movement and the Basis for Public Mobilization, 1920-1944.

3.1 Introduction

A main purpose of this work is to investigate the significance of public promotion with respect to the advancement of the occupational goals of psychiatry as expressed in provincial policy. The medicalization of insanity that successfully culminated in community mental health in the 1960s, was the result of a lengthy process of building support for these policies that began with the mental hygiene movement as far back as the nineteenth century. In the twentieth century, the promotion of mental hygiene, later known as mental health, can be divided into two distinct periods. The first, in which promotional activity was organized under the National Committee for Mental Hygiene (NCMH), lasted in Canada from roughly 1918 to 1950. Its central objective was to establish a core of support for mental hygiene among professionals working in psychiatry and related disciplines, and also among prominent social and political figures.

This chapter outlines the nature and activities of the NCMH during this period in relation to the province's pre-World War II mental health policies. The chapter begins with a brief description of historical trends and events in order to situate the NCMH's introduction into the provincial policy scene. The remainder of the chapter focuses on that organization's origins, ideology, and purposes. As we shall see, a mental hygiene ideology was developed under the
NCMH that was designed to coalesce a number of occupational, and other groups in order to mount a challenge to the existing form of mental hospital psychiatry which was largely under legal control. In this effort, psychiatrists were the main architects of mental hygiene and inscribed into it a key role for themselves.

3.2 Historical Background

In Chapter 1 we saw from the Revisionist literature that in the nineteenth century psychiatry was embroiled in various occupational struggles over policies regarding control of the social management of insanity. In the latter part of the nineteenth century a major flash-point of those struggles, waged at an international level was the legal versus medical control of insanity. Taking the content of state legislation as an indicator of the pre-eminence of a certain group or groups in the formulation of policy, this section examines the thrust of early legislation to determine the terrain of this contest as it first emerged in the region. This is intended to define, in Alford's terms, dominant, challenging and repressed forces in the introduction of the region's founding policies.

As defined, policy involves the state, so that the context in which our study emerges begins with the appearance of the state. Colonial government was first introduced with the creation of the NorthWest Territories in June of 1870, just after the purchase of the region from the Hudson's Bay Company. From then until the creation of the province in 1905, the area was governed under Territorial status. Until 1876 it was directed entirely from Ottawa, after which time local representation was progressively achieved.

In view of the limited constitutional powers of the Territorial Assembly, the first official policy regarding the insane, an "Act Respecting the Safekeeping of Dangerous Lunatics in the NorthWest Territories", was legislated by the Dominion government in May of 1879. Along with the gradual achievement
of self-governance which empowered the Territorial Assembly to pass local ordinances, a series of accompanying ordinances were later added to this basic legislation in the period leading up to the province's formation. The initial phase of policy was thus introduced in advance of mass settlement by government intent on establishing its fundamental sovereignty over the region. In this, the federal legislation, along with later Territorial ordinances that served as the pattern for the province's first insanity laws, concentrated almost completely on the criminal control of the insane.

An 1879 ordinance, for instance, stressed that a person could be remanded for trial and possible incarceration if they "exhibited a purpose of committing some criminal offence". Similarly, an 1888 ordinance stipulated that persons suspected of insanity could be brought before a Justice of the Peace to determine their state of sanity. If found insane, a prisoner was liable to incarceration in "gaol or other safe custody" until discharged by law.

What is significant about this is that there was little in these legislations to suggest that mental disorder was a 'illness'. Rather, Territorial policy was devised by dominant political figures and the thrust of legislation clearly placed insanity under legal control, the enforcement of which fell mostly to the North West Mounted Police. There were, in fact, no Territorial asylums ever built. Territorial inmates were housed first, along with the general prison population, at Manitoba jails and, following their construction, at asylums in that province.

These factors, lack of infrastructural and population development, and the absence of a Territorial psychiatric service, meant that there was no direct professional or other organized interest to contest the predominantly legal concerns as they were laid down in Territorial policy. So while there were attempts being made to medicalize insanity elsewhere, similar efforts did not emerge in the region with any noticeable intensity until some time after 1905.
In that year provincial status was granted and under the terms of the Saskatchewan Act the province assumed complete responsibility for the care of the insane, including legislative autonomy regarding such matters. For the most part, the first provincial statutes were adapted from former Territorial ordinances and thus carried over previous legal control over management of the insane. For instance, the Public Service Act of 1905 named the Attorney General in charge of the "superintendence of asylums, prisons, houses of correction and other places of confinement [and] the admission and discharge of lunatics to and from asylums". The insane from the region continued to be sent to Manitoba asylums, principally Brandon, until provincial facilities were opened at North Battleford in late 1913, and at Weyburn in 1920.

Between 1910 and 1920 three things occurred that subsequently had an important impact on the province's psychiatric policy. First, there was an immigration boom beginning around 1910. Second, medically-trained asylum directors were appointed to run the province's asylums who introduced the wider medical challenge to legal control of insanity into the province. Third, a chapter of the NCMH was founded in Canada which was instrumental in organizing and helping propel that challenge onto the provincial stage.

A sudden swell of settlers around 1910 strained the existing levels of the province's infrastructural capabilities. Coupled with the transfer of patients to Brandon, this 'instant population' seems to have been a significant factor in the immediate over-taxing of the province's asylum facilities. Although asylums and prisons at the time were typically over-crowded, Saskatchewan's institutions were both filled beyond their rated capacities within an alarmingly short time after opening their doors.

As will be shown, institutional overcrowding set the scene for the first concerted efforts to bring insanity under greater medical control in the province, under the auspices of the NCMH. Proof of the organization's importance in these efforts is shown by the fact that it was invited by the province on three separate occasions, in 1920, 1930, and 1944, to evaluate
mental care facilities and programs. These surveys immediately preceded and were the basis for many of the major changes in provincial mental health statutes in which insanity progressively came under medical control.

These surveys contained an interpretation of the existing mental health situation derived from certain observed 'facts', along with recommendations to deal with alleged deficiencies raised by that factual analysis. In this, the NCMH representatives and asylum superintendents who were members of the agency, drew on explanations and solutions that had been more widely refined by the NCMH, and which was adapted to the provincial situation. In view of the NCMH's central role in developing these explanations and their impact on provincial policy, the next sections will review the nature and history of the organization.

3.3 The Ideology of Mental Hygiene

Notwithstanding a terminological change around 1950, mental hygiene was a direct precursor of mental health. The basic principles of mental hygiene were carried over to the mental health movement and the substance of the messages they conveyed were similar if not identical. The aim of this section is to detail the fundamentals of this ideology.

The roots of mental hygiene--broadly, the principles "to prevent mental illness and promote mental health"¹¹--are located in the second half of the nineteenth century. Faced with the absence of an effective cure for insanity, some leading mental health professionals in the United States and Britain came to the conclusion that insanity was best prevented in the first place. These original advocates of mental hygiene, generally asylum superintendents and neurologists, began to offer guidance to the public on behavioral matters based on what they believed to be scientific canons as a prophylaxis against mental disorder¹².
As one social historian has commented of nineteenth century mental hygienists,

by working for mental hygiene [its advocates] reintroduced traditional [religious] values—always under the cloak of science—and asserted their right as physicians to lead others to their desired goals. Advice on mental hygiene resembled nothing so much as the religious precepts these physicians had assimilated as children [i.e. the 'golden rule' of moderation]. But theirs was a liberalized behavioral ethic, better suited to the more secular and bourgeois world of late nineteenth century America.13

This passage illustrates that, consistent with our previous definition of ideologies, mental hygiene was the symbolic representation of a group of medically-trained specialists and their allies, who authorized themselves in the language of (medical) science, to lead others in combating mental disorders. Although it varied in specific applications, the basic core of this ideology is as follows: first, it was designed to attract a variety of groups on the basis of an alleged similarity of interests, to support a public project of social reconstruction, that is the transformation of insanity into mental illness; second, it offered arguments based on reputed factual evidence which tried to convince its audience that mental disorder was best managed as a mental illness; third, it proposed solutions to problems highlighted in the factual analysis which called for actions that would benefit the interests of its promoters.

To amplify these points, the signal feature of mental hygiene was that it postulated a medical model of mental disorder, that is it presumptively declared that insanity was, in fact, a 'mental illness'. Hence, problems endemic to asylums such as overcrowding were identified by hygienists to be a consequence of the current methods of dealing with insanity, then dominated by legal institutions. The proffered solution was that active, preventative methods had to be substituted for the essentially passive methods of custodial confinement. This required both a general public and legislative recognition that insanity was an illness and should be treated as such. The logic of this
position was that it sought to transfer insanity into the jurisdiction of medicine, which also tacitly designated medically-trained psychiatrists as its leading profession.

Yet the preventative ethos entailed in the term hygiene implied much more than one occupational specialty. In practice, mental hygiene aimed at instituting various preventative social policies, especially with respect to improving child-rearing and educative practices to instil 'healthy' attitudes at an early age. The scope of mental hygiene was therefore broad enough to attract the support of a variety of occupational groups that also stood to benefit from the establishment of such views. Mental hygiene was especially attractive to occupations on the immediate boundaries of psychiatry, such as social work, psychology, education and criminology. As an NCMH tract explains,

Mental hygiene permeates all other hygienes. The mental hygiene clinic provides a diagnostic treatment service, but this in order to be effective must be integrated with all the community organizations such as public health, education, social work, delinquency, etc.

Despite a lack of demonstrative proof that mental disorder was a physical illness, it can be seen how mental hygiene promoted the allegiance of these other occupations which were defined as essential to its success, under the rubric of the 'public good'. Mental hygiene held out not only potential material and status rewards for these occupational groups, but also conveyed the sense that it was a morally positive enterprise.

In addition to these neighboring social service occupations, mental hygiene attracted the support of philanthropies and important social and political figures. One line of thought that accounts for avid philanthropic support suggests that mental hygiene principles and activities served to diffuse class antagonisms that surfaced with the development of modern industrial society. That is, the medical model underlying mental hygiene focused on
individual factors, "on the promotion of such conditions as [would] allow man to adjust himself [sic] most effectively to his social environment". Such a focus, it is argued, was generally supportive of the political and economic status quo.

In sum, the key engineers of mental hygiene were medical doctors, principally psychiatrists, who sought support for social preventative measures that required bringing insanity under medical control. Mental hygienists solicited the support of neighboring social service occupations, the financial support of philanthropies, the political support of leading politicians and social dignitaries and, especially after 1950, the support of the 'general', lay public. For politicians the preventative model promised a solution to institutional problems such as overcrowding and thus the expense that new institutions entailed, while philanthropies saw mental hygiene as a way to help deflect class antagonisms.

Added to this, mental hygiene had a potentially wide public appeal, capped as it was with humanitarian reasons for its implementation--that the insane were suffering from illness, for which they should and could receive reasonable (medical) treatment. In all, mental hygiene contained effective arguments for the successful promotion of a medical and psychiatric view of insanity. The following section describes the strategy and activities of the NCMH until the end of World War II by which time the organization had powerful allies and built a solid base of support among the elite sectors of Canadian society. That floor of support was a crucial step towards generating wider support among the lay public which the NCMH felt was indispensable to the ultimate success of the mental hygiene project.
Over the latter half of the nineteenth century the ideas of preventative mental hygiene waxed and waned. There were for instance, a number of short-lived mental hygiene associations that operated in the United States and Britain in that period. But a more robust agency to promote mental hygiene did not arise until after 1900, when interest in mental hygiene resurfaced, carried along with the wave of public health movements dedicated to the eradication of infectious diseases that emerged around then\textsuperscript{18}.

This interest was galvanized into a formal organization when the NCMH was founded in the United States in 1908 by an ex-psychiatric patient, Clifford M. Beers. The fledgling organization "quickly received the enthusiastic support of psychiatrists, including progressive superintendents of mental hospitals, social workers, educators and others"\textsuperscript{19}. The noted psychologist William James for example, endorsed Beer's efforts and contributed a sum to the agency. More than just moral support or donations, however, many individuals from these sorts of professional groups, especially psychiatrists, became members of the NCMH and were instrumental in its initial organization and promotion. In fact, throughout its history, and that of its successor, the Canadian Mental Health Association (CMHA), professionals, especially psychiatrists, made up the bulk of the agency's executive and had a major hand in the direction of its policy\textsuperscript{20}. In other words, from the outset, the NCMH was a vehicle for professional interests.

A determining factor in explaining the immediate and continued success of the NCMH in comparison to previous mental hygiene associations, was its support by philanthropies. The agency received sizeable sums as early as 1912. From 1914 onwards, large philanthropies, notably the Rockefeller Foundations, began to regularly contribute very large sums for "demonstration projects" in the United States and later Canada and elsewhere\textsuperscript{21}. This professional and philanthropic support assured the success of the organization in its birthing stages. The NCMH's 1918 introduction into
Canada marked its growth into becoming an important transnational actor in the formulation of mental health policies.

Patterned on its American counterpart, the Canadian NCMH was founded between February and April of 1918. Among its chief executive officers, all medically-trained doctors, were the noted psychiatrists C.K. Clarke and Clarence M. Hincks. In 1922 Dr. Hincks assumed full executive responsibility for the agency, a post he enjoyed until after World War II. The activities and objectives of the Canadian NCMH from 1918 until it was superseded by the CMHA in 1950, can be divided into two distinct periods--an initial establishment phase, lasting roughly to about 1927, followed by a period of consolidation and expansion up to 1950.

In 1918 the NCMH's stated purpose was to establish an organization to "give leadership in combating mental diseases". The agency's overall program of 1918 declared that it intended to lead the struggle against mental disease in five major directions:

1. War work: (a) psychiatric examination of recruits, (b) adequate care of returned soldiers.
2. Mental examination of immigrants (post-war), to ensure a better selection of newcomers.
3. Adequate facilities for the diagnosis and treatment of cases of mental disease.
4. Adequate care of the mentally deficient.
5. Prevention of mental diseases and deficiency.

Up until 1930, however, the organization did not seriously consider the pursuit of policies for "the prevention of mental disorder". This was because it first had to establish a floor of elite support before it could promote its wider objective of a preventative program. In other words, it first had to rally a critical mass of professional and political elite support as a pre-condition for launching its campaign of public reconstruction. To accomplish this the NCMH in the 1920s initiated research projects for the study of mental hygiene applications to school children and ongoing research programs at the
Universities of Toronto and McGill\textsuperscript{25}. As well, five mental hygiene clinics and a few 'demonstration projects' were placed in large Eastern cities.

The major activity in its first period though, was to voluntarily undertake provincial surveys to determine the prevalence of mental diseases and to appraise existing treatment facilities\textsuperscript{26}. Over this time, extensive surveys were completed in most provinces, including a 1920 survey of Saskatchewan. Although time-consuming, the agency considered this activity to be vital, since it revealed existing conditions in Canadian institutions. This was significant in that through these surveys the NCMH was able to paint a picture of the scope of the alleged problem of mental disorder and thereby highlight deficiencies in the extant, legally-dominated system. Such surveys were also conducted by the American NCMH, which allowed the organization to suggest that the problem of mental disorder, as defined by it, was international in scope. Generally, these surveying activities helped to give mental hygiene a scientific flavor and facilitated eliciting professional support which strengthened its credentials as an expert advisor to government.

The report of the 1920 Saskatchewan survey provides an example of how survey materials were brilliantly used to try to promote mental hygiene and lay down policies for its establishment by lobbying key government figures. Here, the NCMH raised the spectre of institutional overcrowding, then suggested a set of solutions transparently based on mental hygiene principles. NCMH representatives, Drs. Clarke and Hincks, along with Dr. MacNeill the superintendent of North Battleford, himself a member of the agency, met with senior government officials to discuss the survey findings\textsuperscript{27}. At the time Weyburn was under construction, while North Battleford was overcrowded. Although they did not expressly say it, the NCMH representatives and Dr. MacNeill hinted that Weyburn faced a similar fate, unless certain measures were adopted.
The NCMH and MacNeill argued that a preventative approach was the only long-term solution to institutional overcrowding. The major problem they claimed, was that in the current situation people generally associated insanity with crime, and thus with degradation, fear and other negative images. They asserted that, with good cause, people were for the most part horrified of asylums and avoided them if at all possible. As a result, people delayed entering asylums until their disorders had progressed much too far to be easily reversed. Consequently, asylums silted up with large numbers of people who were beyond effective treatment.

Alternatively, the NCMH suggested that if insanity were viewed as the illness it actually was, then people would voluntarily submit to early treatment and stood a much better chance of recovery, perhaps avoiding long-term institutionalization altogether. To cultivate a more cooperative attitude it was necessary to educate the public that insanity was a mental disease and much like physical disease, could be treated by medical specialists armed with the correct knowledge. As the NCMH pointed out, magistrates (those with legal training), had no special expertise in dealing with mental illness. Rather, this was the province of specialists with medical training, and so they asserted that the burden for care of the mentally ill should be thrown "not on the magistrate, but on the medical men". Accordingly, the NCMH contingent recommended that admissions procedures be simplified to allow admission authorization by doctors and that voluntary admissions should also be allowed. It was argued that along with these measures the implementation of preventative services, notably two intensive-care psychopathic clinics and follow-up services to re-integrate released patients, would save the province money.

Despite the fact that this logic ingeniously linked the solution to overcrowding with an ostensibly more cost-effective, preventative medical approach, these arguments were quite radical at the time, and were less than completely successful in the short term. In the interim between 1920 and the next Saskatchewan survey in 1930, none of the NCMH's concrete recommendations were put into effect. Admissions procedures, for instance, were left intact. The
request for voluntary admissions was also denied for fear it might encourage malingering. This is an example that illustrates how the meanings and consequences of proposed policy are worked out in the policy process. At this point, leading politicians judged that the political liabilities of such policies outweighed their potential long-term cost saving. Contrary to Scull's assertions, the economics of the situation did not automatically dictate the course of policy. Rather, the NCMH proposed a set of policies, which they claimed to be more cost-effective, that were nonetheless over-ruled by the government on other considerations such as public safety and potential malingering.

On the other hand, the mental hygienists did succeed in establishing in the 1922 Mental Diseases Act, the legislative recognition that "a disease process was being dealt with rather than a criminal prosecution." This was an important first step in directing provincial policy which would subsequently buttress wider promotional activities. At the same time, it was a reflection of the limited, but realistic scope of the NCMH's political strategy, which consisted almost completely of lobbying government for the implementation of 'enlightened measures'. This in itself was an aspect of the need to assemble a crucial floor of support for mental hygiene among various elite sectors before launching on a campaign of wider lay-public promotion (education), which was indicated in the 1920 survey and which was generally recognized as crucial to the success of the mental hygiene project.

3.5 General Public Promotion to 1945

Even after it was quite well-established, by about 1927 or so, lay promotion by the NCMH was minimal. Instead, from that time right up to its supersession by the CMHA in 1950, the organization basically consolidated its gains and expanded its operations to continue mobilizing support among professionals and leading social and political figures. The agency's 1932 educational strategy rested on the belief that "the success of the whole movement depends on large measure, upon the leaders." It therefore continued to expand research
programs, to gather and standardize statistical information, to promote legislation, to insist on minimal hygiene standards for immigrants and in schools, and to conduct (re)surveys32.

To directly cultivate the training of mental health leaders it established special training centres and fellowships, encouraged the undergraduate instruction of all professional workers and recommended the development of mental hygiene instruction in Canadian medical schools33. The agency also proposed to "initiate studies of the practical workings of the professions, so as to be in a position to advise the professions--law, medicine, education, etc.,--with regards to the practices of mental hygiene"34.

At the same time, the 1932 report identified a crucial need for public education.

[T]he National Committee must have public support to attain their objectives which call for the expenditure of public funds and depend on favorable public opinion which develops out of an understanding of the problem and the need. These require frequent reiteration in a manner comparable to the teachings of habits which are fundamental to physical health. At the present...public education is too isolated in the sense that the whole burden is left with the Director of the division of education.35

It must be emphasized that although the importance of public education was recognized around this time, the NCMH's pre-Second War educational strategy was consciously focused on influencing elite sectors partly out of practical necessity. This was because modern mechanisms for disseminating mental hygiene were largely undeveloped in Canada until after World War II. As authors have pointed out, the modern public emerged with the demise of 'traditional society', which consequently tended to dissolve traditional ties, such as religion, local community and the extended family. These dissolutions created, in part, the 'general public', or groups of individuals that were freed from those ties and thereby available for political and other mobilization on the basis of ideological appeals. Thus, the 'age of ideology' was marked by the rise and expansion of mass media to communicate ideologies to that consuming
public. This is what Ginsberg has called the appearance and growth of the "marketplace of ideas".36

Prior to the development of radio and television, mass communications media, chiefly newspapers, carried information mostly of a local nature. The advent of 'instant' electronic media, radio and later television, widened the range of information conveyed to the public and forced a change in the nature of newspaper coverage as well. However, this was a lengthy process and radio and television were not in general use until after the Second World War. As one author comments,

[N]ewspapers were the first modern mass communications medium with messages reaching many people about the same time. The press, however, had anything but a mass audience in its early days. Many [people] were illiterate and many others could not afford newspapers—not that they were particularly interested in its contents.37

Although various technological innovations reduced press prices and dramatically increased circulation and numbers by 1900, nevertheless, the changes in the "newspaper system in the twentieth century must be seen in the context of a technological revolution that brought electronic communications onto the mass media sphere: radio in the 1920s and television in the 1950s".38 As part of the 'nation building' effort after confederation, railways indeed traversed the country. But newspapers, as perishable items, 'travelled badly' and consequently newspaper content remained largely of a parochial nature. Electronic media changed this. It both compelled and allowed newspapers to become much more (inter)national in scope. Yet, the formation of a truly national mass communications network was a drawn-out process and as late as 1936 Mackenzie King commented to parliament, "if some countries have too much history, ...we have too much geography".39

World War II was an important impetus to the development of modern electronic communications following from the military innovations in electronic tracking devices and weapons guidance systems. This was the basis from which the revolution in civilian communications after the war was
launched, and which subsequently made radio, television and newspapers truly mass consumption items that cheaply and rapidly carried international information. The point is that mass media, along with the general public it helped create and which in turn helped create it, reached a threshold of development suitable for mass ideological transmission only after World War II.

Given this situation, the NCMH was concerned with "breaking down the [then unfavorable] attitude of the public towards mental hospitals and the insane" with public instruction activity that consisted merely of a mental hygiene bulletin, occasional public lectures, periodic newspaper articles and a few radio broadcasts. These had an extremely limited impact, however, since they were irregularly produced and, for the most part, reached a limited audience.

For instance, looking at newspapers, the medium with the widest potential coverage at the time, there appears to have been little attempt to educate the Saskatchewan public in the principles of mental hygiene until after World War II. Evidence shows that from 1918 to 1944 there were fewer than 25 articles on mental health topics in the province's major daily paper. Only three of these make any references to the NCMH or mental hygiene. The only extensive coverage was provided in an article just after 1920, around the time Weyburn hospital was opened.

Entitled "Treatment Given Mental Defectives in Saskatchewan is Praised by Mental Hygiene Committee", this piece was a full page article that outlined the key ideas of mental hygiene focused around some of the findings and recommendations of the 1920 Survey. Some of its text illustrates the flavor of mental hygiene principles in a number of areas, respectively, education, immigration, jails and unwed mothers:

[1] The Saskatchewan Government is keenly alive to the importance that education must play in the making of useful and patriotic citizens. A study of 3,182 children in [urban] schools resulted in the detection of 61 mental defectives. Owing to the fact that the problem of mental abnormality in public schools is of such importance the
committee urges that Saskatchewan adopt measures that will ensure early diagnosis and suitable measures for adequate training and treatment.

[2] The proportion of foreign born in the hospital at North Battleford was even greater than the proportion found in jails. A considerable portion of the burden now imposed on Saskatchewan is due to immigration. Under a more rigid system of inspection the influx of mental defectives and insane would be reduced.

[3] Insanity [is] no crime. The committee deplores the fact that no less than 47 insane prisoners temporarily confined at the Regina jail during the year prior to the survey. Such effect as this adds to the terrors of the people who are confirmed that insanity is a crime rather than a disease.

[4] It is pointed out that the relationship between illegitimacy and mental abnormality is intimate, and the committee found that of 700 unmarried mothers over 50% were mentally deficient. The committee deems it prudent that unmarried mothers should be subjected to a psychiatric examination and special facilities should be provided for their care.

Aside from this instance, there was virtually no systematic attempt evident in the province's newspapers to publish articles to educate and elicit lay public sympathy for mental hygiene until after 1950. While there were limited efforts in the 1940s to stage educational lectures and films for public health nurses and some women's groups, the task of a concerted effort at wider public promotion fell to the CMHA. Under the CMHA some of the ideas as noted above were refined or toned-down, although its main mission was basically to convince the public of the central notion that insanity was a mental disease.

In the interim between 1920 and 1929, as the NCMH had predicted, overcrowding in the province's mental hospitals grew steadily worse. The NCMH completed another survey in 1930, the recommendations of which were essentially the same as in 1920--the institution of preventative services, notably psychopathic hospitals, follow-up services, and a separate facility for mental defectives. However, the institution of a psychopathic hospital at Regina and a training program for ward workers at the mental hospitals were
not enough to stem the steady increase in hospital populations, a situation exacerbated by the ravages of the depression.

The next major legislation after 1922 was in 1936 and its terms showed that the NCMH's lobbying strategy had been effective at the provincial level. The Health Minister at the time, Dr. Uhrich, was in contact with the NCMH and expressed solid support for the preventative ideas of mental hygiene. The 1936 act therefore contained such obviously NCMH-inspired items as legal provisions for the boarding out of mental patients in approved homes\textsuperscript{46}, voluntary admissions\textsuperscript{47}, and the admission to hospitals on the authority of two physicians as an alternative to committal by a magistrate\textsuperscript{48}. Moreover, Dr. Uhrich agreed with the NCMH that "mental hygiene [was then] the biggest problem of public health", and pledged that the province intended to develop "community programmes for an essentially preventative service"\textsuperscript{49}. Dr. Uhrich, in fact, had devised a future program with the assistance of the NCMH which included: (1) the development of a network of hygiene clinics, (2) education of the public, (3) the supervision and training of mental defectives, (4) boarding out mental patients, and (5) the strengthening of psychiatric services in mental and general hospitals\textsuperscript{50}.

This new program did not materialize until after World War II due to a lack of the government's political will\textsuperscript{51} in the face of the province’s abysmal economic performance. As we shall see in the next chapter, much of this program was reiterated in the NCMH's 1944 survey and instituted soon after the provincial election in that year. At that point, however, it was an indication that the NCMH had been highly successful at generating support for mental hygiene in the province's key political circles. Thus, the NCMH's promotional efforts in Saskatchewan and elsewhere laid a foundation of elite support which had prepared the way for the broadening of promotion to the wider public.
3.6 Chapter Summary and Conclusions

We have seen in this chapter that the earliest policy regarding management of the insane in Saskatchewan was dominated by legal concerns. The appointment of asylum superintendents after construction of asylums introduced a group that launched a regional challenge to the legal control over insanity. A key organizational weapon in this challenge was the NCMH, a psychiatrically-dominated, international coalition whose objective was to disseminate the idea of prevention of insanity under the rubric of 'mental hygiene'. In stark contrast to the prevailing legal view, the medical model of insanity embedded within this ideology, defined insanity as a form of illness.

Ultimately, changing the prevailing view of insanity, associated as it was with criminality, into an illness under the purview of the medical profession, required a wide-sweeping social transformation. In short, this 'project of public reconstruction' eventually would require winning the support of the general lay public, especially as service consumers, but also as taxpayers, and political constituents. For the reasons given, however, the NCMH purposively directed its promotional efforts towards select social groups rather than towards the lay public, although it clearly understood the need for broader support as early as the 1920s.

In contrast to Scull's and Ralph's economic reductionism, this directs our attention to the significance of ideological factors in the need to generate enough social power to influence policy outcomes. Although economic factors are typically of great importance, the significance and consequences of economics in relation to a given set of policy recommendations are themselves partly thrashed out in the negotiations among parties involved in the policy process. For instance, we saw that although the NCMH provided sound economic reasons for its preventative proposals in 1920, the government either could not or would not implement them at the time due its perception of the situation. By the 1930s, however, after the NCMH had assembled key support, nationally and provincially, those same ideas were much more palatable to government and readily ensconced in provincial legislation.
With respect to Alford's model, there was a *conspicuous absence* of lay public discourse represented in the newspaper media. Bearing in mind that his analysis is concerned with post-War events, this could mean, as Alford might claim, that such public representation was completely repressed, even before World War II. It may be rather, partly a manifestation of the level of development of mass communications in that period. It might be suggested that, because of this the public was simply not very cognizant of mental hygiene issues. In fact, this would imply that due to the cognitive advantage of psychiatry and other mental health occupations, they might play the leading role in (in)forming the lay public's perceptions surrounding mental disorders, given adequate mass communications. The next chapter, among other things, examines this contention.
Notes to Chapter 3


2. Statutes of Canada (Ottawa: King's Printer, 1879), Chapter 38.

3. Ordinances of the NorthWest Territories, 1888, No. 22, Sec 1.

4. Ordinances of the NorthWest Territories, 1888, Chapter 90, Sec 1.

5. Amended Ordinances of the NorthWest Territories, 1899, Chapter 24, Sec 1.


8. Ibid., pp. 25-27.


12. Ibid.

13. Ibid., p. 218.


17. 1932 Report, op. cit., p. 35, added emphasis.

19. Ibid., p. 316.

20. For example, the organizational roster of the Canadian NCMH in 1932 shows than better than 50% of its entire executive possessed medical degrees. 1932 Report, op. cit., pp 32-33.


23. Ibid.


28. Ibid., p. 3.

29. Ibid., p. 6.

30. Saskatchewan Department of Public Works, Annual Reports, p. 49.

31. 1932 Report, op. cit., p. 35 stated that "[t]he dissemination of mental hygiene principles rests largely with professional groups".

32. Ibid., p. 36.

33. Ibid., p. 39.

34. Ibid., p. 47.

35. Ibid., p. 35, added emphasis.


Given this relatively lower level of development, the basic markets necessary to sustain a critical degree of mass communications development
simply did not exist on a sufficient scale (certainly in Canada) before World War II.

For a discussion of the development of the market for ideas see Ginsberg, chapter 4, *passim*.


38. Ibid., p. 95.

39. Ibid., p. 96.


42. See the Following: "Treatment Given Mental Defectives in Saskatchewan is Praised by Mental Hygiene Committee," *Regina Leader*, January 22, 1921 p. 15; "Weyburn Hospital," *Regina Leader*, May 20, 1921 p. 4; "Increase in Insanity," *Regina Leader Post*, December 31, 1934, p. 4.

43. *Regina Leader*, January 22, 1921, p. 15.

44. *Saskatchewan Department of Public Health*, Annual Reports 1942, p. 81.

45. Harley D. Dickinson, *Community Psychiatry: The Transformation of Psychiatric Work, 1905-1984*, (PhD. Dissertation: University of Lancaster, 1984), pp. 111-112. This work was recently published under a different title, see Notes to Chapter 1, #75.

46. *Statutes of the Province of Saskatchewan*, (King's Printer: Regina, 1936), Chapter 91, Sections 38-40.

47. Ibid., Section 11.

48. Ibid., Sections 12-14.

49. Letter from Dr. Uhrich to Dr. Hincks, December 6, 1940, SAB, R-97, #6b.


51. Ibid., p. 119.

52. Only two articles from lay people (excluding journalists) up to 1945 could be found. One, in the *Regina Leader* dated September 5, 1895, was concerning the necessity to construct a Territorial asylum to keep revenues within the Territories. The other, in the Regina Leader-Post dated June 26, 1939, called for a new mental hospital to be located at Kamsack.
CHAPTER 4

The CMHA and Public Mobilization for Mental Health, 1944-1965

4.1 Introduction

As seen, the promotional efforts of the NCMH starting in 1920 resulted in significant support for a medical view of insanity that was secured in Saskatchewan legislation by the late 1930s. This legislation accepted, in principle, the arguments for a preventative program of mental hygiene, many of which were implemented in the late 1940s and early 1950s. The establishment of these services coincided with, indeed was part of the post-war expansion of social services in health and welfare generally observed across the West. It can be argued that Saskatchewan was in the vanguard of this birth of the welfare state in Canada. And it was in this climate that in 1950 the promotional focus of the NCMH changed dramatically. That year, the NCMH was re-formed into the Canadian Mental Health Association (CMHA), whereupon promotional activity was refocused expressly towards the general public. This reorganization marked the start of a new stage in efforts to mobilize further support for mental hygiene and along with it the occupational objectives of psychiatry and its allies. From that point onwards, promotional efforts were directed towards a previously dormant force, the general public, in an attempt to harness opinion to further strengthen the medical challenge to the legal control of insanity.
Between 1944 and 1950 a number of major factors facilitated the introduction of this expanded promotional focus which was initially launched in the province of Saskatchewan. These factors were, respectively, the election of the Cooperative Commonwealth Federation (CCF), the formation of the Group for the Advancement of Psychiatry (GAP) and support for mental hygiene education by the Dominion government. Before detailing the public crusade engineered under the CMHA, which is the major focus of this work, the section below briefly reviews how these factors contributed to its introduction into this province.

4.2 Factors that Facilitated Public Promotion in Saskatchewan

4.2.1 The CCF and the Advance of Mental Health Services in Saskatchewan, 1944-1950

After assuming power in Saskatchewan in the spring of 1944, the CCF was immediately faced with a crisis of mental hospital overcrowding that had steadily been worsening throughout the 1930s and 1940s. Unlike its predecessor, it rapidly moved to implement many of the preventative mental health services advocated by the NCMH. Remarkably, in 1944-45 Saskatchewan still experienced the second worst provincial debt to personal income ratio of all provinces across the Dominion. Figure 1 graphically depicts provincial debt to personal income trends for Saskatchewan compared to the national mean for most years between 1933 and 1955. In 1937, for instance, Saskatchewan exhibited the highest debt to income ratio in the Dominion, 2.98 times the national mean ratio. In 1945 this figure was still 1.71 times the national mean.

Along with this, Figure 1 also illustrates total government spending on mental health services in constant 1975 dollars as computed from the consumer price index. As can quite clearly be seen, the CCF’s spending generally spiraled continually upward over the period indicated. This increase began in 1944-45, before any assured economic recovery was yet clearly apparent. Moreover, as
we shall see later, this government continued to increase spending even during years of economic down-turn. This spending was ploughed into an expansion of government services which began to be instituted at a time when from a strictly fiscal perspective, such actions might be considered highly questionable. This would seem to indicate that contrary to Scull's assertions, 'economics' alone does not simply dictate policy, but rather that policy is mediated by other factors such as political ideology.

Figure 1.
PROVINCIAL DEBT TO PERSONAL INCOME RATIO AND PROVINCIAL COSTS FOR MENTAL SERVICES, 1937-1955

Debt to income ratio was computed by dividing the annual provincial debt for each province by personal income for that year. A national mean was then computed and divided by the Saskatchewan figures for a Saskatchewan-National ratio. Source for these figures was Historical Statistics, StatsCan. Total expenditures were derived from Saskatchewan Dept. of Finance, Public Accounts, 1933-1955, and adjusted to 1975 dollars using the Consumer Price Index. "Expenditures" include: transport and committal of patients, maintenance and capital construction costs, and service costs.
In this instance, the CCF was an expressly social-democratic party, ideologically committed to a socialized, planned medical system, in many respects congruent with the preventative model of mental hygiene espoused by the NCMH\(^1\). Given its ideological commitment and in view of the problem of extreme mental hospital overcrowding, the CCF quickly decided to implement many of the recommendations of the two health commissions it had inaugurated in 1944. The Sigerist Commission, was aimed at formulating the general guidelines for the development of a comprehensive provincial health system, while the NCMH was mandated to make recommendations specific to mental health services.

Both commissions basically reiterated the core proposals of previous NCMH surveys and generally recommended such things as improving and centralizing services, the separation of mental defectives from mental hospital populations and the establishment of mental hygiene clinics. The NCMH further proposed the construction of a new mental hospital and a training school for mental defectives, another psychiatric unit, a foster care program and the "promotion of positive mental health" in schools, industry and among the general public \(^2\).

Many of these recommendations were put into effect between 1946 and 1950 by a government that was highly receptive to methods that promised to reduce hospital overcrowding. Premier and then Health Minister T.C. Douglas announced to the legislature in 1947, that the province was embarking on an "ambitious mental hygiene program"\(^3\). In words that might have been scripted by the NCMH, Mr. Douglas said.

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\text{[M]ore important than institutions where treatment is given will be mental hygiene clinics which we hope will act as screening places to help pick up cases in their early stages and provide early treatment. Many cases can be prevented from reaching an institution at all; other cases can be treated in a local hospital so that they never need to reach the state where institutional treatment is required.}^4
\]
Starting in 1945, the government began to act on many of the proposals set out in the NCMH's 1944 survey. Significantly, beginning that year the administrative structure of mental services was centralized and brought fully under control of the Department of Health. It is interesting to observe that until 1930 mental services were administered completely under the Department of Public Works, while from 1930 to 1944 they were managed jointly under Public Works and Health. These jurisdictional changes indicate that insanity was in the process of gradually being transformed into a health issue. Additionally, by 1946 a training school for mental defectives had been set up at Weyburn and by 1947 the first mental hygiene clinics were in operation—a full time clinic at Regina and part-time ones at Weyburn, Swift Current, North Battleford and Moose Jaw. That same year, a 560 hour, three year training program for psychiatric nurses, the first of its kind, was established in the two mental hospitals and the Munroe Wing in Regina. In 1948, in cooperation with the NCMH, four teachers were sent to the University of Toronto to be trained for establishing in-service programs of mental hygiene for teachers in small urban centres in Saskatchewan.

To implement these new services and changes, the government had hired Dr. D.G. MacKerracher, hailed as "an outstanding psychiatrist in Canada". Dr. MacKerracher, who had served in the military, was well-versed in new psychological techniques developed during World War II which had proved effective in quickly returning soldiers to active duty. These techniques made extensive use of mental health teams, very similar to the sort of service that had been proposed by the NCMH in its preventative program for civilian life. Given a free hand to implement what was considered a highly progressive program at the time, Dr. MacKerracher, in turn, brought into the province's mental health service a number of innovative psychiatric figures, notably Dr. H. Osmond and Dr. A. Hoffer.

These new services, particularly the psychiatric nurses program, were quite widely publicized in newspapers and began to inform the lay public about the issues surrounding mental health. The nursing program, aimed at professionalizing ward workers, added another professional voice to subsequent promotional campaign for mental health. The net effect of all this
was that Saskatchewan demonstrated, in tangible terms, a commitment to mental hygiene that was unparalleled, at the time, by any other provincial government in Canada. This program attracted some of the most 'progressive' authorities working in psychiatry, who would later play a key role in promoting mental health to the province's public, as executive officers in the CMHA's Scientific Planning Committee.

4.2.2 Formation of the Group for the Advancement of Psychiatry

Accompanying professional promotion by the NCMH, GAP, a parallel organization aimed specifically toward this function, was formed around 1946. Operating from its headquarters in New York City, GAP was founded as a "non-profit, tax-exempt organization that to this day relies heavily on funding by "voluntary contributions and efforts" of its members". Since then it has regularly received contributions from philanthropic and medical foundations, as well as private corporations, particularly pharmaceutical giants, such as Squibb, Sandoz and Ciba.

Since its formation, GAP has increased its annual membership from about 150 to currently more than 300 of the leading psychiatrists in the United States and Canada. Its members, at one time or another, have included such famous American figures as F.J. Braceland, Karl Menninger, and GAP's first president, William Menninger. Among its Canadian members have been Dr. J.S. Tyhurst from Montreal and Drs. H.F. Osmond and D.G. MacKerracher of Saskatchewan.

Since its establishment GAP has been organized into various working committees, numbering anywhere from 15 to 20. Aside from executive committees, each has been given the task of promoting psychiatry in government, professional and other circles respecting social policy areas such as aging, the family, international relations and many others. GAP's overall objective has been to develop, promote, and apply psychiatric knowledge to human relations. In this, the organization has collaborated closely with
specialists in a wide array of subject areas in the health sciences, humanities, and social sciences, such as,

anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, sociologists, social workers, and experts in mass communications, philosophy and semantics. [GAP has envisioned] a continuing program of work according to the following aims: (1) to collect and appraise significant data in the field of psychiatry, mental health and human relations; (2) to re-evaluate old concepts and to develop and test new ones; (3) to apply the knowledge thus obtained for the promotion of mental health in good human relations.11

Accordingly, between 1946 and 1968 GAP formulated and published "a total of 67 reports and 11 symposiums"12, and by 1987, 120 reports. A major purpose of these publications was, again, to promote a psychiatric viewpoint concerning human relations. Thus, GAP made their publications freely available to various professional and governmental agencies. In fact, in some instances they were automatically circulated to such bodies. As an example, material on mental hygiene and public education was distributed to, among others, the American Psychiatric Association, schools of social work, and state, and provincial mental health agencies. To this day, GAP remains an important conduit for the collection, synthesis, and the dissemination of information for psychiatry's promotion among professional groups, governments and voluntary organizations.

Similar to the NCMH, GAP's early educational concerns can be divided into two categories, promotion in education institutions, and lay promotion. The first involved advancing psychiatry in colleges and universities, as well as primary and secondary schools. With respect to lay promotion, GAP's efforts, however, were not towards direct lay public involvement, but rather in the formulation of educational strategy for mental health leaders. So similar were the professional and public promotional functions of GAP and the NCMH, that the former organization was rendered increasingly redundant in this task. This provided the opportunity for the NCMH to convert itself into a 'popular reform' movement, targeted specifically at lay promotion. The re-formation of the
NCMH into the CMHA in 1950 marked, what was, in effect, a 'public promotional division-of-labour'. GAP developed broad lay educational strategy, while the CMHA operated in-the-field to apply such strategy in an effort to generate support for mental health. Thus, by 1950 there were three organizations in existence, operating at different levels, to promote psychiatry and mental health: (1) the American and Canadian Psychiatric Associations to maintain and create professional norms within psychiatry, (2) GAP to promote psychiatry's inter-professional and governmental relations, and (3) the CMHA, aimed at promoting mental health and the psychiatric viewpoint among the general public. It is interesting to note that this organizational specificity closely conforms to Schatzman and Strauss's three basic zones of contact with psychiatry discussed in the public process model in Chapter 2.

Some evidence for such a public promotional 'division of labour' is shown by the fact that around the time GAP educational research was circulated, these directives in fact found their way into the lay promotional strategy of the late NCMH, and shortly after, of the CMHA. The link in this chain was the overlapping incumbency of key psychiatric figures in the province, who were not only members of GAP, but who were members of the NCMH, and later sat on the CMHA's Scientific Planning Committee—a group that was instrumental in directing the CMHA's provincial educational strategy.

Here, two of GAP's early publications dealt specifically with lay promotion. Entitled "An Outline for the Evaluation of a Community Program in Mental Hygiene" and "The Psychiatrist in Mental Health Education", these publications detailed a framework for eliciting lay support and hints for dealing with the media. The first of these, published in 1949, was essentially a tactical guide which contained an extensive list of criteria for evaluating the existing levels of service, along with techniques for engaging public interest in mental hygiene. Thus, this report suggested that,

the first step [to improve mental health] must be a familiarity with existing activities for the sake of evaluating their effectiveness or their deficiencies.
The next step is a long-range plan for an improvement of the situation. Finally, it is necessary to initiate concerted action by all interested groups to bring the long-range plan to fruition.  

This was precisely what the CMHA would do. As we will see presently, such a long-range scheme would be articulated into the 'Saskatchewan Plan', and widely promoted to the public in an effort to mobilize sentiment for it. However, this would not be accomplished until the mid-1950s. In the meantime the public had first to be made far more aware of mental health issues.

4.2.3 Federal Government Support for Mental Hygiene

Federal government support for mental health began in 1949, as part of a system of health initiatives for the construction of hospitals and the expansion of health services. Yet another indication of the promotional success of the NCMH in lobbying for enlightened legislation, Health Minister Paul Martin commented to parliament in 1948 that there were over 50,000 patients in mental hospitals across Canada, and that this was ample evidence of a grave problem. It was, Mr. Martin said, possible with the assistance of federal funds, to make a "direct attack on this disease that would progressively shift emphasis from custodial hospital care to modern diagnostic and preventative services". Dr. Pierre Gauthier, Liberal member from Portneuf, also expressed government sentiments that mental ailments were shown to follow an ascending and descending cycle. Dr. Gauthier added that "a campaign or crusade against mental illness was imperative in order to prevent the ascending cycle which was bound to reappear should we not have a well-planned policy".

The Dominion government bestowed its support for mental health education in a series of annual grants to the provinces for mental hygiene projects. It also provided start-up funds when the NCMH applied for assistance to re-form the agency into the CMHA and to "set up provincial divisions with the idea of
becoming a grass roots organization". The government suggested that a pilot division be established in one province. The province selected was Saskatchewan.

We discussed in this section three related factors which account for the transformation of the NCMH into the CMHA, a lay promotional body, and for its introduction into the province of Saskatchewan. The formation of GAP released the NCMH from its public professional promotion function and made this transformation 'possible and desirable'. Federal incentives nurtured this transformative expansion. The CCF, by 1950, had demonstrated the Province's commitment to what was considered the most progressive mental health program in Canada, if not North America. With electrification, better transport and education in and outside the province, mass media development had reached a stage by 1950, where it was practicable to begin public promotion through mass communication techniques. By 1950, the stage was set to directly promote mental health to the lay public, and complete the social transformation of insanity into mental illness.

4.3 The CMHA and the Campaign for Mental Health, 1950-1965

A well-known CMHA chronicler wrote in 1960 that,

[The NCMH] was not a grass roots organization. There were no provincial branches and there was no way for the ordinary citizen to become involved with the committee.

When in 1950 the NCMH transformed itself into a popular reform movement, the CMHA, this situation changed dramatically. By actively recruiting lay membership the CMHA concurrently publicized the issues surrounding mental health, and greatly broadened its base for supporting social policies and practices. In particular, by recruiting a significant lay public to the organization the NCMH greatly strengthened the claim that mental health was 'everyone's problem', not just the remote concern of professionals. Yet, while the formation of the CMHA entailed a new membership policy, psychiatrists remained its chief spokesmen and tacticians for over a decade.
Starting in 1950, the CMHA launched a massive mental health publicity campaign to attract members and direct public attention to the fact that mental health was a significant social policy issue. This is illustrated in Figure 2 which depicts the volume of mental health articles for major daily papers from 1920 to 1960. Figure 2 shows tremendously increased volume after 1948, and particularly after 1950. This activity reached a peak in 1953 and began to drop slightly after. In comparison to the pre-Second World War levels, which reached a peak in 1921, this clearly shows that mental health issues were being given much more media attention than since the construction of the Weyburn facility. In fact, they received more exposure than they ever had before. How did all this occur?

Source: Computed from newspaper articles listed in The Legislative Library Index, Index to the Western-Producer, and Index to the Regina Leader/Leader-Post. Included are all relevant articles from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix, the Western Producer, the Moose Jaw Times-Herald and the Prince Albert Herald.
4.3.1 Foundational Activities, 1950-55

Nineteen-fifty was a benchmark year in Saskatchewan for efforts to transform insanity into a medical issue. Not only did the CMHA arrive in the province, but that year the province passed major new legislation. This legislation stipulated that the certification of two physicians was, in most cases, sufficient for admittance to the province's mental hospitals. Legislatively, this Act marked the medicalization of psychiatry. Despite this, however, the popular support that was felt necessary for the treatment of the mentally ill in the community was as yet to be developed.

Between 1950 and the early 1960s, two periods in the development of popular support can be distinguished that roughly parallel the kind of strategy laid out in GAP's 1949 directive. First, the larger public had to be made much more aware of mental health issues. This occupied the CMHA's promotional activities until around 1955. Second, a long-range plan had to be worked out, and public support then mobilized for its fruition. That mobilization occupied the agency's efforts from 1955 into the early 1960s.

The introduction of the CMHA brought with it several submerged tensions. Most significantly, the policy of the NCMH had been that "National Committee is not placed in a position of publicly criticizing governments or having to take sides in a political controversy." As we shall see, as the CMHA moved into the realm of public mobilization which involved criticism of existing programs, these submerged tensions would surface. In the early 1950s though, there was a basic consensus among senior government officials, key mental service figures, and the CMHA (which the NCMH and GAP had long-laboured to engineer), concerning the need for public education.

Upon its arrival, the CMHA informed the government that its objective was to build, maintain, and repair mental health in homes, schools and communities in the province through a "fourfold program of research, training, education
and service". The Division began by establishing a board of directors made up of leading social, religious and business figures drawn from across the province. The most influential element in the executive was the Scientific Planning Committee, chaired by Dr. McKerracher and whose other long-term incumbents included such notable figures as Drs. H. Osmond and A. Hoffer. These psychiatrists and psychiatric researchers figured significantly in the direction of policy for the organization because of their "cognitive monopoly". It was they who largely defined the problems and the attendant regional solutions to mental illness.

Once an executive was established, the division's immediate goal was to "get as many citizens to become members [of the CMHA] as [there were] patients in mental hospitals--approximately 5,000" at the time. The CMHA proceeded in a number of ways to enlist this mass membership and generate lay public support. Three key methods used by the agency in this period were recruiting well-known social figures, staging hospital tours, and conducting attitude research.

Along with the already notable personages enlisted to its executive, the CMHA solicited and successfully attracted memberships from the entire provincial cabinet. It subsequently requested and received permission from Premier Douglas to publicize this fact. Premier Douglas, himself, joined the organization. The symbolic value in this enlistment was that it served as an example to ordinary citizens.

In concert, hospital tours were arranged in co-operation with the government, who helped smooth out logistical difficulties such as transportation. For the success of public promotion it was absolutely critical to convince the media, particularly newspapers (the dominant public media into the 1960s), that mental illness was an important public issue, a newsworthy item. It is significant to note in this respect that these tours, particularly when they were first organized, were staged primarily for members of the legislature, press editors and radio station managers. This was done "in order
that these prominent citizens of [the] province might see the problem of mental illness, firsthand...that they might develop a deeper understanding of what is being done in the province for the mentally ill. The rather transparent objective here was to create media sympathy for the plight of the mentally disordered in order to bring the media on-side in what was rapidly building into a full-blown promotional campaign. While showing key media figures that as much as possible was presently being done under less-than-optimal conditions in mental hospitals, it was emphasized that much more could be done if the public were made aware of these problems, in which case they would naturally support improved services. We can see the success of this strategy both from the increased volume of newspaper articles in the 1950s, as well as in their content.

Figure 3.
MENTAL HEALTH ARTICLE ACTIVITY IN ALL SASKATCHEWAN DAILY NEWSPAPERS BY PERIOD, 1895-1960

Source: Computed from newspaper articles listed in The Legislative Library Index, Index to the Western-Producer, and Index to the Regina Leader/Leader-Post. Included are all relevant articles from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix, the Western Producer, the Moose Jaw Times-Herald, and the Prince Albert Herald.
Figure 3 illustrates the increased activity in mental health articles in the province's daily papers by period from 1895 to 1960. Here we can see the tremendous swell of articles from 1951-55. In each year from 1950 through to 1958, the number of articles exceeded those of the entire 1895 to 1945 span.

Between 1950 and 1960, some 16 articles appeared in these newspapers that reported on institutional conditions immediately following tours by the media to provincial institutions. In addition, radio stations lent support by donating free broadcast time to mental health issues. Premier Douglas, himself, broadcast in the early 1950s, scripts prepared by the CMHA to mark the opening of mental health week, which became an annual event after it was first declared by the legislature in 1951.29

Tours, however, were not limited strictly to the media, but were a routine educational tool up into the mid-1960s, and were directed towards wider audiences too such as women's auxiliaries, service groups, union locals and others. In the early 1950s, these efforts were augmented by periodic public lectures by the CMHA and its supporters, as well as by regular public meetings within local branches as they became established throughout the province. By the early part of the 1950s the media were clearly entranced with mental health issues which were beginning to be disseminated to the lay public as never before. Before going on to show how the public was subjected to mental health issues in the newspaper media by examining some of the content of articles, a brief digression is necessary to trace the educational research activities of the CMHA.

From 1951 to 1953 the CMHA fielded, in part or whole, a series of educationally-oriented research projects. Two large-scale investigations, most pertinent to our examination, were the Cummings' study, later popularized under the title Closed Ranks,30 and the Melville Project31.
Jointly conducted under the auspices of the Department of Health and CMHA, and utilizing information supplied by the latter, the Cummings study was concerned with public acceptance of post-release patients. It was thought that public attitudes greatly affected adjustment so that public education was essential to the success of emerging community programs.

The study, conducted in 1951, compared the results of an educational program administered in a town of about 1200 to a matched control community where the program was not administered. Replicated in 1971\textsuperscript{32}, the conclusions of the study showed no appreciable difference in the effects of the educational program geared toward changing public attitudes of stigmatization of the diagnosed mentally ill. These were discouraging conclusions to those who felt that the general public could be easily converted to professional views within a relatively short space of time by rationally exposing the 'facts' surrounding mental illness. Not too surprisingly, the results of the study were not widely publicized at the time, presumably for fears of adverse effects on the overall educational campaign.

Rather than completely succumbing to the conclusions of the Cummings study, which tended to strike at its \textit{raison d'etre}, the CMHA immediately launched two more educational studies. \textit{The Hutterite Study} and \textit{The Melville Project} were hailed as "research projects in community education"\textsuperscript{33}. The former was requested by cabinet for the purposes of developing "harmonious intergroup relations"\textsuperscript{34}. More germane here, the latter was funded entirely by the CMHA for the purposes of developing future education projects\textsuperscript{35}.

This project was conducted completely in Melville between August of 1952 and September of 1953. Directed by Charles Kepner of the University of Michigan and Joseph Fortier of Stanford University, the study was modeled on conceptual learning and communications theory. The major purpose of the study was to determine "where, when, how, and to what extent" information flows through a community after its initial presentation\textsuperscript{36}. Three possible
methods of information dissemination were queried--(1) formal meetings and lectures to specific interest groups, (2) newspaper presentations published in the Melville Advance, and finally, (3) general public meetings announced through informal channels, and in local newspaper notices. The study concluded that public meetings and newspaper accounts were the most effective way to reach the widest possible audience.

The significance of the Melville Study, was that it confirmed to the CMHA the effectiveness of the practical methods of public education it was busy developing and using, while the Cummings research suggested that attitude change may take some time. Although the CMHA did not abandon any of the possible methods to expose mental health issues, the Melville experience highlighted the importance of the newspaper media in this effort. Indeed, to that date, 1953 was the most prolific year for mental health newspaper coverage ever.

Undaunted by the Cummings study, throughout the 1950s the CMHA continued to promote mental health 'in-the-field' through lectures and films at general public gatherings, CMHA branch and service club meetings, and at professional functions. Along with its own specialists, the CMHA invited guest speakers from various mental services, in and outside the province, to address these gatherings. As a regular practice, the CMHA began to submit yearly annual reports to the provincial legislature. In addition, the public was urged to join the CMHA through letter solicitation campaigns. Also, on numerous occasions the CMHA suggested to its members to contact their government representatives to approve measures for mental health.

Now, while similar techniques are today commonly used by advocacy groups of every description, at the time there were noticeably fewer promotional agencies in existence. Along with hospital tours for the press which elicited their sympathy, all this novel activity was exceptionally newsworthy. In this manner, the ideology of mental health was powerfully propelled into the public forum of the newsprint media. Some idea of the extent of its
representation can be gauged from examining the authorship and content of some of the articles representative of these periods.

Looking at newspapers articles up to 1960 that were available for content analysis (see Chapter 2, Tables 1A and 1B), Figure 4 illustrates which groups were the principle sources for these works. In other words, it shows whose ideas were being cited, either in terms of direct authorship or more often, indirectly in interviews and news stories. Here, "professionals" refers to all mental health groups, although chiefly psychiatrists, while "CMHA" refers to NCMH/CMHA spokespeople. "Other" includes all other groups, mostly government officials and journalists up to 1960, but also local councils, unions and service groups, and in a very few instances, private citizens.

Figure 4 generally illustrates the overwhelming preponderance of representation by professionals and the CMHA. It documents too, the increase in CMHA representation from 1951 onwards. Professionals were cited in 90% of all articles relating to mental disorder in the pre-Second War period. From 1945 to 1950 the combined total for professionals and the CMHA fell to about 70%. The reason for this was the publicity surrounding new mental services in which government spokesmen directly addressed the press. After 1950, the combined total of professional/CMHA-inspired articles rose to 80% and above. It should be added, that although the views of the other groups mentioned above received some exposure, in almost all cases, they were fully consistent with the precepts of mental health.
To an extent, all articles can be considered 'educational' in that they simply exposed mental health issues to the general public. But in view of our definition of ideological promotion, articles must be differentiated for analytical purposes. Thus, Figure 5 and Table 2, distinguish between articles which were essentially promotional and those which were not. Promotional articles, consistent with our definition of ideological promotion, were those in which the text of the article transparently attempted to incite its readers to some course of action or change of attitude to support action. Such articles typically highlighted some problem with existing mental health attitudes and/or services and suggested some "prescription" for change. "Prescriptive" articles are contrasted with "report" articles which straightforwardly recounted such things as the introduction of new services, rates of mental illness, the construction of new buildings, and so forth.
Figure 5 shows the overall growth in prescriptive articles compared to report articles after 1950. Table 2 illustrates which groups were respectively represented in each categories, and again, shows the preponderance of CMHA and professional representation, focused after 1950 especially in prescriptive articles (highlighted cells). As noted, before about the mid-1950's, the mental health coalition had no well-developed plan with which to pursue its objectives. From about 1956 to 1960, after the "Saskatchewan Plan" had been devised, although the total number of articles dropped somewhat, the portion of prescriptive articles was even higher than the previous period. Prescriptive articles up to about 1950 were generally concerned with bringing mental health to the public's attention. Hence, throughout the first half of the 1950s, prescriptive articles were centered around a limited number of basic themes shaped to meet this end.

Source: Computed from newspaper articles taken from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix and the Western Producer.
Table 2

BREAKDOWN OF REPORT-PRESCRIPTION ARTICLES BY GROUP, 1895-1960

<table>
<thead>
<tr>
<th>PERIOD</th>
<th>REPORT</th>
<th>PRES</th>
<th>REPORT</th>
<th>PRES</th>
<th>REPORT</th>
<th>PRES</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>to 1945</td>
<td>15</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>1946-50</td>
<td>27</td>
<td>5</td>
<td>1</td>
<td>10</td>
<td>14</td>
<td>5</td>
<td>62</td>
</tr>
<tr>
<td>1951-55</td>
<td>16</td>
<td>41</td>
<td>6</td>
<td>36</td>
<td>12</td>
<td>13</td>
<td>124</td>
</tr>
<tr>
<td>1956-60</td>
<td>7</td>
<td>42</td>
<td>2</td>
<td>38</td>
<td>4</td>
<td>10</td>
<td>103</td>
</tr>
</tbody>
</table>

Source: Computed from newspaper articles taken from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix and the Western Producer.

Although it must be emphasized that they were not confined strictly to this period, three inter-related, often overlapping themes formed the central focus of prescriptive articles in the initial stage of CMHA promotion. The first two were concerned with impressing on the lay public the scope and gravity of the problem of mental health, while the third suggested general directions for a solution and appealed for support.

Theme one attempted to establish a picture of the gravity of the problem of mental illness. Articles of this genre argued along the lines that mental illness was a scourge of modern life approaching epidemic proportions. Evidence for this contention was that mental illness took more hospital beds than any other single physical disease, yet far less research, prevention and treatment resources were devoted to it. Some examples are in order:
1) "Mental cases top T.B., cancer"\(^{38}\) stated that,

There are five patients in Saskatchewan's mental hospitals for every one in the province's tuberculosis sanatoria, two for every one in cancer clinics, and six for every person hospitalized with heart disease. (S)chizophrenia, one of the commonest mental disorders which is now confining to hospital 1,200 people in Saskatchewan--almost twice as many as T.B.--remains a mystery, shrouded by fear and ignorance, in the minds of most laymen. These facts--and many others--will be stressed by psychiatrists and mental health organizations alike when National Mental Health Week will be observed beginning Monday. In an interview, Dr. D.G. McKerracher stressed the need for public understanding of mental illness.

2) "Mentally ill top others"\(^{39}\) reported,

More hospital beds are occupied by mentally ill patients than by patients of all other illnesses combined the executive director of the Saskatchewan CMHA said Thursday night. In order to develop the work of education and research, a penny round-up is to be held in six Saskatchewan cities on May 10. Service clubs in each of the cities will sponsor the campaign.

3) "Our Top Health Problem"\(^{40}\) related after a tour of the Training School and Weyburn that,

Saskatchewan is doing it again! [In a] vigorous attack upon the top health problem in Canada, new techniques are being used. [But] [p]ublic education must not lag behind these achievements. For too long, the attitude of most of us toward mental health has been shrinking horror, and to aid in public understanding of the true nature of the disease, the Mental Health Association last fall organized groups of visitors to the mental hospitals. How can we help? As individuals our big job is to be more understanding, to acquire a new attitude towards mental illness.

4) "A Nickle for the Mind"\(^{41}\) emphasized,

To meet Canada's No. 1 health problems Canadians spend for research five cents per person per year--a nickle for the mind. In Canadian mental hospitals and institutions there are more than 60,000 patients, as many as there are in the other general and special hospitals combined. It's
poor economics, poor sense and poor humanity for Canadians to be spending only five cents per person per year into studying the "why" of mental illness. What is needed is aroused public opinion that will insist on money being spent to push the matter on.

The second theme, in many cases intertwined with the first and third, was aimed at establishing the universality and nature of the problem. That is, mental illness was a disease. As such, it was no respecter of class, age or gender. Anyone could fall victim to it, and it was everyone's problem. This accords with a fundamental characteristic of successful ideologies. Namely, they are built on universal themes intended to mobilize wide support across class and traditional lines. A few examples here are:

1) An editorial "Old attitudes must go" by Dr. McKerracher pointed out,

There are about 840,000 people in this province. All have mental health problems--some severe, others small. [There is] no sharp distinction between a person with one type of mental disorder and the individual immediately adjacent to him. The differences would be in degree rather than kind. Public attitude towards mental illness presents a hindrance to a good therapeutic program, almost as serious as [institutional] overcrowding. People cannot yet bring themselves to realize that mental illness is a sickness comparable in frequency and cause to any physical illness. The idea still persists that psychiatric disorder affects a very restricted group of the population. Facts prove the reverse. [A]n average of one person out of three or four families will at one time receive treatment in a mental hospital.

2) Another editorial "Disease without boundary" reported,

Every citizen in Saskatchewan can be a sniper from the sidelines against the enemy, mental illness, or he can be a front line fighter waging direct and daily battle. Inaction in this respect is unthinkable. Here is why [(cites statistics indicating the scope of the problem)]. The fight for mental health must not be left to a courageous few. It requires the concentration of forces, beginning first with the individual, with the home and then with a community and into a larger field without boundary. For mental illness recognizes the boundaries around no one.
3) Yet another editorial, "Mental Health" commented,

[W]e are beginning to discover that there is more mental illness abroad in the community than there has any right to be. Of the points the [Mental Health] association would like to make is that we should regard mental illness just as we would regard diabetes or tuberculosis. Mental illness is as likely to strike the individual as physical illness and there is no more "disgrace" attached to having one than the other. The association would also like to make people aware of the fact that mental illness can be treated and cured by the right methods just as physical illnesses are.

The third theme attempted to suggest some solutions to the problems raised. It was generally argued that since mental illness was a disease it could be conquered with the proper measures. This required public recognition and support for the provision of public sponsored research, education and an expansion and refinement of services. A few examples of this type of article are:

1) An editorial entitled "Research a Pressing Need" by Dr. McKerracher stated,

[T]he recognition of the extent of the problem, by professional groups will not alone lead to its solution. An informed public is essential. To gain the interest and participation of the public in a mental health program is the major goal of the Canadian Mental Health Association. Not only are funds needed to carry out research, training and public education programs, but also it is important to have the sympathetic understanding of the people of the province as a whole. [Becoming a member of the CMHA] will indicate how [people] may participate in the solution of Saskatchewan's mental health problems.

2) "Mental hospital picture not good" explained,

While the overall picture of mental hospitals in Canada is improving, nevertheless, it is not good. Sympathetic care alone is not enough to meet the problem, there has to be a change in the whole picture. We've got to switch to more active and vigorous treatment. If this is going to be achieved we need the co-operation of the public, Dr. McKerracher said. The public will have to stop closing its eyes towards mental institutions and show more interest
and the federal and provincial governments will have to provide better psychiatric facilities and more staff.

3) An article "Disgrace in Mental Illness on Community, not Patient" noted,

Herding together in wards often as many as 100 or 150 of the worst mental casualties, [Dr. Yonge said] is often much more of a hindrance than a help to those involved. The big problem [is] the indifferent mental health of the everyday citizen. No one enjoy[s] perfect mental health, but it should be striven for and that was the problem of the whole community. The fight for improved mental health...was the fight to improve human relations in all phases of life.

4) "Mental facilities necessary" reported,

Some progress has been made towards the rehabilitation of mentally ill patients in Saskatchewan hospitals, but real improvement will not be achieved until proper facilities and accommodations are provided Harold Lobb, executive director of the Saskatchewan division of the CMHA said in an interview. A person who is mentally ill is sick and needs hospital attention as well as a person who is hospitalized for physical ailments. The main problem of the association is to make the public understand the problem of mental health, so that people can help in the rehabilitation of patients.

This series of quotations were representative of the barrage of articles published in the first half of the 1950s. We can see in them an unmistakable continuity with the ideas of pre-World War II mental hygiene, except that now they were aimed directly at the lay public. Due to the extensive public relations work in the press and elsewhere of the province’s psychiatrists (especially Drs. McKerracher and Osmond), and the CMHA, the organization claimed a province-wide membership of 20,000 by 1956. During that time McKerracher, Osmond, Hoffer and other members of the Scientific Planning Committee articulated what had been diffuse, general solutions to mental illness into a long-range scheme, the "Saskatchewan Plan". Although the agency continued to publicize the basic themes of the early 1950s, from about 1955 until the early 1960s, the CMHA’s major promotional efforts were funnelled into mobilizing support for the Saskatchewan Plan.
4.3.2 Mobilization For the Saskatchewan Plan

The "Saskatchewan Plan" was developed by the Scientific Planning Committee in the early 1950s and was publicly unveiled in the CMHA's 1955 brief to the Saskatchewan legislature. Consistent with the World Health Organization Report Number 73, the plan reflected what was hailed as a revolutionary thesis at the time, that large, isolated hospitals caused 'institutional syndrome'. That is, the design and location of these institutions severed outside contact which made patients institutionally dependent and militated against community re-integration. In this respect, large, centralized mental hospitals were actually anti-therapeutic. Acclaimed to be the zenith in therapeutic thinking, but very similar to the Low Report of 1907, the plan called for a network of from six to seven small mental hospitals, with self-contained, cottage-style accommodation to be instituted at strategic locations throughout the province. The system was intended to serve as the focal point from which preventative and rehabilitative programs were to be operated.49

The government, however, was in a quandary over the plan. On the one hand, it had generally continued to expand services from 1944 onwards, so that by 1956 it had instituted a training school at Moose Jaw, additional psychiatric clinics at Saskatoon and Moose Jaw, and a number of mental health clinics.50 To run these services the government had hired teacher-psychologists, social workers, and set up an accredited program in psychiatry at the University of Saskatchewan.51 Regardless of long-term economic benefit, all of this, as Figure 1 showed, was costly in the short-run. Since the Saskatchewan Plan would entail considerable additional public expense, the government was hesitant to fully endorse it when it was first introduced. On the other hand, the government had long-championed the mental health cause, and did not want to disassociate itself from a highly progressive plan, especially in the face of the wide publicity mental health had received at the hands of the CMHA. Rather than rejecting the plan at this stage, the government implied its support for regional hospitals provided the CMHA and psychiatrists could show.52
(1) evidence that it was professionally sound, and (2) evidence that the people of Saskatchewan were interested in improving psychiatric facilities and would be willing to stand the cost of these.

Dr. McKerracher stated in this respect,

Since [late 1955] the plan developed in Saskatchewan has had careful consideration by most of the senior psychiatric administrators in this country. I have reported to you their general approval. Through the CMHA many groups...have had an opportunity to study the problem...[and] have already expressed their agreement with this view in statements to you.

What Dr. McKerracher was referring to was a letter writing campaign the CMHA had initiated among its membership and supporters in an effort to lobby the government to institute its plan. This was one of the measures that the CMHA was conducting to demonstrate and generate public support for the plan. Accompanying this, there was tremendous support for it voiced in the press, reflected in the fact that 1955 to 1960 shows the highest proportion of prescriptive articles to that date. There was displayed in these articles almost unanimous consent for the plan, an indication of the mental health coalition's promotional success, for example.

(1) An article entitled "Health group voices need of 4 new mental hospitals" reported.

Overcrowding is still the most serious problem of Saskatchewan's mental hospitals and four new hospitals, smaller hospitals of 300 beds each should be located at Prince Albert, Saskatoon, Yorkton, and Swift Current. The [CMHA] recommended that: The existing mental hospitals should be limited to 1000 beds or less. "This would be a move in the right direction, but because of population distribution, five more community hospitals would be needed to service the province adequately." "The new hospitals [should be] functionally sound, according to modern psychiatric architectural practice."

2) "Mental health problems discussed in CMHA brief" reported a CMHA interview.
Poor mental health is a contributing factor in many of our social problems. Saskatchewan was selected as the first province to demonstrate how citizens could be brought into partnership with scientists in the promotion of mental health. The idea of having smaller, adequately staffed hospitals is sponsored by the National Scientific Planning Committee [and] is fully endorsed by the Canadian Psychiatric Association. The success of the CMHA depends upon the support and active interest shown by all the people in the province.

3) "Mental hospital plan discussed", an interview with Dr. Lawson noted57.

The plan to locate the hospitals in districts to bring mental patients closer to home has not been approved by the government. When the government assumes the responsibility of caring for the mentally ill that responsibility includes looking after them in a humane way. The institutions at Weyburn and North Battleford are overcrowded, understaffed, and too distant from the homes of the patients making it difficult for relatives to maintain contact. [New hospitals would limit] the number of persons in each hospital ward [and] the use of small separate buildings gives flexibility to the planning and construction of the hospitals.

4) An editorial entitled "New View of Mental Hospitals" argued58,

Not long ago, most people wanted to remove themselves as much as possible from even thoughts about institutions for the mentally ill. The change that has come over public thinking can be measured by the fact that four cities—Saskatoon, Prince Albert, Yorkton, and Swift Current—are leaders in a competition of sorts, each seeking to be the site of the next mental hospital which the provincial government will build. If we want a hospital we must want to see the mentally ill properly cared for. This is as it should be. [D]octors are building support for smaller hospitals throughout the province. Now the college of Physicians and Surgeons has unanimously endorsed a resolution recommending 300 bed hospitals at Regina, Saskatoon, Prince Albert, Yorkton and Swift Current as soon as possible. Public opinion has come a long way when acceptance and support begin to blossom out in friendly and constructive local rivalries.

Despite what appeared to be widespread support, the government had not actually approved the scheme by 1958. The major obstacle from the government's perspective, was that its option to proceed with the plan hinged on its negotiations with its federal counterpart over the terms of the national hospital insurance plan. Both the CMHA and the provincial government
lobbied to have mental hospitals and services included in the national plan. But by 1958, Ottawa decided that psychiatric services in general hospitals would be eligible for cost-sharing, while other hospitals and institutions definitely would not. In effect, this meant that if regional hospitals were to be built and operated, it would be strictly at the province's expense. From that point, the Saskatchewan government's option was sealed in favour of general hospital psychiatry. That is to say, it favoured treatments for mental disorder in psychiatric and general wards of general hospitals, often by general practitioners, rather than by psychiatrically-trained personnel in separate mental hospitals.\(^59\).

The fact that the government did not immediately reject the Saskatchewan Plan after that outcome, attests to its perception of the degree of popular support for it that had been engineered under the CMHA. The government publicly had endorsed the plan "in principle" in 1956\(^60\), though it continued to stall on the plan's implementation through to 1959. This delay was met with prescriptive articles during that time that called for the plan's implementation, and that sometimes grew quite pointed in criticism of government inaction. For instance, the President of the Saskatchewan CMHA said,

> It is gratifying to note the Ontario government has seen fit to pass legislation whereby the mentally ill in that province will be treated on a community basis. We have urged the [Saskatchewan] government over the years to build at least one of these small units in Saskatchewan. To date nothing has been done. We feel is is regrettable that the Saskatchewan government has stepped aside and allowed Ontario to be the first province to put into effect the Saskatchewan Plan. We congratulate Ontario. This plan is bound to have world-wide acclaim.\(^61\)

About the only dissenting public voice around 1959 and 1960 was registered by the College of Physicians and Surgeons, who had reversed its earlier stance and claimed that there was "no public clamor for the plan" and instead called for more psychiatric beds in general hospitals. However, the government must have felt there was sufficient clamor for the plan, because in January of
1960, it reluctantly announced its intentions to proceed with a regional hospital at Yorkton62.

But, this placatory measure was about as far as the original plan ever proceeded. Indeed, the 1950s were the high point in the CMHA's role as a major player in provincial mental health policy based on its ability to mobilize public sentiment. This registered in a decline in the number of newspaper articles from 1960 to 1965, as shown in Figure 6. Although the proportion of prescriptive articles remained high after 1960, Figure 7 illustrates a downturn in the CMHA's percentage of these articles. After 1965, as we will see, CMHA representation exhibited a precipitous decline. What accounts for this decline in the CMHA's policy role starting after roughly 1960?

Figure 6.
PRESCRIPTIVE AND REPORT MENTAL HEALTH ARTICLES IN SASKATCHEWAN NEWSPAPERS BY PERIOD, 1895-1965

Source: Computed from newspaper articles taken from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix and the Western Producer.
4.3.3 The Demobilization of Public Support for the Saskatchewan Plan, 1960-65

As we have seen, in the early 1950s the CMHA successfully engineered the formation of a wide coalition based on an ideology of mental health and whose objectives were articulated into the Saskatchewan Plan by 1955. Major supporting elements in this coalition began to fade away over the latter half of the 1950s. The roots of the CMHA's decline as a major policy actor go back to the federal government's refusal to include mental hospitals in the national health plan. Although, as seen, due to its perception of popular support the Saskatchewan government stalled on its public position regarding the plan, in
actuality, it favoured general hospital psychiatry, because under this arrangement mental services were eligible for federal cost-sharing.

This situation eventually introduced a split within psychiatric thinking which undermined the coherence of mental health objectives as they had been articulated into the original Saskatchewan Plan. This spilt emerged when Dr. McKerracher, then teaching psychiatry at the University of Saskatchewan, subjected the effectiveness of general hospital treatment to a series of feasibility studies around 1959. For Dr. McKerracher, the results showed conclusively that

> with appropriate training for ward staff, consultation by psychiatrists and psychotropic drugs to control behavior, all categories of mental illness could effectively be treated by GPs [general practitioners] in a general hospital ward.

From that point on Dr. McKerracher and his associates publicly championed general hospital psychiatry. On the other side, Dr. Lawson, McKerracher's replacement as Director of Psychiatric Services, continued to support the original plan which, in contrast, stressed a chain of small, separate mental hospitals. Although it too favoured general hospital psychiatry, the government diplomatically attempted to steer a somewhat neutral course, and delayed the start of construction of the Yorkton facility for close to two years.

In the face of inaction, Dr. Lawson's criticism of the government grew increasingly heated. It reached its height in late 1961, when he denounced the government for wasting money on existing hospitals instead of proceeding with Yorkton, and hence of forfeiting the province's leadership in mental health. The irritated government responded by defending its policy, and it appears, by threatening to dismiss Dr. Lawson. From 1962 onwards, Lawson and other sympathizers of the plan in government employment were publicly silent on the issue.
Thus, a key sector of the psychiatric establishment that had articulated and supported the Saskatchewan Plan had been effectively neutralized. In 1961, the province's new Mental Health Act facilitated the trend toward general hospital psychiatry, by bringing mental hospital admission requirements in line with general hospital and community service operations. This legislation marked the complete medicalization of psychiatry since it "made the admission of psychiatric patients very much like the admission of any other patient to any hospital"[67]. What was to be a new leading group of psychiatrists in mental services helped engineer this reorganization by conducting research at Weyburn that showed that such policies could facilitate the early release of patients from mental hospitals[68].

Since psychiatrists were the key ideologists behind mental health, this split in psychiatric thinking registered in the CMHA in the shape of ideological uncertainty. Mental health articles from the early to mid-1960s betray a lack of coherent ideological leadership that was displayed formerly. Some articles supported the McKerracher option, some the mental hospital option, and yet others some felicitous combination of the two. The split also marked the start of the transfiguration of the Saskatchewan Plan, into what would emerge as community psychiatry in the late 1960s and early 1970s.

A more immediate effect was that the partial ideological vacuum created by the split struck at the very heart of the CMHA's promotional function that had been concentrated in the Saskatchewan Plan. This greatly weakened the CMHA's promotional momentum and its ability to mobilize public sentiment around a clearly articulated set of issues. And since its power as a policy actor hinged on its ability to publicly generate sentiment, by 1965 the CMHA had begun to forfeit its position in this respect. In short, by then it had forfeited its role as a vehicle for leading psychiatric interests, and thus lacked the clear ideological leadership necessary for its ability to effectively promote mental health to the public.
4.4 Chapter Conclusions

This chapter has described how mental health promotion to the lay public came to be introduced into Saskatchewan. Two questions were examined to this point: (1) whether costs alone always dictated policy and, (2) if and to what extent public promotion was a mitigating factor in mental health policy over this period. Cost factors were shown to be an extremely significant factor throughout the analysis. However, it was illustrated at several points that cost was overdetermined by other considerations, such as political ideology. Another example was that although the provincial government favoured general hospital psychiatry because of costs, it either could not or did not immediately reject the Saskatchewan Plan because of its perception of popular support.

The analysis also tended to support the conclusions from the last chapter which suggested that after the development of mass media, challenging groups challenge dominant ones by harnessing public sentiment to their objectives by ideological promotion through the media. In this process, psychiatrists were shown to be the leading ideologists behind a popularized mental health reform movement, the CMHA. With the achievement of medicalization, ensconced in legislation in 1961, the major objective of a new leading wing of psychiatrists had been met. By 1965, the CMHA had forfeited its role as a vehicle for promoting leading professional advancement under the rubric of the 'public good'. The next chapter examines how essential this leadership was in the viability of the organization as a promotional agency.
Notes to Chapter 4


4. Ibid.


10. Ibid.

11. GAP Report #3, Preface.

12. GAP Report #120.


15. Ibid., p. 2.


18. Ibid., p. 802.


20. Ibid.


22. Ibid., p. 179.


24. Letter to Health Minister T. Bentley from Dr. S. Laycock, January 1, 1951, SAB, Bentley Papers, R11, 14-84.

25. Ibid.

26. Ibid.


28. Letter to Health Minister T. Bentley from Dr. S. Laycock, October 12, 1951, SAB, Bentley Papers, R11, 14-84.


33. Annual Reports of the CMHA, op. cit., p. 106.

34. Ibid.

35. Laycock to Bentley, October 12,1951, op. cit.

36. Melville Project, op. cit.

37. As an example see a mail out entitled "Dear Reader" signed B. Gofine of the CMHA, SAB, Pamphlet File, "Mental Hygiene".


40. "Our Top Health Problem," Western Producer, Feb 8, 1953.


42. "Mental Health a Challenge to Everyone: Old Attitudes Must Go," Regina-Leader Post, April 28, 1951.


44. "Mental Health," Saskatoon Star-Phoenix, Feb 9, 1951.


49. Submission to the Government of Saskatchewan by the Canadian Mental Health Association, September, 1955, p. 4; also see, the accompanying survey prepared by the Scientific Planning Committee, pp. 10-13, in SAB, Douglas Papers, 33.5, 135 III, 14-26.

50. Saskatchewan Department of Public Health, Annual Reports, 1949 through 1956.

51. Ibid.

52. Letter from Dr. McKerracher to Minister Bentley, April 17, 1956, SAB Bentley Papers, R-11, 14-84.

53. Ibid.
54. Aside from letters received from individuals the government received: a petition signed by 30 clubs and organizations in the Prince Albert area; numerous endorsements from the Women's Division of the Sask Farmer's Union; a number of local Chambers-of-Commerce solicitations for regional hospitals in their respective areas, and; a petition from the Saskatoon Council of Women. See SAB Erb Papers, R-34, 172G.


60. "Regional Mental Hospital Backed by Cabinet," Saskatoon Star-Phoenix, Nov 20, 1956.


63. Dickinson op. cit., p. 256.


66. See Letter from Dr. F. Cowburn to Health Minister Erb, Feb 7, 1961, SAB, Erb Papers, R-34, 172A.


68. Reducing the Population of a Mental Hospital, by Drs. Grunberg, LaFave, Horbaczewski, Ross, and March, no date (sometime in 1964), SAB, Steuart Papers, R-94, 120 (9-1).
CHAPTER 5

The CMHA, Public Opinion, and The Emergence of Community Mental Health, 1965-1975

5.1 Introduction

As seen, starting in the early 1960s the CMHA's public promotional efforts in newspaper media began to show signs attenuation. As we will see, this proved to be a 'slippery-slope' for the agency, and after 1965, and particularly after 1968, it ceased to play a significant part in the direction of provincial policy. This chapter describes the events leading up to the CMHA's marked retreat from the field of provincial policy-making, which was directly reflected in the organization's promotional efforts in the newspaper media.

One major reason for this was the loss of ideological leadership which occurred with the successful medicalization of psychiatry that had been achieved under the provisions of the 1961 Mental Health Act. For the most part having achieved its objectives, the leading wing of psychiatrists abandoned the CMHA as its key promotional vehicle by the mid-1960s. Without this ideological leadership the CMHA's lay promotional activities withered. In the ensuing gap it was transformed into a government-dominated provider of community after-care services.

A key contributing factor in these events, co-extensively marked by the blossoming of community psychiatry, was a radical change in the province's political climate. The first section describes this factor as it relates to our analysis. Subsequent sections proceed to detail how this and other changes
accelerated the emergence of community psychiatry and how it affected the character of public promotion, especially the CMHA's role in it.

5.2 Mental Health Policy and Promotion from 1964 to 1971:

Government Initiatives and the Neutralization of the CMHA

In May of 1964 a Liberal Government assumed provincial power. It had a vastly different political philosophy than the former administration, one that emphasized free markets and minimal government in lieu of state distributional interventions in social reproduction¹. While in power it sought to act on its principles by shifting resources away from the network of provincially-sponsored programs that had been fostered under the CCF, in order to nourish private sector development. One of the new government's immediate targets was the rapidly growing area of medicine, and with it psychiatric services². Figure 8 clearly shows the trend in reduced government spending on psychiatric services initiated by this administration beginning in 1965.
Debt to income ratio was computed by dividing the annual provincial debt for each province by personal income for that year. A national mean was then computed and divided by the Saskatchewan figures for a Saskatchewan-National ratio. Source for these figures was Historical Statistics, StatsCan. Total expenditures were derived from Saskatchewan Dept. of Finance, Public Accounts, 1933-1975, and adjusted to 1975 dollars using the Consumer Price Index. "Expenditures" include: transport and committal of patients, maintenance and capital construction costs, and service costs.

Figure 8 also provides some evidence for an interpretation that the government acted out of ideological motives as much as it did on strictly cost considerations. More precisely, the significance of economic factors in policy are not invariant, but rather are partly determined through the policy process, and are typically related to such things as the political perspectives of key policy participants. As shown, although provincial debt to income, for the most part, had been steadily rising since the early 1950s, the former government nevertheless kept increasing expenditures on mental health services. Provincial debt relative to personal income reached its post-War
zenith at 1.61 times the national average with the introduction of medicare in 1961. However, by 1963 that ratio had dropped to 1.10, its lowest level since 1953. In 1964 the provincial economy appears to have been relatively buoyant, especially in comparison to the 1944-46 period during which the CCF had started to expand services. In contrast, in 1965 the new liberal government began an effort to rationalize mental services which threatened to lead to their contraction and de-professionalization. Many of the key mental health issues from about 1965 to 1970 were centered around government actions in this direction.

5.2.1 Government Initiatives, Public Opinion, and the CMHA, 1965-1968

The CMHA had played a major role in publicizing mental health issues up to the early 1960s. These efforts had helped pave the way for a smooth passage of the 1961 Mental Health Act and opened up mental health policy to the scrutiny of the lay public as never before. Events under the former administration had demonstrated that public mobilization under a relatively independent agency could easily pose certain political dangers, such as a loss of credibility following public criticism. So on the one hand, the CMHA had politicized mental health issues to a point where public opinion was significant. On the other hand, from the government's perspective, it was too hazardous to leave the direction of public opinion in the hands of the CMHA. That is to say, in 1965 the CMHA was well-organized and claimed a province-wide membership of 50,000. Thus, the CMHA at this point was a relatively independent, potentially powerful body. Moreover, it was an organization somewhat at odds with the new government concerning the role of the state in the provision of social services.

The government dealt with the situation by pre-empting the CMHA's role in the public forum. In other words, in what has been termed the 'domestication of mass belief', Saskatchewan, as did other Western governments, started to intervene directly in the management of public opinion. Henceforth,
"government did not simply surrender to mass opinion as they found it, rather they began an effort to reshape the character and political contents of their subject's views". Up to about 1968, the Saskatchewan government accomplished this through a series of public commissions designed, among other things, to show its concern for popular support of its controversial policies, thereby essentially circumventing the CMHA.

This resulted in a diminished promotional role for the agency as reflected in its newspaper article activity. Figure 9 graphically depicts the trends in mental health newspaper activity over the period 1945 to 1970. It shows an initial peak in 1953 with a gradual, but progressive decline in the raw volume hitting a new low in 1965, followed by a sudden upsurge that reached new peaks in 1966 and 1968. These peaks indicate a mass of publications surrounding the series of public inquires instituted by the government.

Figure 9.
TOTAL VOLUME OF MENTAL HEALTH ARTICLES IN SASKATCHEWAN DAILY NEWSPAPERS, 1945-1970

Source: Computed from newspaper articles listed in The Legislative Library Index, Index to the Western-Producer, and Index to the
Regina Leader/Leader-Post. Included are all relevant articles from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix, the Western Producer, the Moose Jaw Times-Herald and the Prince Albert Herald.

Figure 10 shows the trajectory of prescriptive article activity compared to report activity. As shown, this rose from 32.3% in 1946-50, to 72.6% in 1951-55, and with the attempt to mobilize the public for the Saskatchewan Plan, to a high of 87.4% in 1956-60. After that, prescriptive article activity dipped to 73.7% from 1961-65 and further declined to 63.2% from 1965-70.

Source: Computed from newspaper articles taken from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix and the Western Producer.
Figure 11 depicts the percentage of prescriptive articles by group from 1951 to 1970. Here, we can see that the professionals' share of articles remained relatively constant at about 45%-50%. The CMHA's share declined from about 40% to under 35% in 1961-65, and then plummeted just under 12% from 1966-70. At the same time, prescriptive articles by other groups rose substantially over the 1966-70 period.

In sum, Figures 10, 11, and 12 show an increased volume in mental health article newspaper publication, with a slight decrease in prescriptive activity. Prescriptive activity by other groups rose as dramatically as the CMHA's share declined. This indicates, as documented below, that the government's tactics for managing public opinion in order to legitimize its policies was to conduct a
series of public hearings in which the CMHA was merely one of a number of public interest groups.

Consistent with its pre-election position, the new Liberal government publicly expressed its support for the much acclaimed Saskatchewan Plan at the opening of Yorkton's regional hospital in the fall of 1964⁴. Yet, as one author notes⁵, the government's 'hidden agenda' was initially to reduce the costs of mental services, particularly, expensive in-patient care,

[P]rior to 1968 the Liberals had no specific plan for psychiatric in-patient facilities. Cost reduction was the only guiding principle.

The government immediately and unilaterally applied its cost-cutting principle to most of its social programs and tried to rationalize mental services in two major ways: (1) to reduce its size by cutting its number of positions and personnel, and (2) to develop policies in order to depopulate mental hospitals⁶ which completely drained Weyburn of its patients by 1971.

The techniques necessary for the depopulation of mental hospitals had been under development as early as 1959. That year, a pilot project at Swift Current had demonstrated that "many severely mentally ill patients could be cared for in the community if adequate follow-up and community services could be provided thus reducing the need and/or the length of hospitalization"⁷. Coupled with the development of drugs and the extensive use of psychiatric teams, the effectiveness of such methods were again proved at Weyburn in 1963-4, and shortly after, at Yorkton. As a result, Yorkton for instance, saw its bed capacity cut from 148 to 60 by 1966⁸.

Along with these techniques, the legislative warrant for depopulation of mental hospitals had been provided under the terms of the 1961 Mental Health Act. This legislation and its 1963 amendment spelt out the framework for the establishment of a program of "community resettlement" for hospital patients. The Community Resettlement Program involved three types of resettlement,
which in all cases amounted to significant cost savings over housing patients in mental hospitals.9

Although a policy of depopulation had been pursued to some extent by the former government, supposedly to improve staff to patient ratios10, the Liberals were able to use these legislative provisions to rid provincially funded hospitals of long-term patients by tightening admissions, and accelerating the rate of discharge, and resettling patients 'in the community'.

The new techniques were used in the government's resettlement policy which was most vigorously applied at Weyburn. Hence, by 1966 that institution reduced its in-patient population to 425 from a 1962 total of 1,478. This distinguished it as showing "a sharper decline than any other hospital in North America or the United Kingdom"11. However, the government's cost-reduction policies did not proceed unchallenged. They resulted in a series of commissions implemented by the government in response to public criticisms of its policies. In each of these cases the CMHA played a relatively minor role, and was only one of a number of groups included to represent public opinion. The first of these was the institution of an Ad Hoc Committee in 1966.

5.2.2 The Ad Hoc Committee on Community Resettlement

The rapid depopulation of Weyburn from 1964 to 1966 was accompanied with an increasing number of complaints from three basic sources: from opposition members in the legislature, from the CMHA, but most vociferously, from the Weyburn district led by its city council12. These complaints generally centered around concerns obviated by the depopulation of Weyburn—public safety in view of the pre-mature release of patients, allegations that patients were being placed in sub-standard accommodation, and anxiety concerning the economic effects of a possible closure of the mental hospital. To diffuse the situation the government appointed an eight member Ad Hoc Committee,
mandated in "the public interest", to assess the resettlement program to make recommendations for possible changes.\textsuperscript{13}

However, the committee's findings were in no way binding on the resettlement policy. In any event, only two members of the committee were medically-trained, and so it considered itself a "lay body" with "limited qualifications" and therefore not "competent to judge a professional program."\textsuperscript{14} In the end, the government outmaneuvered the committee by declaring that patient release was fundamentally a therapeutic matter, outside the scope of the committee's expertise.\textsuperscript{15} This tactic allowed the government to temporarily dissipate opposition by publicly airing the matter, while legitimating the continuation of its depopulation policy.

During this entire affair the CMHA remained in the shadows of the resistance. It was true that the agency had quietly lodged complaints with the government that its "after-care program and the accommodation for patients was being made on a 'crash' basis that called for an independent study" and had presented a brief at the Ad Hoc hearings. But there was literally no attempt made by the agency to mobilize the public in a concerted action against depopulation. In 1965, for instance, the CMHA was not cited in a single prescriptive newspaper article. And while the number of articles surged to a total of 49 in 1966, only four originated from the CMHA. Of these, not one made any mention of the Weyburn situation. In contrast to its earlier, highly vocal public role, and given that the agency then had a membership of around 50,000, it seems odd at first glance that no protest campaign was attempted.

There were two major reasons for this. One was that often tense relations between the CMHA and the government under the CCF deteriorated to a icy gap under the Liberals.\textsuperscript{16} Two was that the CMHA had served to mobilize support around the original Saskatchewan Plan in concert with the then leading psychiatrist interests, who were the agency's leading ideologists and who had articulated that scheme. After 1962, however, the scheme, as originally conceived was moribund, so that the CMHA had temporarily outlived its
usefulness as a mobilizing agency for the new policy directions being supported by a new wave of professional interests that emerged in the interim. Added to this was the fact that the CMHA had been quite successful in promoting policies which had alleviated some of the worst mental hospital conditions which had been the main target of their criticisms in the 1950s. As a result, many of the key issues which had previously attracted public support had effectively been dissolved by the mid-1960s. In short, by the mid-1960s the mental health coalition formed under the CMHA in the 1950s and whose objectives been concentrated into the original Saskatchewan Plan, had effectively disintegrated. In this context, the CMHA was sheared of its former political alliances and its ideological leadership in the province. Given the government's harsh treatment of its mental health service, the CMHA was in too vulnerable a position to attempt public mobilization. Besides, the desertion of the agency by leading psychiatric interests left the organization in a state of strategic uncertainty. These factors were generally reflected in the marked diminution of the organization's representation in newspaper coverage after 1964.

Although the Ad Hoc Committee had endorsed the original Saskatchewan Plan, senior provincial psychiatrists proposed to the government an alternative course of action more consistent with its principles. In the spring of 1966, leading psychiatrists submitted an internal document for the purpose of assisting "the government to formulate a policy as to the redistribution of psychiatric services [and] the future of mental hospitals by 1970-1971." The document stated that there were strong financial reasons why mental hospitals should be abandoned for psychiatric units in general hospitals, reinforced by community psychiatric services. The major reason was that mental hospital costs were paid entirely by the province while services in general hospitals and community services were eligible under the federal cost-sharing arrangement.

This was the silent obituary of the original Saskatchewan Plan of regional mental hospitals, and a prophecy of the course of action the government would take. A key facilitating factor in the government's ability to proceed in
this direction was that the leading wing of psychiatrists was now in agreement that depopulation was the preferred course of action. Thus, from 1966 on, the Saskatchewan Plan was successively re-defined to the public as "community psychiatry"--maintaining patients in the community through general hospital psychiatry supplemented by various community programs. What had begun as a CMHA centered critique of large mental hospitals in favour of small, regional ones, had given way to the notion of overthrowing mental hospitals altogether, as the main site for treating mental disorders. As the terms of debate over the Saskatchewan Plan began to noticeably shift after 1966, CMHA demands for regional hospitals were dropped, and the agency fell back to concentrate on the problems of insufficient community services and inadequate staffing.

After the Ad Hoc Committee's report, the government continued to depopulate the province's hospitals, especially Weyburn. At the same time it greatly expanded the number of after-care facilities, mostly in approved homes which grew from 0 in 1963, to 496 by 1971 although following the committee's recommendations, stipends to home operators were increased while minimum physical restrictions were placed on their operations. However, despite this, the criticisms of depopulation and understaffing did not completely subside, and an incident in 1967 threatened to escalate into a political crisis. As we will see in the next section, this incident ushered in another government commission.

5.2.3 The Frazier Commission

On August 15, 1967, just shortly after he was released from North Battleford Hospital, Victor Hoffman was charged with killing several members of the Peterson family at their home near Shell Lake. This was the second capital offense lodged against a mental patient in the province within the previous two years. Shell Lake, in particular, triggered heated controversy over public safety and depopulation. This was further fanned by an incident in Regina in which a released patient was apprehended for discharging a firearm in
public. Responding to the event, a public health official reported to the press that "for the protection of the community, each case should be carefully reviewed before discharge"23.

From the government's perspective, such criticism presented a politically explosive atmosphere. For example, it deliberated that Hoffman's trial itself would again raise criticism and "if found guilty [would] give rise to further concern about the program"24. Furthermore, it was still concerned about lingering criticisms following the Ad Hoc report:

Under the circumstances, it is not only important that the government be satisfied that these services are satisfactory, but to manifestly demonstrate this. For this reason I am suggesting [to the Health Minister] a one-man committee or commission be established who would be an eminent psychiatrist outside of and unconnected with this jurisdiction, to carry out an audit of our program.25

At the end of September in 1967, Health Minister Grant announced such a commission, stating that "criticisms are capable of shaking public confidence" in the program. Although "the Ad Hoc Committee upheld the concepts of psychiatric care in Saskatchewan", Grant said, "as an additional measure we are asking one of the leading psychiatrists in North America to review our program and to make any comments he desires"26. Grant explained that the investigation was to be conducted by Dr. Shervet Frazier, an eminent psychiatrist from Baylor University, at Houston, Texas, who expected a report to be completed by the new year.

What is interesting about the Frazier Commission from our perspective is the fact that, as was the case with the Ad Hoc Committee, the government actively solicited public opinion for it27. Hence, assisted by an associate, Dr. Podkorny, Dr. Frazier visited provincial facilities, held private, and public meetings, and received written and oral briefs from roughly October to December of 1967. Here, the local chapters of the CMHA submitted two of 23 written presentations, while the provincial division delivered one of the 17 oral briefs28. Table 3
provides a breakdown of which groups were involved in public representations.

As can be seen, the CMHA was only one of a growing number of groups and individuals with an interest in mental health. This 'pluralization of public interest' was partly a consequence of a more complex psychiatric division of labour that began to emerge with community psychiatry in which additional occupational groups such as social workers and psychologists were hired in sufficient numbers to make independent representations of their specific interests. But also it indicates the rise of other advocacy groups, such as Schizophrenics Anonymous, Society for Children with Emotional Problems, and others, each bringing their own particular perspective on the problems of mental disorder. Many of these groups were closely affiliated with, in fact in some cases, originally spawned by the CMHA. Somewhat ironically, as the CMHA would become more dependent on government funding, it was in competition for public resources with the other agencies it helped establish. The major point is that the lay promotional monopoly the CMHA had enjoyed up until the 1960s had fragmented, especially because the agency was no longer a key vehicle through which a now more complex spectrum of occupational interests were being represented.

Table 3

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<th>Written Briefs</th>
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</tbody>
</table>
The 'pluralization of public opinion' was reflected not only in presentations to the Frazier Commission, but also in the number of groups cited in newspaper
articles. It accounts for the general trend of article publication in the 1966-70 period as was shown in Figure 11. Here, while professional representation declined only slightly, the CMHA's share dropped significantly to under 12%. At the same time, the share of articles by other groups (including commissions) jumped to over 40%. Thus, after 1965, the non-professional share of articles was much more evenly distributed across groups in addition to the CMHA, such as government representatives, commissions, other advocacy groups and legislative members-in-opposition.

The government's direct appeal to a wide spectrum of public opinion, at one level, appears to have been highly democratic. However, one effect of this was that it tended to undermine the potential for coalition formation which therefore eased management of the impact of public opinion on the direction of policy. Since professional groups, partly by virtue of their structural location, were the best organized, most articulate sets of interests, the government was forced to take cognizance of their demands. While there were of course differences between these groups, they were in general agreement on the issue of the staff depletion of mental services. This was reflected in Frazier's recommendations, a major thrust of which called for increased pay and benefits to attract personnel to the service.

Overall, Frazier attempted to sort out the confusion surrounding the Saskatchewan Plan and called for its eclectic reinstatement "to permit an orderly development of a consistent and integrated system". He therefore recommended the implementation of a rural component "modelled on Yorkton Center", along with an urban component "centered in psychiatric units of general hospitals", supported by community facilities. Given the province's growing urban population, this recommendation was clearly in the direction of community psychiatry. This would require the further expansion of community aftercare services. By 1967 the CMHA, shorn of its professional and governmental connections, was vulnerable to conversion into a government-dominated supplier of these kinds of services. This is exactly what happened in the events surrounding the government's decision to proceed with the complete depopulation and closure of Weyburn.
In 1968 the federal government implemented a medical care insurance program which allowed for equal sharing of all (non-mental hospital) medical costs with the provinces. Given this incentive, just shortly after the Frazier Report was tabled in the legislature, the Saskatchewan government decided on the complete privatization of psychiatric in-patient services, and a further cheapening of out-patient community services31. The government took this decision despite the fact that the Frazier commission had strongly recommended that "no heroic efforts be made to reduce the in-patient population of North Battleford, [and] easing off discharge from Weyburn"32. So in order to legitimize its actions and overcome possible opposition, the government commissioned yet another study, the Prefontaine report. The government felt that the use of an outside consultant would allow it to deflect criticism to that source, and at the same time to gauge response before it publicly committed to the phase-out33. The Prefontaine report was able to effectively support the government's proposed actions by pointing out that not only were there therapeutic reasons for closing Weyburn--i.e.,"that locking people up in mental hospitals was no longer in keeping with progressive principles of modern psychiatry"--but also, that mental hospitals were a "misallocation of resources" because community programs were more cost effective. In this regard, the Prefontaine report stated that 84% of the mental health budget was spent on hospitals which provided only custodial care to 2800 patients, while community services on 16% of the budget provided preventative and educational services to 5000 people34.

The strongest opposition came, again not from the CMHA, but from the Weyburn district, especially business interests fearful of the economic repercussions of the closure. To help quell resistance, the government conceded that the facilities would be converted to "an agricultural college or nursing home"35. This neutralized opposition sufficiently that shortly after, the town "council and the people of Weyburn accepted that the hospital [would] be closed"36.
These events attest, once again, to the significance that public opinion had assumed by this time, and the government's concern to manage it. Although the CMHA was not entirely opposed to phasing out mental hospitals, since 1965 it had been less than enthusiastic about the pace of depopulation in conjunction with the adequacy of aftercare services. Yet, again, the organization abstained from any real efforts to mount opposition to the manner in which the policy was implemented. The agency's caution in this respect, as noted, was due, in part, to the government's somewhat "hostile attitude" towards it. However, now that the government wished to depopulate Weyburn, and thus to further expand community services, it began to eye the CMHA as a convenient way to expand services at minimal expense^3^7.

The Prefontaine Report, which mutually buttressed cost considerations with therapeutic arguments, provided the government with the ammunition it needed to proceed with its version of the Saskatchewan plan. The CMHA basically agreed with the closure of Weyburn provided that sufficient post-release and preventative services were in place. In the government's desire to depopulate mental hospitals, and expand community services, and given the CMHA's position of vulnerability, events were ripe for a government 'takeover' of the agency. The next section describes how in 1968 the CMHA was converted from a relatively autonomous interest group, which had at one time been a major policy player, into an essentially government dominated supplier of support services. This would be the organization's major role into the 1970s. The result was a continuation of the trend toward the pluralization of public opinion, and with it, the fractionalization of attempts at mobilizing lay support in mental health issues.
5.2.4 The Formal Transformation of the CMHA into a Service Provider

In the 1950s the CMHA had viewed its role as largely promotional, although since 1955 the agency had run a limited number of rehabilitation services for ex-patients, notably "White-Cross" drop-in centers. Its successful fund-raising drives and large membership contributions meant that, apart from occasional government funding, the organization was basically self-sufficient until about the mid-1960s. Evidently, its financial requirements outstripped its resources so that by the late 1960s and early 1970s, it was operating in a deficit position. The demand on White Cross centres was particularly heavy because of depopulation, and these facilities constituted a major portion of the organization's expenses.

Consequently, the CMHA began to depend much more on government to meet its financial requirements. Starting in 1965, the agency began to apply annually to the government for funds to assist in running its White Cross program. In 1967, for instance, the president of the CMHA appealed to the province's Health Minister, that the agency had no sources of help except the government, and "without assistance" would be "forced to cut [its] workshops". The government responded meagerly from 1966 to 1968. In 1969, however, the government started to provide more generous allowances, but only after the CMHA complied with its requirement to reorganize its operations. This occurred in 1968 as part of the government's efforts to expand community services and it placed the government in indirect control over the agency through its board of directors.

The precise events surrounding this 'takeover' are documented in detail elsewhere, but briefly, they involved firing the agency's executive director to purge any possible resistance to the government's plan to reorganize the CMHA into a purely service agency. The government offered "substantial grants [for] White Cross programs" to the CMHA's board of directors "providing a separate administrative organization was established". The executive
complied by voluntarily re-organizing its operations in line with the
government's recommendations and dismissing its Executive Director. To avoid
public controversy the entire issue was buried. For example, the government
refused an independent public inquiry\textsuperscript{44}, and there was literally no mention
of the incident in any newspaper coverage.

Although the CMHA's function as a promotional agency had been on a decline
since the early 1960s, this 'takeover' formally marked the exit of the CMHA as a
major policy actor into the 1970s. From 1968 into the 1970s it attempted to
promote, alongside a growing number of advocacy groups, and along with the
mental health professions, a general concern for mental health issues. But,
unlike the 1950s, neither the CMHA, nor any other single group emerged as an
umbrella organization through which mental health promotion was co­
ordinated into a focused scheme.

Figure 12 shows all located newspaper articles by group from 1951 to 1975. Here, "others" refers to groups such as government spokespeople, unions,
commissions, opposition members, lawyers/courts, and a growing number of
advocacy groups such as Schizophrenics Anonymous, the John Howard
Society, the Church of Scientology, and others. Similarly, a more complex
structure of mental health occupations resulted in various occupations
addressing the press somewhat independently. We can see here that the
CMHA's share of articles dropped to under ten percent of all prescriptive and
report articles for the 1966 to 1970 period. It remained at about the same level
from 1971 to 1975. Compared to the previous period, the professions share
dropped slightly over 1970 to 1975, while the other group's share increased
about the same amount.
Figure 12.
PORTION OF PRESCRIPTIVE MENTAL HEALTH NEWSPAPER ARTICLES BY GROUP FOR SELECT PERIODS, 1951-1975

Source: Computed from newspaper articles taken from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix and the Western Producer.

Table 4 gives a somewhat finer breakdown of prescriptive articles from the level of peak activity in the 1956 to 1960 period to 1971-1975. The bracketed figures in the "TOTALS" column show a high point of prescriptive activity in the 1956 to 1960 period with a gradual decline until 1970-75. We can see here that although activity began to pick up, nonetheless, there was a further slight decline in the CMHA's portion. The agency was matched or exceeded in prescriptive article activity by professionals, local councils/ions, other advocacy groups, and a residual category, "all others". In short, outside professions, whose promotional activity was quite occupationally specific, representations by other groups were much more evenly distributed than they had been, especially during the 1950s.
Table 4
Prescriptive Article by Group, and Period
1956-1975

<table>
<thead>
<tr>
<th>GROUP</th>
<th>1956-60</th>
<th>1961-65</th>
<th>1966-70</th>
<th>1971-75</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals</td>
<td>42 (46.6)</td>
<td>25 (55.6)</td>
<td>38 (55.2)</td>
<td>15 (32.5)</td>
</tr>
<tr>
<td>CMHA</td>
<td>38 (42.2)</td>
<td>15 (33.3)</td>
<td>10 (21.9)</td>
<td>4 (10.5)</td>
</tr>
<tr>
<td>Government</td>
<td>3 (3.3)</td>
<td>0 (---)</td>
<td>2 (2.3)</td>
<td>1 (2.6)</td>
</tr>
<tr>
<td>Local Council, Union</td>
<td>0 (---)</td>
<td>3 (6.7)</td>
<td>8 (9.5)</td>
<td>4 (10.5)</td>
</tr>
<tr>
<td>Advocacy Group</td>
<td>0 (---)</td>
<td>0 (---)</td>
<td>4 (4.6)</td>
<td>4 (10.5)</td>
</tr>
<tr>
<td>Commission</td>
<td>0 (---)</td>
<td>0 (---)</td>
<td>14 (16.7)</td>
<td>1 (2.6)</td>
</tr>
<tr>
<td>Journalist</td>
<td>4 (4.4)</td>
<td>1 (2.2)</td>
<td>1 (1.2)</td>
<td>1 (2.6)</td>
</tr>
<tr>
<td>Opposition Members</td>
<td>0 (---)</td>
<td>0 (---)</td>
<td>4 (4.6)</td>
<td>1 (2.6)</td>
</tr>
<tr>
<td>All Others</td>
<td>3 (3.3)</td>
<td>1 (2.2)</td>
<td>3 (3.6)</td>
<td>7 (18.4)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>90 (87.4)</td>
<td>45 (73.7)</td>
<td>84 (63.2)</td>
<td>38 (74.5)</td>
</tr>
</tbody>
</table>

Source: Computed from newspaper articles taken from the Regina Leader/Leader-Post, the Saskatoon Star-Phoenix and the Western Producer.
5.3 The CMHA, Services, and Promotion after 1968

The CMHA's conversion into mainly a provider of after-care services relegated the organization to a position of greater dependence on government. Since effective public promotion entailed the ability to critically influence policy, and the agency could ill-afford to 'bite the hand that fed it', the CMHA was placed outside the field of major players in provincial policy and less of a shaper of public opinion. Yet, these events did not spell the extinction of the CMHA. On the contrary, serving this function helped to ensure its viability, albeit in a relatively more muzzled fashion.

On the other hand, this did not automatically put an end to the agency's financial woes. Under the Liberals, and the New Democratic Party (NDP) after 1971, mental health services were dramatically re-shaped over the late 1960s and 1970s. What emerged was the "bifurcation" of psychiatric services into two basic sectors. On one side, there developed a "private sector", dominated by "general practitioners and specialist psychiatrists", operating on a fee-for-service basis, which treats the majority of people seeking professional services. This is supplemented, on the other side, by a "public sector" operating on a decentralized basis and "offering specialist care in both in-patient and out-patient context", (including community services)\(^45\).

Although public psychiatric service spending, notably in mental hospitals, began to be cut back in 1965, (see Figure 8, this chapter), Figure 13 shows that service spending was not cut absolutely, but rather was shifted. Here, we can see first of all an upward trend of spending in general hospital psychiatry as shown by increases to Medical Care Insurance Commission (MCIC) and Saskatchewan Hospital Services Plan (SHSP) expenditures. Coupled with this,
we can see massive increases in private and public spending on special care homes--facilities which provide accommodation for a significant group of elderly, and 'special' populations that were formerly warehoused in mental hospitals. Since these kinds of services were eligible for federal cost sharing, the provincial government partly shifted costs from the province to Ottawa. Bearing in mind that these figures are estimates, and assuming that spending translated into an expansion of services, this suggests that Scull's assertions that services are non-existent are questionable.

**Figure 13.**
**ESTIMATED TOTAL EXPENDITURES FOR OTHER MENTAL SERVICES**

Source: Based on figures from MCIC and SHSP Annual Reports. Calculations involved multiplying the number of patient days or service episodes by the average cost of services. Special Care Home figures were estimated from Public Health and Welfare, *National Health and Welfare Expenditures, 1970-82*, using a conservative estimate of 5% of national figures. All figures are in 1975 dollars.

Although mental hospitals were depopulated, and community services expanded, a larger number of professional and advocacy groups vied for public funding. Thus, into the 1970s, the CMHA's energies were largely
absorbed in an ongoing struggle to obtain a share of funding adequate to meet its needs as a service provider. The situation did not immediately improve with the 1971 election of the NDP. That government completed Weyburn's depopulation and converted it into a psychiatric unit, and also greatly reduced North Battleford's population. Despite this, the NDP did not increase their funding to the CMHA.

Consequently, the agency had difficulty maintaining its operations, let alone expanding them. In 1972, the matter finally became concentrated into the issue of block funding versus reimbursement on a fee-per-patient basis. While fee-for-patient funding would have been to the CMHA's advantage, it would have resulted in higher public costs in providing services. To overcome the government's intransigence, the CMHA resorted to a tactic it had used in the 1950s. It directed its membership to launch a letter writing campaign to lobby the government in its favor. Unlike the 1950s, however, there was no accompanying newspaper coverage. In the absence of wider public mobilization, the campaign was less than successful because additional funding was largely at the government's discretion. This incident was indicative of the relations between government and the CMHA for the latter 1960s and much of the 1970s. Over that time the government was in a highly dominant position to limit the CMHA's (and other agency's) influence on policy through the mechanism of funding control.

Dominated by the government, shorn of its most vital ideological leadership, the CMHA languished as a promotional agency through the early 1970s. While systematic evidence was not available for a reliable analysis, there is some indication that perhaps it has enjoyed a resurrection in this role by the later 1970s. For from 1975 to 1980 the CMHA's share of prescriptive newspaper articles rose from about 10.5% to 27.3%. If accurate, then the available documentary evidence from the early to mid-1970s indicates it was because the CMHA was adopted by a rising set of occupational interests.
As seen, the CMHA was abandoned by dominant psychiatric interests in the 1960s, which saw the rise of community psychiatry and the bifurcation of psychiatric services. Since that time, community service occupations such as psychologists, social workers, and other mental health workers have been hired in increasing numbers for community services in mental health’s public sector. The general therapeutic orientation of these occupations is based on a non-medical model which includes various psychotherapies aimed at dealing with "problems in living". These occupations have apparently mounted a challenge to psychiatry's dominance of mental health which started to de-medicalize community psychiatry into the 1980s and threatens to further this direction into the 1990s.

The links between the CMHA and community service occupations began to be forged in the early 1970s, when George Rohn was appointed as General Director of the CMHA in 1972. Unlike the previous directors of the organization who were psychiatrists, Rohn held a Master's degree in Social Work, and "was the first appointment of a non-medical professional head". Along with the subsequent expansion of community services, the mid-1970s to the early 1980s witnessed the emergence of "patients right's" and "self-help groups" which, for the most part, were organized by community occupations as a way to assist patients in dealing with their 'problems in living'. The CMHA appeared to take an active role in promoting this theme, for example, by setting up a task force in 1981. Its objective in this was to "look at the state of mental health services and make recommendations for future programs". The task force publicized that there was a "crisis situation" due to government cutbacks, and called for public education and information to remedy the situation, otherwise the province was in "imminent danger of seeing the collapse of community psychiatry".

In 1981 the agency published fully 20% of all newspaper articles, its largest share since 1961-65. Among its major themes were the need for a new mental health act ensconcing patients rights and the need for more community services and personnel. The CMHA, it seems, was again on the move to champion mental health to the province's public.
Notes to Chapter 5


6. Ibid., p. 278.


10. Letter from Health Minister A. Blakeney to Dr. T. Cowburn, November 15, 1963, p. 4.

11. Ad Hoc Committee document, op. cit., p. 5.


16. A confidential memo from Deputy Minister Clarkson to Health Minister Grant stated that "for some years,...the department has taken a somewhat hostile attitude towards the Association", SAB, 203B "Grant Papers".

17. Ad Hoc document, op. cit., p. 11.


24. Memo Clarkson to Health Minister Grant, August 29, 1967, SAB, R-45, 75(9-14) "Grant Papers", p. 3, added emphasis.

25. Ibid., added emphasis.


28. Ibid., pp. 55-56.

29. Ibid., p. 36.

30. Ibid.


34. Ibid., p. 2.


36. Ibid.

37. See "Proposed Re-organization For the Saskatchewan Division, CMHA, February 12, 1968 and, Letter from Deputy Minister Clarkson to Minister Grant, March 29, 1968. Clarkson stated,"it would be imprudent to take a stand [with the CMHA] since we very much desire their assistance and support in developing White Cross Centers across the province", SAB, 24-C-4 (203B) "Grant Papers".
38. Excerpts from the CMHA Reporter, SAB, Bentley Papers, R-11, (14-84), no date, pp. 5-6.


41. Letter Riddell to Grant, November 17, 1967, SAB, R-45, 90(9-10), "Grant Papers".

42. Dickinson, op. cit., pp. 334-337.

43. Letter from I. Kahan to C. Smith, July 2, 1968, SAB, (24-C-4) 203B "Grant Papers".

44. Ibid.


46. "Minutes of a Meeting with the CMHA", September 22, 1972, SAB, R-82-549, "Grant Papers" II 61A, p. 1.

47. Memo, G. Townsend to M.B. Derrick, July 19, 1972, SAB, R-82-549, "Grant Papers", II 6A.

48. September-October 1972, SAB, R-82-549, V.61B, CMHA.


50. CMHA Press Release, February 23, 1972, SAB, R-82-549, "Grant Papers", CMHA.

CHAPTER 6

Summary and Conclusions

6.1 Introduction

This work has been addressed to two major, and in our view, related questions: the issue of cost factors, and the significance and role of public opinion in policy. One of the main objections to some of the revisionist accounts of recent mental health policy raised in the opening chapters was that they tended to reify social policy. Thus, we saw that Scull's and Ralph's accounts placed too much emphasis on an abstract notion of economic pressures which presented a picture of policy as somehow automatically determined by 'economics'. Scull, for example, rejected technological innovation and humanitarianism as basically unimportant. Here, we took the position that policy was the product of human action, and we examined the impact of ideological factors on policy.

A dynamic view of policy was thus assumed in which the question of the social management of insanity was not 'automatically' settled by objective cost consideration. Rather, the view here, was that this question was, for the most part, settled through occupational struggles in which one weapon was the mobilization of public support through promotional activity. We used Alford's framework of dominant, challenging and repressed interests, along with the idea that ideological promotion was a way in which challenging groups launched their challenges, in order to examine health policy developments in Saskatchewan. The next sections present conclusions from the evidence that was examined with respect to costs, the role and significance of public
promotion, and the adequacy of our framework. The final section ends the chapter with suggestions for possible future research.

6.2 Costs Factors In Policy

Since Chapter 3 was essentially a background chapter, costs were not specifically addressed. Nevertheless, there was some suggestion that although sound arguments for the preventative services were presented to the government by the CMHA as early as 1920, the implementation of these were overruled in the short-run due to perceived political liabilities.

Evidence presented in Chapter 4 showed that the CCF started to expand preventative services immediately after their election, even though it was faced with discouraging economic conditions in the province at the time. We saw too that, although by the late 1950s the government favoured general hospital psychiatry due to costs, it was unable to simply proceed with its wholesale implementation, in significant part, because of the support for the Saskatchewan Plan that had been mobilized under the CMHA.

Similarly, while the political ideology of the Liberals was more readily attuned to 'market-efficiency' of the mental health services, it too met some stiff resistance against its cost-cutting policies. Thus, the evidence examined here tends to support our contention that 'costs' are over-determined by other political and social factors. In fact it seems to support our claim that the determination of the significance of costs relative to a given set of policies is partly a political question worked out in the policy process.

6.3 Significance of Public Opinion

The general movement of Western states from liberal to a liberal-democratic regimes was a protracted process which, in part, depended on the development of mass communications which dissolved the old political patronage system. In Canada, this development saw the emergence of the universal political
franchise system, generally by about 1920. Since the dominance of the liberal-democratic form, government responses to public opinion are an indication of how opinion can have 'political costs' and how the development of a given set of social policies partly rests on a degree of popular sentiment. In analyzing mental health policy in Saskatchewan in terms of the medicalization of insanity we traced, in part, developments in the form of mass mobilization used to generate such sentiment.

We saw, for instance, evidence that although the NCMH realized that overall public support was essential to the implementation of mental hygiene, and the social transformation of insanity into mental illness, nonetheless, the organization did not actively pursue this objective in Canada much before 1950. One major reason suggested for this was the lack of development of the mass media based on modern electronic communications. Does this mean that there was no mass mobilization before World War II? Or does it suggest an alternate form of mobilization before then? A number of empirical works point to the idea that before the advent of modern communication direct political patronage was the major means to mobilize public support. Lipset's classic study, Agrarian Socialism for instance, details how voting patterns during elections were affected by patronage in civil service jobs at mental hospitals, which apparently reached down to the day-to-day operations of asylums which were run on a patronage basis. This is an interesting question which was outside the scope of the present study, but which deserves further research.

Without specifically addressing this question, it was argued that with the development of modern mass communications, mobilization through ideological appeal across traditional lines became a more predominant mode for the generation of support to achieve policy objectives. By about 1950, after a groundwork of support for mental hygiene engineered among elite social sectors, a massive campaign to educate the lay public was launched under the newly formed CMHA in Saskatchewan. The evidence showed that under the CMHA significant popular support for mental health had been amassed through newspapers and other public-promotional media by the mid-1950s. Evidence was also presented that around this time the objectives of a mental health coalition had been articulated into a long-range scheme, the
Saskatchewan Plan, which was widely supported in the newspaper media. This was shown by the fact that the 1956-60 period exhibited the highest portion of 'prescriptive articles' over the entire sample, almost unanimously expressing approval for the scheme.

We saw too how a split in psychiatric thinking around 1960s had the effect of demobilizing public support which with the subsequent election of a new regime led to the CMHA's downfall as a major policy actor, along with its attenuation as a promotional agency. Thus, it has been amply demonstrated that public opinion was actively mobilized by certain groups, and that this played a significant, although variable, role in policy agenda setting, policy formation, and policy outcomes.

This relates to the question raised in the review of Boudreau in Chapter 1, "has the character and role of public opinion noticeably changed"? In general terms, we saw in this case study a sequence of development from mainly elite mobilization predominantly through lobbying, to active mass promotion by professions employing ideological appeal of mental health in the 1950s, and finally to state management of opinion by a series of public commissions after the mid-1960s. The last case, would seem to lend some support to Ginsberg's contention that Western states have learned techniques to manage mass opinion in a way that expands their power. As Boudreau hinted, public commissions that solicit a wide range of public opinion would seem to be highly democratic, a direct governmental response to popular opinion, which can expand state popularity and power in its role as an unbiased mediator. Yet, governments hold executive power over the final shape of policy. On one hand this allows the state to play off competing interests to an extent. Differences can be amplified in such a way that may often undermine coalition formation of diverse groups into larger, (politically more dangerous) units.

On the other hand, this is obviously a situation of 'unequal representation' since some groups are better organized, and 'politically' more articulate and connected than others. In this context, governments establish policy which responds to a hierarchy of represented interests designed to mesh with what it
perceives to be in its best interests. Obviously, the collective interests of the various organs that make up the state are similarly ordered in a hierarchical, though shifting relationship. From such a perspective, rather than psychiatry's "capture by the state" as Boudreau contends, it seems that with successful medicalization psychiatry became a dominant institution strongly represented through the state. If the state management of public opinion is accurate, it seems possible that coalition formation and mobilization of the magnitude of the 1950s will require unusually concerted efforts. This topic leads into the next section, the question of professional representation in relation to evidence about the adequacy of our model.

6.4 Dominant, Challenging, Repressed Interests

Alford's study provided a framework, but gave little indication regarding the possible dynamics between dominant, challenging, and repressed interests that might be directly pertinent to our study. In other words, it provided no information about the concrete ways whereby some interests are 'dominant', some 'challenging', and yet others, 'repressed' relative to each other. Thus, we drew on the idea of ideology as a device for cementing coalitions, and mobilizing support for 'projects of public reconstruction'. The material presented showed clearly that the social transformation of insanity into mental illness involved ongoing attempts at various levels of promotion. This effort was spearheaded through a challenging coalition, the NCMH and its successor, the CMHA, which was led by psychiatrists and which culminated in the predominantly medical view of insanity by the 1960s. Their objectives largely met by these events, psychiatry largely abandoned the CMHA as a vehicle for the advancement of their occupational objectives which left the CMHA, at best, in a caretaker role in the mental illness crusade.

What was clearly absent in this study was much mention of "repressed public interests". In one sense, this was not too surprising since by definition such interests are 'unorganized and unrepresented'. The evidence showed only two articles that were located in the pre-World War II era that originated from
"private citizens". These presented terse arguments about the benefits of locating mental hospitals in their respective regions. Proportionately, there were not many more newspaper representations by "private citizens" in the post-War period. In any event, in almost all cases, post-War articles were "testimonial-style", human interest stories appealing to their readers for support for mental health--such as, change in attitudes, approval for additional services, and sympathy for the plight of mental patients. In other words, these sort of articles, for the most part, were completely consistent with mental health arguments.

What, if anything, might this tell us about repressed interests? For one thing, it seems to reflect a characteristic feature of ideological promotion. A lengthy, but informative quote from Gouldner points out,

> ideology performs its consciousness-raising social function [by the selective] "publication" of consciousness [which] permits new modalities of communication. Ideology then premises that it can transform society through symbolic articulation which links the individual to society, persons to groups [through language].

> Ideology allows only certain (limited) things to be communicated, objectified and discussed. If, on the one side, ideology functions "expressively", it also functions--as expressions always must--selectively; which is to say, it functions repressively in relation to certain other matters. Ideology thus generates a public discourse and communication which both includes and excludes; it is the later that creates a public "unconscious".

> The public "unconscious" consists of those shared concerns of persons from which ideology systematically diverts attention, [does] not express [concerns], and hence represses, suppresses, and distorts. Expression and repression via ideological structuring are not mutually isolated, but are, rather both mutually constructive.

The notion of "public unconsciousness" would seem to be relevant to the discussion of "repressed public interests". This passage makes it plain that by expressing and focusing consciousness on a set of issues, ideological representations simultaneously tend to silence possible rival public concerns. Where, as in our case, a coalition with a high degree of consensus was
constructed, which launched a massive promotional campaign, it is not surprising that the terms of public debate over mental disorders were conducted almost completely within the limits of mental health discourse. In other words, the successful formation of this coalition ensured that more coherent responses to it would have to be couched in terms of the public language of these 'helping' professions. The observed preponderance of professional articles over the entire sample leads us to conclude that the savoir enjoyed by the professions, partly as a result of their day-to-day practices, gives them a significant edge in the production of ideologies, and thus in the potential for mobilizing political support.

In sum, we conclude that 'economics' were generally found to be significant in our case study of mental health policy. Yet, as was seen, 'costs' may take more than one form, and Scull's and Ralph's extreme reductionism needs significant, additional qualification to account for mental health policy developments in Saskatchewan, and likely in other places as well. By extension, a similar argument may hold for other types of social policy, a question that deserves additional research. Supporting evidence was found in this study that an additional important determinant was public promotion, especially with the advent of modern mass communications.

During the 'takeoff' stage of modern electronic communications, experienced in Saskatchewan in the late 1940s and in the 1950s, we saw how a strong coalition was developed that produced a coherent ideology which facilitated the successful completion of the transformation of insanity into mental illness. It remains to be seen whether the recent rapid changes in communications technologies, coupled with the apparently more pluralized, but more managed public opinion has foreclosed the possibility of radical transformations to mental services. Our analysis suggests, however, that this would require significant levels of political mobilization by a challenging coalition in which professionals would likely play a major role in being able to harness public opinion to its cause through ideological promotion.
6.5 Some Research Suggestions

Along the lines of what has been suggested above, the following research could be undertaken to further our understanding of the role of media and promotion in the determination of policy:

1) A similar study into the role of electronic media, such as radio and television, in public mobilization efforts for mental health in order to understand differences/similarities with print media as promotional medium. Some data sources, such as radio broadcasts are available. Television coverage may be stored on tape in local stations, and may be available for analysis.

2) The study of a 'twin' province or state based on a quasi-experimental design. Such a comparative study may yield valuable findings that contrast differences/similarities in methods of mobilization, the effect of different political arrangements and other information.

3) If accessible, examination of NCMH/CMHA records in Eastern Canada would be extremely valuable in fleshing out particular aspects of the preceding analysis which in some instances had to be inferred from events and existing data.

4) Relatedly, such access might provide a core of information that would allow a more current picture of the policy area. For example, there may be some accommodation between psychiatry and other occupations in the 1980s. This possibility requires further research to determine if such an alliance is in the making, and whether it perhaps presages another 'golden age' of mental health promotion on the scale which had been launched under the CMHA in the 1950s.
Notes to Chapter 6

1. Former Premier T.C. Douglas stated that in 1944 "Saskatchewan had the unfortunate distinction of being one of the poorest provinces in Canada...with the highest per capita debt [and] the lowest per capita income". Harley D. Dickinson, Community Psychiatry: The Transformation of Psychiatric Work, 1905-1984. (Ph.D. Dissertation: University of Lancaster, 1984), p. 137. Evidence presented in Chapter 4 tends to bear out this claim.


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