

**INTO THE VOID: A CROSSBORDER COMPARISON OF THE MENTAL
ASYLUM ON THE AMERICAN AND CANADIAN FRONTIER**

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By

BLAINE WICKHAM

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ABSTRACT

This dissertation examines the history of the mental asylum in comparative context. It presents a cross-border study that analyzes an institution in Washington State (Western Washington Hospital) with one in the Province of Saskatchewan (Saskatchewan Hospital, North Battleford) in the late nineteenth and early twentieth centuries. Scholars and others close to the asylum have described it as a symbol of modernity, a policing institution, and a medical structure. To make these claims they have looked almost exclusively at institutions in eastern Canada and the United States. This work traces those ideas as they moved west. It shows that the superintendents of these regions borrowed established eastern asylum principles in an effort to assert their own modernity and medical authority with appreciation to the civilizing missions of the respective nation states. They merged the political goals of the institution and their government with social and medical realities and presented a system of asylum-based care that helped them medicalize the understanding of insanity in their respective hospitals.

This study also addresses how superintendents unconsciously let regional social ideals of assimilation, the closing of the frontier, statehood, beliefs of what constituted a proper society, urban expansion, and the ideal of citizenship influence their treatment of people with mental disorders. Despite external influences, physicians in the western asylum strove to implement innovative asylum-based therapies. These practices allowed them to move past much of the stigma that had developed against the asylum and their patients. The result was that they showed insanity was ostensibly a curative condition and a fraction of people judged insane were able to resume normal functioning, however fraught, and return to their communities. Using a lens of local and transnational ideas about deviance and madness, this study ultimately argues that the asylum offers an additional gauge to interpret societies as they established their identities; it is a

microcosm of the society it serves. The examination of these institutions presents a better understanding of the regions in which they are situated.

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DEDICATION

I dedicate this work to Austintasia, Oliver, and most especially Rosa. Your support and enthusiasm kept me on course and helped me to always move forward.

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LIST OF ABBREVIATIONS

AMPA – American Medico-Psychological Association

AMSII – Association of Medical Superintendents of American Institutions for the Insane

CNCMH – Canadian National Committee for Mental Hygiene

MMSWT – Members of the Medical Society of Washington Territory

WWH – Western Washington Hospital for the Insane

Introduction

In the fall of 1887 Dr. John W. Waughop, the superintendent of the Hospital for the Insane in Washington Territory, was in a congratulatory mood. For the past sixteen years the hospital consisted of an assortment of decommissioned army buildings. The situation was about to change as after more than a year of planning and construction efforts, the government was about to open a new purpose-built institution that was replacing the old dilapidated military structures. In Waughop's words the new hospital was "the most approved plan," complete "with all modern improvements and conveniences." It was, he continued, "fine looking and substantial, without useless ornamentation, and well adapted to the end for which it was built."¹

Superintendent Waughop was not the only person excited about the new building, the hospital's Board of Trustees also saw it as cause to celebrate. According to the Board, the completion of the new structure marked "the dawning of a new era in the history of our territory" – an era that they believed would be teeming with increased public support for the people receiving help in the institution and for the government.² They remarked that the new hospital was "one of the finest permanent public buildings erected."³

When the asylum was nearing completion, Waughop sent a written description and a photograph of the new building to a colleague for approbation. He reached out to Dr. Pliny Earle, a founding member of the Association of Medical Superintendents of American Institutions for the Insane (AMSAIL) and a veteran superintendent of more than 20 years at the Northampton Asylum, Massachusetts. After viewing the material sent by Waughop, Earle replied with his

¹ Territory of Washington, *Report Board of Trustees and Resident Officers of the Hospital for the Insane in the Territory of Washington, 1887*, (Olympia: Thomas H. Cavanaugh, Public Printer, 1887), 18.

² *Hospital for the Insane in the Territory of Washington, 1887*, 6.

³ *Hospital for the Insane in the Territory of Washington, 1887*, 6.

concise opinion: “It looks like a very sensible building.”⁴ Having received professional commendation, Waughop congratulated the Board and the whole territory for constructing “so good [a] building at so small a cost.”⁵

Waughop wanted and sought validation from an experienced asylum superintendent, in doing so he purposefully looked for confirmation from the eastern-based authorities. His action underlined his desire for having reputable and more established superintendents recognize the developments in the west as comparable to their own. Washington, still two years away from achieving statehood, was attempting to fashion state institutions that approximated the “civilized” east. When writing about the West, Fredrick Jackson Turner argued western regions evolved by “seeking an equilibrium” with their urban and industrialized eastern counterparts.⁶ In this particular instance, Waughop attempted to fuse Washington’s treatment of insanity with those in the east; he strove for “national unity” of his profession.⁷ Residing in the western region of the United States, Washington was methodically adopting the social conventions, medical understandings, and political institutions of the eastern regions.

This doctoral study examines the manner in which two western asylums, Washington State’s Western State Hospital and the Saskatchewan Hospital, North Battleford, responded to local as well as national practices of institutionalization and mental health care. By presenting a history of two western hospitals from their inception (Washington began separating insanity from society in the 1860s and Saskatchewan opened their first asylum in 1914) to 1930, this study offers specific and diverse samplings of what constituted a “typical” western asylum to

⁴ *Hospital for the Insane in the Territory of Washington, 1887*, 19.

⁵ *Hospital for the Insane in the Territory of Washington, 1887*, 19.

⁶ Fredrick Jackson Turner, “The Problems of the West,” *Atlantic Monthly* 77 (September 1896), quoted from *Rereading Fredrick Jackson Turner: “The Significance of the Frontier in American History” and Other Essays*, with commentary by John Mack Faragher (New York: Henry Holt and Company, Inc., 1994), 75.

⁷ Turner, “The Problems of the West,” 75.

make this argument. These western institutions evolved and operated under social, political, and medical influences different from those in the east and from each other, but offer an important set of insights into the blending of local and national imperatives in the asylum era.

On the surface there are noticeable differences between the Washington and the Saskatchewan asylums. For a time Western operated in an abandoned military fort; it functioned within a region that was urbanizing and developing a commercialized economy. North Battleford, on the other hand, opened within a purpose-built structure in a province that consisted largely of small rural communities and a strong agrarian-based economy. Despite operating under different regional influences, when Washington and Saskatchewan opened their first asylums the two institutions began at a similar medical place and with comparable political goals. The governments of each region initially constructed their buildings in order to incarcerate and manage insanity. In light of this, superintendents worked to medicalize insanity in a manner that brought asylum practices in line with national trends. Moreover, by comparing these facilities, the role of the asylum in managing the population becomes more evident. Each facility provided an anchor or physical embodiment of a form of state, and later medical, discipline over its surrounding population. In other words, the asylum evolved alongside the society.

This study considers (inter)national trends to highlight how these two asylums evolved and how superintendents redefined trends in asylum care at a local level that merged the political goals with social and medical realities. It advances the notion that wider mental health developments were redefined at a regional level due to local influences and social concepts of regional identity. Nevertheless, each institution followed a similar pattern of development, suggesting that the process of integrating asylum-based care into a community revealed a lot about how that society saw itself with respect to ideals of civility and modernity. The respective

superintendents fought to claim medical authority over insanity, yet they were not immune to local political and social forces. Ideals of assimilation, the closing of the frontier, beliefs of what constituted a proper and ordered society, urban expansion, and concepts of state governance influenced the practices within the asylum. Despite external pressures, however, the superintendents strove to implement the latest asylum therapies in an attempt to reflect national professional practices and prove the building's curative function by offering their patients the best opportunities to leave the asylum and return home as better adjusted, functioning members of society. To accomplish this outcome, superintendents played a key role in medicalizing insanity, as part of what constituted a natural part of settling the frontier. Medicalizing insanity presented a progressive alternative to the legal designation of insanity that carried criminalizing connotations. The language of disease and disorder promised to remove the moralizing stigma that had developed against the asylum and its patients. The result was that these superintendents showed the disorder was a non-criminal, treatable condition and that patients leaving the institution were capable of resuming a productive role in their communities.

While the evolution of these institutions parallel one another, their differences offer a better understanding of the respective region. Each of these asylums function as a microcosm of the society they served.⁸ By examining local concepts of criminality, medical care, normality, economic efficiency, and the understating of insanity through the context of the asylum we gain a better understanding of the region.

Asylum Historiography

Into the 1960s scholars tended to argue the asylum and asylum-based therapies were progressive steps in mental health history. These melioristic studies, or Whiggish histories,

⁸ Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (Ithaca: Cornell University Press, 1995), 56-59.

focused on the political and administrative features of running an efficient asylum and the struggles of managing and accommodating insanity. These scholars admitted that the asylum generally had its faults, yet they suggested that the era of the asylum was an improvement over the previous periods of brutal care and neglect for people considered insane. Early American physicians, such as Benjamin Rush, believed that insanity was a condition to be controlled through corporal means.⁹ That ideal changed with the asylum, as the institution provided a place of dedicated care overseen by men who wanted to turn away from former harsh practices. The faults of the asylum, melioristic scholars argued, arose from administrative shortcomings and political intrusiveness.¹⁰ Nevertheless, scholars concluded that physicians, politicians, and other asylum administrators constructed a workable system that sought to effectively accommodate insanity by housing people in purpose-built facilities whose function was to heal and not simply incarcerate insanity or control it.

The first public asylum in America opened in 1834 near New York City. In the succeeding decades, governments followed New York's example and built their own public institutions to treat insanity. Superintendents of these institutions believed there were established links between medicine and insanity. As insane asylums increased in number across the Eastern United States, superintendents of those institutions reconceptualized insanity as a medical condition and began to adopt humane medical treatments to care for people under their supervision. They also saw the value in sharing among other likeminded professionals their innovative understandings of insanity and asylum-based care. In 1844 thirteen superintendents organized the Association of Medical Superintendents of American Institutions for the Insane to

⁹ Benjamin Rush, *Medical Inquiries and Observations upon the Diseases of the Mind*, (Philadelphia: Kimber & Richardson, 1812).

¹⁰ For examples please see Erwin Ackerknecht, *A Short History of Psychiatry* (New York: Hafner Publishing Co., 1959) and J. Sanbourne Bockoven, *Moral Treatment in American Psychiatry* (New York: Springer Publishing Company, Inc., 1963).

help establish uniform practices and ideals throughout their institutions.¹¹ It was through this professional organization that other superintendents throughout American and Canada adopted a humane regimen in which to treat insanity. With a goal toward improving the image of the asylum and presenting a more medicalized understanding of insanity, this new therapeutic system, which the AMSAII termed moral treatment, allowed these emerging professionals to focus on developing a unified set of practices within the asylum while claiming expertise over insanity.

Moral treatment is broadly defined as a combination of work, religious services, amusements and recreation, offered within a daily regimented schedule and controlled asylum environment that isolated people from society, and stressed order and discipline. It was not an explicit set of treatments; in offering these practices each superintendent was free to adopt varied therapies.¹² For example, some superintendents offered work in addition to physical recreation activities, while others combined work with recreation under the ideal that both offered the patient physical exercise. Specific treatments were not as important as the holistic ideal behind moral treatment: using the regimen to improve upon established practices advocated by physicians such as Rush.¹³ Through moral treatment superintendents minimalized social influences, while also limiting physical coercion and invasive practices. Superintendents

¹¹ John Curwen, *History of the Association of Medical Superintendents of American Institutions for the Insane, From 1844 to 1874, Inclusive*, (1875), 5; John Curwen, *The Original Thirteen Members of the Association of Medical Superintendents of American Institutions for the Insane*, (Warren, PA: E. Cowan & Co., Printers, 1885), 5-6.

¹² *Report Board of Trustees of the Hospital for the Insane of the Territory of Washington, 1883*. (Olympia: C. B. Bagley, Public Printer, 1883), 18; Association of Medical Superintendents of American Institutions for the Insane (AMSAII), "The Moral Treatment of Insanity," *American Journal of Insanity (AJI)* 4, (July 1847); James Moran, *Committed to the State Asylum* (Montreal: McGill-Queen's University Press, 2000) 4-5; David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, 1st ed., (Boston: Little, Brown and Company, 1971), 137-144 outlines the basics of moral treatment as written above, yet he stresses there was a heavy isolation aspect; and Andrew Scull, "Madness and Segregative Control: The Rise of the Insane Asylum," in *Social Problems* 24, no. 3 (Feb., 1977): 345-6. Scull argues that as moral treatment evolved in the large public asylums, it was increasingly simplified and reduced to a set of internal management devices. Typically the devices outlined above.

¹³ AMSAII, "The Moral Treatment of Insanity," 6.

believed that the controlled environment of the asylum induced inmates to internalize acceptable behavior and values of a “normal” society, thereby stimulating their recovery. Moral treatment held two meanings. One, superintendents believed it offered a superior “moral” means to treat insanity, approaching people humanely, with the idea that they could be restored or rehabilitated, rather than the earlier alternative that cast off insanity as ‘hopeless’ or beyond reproach.¹⁴ And two, by appealing to and improving the patient’s self-worth, moral therapy reoriented a patient’s moral and social behavior so that it approximated someone who accepted and portrayed conventional social values.

According to the melioristic studies, the efforts of the AMSAII purportedly resulted in a more humanitarian approach to managing insanity by recognizing the inherent human qualities of people in the asylum, regardless of the behavior of the individual. Reconceptualizing madness, medical entrepreneurs then organized to manage, systematize, and attempt to treat insanity as a pathological construct. In this way medicalization and moral treatment went hand in hand, first by recognizing the subject as human, then in devising interventions aimed at rehabilitating or normalizing their behavior.

This description of the history of madness attracted critics. In 1961 Michel Foucault published his highly critical and influential work *Histoire de la folie à l’âge classique* (*History of Madness*) and the abridged English translation *Madness and Civilization* (1965).¹⁵ This work challenged the entrenched melioristic historiography. According to Foucault, the asylum did not usher in an era of humanitarian therapeutic advancement, as previously claimed. During the “age

¹⁴ Carla Yanni *The Architecture of Madness: Insane Asylums in the United States*, (Minneapolis: University of Minnesota Press, 2007), 24.

¹⁵ Michel Foucault originally published his work *Histoire de la folie à l’âge classique* in France in 1961 yet a full English translation of this did not appear until 2006 with the title *History of Madness*, ed. by Jean Khalifa; trans. by Jonathan Murphy and Jean Khalifa (New York: Routledge). Prior to this Anglophones had Foucault’s *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. by Richard Howard (New York: Vintage Books), an abridged work that was published in 1965.

of reason,” from which it emerged, a divide developed between “reason” and “unreason” wherein civilization “sketched the profile of its own experience of unreason.”¹⁶ It marked an era of oppression for the insane. Instead of providing a setting of humane and improved care for insanity, the asylum became a way for civilization to confine it.

The emergence of the asylum, according to Foucault, proved detrimental to people suffering from insanity. It physically confined them and provided the setting in which physicians inculcated them to conform to the rest of society. In public, madness already had to contend with social barriers that separated it from the rest of civilization.¹⁷ The asylum placed additional physical barriers around them and allowed a small group of men to establish dominance over people in the name of professionalism and care. This emerging group of asylum superintendents claimed their medical authority at the expense of a more tolerant understanding of madness, whether part of the human condition, or a truer expression of free will than that exhibited by people who conformed to social norms. Perhaps worst of all, the medical profession created an additional internal wall for people with insanity, this one founded on the notion of personal shame and perpetual judgement.¹⁸ According to Foucault, “the birth of the asylum” ushered in an era of “gigantic moral imprisonment.”¹⁹ It was not “the liberation of the insane” that scholars had previously argued it was, but a seismic shift towards codifying “reason” and “unreason” with the full support of medicine and professional discipline.²⁰

The same year that Foucault challenged academia in his home country of France, Canadian-born, American-based sociologist Erving Goffman published his own critical study

¹⁶ Foucault, *Madness and Civilization*, 65. See also: chapter 2, “The Great Confinement,” pp. 38-64, specifically p. 48; chapter 3, “The Insane,” and chapter 9, “The Birth of the Asylum,” pp. 241-278, specifically p. 243-244.

¹⁷ Foucault, *Madness and Civilization*, on pages 7-13, Foucault presents examples wherein the insane “were not invariably expelled” from European cities (p. 9). Even as cities set aside specific areas for insane people, on pages 13-37 Foucault notes that there was a growing unease toward “madness,” especially through the arts.

¹⁸ Foucault, *Madness and Civilization*, 246-247.

¹⁹ Foucault, *Madness and Civilization*, 278.

²⁰ Foucault, *Madness and Civilization*, 278.

titled *Asylums*.²¹ As the subtitle indicated it focused on the “social situation of mental patients and other inmates.” Arguably one of the first anti-institutional studies in America (predating Foucault’s English translation by four years), Goffman’s work examined the intended purpose of the asylum in relation to actual patient experiences and treatment. He argued that there was more to institutions than the physical features “such as locked doors, high walls, barbed wire, cliffs, water, forests, or moors.”²² Asylums, he maintained, created a world apart from society that maintained their own rules and regulations; these places he termed “total institutions.”²³

Goffman argued that in spite of the efforts of the asylum workers, the people receiving care within institutions never left rehabilitated because the staff was unable to cure them along socio-normative values. Instead, these “total institutions” removed people from society as a mode of treatment or even punishment due to some deviant or unacceptable act exhibited by the person. Above all else, these asylums operated with the intent of treating those in need by correcting their behavioral problems and instilling within them acceptable socio-normative values. The very nature of the asylum as an institution separated from society, complete with its own rules and rituals of performance, prevented re-integration or “normalization” from happening. According to Goffman, inmates cannot learn the values of society within a “total institution” that operated under strict rules that placed security and efficiency above social rehabilitation. Its very rule-rigid nature made it incapable of mirroring society.

The purpose of the asylum was to “fix” people in very specific ways, and as such the administration created unique barriers that aimed to maintain order while inculcating “proper” social behaviors within patients. By creating these barriers the asylum fabricated a new society

²¹ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, N. Y.: Anchor Books, 1961).

²² Goffman, *Asylums*, 4.

²³ Goffman, *Asylums*, 17.

within its walls; one that allowed authorities to maintain control but consequently encouraged patients to internalize the rules and order of the asylum and not society, ultimately doing more damage than good. After the authorities had subjected the inmates to this pseudo-society for a time, patients became accustomed to the strict rules of the institution, a process Goffman calls “disculturation.” Once an inmate became “discultured” by adopting the lifestyle of an inmate, they were “incapable of managing certain features of daily life on the outside.”²⁴

In contrast to the arguments before the 1960s, Goffman and Foucault argued that the “advances” stemming from the advent of the asylum had little to do with progressive therapies and everything to do with social control. Their highly critical works blazed a path for other academics to follow. In their wake a generation of revisionist scholars challenged the traditional view of the mental hospital. Scholars such as historians David Rothman and Gerald Grob, and sociologist Andrew Scull were critical of the asylum in ways that lent credence to the new revisionist view. With their detailed analyses of particular institutions, regions, and policies they presented further support to the idea that asylums represented a regression rather than a progression in humanitarian treatment or social justice.

Rothman’s *Discovery of the Asylum* argued that American institutions emerged as a result of the changes brought on during the Jacksonian era (1829-1840s).²⁵ As the United States became more industrialized and urbanized, people realized that traditional community-based methods of managing deviance or insanity no longer proved useful. Asylum advocates and other social reformers linked insanity to the pressures of urbanization and the associated stresses of industrialization. The asylum became one answer to the problem of modernity and industrial capitalism. Superintendents and other supporters of the mental asylum promised humane

²⁴ Goffman, *Asylums*, 13.

²⁵ Rothman, *Discovery of the Asylum*.

treatments – moral treatment – to alleviate the growing prevalence of insanity in America. Rothman argued early superintendents designed the asylum to “exemplify the advantages of an orderly, regular, and disciplined routine.”²⁶ They believed that asylums were able to instill traditional American values within their inmates by recreating order and discipline in the environment. Superintendents of the Jacksonian era created within the asylum a microcosm of their ideal American society. Their methods, however, did not fulfill their promises. They were unable to respond to the rising incidence of allegedly insane or deviant responses to modernization.

Gerald Grob forwarded a more pragmatic view of the emergence of the American asylum, one that was neo-traditionalist but still critical of its limitations and the young psychiatric profession.²⁷ According to Grob, the first generation of superintendents were not all physicians, but instead authorities who championed moral treatment due to its humane practices. With the best of intentions they wanted to improve the care for people considered insane and promote effective cures. Rothman argued that industrialization, urban expansion, and immigration were social problems that contributed to the rise of the asylum; Grob, however, maintained that, in addition to restrictive government oversight, they were factors in its failure. Under the strain of these developments, combined with the progressively humane but terribly ineffective moral treatment, the asylum population grew faster than superintendents were able to cope with and people languished in the institution uncured. The crowded asylum affected both the quality of care and altered the daily objectives of the superintendent, from a curative retreat to a desperately under-resourced warehouse for society’s deviants. The second generation of

²⁶ Rothman, *Discovery of the Asylum*, 129.

²⁷ Grob, *Mental Institutions in America*.

superintendents, according to Grob, became administrators who sought order over therapies as their hospitals devolved into an overcrowded and ineffective institution.

Following those before him, sociologist Andrew Scull also presented a scathing critique of the mental asylum and the emerging professionals associated with their management. With his neo-Marxist view, and concentration on British institutions, he argued that the asylum emerged as the direct result of socioeconomic changes that disrupted traditional social and economic relationships. The rise of the market economy and wage-based work exacerbated the burden of care for family members. Based largely on the assumption that the lower classes were unable to come to terms with the new changes, the bourgeois began to lock away people according to their deviant behaviors, which, according to Scull, the upper classes largely defined along the lines of work ethic and work capacity. In that milieu the insane went to the asylum. There, Scull argued, superintendents adopted the “humane” moral treatment, which provided “less benevolent aspects” to addressing madness. Unable to cure, the system quickly deteriorated “into a repressive form of moral management.”²⁸ Agreeing with Foucault and other likeminded revisionists, Scull fundamentally argued the asylum became a storage facility for society’s outcasts and deviants; it was an institution of social control.

Each of the first wave revisionists presented a view that leveled most of their disapproval at the hospital administration and the politicians associated with the hospital, each approaching it in their own way. Foucault took aim at the asylum and the psychiatric profession’s assumption of authority over madness. Rothman analyzed the unfavorable social factors that led to America embracing the asylum as a rational response to the growing pains of modernization. Grob remained a bit more tempered and argued that the asylum was well meaning but ultimately

²⁸ Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Los Angeles: University of California Press, 1989), 80-81. See also Scull’s, *Museums of Madness: The Social Organization of Insanity in Nineteenth-Century England*, (New York: St. Martin’s Press, 1979).

flawed, due to external factors and superintendents' support of a program that was not able to live up to its promises and unable to establish cures for irregular behaviors. Finally, Scull presented a critical analysis of the socioeconomic dynamics that provided the upper class with the power to round up lower class "deviants" and place them into the custodial asylum due to a perceived inability to contribute to the economy.

Building on the critiques of Foucault and others, some scholars focused on the institution itself as a way to examine the relationship between institutionalization and madness. Nancy Tomes, for example, considered how Superintendent Thomas Kirkbride, while lamenting the deficiencies of his own hospital, mapped out features he deemed essential for a mental hospital that supported and enforced curative therapies by paying close attention to the physical environment.²⁹ Instead of focusing on one hospital and one superintendent, Carla Yanni examined several American asylums throughout the east coast and into the American Midwest to compare and chart their evolving physical architectural features in relation to the evolving nature of mental health ideals.³⁰ More recently Janet Miron combined an assessment of the physical qualities with the institution as well as its position in the broader community. She ultimately argues that the asylum was more than a state institution. It became an "important loci of social activity that fostered popular understandings of and insight into mental illness" because officials "believed the public had the potential to influence both the success of the asylum and the treatment of mental illness."³¹

²⁹ Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883*, (Cambridge: Cambridge University Press, 1984).

³⁰ Yanni, *The Architecture of Madness*.

³¹ Janet Miron, *Prisons, Asylum, and the Public: Institutional Visiting in the Nineteenth Century*, (Toronto: University of Toronto Press, 2011), and her article "'Open to the Public': Touring Ontario Asylums in the Nineteenth Century," in *Mental Health and Canadian Society: Historical Perspectives*, eds. James Moran and David Wright (Montreal: McGill-Queen's University Press, 2006), 19-48. The quote is from page 20 of "Open to the Public."

Slowly, however, scholars have turned even further away from administrative heavy narratives and started critically examining the hospital from the patient experience.³² These second-wave revisionists began to combine previously unused primary sources to give a voice to the long silenced asylum residents – inmates, patients, and mad people depending on the political framing of the experience. Scholars examined files that described patients as people, including care files, patient records, committal and discharge reports, patient correspondence, superintendent correspondence with patients’ families, and personal journals. This fresh view allowed the purview of asylum narratives to expand beyond the superintendent’s office and presented readers with more balanced account of the asylum. Bringing in patients’ point-of-view, scholars such as historians Geoffrey Reaume, James Moran, and Ann Digby and Jonathan Andrews repositioned their studies to guide readers into the asylum wards, patient workrooms, and the asylum farms. They extended their scope out of the asylum by examining the conditions leading to a person’s committal on through to their discharge, if and when that became possible.³³

Other scholars, such as Benjamin Reiss, and André Cellard and Marie-Claude Thifault adopted a social historical approach and pushed beyond the institutional walls to the fringes of the patient experience, by including areas such as families, neighbors, and friends of those who were committed to highlight how they often continued to be active in the patients’ life before, during, and after their time in the asylum.³⁴ These works challenged the position the asylum and

³² For examples, please see the works of Roy Porter, *A Social History of Madness: Stories of the Insane*, (London: Weidenfeld & Nicolson, 1987); Elaine Showalter, *The Female Malady: Women, Madness, and English Culture* (New York: Pantheon Books, 1985).

³³ Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Toronto: University of Toronto Press, 2000); Moran, *Committed to the State Asylum*; Ann Digby and Jonathan Andrews, *Sex and Seclusion, Class and Custody: Perspectives on Gender and Class in the History of British and Irish Psychiatry* (New York: Editions Rodopi B. V., 2006).

³⁴ Benjamin Reiss, *Theaters of Madness: Insane Asylums and Nineteenth-Century American Culture* (Chicago: University of Chicago Press, 2008); André Cellard and Marie-Claude Thifault, “The Uses of the Asylum,” in *Mental*

its administrators held at the center of early mental health narratives. They supplanted a traditional examination of institutional administrative practices with one that focused on the impact institutionalization had on patients and their families.

More recently asylum historiography has developed in interesting, if divergent, ways. Some accounts present a neo-traditionalist view of the asylum, by revisiting the concept that the institution and moral treatment were positive medical innovations. Some scholars, however, continue the trend of challenging the place of the institution in the care of insanity, while others have gone so far to have exclude the structure altogether.³⁵ These works underplay the persuasive position of the institution as the defining feature of historical mental health practices. Instead they purposefully ignore the asylum and focus on community and family-based customs to show that the asylum was not the only place to care for insanity.³⁶

There are problems and conflicting arguments that emerge from this historiography. For example, Goffman argues institutions remained separate from society thereby allowing institutional rules to flourish and order to reign without external opinions creating conflict. On the other hand, Miron argues that asylums maintained connections with the communities and often became important social centers where the public was able to develop a better understanding of insanity and, however minor, influence the practices within the asylum. Additionally, Rothman argues that society turned to the asylum as a means to supplant the failed community-based system of care. Moran in his article “Asylum in the Community” challenges

Health and Canadian Society: Historical Perspectives, eds. James E. Moran, and David Wright, (Montreal: McGill-Queen's University, 2006), 97-116.

³⁵ Peter Bartlett and David Wright, eds., *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000*, (New Brunswick: The Athlone Press, 1999); David Wright and James Moran edited a work *Mental Health and Canadian Society: Historical Perspectives* (Montreal: McGill-Queen's University Press, 2006), has sections that challenge the place of the asylum in mental health history, see specifically Thierry Nootens, “Happy Home,” pp. 49-68.

³⁶ James Moran, “Asylum in the Community: Managing the Insane in Antebellum America,” in *History of Psychiatry* 9, (June 1998): 217-240.

that view and argues that various forms of community care were active and offered families an additional option of care throughout America into the 1860s.³⁷

More broadly, as creative and diverse as the studies of asylums are now, many of them place their studies in the east and extrapolate those findings to the rest of their respective country, Canada or the United States.³⁸ That is to say, whether giving a needed voice to the patients, examining the place of the asylum in social structures, or criticizing its administration, scholars focus their studies on institutions in the increasingly urbanized eastern regions of America and Canada in the nineteenth and early-twentieth centuries. To date, there have been relatively few concentrated examinations of asylums in the west, although governments established most of the institutions decades later, and in some cases long after internal critiques of custodial care began to undermine the consensus held by administrators that large-scale institutions were the best option for managing madness. By not examining the emergence of the asylum in western United States and Canada there remains a gap in knowledge concerning the pervasiveness of the asylum and the treatment of insanity in relation to the development of frontier societies. This study will begin to fill that void.

³⁷ Moran, "Asylum in the Community," see pages 224, 229, 235 for specific examples.

³⁸ There are a few exceptions to this claim. In 1978, historian Richard W. Fox published a study, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978). This book is less about any one particular institution and more about the plight of the insane in that state, particularly those in the San Francisco area. Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*, (Berkeley: University of California Press, 1997), is also about the California mental hospital system. Additionally there is a book by Richard L. Lael, Barbara Brazos, and Margot Ford McMillen, *Evolution of a Missouri Asylum: Fulton State Hospital, 1851-2006* (Columbia: University of Missouri Press, 2007) that, while only technically in the mid-west, does examine a mental asylum in Missouri. Yet, due to the timeframe of the work, 1851-2006, and the fact that McMillen was a former nurse of the institution had the authors dedicating most of the pages to late 20th century when she worked there. With the exception of Braslow (whose study begins at too late a date to discuss moral treatment), these works mention the impact of moral treatment (or in the case of Fox, the lack thereof) in their respective areas. Other works, such as a recent article by Ann L. Magennis and Michael G. Lacy titled "Demography and Social Epidemiology of Admissions to the Colorado Insane Asylum, 1879-1899" in *Social Science History* 38, no. 1 (2014): 251-271; and the book *They Called It Madness: The Canton Asylum for Insane Indians 1899-1934*, (Frederick, Maryland: America Star Books, 2009), by Todd E. Leahy, do not mention the system.

To present this analysis this work utilizes the works of Michel Foucault, David Rothman, Andrew Scull, Gerald Grob, Geoffrey Reaume, James Moran, and Nancy Tomes and Lynn Gamwell. These scholars conclude that superintendents, upon realizing that moral treatment was ineffective, stopped utilizing it in mental hospitals in the 1860s and 1870s.³⁹ The intent of this study is not to call into question these claims but rather to contribute to them by showing that asylum practices utilized throughout Canada and America were uneven and complicated by regional differences. Even as eastern superintendents turned away from moral treatment, the system continued to attract support in western Canada and the United States into the twentieth century. Moving the focus of analysis west helps to underscore the power of that conceptualization as a necessary approach to managing madness as part of modernizing, and as a critical element of nation building.

At its core this study challenges arguments made by previous scholars who have analyzed one or two nineteenth century asylums in the east and used their findings to forward arguments about national trends. This methodology is inadequate as the resulting arguments, when placed in the context of regional versus national and eastern versus western trends, do not translate well. Each asylum throughout the United States and Canada was constructed with the intention to deal with insanity. Yet, how each region dealt with it was a matter of contention that arose among politicians, physicians, and the public. To provide a full appreciation of the asylums in these countries, my study gives a voice to these western areas. It shows that, even in the face of political intrusion, superintendents believed that their practices and the mental hospital were essential instruments in providing humane care for insane people, despite evidence to the contrary.

³⁹ Gamwell and Tomes, *Madness in America*, 121; Rothman, *Discovery of the Asylum*, 265-287; Moran, *Committed to the State Asylum*, 96-99; and Grob, *Mad Among Us*, 91-92.

While examining the two western asylums in Washington and Saskatchewan, this doctoral study engages with the highly critical first-wave revisionist arguments and the neo-traditional works that argue the asylum and moral treatment were positive markers on the march of medical progress. By placing the study in the west, the study shows that, despite the perceived failures and disillusionment of eastern superintendents toward the failures of asylum-based care, moral treatment and institutionalization helped western superintendents reposition the understanding of insanity under their growing medical expertise and out of the hands of politicians and other non-medical players.

It is clear the physicians in Washington and Saskatchewan adapted moral treatment within their asylums, sometimes even invoking its terminology directly, well into the 1900s. Despite the system's collapse, superintendents in the western regions in Canada and the United States used it as a way to justify the continued use of the asylum, as the institution had, in part, become a symbol of the "civilized" west. The system provided superintendents with the means to improve the public and political understanding of insanity by harmonizing the concept of madness as an ailment that requires humanitarian care offered within a hospital setting, and by suggesting that madness was an inevitable by-product of modernization. The adoption of moral treatment and superintendent's need to advertise it as an effective means to treat insanity highlights how the concept of insanity began as a social understanding despite superintendents having claimed medical authority over it in the eastern regions of both countries.

Both regions modified the ideal of moral treatment, refashioning it to fit within regional concept of effective medical care and normality thereby allowing local regions to create an asylum-based system of care and fashion curative markers accepted by their society. By arguing that humane treatments were of therapeutic value in effectively alleviating insanity, and at times

highlighting the economy of treating and paroling people back into their community, western superintendents emphasized the efficiency of the asylum and reconceptualized insanity as a medical condition.

Superintendents of Washington and Saskatchewan were motivated to follow the same paths as their eastern predecessors to demonstrate their professionalism and sophisticated, modern position in their respective nations. They incorporated these features, in part, to combat the association between the west and backwardness that prevailed. In the east during the nineteenth and early twentieth century, superintendents fashioned their therapies and inmate curative markers around ideas of acceptable socio-normative behaviors. At that time, as scholars point out, societies defined social markers against urbanization and industrialization lifestyles, i.e. modern industrial capitalism. Superintendents amalgamated these indicators with the acceptable cultural norms of the communities, provinces, states, or regions that they served. Therefore, as eastern regions slowly but steadily moved away from rural agrarianism and community-based care, effective treatments and curative markers also evolved. In contrast, many western regions were not on the same urban-industrial or socio-economic track as their counterparts in the industrializing east and therefore did not hold the same curative markers.⁴⁰ While some western states, provinces, and territories were home to a few small cities, they continued to have many modest rural communities that relied on agrarian substance.⁴¹ As

⁴⁰ Turner, "The Problems of the West," 62.

⁴¹ As the Puget Sound region of the Washington Territory continued to urbanize (by 1890 the city of Seattle ranked 70th largest city in the United States), the eastern areas of the Territory consisted of smaller cities and farming towns. The inland areas of the state, east of the Cascade Mountains, farming is still a major industry. The Puget Sound region, as it concerns this study, is the coastal and now largely urban area of Washington State that surrounds Puget Sound, but includes the nearby lowlands. It is generally delineated as being west of the Cascade Mountain Range and east of the Olympic Mountains. It extends as far north as the city of Everett and as south as Olympia. It is a similar scenario in Saskatchewan. Despite the growth of Regina, Saskatoon, the Battleford area, and a few other cities, the province still boasts a large farming population that reside in smaller urban centers.

urbanization and industrialization were increasing issues in eastern regions, these issues affected a significantly smaller proportion of the population in the west.

In spite of these differences, western governments looked east to replicate the institutional models without paying sufficient attention to the environment or socio-political conditions that allegedly underpinned the entire philosophy of institutional care and rehabilitation. Using the asylum as a gauge on human value, establishing this institution became an important marker of modern civilization, both internally and nationally.

This work engages and challenges Rothman's thesis that the emergence of the asylum was a Jacksonian specific ideal. The asylum in America and Canada rises above specific epochs; it is not identified by any one nation or region. When Americans "discovered" the asylum, according to Rothman, it emerged in response to people desiring a strong society that equated stability with traditional values. It allegedly helped to cultivate social cohesion and exerted a homogenizing influence over hard working Euro-Christian values.⁴²

Building on Foucault and Rothman, this study examines the social and political incentives that led to the establishment of asylum-based care in Washington and Saskatchewan. Whereas many scholars have described the asylum as subscribing to a set of universal principles, a closer examination of regional influences on decision-making and care offers a detailed analysis of how the region conditioned the discourse about madness, psychiatry, rehabilitation, and civilization. In the east as well as in the west, Canada as well as the United States, and throughout different decades, the medicalization of insanity and the asylum followed international trends, but adapted those influences to the regional conditions.

Similar to Grob, Rothman, and Tomes this work examines why western American and Canadian societies believed the asylum was necessary. Although local governments initially used

⁴² Rothman, *Discovery of the Asylum*, 48, 50, 121-123.

it as a means to incarcerate insanity, politicians and hospital administrators believed it offered a benevolent form of civilizing care. The superintendents increasingly adopted medical language used in the east to stress the perceived medical qualities of insanity and the asylum. Their practices were based on, or copied from the failed moral treatment regimen, which were initially humane but not therapeutically effective. Nevertheless, the system heavily influenced the asylum in each region, beginning with the building layout. Even Scull with all his criticisms against the asylum and moral treatment argues that the asylum offered an improvement over the historic interventions aimed at controlling madness.⁴³

The superintendents of Washington and Saskatchewan were motivated by a desire to establish, improve, and maintain a high public opinion of their profession and the asylum. These asylums were not Goffman's "total institutions" separated from society. They were instead more in line with Miron's conceptualization of institutions wherein they at times fulfilled an important social role as community centers. Superintendents understood they did not work in a vacuum. These men answered to the public, the patient's family members, and more directly to politicians. The asylums in Washington and Saskatchewan also became important community centers. They hosted Christmas bazaars, public events, and held public tours. These events placed the superintendent and the asylum in a position that made them directly visible and accountable to the wider society.

This study compares the evolution of the western asylum in Canada and the United States. These neighboring nations developed their mental health practices largely under the same influences. Superintendents throughout Canada and the United States held to philosophies that transcended political borders, as the asylum was a product of professionalizing psychiatrists but also part of a nation-building exercise.

⁴³ Scull, "Madness to Mental Illness," 223-226.

In examining the disparity between the eastern and western institutions this study uses a variety of primary and secondary sources. The secondary scholarship surrounding the Washington and Saskatchewan institutions is scarce.⁴⁴ The paucity of the research attests to how scholars recognize these institutions as archetypal Canadian and American mental hospitals that followed a standard evolution of asylum practices. The primary sources focus on hospital annual reports, regional newspapers, official correspondence, and letters to patients' family members. This restricted qualitative dataset presents both official and unofficial sources for analysing the function and form of the respective asylums.

The annual reports reveal the opinion of the superintendent and communicate the "official" history of the asylum. In these records asylum physicians highlighted the practices and decisions they believed were important for the asylum and its residents. Often times, they underscore the importance of institutional efficiency. As a wartime economy affected both regions, due to World War I, patients and the quality of care diminished as superintendents, often under pressure from politicians, stressed the economic efficiency of the institution over the welfare of the patients. The reports underscore how the administration managed the institution under these conditions. In Washington, state newspapers published an abbreviated form of the annual reports. This practice helps us understand how information was selectively distributed to the public.

⁴⁴ Due to its innovative psychedelic therapies, Saskatchewan Hospital, Weyburn has justifiably been the main source of asylum scholarship in the province. (For a few examples please see: Erika Dyck, *Psychedelic Psychiatry: LSD From Clinic to Campus*, (Baltimore: John Hopkins University Press, 2008); Erika Dyck, "Hitting Highs at Rock Bottom: LSD Treatment for Alcoholism, 1950-1970," *Social History of Medicine* 19 no. 2 (2006): 313-329.) Concerning the historiography of North Battleford, there is Harley Dickinson's *The Two Psychiatries, in addition to a few Master's thesis.* (Harley D. Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: University of Regina, 1989); Paul Nishida, "The Establishment of Saskatchewan's Mental Hospitals: 1912-1940," (M.A. Thesis, University of Regina, 1988); Jennifer Creighton, "Depression and The Depression: An Analysis of the Patient Ledgers of the Saskatchewan Hospital North Battleford, 1929-1939," (M. A. Thesis, University of Saskatchewan, 2011).) Washington's Western State Hospital has only Russell Hollander's article "Mental Health Policy in Washington Territory, 1853-1875." (Russell Hollander, "Mental Health Policy in Washington Territory, 1853-1875," *The Pacific Northwest Quarterly* 71 no. 4 (Oct., 1980): 152-161.)

Newspaper reports help to gauge public's opinion toward insanity, the asylum, and its administration. At times the articles adopt medical views and depict a progressive interpretation of insanity and the institution. Some of the more tolerant reports also merge archaic social and moral conceptions of insanity with progressive medical understandings. The newspapers are also representative of the ideals the hospital administration believed was important for public consumption. The reports often criticized the failings of politicians and the superintendents, features that did not appear in the annual reports.

The correspondence is limited to letters sent or received by superintendents, typically toward other physicians or local politicians. The communication between the superintendent and the government highlights the personal management style and opinions of the superintendents. These letters illustrate the sometimes confrontational attitude superintendents took toward those who questioned their medical authority. The correspondence also underscores how the unofficial opinion of superintendents often differed from that presented in the asylums' reports, helping to reveal the motivations of superintendents and how they differed from the more polished public relations texts.

These sources highlight the social, cultural, political, medical, and economic factors that first led to the construction of the asylums in Washington and Saskatchewan. They chart the evolution of these institutions by examining national trends in mental health against the particular regional manifestations. This study shows that the asylum did not evolve in a political-medical vacuum, nor were practices merely transported west without adaption or reflection upon the impact they might have on the public perception of the institution. Regional stimuli, as much as national ones, moulded asylum practices.

Chapter breakdown

This study is divided into five chapters. Chapter one focuses on the physical asylum structure, what it meant, and why specific designs and layouts were favored over others. Using key secondary works by Tomes and Yanni, it examines how Saskatchewan and Washington policy makers constructed their institutions to mirror those in the east, even as the AMSAII designed those structures to be an essential ingredient in their ineffective moral treatment program. Despite the failure of the system, its ideals became engrained into institutional mental health practices. The chapter also examines the physical representation of the asylum in the west. It shows how politicians constructed the institution with the specific goal of erecting it as a political symbol. Those involved in establishing and constructing the asylum understood the building as a symbol of civilization, the might of the government, and medical progress. By focusing on factors such as architecture, location, symbolism, and the intent of politicians and superintendents, this chapter emphasizes how regional attitudes became inscribed in the physical layout of the asylum and its grounds.

The next two chapters focus on the process of medicalizing insanity in the two institutions through the adapted use of moral treatment therapies. These chapters explore the evolution of moral treatment in each institution to show how policy makers first accepted the medical authority of the superintendent and then allowed them to reshape the principles of care to reflect the socio-economic and cultural realities of their region. Here the case studies diverge, emphasizing the local economic and agricultural conditions that influenced the treatment options.

Chapter two begins in the east before settling on Washington. It examines the introduction of moral treatment, as well as explaining its failure in the east. It scrutinizes how in the immediate wake of the AMSAII moving away from moral treatment Washington superintendents overtly began to use and advertise the system. The superintendents only adopted

the regimen, however, after they had wrested control of the asylum from powerful Washington politicians who were misusing the institution for monetary gain. To the physicians, moral treatment was an effective and humane system that helped alter the public's perception of insanity and the asylum. It allowed the superintendents to stress the therapeutic goals of the asylum and the medical nature of insanity.

Chapter three examines Saskatchewan's superintendent, Dr. James MacNeill's efforts at medicalizing insanity and improving the image of the asylum. The chapter considers how MacNeill wanted to be seen as the expert authority over insanity and desired the asylum to be understood as a medical institution. Although he frequently invoked the therapeutic well-being of his patients, the superintendent was concerned with solidifying his own professional standing. The chapter analyses how in the wake of the Canadian National Committee for Mental Hygiene inspection in Saskatchewan, the provincial government began the process of legally redefining insanity as a medical condition. It ends by examining how MacNeill advertised moral treatment therapies to the public to help them develop a more sympathetic view of insanity.

The regional differences define how the medicalizing approaches were justified and practiced in each region. Western superintendents readily adapted and advertised practices that had been forged in the east. They utilized these established eastern developments in a manner that ensured a continuation of their western traditions while also reflecting their own social and cultural realities. Although these superintendents supported moral treatment as therapeutically effective and humane when compared to traditional methods, there was an undercurrent in their language that reveals how they defined a functional and regionally appropriate citizen that bore out more subtle regional characteristics.

The last two chapters focus on patient labor, a key aspect of moral treatment. Superintendents established patient labor programs convinced that physical work was therapeutic. The subtleties between work and treatment, hard labor practices and occupational work, however, allowed politicians and superintendents to exploit this model for financial benefits.

Chapter four moves the narrative back to Washington where its first superintendent was business-minded and worked the inmates for his own financial gain at the expense of their therapeutic needs. Once his contract ended, the government changed the hospital administration, allowing asylum physicians to end the abuse that had become endemic in the program. Subsequent superintendents were initially hesitant to continue the labor program with the same intensity. Under political pressure and eventual acceptance from succeeding superintendents work therapy – sometimes refashioned as occupational therapy – once again flourished and became part of the hospital regimen albeit with politicians emphasizing farming over other forms of work therapy. This chapter highlights how local political and economic ideals, in this case relying on patient labor to offset institutional costs, shaped and sometimes overshadowed the medical goals of treatment. It shows how the superintendents in Washington wanted to build and maintain an occupational therapy program that centered on teaching locally applicable skills, rather than rely on farm labor and other labor intensive activities that were more traditionally associated with asylum care.

Chapter five examines how Saskatchewan found greater success with farming as therapy. In 1914, when Saskatchewan Insane Asylum at North Battleford opened its doors, the residents of the region understood, and, according to the *Battleford Press* newspaper, accepted matter-of-

factly that the hospital would work its patients for the improvement of the institution.⁴⁵ While Superintendent MacNeill did not disappoint in this regard, he initially had patients mainly work in occupational therapy rooms (ostensibly to build upon their established skillset or teach patients new skills), clean the wards, help with hospital chores, and perform minor landscaping duties. It was not long, however, before he put efforts into increasing the work done in the hospital farm, raising livestock, and contributing to construction programs. The chapter shows how MacNeill slowly advertised that by performing the “everyday” tasks similar to that of farmers and other residents of Saskatchewan his patients were once again able to be productive members of society and could reintegrate into the local economy. It considers the process of how matching institutional labor practices with the local economic environment; MacNeill convinced the surrounding community that agrarian work was an integral part of a patient’s rehabilitation and treatment.

The asylum in Canada and the United States had a longevity that outlasted its support in the east. By turning our gaze westward and examining governments and societies as they adopted the institution, we can more fully understand the persistence of the American and Canadian mental asylum and its relationship with ideals of civilization. Nationally established practices and therapies may have informed the practices employed within the Washington and Saskatchewan asylums, but as these institutions evolved over time the practices and therapies changed to reflect regional normative markers and acceptable cultural practices. By taking that understanding and examining asylums in the American and Canadian west, we can better understand what factors defined those regions.

⁴⁵ In a news article published on February 5, 1914, in the *Battleford Press*, the reporter stated that before the patients had arrived at the asylum, a landscaper was “on the ground preparatory to laying out roads and planning to beautifying of the grounds,” followed by, “Practically all this manual work will be performed by the patients, as well as the farm work which will be conducted later.”

Chapter One

Echoes of the East: The Western Asylum Building

In the preliminary remarks for the second edition of his book *On the Construction, Organization, and General Arrangements of Hospital for the Insane*, Thomas Kirkbride argued that insane asylums provided the “most enlightened treatment for all the insane.”⁴⁶ While “most other diseases may be managed at home,” he wrote, “it is not so...with insanity.” Although not every case needs to leave home, experience dictated “that a large majority of [people considered insane] can be treated most successfully among strangers...in institutions specially provided for this class of disease.”⁴⁷ Kirkbride was a founding member of the Association of the Medical Superintendents of American Institutions for the Insane (AMSAI) and one of its leading figures throughout his career. First published in 1854, his book, according to historian Nancy Tomes, “established him as the acknowledged American authority on asylum construction and design.”⁴⁸

Construction and hospital arrangement was a topic that interested most of the AMSAI membership, as many members believed only an appropriately designed asylum had the ability to help treat insanity effectively.⁴⁹ During its inaugural meeting, the 13 founding members proposed a “variety of subjects . . . for the consideration of the Association.” When the discussion ended they settled on five topics they deemed essential for the development of their profession and the successful treatment of insanity. Fifth on that list was “the Construction of Hospitals for the Insane.”⁵⁰ Although last on the list, the topic of asylum construction and

⁴⁶ Thomas S. Kirkbride, *On the Construction, Organization, and General Arrangements of Hospital for the Insane with some remarks on insanity and its Treatment*, 2nd ed., (Philadelphia: J. B. Lippincot & Co., 1880), 18.

⁴⁷ Kirkbride, *Construction, Organization, and General Arrangements*, 18-19.

⁴⁸ Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883* (Cambridge: Cambridge University Press, 1984), 6.

⁴⁹ On pages 19-20 of his book, Kirkbride claimed that as late as 1880 he was receiving letters inquiring about appropriate hospital layout.

⁵⁰ “Medical Association. Meeting of the Association of the Medical Superintendents of American Institutions for the Insane,” *The American Journal of Insanity* (hereafter referred to as *AJI*) 1 (January 1845): 253. According to the

arrangement became important to the AMSAII; they believed the correct layout helped alleviate insanity while a deficiently designed and built asylum hindered recovery. Over the years, the mental asylum became the defining feature of the Association; it was a cornerstone of their leading moral treatment regimen and a physical representation of their profession.

Emerging from a mixture of medical and social ideals, the AMSAII, led by Kirkbride, designed the insane asylum with an eye to medical and professional efficiency. They intended it to be a symbol of hope, security, order, and medicalization. While the therapies within the asylum induced traditional behaviors, the structure outwardly represented modernization and progress; it became an emblem of professional legitimization both to society and to the Association's own professional ranks. Although it initially assumed these qualities the AMSAII had designed the hospital based on moral treatment ideals of the early to mid-1800s. According to the Association, moral treatment was the humane therapeutic regimen that inculcated traditional normative values into asylum inmates. In the asylum superintendents treated their inmates with a combination of work, past-time activities, and a monitored diet, all offered within a strict daily regimen. These were the elements authorities believed worked toward easing or relaxing a disturbed mind. With this conviction, the building itself became an essential part of a superintendent's therapeutic armament.

This chapter shows how the insane hospital in Washington became a symbol of the medicalization of insanity and the power of the emerging state government. When advancing arguments for a new structure, hospital administrators, while advancing arguments of improved

minutes of the first organizing meeting, members of the AMSAII proposed a "variety of subjects . . . for the consideration of the Association." When the discussion ended, the members had five issues that they deemed essential for the advancement of their newly formed profession. On that list was 1. The Moral Treatment of Insanity; 2. Medical treatment; 3. Jurisprudence of Insanity; 4. Statistics of Insanity; and 5. Construction of Hospitals for the Insane. These were the most important areas on which the Association wanted to focus. They subdivided these topics into more nuanced areas and doled out the responsibilities of each to committees. This was an effort to standardize practices and solidify their position as experts on all things related to insanity.

asylum practices, placed enhanced therapies secondary to other arguments that more readily appealed to politicians. Overtly, the hospital's Board of Trustees argued a new state-of-the-art building represented the benevolence of the government toward its citizens, especially those in need. Built two years prior to Washington achieving statehood, the asylum helped mark the modernization and civilization of the region. It symbolized the trust the public needed to place in its regional government and it became a symbol of the growing dominance of medicine over insanity.

The chapter will then describe how Saskatchewan, following similar ideals of civilization and social modernization, built its mental hospital in the decade after becoming a province. Similar to Washington, Saskatchewan's provincial "insane asylum" was a marker of modernization, yet it deviated from its American counterpart in that the building also emerged as a symbol of security. Initially the provincial government used the asylum as a place to incarcerate people deemed "insane and dangerous to be at large," people they legally referred to as inmates.⁵¹ Its first superintendent, Dr. James MacNeill, quickly worked to change that. Underplaying the idea of confinement, he altered the image of the asylum as a place for incarceration – protecting the public from insanity – to an institution of clinical care, a hospital. Despite these semantic differences, superintendents in both regions used the asylum structure to legitimize their efforts and garner public support for their professional goals as psychiatrists.

The older issues these superintendents challenged and the perceived image of the asylum were not new to Saskatchewan and Washington. Indeed, these two regions built their hospitals following the layout promoted by early members of the AMSAII. To the Association the asylum was an effective tool for accommodating insanity, at times more valuable than medicine. To

⁵¹ Saskatchewan Legislative Assembly, *An Act Respecting Insane Persons*, chapter 22, section 1, 1st Legislature, 1st session, (Regina, 1906), 104.

many of the members, the organization and efficiency wrought from the building were valuable instruments; anything less than the proper construction and organization made curing insanity more difficult. As historian David Rothman wrote, early superintendents believed “the institution itself held the secret to the cure of insanity. Incarceration in a specially designed setting, not the medicines that might be administered or the surgery that might be performed there, would restore health.”⁵² These men were not motivated to change the hospital construction for construction’s sake, nor did they want to improve upon previous building conditions, although both ideals played a part. The impetus resided in the notion that a carefully constructed and maintained atmosphere, one of order and rules, eased the disordered mind. Anything less than the proper building was, as historian Carla Yanni explained, “a sad compromise.”⁵³

Insanity, as early members of the AMSAII defined it, stemmed from a disordered mind that caused a person to display erratic behavior. These superintendents believed the condition resulted from a person’s inability to cope with the social pressures and turmoil that existed in their environment. According to historian James Moran, asylum advocates believed “the presence of the insane in the community was disruptive and unhealthy for both patient and family, and they almost always recommended the patient’s prompt removal from the social milieu of ‘morbid associations’ to the curative influence of the asylum setting.”⁵⁴ In the asylum, through their moral treatment regimen, they worked to replace disorder with order to incite relaxation and calmness. According to Rothman, superintendents wanted to “re-create fixity and stability” in the inmate’s life by creating “a different kind of environment, which methodically

⁵² David J. Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic*, 1st ed., (Boston: Little, Brown and Company, 1971), 133.

⁵³ Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007), 49.

⁵⁴ James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal: McGill-Queen’s University Press, 2000), 18.

corrected the deficiencies of the community,” only then, they believed, “a cure for insanity was at hand.”⁵⁵ The fast pace of modern, especially urban or industrial environments, arguably excited the mind, causing disordered thinking and nervous breakdown. Whereas social disorder caused personal disorder, that is to say insanity, superintendents believed inculcating order overcame it. Thus, the Association structured everything related to the regimen around organization and routine.

Order and stability were important to alleviate the patient’s conditions, yet the asylum also needed to be a welcoming environment. In 1844 Dr. John Galt of the Eastern Lunatic Asylum, in Williamsburg, Virginia, argued the institution must make incoming patients feel comfortable in their new surroundings. “In many instances,” he wrote, “patients received into an asylum are taken from close confinement at home, or from such dark disagreeable rooms in a jail. Being admitted from such situations, if the asylum is comfortable and pleasant, the mere change itself is soothing and restorative.”⁵⁶ Galt’s statement underscores a belief in the asylum as the best place for curing insanity, even above home care. He argued that the institution needed to be a pleasant place that provided refuge from external troubles. The asylum instilled order, but it also had to provide a soothing environment that both calmed and even had the capacity to restore a disturbed or anxious mind. Despite the Association’s desire for constructing the proper asylum building, their understanding of what that constituted developed slowly and unevenly.

In 1851 the AMSAII published a set of guidelines in the *American Journal of Insanity* (*AJI*).⁵⁷ These instructions advanced building ideas that the Association believed were essential

⁵⁵ Rothman, *Discovery of the Asylum*, 133.

⁵⁶ Virginia Hospital for the Insane, *Annual Report* (Williamsburg), 1844, 25, as quoted in Yanni, *The Architecture of Madness*, 54. Yanni never attributes this quote to anyone, but the time does coincide with the appointment of AMSAII founding member Dr. Galt.

⁵⁷ The Association of Medical Superintendents of American Institutions for the Insane (hereafter referred to as AMSAII), “Report on the Construction of Hospitals for the Insane, made by the Standing Committee of the

for the successful treatment of insanity. The committee that wrote the article based their concepts on an 1847 article written by AMSAII member Horace Buttolph.⁵⁸ When Buttolph's wrote his article, titled "Modern Asylums," he was preparing to become the superintendent of the New Jersey State Lunatic Asylum. While not naming that institution, he essentially described its layout, which Kirkbride had previously drafted at the request of New Jersey's Asylum Commissioners.⁵⁹

Carla Yanni claims Buttolph "almost certainly worked with Kirkbride" when he wrote the article.⁶⁰ Due to Kirkbride's substantial influence, who was already at the forefront of building reform, the AMSAII construction committee took note. They assumed many of Buttolph and Kirkbride's building concepts and presented them at the Association's 1850 annual meeting, eventually publishing their findings under the title "Report on the Construction of Hospitals for the Insane." The report outlined twenty-six "propositions relative to the structure and arrangement" of American asylums – points the committee believed were essential when constructing the proper curative insane asylum.⁶¹

In 1854 Kirkbride published his own book on hospital construction. Although the New Jersey asylum in Trenton followed his plans he "regretted that various modification were made in the details of the original plan and made it...less perfect than it otherwise would have been."⁶² While Buttolph's article and the committee's report used the "less than perfect" Trenton asylum as a template, Kirkbride's book provided him with the room to expound on ideas and resolve any

Association of Medical Superintendents of American Institutions for the Insane, at its meeting in Philadelphia, May, 21, 1851," *American Journal of Insanity* 8 (July, 1851): 79-81.

⁵⁸ H. A. Buttolph, "Modern Asylums," *AJI* 4 (April, 1847): 364-78.

⁵⁹ Horace Buttolph, "Historical and Descriptive Account of the New Jersey State Lunatic Asylum," *AJI* 6 (1849-50): 5; Kirkbride, *Construction, Organization, and General Arrangements*, 136-37.

⁶⁰ Yanni, *The Architecture of Madness*, 52.

⁶¹ AMSAII "Report on the Construction of Hospitals for the Insane," 79.

⁶² Kirkbride, *Construction, Organization, and General Arrangements*, 137.

assumed deficiencies of current notions concerning construction – though he did not stray from the initial points presented in either of the previous articles.

In 1854, however, the proper asylum still did not exist in North America, according to Association founding member Isaac Ray. Ray argued there were many inadequacies found in American asylum buildings, which hindered the therapeutic work of the superintendent and the comfort of the inmates. The buildings, he observed, caused “the classification of the patients [to] be poorly provided for, or the fixtures frail and inadequately secured, or the supply of water deficient.” He continued,

The whole establishment has a narrow and cramped appearance, probably with a mean exterior, presenting, perhaps, some abortive attempts at architectural display, while the grounds have been suffered to remain very much as Providence left them. The lunatic hospital does not exist among us, in which nothing is wanted to fit it completely for its destined purpose. It is far from being generally understood how important a part architectural arrangements act in the custody and cure of the insane.⁶³

Through his book, Kirkbride advocated for a structure that overcame the problems forwarded by Ray while prioritizing the need for a calming environment to relax inmates and facilitate with the regulation of a disordered mind. Kirkbride’s writings, he claimed, outlined features “originally proposed as desirable in a hospital for the insane... Everything, so far as buildings are concerned, requisite for the custody, comfort, and *enlightened treatment of the patients*; and arrangements throughout that will allow the supervision to be thorough and effective, and the management to be liberal and at the same time strictly economical.”⁶⁴ Kirkbride believed that when following what he termed “the linear plan” (what Buttolph called “the Lineal form”) the asylum provided practical assistance in treating insanity. Moreover, the building structure he advocated for reinforced the AMSAII’s “enlightened” moral treatment

⁶³ Isaac Ray, “American Hospitals for the Insane,” *North American Review* 19 (July, 1854): 71-72.

⁶⁴ Kirkbride, *Construction, Organization, and General Arrangements*, 141. Emphasis added.

ideals. As historian Gerald Grob maintained, “The asylum was designed in such a way as to facilitate moral and medical treatment.”⁶⁵

Some of the building features Kirkbride, Buttolph, and the Association deemed essential were based on practicality and the technology of the time. Others were more innovative and molded from more explicitly medical understandings of the triggers of disorder as well as their antidotes. They agreed that a suitable location allowing for a compelling and soothing view and plentiful fertile soil was as important as the building itself. According to Isaac Ray, the asylum needed “spacious windows” through which “the inmates should have constantly before their eyes the surrounding country, which is, certainly, a more agreeable object to behold than a monotonous range of doors in a dreary expanse of brick wall.”⁶⁶ Kirkbride concurred that building planners needed to situate a hospital so that “every possible advantage may be derived from the views and scenery adjacent.” He continued, agreeing with Ray, that “the prevailing winds of summer and the finial influence of the sun’s rays at all seasons, may also be made to minister to the comfort of the inmates,” as such the “hospital should have a gradual descent” so that inmates may take advantage of an unobstructed view, light, and air flow.⁶⁷ Placed on a hill and a sufficient distance from the disturbing pace of urban environments, the asylum needed to allow for plenty of sunlight and ventilation, while its isolated location ensured patient privacy, despite the “spacious windows.”

Buttolph recommended the asylum be “surrounded by land of a dry fertile soil and at a convenient distance from some market town.”⁶⁸ Kirkbride agreed. He wrote that “the land chosen should be of good quality and easily tilled . . . Every hospital for the insane should

⁶⁵ Gerald Grob, *The Mad Among Us: A History of the Care of America’s Mentally Ill*, (New York: The Free Press, 1994), 71.

⁶⁶ Isaac Ray, “American Hospitals for the Insane,” *North American Review* 79, no. 1, (July 1854): 78.

⁶⁷ Kirkbride, *Construction, Organization, and General Arrangements*, 53.

⁶⁸ Buttolph, “Modern Asylums,” 364.

possess at least one hundred acres of land, to enable it to have the proper amount for farming and gardening purposes.”⁶⁹ Locating the farm on fertile soil, according to historian Geoffrey Reaume, supported the belief that the increasingly popular work therapy helped effectively treat insanity, but also that farms and gardens, sustained by patient labor, alleviated hospital maintenance costs.⁷⁰ Placing the hospital on quality soil, he wrote, “allowed asylum officials to exploit people who were in no position to contest their...status.”⁷¹

Although work therapy became an indispensable aspect of moral treatment within the North American mental hospital, the AMSAII did not include land quality on their list of proposals, as patient labor had yet to gain wide professional acceptance as a therapy in 1851 when the Association published their guidelines.⁷² The article did state, however, that for every 200 patients there needed to be 100 acres of land, but “the highest number that can with propriety be treated in one building is two hundred and fifty, while two hundred is a preferable maximum.”⁷³ Accordingly each hospital needed to maintain a 250-population capacity, and only required 125 acres of land.

Kirkbride argued it was imperative to locate the asylum on an advantageous area that provided many essential characteristics. The land and site needed to be carefully selected, even if it meant paying a premium.⁷⁴ Beyond the amount and location of the land, the necessary scenery, and ample sunlight, the AMSAII article stated, “all buildings should be constructed of stone or

⁶⁹ Kirkbride, *Construction, Organization, and General Arrangements*, 38.

⁷⁰ Geoffrey Reaume, “Patients at Work: Insane Asylum Inmates’ Labour in Ontario, 1841-1900,” in *Mental Health and Canadian Society*, ed. James E. Moran and David Wright (Montreal & Kingston: McGill-Queen’s University Press, 2006), 69.

⁷¹ Reaume, “Patients at Work,” 88.

⁷² In 1866 Association member Isaac Ray published an article titled “The Labor Question, and Hospitals for Incurables” (*AJI*, 22, (April, 1866)). On page 441 he wrote that patient labor was increasingly popular in insane asylums, not under the “idea of proving a theory, but solely for the purpose of making the most of a good thing.”

⁷³ AMSAII, “Report on the Construction of Hospitals for the Insane,” 79, 80.

⁷⁴ Kirkbride, *Construction, Organization, and General Arrangements*, 37.

brick” to make them “as far as possible . . . secure from accidents by fire.”⁷⁵ Buttolph shared a similar position: “the material of which an asylum is constructed, should be of the most durable character, and on this account, as well as for other reasons, stone is preferable.”⁷⁶ Kirkbride advocated for either of these, whichever one is “most convenient and economical,” but that the material “be made as neatly fireproof as circumstances will permit.”⁷⁷

In her book on asylum construction, Yanni wrote, “The sheer size of the building, the use of stone, and the formality of the entrance suggested the stability of a state institution.”⁷⁸ Architects aimed to project “stability of a state institution” through the mental hospital, but these features had the possibility of making the asylum appear dreary or mundane. Moreover, having emerged in the same era as prisons, almshouses, and orphanages there was a tendency for the public to link the mental hospital to other aspects of deviancy, poverty, or criminality.

The belief of insanity as personally electable abnormal behavior that required incarceration persisted in the minds of the public. To overcome this misconception and to break association with other institutions associated with deviancy or personal inadequacy, superintendents had to make the asylum as inviting as possible. Overall, Kirkbride believed, “a hospital for the insane should always . . . have a cheerful and comfortable appearance, every thing [sic] repulsive and prison-like should be avoided . . . as far as possible, by arrangements of a pleasant and attractive description.”⁷⁹ He advocated that mental asylums not resemble other state institutions; specifically, they must vary in appearance from prisons and be “distinguished from factories or workshops.” Because “the surroundings of patients greatly influence their

⁷⁵ AMSAII, “Report on the Construction of Hospitals for the Insane,” 80.

⁷⁶ Buttolph, “Modern Asylums,” 365.

⁷⁷ Kirkbride, *Construction, Organization, and General Arrangements*, 62, 63.

⁷⁸ Yanni, *The Architecture of Madness*, 52.

⁷⁹ Kirkbride, *Construction, Organization, and General Arrangement*, 52.

conditions and feelings” and helped soothe a disturbed mind, he recommended the hospital and its grounds maintain a pleasant appearance.⁸⁰

The building proper needed to follow basic guidelines in order to be effective; a judiciously constructed building helped calm a disordered mind. Its various aesthetics held meaning and purpose to the Association membership. The linear layout, Buttolph wrote, required a central administration building with wings emanating from either side. The central building housed the “officers, the necessary domestics . . . offices for the physician and steward, and [a] reception room.”⁸¹ The AMSAII affirmed that the central building must contain the offices, receiving rooms for visitors, and private apartments for the superintending physician and his family, “in case that officer resides in the Hospital building.”⁸² Kirkbride advanced that idea further and recommended the central building have the “apartments of [all] the officers, who are expected to reside in it,” for, “not to do this, is neither wisdom nor economy.”⁸³

The center administration section was typically the largest section of the hospital. It was, writes James Moran, placed “symbolically” in the center, and was the “supreme medical and moral power of the institution,” often housing the superintendent.⁸⁴ The superintendent was the highest-ranking member of the institution, as a father was the head of the household, so too was he the head of the asylum family. Michel Foucault argues, the asylum took on “the myth of the patriarchal family: it aimed to be a great fraternal community of patients and helpers, under the authority of the directors and the administration. It was a rigorous family, without weakness or complacency, but fair, in accordance with the great image of the biblical family.”⁸⁵ The asylum,

⁸⁰ Kirkbride, *Construction, Organization, and General Arrangements*, 47.

⁸¹ Buttolph, “Modern Asylums,” 366.

⁸² AMSAII, “Report on the Construction of Hospitals for the Insane,” 80.

⁸³ Kirkbride, *Construction, Organization, and General Arrangement*, 54.

⁸⁴ Moran, *Committed to the State Asylum*, 84.

⁸⁵ Michel Foucault, *History of Madness*, ed. Jean Khalfa, trans. Jonathan Murphy and Jean Khalfa (London: Routledge, 2006), 474.

he argued, was structured around the ideal of family. The superintendent in the dominant center position was the father figure.⁸⁶ It was not all symbolism, however. For example, the center administration section was large because before modern plumbing it typically housed the water storage tank and gravity fed water to the hospital wings. Technology demanded that it be taller than the rest of the building. Much of what the Association desired in the proper asylum was born of necessity, but also reinforced a particular power dynamic that flowed through the institution.

Emanating out from the center, were “wings on either side...sometimes joined by others running backward [in a U-design], or overlapping half their width, and extending in the same direction [in a shallow V].”⁸⁷ They designed the wings as a means to classify and separate patients by sex and severity of illness, but also to maximize natural light and ventilation. The AMSAII advocated having the male and female wings divided into eight wards for further classification of the patients. Each of these wards were to have the patients’ basic necessities, including “a parlour,” “single lodging-rooms,” “a clothes room, a bath room, a water closet, [and] a dining room.”⁸⁸

Nancy Tomes, who wrote extensively on Kirkbride and his asylum ideas, believes that his opinion “of asylum construction and management posited an absolute control of the hospital environment.”⁸⁹ Many members within the Association saw this as a necessity, only a properly maintained and ordered hospital, from building structure to patient management, was successfully able to treat insanity. Kirkbride advocated for his particular hospital design

⁸⁶ Gerald Grob, *Mental Institutions in America: Social Policy to 1875*, (New York: The Free Press, 1973), 168-169; for the asylum as a faux family see also: Anthony Brandt, *Reality Police: The Experience of Insanity in America* (New York: William Morrow and Company, Inc., 1975), 36.

⁸⁷ Buttolph, “Modern Asylums,” 366.

⁸⁸ AMSAII, “Report on the Construction of Hospitals for the Insane,” 80.

⁸⁹ Tomes, “A Generous Confidence,” 138.

forcefully and frequently enough that people began to associate hospitals built with the linear layout as the “Kirkbride plan.” Its physical shape and dimensions fit together elements of health with cost efficiency and state priorities. The building displayed a manufactured image of strength and order, both for the emerging psychiatric profession and regional governments.

Washington Builds for Change

Despite the attention the architecture received from the AMSAII, Washington legislators, reminiscent of eighteenth century European caretakers, cared little about the ostensible healing environment of the asylum. Sociologist Andrew Scull argues when tasked with establishing a site for a new mental hospital people associated with the treatment of insanity (i.e., governments and physicians) “disdained the expense of building from scratch...instead [they] crudely adapted and renovated existing buildings...that could be cheaply fitted up to contain their charges.”⁹⁰ For many years after selecting the abandoned Fort Steilacoom as a permanent site for their first mental hospital, the government and the asylum administration faced many difficulties pertaining to building conditions, water rights disputes, and soil quality. As it was, the politicians created that situation, having failed to adhere to the advice of Thomas Kirkbride. In his book on proper construction, the AMSAII founding member warned, “under no circumstances should an unsuitable site [for an asylum] be accepted because it is offered as a gift to the State.” Just like the novel features, “such a gift,” he warned, would “prove costly in the end.”⁹¹ This was prophetic for Washington. When selecting a permanent location for their hospital the government focused on its immediate financial obligations and bought a site for cheap. The land and the buildings may have been financially beneficial for the government in the interim, but over time they became expensive burdens to the state coffers.

⁹⁰ Andrew Scull, *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine*, London: Thames & Hudson Ltd., 2015), 137-8.

⁹¹ Kirkbride, *Construction, Organization, and General Arrangements*, 37.



Figure 1. Hospital for the Insane of the Territory of Washington, Fort Steilacoom, circa 1870s, photographer unknown, photo courtesy of Western State Historical Society, Washington.

When the federal government put Fort Steilacoom up for sale in 1869, the territorial government sent an appointed Board of Commissioners to purchase the land and the buildings “at a reasonable sum” from the federal government so that they could establish a permanent site their “insane asylum.”⁹² Despite their willingness to pay a “reasonable sum,” the legislative assembly anticipated not paying at all. In October of 1869 (two months before they drafted the act to purchase the fort), the territorial legislation passed a resolution to create a committee to inquire “what steps are necessary to procure a grant [for the] buildings and the grounds...for the purpose of permanently establishing an asylum for the insane.”⁹³ The Washington government understood the necessity of having an asylum, yet they were not financially able to pay for the

⁹² Washington Territorial Legislative Assembly, *An Act to Authorize the Purchase of the Government Buildings at Fort Steilacoom for an Insane Asylum*, Made and Passed at a session of the Legislative Assembly begun and held at Olympia on the Fourth Day of October 1869, and Ended of the Second day of December 1869, Ninety-Fourth Year of Independence, Chapter IV, (Olympia: James Rodgers, Printer, 1869), 553, Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx, accessed on September 30, 2013.

⁹³ Washington Territorial Legislative Assembly, *Creating a Joint Select Committee to Visit the Government Buildings at Fort Steilacoom and the Territorial Penitentiary*, (Olympia, 1869), 513-12.

style of building advocated by Kirkbride and the AMSAII. By their own admission, “the present revenues of the Territory [were] barely sufficient to pay for the administration of justice.”⁹⁴ The government settled on a permanent site but had little money to invest in it; they had dedicated most of their budget toward maintaining order and enforcing the law. Nevertheless, their definition of “administration of justice” prompted them to acquire a fixed location for the incarceration and treatment of insanity.

Washington Legislature reached out to the federal government for assistance. Initially, the US government agreed to sell the buildings and the land for a total sum of \$850. After some negotiation, however, they agreed to donate the site as long as Washington used them expressly for the housing and treatment of insane people.⁹⁵ With the purchase of the fort, the government secured “all the aids that nature can afford to restore lost reason.” The site was so agreeable, wrote one news account from the *Weekly Pacific Tribune*, “little will be required at the hands of the keepers beyond humane treatment.” That news report argued that nature, and not medicine, afforded the greatest aid in the treatment of insanity. Beyond providing “humane treatment” they believed there was little required of the staff. Placing the environment over medicine in the treatment of insanity was a concept repeated by the public 40 years later when the Saskatchewan government began looking for a site to place their first asylum. Nevertheless, due to its economical price and therapeutic environment, the Washington newspaper wrote the transaction was the “most sensible act of the late Legislature.”⁹⁶

⁹⁴ Washington Territorial Legislative Assembly, *Asking a Grant of Government Buildings and Grounds at Fort Steilacoom*, Made and Passed at a session of the Legislative Assembly begun and held at Olympia on the Fourth Day of October 1869, and Ended of the Second day of December 1869, Ninety-Fourth Year of Independence, Memorials, (Olympia: James Rodgers, Printer, 1869), 553, Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx, accessed on September 30, 2013.

⁹⁵ Washington Society for Mental Hygiene, *Mental Health in Washington: Facilities and Needs*, (Seattle, 1929), 14.

⁹⁶ “A Good Day’s Work,” *Weekly Pacific Tribune*, January 2, 1870.

By 1871 Washington Territory owned 25 buildings and 728 acres of land for its first insane hospital. The procurement of the decommissioned fort was fiscally beneficial for the government at the time, yet the deteriorating buildings were expensive to maintain. Before the first inmates moved into the asylum, the government spent \$3,606.23 in repairs to make the buildings inhabitable.⁹⁷ Thereafter the hospital's superintendents fought against the decay as they continually invested in maintenance just to keep the buildings inhabitable.

Over the 12 years the hospital utilized the old military buildings, the structures became progressively worse. Meanwhile, the patient population was reaching maximum capacity. Instead of expanding to fit the needs of the patients, the poor conditions forced Superintendent John Waughop (1880-1897) in 1883 to vacate buildings as they became too dangerous to use, thereby exacerbating the poor living conditions. The structures became a problem larger than the asylum staff was capable of managing. According to the Trustees their condition hampered the goal of the institution, which was "the care, custody, and, if possible, the restoration to reason" of the inmates.⁹⁸ The circumstances had forced Waughop to invest in increasingly heavy repairs, putting the hospital \$1,500 in debt and eschewing funds originally set aside for treatments.⁹⁹ Furthermore, due to the "extreme age of the buildings" the superintendent had a difficult time getting and storing water, he argued. This was a problem, as a lack of on-site water not only made it difficult to store enough water for "domestic use" it called into question the protection of

⁹⁷ Washington Territorial Legislative Assembly, *An Act for the Relief of Hill Harmon*, Statutes of the Territory of Washington, Made and Passed at a session of the Legislative Assembly begun and held at Olympia on the Second Day of October 1871, and Ended of the Thirteenth day of November 1871, Ninety-Sixth Year of Independence, Local and Private Laws, (Olympia: Prosch & McElroy, Printers, 1871) 167, Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx, accessed on Sept., 30, 2013. According to the United States Department of Labor, (which only tracks inflation back to 1913) \$3,606.23 was valued greater than \$86,000 by today's worth.

⁹⁸ Territory of Washington, *Report Board of Trustees of the Hospital for the Insane of the Territory of Washington, 1883*, (Olympia: C. B. Bagley, Public Printer, 1883), 3.

⁹⁹ Territory of Washington, *Report of the Hospital for the Insane of the Territory of Washington, 1881*, (Olympia: C. B. Bagley, Public Printer, 1881), 16-17.

“inmates against the danger of fire.”¹⁰⁰ Although it was a gift, Fort Steilacoom was proving costly for the administration and the government. The location was proving costly in ways beyond money. The lack of sufficient water rights potentially exposed the inmates to the threat of fire and resulted in daily limited water usage.

The physical issues made the day-to-day operations difficult, however the hospital had other, arguably larger problems. The Trustees explained there was a growing disparity between the general population increase (44% from 1881-1883) and the hospital population increase (only 35% increase). One possible explanation they gave for this was that extensive repairs on the dilapidated buildings precluded the hospital administration from investing in necessary expansions. Another explanation suggested the public had a low opinion of the hospital and its staff. The public opinion, they concluded, prevented people, despite exhibiting symptoms, from being committed until it was too late for successful treatment.

While not unique to Washington, the territorial laws essentially made commitment and parole of people judged insane a legal prerogative. It was a situation that placed the superintendent’s medical opinion second to judges, juries, and oversight committees.¹⁰¹ Additionally, the use of military buildings reinforced the public perception that caring for insanity ranked low in priority, or that perhaps the institution was merely a stop-gap measure to remove people from society and keep them from view rather than invest in modern medicine.¹⁰²

¹⁰⁰ *Hospital for the Insane of the Territory of Washington, 1883*, 4.

¹⁰¹ During its early years, Superintendent H. C. Willison complained “Only the “Board of Inspectors, (none of whom are medical men) have the legal authority to say when patients shall be discharged. Yet, it may not be generally known that this very important prerogative is never exercised by them without first consulting the judgement or wishes of the contractor in the matter [in this case Hill Harmon]. The popular opinion that the physician is the proper one to judge of a patient, whether he is fit to leave the hospital, or not it seems is entirely ignored in the management of this institution.” This comes from, Members of the Medical Society of Washington Territory, *A Supplement to the Late Asylum Controversy*, (Olympia, W. T., Printed at the Olympia Transcript Job Rooms, 1875), 22.

¹⁰² Using Fort Steilacoom as a mental hospital only served to hurt the hospital’s already marginalized public image. Historian Annmarie Adams, when writing about extemporized medical centers, argues, “with respect to this question of the borrowed building as space for the excluded that it was particularly marginalized and/or ethnic groups which

Instead of being a medical issue, insanity at that time in Washington was a marginalized condition that received minimal political attention. In place of a reserved hospital structure, the government forced people judged insane to seek help in derelict military buildings, further underscoring the desperate nature of seeking care for insanity. By their nature, those buildings established an air of intensity and military style rehabilitation instead of humane medical treatment. As the government continued to utilize the original Fort Steilacoom structures, the public failed to see the institution as a medical center. For example, although Waughop constructed and maintained an atmosphere of order and rules, as advocated by AMSAII guidelines, after taking a tour of the hospital in 1881 one news reporter from the *Puget Sound Weekly Argus* described the environment as having an air of “military neatness.”¹⁰³

To improve the image of the hospital and its inmates, the Trustees, in 1883, first recommended a simple change: amend the law to dispense “with the word ‘prisoner.’” Doing so, they contended, would help break links between insanity and criminality that were persistent throughout the region and “be in better taste, and far preferable” for people needing care.¹⁰⁴ Their next recommendation was far more costly and crucial. They asked for a new hospital to replace their inadequate buildings. This move, the Trustees believed, would improve the image of the institution, help legitimize the superintendent and his profession, and exhibit the benevolence of the government toward those in need. In the east the AMSAII had already medicalized insanity and professionalized psychiatry in an effort to clean up the image of care for people deemed insane. The superintendents in Washington, in a desire to do the same, were

saw the origins of their health care institutions in...ad hoc situations.” (Annemarie Adams, “Borrowed Buildings: Canada's Temporary Hospitals during World War I,” *Canadian Bulletin of Medical History/Bulletin Canadien d'histoire de la médecine* 16 no. 1 (1999): 42-43.)

¹⁰³ “Steilacoom,” *Puget Sound Weekly Argus*, Sept. 16, 1881.

¹⁰⁴ *Hospital for the Insane of the Territory of Washington, 1883*, 5.

keen to follow this path of “progress” and establish their own proper asylum, complete with modern medical approaches and clinical language.

The Hospital for the Insane of the Territory of Washington also had the undertaking of reforming its image following years of allegations of abuse and mismanagement brought against its first superintendent, Hill Harmon. Harmon did not have any medical training, he was a businessperson turned politician who, in 1870, used his political connections to secure the superintendent position at the hospital. His business and political background shaped his management style in a manner that clearly placed fiscal responsibility above medical treatment or the basic needs of the inmates. This approach led to frequent charges of abuse and prompted family members of inmates, physicians, and local newspapers to ask questions and accuse Harmon and his staff of maintaining an inadequate level of care.¹⁰⁵ Their allegations tended to emphasize the incarcerate nature of the asylum. In an effort to overcome this image and solidify links between the asylum and medicine, resident physicians under Harmon sought out and received professional support from The Medical Society of Washington Territory as they levelled their own accusations of abuse against Harmon.¹⁰⁶

When attempting to overcome these not-too-distant issues and facing the increasingly decrepit structures, Waughop and the hospital’s Trustees, beginning in 1883 and continuing into 1885, urged the government to erect a new hospital and tear down the buildings deemed unusable and hazardous. The fact that it took over three years for the government to comply with their requests reveals the persuasive nature of the administration and how important they believed the building to be in establishing the proper care of insanity. The motivation varied,

¹⁰⁵ Hill Harmon and the accusations levelled against him are examined in better detail in chapter 2.

¹⁰⁶ Eight years later Waughop was still fighting to establish a medical image for himself. To stress the professional disparity between Washington superintendents and those working in the eastern regions of the United States further, the larger AMSAII body had frequently refused to affiliate with American Medical Association, believing their profession was, according to Grob, “secure, well-paying, and provided status and prestige.” (*Mad Among Us*, 76.)

however. The Trustees saw a new building as symbolizing the power of the government toward those in need of assistance, an act of benevolence. For Waughop it represented progressive medicine and the humane treatment of insanity.

To gain support for a new building, the Trustees appealed to the Christian nature of the politicians to help those in need. In colonial America pastors encouraged their congregation specifically and the community in general to care for the poor, which they defined as insane peoples, criminals, delinquents, etc. In proclaiming the Christian duty of the individual, the pastors, according to David Rothman, focused “on the doer and his deed” and not necessarily the poor or their needs. It was God’s will that people were poor; they suffered so that devout Christians had the opportunity to help their neighbors and prove themselves to the Almighty. Pastors advocated the Puritan ideal that one’s outward actions proved their Christian and personal worth. How they performed those deeds and who they helped was of lesser concern.¹⁰⁷ Although the orthodox Puritan faith had disappeared by the eighteenth century, the idea of proving one’s worth through their acts persisted.¹⁰⁸

When appealing to Washington’s government for a new building in 1883, the Trustees of the insane hospital adopted a position that was reflective of the opinions of early asylum advocates. The Trustees argued the public was “particularly sensitive” in the management of the insane. The old derelict buildings that made up the hospital, they claimed, failed to invoke public confidence in the institution and by extension the government. Other states, which the Trustees wanted to emulate, had “erected lofty and elegant structures,

perpetual monuments to the achievements of an age of civilization, to an era of humanity, showing by the princely sums thus expended, that the people

¹⁰⁷ Rothman, *Discovery of the Asylum*, 9-10.

¹⁰⁸ Daniel Feller, *The Jacksonian Promise: America, 1815-1840*, (Baltimore: Johns Hopkins University Press, 1995), 95; 114-115; 125. See also Ning Kang, “Puritanism and its Impact upon American Values.” *Review of European Studies* 1 no. 2 (Dec., 2009): 148.

sympathize with this class of unfortunate humanity, and with true Christian-like spirit, desire to ameliorate, as far as possible, their deplorable condition.¹⁰⁹

Framed in this manner, the asylum was more than a symbol of the psychiatric profession, it was a physical representation of the state and the government.¹¹⁰

The hospital exhibited the benevolence of the government, and expressed the idea of a stable society overseen by governments and superintendents. As noted above, early asylum advocates subscribed to the ideal of a dedicated and meticulously constructed insane hospital that allowed superintendents to treat insanity within an ordered environment. Nevertheless, the superintendent's preoccupation with creating these environments, down to the most diminutive detail, also addressed anxieties they had about society and the emerging psychiatric profession. According to Rothman, superintendents utilized the physical layout of the asylum, in part, "to promote the stability of the society at a moment when traditional ideas and practices appeared outmoded, constricted, and ineffective."¹¹¹ The large hospital was an effective public relations tool, yet superintendents also expected the promotion to extend to the patients. After patients had accepted the proper behavior taught to them within the order asylum environment, they were to return to their communities as model citizens. Their post-asylum behavior was a testament to the effectiveness of both the superintendent and the ordered asylum. As Rothman explains, in the hospital superintendents were to "rehabilitate inmates and then, by virtue of [their] success, set an example of right action for the larger society." He continues, "The well-ordered asylum would exemplify the proper principles of social organization and thus insure the safety of the republic and promote its glory."¹¹² The hospital was a symbol of stability. Superintendents wanted the

¹⁰⁹ *Hospital for the Insane of the Territory of Washington, 1883*, 5.

¹¹⁰ Rothman, *Discovery of the Asylum*, xix.

¹¹¹ Rothman, *Discovery of the Asylum*, xviii.

¹¹² Rothman, *Discovery of the Asylum*, xix.

building to promote and reflect what they expected society to be. The mental hospital thus became an emblem of order and symmetry, both inward and out.¹¹³

In the 1880s Washington underwent economic changes, influenced by the completion of railroads and shipping ports in Tacoma and Seattle. This led to an increase in lumber, lumber-related goods, fishing, and mining exports and greater economic growth for the region. These developments also brought about an increase in migration, immigration, and urbanization to the Puget Sound region.¹¹⁴ This, Waughop argued, meant the prevalence of insanity was “more likely to be increased than diminished,” an issue exacerbated by the “alarming increase...from the old world” as “defective classes of Europe are evidently unloaded upon our shores.” “Even Asia,” he continued, was “well represented” in west coast asylums.¹¹⁵ Washington needed a larger building in which to house and treat the guaranteed increase of insanity. Effectively, he argued the government needed an asylum that ensured social stability in the face of growing pervasiveness of European and Asian immigrants.

Concurrently with social upheaval, the territory was on the eve of becoming a state, a process that required the territorial government to alter its structure and draft a state constitution that not only adhered to the dictates of the federal constitution, but also preserved the uniqueness of the region and the rights of its citizens.¹¹⁶ Leading up to and during that transformation, the public, the Trustees argued, needed to see the government expend “princely sums,” specifically by erecting improved government structures. Waughop, for his part, adopted a financial approach in hopes of convincing politicians to invest in a new asylum as one such feature. He

¹¹³ Moran, *Committed to the State Asylum*, 84.

¹¹⁴ Elaine Naylor, *Frontier Boosters: Port Townsend and the Culture of Development in the American West, 1850-1895* (Montreal & Kingston: McGill-Queen’s University Press, 2014), 112; 171.

¹¹⁵ Territory of Washington, *Report Board of Trustees and Resident Officers of the Hospital for the Insane in the Territory of Washington, 1887*, (Olympia: Thomas H. Cavanaugh, Public Printer, 1887), 17.

¹¹⁶ As a territory, Washington only had a territorial legislature, territorial governor, and a basic judicial system. Upon becoming a state it split the legislative branch into a state Senate and a House of Representatives. Moreover, it had to expand the judicial branch to include trial courts, Court of Appeals, and a state Supreme Court.

urged “the erection of a new building, first, because it is needed, and, second because it is not economy [sic] to keep in repair old wooden buildings.”¹¹⁷ The government put a steady stream of taxpayers’ money into the buildings with no real benefit above keeping them from collapsing. “Surely the territory, with all her wealth” Waughop argued in 1885, “is able [to] build a creditable hospital for her insane.”¹¹⁸ Sharing the view of the Trustees, the superintendent linked a new asylum to the might of the government. Building state-run institutions showed the government, in all its power, worked to ensure continued stability even as the territory faced statehood and a more industrialized future, both of which meant changes that moved the established society away from its traditional economic roots.

Tied into the ideal of the ordered asylum as a symbol of state power, superintendents wanted society to view the mental hospital as a place of healing separate from other institutions. Gerald Grob explains that early AMSAII members’ “involvement in such minutiae reflected their view of the hospital as an institution that cured mentally ill people by providing them with a proper and moral environment.”¹¹⁹ To the Trustees and Waughop, the building played into a belief that the hospital, as much as the therapies offered within, was a medical institution wherein a physician was able to alleviate insanity by providing patients with structured and a hygienic environment. Doing so allowed society to see that the superintendent (and the politicians, really) exhibited a true “Christian-like spirit” in the welfare of people deemed insane.

The building also provided a means for Waughop to promote psychiatry. The Trustees argued that the older ideas about madness prevailed and kept people from seeking help from professionals. Housing care in dilapidated military buildings encouraged continued stigmatization against the institution and invited further doubt as to the proper care or

¹¹⁷ *Hospital for the Insane of the Territory of Washington, 1883*, 16.

¹¹⁸ *Hospital for the Insane in the Territory of Washington, 1885*, 22.

¹¹⁹ Grob, *Mental Institutions in America*, 171.

sophisticated methods of care available from the state. Those criticisms, however, “eminate[ed] from persons who [knew] little or nothing of matters pertaining to insanity,” or they stemmed from “hostile officials and dissatisfied employees, or upon their own ideas.” These “adverse and false criticisms,” however, perpetuated “vague horrors” about the institution and the people treated there “to such an extent that [people]...are not committed until it is too late for recovery.”¹²⁰ The Trustees wanted to address these criticisms while at the same time improve care for Washington’s “class of unfortunates.” Using the asylum as a place of last resort further compounded the problems of care and left administrators cornered when attempting to make improvements in institutional care, or effectively rehabilitate patients who could then be returned to their families.

Some of the superintendents believed that building a new asylum might improve public opinion and alter the flow of people through the institution if they recognized it as a facility that provided medical care, rather than simply custodial protection. “Insanity,” Waughop argued, “can be successfully treated *only at its outset*. Then there is hope of cure.”¹²¹ With a new modern building, he continued, “the public generally are more and more convinced of the necessity of early commitment to the asylum, where, as a rule, cures are more likely to be obtained.”¹²² Waughop reasoned that a new structure would help to generate public confidence in asylum-based medical care.¹²³

The Trustees and Waughop wanted to erect their own “monument to the achievements of an age of civilization:” a modern mental hospital that symbolized social stability and political

¹²⁰ *Hospital for the Insane of the Territory of Washington, 1883*, 5.

¹²¹ *Hospital for the Insane in the Territory of Washington, 1887*, 17. Emphasis added.

¹²² *Hospital for the Insane in the Territory of Washington, 1887*, 17-18.

¹²³ This was a common belief in the early years of the AMSAII. Please see: Nancy Tomes, “A Generous Confidence: Thomas Story Kirkbride’s Philosophy of Asylum Construction and Management,” in *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era*, ed. Andrew Scull (Philadelphia: University of Pennsylvania Press, 1981), 122-123.

benevolence. Such a “lofty and elegant structure” was, they maintained, a mark of modernity that placed the territorial government on the same “magnanimous and philanthropic mission” as their eastern counterparts.¹²⁴ It was not sufficient enough for governments to house or lock away insane people in derelict buildings. If constructing a new hospital represented a mark of civilization, then utilizing derelict buildings that hindered the superintendent’s treatments was a feature of an “uncivilized” society. Administrators urged the government to pass this “wise legislation” so that the Territory of Washington “may not be behind” other states in their mission of helping people with insanity.¹²⁵

Thomas Kirkbride had argued that governments needed to appoint building commissioners to design and oversee the construction of asylums. These commissioners should seek the advice of experienced asylum keepers elsewhere when developing building plans.¹²⁶ If designers are not “already familiar with the requirements of such institutions,” he argued, they should “at least possess . . . a willingness to profit by the experience of those who have had a practical acquaintance with the subject.”¹²⁷ When stressing the “importance of architectural arrangements” he added,

No reasonable person at the present day, when planning a hospital for the insane, would think it necessary or desirable to propose a building entirely original in its design; for such a structure could hardly fail to lose in usefulness what it gained in novelty. Instead of attempting something entirely new, the object should rather be to profit by the experience of the past, by the knowledge of those who have had a practical familiarity with the wants and requirements of the insane, and after a careful study of existing institutions, to combine, as far as possible, all their good features, and especially to avoid their defects and inconveniences.¹²⁸

¹²⁴ *Hospital for the Insane of the Territory of Washington, 1883*, 9.

¹²⁵ *Hospital for the Insane of the Territory of Washington, 1883*, 8; 9.

¹²⁶ Kirkbride, *Construction, Organization, and General Arrangements*, 35-36.

¹²⁷ Kirkbride, *Construction, Organization, and General Arrangements*, 36.

¹²⁸ Kirkbride, *Construction, Organization, and General Arrangements*, 46.

Kirkbride encouraged governments to follow established hospital designs, as constructing a hospital without utilizing prior knowledge guaranteed it would contain “defects and inconveniences” that hindered the care of patients.¹²⁹ Experience needed to dictate hospital design. No matter how forward thinking or “novel” some features might seem in the end they were bound to fail.

When outlining what was necessary for an efficient the building, Waughop echoed points forwarded by Kirkbride and the AMSAII. He recommended a pavilion style layout. He reasoned, “Experience has proved this to be the proper plan as nearly all asylums are built in this way.”¹³⁰ Waughop wanted to replace the “scattered” layout of the buildings with one substantial building as “attendants can take care of more patients in one building.” The building, he indicated, should be “made of brick with a metallic roof so as to be fire proof.” A brick building may be expensive, but the superintendent assured the local legislators that by having the patients assist in the brick-making process it would help make the overall cost of construction “small.”¹³¹ Additionally, repeating the points forwarded in Kirkbride’s book on hospital construction, Waughop recommended avoiding ornamentation, the government needed to build “cheaply...in a plain, strong, and durable manner.”¹³²

The government did not approve of a new building in 1883, compelling Waughop to exclaim two years later, “*We need a new Hospital building, and we need it badly.*”¹³³ He continued to press for this building, repeating many of his claims from the previous report. The hospital needed to be “plain, substantial, without undue ornament, but of comely appearance,”

¹²⁹ Kirkbride, *Construction, Organization, and General Arrangements*, 46.

¹³⁰ *Hospital for the Insane of the Territory of Washington, 1883*, 15-16.

¹³¹ *Hospital for the Insane of the Territory of Washington, 1883*, 15.

¹³² *Hospital for the Insane of the Territory of Washington, 1883*, 16. See also: Kirkbride, *Construction, Organization, and General Arrangements*, 46-47.

¹³³ *Hospital for the Insane in the Territory of Washington, 1885*, 21. Emphasis original.

following the layout advocated by Kirkbride.¹³⁴ In 1885, however, Waughop presented the twenty-six building proposals adopted by the AMSAI.¹³⁵ He wrote that “[a]fter extensive observations in the Eastern and Western States...and conferring with numerous superintendents, I am satisfied this is the best and most economical plan.”¹³⁶ He believed the government had the finances necessary to build a new asylum “at once” and argued doing so was a “justice to herself and her insane.”¹³⁷ “Surely,” Waughop wrote, the government “with all her wealth...can build a creditable hospital for her insane.”¹³⁸ Emphasizing how the asylum demonstrated the state’s willingness to protect its citizens, he reinforced the need for this facility as an act of nation-building and Christian benevolence.

Waughop wanted the Washington asylum modeled after facilities in the east. He maintained that the Association’s opinion on building construction and layout had not altered over the course of 34 years.¹³⁹ Washington’s hospital needed to embrace “the wisdom and experience of those who have had charge of the insane.”¹⁴⁰ Rather than utilizing structures out of convenience, Waughop advised the state to follow the opinions of an established medical group that had experience in treating insane persons. Accordingly, he argued, it was unwise to turn anywhere else for advice.

In 1886 the territorial passed *An Act to Provide for the Permanent Location and Construction of a Hospital for the Insane at Fort Steilacoom in Washington Territory*. The Act, formed a building committee that, with Waughop’s company, toured the Oregon State mental

¹³⁴ *Hospital for the Insane in the Territory of Washington, 1885*, 21.

¹³⁵ *Hospital for the Insane in the Territory of Washington, 1885*, 22.

¹³⁶ *Hospital for the Insane in the Territory of Washington, 1885*, 22.

¹³⁷ *Hospital for the Insane in the Territory of Washington, 1885*, 21. Emphasis Original.

¹³⁸ *Hospital for the Insane in the Territory of Washington, 1885*, 22.

¹³⁹ *Hospital for the Insane in the Territory of Washington, 1885*, 22.

¹⁴⁰ *Hospital for the Insane in the Territory of Washington, 1885*, 24.

hospital and viewed other asylum plans for inspiration.¹⁴¹ Upon returning, the Washington Building Commissioners wrote, “it is decided that the general plan of the Oregon Asylum be adopted.” They however, left themselves a caveat that allowed them to make “change[s] as the Board may see fit to make hereafter.”¹⁴² They agreed that following the eastern plans was in the territory’s best interest. They needed the facility to be recognized as a hospital, but they were also cautious about keeping construction within a budget.



Figure 2. Hospital for the Insane of the Territory of Washington, 1886, Photographer Unknown. Photo courtesy of Western State Historical Society, Washington.

Construction lasted sixteen months, and finished in late 1887. Ultimately, the committee had settled on a U-shape layout that, while not strictly adhering to Kirkbride’s echelon style,

¹⁴¹ Washington Territorial Legislative Assembly, Enacted by the Legislative Assembly, Tenth Biennial Session 1885-6, *An Act to Provide for the Permanent Location and Construction of a Hospital for the Insane at Fort Steilacoom in Washington Territory*, sec. 9 (Olympia: Thomas H. Cavanaugh, Public Printer, 1886), 141-144; 143, Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx accessed on October 16, 2013.

¹⁴² Territory of Washington, *Report of the Hospital for the Insane at Fort Steilacoom in Washington Territory Building Commissioners, Sept. 2, 1887*, pg. 1, Washington State Archives (WSA); Record Group: Institutions Dept.; Sub: Western State Hospital; Series: Board of Building Commissioner Minutes; Description: Record; Dates: 1886-1897; Accession.: 05-A-393; Box: 1

followed the twenty-six points advocated by the AMSAII.¹⁴³ The 413 foot long building was, Waughop wrote, “fitted up in the most approved plan, with all modern improvements and conveniences.”¹⁴⁴

Having embraced the conventions of eastern asylum, long wings, tall main section, segregated wards, etc., without any great deviation, Waughop believed the new hospital in Washington was “fine looking and substantial, without useless ornamentation, and well adapted to the end for which it was built.”¹⁴⁵ The final product satisfied him, but instead of focusing on what that meant for the patients and for him as a medical superintendent, he instead “congratulated” the Trustees, politicians, and “the whole territory” for constructing “so good a building at so small a cost.”¹⁴⁶ In the end the building (and its economic cost) was cause for celebration. When it came to identifying the advantages of the new building Waughop focused on what it meant to society but not the therapeutic advantages it afforded his patients. Although Waughop and the Trustees believed the institution was a symbol of the presence of psychiatry, and that it replaced the distrust and fear the old military structures had come to represent, it was, as Rothman argued early asylums were, an emblem of government presence and stability to society.¹⁴⁷ It instilled a sense of trust and confidence within the public toward authority. To that end, the Hospital for the Insane in the Territory of Washington was successful. Two years after it

¹⁴³ The building initially accommodated 300 patients. This, however, seems to be a compromise as the Trustees wanted the hospital to house 500 patients, even though the law called for 250 maximum. (*An Act to Provide for the Permanent Location and Construction of a Hospital for the Insane*, 143.) Additionally, the Commissioners opted for electric lighting over gas, for convenience and safety. (*Report of the Washington Territory Building Commissioners*, pg. 89.)

¹⁴⁴ *Hospital for the Insane in the Territory of Washington, 1887*, 18.

¹⁴⁵ *Hospital for the Insane in the Territory of Washington, 1887*, 18.

¹⁴⁶ *Hospital for the Insane in the Territory of Washington, 1887*, 19.

¹⁴⁷ Rothman, *Discovery of the Asylum*, xviii. The state’s eastern insane hospital also plays into the emergence of statehood that government presence, is as it was completed in 1891 (two years after statehood) and served the easternmost region of the state opposite of the capital.

opened, the hospital population reached full capacity and Waughop began demanding the construction of additional wards.

Under Waughop, Washington's first insane hospital went from a collection of old military buildings to a purpose-built state asylum that mirrored those in the eastern region of the United States and Canada, not because it was therapeutically beneficial or even effective at alleviating insanity. It was a political tool. Predating the emergence of Washington as a state, government approval of the new asylum was a long process that the Trustees and Waughop achieved only after they associated the new structure with the promotion of government benevolence and social stability.

Saskatchewan Constructs a Medical Institution

In 1881 – 20 years before Saskatchewan began construction on its first dedicated mental hospital – AMSAII president Dr. Orpheus Everts defended the asylum structures before an annual meeting of superintendents. He explained to the assembled body of physicians that critics of the hospital were comparing it to expensive prisons. Opponents claimed, according to Everts, “that American hospital buildings [were] too large, too palatial, too expensively constructed; disagreeably monotonous in linear extension, and offensively prison-like in aspect.”¹⁴⁸ It was not only that the “palatial asylums” were expensive, according to one critic, but also that they were “constructed and furnished at an expense unparalleled in the world.”¹⁴⁹ To this Everts conceded the “hospital buildings [were] very large—much larger than the expressed opinion of the Association of Superintendents has justified.”¹⁵⁰ Rather than offer alternatives, however, he defended these large structures. The Kirkbride asylum was superior to other styles “both in a

¹⁴⁸ Orpheus Everts, “The American System of Public Provision for the Insane, and Despotism in Lunatic Asylums,” *American Journal of Insanity* 38 (1881): 119-120.

¹⁴⁹ Dorman B. Eaton, “Despotism in Lunatic Asylums,” *North American Review* vol. 132, no. 292 (Mar. 1881): 264.

¹⁵⁰ Everts, “American System of Public Provision for the Insane, and Despotism in Lunatic Asylums,” 125.

scientific and an economical sense.”¹⁵¹ Even after the mental hospital populations grew and the asylum continued to expand, superintendents defended them as economical and therapeutically, i.e., “scientifically” effective.

In the wake of this professional recommitment, provincial and state governments continued to build pavilion style asylums throughout North America; they became, according to historian Janet Miron, “important and familiar sights in the urban landscape.”¹⁵² Gerald Grob agrees, they were important and familiar, but argues they became an emblem of the early psychiatric profession. “If any single symbol represented mid-nineteenth century psychiatry, it was the architecture and organization of the asylum... Its very existence was intended to inspire public faith in the state and to reinforce the institutional and professional legitimacy of psychiatry.”¹⁵³ Superintendents developed a commitment to their expansive asylums even when confronted with a growing criticism concerning the building’s efficiency, medical and otherwise.

Saskatchewan’s path to securing their first mental asylum was shorter and less difficult than was the case for Washington. The process was fairly straightforward, even if local opinions differed on the needs of the region. In Washington, Waughop championed the cause and lobbied politicians to accept the need to build such an institution as a way to advertise the strength of the government. In Saskatchewan the government initiated construction of an asylum on the basis that their insane residents needed to be housed in their own province. Politicians purpose-built the asylum to incarcerate insanity, by removing people from their homes and protecting the public *from* it. Upon taking his post as superintendent, James MacNeill articulated how to view and effectively care for people deemed insane. He adopted a position that the asylum was

¹⁵¹ Everts, “American System of Public Provision for the Insane, and Despotism in Lunatic Asylums,” 126.

¹⁵² Janet Miron, “‘Open to the Public’ Touring Ontario Asylums in the Nineteenth Century,” in *Mental Health and Canadian Society: Historical Perspectives*, eds. James E. Moran, and David Wright, (Montreal: McGill-Queen’s University, 2006), 33; 41.

¹⁵³ Grob, *Mad Among Us*, 71.

intended to help people recover from their condition. He emphasized the welfare of the patient more than the welfare of the community. The argument was not whether to build an asylum, rather it was how to utilize it and how that affected the public perception of insanity.

On September 1, 1905 Saskatchewan entered Confederation and became an official province of Canada and soon afterwards the new provincial government entered into negotiations with local municipalities concerning the location of state institutions, specifically the Legislative buildings, penitentiary, university, and a provincial mental hospital. In May 1906 the province passed a law that ensured insanity remained a legal designation, as it had been while the region was part of the North West Territories.¹⁵⁴ Prior to becoming a province, the territorial government managed insane people by sending them to Manitoba under police custody, to reside either in a penitentiary or an asylum indefinitely.¹⁵⁵ The Saskatchewan laws changed to acknowledge the new provincial authorities, but did little to alter the spirit of the law that prioritized incarceration over care.

According to Saskatchewan's 1906 *Insanity Act* if after hearing evidence against a person a justice believed the accused was "insane and dangerous to be at large" they were to commit them "to the nearest gaol [or] to an asylum in this or some other province of Canada" until "discharged by law."¹⁵⁶ According to psychologist John Elias, during commitment, "medical evidence could be heard, but the decision was a legal one." Additionally, there was no "provision for voluntary admission."¹⁵⁷ Without an institution of their own, psychologist Maurice Demay explains, the Saskatchewan government continued to send "lunatics" to "some asylum for the

¹⁵⁴ Ordinances of the Northwest Territories passed by the Lieutenant Governor in Council, *An Act respecting the Safe-keeping of Dangerous Lunatics in the North West Territories*, Ordinances No. 2, 1879. In 1906, Saskatchewan passed the *Act Respecting Insane Persons*, that adopted much of the same language.

¹⁵⁵ John W. Elias, "Continuity and Change in the New Mental Health Services Act," presented at the Annual Clinical Conference of Psychiatric Services Branch, Saskatchewan Health, Regina, SK, October 9, 1985.

¹⁵⁶ Saskatchewan Legislative Assembly, *Act Respecting Insane Persons*, 104.

¹⁵⁷ Elias, "Continuity and Change in the New Mental Health Services Act," 1.

insane in the Province of Manitoba.”¹⁵⁸ The Manitoba mental asylum was located near the southwestern city of Brandon and became the last out of province stopgap Saskatchewan used until it built its own insane asylum. Despite sending people to “some asylum,” insanity and danger were already intrinsically linked. Commitment was based on ideals of incarceration and the safety of others; medicine and treatment had little to do with insanity.

After it became a province the Saskatchewan government wanted to develop its own political resources for managing its territory, including establishing services to control insanity within its borders. Before politicians could agree on how to do that, they settled on a hospital design that politicians identified as modern while capable of weathering the harsh Canadian prairie winters.

The government commissioned Dr. David Low, a provincial health officer living in Regina, to travel east in February 1907 to visit and inspect institutions in eastern Canada and the United States and report back with recommendations on a suitable building design, contemporary treatments, and essential equipment for the asylum.¹⁵⁹ Interestingly Low’s report challenged existing models of insanity as a criminal state, arguing instead that it should be defined and treated as an illness. To that end, he recommended a facility with appropriate space for outdoor activities, farming, and occupational therapy.

In 1907, occupational therapy was an innovative form of treatment. Historian Gerald Grob, however, links it to early work therapy ideals. He maintains it emerged from the idea “that meaningful labor and recreation had a beneficial impact upon institutionalized patients.”

¹⁵⁸ Maurice Demay, “The Beginnings of Psychiatry in Saskatchewan,” *Canada’s Mental Health* 21 (January-February 1973): 21.

¹⁵⁹ David Low, “Report submitted to his Honour the Lieutenant Governor in Council, Regina, Saskatchewan, May 1, 1907,” (hereafter referred to “Low Report”) SAB, Douglas Papers, R-33.5, III, 127, p. 1; See also: Demay, 21, and Harley D. Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: University of Regina, 1989), 20-21.

Occupational therapy developed in the early twentieth century from the realization that there was, despite the pervasiveness of hospital farms and the firmly established work therapy programs, a “lack of adequate opportunities and facilities” for patients to work.¹⁶⁰ It was an attempt to introduce patients to tasks that matched and improved their individual and localized skills. In this manner occupational therapy was different from work therapy. Work therapy worked patients in traditional areas such as farming, raising livestock, landscaping, cleaning the wards, doing laundry, and assisting in the kitchen. In an agrarian society these activities potentially maintained a patient’s skillset. If the patient came from a more urbanized setting, however, they did not. Because occupational therapy offered various work opportunities, such as toy making, woodworking, and sewing, however, it provided a more nuanced approach to teaching patients relevant and regionally appropriate work habits.¹⁶¹

Most of Low’s suggestions resurrected the 1851 AMSAII report, in that he suggested the government situate the asylum on “Good, fertile, tillable agricultural land.”¹⁶² This idea struck a particular chord with the prairie politicians. Farming, as chapter five will show, was an important practice in the region and finding suitable farming soil played a vital part in the land selection and a fundamental role in the history of the institution.

In addition to careful land selection, Low suggested that the asylum have “an abundant, continuous and assured source of water.”¹⁶³ This was important for obvious reasons, but, as he explained, also for the frequent application of hydrotherapy, which he argued was “largly [sic] employed in treating the acute insane.”¹⁶⁴ Lastly, Low believed the asylum needed to be “a

¹⁶⁰ Gerald Grob, *Mental Illness and American Society, 1875-1940*, (Princeton: Princeton University Press, 1983), 258.

¹⁶¹ Grob, *Mental Illness and American Society*, 259.

¹⁶² Low Report, 1.

¹⁶³ Low Report, 2.

¹⁶⁴ Low Report, 2.

sufficient distance from a town.” In a departure from AMSAII ideals, however, he warned it should not be such a distance that its location discouraged interested persons from visiting the asylum. Yet, being too close encouraged too “frequent intercourse between the town and the institution,” thus ruining the soothing effects the calm environment provided.¹⁶⁵

As for the building, Low did not follow precedent established by the Association. Against the “experience” of other superintendents, he argued in favor of the cottage layout, which he claimed prevented the government from investing in wasted space. He advised, the government to build smaller singular structures needed for the “present population” and then add “others...as required” without interfering with the patient’s comfort.¹⁶⁶ Low was concerned with the medical ideals surrounding classification and treatment. Yet as the debate proceeded over building design, his cottage plan and the idea of walking outside from structure to structure seemed impracticable for Saskatchewan’s harsh winters.¹⁶⁷

After accepting Low’s report the government sent out calls to architecture firms. They initially settled on the Toronto-based architectural firm Darling and Pearson, which had received advice on the design from the well-known psychiatrist and Toronto Hospital for the Insane Superintendent, Dr. C. K. Clarke.¹⁶⁸ Perhaps they did this due to Kirkbride’s advice that any hospital plan needed “approval of one or more physicians who have...acquaintance with the insane.”¹⁶⁹ Yet, as retired architect Arthur Allen argues, Clarke’s involvement is highly

¹⁶⁵ Low Report, 2.

¹⁶⁶ Low Report, 2-3.

¹⁶⁷ Dickinson, *Two Psychiatries*, 21; Darling and Pearson, Architects, 2 Leader Lane, Toronto, Ontario, to deputy Commissioner, Public Works, Regina, Saskatchewan, May 9, 1908, SAB, R-33.5, III, 127. (14-8). Douglas Papers; “Saskatchewan’s New Hospital for the Insane at Battleford,” *Regina Leader*, Dec. 23, 1911.

¹⁶⁸ Dickinson, *Two Psychiatries*, 21; Arthur Allen, *Habitat and Healing at the Early Asylum of Western Canada*, (Vancouver, British Columbia, June 1, 2012) 68-69.

¹⁶⁹ Kirkbride, *Construction, Organization, and General Arrangements*, 52.

questionable with the only claims to his involvement coming from the architectural firm.¹⁷⁰ In contrast to Low's recommendations, the firm supported the traditional pavilion layout for "economic and climatic reasons." Moreover, they contended, the "cottage arrangement is practically abandoned: it is expensive and unworkable."¹⁷¹ These statements further call into question Clarke's involvement, as he vocally questioned the effectiveness of the large pavilion asylums that Darling and Pearson recommended. Allen notes that Clarke supported the cottage plan for a new asylum that was to be built in Whitby, Ontario, in 1907-08.¹⁷² Additionally, he became a vocal critic of the traditional asylum. In 1918, when he became medical director of the Canadian National Committee for Mental Hygiene, he argued in favor of smaller psychiatric clinics in lieu of large state hospitals, a fact he reiterated when the Committee toured the province in 1920.¹⁷³ Nevertheless, according to a newspaper article from the *Regina Leader*, the government favored Darling and Pearson's recommended pavilion style structure due to Saskatchewan's "climatic conditions."¹⁷⁴

In the end, the government discontinued the services of Darling and Pearson, opting instead to use local provincial architects to draft the final layout. They turned to Regina architects Edgar M. Storey and William G. Van Egmond, who, according to the then acting deputy minister of public works, H. S. Carpenter, had drafted a "quite plain design...for this

¹⁷⁰ Arthur Allen, *Habitat and Healing at the Early Asylum of Western Canada*, (Vancouver, British Columbia, June 1, 2012) 69.

¹⁷¹ Darling and Pearson to deputy Commissioner, Public Works, 14-8. As quoted in Allen, *Habitat and Healing*, 70.

¹⁷² Allen, *Habitat and Healing*, 70.

¹⁷³ Canadian National Committee for Mental Hygiene (CNCMH), "Confidential Report," ND, Saskatchewan Archives Board (SAB), Scott Fonds I. 153, (40,716 – 40,905), Social Welfare: Mental Defectives, 1917-1921, M4. File no. 40,743 – 40,750, p. 3; Canadian National Committee for Mental Hygiene, "Mental Hygiene Survey of the Province of Saskatchewan," *Canadian Journal of Mental Hygiene* 3, no. 4 (Jan. 1922): 342.

¹⁷⁴ "Saskatchewan's New Hospital for the Insane at Battleford," *Regina Leader*, Dec. 23, 1911.

building.”¹⁷⁵ While the building and its design were important, owing to practicality and what it represented, equally as significant was the land selection. The government sought a suitable location based on Low’s recommendations. Specifically they wanted a site with fertile soil in order to develop farms for the essential work therapy program and, more practically, to reduce the cost of hospital maintenance. The Saskatchewan government entertained proposals from interested communities throughout the province.

The Battleford cities took part in this search; and like many other communities, they aggressively fought for the opportunity to have the asylum in their region.¹⁷⁶ The residents knew that locating the institution in their vicinity would lend itself to social, political, and economic stability – attributes desired of any small city.¹⁷⁷ An excerpt from their brief downplayed the financial and political benefits the institution offered the region, instead focusing on what their locality had to offer in terms of providing the right setting for such an institution. Similar to the article from the Washington newspaper, the *Weekly Pacific Tribune*, the Battleford proposal captured the early AMSAII belief regarding the curative effects of the environment. In focusing on that feature it underlined what many Saskatchewan residents understood about the nature of insanity – that it was something other than a medical condition, alleviated within the proper natural atmosphere. The brief stressed that “life itself” is dependent on the proper location. As such,

The location which tends to best assist them to restoration of mind and body should be selected. Environment and surroundings have the greatest influence over the mind, and when this environment is suitable, it *alone unaided by medical science* is frequently sufficient to restore both the mind and the body to their normal healthy condition. What this environment should be needs hardly to be

¹⁷⁵ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year, 1911-1912, Ended February 29, 1912*, SAB, PW. 2, (Regina: John A. Reid, Government Printer, 1912), 81.

¹⁷⁶ The Battleford region (or as I have seen it The Battlefords) consists of the city of Battleford and North Battleford.

¹⁷⁷ Dickinson, *Two Psychiatries*, 21.

pointed out. Beauty, scenery, trees, lakes, rivers, valleys, quiet rest, air, climate, health, etc., are all factors which go together to constitute a suitable location. *Such environment will do more for the patients than medical treatment.*¹⁷⁸

According to the residents of the Battleford region, the environment, more than medicine, was a critical factor in restoring the mind back to its “normal healthy condition.” The residents of the prairie region relegated medicine behind other factors in the care of insanity, despite the efforts of the AMSAII and other psychiatrists who believed it was a medical condition. Inmates, the Association believed, benefited from the effects of fresh air. As advantageous as nature was in combating insanity, early superintendents defined it as a soothing environment which allowed for outdoor pastimes such as walking and simple exercises, activities that provided physical exercise and kept the patients occupied while reducing anxiety. It was not, initially, a fundamental therapeutic element. According to historian Norman Dain, by the late 1800s superintendents questioned the therapeutic value of the “pleasant environment.”¹⁷⁹ The belief that the environment was effective evolved as work therapy became an essential part of the asylum regimen. Even so, from the AMSAII’s earliest etiological conceptions of insanity, the curative effects of nature came second to their other humane practices: rest and work. The residents of the Battleford region, however, clung to older ideas about the importance of a bucolic environment for securing sanity.

When choosing a location, politicians agreed with the residents of the Battleford area that its location offered the best soothing environment. It was in this “suitable location” that the government placed what sociologist Harley Dickinson calls the “more expensive and less

¹⁷⁸ “Brief, submitted to the Premier, and Members of the Executive Council, Province of Saskatchewan, recommending the location of the proposed mental asylum at Battleford, 1910,” Saskatchewan Archives Board (SAB), R-33.5, III, 127, 14-8. Douglas Papers. Unable to locate this brief or any other briefs, this quote comes from Dickinson, *Two Psychiatries*, 22-23. Emphasis added.

¹⁷⁹ Norman Dain, *Concepts of Insanity in the United States, 1789-1865* (New Jersey: Rutgers University Press, 1964), 135.

functional” Kirkbride asylum.¹⁸⁰ The *Regina Leader* newspaper published an article in 1911 explaining the motivations of the government in choosing that design. With a pavilion style, unlike the cottage layout, the wards are “joined so that the food may not have to be taken outside at all, and yet joined in such a way that there will be no possibility of patients in one unit seeing or hearing anything of those in another.” Taking into account the “climate of Saskatchewan” the government placed comfort and practicality above economy and designed an asylum that “best serve [sic] the uses and interests of the people of this province.”¹⁸¹ It was sensible to ensure only one building stayed warm and secure while comfortably allowing the superintendent to visit patients in all wards without having to go outside.

Low’s other main point for favoring cottages, was that the system allowed for better separation of the patients by sex and illness. The *Regina Leader* article countered this point by noting that “each wing is a complete hospital in itself, having dining rooms, large day rooms, private and public wards, exercise rooms, lavatories, and showers and separate verandahs” they were “a little world to itself, absolutely without connection with the remainder of the institution,” save for the main kitchen.¹⁸² This allowed for Low’s classification without requiring the staff to venture outside when going between the separate buildings. The article concluded, “In practically all other main features the hospital is modeled along the lines of the best to be found.”¹⁸³ The chosen design was just as good, if not better, than other institutions, they argued, by improving upon older structures with new ideas but maintaining the strength and economic

¹⁸⁰ Dickinson, *Two Psychiatries*, 21. The building was quite expensive. Initially government set aside \$450,000 to build the main building. When it reached completion, however, the cost was closer to \$1,250,000 – almost three times the initial budget. Nevertheless it is impossible to say it was “more expensive” than what the cottage would have been, seeing as the government never built nor budgeted for that. The final and budgeted cost comes from *Regina Leader*, Dec. 23, 1911 and *Saskatchewan Herald*, “New Provincial Hospital for the Insane Receives First Patients,” Feb. 6, 1914.

¹⁸¹ *Regina Leader*, Dec. 23, 1911.

¹⁸² *Regina Leader*, Dec. 23, 1911.

¹⁸³ *Regina Leader*, Dec. 23, 1911.

value of the single building design. The reporter revelled in the excitement at having one of the most modern asylums erected in Saskatchewan.

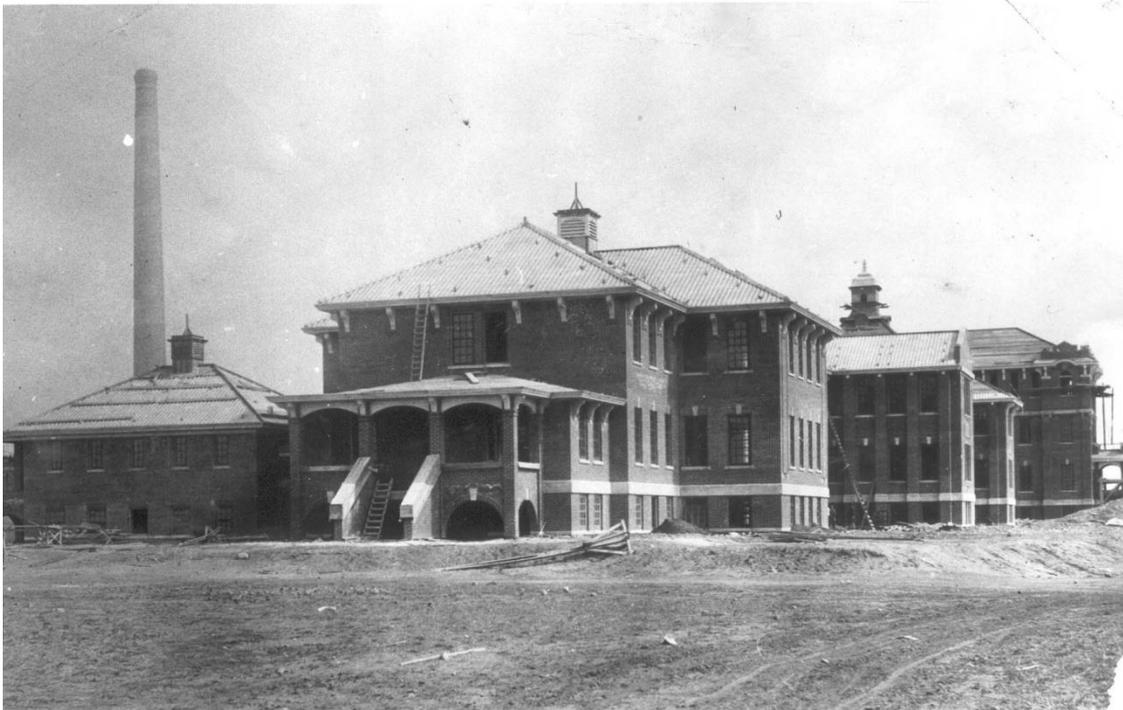


Figure 3. Hospital for the Insane, Battleford, circa 1912, photographer unknown, “NBSB01-08-P129,” photo courtesy of City of North Battleford Historic Archives, North Battleford, Saskatchewan.

Storey and Van Egmond designed the layout of the interior with an eye to quality, safety, prior expertise, and tradition. They installed a ventilation system with forced air ducts, required by Buttolph, Kirkbride, and the AMSAII.¹⁸⁴ Moreover, according to the *Regina Leader*, they used brick to ensure the structure was fireproof. “The walls are of solid brick, the floors and beams of reinforced concrete, while the linings to the walls and all partitions are tile and the

¹⁸⁴ Buttolph, “Modern Asylums,” 306; Kirkbride, *Construction, Organization, and General Arrangements*, 85-90; and AMSAII, “Report on the Construction of Hospitals for the Insane,” 81.

whole is surmounted by a metal roof. There will be no wood at all in the structure except in the doors and window frames.”¹⁸⁵ Again, these were not innovative points.¹⁸⁶

The building was modern but at the same time followed a traditional style. It was, wrote the reporter, “one of the finest institutions of its kind.”¹⁸⁷ The design followed Kirkbride’s advice that “the building should be in good taste, and that it should impress favorably” upon anyone who saw it. By all news accounts it accomplished both. Having constructed a building “of which any province might well be proud,” the hospital was a testimony to of the strength of the government in erecting such an institution for the residents of Saskatchewan.¹⁸⁸ Above all else, the institution ensured the continual incarceration of insanity and the safety of the rest of society.

With the construction of its first Provincial Insane Asylum in North Battleford, Saskatchewan slowly set about working at de-criminalizing insanity. The transformation included reshaping the public image of the insane asylum. At the forefront of this effort was Superintendent MacNeill, who advocated for change to the government in official reports, letters, and at times in person. He utilized the hospital structure and the image it projected to improve public opinion about the institution and its patients. Instead of viewing the institution as a place of incarceration, he wanted society to see it as a curative hospital, as he truly believed in the medical nature of insanity. Although he “paroled” people from the institution as merely “improved,” MacNeill believed that insanity was a treatable condition and that people who came to the asylum could be “permanently restored.”¹⁸⁹

¹⁸⁵ *Regina Leader*, Dec. 23, 1911.

¹⁸⁶ Buttolph, “Modern Asylums,” 306; Kirkbride, *Construction, Organization, and General Arrangements*, 62-64; and AMSAII, “Report on the Construction of Hospitals for the Insane,” 80.

¹⁸⁷ *Regina Leader*, Dec. 23, 1911.

¹⁸⁸ *Regina Leader*, Dec. 23, 1911.

¹⁸⁹ *Saskatchewan Provincial Hospital Battleford*, prepared and published under the direction of Hon. A. P. McNabb, Minister of Public Works, Saskatchewan Archives Board (SAB) PW 2, Special Publications, (Regina, Saskatchewan, Date unknown), 9.

Being a physician, before he briefly turned to politics (he was elected to the provincial legislature as a member of the Liberal party from 1908-1913), MacNeill took his medical convictions with him to the institution.¹⁹⁰ Upon assuming his post as head of the asylum he considered the people under his charge as patients with treatable mental conditions. It was not just his own past that informed his convictions. While the government completed construction on the asylum, MacNeill travelled east to speak with and observe the practices of other superintendents. Influenced by what he witnessed, he took their ideas back with him to Saskatchewan and incorporated them into his own practices. It was opportune that politicians, and the people who advised them about asylum structures, selected a Kirkbride design as it was the embodiment and facilitator of MacNeill's accepted therapeutic practices.¹⁹¹

Through visiting and corresponding with superintendents in the east, MacNeill became committed to transforming the image of insanity from a criminal pathology to a medical one. Bolstered by what he witnessed and his own medical background, he put his energies into doing the same for the residents of Saskatchewan. Through his efforts, and the opinions of other prominent physicians who believed the same, the provincial government gradually followed suit. These positive changes can be traced back to the fact that, while at first the residents of Saskatchewan were mildly interested in the care of their neighbors who were deemed insane, their interest increased when the government built and opened its first mental hospital in North Battleford.¹⁹² To summarize Nancy Tomes: the hospital appearance showed the people of

¹⁹⁰ Delores Kildaw, *A History of the Saskatchewan Hospital North Battleford, Saskatchewan*, (Saskatoon: Health Care Administration, University of Saskatchewan, College of Commerce, 1990-91), 14; and Colin M. Smith, "Mental Health Services," *The Encyclopedia of Saskatchewan*, http://esask.uregina.ca/entry/mental_health_services.html (accessed on Aug. 20, 2014).

¹⁹¹ Moran, *Committed to the State Asylum*, 84.

¹⁹² Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1914-1915, Ended April 30, 1915*, SAB, PW. 2, (Regina: J. W. Reid, Government Printer, 1915), 61.

Saskatchewan that there was hope for such a dreaded ailment. It was, in her words, a “most effective public advertisement.”¹⁹³

To the public, the asylum represented modernity and government magnanimity. Reading over newspapers reports, there were also allusions to criminality and insinuations of it being a medical institution. For example, *Saskatchewan Herald* printed an article in 1914 celebrating the fact that the “hospital” was about to open its doors and accept its first “patients” – both medical terms. These patients, however, travelled under armed guard – “two mounted police...in each coach” – who took “every precaution...to guard against accident or inconvenience” while the patients were transported by train from Brandon, Manitoba. The article then reported how H. T. Hadley, the manager of the institution, firmly believed a “satisfactory percentage” of people with insanity can “recover control of their mental powers” when treated in an “insane asylum [and] under modern treatment.”¹⁹⁴ Amalgamating themes of criminality with medicine, professionalism with the power of the institution, the article summarized that under the medical care of MacNeill, the “inmates” had their best chance of overcoming insanity in the hospital.

The reporter concluded the article by praising the government and emphasizing the gratitude of the public toward the government.

The opening of this institution brings to a realization the efforts that have been made by the Province of Saskatchewan to take care of its less fortunate population and provide them with the best to be had in care and treatment. This institution is provided with the best facilities and conditions known to the world and the Province as a whole, as well as Battleford, should and does appreciate the completion of this institution.¹⁹⁵

¹⁹³ Tomes, “A Generous Confidence,” 123.

¹⁹⁴ *Saskatchewan Herald*, Feb. 6, 1914.

¹⁹⁵ *Saskatchewan Herald*, Feb. 6, 1914.

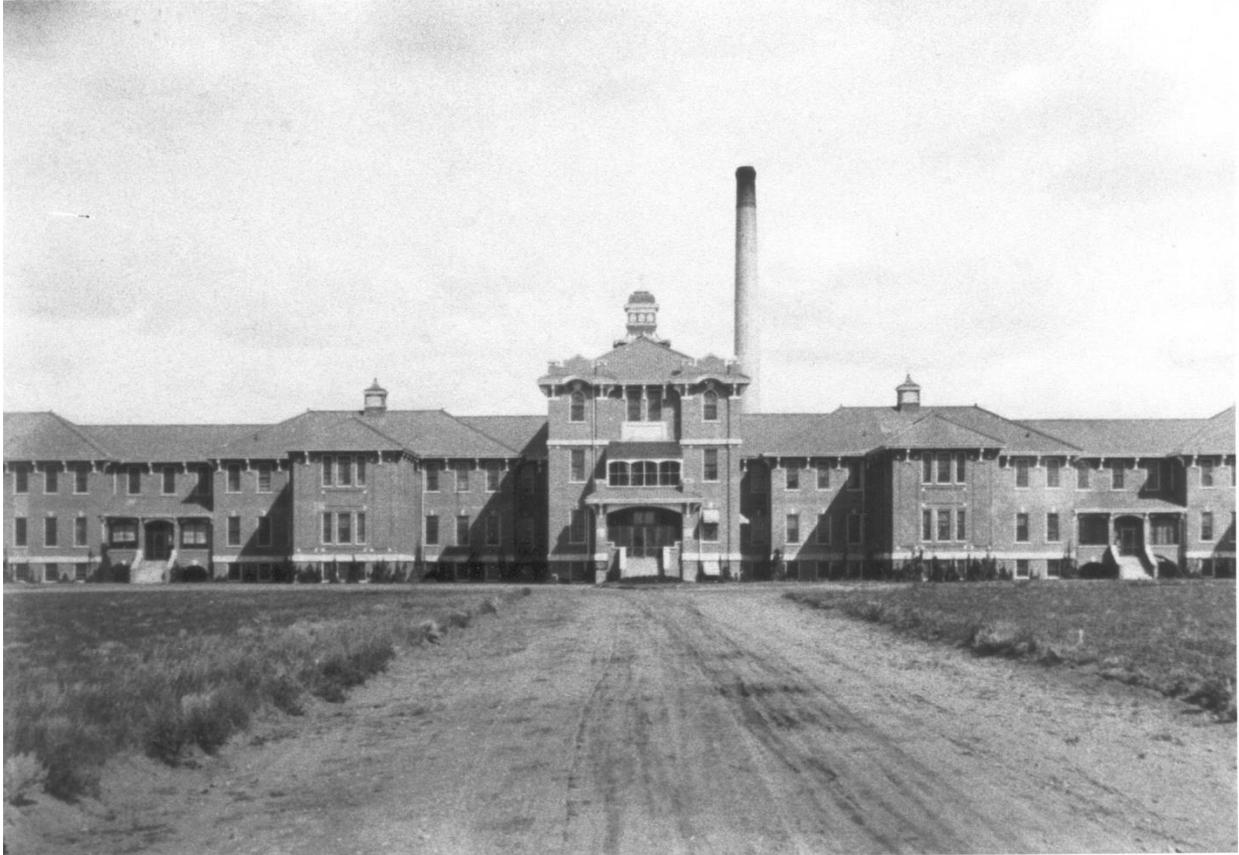


Figure 4. Hospital for the Insane, Battleford, circa 1914, photographer unknown, “1992-17-A164,” photo courtesy of City of North Battleford Historic Archives, North Battleford, Saskatchewan

When MacNeill finally arrived at the asylum in late 1913, he observed that the place resembled an institution of incarceration, wherein restraints, bars on the windows, and a fenced-in airing courts were dominant features. These features, which stemmed from a fusion of public precaution, based on preconceived notions, and poor architectural designing, conflicted with his belief of the hospital (to MacNeill it was always a “Hospital not an Asylum”) being an institution of healing.¹⁹⁶ As it were, they were not uncommon fixtures throughout North America, as the primary objective of hospital in the early twentieth century was custodial care. Cecilia Wetton, who contributed to Delores Kildaw’s official history of the North Battleford hospital, argues the

¹⁹⁶ *Saskatchewan Provincial Hospital Battleford*, 8. MacNeill refused to call the institution an asylum. From his first annual report, Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1913-1914, Ended April 30, 1914* (Regina: J. W. Reid, Government Printer, 1914), 38-39, he referred to it as a hospital.

government built the institution to resemble “that of a prison, with cage beds, straight jackets [sic], bars on the windows and a high-walled airing court in which the patients milled.”¹⁹⁷ The prison-like features, while conflicting with the medical ideals, did not send the proper impression to the public concerning insanity, the institution, or even MacNeill’s profession.

Most superintendents, Nancy Tomes argues, “devoted their best efforts not to the rehabilitation of society but to the legitimation of the asylum and their position within it.”¹⁹⁸ Rehabilitating society and treating insanity, accordingly, came second to validating the profession and promoting the asylum. Superintendents intended the hospital to be a place of order and comfort for people, sheltering them from outside influences. Underneath their posturing about the ideal therapeutic asylum, however, it was a promotional tool, which they used to legitimize their vocation to society. While this was true of early members of the AMSAII, the view that the hospital made for an effective public relations device not only for the state government, but also for psychiatry remained. Because the building and the profession were intimately linked, as Gerald Grob had argued, a low opinion of one meant a low opinion of the other. If the public were going to place their faith in the North Battleford hospital or MacNeill as its superintendent, then the public’s view of both needed to improve.

Superintendents intended for the asylum to be a beacon of hope to society. More than an image of the state, it needed to proclaim the confidence of the profession in treating insanity. Tomes continues, “The hospital’s unique appearance and regimen offered proof to the families of the afflicted that these doctors were making use of a radical new treatment for a dreaded ailment.” The institution served as MacNeill’s “most effective public advertisement,” as it helped

¹⁹⁷ Wetton, “The First superintendent,” 15.

¹⁹⁸ Tomes, “A Generous Confidence,” 122

place him as an expert over insanity.¹⁹⁹ This was why he made renovations in the hospital. He needed, as Tomes argues, “to convince the public that insanity was a curable disease, best treated in a mental hospital,” instead of having it languish in a place of incarceration.²⁰⁰ MacNeill wanted to remove the established atmosphere of oppression that made it appear that his patients were imprisoned criminals forced into rehabilitation. Despite this resolution and Wetton’s claims, however, both the restraints and the airing courts remained in the hospital until 1922 – although MacNeill did order the removal of the bars over the windows.²⁰¹ He worked at transforming the institution in other ways, such as when he forbade the use of the word “asylum” from being spoken on the grounds and in any official report that originated from it – despite that “asylum” was still its legal designation. In the place of that “archaic” word he used “hospital” and demanded all the staff to do the same.²⁰²

Under MacNeill, the North Battleford hospital had a threefold purpose: it legitimized his new (to him and to the region) profession, it advertised his expertise to the residents of the province, and it provided hope to the public that in the hospital and under his guidance, people could be “permanently restored.”²⁰³ In spite of its few drawbacks, he appreciated what he called the “magnificent” building and claimed that people constantly remarked it was “a beautiful

¹⁹⁹ Tomes, “A Generous Confidence,” 123.

²⁰⁰ Tomes, “A Generous Confidence,” 122-123.

²⁰¹ Although it is an official history, and she and her contributors provide insightful arguments and point to many important dates and events, Kildaw’s work is brief and less than objective. For example, Wetton claims “First, Dr. MacNeill ordered the demolition of the airing court...He removed the bars from the windows and forbade the use of all mechanical restraints.” (15) Only one of those claims is true. MacNeill did have the bars removed from the windows, but inmates in his occupational therapy department were still making patient restraints in 1916 and during the 1920 Canadian Mental Health Committee (CMHC) visit, the official post-visit report remarked the staff’s continued use of the airing courts was antediluvian.

²⁰² Wetton, “The First superintendent,” 15. MacNeill made clear his crusade against the word “asylum” as well as “insane” in his second annual report (1915-1916). It was a crusade he did not end until the government legally changed both terms.

²⁰³ *Saskatchewan Provincial Hospital Battleford*, prepared and published under the direction of Hon. A. P. McNabb, Minister of Public Works, Saskatchewan Archives Board (SAB) PW 2, Special Publications, (Regina, Saskatchewan, Date unknown), 9.

place.”²⁰⁴ In the 1920s the government published a booklet that sought to build public support for his hospital. In it, the superintendent wrote that “one is impressed with the evident policy of the government, to spare no expense in erecting and equipping [the] institution.” Throughout the booklet MacNeill maintained that the residents appreciated the building because it exemplified the lengths to which the government went in ensuring a safe and modern society. He, like Washington’s Board of Trustees and Superintendent Waughop, believed the hospital proclaimed the benevolence of the government toward its citizens. But, he continued in the booklet, even as it symbolized safety and modernization was there principally for the “caring for the mentally ill of the province.”²⁰⁵ The building proclaimed the generosity of the government *and*, most importantly, at the same time announced insanity was a medical condition best treated in an asylum under professional care.

Conclusion

In the opening of the 1880 edition of his book *On the Construction, Organization, and General Arrangements*, Thomas Kirkbride wrote,

The proper custody and treatment of the insane are now recognized as among the duties which every State owes to its citizens; and as a consequence, structure for the special accommodation of those labouring under mental disease, provided at the general expense, ample in number, and under the supervision of the public authorities, will probably, before any long period, be found in every one of the United States.²⁰⁶

This recognition, he continued, should compel every government to “make full provision, not only for the proper custody, but also for the most enlightened treatment of all the insane within its borders.” While “most other diseases may be managed at home...the universal experience is,

²⁰⁴ *Saskatchewan Provincial Hospital Battleford*, 5.

²⁰⁵ *Saskatchewan Provincial Hospital Battleford*, 9.

²⁰⁶ Kirkbride, *Construction, Organization, and General Arrangements*, 17.

that a large majority of [the insane] can be treated most successfully...only in institutions specially provided for this class of disease.”²⁰⁷

It was the “duty” of the Saskatchewan and Washington governments to provide mental hospitals to their residents as a public service. Based on the expert opinions of Association members, and following the guidelines forwarded by the AMSAII and Kirkbride, these institutions were to proclaim the benevolence of the government, institute the medicalization of insanity, and advertise the profession of the superintendent. According to the Association they were to show society that insanity was best treated in the asylum under the physician’s medical care and following proper therapies.

The pavilion style championed by Kirkbride, Buttolph, and the AMSAII gave rise to large edifices that were particular in all their aspects and, much to superintendents’ eventual detriment, expensive to maintain.²⁰⁸ Early hospital advocates reasoned that a specific style of structure was therapeutically beneficial to patients as its features worked symbiotically with the superintendent’s therapies toward the alleviation of insanity. The Association’s therapeutic promises led to a proliferation of the style throughout Canada and the United States.

Washington and Saskatchewan, however, constructed their Kirkbride hospitals based on “experience of the past,” even as, due to low cure rates, experience had shown that the institution was not therapeutically practical.²⁰⁹ Not only did the superintendents embrace the building layout

²⁰⁷ Kirkbride, *Construction, Organization, and General Arrangements*, 18.

²⁰⁸ In 1877, Hervey B. Wilbur, an adversary of expensive asylums presented an exposé titled *Buildings for the Insane* that described the high-price of maintenance. (Hervey B. Wilbur, *Buildings for the Insane: A Report Read at the Saratoga Conference on Charities*, (Boston: A. J. Wright, 1877)) He argued, according to Yanni, “that on average [the] buildings cost \$2,600 per bed” to maintain. The cost of running a mental hospital was, she concludes, “was far more expensive than a luxury hotel.” (Yanni, 165) Despite Wilbur’s efforts, many governments and private financiers continued to follow Kirkbride’s guidelines in order to build their own expensive and “unsightly edifices” so they too could house and treat insane people following these innovative principles. This information comes from appendix C (p. 165) of Yanni’s book. In appendix D she has illustrations that chart the growing size of the hospitals. On the scale provided the hospitals grew from 100 feet in length in 1770 to 2,200 feet in 1871.

²⁰⁹ Kirkbride, *Construction, Organization, and General Arrangements*, 46.

because tradition dictated it, the governments adopted the layout because it was the standard used throughout the east. Despite Washington sending a committee to Oregon and claiming that as the foundation of their own design, they ultimately borrowed from the east when establishing their own practices. As it was in the east, both western regions employed the particular structure as it promoted the strength of the government and the medical nature of care for insanity. In Saskatchewan and Washington the asylum emerged as an extension and reinforcement of social stability, and government benevolence and control.

In Washington, through official reports, Waughop, with the support of the Trustees, appealed to the government to construct a new building to replace the hospital's deteriorating military structures. He advocated adhering to the Association's building guidelines, because he wanted an institution that answered many of the same issues that plagued the early AMSAI members. Nevertheless, while framing it as a need to improve living conditions within the institution, he and the Trustees were in reality responding to the changing social and political conditions of the region. The hospital promoted benevolence of the government and stability in the face of social, political, and economic change. It represented order, both for the patients and for the public. Overall, in Washington, the structure was less about insanity and effective treatments and more about the presence of control. When presented in that manner the government agreed to construct a new building.

Under different motivations the Saskatchewan government, adhering to the words of Kirkbride, sought out the "knowledge of those who have had a practical familiarity with the wants and requirements of the insane" before they designed and erected their own hospital.²¹⁰ While initially constructed as an institution of incarceration and protection from insanity, MacNeill, after taking his post, immediately utilized it as a promotional tool of a different kind.

²¹⁰ Kirkbride, *Construction, Organization, and General Arrangements*, 46.

While maintaining the concept of state benevolence, he altered the “hospital’s” atmosphere to emphasize its medical purpose and his expert authority over insanity, while beginning the task of breaking links between insanity and criminality. This he did to improve the image of the institution and his profession, while challenging the public stigma surrounding insanity.

Chapter Two

The Persistence of Moral Treatment in Washington Territory

In 1883 Dr. John Waughop was upset by public allegations concerning patient abuse and wrongful commitment at his institution. Waughop was three years into his appointment as superintendent of the Washington Territory Insane Hospital and had already dealt with previous similar claims that led to one “unsuccessful attempt...to oust” him from his position.¹ In 1883 he was troubled with the persistent accusations the public levied against him and the hospital. These accusations began in 1866 under James A. Huntington and had continued with different veracities into Waughop’s term. At times the allegations pitted physicians against politicians and the oversight committee and highlighted a system of patronage that showed the Governor favoring political cronyism over the needs of the patients.

Beginning in 1877, under the direction of Dr. Rufus Willard, who was John Waughop’s immediate predecessor and the first resident physician also to hold the position of superintendent, the hospital administration worked to challenge the established image of the asylum to reframe it as an institution free from abuse. In his 1883 report Waughop fended off the accusations by writing many other “hospitals for the insane [were] constantly charged with abuse of inmates.”² There was truth to this claim; by the late 1800s, similar claims of mismanagement and abuse were levelled at asylums across Canada and America.³

Waughop and the Hospital Board of Trustees refuted any claims about the hospital being an abusive place by publishing more positive appraisals in the local newspapers. Under the heading “Abuse of Patients” in the 1883 biennial report – a heading never used before, nor again

¹ *Puget Sound Argus*, May 23, 1883, p. 5.

² Territory of Washington, *Report Board of Trustees of the Hospital for the Insane of the Territory of Washington, 1883*. (Olympia: C. B. Bagley, Public Printer, 1883), 20.

³ For an example of general accusations for North American Insane Hospitals please see: Dorman B. Eaton, “Despotism in Lunatic Asylums,” *North American Review* vol. 132, no. 292 (Mar. 1881).

in the reports – Waughop argued, “the insane are the most helpless of any of our people. To abuse such persons would be the grossest outrage and an act of cruel cowardice.” Despite this statement, charges of this type continued. Careful not to implicate hospital staff in his response, Waughop believed the main source of the charges arose from the inmates, who, he described as “difficult to manage” and “full of delusions.” When their fantasies were extreme, people tended to excuse it as “insane talk.”⁴ However, when their talk reached the realm of possibility, such as them being “victims of conspiracy or spite,” then “the credulous begin to think that maybe there is something to it.”⁵ These accusations, he claimed, generated many problems as visitors of the hospital who had contact with inmates, family members who corresponded or visited them in the asylum, and various other people with whom patients corresponded were prone to believe them and in turn promulgated claims of abuse.

Waughop explained that upon arriving at the hospital the staff only treated inmates with kindness and honesty and created a welcoming environment. This reception helped newly admitted patients feel comfortable in the hospital while simultaneously worked to improve the public image of the institution as a caring place. To refute the abuse claims further, Waughop outlined in print the “kind and firm” therapeutic program that he employed at his hospital.⁶ By utilizing work therapy, religious services, amusements and recreation, offered within a daily regimented schedule that stressed order and discipline, he employed a system that he “summed up as moral treatment.”⁷

This chapter argues that in its early years, the Territory of Washington’s legislation defined insanity in a manner that was aligned more with criminality than medicine. Under early

⁴ *Hospital for the Insane of the Territory of Washington, 1883, 18.*

⁵ *Hospital for the Insane of the Territory of Washington, 1883, 18; 20.*

⁶ *Hospital for the Insane of the Territory of Washington, 1883, 18.* The actual quote is that the patients are “treated with kindness and firmness.”

⁷ *Hospital for the Insane of the Territory of Washington, 1883, 18.*

territorial laws, inmates were incarcerated in the asylum due to the “danger” they posed to those around them.⁸ Once committed they were confined and subjected to physical labor, more for the superintendent’s pecuniary gain than for their own therapeutic benefit. The law did not stipulate medical care beyond attending to their physical needs. After the government purchased Fort Steilacoom and relocated the asylum, the first superintendent continued the practice of patient labor for personal financial profit, much to the dismay of the resident physicians. It was not until 1877, when Willard became superintendent, following a change in the law that mandated a physician have sole authority over the management of care in the institution, that the notion of therapeutically treating people began to take hold, albeit tenuously.⁹ In his first report he argued that the duties of the superintendent were “higher” than simply the “care and custody” of the patients.¹⁰ The physician’s ultimate purpose was to achieve permanent relief from insanity. Once this approach was “understood and accepted by every community,” he wrote, “we shall be able to carry out the true aim and object of this institution.”¹¹ This shift from a custodial to a therapeutic space transformed the image of the asylum, as well as the population inside its walls. Moral treatment, although no longer actively promoted in eastern regions of Canada and the United States, moved west and physicians leaned on its principles to modernize their institution as they worked to align their practices with their eastern counterparts from half a century ago.

⁸ Washington Territorial Legislative Assembly, *Of Trials, Made and Passed at a session of the Legislative Assembly begun and held at Olympia on the Fourth Day of October 1869, and Ended of the Second day of December 1869. Ninety-Fourth Year of Independence, Chapter XXII, section 256*, (Olympia: James Rodgers, Printer, 1869), p. 254, Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx, accessed on September 30, 2013.

⁹ Washington Territorial Legislative Assembly, *An Act to Regulate the Government of the Hospital of the Insane*, Enacted by the Legislative Assembly, 1877, Together with Joint Resolutions and Memorials, Sec. 5, (Olympia: C. B. Bagley, Public Printer, 1877), 226, Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx, accessed on September 30, 2013.

¹⁰ Territory of Washington, *Report of the Superintendent of the Hospital for the Insane of the Territory of Washington from August 15, 1876, to August 15, 1877*, (Olympia: C. B. Bagley, Public Printer, 1877), 7. By the late 1870s the superintendent’s began referring to the people in the hospital as patients, despite their legal designation still being inmate and the Trustees continuing to label to them as such.

¹¹ *Report of the Hospital for the Insane of the Territory of Washington, 1876-1877*, 7.

Adopted from the writings of eastern practitioners, moral treatment allowed Washington's superintendents to promote and implement benevolent practices aimed at curing people in the hospital, with the added benefit of medicalizing insanity. Placed into the larger context of the closing frontier and regional urbanizing, the system, as it had in the east, became a means to help maintain order in society by inculcating order with individuals through the state institutional system. Promoted in the years leading up to Washington's statehood and again thereafter in 1890, moral treatment became a way to highlight the advancement of the region by allowing the physicians to turn from the past ostensibly by embracing a modern, medical facility for furthering civilization.

Origins of Moral Treatment

Moral treatment emerged from practices developed by Philippe Pinel of France and William Tuke of England. Independent and unaware of one another, these men constructed a therapeutic system within their mental hospitals that they called moral treatment, or *traitement moral*. Individually they developed a similar system of care with the modest objective of improving the treatment of insanity. In each case, their actions had lasting influences beyond their own institutions.

At his York Retreat, founded in 1796, Tuke created "an atmosphere in which internal self-restraint and discipline replaced external fetters," as historian Gerald Grob maintains.¹² As a Quaker reformer and not a physician, Tuke founded his institution because he supposed that the harsh practices of the time failed to treat people deemed insane adequately or even as humans.

Tuke did not, however, advocate for stronger medical methods. As historian Lynn Gamwell and

¹² Gerald Grob, *Mental Institutions in America: Social Policy to 1875*, (New York: The Free Press, 1973), 46; Andrew Scull with his Marxist ideal, on page 227 of his article "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs," *European Journal of Sociology*, vol. 16, no. 2, (1975), argues that Tuke sought to establish an atmosphere at the Retreat that worked on improving a patient's self-worth and personal restraint in order to transform them into "the bourgeois ideal of the rational individual." Although coming at it from different perspectives both argue that Tuke sought to instill within his inmates proper social behaviors.

Nancy Tomes argue, Tuke believed “that a purely medical approach to mental illness was doomed to failure.”¹³ At his Retreat he strove to create a system that offered better, more humane care for people but also treated them along the lines of increasing their self-restraint and improving their self-worth.¹⁴ His approach involved a blend of Christian principles of charity, with pious interpretations of self-worth. Tuke meant for his system to offer a humane alternative to the institutional-based practices common throughout England.

Asylum-keepers did not always prescribe to the kindness advocated by Tuke. Historian Edward Shorter argues that pre-therapeutic institutions were “custodial asylum[s]” that governments and communities used to “confine raging individuals who were dangerous to themselves and a nuisance to others.”¹⁵ In the pre-moral treatment asylum, asylum-keepers subjected the “raging individual” to “traditional medicine” such as “bleeding, purging, and giving emetics” – all of which, Shorter contends, were “designed to cure” the individual.¹⁶ Into that milieu, Sociologist Andrew Scull adds discipline. Insanity, he maintains, “required a firm hand;” people in the asylum were often subjected to “beatings and intimidation.”¹⁷ Physicians used invasive practices and harsh physical discipline and tame insanity as much as control it. It was these methods that Tuke sought to replace with his practices at the York Retreat.

Tuke developed his methods around the ideal of what constituted socially acceptable “normal” behavior.¹⁸ He did this, argues Scull, to restore “qualities [that the patient] lacked...so

¹³ Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (Ithaca: Cornell University Press, 1995), 37.

¹⁴ Scull, “Madness to Mental Illness,” 225-226.

¹⁵ Edward Shorter, *The History of Psychiatry: From the Era of the Asylum to the Age of Prozac*, (New York: John Wiley & Sons, 1997), 7.

¹⁶ Shorter, *History of Psychiatry*, 8.

¹⁷ Andrew Scull, *Madness in Civilization: A Cultural History of Insanity from the Bible to Freud, from the Madhouse to Modern Medicine*, (London: Thames & Hudson Ltd., 2015), 153; 154.

¹⁸ Scull, *Social Order/Mental Disorder*, 88-90.

that he could once more function as a sober, rational citizen” in society.¹⁹ Tuke embraced his methods as a means to inculcate “hard work and self-discipline” within the residents of his asylum to refashion them “in the image of bourgeois rationality” and make them competent workers in the emerging marketplace, thereby contributing once again to society.²⁰ Tuke, driven by his religious convictions, offered a system that improved care of the individual within the asylum setting. As scholars argued, he sought to re-orientate the behavior within his residents as defined by what he perceived as appropriate social conducts but without resorting to established invasive medical treatments. Although he offered a humane system aimed at the individual, he allowed his religion and the social standards of his time and region shape his concept of insanity.

Although unaware of Tuke or his practices, French physician Philippe Pinel also developed a form of moral treatment beginning in 1793 at Bicêtre Hospice, and later at the Salpêtrière hospital. He too wanted to improve the care of people under his charge. As Shorter maintains, Pinel believed that the asylum was “a place where psychological therapy could be carried out.”²¹ Shorter explains that Pinel wanted to use “the experience of incarceration itself in a healing manner.”²² He inserted a regimen that made his institution an improvement over the jails and madhouses previously used to contain insanity.²³ “Public asylums,” wrote Pinel in 1809, “have been regarded as places of confinement for such of its members as are become dangerous [sic] to the peace of society.”²⁴ Scull interprets Pinel’s system as utilizing the “physical boundaries” of the hospital to reinforce society’s “moral boundaries.” In tandem “with increased freedoms and opportunity for work and amusement, this system provided further ways of

¹⁹ Scull, *Social Order/Mental Disorder*, 88.

²⁰ Scull, *Social Order/Mental Disorder*, 94.

²¹ Shorter, *History of Psychiatry*, 11.

²² Shorter, *History of Psychiatry*, 11-12.

²³ Scull, *Madness in Civilization*, 206.

²⁴ Philippe Pinel, *A Treatise on Insanity, in which are contained the Principles of a new and more Practical Nosology of Maniacal Disorders than has yet been offered to the public*, trans. by D. D. Davis, (Schiffeld: Todd, 1809), 3-4.

inducing patients to bring their deranged faculties and feeling under control.”²⁵ Using the atmosphere of the asylum as well as the innovative therapies, Pinel believed he was effectively able to treat insanity. In his book, *A Treatise on Insanity*, he defined his moral treatment as a “medical treatment.”²⁶ This connection allowed him to argue that insanity was a curable disease. By inducing a greater system of self-control in his patients – something he called “interior police” – he was able to release people back into the community.²⁷

As a devoted Quaker, Tuke emphasized Christian morality through his system while weakening connections to medical treatment.²⁸ Pinel, on the other hand, fortified the associations between his “moral regimen” and medicine.²⁹ “More than any other public medical figure...Pinel offered society assurance that mental illness is treatable and sometimes curable,” writes historian Dora Weiner.³⁰ In her essay “‘Le geste de Pinel’: The History of a Psychiatric Myth,” Weiner outlines many progressive mental health practices of the French reformer. Although, the more dramatic accomplishments, such as the legendary “unchaining the maniacs” at his Bicêtre hospital, to which many early American reformers made repeated reference, were more exaggerated than fact. Even so, his actions had a larger impact on the insane. Weiner argues, “the fact is that [Pinel] attempted to raise the rejected madmen and madwomen housed in the kingdom’s public institutions to the *dignified status of medical patients* in the newly formed French republic. In that sense, and in that sense only, did he liberate the insane men at Bicêtre

²⁵ Scull, *Madness in Civilization*, 205.

²⁶ Pinel, *Treatise on Insanity*, 5-6.

²⁷ Pinel, *Treatise on Insanity*, 6.

²⁸ Grob, *Mental Institutions in America*, 45.

²⁹ Pinel, *Treatise on Insanity*, 5.

³⁰ Dora B. Weiner, “‘Le geste de Pinel’: The History of a Psychiatric Myth,” in *Discovering the History of Psychiatry*, eds. Mark S. Micale and Roy Porter, (Oxford: Oxford University Press, 1994), 232.

from their chains.”³¹ As part of introducing humane practices, Pinel paved the way toward medicalizing insanity in France by developing a moral treatment system.³²

The Impact of Moral Treatment in Eastern United States and Canada

Similar to Tuke and Pinel, American reformers believed in self-control for the betterment of society. Into the late-1700s, under the influence of Protestant theology, colonists believed that based on their earthly good works God would reward them in the afterlife. They were only able to achieve these rewards, however, through work and fervent, moral self-discipline. By the emergence of the Jacksonian Era, the ideal of personal restraint remained but its links to religion were muted.³³ Instead of spiritual consequences, the behavior of the individual defined and affected their place within the community. Society defined wealth and influence as by-products of hard work, self-control, and good behavior.³⁴ Alternatively, being poor was the result of indolence and succumbing to basic inner desires. As Grob argues, a person who practiced “the inner check of conscience and self-control” would not only be “free from the temptations of evil but would voluntarily undertake the work of...building a better world.”³⁵ Reformers accepted that abnormal behavior of individuals affected the lives of those in their home and had the

³¹ Weiner, “‘*Le geste de Pinel*,’ 232, emphasis added. In an essay by Amariah Brigham, entitled “Insanity and Insane Hospitals,” *North American Review* 44, (January 1837): 103, Brigham declares that Pinel marched to the French authorities, during the height of the Reign of Terror, and demanded that the insane be set free. This undoubtedly seems untrue. What seems more likely is that the doctor kept his head down, and if he ever brought attention to himself it was to show to the new Republic that he was an asset, not an obstruction to the new government. However, this is called into question not only by Weiner, but also Shorter (*History of Psychiatry*, 11) and Scull (*Madness in Civilization*, 207).

³² Grob, *Mental Institutions in America*, 39-42.

³³ The Jacksonian Era, or the Age of Jackson, stems from US President Andrew Jackson (1829-1837). The era does not have a set timeframe – similar to moral treatment scholars diverge on the ending. It began with the election of Jackson to the office of US President but ended sometime in the 1840s; certainly by 1850 when the slavery issue overtook and divided America. Nevertheless, as historian Daniel Feller writes, “Jacksonian historians see this period as the seedbed of modern America. In these years...appeared the distinctive features that have marked [American] society ever since.” *The Jacksonian Promise: America, 1815-1840*, (Baltimore: Johns Hopkins University Press, 1995), xi.

³⁴ Grob, *Mental Institutions in America*, 49.

³⁵ Grob, *Mental Institutions in America*, 49.

potential to disrupt organization of the community.³⁶ Reformers assumed “that deviant behavior was symptomatic of a failing society,” as David Rothman argues.³⁷ Therefore they advocated for individual self-control.³⁸ Each person was to learn, accept, and exhibit proper “normal” behaviors – behaviors characterized within an acceptable moral framework. When writing about the Jacksonian Era, historian Daniel Feller explains, “Everyone from evangelists to labor activists agreed that self-discipline was the key to success in a free society. The obsession with the minutia of prison and asylum routine, even with the details of institutional architecture, reflected a wider faith...in the capacity of rational, holistic systems to unleash human potential and catapult Americans to a new plane of happiness and achievement.”³⁹ Self-discipline emerged at the center of American’s vision for social morality, defined as being a productive member of a community.

In addition to overseeing the shift to a more secular moral center, the Jacksonian Era was also characterized by industrialization and urbanization as people migrated to cities for non-agrarian work. With this relocation came an increased prevalence of newcomers and “strangers” exhibiting abnormal behavior, which social reformers defined, in part, as insanity.⁴⁰ These perceived abnormal actions were not agreeable to people already living with the pressures of an industrialized society. Reformers turned to the asylum to ensure social stability and to rehabilitate people who failed to practice self-control.⁴¹ The asylum represented a state monument to these ideals. Advocates of the asylum, historian David Rothman argued, saw the

³⁶ David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown, 1971), 123-126.

³⁷ Rothman, *Discovery of the Asylum*, 69.

³⁸ Constance McGovern, *Masters of Madness: Social Origins of the American Psychiatric Profession* (Hanover, NH: University Press of New England, 1985), 23.

³⁹ Feller, *Jacksonian Promise*, 143.

⁴⁰ Feller, *Jacksonian Promise*, 142.

⁴¹ Marshall Foleta, *Coming to Terms with Democracy: Federalist Intellectuals and the Shaping of an American Culture* (Charlottesville: University Press of Virginia, 2001), 135-36.

new institutions as the place of “first resort, the most important and effective weapon in their arsenal” to ensure social stability.⁴² Within the well-ordered and carefully maintained asylum, reformers taught people self-control and (re)inculcated in them the means to be productive members of society, thereby allowing them to return back into their communities.

The founding superintendents of the Association of Medical Superintendents of American Institutions for the Insane (AMSAAI) wanted to change, or in the very least improve upon the treatments and ideals developed during earlier eras. They believed it was a “prevailing error” that insane people needed “to be disciplined and governed” or that one must seek “dominion over them by fear or by other means that we think improper.”⁴³ Similar to the European reformers, the Association wanted to move away from practices that relied on fear, physical dominance, and the coercion of inmates. They borrowed moral treatment practices they adapted from Tuke and Pinel. When the AMSAAI designed their own system, they attributed the majority of their own inspiration to Pinel.⁴⁴

The Association believed that Tuke “did not seem to have had very clear ideas respecting the nature of insanity, or its proper treatment.”⁴⁵ While the introduction of humane treatments at his York Retreat was a noteworthy achievement, the lack of medical theory did not sit well with men who saw themselves as “medical superintendents,” as their name stated. According to Grob, despite their desire to appear medically driven, American superintendents were actually religious men who, like Tuke, allowed their faith to influence their understanding of insanity. They believed there were “immutable natural laws that provided a guide to proper living” and “by ignoring the laws of governing human behavior the individual placed himself on the road to

⁴² Rothman, *Discovery of the Asylum*, 131.

⁴³ AMSAAI, “The Moral Treatment of Insanity,” 6.

⁴⁴ AMSAAI, “The Moral Treatment of Insanity,” 4.

⁴⁵ AMSAAI, “The Moral Treatment of Insanity,” 5.

mental illness.”⁴⁶ They framed their own medical theories within contemporary American social identities. The Association’s medical concepts of insanity supported their own religious perceptions of what constituted proper social-morality. Although, Grob continues, the first generation of the Association defined insanity in these terms, upon accepting more trained physicians within their ranks, they increasingly strove to classify it in medical terms.⁴⁷

In 1847, Amariah Brigham, a founding member of the AMSAII, wrote an article in the Association’s periodical *Journal of Insanity* that outlined the tenets of what constituted their moral treatment program.⁴⁸ He argued that any person judged insane needed to be sent to the asylum and placed under the care of a superintendent, as it was imperative to remove the inmate immediately “from home and former associations.” Once under the care of the asylum physician, the person was to receive “respectful and kind treatment under all circumstances.” The goal of the institution was to instil “self-control” and encourage patients to adopt “regular habits” accepted by society. To accomplish this Brigham recommended employing normative practices such as dedicating most of the inmate’s time to “manual labor” – a practice that began under moral treatment and grew in importance over time throughout Canadian and American asylums. Even so, superintendents were to allow patients enough free time to attend weekly “religious services.” Lastly, inmates needed recreation and entertainments to help divert their minds from their “morbid thoughts.” These acts, Brigham wrote, were “essential in the Moral Treatment of the Insane.”⁴⁹

⁴⁶ Gerald Grob, “The State Mental Hospital in the Mid-Nineteenth-Century America: A social Analysis” in *The American Psychologist* 21, no. 6 (1966), 513.

⁴⁷ Grob, “The State Mental Hospital in Mid-Nineteenth Century America,” 512; see also, John Albert Pitts, “The Association of Medical Superintendents of American Institutions for the Insane, 1844-1892: A Case Study for Specialism in American Medicine” (PhD dissertation, University of Pennsylvania, 1979), 214.

⁴⁸ AMSAII, “The Moral Treatment of Insanity.”

⁴⁹ AMSAII, “The Moral Treatment of Insanity,” 1. Although the article does not cite the author, an editorial note in the *AJI* states: “While on the subject of the Journal, it may be proper to state, that for all the articles without any name or initials attached, Dr. Brigham, the principle Editor, is alone responsible.” (*AJI*, 1 (Jan., 1845), 288.)

Another American physician, Theodric Beck, summarized moral treatment as first “removing patients from their residence to some proper asylum.” The home and community setting, he argued, “aggravates the disease, as the improper association of ideas cannot be destroyed.” In the asylum the staff was to treat the patient with “humane vigilance” and refrain from “coercion...blows, strips, and chains.” The superintendent was to convince the patient that his authority “is absolute.” The asylum was to operate on a strict daily schedule to help the patients “adopt a system of regularity.” When the patient accepted regularity, then the superintendent was to “introduce entertaining books and conversation, exhilarating music, [and] employment of the body.” The main purpose of the system was to separate the inmate from society and provide a unique setting in which to instil in them regularity of habits and thought through moral suasion, daily rigor, amusements, and mental diversions.⁵⁰

Through their system the Association combined the humanitarian ideals of Tuke that stressed kindness in the asylum, with Pinel’s belief that insanity was curable with medical treatments. Although these ideals were important to the American reformers, they utilized moral treatment in a manner reflective of Europe’s bourgeois. Facing a new landscape, one that was increasingly urban and industrial but also considered to be filled with disorder, the AMSAII, which extended its membership to include Canadian superintendents in as early as 1846, adapted the system in a manner that highlighted their conservatism.⁵¹ They argued that their innovative regimen helped a person recover from insanity through the inculcation and exhibition of traditional values, defined by their own upper and middle class Protestant values.⁵² They structured their system around practices that socially and morally rehabilitated inmates through

⁵⁰ Theodric Romeyn Beck, *An Inaugural Dissertation on Insanity* (New York: Printed by J. Seymour, 1811), 27-28.

⁵¹ John Curwen, *History of the Association of Medical Superintendents of American Institutions for the Insane, From 1844 to 1874, Inclusive*, (1875), 9.

⁵² Rothman, *Discovery of the Asylum*, 152.

self-discipline. Nevertheless, according to Rothman, they shaped their practices around the modern urban lifestyle that emphasized structure and daily routine. Because it induced inmates to come to terms with a lifestyle that demanded they “adopt a system of regularity” – specific times to eat, clean, work, and retire – moral treatment helped them and superintendents develop a new understanding of urban-industrial landscape.

The AMSAII believed that by stressing regularity and self-control the asylum rituals could instil reason within individuals and return people back to their communities cured. Nancy Tomes argues that superintendents only pronounced a person cured once they were “free of all symptoms of insanity and able to resist undesirable impulses; they had to believe in their own reformation” and announce their determination to lead a better life.⁵³ Founding member Thomas Kirkbride wrote, under moral treatment “it is safe to say that about as many as eighty per cent. [of inmates] may be expected to recover.”⁵⁴ Armed with their conviction that they were able to cure insanity the AMSAII began promising high recovery rates for people treated within the asylums.

The Association began to adopt medical language to claim insanity was a curable disorder. Superintendents argued it was caused by a disordered operation of the nervous system, produced by social pressures and manifested by bodily impairment. Nervous actions then transmitted to the brain and hindered normal functioning.⁵⁵ This definition reinforced the concept that perceived abnormal behavior was another cause of insanity. If left unchecked, members of

⁵³ Nancy Tomes, *A Generous Confidence: Thomas Story Kirkbride and the Art of Asylum-Keeping, 1840-1883*, (Cambridge: Cambridge University Press, 1984), 219.

⁵⁴ Thomas S. Kirkbride, *On the Construction, Organization, and General Arrangements of Hospital for the Insane with some remarks on insanity and its Treatment*, 2nd ed., (Philadelphia: J. B. Lippincot & Co., 1880), 23. Kirkbride believed a maximum of 80% could recover, in his book *The Mad Among Us: A History of the Care of America's Mentally Ill*, (New York: The Free Press, 1994), Gerald Grob writes that some superintendents placed that percentage as high as 90% (pg. 99-100).

⁵⁵ Tomes, *Generous Confidence*, 80. See also Thomas Hun, “Thoughts on the Relation of Physiology to Psychology,” *AJI* 3, (1846): 1-10.

the AMSAII believed, the behaviors could alter the makeup of the brain, resulting in permanent insanity.⁵⁶ Superintendents, therefore, treated the nervous disorders by retraining or conditioning the brain to adopt normal thoughts and actions.

As it had in Europe, this system permitted members of the AMSAII to adopt treatments that they argued were more humane than those practiced by their predecessors. Moreover, by adhering to the principles of moral therapy, superintendents effectively introduced medical discourse into the asylum in a manner that placed them as experts over it. They presented new ideals concerning the curability and etiology of insanity within a medical language that stressed nervous disorders and brain functioning. Nevertheless, at its core the experience of insanity was still defined by the rejection and eventual inculcation of normal social behaviors.⁵⁷ These concepts allowed superintendents to suggest diagnoses such as moral insanity, which, as historian Linda Carlisle explains, permitted them to argue the “moral, or emotional, faculties [of a person] were deranged without apparent involvement of the intellectual faculties.” Impairments of this type required superintendent’s professional opinion, as the derangements were “distinguishable only by someone expert in dealing with cases of insanity.”⁵⁸ Their perceived authority combined with the promise of curing insanity led many people to place their faith in the superintendents and the well-ordered asylum.⁵⁹

The Decline of Moral Treatment in the East

Under moral treatment, insanity came to be understood as a treatable condition, and to emphasize this perception superintendents publicized high numbers of cured patients.⁶⁰

⁵⁶ Edward Daniell and Newport Pagnell, “On Impulsive Insanity,” *AJI* 3, (1846): 19.

⁵⁷ Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (Ithaca: Cornell University Press, 1995), 65-70.

⁵⁸ Linda V. Carlisle, “‘New Notions and Wild Vagaries’: Elizabeth Packard's Quest for Personal Liberty,” *Journal of the Illinois State Historical Society* (1998-) 93, no. 1 (Spring, 2000): 50.

⁵⁹ Gamwell and Tomes, *Madness in America*, 39.

⁶⁰ H. A. Buttolph, “Modern Asylums,” *AJI* 4 (April, 1847): 374.

However, AMSAII member Pliny Earle, after critically analyzing the numbers of patients cured in various eastern asylums, explained that the facts did not support the claims, leading him to wonder even if a large “proportion [of patients] are susceptible of cure.”⁶¹ He found that superintendents were attributing multiple cures to single individuals. They were reporting “the recoveries of *cases* rather than of *persons*,” as such if a patient was readmitted to the asylum and subsequently treated and discharged, their readmission constituted filing them as a new case.⁶² The “uninitiated reader,” such as a politician or a member of the public, Earle wrote, “has no reason even to suspect that the number or *persons recovered* is not equal to the *number of recoveries*.”⁶³ While superintendents relied on these numbers to present their asylums as curative institutions and to stress the perceived effectiveness of the moral treatment regimen, the reality of the situation was that many patients entered the asylum without ever achieving cures. Despite the exaggerated claims, the steadily expanding population underscored the notion that moral treatment was not helping people recover at the rate assured by Kirkbride and other members of the Association.

This low recovery rate was particularly exacerbated, Nancy Tomes argues, in the late 1860s in the aftermath of the American Civil War when an influx of returning soldiers sent to the institution thrust asylum expenses to the forefront of state political discussions.⁶⁴ By the late

⁶¹ Pliny Earle, *The Curability of Insanity: A Series of Studies* (Philadelphia: J. B. Lippincott C., 1887), 9.

⁶² Earle, *Curability of Insanity*, 9. From pages 9-14, Earle sites examples of high cure rates being attributed to a handful of readmissions. At the State Hospital at Worcester, “of the ninety-two recoveries presented to the readers [in 1876] the *permanent recoveries of persons* were, at most, only *four*. (12) In 1892 the superintendent of Western Washington Hospital admitted previous superintendents had also exaggerated recovery numbers along these same lines. He conceded, “the percentage of recoveries depends a great deal on the person making them.” Washington State, *Biennial Report of the Board of Trustees of the Western Washington Hospital for the Insane of the State of Washington, 1891-92*. (Olympia, Wash.: O. C. White, State Printer, 1892), 10-11.

⁶³ Earle, *Curability of Insanity*, 14. Emphasis original.

⁶⁴ Tomes, *Generous Confidence*, 290-93. Ellen Dwyer argues that as early as 1855 the staff at New York’s Utica State Hospital was aware of the ineffectiveness of moral treatment and replaced “moral therapy with a reliance on chemical and mechanical restraints.” Ellen Dwyer, *Homes for the Mad: Life Inside Two Nineteenth-Century Asylums* (New Brunswick, NJ: Rutgers University Press, 1987), 4. Political interference also added to the situation. As outlined, for moral treatment to be truly effective, the AMSAII recommended maintaining a patient population

1800s, the mental asylum throughout the United States and Canada became overcrowded and expensive. The early promises forwarded by the AMSAII members, specifically the curability of insanity, failed to materialize. As Gamwell and Tomes explain, due to a high population consisting of people who had not recovered combined with rising numbers of returning soldiers “state mental hospitals were filled with patients left uncured by moral treatment.” As a result “many of the leading superintendents of early asylums found themselves ... defending moral treatment before hospital boards and state legislatures.”⁶⁵ The overcrowded conditions compelled superintendents to change their focus from treating insanity to maintaining order within the asylum as their system failed to produce the promised results.

The Association eventually realized the shortcomings of the program and advocated that superintendents adopt more regionally relatable therapies. At their annual meeting in 1888, a special committee reported its findings “on the Revision of the ‘Propositions of the Association’” – the same propositions that the AMSAII adopted in 1844. The committee concluded that instead of superintendents utilizing treatments based on a system dictated from national ideals, they should adopt practices that best benefitted patients within their respective hospitals and regions.⁶⁶ The committee advocated moving away from moral treatment.

Washington Territory

When writing about the American West, Fredrick Jackson Turner argued that it takes time before western societies adapts conventions that resemble those in the east. Over time, he

that reached the maximum of 250 inmates. Nevertheless, that was something superintendents did not have the authority to enforce. Under pressure from governments to accept all people deemed insane, the inmate population at public asylums increased beyond the recommended number hindering the superintendent’s ability to see and treat individuals on a daily basis. See: Grob, *Mad Among Us*, 91.

⁶⁵ Gamwell and Tomes, *Madness in America*, 121.

⁶⁶ Orpheus Everts, and Foster Pratt, “Report of the Special Committee on the Revision of the ‘Propositions of the Association,’” *AJI* 44 (July 1888): 52. It is interesting to note that these new set of proposals were presented after all of the original AMSAII members had either passed on or were no longer active with the Association, save Pliny Earle.

wrote, the west “loses its primitive conditions, and assimilates itself to the type of the older social conditions of the East, but bears within it enduring and distinguishing survivals of its frontier experience... [It] is not a history of imitation, of simple borrowing; it is a history of the evolution and adaption.”⁶⁷ The history of Washington’s first asylum plays into that argument. Before the government was able to construct and support a large structure that resembled similar institutions in the east, public and political attitudes towards insanity had to evolve.

Initially Washington Territory did not have the resources to treat insanity. The political priority of the legislature concerned maintaining order and safety for the people in the region. The government eventually set aside funds for the care of insanity and in doing so, as historian Russell Hollander argues, “began to bring Washington into conformity with the pattern [of care] accepted in most regions of the country.”⁶⁸ In the 1863 Governor William Pickering addressed the House of Representatives for the Territory of Washington. At this address Pickering announced the “Territorial Legislature very wisely and humanely passed an act to provide for the safe keeping of Insane and Idiotic persons.”⁶⁹ According to the act, the government sent people to the St John lunatic asylum under the charge of the Sisters of Charity at Vancouver, located in southern Washington, who charged \$8 a week per person.

Due to budget restraints, the government did not attempt to erect and maintain a building or demand a level of care that reflected the advances made in the eastern regions of the United States and Canada. Under Washington’s contract, the Sisters’ duties did not extend to ameliorating the conditions of those placed in their charge.⁷⁰ They were only to provide

⁶⁷ Fredrick Jackson Turner, “The Problems of the West,” *Atlantic Monthly* 77 (September 1896), quoted from *Rereading Fredrick Jackson Turner: “The Significance of the Frontier in American History” and Other Essays*, with commentary by John Mack Faragher (New York: Henry Holt and Company, Inc., 1994), 62.

⁶⁸ Russell Hollander, “Mental Health Policy in Washington Territory, 1853-1875,” *The Pacific Northwest Quarterly* 71 no. 4 (Oct., 1980): 153.

⁶⁹ *Washington Statesman*, “Governor’s Message,” January 3, 1863.

⁷⁰ Washington Society for Mental Hygiene, *Mental Health in Washington: Facilities and Needs*, (Seattle, 1929), 13.

“clothing, care, medical attendance, and safe keeping” of their “insane and idiotic inmates.”⁷¹ Politicians considered this level of care sufficient, as its limited financial means prevented the territory from spending more “without entirely neglecting other and very important subjects of legislation.”⁷² Policy makers reasoned that the “physical wants [of the insane] are fairly attended to, but no adequate provisions can be made with the means at command to minister to a mind diseased.”⁷³ Although the government stipulated the need for care and medical attendance for the people sent to the Sisters of Charity, its efforts amounted to little more than confining insanity by sending such people away for care. The level of care required of the contract holder matched pre-moral treatment care offered in eastern institutions in the early nineteenth century.⁷⁴

By justifying their actions as fiscally responsible, the government established a system of care that placed patients under the custody of various contract holders who won the contract by submitting the lowest bid for their services. Whether the bidders were physicians or not was of no concern, what mattered was attending to their physical needs of the sufferers with minimal expenditures. In 1866 the territorial legislature decided not to renew their contract with the Sisters of Charity and instead sent out calls for bids from new contractors.⁷⁵ James Huntington won the next contract and secured a five-year agreement to care for people at his farm at a promised rate of \$1 a day per patient. When the contract was finalized the government moved

⁷¹ “Governor’s Message,” *Washington Statesman*, January 3, 1863. Unless quoted as such, I will refer to people receiving help in the mental asylum as patients.

⁷² Washington Territorial Legislative Assembly, *Relative to an Appropriation for an Insane Asylum, Made and Passed by the Legislative Assembly at the First Biennial Session, begun and held at Olympia, the Seat of Government, on Monday, Dec. 2, 1867, Memorials*. (Published with Authority, Olympia: Chas. Prosch, Printer, 1868), 166. Washington State legislature website:
http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx, accessed on October 1, 2013.

⁷³ *Memorial Relative to an Appropriation for an Insane Asylum*, 166.

⁷⁴ McGovern, *Masters of Madness*, 37-39.

⁷⁵ According to *The Daily Ledger*, the “squabbles” resulted from the Sisters insisting the government continue to pay in gold instead of their new paper currency, which they were unable to do. (“Hospital Proves Tacoma,” *The Daily Ledger*, May 28, 1916.) Hubert H. Bancroft, *Bancroft Works*, Volume 31, History of Washington, Idaho, and Montana, 1845-1889 (San Francisco: The History Company, 1890), 274; *Olympia Washington Standard*, February 10, 1866. The medical treatment they advertised was for physical ailments, not mental.

the people from Vancouver to Huntington's farm in the Cowlitz valley where, according to historian Hubert Bancroft, the "accommodations were inadequate."⁷⁶

A year into his contract a flood damaged Huntington's farm, causing all "improvements [to be] swept away."⁷⁷ This led to public charges of unsatisfactory conditions and poor treatment. This "slander," as Huntington called it, led the governor to organize a Board of Commissioners to inspect the "asylum." The commissioners concluded that there was "sufficient room for the accommodation of all the patients, and that they [were] well provided with food and necessary clothing." Moreover, "the inmates [had] plenty of outdoor exercise...and appear to [have been] well supplied with food and common necessities [sic] of life."⁷⁸ The report then listed each patient by name and explained his or her physical and mental condition. Huntington sent copies of the report to the Vancouver newspaper the *Register* and the *Walla Walla Statesman*, to show that contrary to what the public believed his institution functioned satisfactorily. Nevertheless, two years later Huntington again faced allegations, this time from a more prominent voice.

After the US Civil War, asylum advocate and reformer Dorothea Dix, who lent her services as a nurse during the war, inspected institutions in the western regions of the United States. While she never made it to Washington Territory, she did send a delegate who informed her of the terrible conditions to which Huntington had subjected his patients. After hearing of the state of affairs at Cowlitz, Dix sent a letter to Governor Alvan Flanders pleading for better care for this "helpless and irresponsible class of sufferers." Under Huntington, she wrote, the "provision and care [of the insane] are both inadequate and unsuitable and...patients suffer

⁷⁶ Bancroft, *Bancroft Works*, 274. Bancroft never explains how the accommodations were inadequate.

⁷⁷ Bancroft, *Bancroft Works*, 274.

⁷⁸ *Walla Walla Statesman*, November 29, 1867.

through want of intelligent liberal care and humane direction.”⁷⁹ Dix argued that the care of the insane was an important duty that required great effort from all involved. She felt that those who took up this responsibility often did not fully appreciate the importance of their position. She argued the patients were a “helpless, irresponsible class of sufferers” that deserved no less than humane care desired of any other person.⁸⁰ Dix concluded her letter by pleading with the governor to understand the same and dramatically improve the quality of care provided to them.

Dix argued that the low quality of care was due to “ignorance” of the people involved, more experts needed to be involved. She believed that due to lack of understanding, the officials who oversaw or managed the Cowlitz facility were unable to “perform their duty rightly.”⁸¹ Despite the advances made in the east concerning asylum-based care, Washington officials believed that minimal care of insanity was sufficient.

The criticisms that Dix levelled against the institution spurred journalists into action. Some reporters voiced their opposition to Huntington’s methods and the territorial laws that permitted such a system of care. The *Weekly Pacific Tribune of Olympia* argued that the government needed “to change the law in this matter... The contract system is liable to abuse, [and] should be done away with altogether.”⁸² Awarding a contract to the lowest bidder compelled contractors to cut corners in order to make a profit, while people in the system suffered.

The *Daily Pacific Tribune* sent a delegation to investigate the asylum and presented their findings to the territorial government. The report stated that the contract system was “wholly inadequate for [its] purpose, and is an expensive failure.” They noted the patients slept “in bunks,

⁷⁹ Dorothea Dix, “Washington, D.C. October 20, 1869,” from the article “Miss Dix on the Insane,” *Weekly Pacific Tribune of Olympia*, Nov. 13, 1869.

⁸⁰ “Miss Dix on the Insane,” *Weekly Pacific Tribune of Olympia*, Nov. 13, 1869.

⁸¹ “Miss Dix on the Insane,” *Weekly Pacific Tribune of Olympia*.

⁸² *Weekly Pacific Tribune of Olympia*, Nov. 13, 1869.

in cells [approximately 8 by 5 feet], in a coarsely finished unplastered building, [which was] very little better than a barn.” The staff locked some people in their cells, which they described as filthy and showed signs of never being washed. One inmate cooked the food while another did all the washing. Despite its deficiencies, the article explained, administrators wanted to keep the *status quo* as they were the ones who benefitted most from the contract system.⁸³

The *Daily Pacific Tribune* delegates linked the reputation of the government to the proper care of the insane – a tact adopted by hospital administrators in 1883 and 1885 when they appealed to the government for a new building. “The fame and shame of this institution,” the *Tribune* article warned, may “have a wider range than we were before aware of, and may and will [sic] detract seriously from the rising reputation of our Territory and our people, and should be at once amended.”⁸⁴ The quality of care offered by Huntington was not just indicative of his ethics, it was symbolic of the overall quality of care offered in the region. Under the lowest-bidder contract system, the asylum had become a source of shame for Washington society, the territory, and its government.

The letter from Dix and the support of two newspapers put pressure on the government to relocate the asylum to a permanent location, which gave politicians greater oversight over the institution, specifically concerning patient accommodations and the level of care offered. When Huntington’s contract ended in 1871, the government did not to renew it, instead opting to procure, for a low reasonable price, the abandoned US Army base of Fort Steilacoom as a new site for a territorial mental asylum. The location had its advantages for a government with limited funds. The decommissioned fort already had 25 buildings in which to house patients and staff, and it moved the institution closer to the developing urban areas around the Puget Sound. The

⁸³ “Insane Asylum,” *Daily Pacific Tribune*, Nov. 26, 1869.

⁸⁴ “Insane Asylum,” *Daily Pacific Tribune*, Nov. 26, 1869.

government, however, continued to award care to the lowest bidder through a contract system, and the military buildings, as described in the previous chapter, did very little to improve care for the insane in the region.

Harmon, physicians, and the conflict at Fort Steilacoom

Locating the insane hospital in a permanent location ushered in the potential for improving care for Washington's insane citizens. When newspapers announced the purchase of the Fort Steilacoom, no one questioned why the government decided to use deteriorating military buildings for asylum wards. In 1871, the patient population was still relatively small.⁸⁵ This allowed the administration to use the better buildings and demolish the rest. The government appeared to be taking positive steps toward improving the care of the insane; but soon the asylum once again became the center of conflict.

The next crisis, which unfolded between 1873 to 1875, concerned many of the same issues that plagued the institution under Huntington's direction: poor care, patient abuse, overworking of patients for the financial benefit of the superintendent, deficient living conditions and then the added concern about political cronyism, all of which the resident physicians made public in letters to newspapers and in their official reports. The hospital's new superintendent, Hill Harmon, soon emerged as the crux of many of the problems.

Harmon, like his predecessors, was not a physician, nor did he have any medical training nor even a particular interest in insanity and its causes. He was a former hotel manager from Olympia turned politician who at the height of his political power prior to his appointment as superintendent held the office of territorial treasurer. In that position he secured Fort Steilacoom from the federal government, then used his political and personal connections to maintain the

⁸⁵ According to an August 26, 1871 *Weekly Pacific Tribune* article there were "15 men and 6 women, 21 in all."

contract system and become superintendent of the hospital.⁸⁶ Once he took up his position, he adopted practices that, as they had under Huntington, benefitted the superintendent more than the patients or the territory.

Under Harmon, the government introduced a two-contract system into the hospital: one for a superintendent and another for a dedicated physician. This was an improvement on paper, as the government placed medical care for people in the institution on equal terms with their physical well-being. Initially the two-contract system divided the duties of the institution between resident physician Stacy Hemenway and Superintendent Harmon. Accordingly, Harmon secured the “food and raiment” and hired attendants while Hemenway oversaw “the medical, moral and sanitary management of the institution.”⁸⁷ As time passed, though, Harmon, due to his personal and political connections to the governor and other high ranking political figures, expanded his authority in the hospital and shifted much the decision making power away from the resident physician.

The people of Washington distrusted the government’s continued use of a contract system that bestowed so much power in the hands of a man who ran the asylum not for medical or social gain, but for personal profit. News reports, such as one from the *Puget Sound Dispatch*, accused Governor Elisha P. Ferry of believing the care of insane people was secondary to “the sacredness of Mr. Harmon’s contract.”⁸⁸ It alleged that even though Washington was a “republican government, where the will of the people is supposed to be the supreme law” Ferry ignored public demands to improve the care of the patients and amend the “management of that

⁸⁶ Although not the lowest bidder, Harmon’s political connections ensured he received the contract with the winning bid of \$0.91 per patient *per diem* for five years.

⁸⁷ Territory of Washington, *Report of the Resident Physician of the Asylum for the Insane of Washington Territory. For the period commencing: October 1, 1871, and ending September 30, 1873*, (Olympia: P. T. Gunn, Public Printer, 1873), 8.

⁸⁸ “The Insane Asylum,” *Puget Sound Dispatch*, Dec. 3, 1874.

institution.”⁸⁹ Instead, he continued to place the “welfare of fifty or more helpless, unfortunate citizens” in the “hands of a man with no restriction as to their care.”⁹⁰ Many of the complaints, such as these, came from H. C. Willison, the second resident physician of the asylum during Harmon’s contract term. Willison and his immediate predecessor, Hemenway, believed that insanity, contrary to the governor’s belief, deserved to be treated in the medical arena wherein the care of the patients was placed above all else.

The conditions at Washington, while not being explicitly the same, echoed what the AMSAII had wanted to overcome in the east in the early 1800s. The deficiencies of the contract were well known, according to the Medical Society of Washington, who supported the resident physician. The hospital, the Society wrote, was “merely going over the ground and having the experience of older Asylums [sic].”⁹¹ Even as the governor resisted a move away from the contract system due to his close relationship to Harmon, the continuation of that arrangement helped to underscore Fredrick Jackson Turner’s argument of the west evolving and adapting eastern practices in a manner defined by an understanding of their own past.⁹² Washington politicians were reluctant to move significantly from their established practices, in this case awarding a control of the asylum to the lowest bidder. They continued in this manner despite eastern advances of placing a physician as sole superintendent.

Under the law, the territory continued to utilize the “enduring” contract system of the past, despite its deficiencies, as it became part of the process of modernizing. Nevertheless, the government introduced medicine into the hospital by hiring a resident physician, albeit in a manner that situated him in a weakened position under a former politician turned superintendent.

⁸⁹ *Puget Sound Dispatch*, Dec. 3, 1874.

⁹⁰ *Puget Sound Dispatch*, Dec. 3, 1874.

⁹¹ Members of the Medical Society of Washington Territory, *A Supplement to the Late Asylum Controversy*, (Olympia, W. T., Printed at the Olympia Transcript Job Rooms, 1875), 25.

⁹² Turner, “The Problems of the West,” in *Rereading Fredrick Jackson Turner*, 62.

By the 1870s, having a non-medical person in charge of a mental hospital was an out-dated practice throughout most of the United States. In his book on the organization of mental hospitals, Thomas Kirkbride argued, “the Physician-in-Chief should be the Superintendent and executive officer” of the asylum and should be “a well educated physician...of irreproachable moral character.”⁹³ Despite his recommendation, uniformity across America in the nineteenth century was not typical. Local politics, traditional institutions, and regional social understandings of insanity and care all influenced asylum policy and practices as Washington moved through the process of first stimulating insanity, then securing care for it.

The fact that Washington politicians failed to allow the physician to follow the AMSAII’s guidelines was not lost on Hemenway. He loathed the political favoritism that brought about to the two-contract system of the asylum, had restricted his authority over the patients, and awarded a contract to the lowest bidder. He believed the process was “wrong in principle and cruel in practice.”⁹⁴ The division of duties led to conflict between the superintendent and the resident physician, as both Hemenway and Harmon took issue with how the contract divided the managerial, medical, and moral responsibilities between the political and medical advisors. Both wanted greater control over the asylum administration and the patients.⁹⁵ Invoking his duty as a physician, Hemenway took to the hospital’s official reports to make a case against this system. Members of the Medical Society of Washington Territory, and later Willison, also sided with Hemenway, as they condemned the conditions at the asylum while pointing to the backwardness of its management.⁹⁶ The newspaper *Puget Sound Dispatch* also

⁹³ Thomas S. Kirkbride, *On the Construction, Organization, and General Arrangements of Hospital for the Insane with some remarks on insanity and its Treatment*, 2nd ed., (Philadelphia: J. B. Lippincot & Co., 1880), 193.

⁹⁴ Territory of Washington, *Report of the Resident Physician at the Insane Asylum of W. T.; Ordered Printed by the Legislated Assembly*, (Olympia: Prosch & McElroy, Printers, 1871), 8.

⁹⁵ At this time the legal designation of the people judged insane alternated between “inmate” and “patient.” For the sake of consistency I will use patients, unless the quotes state otherwise.

⁹⁶ Medical Society of Washington Territory, *Supplement to the Late Asylum Controversy*, 25.

denounced the situation and criticized the political patronage that permitted Harmon's position as superintendent.⁹⁷

Harmon, as a businessman, ran the asylum like a business enterprise. In spite of the introduction of a full time physician, he adopted managerial methods within the institution that matched the growing economy of the region. He favored frugality and above all else and his techniques fiscally benefitted him as head of the institution. For example, Harmon attempted to keep patients in the asylum. Because the government paid *per diem* for each person residing in the institution the more who remained and were able to work the more money Harmon made. To ensure he received maximum profits from his position, he also refused to invest in basic building repairs, allowing the living conditions to deteriorate at the asylum.

One of the ways Harmon increased profits was through his use of patient labor. The patients improved the hospital site by cutting trees, levelling the grounds, and maintaining a garden. In itself, this was not unusual, as labor was a key therapy used in many mental hospitals at this time.⁹⁸ Harmon, however, also used patients as his personal cooks, cleaning staff, and servants. By putting them to work around the asylum in lieu of hired employees, he drastically cut operating expenses.⁹⁹ The asylum wardens were eager to help in this regard, since Harmon had the authority to hire and fire them. The wardens followed Harmon's orders, but also under their own volition, pressured all capable patients into working and abused and/or locked away

⁹⁷ The *Puget Sound Dispatch* published a series of articles against Harmon and Gov. Ferry in their Dec. 3, 1874; Dec. 10, 1874; and Dec. 17, 1874 editions.

⁹⁸ Geoffrey Reaume, "Patients at Work: Insane Asylum Inmates' Labour in Ontario, 1841-1900," in *Mental Health and Canadian Society*, ed. James E. Moran and David Wright (Montreal & Kingston: McGill-Queen's University Press, 2006), 77; Rothman, *The Discovery of the Asylum*, 146; Moran, *Committed to the State Asylum*, 92-92; Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States* (Minneapolis: University of Minnesota Press, 2007), 73-74; Harley D. Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: University of Regina, 1989), 30; Cheryl Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen's University Press, 1989), 117-118.

⁹⁹ *Supplement to the Late Asylum Controversy*, 22.

those who refused to work in the old military jail as punishment.¹⁰⁰ According to one former warden, he “heard Hill Harmon give *orders* to administer this sort treatment, when patients refused to obey orders, and caution[ed] his attendants to not allow this sort of treatment to become known.”¹⁰¹ Harmon’s accusers maintained that his methods were harsh, and alleged that he ignored the physician’s opinion. Harmon harsh business methods favored economy at the expense of allowing even basic care to flourish in the asylum.

Another area of contention was Harmon’s insistence on keeping people in the hospital after the resident physician had cleared them for parole. Hemenway argued that upon being admitted, the patients were “turned over to...brokers in human flesh, who in turn deliver their victim over to hired jailors, who were...expected to serve in the interest of their employers.”¹⁰² As a physician, he believed that the asylum’s purpose was to “CURE rather than to *keep*” patients. A “permanent cure” should always have been the goal of the asylum, anything less and the institution was, as Hemenway wrote, “radically defective.”¹⁰³ The resident physician grew frustrated with the situation at the Territorial Asylum; as a “medical institution,” both the building and the administration failed in his estimation.

In his first report to the government Hemenway presented two lists of points for the proper organization of mental asylums, maintaining they were “adopted recently” at a June 1871 meeting of the AMSAIL. The first 26 points outlined specific building points that were essential in the care of patients following moral treatment ideals.¹⁰⁴ The second set were 14 “suggestions” that described the appropriate administrative organization for the asylum, as approved by the

¹⁰⁰ *Supplement to the Late Asylum Controversy*, 20. See also, “Granger’s Letter,” where a man identified as “Granger” refused to move to Washington due to the “brutal treatment of those poor insane” at the asylum. This is found in the appendix section of the *Supplement to the Late Asylum Controversy*, pages 27-28. Emphasis original.

¹⁰¹ *Supplement to the Late Asylum Controversy*, Appendix, “N. S. Kellogg’s Statement Regarding Maltreatment of Insane Patients,” 29. Emphasis original.

¹⁰² *A Supplement to the Late Asylum Controversy*, 4.

¹⁰³ *A Supplement to the Late Asylum Controversy*, 4-5. Emphasis original.

¹⁰⁴ *Report of the Resident Physician at the Insane Asylum of W. T. (1871)*, 5-8.

AMSAAI. Hemenway summarized the points by concluding that the physician should “have the entire control of the medical, moral, and dietetic treatment of the patients.”¹⁰⁵ While he claimed the AMSAAI ratified these points at a meeting in 1871, Hemenway repeated features that the Association had officially approved earlier in 1851 at a time when they were still actively employing moral treatment in their hospitals.¹⁰⁶ Hemenway forwarded these points in an effort to borrow from eastern experiences in order to promote, and perhaps expedite, the medicalization of insanity at Washington’s asylum, but also by adhering to the patterns established in the east. He highlighted what he saw as proper treatment and hospital administration adopted by the professional body that oversaw asylums in the United States and Canada.

The AMSAAI had “re-affirmed” the 1871 proposals listed by Hemenway in order to clarify ideals among superintendents concerning proper building construction and hospital administration, ideals that had formed the basis of moral treatment.¹⁰⁷ The proposals, as presented by Hemenway, stated that “proper” asylum treatment was “divided into medical and moral,” the latter of which he argued influenced an individual’s “employment, exercise and amusements, rising and retiring, habits of order and cleanliness, attendance on religious services, and the like.”¹⁰⁸ Purportedly, Hemenway’s contract placed him in control of the “moral management” at the Washington hospital. In practice, however, Harmon oversaw the activities that Buttolph outlined as moral treatment, such as food, raiment, building maintenance, patients’

¹⁰⁵ *Report of the Resident Physician at the Insane Asylum of W. T. (1871)*, 9.

¹⁰⁶ In his report, Hemenway admitted that while the AMSAAI approved these points on May 10, 1853, he maintained they “unanimously re-affirmed [them] at one of their meetings in June, 1871.” *Report of the Resident Physician, 1871-1873*, 10. Both sets of points, however, were older than 1853. For the original 26 points presented by the AMSAAI, see: AMSAAI “Report on the Construction of Hospitals for the Insane, made by the Standing Committee of the Association of Medical Superintendents of American Institutions for the Insane, at its meeting in Philadelphia, May, 21, 1851,” *American Journal of Insanity* 8 (1851-52): 79-81. See also: Buttolph, “Modern Asylums,” 364-378.

¹⁰⁷ *Report of the Resident Physician, 1871 – 1872*, 10. AMSAAI “Report on the Construction of Hospitals for the Insane,” 79-81.

¹⁰⁸ Buttolph, “Modern Asylums,” 375.

physical activities, and other equivalent areas.¹⁰⁹ This restricted Hemenway from applying therapies that influenced the moral character of the asylum residents. Unable to offer moral treatment Hemenway understood that his hospital was not achieving its main purpose as a curative institution.¹¹⁰

Harmon also oversaw the patients' physical needs, which meant that he controlled their employment, exercise, and daily activities. Despite Hemenway ostensibly being in charge of the moral aspects, his actual duties were restricted to prescribing medicine for, and treating the patients' physical afflictions. Washington politicians continued to believe that the medical treatment of patients in the asylum did not extend beyond their physical needs. The government approved a contract for a full-time physician in response to the changing asylum environment and interpretations of insanity. Nevertheless, as Harmon assumed responsibility for areas within the asylum that were conducive to the mental health of patients, western and eastern ideas converged in the asylum.

Hemenway became increasingly discouraged by the lack of action on the part of the government to remove Harmon or change the two-contract system. He wrote to Superintendent J. A. Reed of the Western Pennsylvania Hospital for the Insane seeking advice on his situation. The reply he received was less than encouraging. In the letter, Reed stated that in the eastern regions of the United States the demarcation of politics and medicine in asylums was more pronounced than in the west where there was a muddled and damaging relationship between the two. "Institutions from this eastward [sic] differ very much in their management from those west of us," he wrote, "and I can frankly say that no money would induce me to assume the care of any institution west of Pennsylvania, simply because the managers reserve to themselves the control

¹⁰⁹ *Report of the Resident Physician, 1871-1873*, 8.

¹¹⁰ *A Supplement to the Late Asylum Controversy*, 4-5. Emphasis original.

of employees and leave the superintendent to carry the responsibility.”¹¹¹ At his own hospital, the Trustees held Reed strictly accountable for his actions, yet, he stated, “they do not interfere...I cannot conceive how an institution can be conducted satisfactorily on any other basis.”¹¹² In the east, where Reed claimed they had learned from past experience, politicians maintained oversight but realized the necessity of being separate from the institution. This relationship allowed physicians to work unhindered while still being held responsible for his administrative decisions.

Reed’s letter led Hemenway to argue that the hospital needed an administrative oversight committee separate from political pressures. “General control [of the asylum],” he wrote to the government, “should be in the hands of a Board of Trustees, which should be set in a way to prevent political favouritism.” The Trustees, Hemenway believed, were to be “above all political influence.”¹¹³ Initially, Washington’s Insane Hospital did not have a Board of Trustees; instead, they had hospital commissioners, of which the governor and the territorial auditor, both supporters of Harmon, were *ex-officio* members. The administrative organization ensured that the relationship between the state and the medical opinion of the resident physician remained tense and contentious.

In his study of institutions in the east, Gerald Grob has argued that there was never such a pronounced separation between politicians and hospital administrators. “Asylums were shaped not only by patients and staff, but by the constitutional, legal, and political environment on which they existed,” he wrote. “[T]hey could not function as independent and autonomous entities. Their governing structures, admission policies, and the ways in which they were financed were

¹¹¹ *Report of the Resident Physician, 1871-1873*, 6-7.

¹¹² *Report of the Resident Physician, 1871-1873*, 6-7.

¹¹³ *Report of the Resident Physician, 1871-1873*, 8.

generally determined by state and local government officials, both elective and appointive.”¹¹⁴

Accordingly, politicians shaped policies and administrations; at times they also abused these policies and appointments for their own needs.¹¹⁵ Resident physicians, many of whom also held the position of superintendent, followed the guidelines established by the Association in order to achieve a basic level of care, but did so within the parameters laid out by their local and regional governments. As such, due to Washington’s laws defining the asylum predominantly in legal terms the institution ran more like a business and was open to abuses by administrators seeking personal financial gain.

Hemenway was undeterred by the prospect of introducing a medical agenda into the institution. He appealed to the territorial legislators in his biennial reports requesting that they draft a new law to replace the “defective plan of management” and grant the physician more control over the treatment of the patients.¹¹⁶ Looking for professional support, he quoted Superintendent A. S. McDill of the Wisconsin State Hospital for the Insane: “The proper internal organization of the hospital for the insane is now well understood... [P]lacing the right people in these official positions...is essential to the success and usefulness of such institutions.”¹¹⁷ Hemenway added the asylum needed outside supervision from men who did not have “pecuniary interest in the Institution” and held “the highest motives to promote its usefulness” and concentrate on “the interest of its patients.”¹¹⁸ Superintendent Reed of Pennsylvania and McDill of Wisconsin both pointed to issues that eastern superintendents were well aware of: in order for the asylum to be “successful” it needed to have a stronger medical voice unhindered by political interference.

¹¹⁴ Grob, *Mad Among Us*, 95.

¹¹⁵ Grob, *Mad Among Us*, 137.

¹¹⁶ *Report of the Resident Physician, 1871-1873*, 8.

¹¹⁷ *Report of the Resident Physician, 1871-1873*, 9.

¹¹⁸ *Report of the Resident Physician, 1871-1873*, 9.

Despite Hemenway's efforts, the government in Washington did not abolish the two-contract system, nor did it shift administrative duties to the resident physician. When his contract expired after his two-year term in 1873, Hemenway left his post in frustration. His successor, resident physician Willison, who believed in the medicinal nature of the hospital and insanity, took up the cause against Harmon and the hospital administration, but underestimated the influence of the current superintendent. Like Hemenway, Willison fought to place the medical care of patients above all else, including personal gain. In spite of his efforts, however, the situation grew worse. Whatever authority the resident physician had under the original contracts, the government effectively removed when Willison took his post. According to a letter sent to the *Puget Sound Dispatch*, Harmon, being an "intimate friend of the Governor" used his connections to change "the form of the Physician's contract by taking the sanitary and moral oversight of the patients out of [the physician's] hands" and placed it in his own.¹¹⁹ Harmon petitioned to change the contracts to reflect the reality of the asylum environment. By strengthening his authority he further minimized the resident physician's influence. With the new contracts in place the government codified in law what Harmon and staff had already done in practice under Hemenway: they legally restricted the resident physician's influence to prescribing pills and ointments to satisfy the patients' physical ailments.¹²⁰

The accusations against Harmon did not always come from former resident physicians. In 1874 after visiting the asylum, T. J. Swanson sent a letter to the *Puget Sound Dispatch* decrying its conditions.¹²¹ Swanson wrote that prior to visiting his brother at the Steilacoom institution he thought all "asylums were all under the care of physicians."¹²² Yet at the asylum he witnessed a

¹¹⁹ "The Insane Asylum," *Puget Sound Dispatch*, Dec. 3, 1874.

¹²⁰ *Supplement to the Late Asylum Controversy*, 13.

¹²¹ All the names of patients and their relatives are pseudonyms.

¹²² "The Insane Asylum," *Puget Sound Dispatch*, Jan. 14, 1875.

warden/attendant beating a patient. Swanson was appalled at what he saw. He “went to the physician [Willison] and urged something be done.”¹²³ To this Willison replied “he could do nothing [as] he had no authority over the attendants nor patients.”¹²⁴ He explained the wardens treated him with contempt and the patients were suspicious of him and his treatments. At Steilacoom Swanson witnessed attendants “kick or strike a patient,” “deride” Willison in the presence of others including family members of the inmates, and do “all they could to make the patients dissatisfied with his treatment of them.”¹²⁵ It was apparent, he stated, “the doctor only filled the place of a figure-head,” and concluded he would “rather see a relative of [his] enter the wards of a penitentiary, as a convict, than become an inmate of [that] den.”¹²⁶ Coming at the expense of providing the patients with therapeutic aid, the warden’s harsh actions helped advance Harmon’s position of ultimate control over the asylum.

In the wake of the accusations from Swanson, which resulted in the firing of an attendant, Governor Ferry approved an investigation into the practices and conditions at the hospital. The findings did not carry much weight, as physicians who made up the investigating body were also personal friends of the governor and Harmon. Indeed, the members resided in Harmon’s home and enjoyed his hospitality while they “looked into” his administrative affairs. Unsurprisingly, they concluded that the superintendent had not committed any wrongdoing.¹²⁷ The contention between the resident physicians and the superintendent, they wrote, was “from want of full and perfect understanding between those having the charge of the insane, as the law does not define the relative duties of those in charge.”¹²⁸ The disagreements between Harmon and Willison,

¹²³ *Puget Sound Dispatch*, Jan. 14, 1875.

¹²⁴ *Puget Sound Dispatch*, Jan. 14, 1875.

¹²⁵ *Puget Sound Dispatch*, Jan. 14, 1875.

¹²⁶ *Puget Sound Dispatch*, Jan. 14, 1875.

¹²⁷ “Report of the investigating Committee,” *Puget Sound Dispatch*, Jan. 21, 1875.

¹²⁸ *Puget Sound Dispatch*, Jan. 21, 1875.

according to the investigators, arose simply from a misunderstanding of duties concerning authority over and care of the patients, not from Harmon maintaining almost complete control while he and his attendants undermined Willison. The government approved the report, and in doing so they sanctioned the harsh methods employed by Harmon and his staff.

Willison left his position in late 1874 before his contract was over. After departing he contacted local newspapers in an effort to rouse public support in favor of his position and to pressure the government into rectifying the situation at the asylum. The result was public defamation of Harmon and his political network and a damning report printed from the Medical Society of Washington Territory.¹²⁹ Even the AMSAII, upon hearing of Willison's untimely resignation wrote in the *American Journal of Insanity*, "no special foresight was needed to predict the troubles which have arisen from such a division of responsibility...The self interest of the contractor, and the duty of the physician, led to diversity of opinion and action...a house divided against itself cannot stand."¹³⁰ The results of the two-contract system was not surprising to other superintendents, especially those in the eastern regions of Canada and the United States. The system, a report read, had already proved faulty "both in England and the Atlantic States." Their experience had shown "over and over again, the futility, inhumanity, and cost of the care of the insane by the contract system."¹³¹ Notwithstanding eastern regions having adopted an organizational structure with a physician as head of the asylum, Washington, as a western territory shaping its own identity, was unwilling to imitate them.

Upon Willison's departure, Harmon personally sought out and appointed Dr. A. M. Ballard (who was a member of the aforementioned investigating committee appointed by

¹²⁹ *Supplement to the Late Asylum Controversy*, 25. Emphasis original.

¹³⁰ AMSAII, as quoted in *Supplement to the Late Asylum Controversy*, 10.

¹³¹ *Supplement to the Late Asylum Controversy*, 25.

Governor Ferry) as resident physician.¹³² Ballard, recalled one visitor to the asylum, “had no authority over attendants nor patients, only to give them a dose of [medicine] when they needed it.”¹³³ A journalist from *The Standard*, which reported in favor of Harmon, wrote “the Asylum appear[ed] to be under the best management.”¹³⁴ There was a stark difference between actions and perceptions concerning the hospital. On one side there were the terrible conditions reported by newspapers and people sensitive to the needs of the patients, coupled with the frustration of the previous resident physicians at being constrained in offering therapeutic aid to the patients. On the other was the superintendent and his wardens, high-powered government officials, and the newspapers that supported them – those that looked out for the interests of the *status quo* at the expense of the institution and the patients.

Each side justified their positions differently, characterized by the following exchange. Before Willison left his position he went to the governor to complain about how the two-contract system favored economic management at the expense of providing care. He argued that perhaps patients were sent to the asylum “for the treatment of a disease,” and since the government hired a “physician to treat them, the sanitary, moral and dietary treatment of [the] sick persons” ought to fall under his authority. Governor Ferry responded with, “Is it so nominated in the bond? I cannot find it; ‘tis not in your contract.”¹³⁵ When asked to allow the physician more authority, the governor, ignoring the needs of the inmates and medicine’s place in the institution, used the law to justify the situation. The resident physicians and their supporters argued that the hospital

¹³² According to the *Supplement to the Late Asylum Controversy*, Harmon secured Ballard’s services by offering him “a per centage [sic] on the profits accruing from keeping the patients, or a bonus of five hundred dollars per annum.” (9)

¹³³ *Puget Sound Dispatch*, Jan. 14, 1875.

¹³⁴ This quote from *The Standard* comes from the *Puget Sound Dispatch*, Mar. 4, 1875.

¹³⁵ *Supplement to the Late Asylum Controversy*, 14.

was a “medical institution” and as such it needed to place the therapeutic needs of the patients above all else.¹³⁶

Waughop and improving (civilizing) the asylum

Despite growing criticisms, the government did not terminate Harmon’s bond. He remained superintendent until his contract expired in 1875. By that time, the public outcry against him was so great that renewing his appointment was not feasible. According to the *Washington Standard*, “it was though[t] [sic] advisable by the Legislature ... to repeal the old law, and establish the Hospital on a different principle.”¹³⁷ Public pressure, stoked by interested and sympathetic newspapers, compelled the government to change the hospital administration.

The Legislature created a “Board of five Trustees” and granted them the authority to establish a new administrative system that “they considered right and just.”¹³⁸ The Board decided to employ a “skillful practicing physician” to replace Harmon as superintendent. Under a new territorial law, it was the duty of the physician to maintain “control of the medical, moral and dietetic treatment of the patients.” The government also amended the legal designation for people receiving care at the hospital from inmates to patients – although beginning in 1875 the law indiscriminately alternated between the two designations. Moreover, the state officially rebranded the institution the Hospital for the Insane in the Territory of Washington.¹³⁹ These seemingly minor yet important changes highlighted the steps the government was willing to take toward improving the image of the hospital and codifying the need for a medical approach in treating insanity.

¹³⁶ *Supplement to the Late Asylum Controversy*, 4-5.

¹³⁷ *Washington Standard*, July 4, 1877.

¹³⁸ *Washington Standard*, July 4, 1877.

¹³⁹ Washington Territorial Legislative Assembly, *An Act to Establish a Hospital for the Insane in Washington Territory*, Enacted by the Legislative Assembly, 1875, Together with Joint Resolutions and Memorials, Sec. 6, (Olympia: C. B. Bagley, Public Printer, 1875), 85, Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx, accessed on September 30, 2013.

Harmon's practices had done more than damage the image of the hospital. His management style perpetuated the idea that society needed to incarcerate and control insanity. That ideal was what, in part, the AMSAII had worked to move past in its early years. In Harmon's wake, Washington's medical superintendents followed their eastern predecessors and strove to redefine insanity not as something to control but as a condition that under their expert care became a treatable medical "disease."¹⁴⁰ By adopting medical language and stressing insanity's medical etiology superintendents labored to show that people living with insanity were able to return to their communities free of whatever sent them to the hospital in the first place.

In the years following the removal of Harmon, the succeeding superintendents, Dr. F. S. Sparling and Willard, each took up the issue of improving the living conditions and image of the hospital.¹⁴¹ While advancing better public relations and humanizing patient care remained important, for the most part these features fell secondary to the more pressing need to fix the derelict buildings. Sparling, according to reports, did much "to beautify and improve the general appearance of Hospital Grounds."¹⁴² For his part, Willard maintained much of the same focus but argued that the hospital was in desperate need of an upgrade, owing to the condition of the old structures and the increased patient population due to population increases in the territory. Willard claimed that under his guidance he and the patients were able to manage basic repairs, which did little to ameliorate the more significant needs for structural improvements.

¹⁴⁰ Hemenway first labeled insanity as a medical "disease" in his 1871 report (*Report of the Resident Physician at the Insane Asylum of W. T. (1871)*, 3). Willison did not use it. However, it became a common label for superintendents to use after Harmon left.

¹⁴¹ Both Sparling and Willard were superintendents for only two years. The 1875 annual report was not in the hospital files at the Washington State archives, so it is difficult to determine Sparling's opinion about anything related to the insanity. A news report from a Seattle paper, argued that Sparling perhaps had some experience working with insanity, based on his appointment. Nevertheless, they believed him a fine selection considering "the material the Trustees had to select from." *Puget Sound Dispatch*, May 18, 1876.

The only reference to him, that I could find, came from Willard's 1877 report. From what was reported, it appears that Sparling was preoccupied with the physical conditions of the hospital.

¹⁴² Territory of Washington, *Report of the Superintendent of the Hospital for the Insane of the Territory of Washington from August 15, 1876, to August 15, 1877*, (Olympia: C. B. Bagley, Public Printer, 1877), 4.

Willard believed the public had yet to view insanity as a treatable issue and pointed to the law to make his case. Under the 1875 law, a judge and jury were the only people that had the power to commit a person to the hospital. In 1877, politicians expanded the commitment process to include “one or more respectable [general] physicians who shall state under oath in writing, their opinion of the case.”¹⁴³ The law, however, did not require this information, nor was any other medical information concerning new patients, to be forwarded to the mental hospital. Accordingly, the law did not define the hospital as a medical institution. To this point, Willard complained, “At present nothing further is required than the simple statement of the medical examiner that the individual is insane and unsafe to be at large.”¹⁴⁴ That basic information was all the superintendent legally needed to know about a patient. The commitment process was a legal issue, thus, he reasoned, the public still saw the committed people as legal, not medical, wards of the territory.

Despite Willard’s concerns, it seemed that the public held a more nuanced view of insanity. Newspaper reports often focused on the commitment process and typically announced the judge’s ruling, excluding any medical opinion.¹⁴⁵ Many of the reports linked violence to insanity, thereby perpetuating the notion that people with insanity were dangerous and deserved to be locked away.¹⁴⁶ One article titled “Strange Freaks of the Insane” sensationalized the dangerous and peculiar behavior of people with insanity.¹⁴⁷ Despite these reports, however, articles increasingly described insanity as a curable affliction, writing, in one example, that “after a few months treatment at the Asylum [a person could] be restored to his normal mental

¹⁴³ Washington Territorial Legislative Assembly, *An Act to Amend an Act Entitled ‘An Act Defining the Jurisdiction and Practice in the Probate Courts of Washington Territory*, Enacted by the Legislative Assembly in the year 1877, Sec., 327. (Olympia: C. B. Bagley, Public Printer, 1877), 210. Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx accessed on October 1, 2013.

¹⁴⁴ *Report of the Hospital for the Insane, 1876-1877*, 4.

¹⁴⁵ “Insane,” *Puget Sound Mail*, Jan. 14, 1882.

¹⁴⁶ “Insane,” *Puget Sound Mail*, Dec. 16, 1882.

¹⁴⁷ “Strange Freaks of the Insane,” *Puget Sound Weekly Argus*, Dec. 29, 1876.

condition.”¹⁴⁸ The reports yielded to the opinion of the judge on who was insane. Yet, they increasingly saw a place for medicine in the discussion, even as they continued to downplay its role in the decision making arena.

Willard considered himself to be at a disadvantage in treating patients “without any knowledge whatever of the cause, manner of invasion, duration of disease.”¹⁴⁹ Most admissions arrived at the asylum based on concerns about public safety, and the efforts of medical men were stymied by a lack of information about potential causes, duration of symptoms, or contextual triggers that might have prompted a pathological response. Willard understood that people did not submit such information because he believed they were quite ignorant “as to the nature and curable [sic] of insanity.”¹⁵⁰ The law still defined insanity in legal terms, structured around the ideal of criminality, if judged insane then a person was “unsafe to be at large.”¹⁵¹ This was a fallacy, he argued; insanity was “a ‘manifestation of disease of the brain,’” and if treated swiftly and properly “the better...the prospects of recovery.”¹⁵² “Such facts,” Willard continued, “should be disseminated throughout every part of the Territory.” The public needed to understand that the hospital was more than a place for “care and custody.” He argued,

the chief duties of a medical superintendent are higher than this. To afford permanent relief is his great object, and to accomplish this, the sooner the views already expressed are clearly understood and accepted by every community having the welfare of this the most unfortunate class of our population at heart, the sooner we shall be able to carry out the true aim and object of this institution.¹⁵³

¹⁴⁸ “Insane,” *Puget Sound Mail*, Dec. 16, 1885. See also, “Regarding the Insane,” *Puget Sound Weekly Argus*, Oct. 6, 1876, which reported on the proceedings of a conference wherein Dr. Nathan Allen, “an authority on the subject of insanity” argued that half the cases of insanity throughout American asylums were curable.

¹⁴⁹ *Report of the Hospital for the Insane, 1876-1877*, 4.

¹⁵⁰ *Report of the Hospital for the Insane, 1876-1877*, 7.

¹⁵¹ Washington Territorial Legislative Assembly, ‘*An Act Defining the Jurisdiction and Practice in the Probate Courts of Washington Territory*,’ Sec., 327, p. 210.

¹⁵² *Report of the Hospital for the Insane, 1876-1877*, 7.

¹⁵³ *Report of the Hospital for the Insane, 1876-1877*, 7.

Willard assumed that by publicizing details about how the hospital had turned from its past and now provided therapeutic care of the patients for the “permanent relief” of their condition, he could improve its image and the understanding of insanity throughout the region.

Upon taking his post in 1880, Superintendent Waughop continued his predecessor’s task of improving the public perception of the hospital. Unlike Willard, however, Waughop’s 17 year tenure as superintendent allowed him to accomplish much more than he or Superintendent Sparing had. He put his efforts toward developing a system that he believed offered effective and more humane therapies. The regional newspapers began publishing abridged versions of the hospital’s biennial reports alongside other positive articles, such as a typical one from the *Puget Sound Argus* that exclaimed how the “Asylum was found to be in most perfect running order.”¹⁵⁴ It was through these articles that Waughop illustrated his therapeutic system to the public and stressed the rhetoric of patient care as his principal concern.

The superintendent maintained that he had “secured kindly treatments” at the Insane Hospital.¹⁵⁵ He defined this accomplishment as having the patients worked to ensure they received physical exercise, maintained a healthy appetite, and slept well at the end of the day. Waughop also emphasized recreations and entertainments, which in 1881, due to budgetary restraints, were “not numerous.” He wanted the public to understand that unlike the abusive wardens of the past he only hired attendants who held a “Christian fortitude.” The public did not have to trust his word; he let them know that “visitors [were] freely allowed at the hospital,” and “all parts” were open for their inspection.¹⁵⁶ With these points, Waughop was recasting the

¹⁵⁴ “From Daily of 20th inst.,” *Puget Sound Argus*, Jul. 28, 1882. Even *The Spokan Times* [sic] published Ft. Steilacoom’s abridged annual reports.

¹⁵⁵ Territory of Washington, *Report of the Hospital of the Insane of the Territory of Washington, 1881*, (Olympia: C.B. Bagley, Public Printer, 1881), 14.

¹⁵⁶ *Report of the Hospital for the Insane, 1881*, 15-18. It is unknown how many people were visiting the hospital at this time, the visitor log began Jan 1, 1900.

hospital in a more favorable light. Under his direction, he maintained that there were no more secrets at the hospital.

Waughop increased his efforts and by 1883, he outwardly advertised his therapeutic regimen as moral treatment; a regimen that he believed emphasized the humane and curative goals of the hospital. Under this system, he stressed the importance of working patients. One newspaper argued this “greatly reduced” the “cost of maintaining the hospital.”¹⁵⁷ The superintendent, however, adopted a different rhetoric due to its past associations to abuse and slave labor in the hospital. Echoing the same language of the early AMSAII members, Waughop claimed that work helped “restore the unbalanced mind” by inculcating proper work ethics, and allowed patients to feel pride in the knowledge that they were providing their own food.¹⁵⁸ Patients worked for their own therapeutic benefits, he suggested. He argued that idleness was detrimental to their condition, therefore if a patient was able to work, they did. Waughop believed proper physical labor was an important ingredient in his therapeutic offerings; it was essential for the restoration of a disordered mind.¹⁵⁹

Of equal importance to work were amusements and entertainments, which, he claimed, the staff offered on a weekly basis. These activities encouraged the patients to gather and enjoy “theatrical and minstrel performances and dancing.” According to Waughop they were of “great benefit to the patients.” “If in no other way,” he admitted, they helped “relieve the monotony of hospital life.”¹⁶⁰ Adopting a similar argument to that of working patients, the superintendent believed amusements helped focus the patient’s attention and stimulate their mental abilities. However, unlike labor, which required physical effort thereby excluding the less capable

¹⁵⁷ “From Daily of 20th inst.,” *Puget Sound Argus*, Jul. 28, 1882.

¹⁵⁸ *Report of the Hospital for the Insane, 1881*, 14-15.

¹⁵⁹ Washington’s work therapy program and its perceived benefits are discussed in further detail in chapter 4.

¹⁶⁰ *Report of the Hospital for the Insane, 1883*, 19-20.

patients, amusements and entertainments were something that all patients were able to enjoy regardless of physical limitations.

Although the budget did not warrant a fulltime chaplain, “through the kindness of ministers in the vicinity [they were] enabled to have frequent services.”¹⁶¹ According to historian James Moran, early superintendents believed church services has “a strong therapeutic component.” He argues that religion and church worship were important because they re-emphasized “customs and practices in which patients had formerly participated while in a sane condition.”¹⁶² Religious services often provided patients a link to their former pre-hospital life and, as Waughop wrote, filled “a spiritual want and are productive of only good results.”¹⁶³

Waughop fulfilled his therapies “with kindness and firmness,” which he suggested encouraged patients to “behave in an orderly manner.” To facilitate that behavior, the superintendent followed a daily regimented schedule. He maintained “a certain hour for rising in the morning, for breakfast, dinner, supper and for going to bed.”¹⁶⁴ While this helped with the administrative needs of running a state institution Waughop believed the strict schedule ultimately benefitted the patients. As many east coast superintendents before him had believed, he expected the patients to internalize the ordered environment around them.¹⁶⁵ Waughop admitted the strict rules made it a “strange place” for many newcomers, but he believed that learning to adhere to a routine and restrain one’s behavior in the face of such order was “a potent means of cure.” At home, in a disordered environment, people became less inclined to feel the

¹⁶¹ *Report of the Hospital for the Insane, 1883*, 20.

¹⁶² James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal: McGill-Queen's University Press, 2000), 96.

¹⁶³ Territory of Washington, *Report of the Board of Trustees and Resident Officers of the Hospital for the Insane in the Territory of Washington, 1887*, (Olympia: Thomas H. Cavanaugh, Public Printer, 1887), 21.

¹⁶⁴ *Report of the Hospital for the Insane, 1883*, 18.

¹⁶⁵ *Report of the Hospital for the Insane, 1883, 1883*, 18.

need to restrain their behavior and they often gave “way to impulses.”¹⁶⁶ His hospital maintained an ordered environment necessary to help patients recover from their insanity. It was more than just a refuge from the disordered home or community, however. While the hospital atmosphere helped patients to adopt a system of regularity it also induced them to accept practices that ostensibly socially and morally rehabilitated them through self-discipline.¹⁶⁷ Waughop encouraged patients to accept Washington’s traditional values, such as farming, hard work, and attending church services, characteristics that were vital to their rehabilitation, but also ones that matched the values of the community and nation at large.

Although adopting moral treatment helped to increase Waughop’s authority over insanity, he continued to justify this approach as a humane regimen that inculcated acceptable social morals and improved on prior asylum offerings. The superintendent argued that these approaches worked because they compelled patients to “apply the restraints of reason to their whims and delusions.”¹⁶⁸ When writing about the mental hospital, Michel Foucault argued, it “sets itself the task of the homogenous rule of morality, its rigorous extension to all those who tend to escape from it.” He continued, “The asylum becomes in [the superintendent’s] hands, and instrument of moral uniformity and social denunciation.”¹⁶⁹ Under Waughop, the asylum began to conform to this description. To achieve a cure at the Washington Insane Hospital patients had to imitate moral uniformity.

Moral treatment, positioned as the employment of humane and socially relatable activities, was perceived as a necessary step toward improving the public opinion of the hospital

¹⁶⁶ *Report of the Hospital for the Insane, 1883*, 18.

¹⁶⁷ Beck, *Inaugural Dissertation on Insanity*, 27-28. See also: Rothman, *Discovery of the Asylum*, 152.

¹⁶⁸ Washington State, *Report of the Board of Trustees of the Western Washington Hospital for the Insane 1890*, (Olympia, Wash.: O. C. White, State Printer, 1890), 14.

¹⁶⁹ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. by Richard Howard (New York: Vintage Books, 1965), 258, 259. See also Michel Foucault, *Histoire de la folie à l’âge classique (History of Madness)*, ed. by Jean Khalifa; trans. by Jonathan Murphy and Jean Khalifa (New York: Routledge, 2006), 504-505.

and its patients. Waughop's view of insanity and moral treatment did not stray from the interpretations forwarded by the earliest members of the AMSAII. Although he argued insanity was a curable condition, and therefore medical, he allowed contemporary religious and social American ideals to inform this interpretation.

Waughop's introduction of moral treatment arrived while both he and the Trustees began arguing that the crowded conditions, crumbling buildings, and faulty public misgivings were keeping people away from the institution, and an overhaul of the image was desperately required.¹⁷⁰ Waughop's new system of care was a way to highlight a new humane system and address the public misgivings. A new building, which was discussed in chapter one, attended the hospital's physical shortcomings. These changes marked an important turning point for Fort Steilacoom; the public showed an increased confidence in the hospital as families sent more people to the hospital. Waughop reported that the percentage of patients was showing "a very steady ratio with the increase population," for approximately every 1,000 inhabitants there was one insane person.¹⁷¹ This increase meant that insanity was, according to the superintendent, "better cared for to-day than ever before. All the insane [people] are sent to hospitals for treatment and care nowadays, or at least much more nearly so than ever before."¹⁷² According to Waughop, by 1890 the public saw the hospital for the insane as an institution of medically-focused care.

Local newspapers reveal that this shift took hold in the public sphere. In the 1870s and into the early 1880s articles argued that ruined, "sad," and "misspent" life choices were what lead to insanity.¹⁷³ The condition was the result of an individual's poor life choices, echoing the

¹⁷⁰ *Hospital for the Insane of the Territory of Washington, 1883*, 7, 17.

¹⁷¹ *Western Washington Hospital for the Insane 1890*, 12.

¹⁷² *Western Washington Hospital for the Insane 1890*, 12.

¹⁷³ "A Ruined Man," *Port Townsend Argus*, n.d.

overt religious/social etiology that was popular in the early 1800s. Because insanity stemmed from poor life choices, it was “the family...and their highly respected relatives” who deserved public sympathy.¹⁷⁴ These reports highlighted how people continued to link insanity to criminality or immorality and it was the family or the wider community, not necessarily the patient, who greatly suffered. This interpretation was in direct opposition to the superintendent and the Trustees’ opinions that the patients, not the family, deserved sympathy.¹⁷⁵

After Waughop took charge of the institution, *The Yakama Herald* wrote that going to the mental hospital meant obtaining “medical attention.”¹⁷⁶ A reporter for *The Puget Sound Mail* explained that “after a few months of treatment” in the hospital patients would “be restored to [their] normal mental condition.”¹⁷⁷ Even with these subtle changes, however, local news media continued to connect insanity with criminality. People did not seek out treatment at the hospital, rather they were “turned over to the authorities” where the sheriff escorted insane individuals to the “asylum.”¹⁷⁸ While the public perception of insanity and the hospital improved, changes away from traditional conceptions were not immediate.

Waughop continued pushing for a better public understanding of insanity. Patients, he argued, are seldom “so insane that [he or she] does not appreciate good treatment and straightforward, honest dealing.” Waughop held to one “important” rule: “*treat them kindly, treat them honestly.*” As a guiding principle, this ideal motivated him to improve care within in the hospital, but he also linked it to the process of social enlightenment, arguing that humanity and medical care of the insane were markers of progressive societies “all over the civilized world.”¹⁷⁹

¹⁷⁴ “A Sad Case of Insanity,” *The Spokan Times* [sic], June 12, 1880.

¹⁷⁵ *Report of the Hospital for the Insane, 1881*, 3; *Report of the Hospital for the Insane, 1883*, 19.

¹⁷⁶ “Crazy on Religion,” *The Yakama Herald*, December 31, 1891.

¹⁷⁷ “Insane—,” *The Puget Sound Mail*, Dec. 16, 1882.

¹⁷⁸ “Crazy on Religion,” *The Yakama Herald*, December 31, 1891.

¹⁷⁹ *Western Washington Hospital for the Insane 1890*, 14. Emphasis original.

Viewing insanity as a curse, he maintained, was an out-of-date ideal linked to uncivilized beliefs. Insane people were not criminals; they did not succumb to poor life choices, nor were they inmates in need of rehabilitation. They were only people whose “will [was] weakened by disease.”¹⁸⁰ Such individuals desired kindness, honesty, and, following the example of “civilized” eastern regions, they needed to receive proper medical care.

It was no coincidence that Waughop forwarded this argument one year after Washington achieved statehood. By arguing these were the guiding principles of “the civilized world,” Waughop further solidified the image of the patient as a person in need of medical care and simultaneously connected it with the ideal that insanity was a marker of social evolution. In Washington moral treatment became a way to elevate the young state to established eastern standards. In a commencement speech at Washington University, Fredrick Jackson Turner argued that when facing with the prospect of civilization, western societies “saw in government no longer something outside of [them], but the people themselves shaping their own affairs. [They] demanded therefore an extension of the powers of the governments in the interest of [their] historic ideal of democratic society.”¹⁸¹ Utilizing the hospital as an extension of the government, Waughop argued that Washington needed to model its democratic society after the civilizations in the eastern part of the country. For their part the government saw in the asylum a proper institution in which to help shape “their own affairs” through the promotion of their benevolence and the advancement of civilization.

¹⁸⁰ *Western Washington Hospital for the Insane 1890*, 14.

¹⁸¹ Fredrick Jackson Turner, “The West and American Ideals,” Commencement Address, University of Washington, June 17, 1914, *The Washington Historical Quarterly*, (October, 1914), quoted from *Rereading Fredrick Jackson Turner: “The Significance of the Frontier in American History” and Other Essays*, with commentary by John Mack Faragher (New York: Henry Holt and Company, Inc., 1994), 154.

Conclusion

“Why fear a hospital?” a Washington newspaper asked in a 1916 article that offered the public a look into the newly renamed Western State Hospital (WSH). The superintendent at the time, W. N. Keller, answered that “Insanity is only a sickness.” By the early twentieth century, Keller had replaced Waughop’s moral therapy and ordered environment with “modern science and restful surroundings.” These “modern” tools were the only ones necessary, he argued, to send patients “back to society.”¹⁸²

The reporter of *The Daily Ledger* agreed that the hospital had a relaxing atmosphere about it. “Let’s all be crazy, or just a little abnormal,” the article stated, “Then we can go to a place where there are vast expanses of velvety grass, wonderful beds of fragrant, colorful flowers; tall, restful trees.” This picture contrasted the older images of Western as a dark and dangerous place. The people who sought treatment at this new and relaxing asylum, the article concluded, tended to “regain [their] mentality and strength—yes, and ambition.”¹⁸³

Operating out of decrepit military buildings when it first officially opened in 1871, Washington’s insane hospital quickly developed a reputation of inmate abuse and incompetency. The public viewed it and its administration with fear and suspicion. During that time, Superintendent Hill Harmon employed a system that placed pecuniary gain above inmate comfort and medical care. To combat the situation, resident physician Stacy Hemenway used the writings of the AMSAII and institutions in the eastern region of the United States as examples of proper hospital administration and effective inmate therapies. Nevertheless, until 1876 the hospital remained outside the authority of the medical community in Washington. Up to then the territory personified the amalgam of characteristics of the western region as it held to its frontier

¹⁸² “Hospital Proves Tacoma: Fort Steilacoom Institution Spends Most of \$230,000 Annually in this City,” *The Daily Ledger*, May 28, 1916.

¹⁸³ “Hospital Proves Tacoma,” *The Daily Ledger*, May 28, 1916.

traditions. It held onto older ideals dominated by political lay-understandings of controlling insanity. After 1876, as it marched toward statehood and adopted more civilized understanding of insanity defined by eastern practices and customs, it altered the law and ensured a physician remained the sole superintendents.

Beginning with Hemenway in his 1871 report, the various Washington resident physicians/superintendents defined their profession and adopted what they believed were effective treatments following moral treatment ideals. To them the system represented practices held by more the more “civilized” regions in the east, in that it sought to replace the harsh practices traditionally employed as the asylum was mired in controversy and allegations of abuse. Even as eastern superintendents had stopped advertising the system, in Washington it was a way to advance humanitarianism, particularly for people considered insane. In 1883 Superintendent Waughop outwardly argued for the adaptation of moral treatment as part of the process of medicalizing insanity. In his hands, moral treatment became an ideology that worked to improve the image of the patients and the hospital. It elevated the status of the inmate to a patient and helped break the association between insanity and criminality. It brought the hospital and the region up to national standards, and placed Washington in line with “civilized” regions in the east.

Within this framework, it is tempting to cast the asylum and moral treatment as a progressive advancement in asylum-based care. But in spite of the changes, the superintendents continued to define insanity as a moral condition. They utilized treatments that did not cure mental disorders, but rather encouraged patients to repress their delusions and adopt socially acceptable behavior to appear more “civilized.” Moral treatment improved the image of the hospital and its residents. It pushed Western along the path of medicalization, yet it continued to

allow a therapeutic regimen that had superintendents defining curability around whether patients accepted and reflected normative social values; repression and imitation were the new markers of success. Moral treatment was a social ideal that promoted the civilization of the region, albeit masked as medicine.

Chapter Three

The North Battleford Hospital and Public Opinion in Saskatchewan

In his book, *Remembrance of Patients Past*, Geoffrey Reaume wrote that although “medical practices” changed at the Toronto Hospital for the Insane between 1870 and 1940, “perhaps the one continuity was that elements of moral treatment remained in place during the entire period.”¹ The Toronto asylum opened in 1841 and its superintendents subjected the patients to a system that maintained a fixed daily routine, offered exercise and entertainment programs and encouraged work in an effort “to instil self-discipline and a firm ‘guidance’ over the behaviour of their charges through moral suasion.”² While aspects of moral treatment remained intact, Reaume explains that there were some therapeutic innovations. For example, in 1906 a hydrotherapy department was constructed at the hospital. Utilizing the effects of water to “calm the nerves of ‘excited’ patients and soothe depressed people” by placing them in warm baths, it became an important “active treatment” at the institution into the 1930s.³ Its introduction into the hospital, however, was not enough to convince superintendents to move away from using traditional moral treatment therapies that relied on work.

The situation at Toronto’s hospital is indicative of most institutions throughout Canada and the United States. When the Saskatchewan government opened the Saskatchewan Provincial Insane Asylum in 1914, the American Medico-Psychological Association (AMPA), successor of the Association of Medical Superintendents of American Institutions for the Insane (AMSAIL), had stopped actively advocating moral treatment as an effective regimen of care within their

¹ Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940* (Toronto: University of Toronto Press, 2000), 11.

² Reaume, *Remembrance of Patients Past*, 14.

³ Reaume, *Remembrance of Patients Past*, 18.

hospitals.⁴ Furthermore they had removed “institutions” from their revised name in an attempt to distance the profession from its turbulent beginnings.

Historian Gerald Grob explains that in the late nineteenth century, some superintendents began to adopt “scientific” concepts of insanity and were increasingly dissatisfied with “outmoded and obsolete” practices of the earlier generation.⁵ Despite their new focus, however, he contends that these administrators did not offer new “therapies that were demonstrably effective.”⁶ Michel Foucault contends that asylum superintendents never did open the institution “to medical knowledge” nor did they “introduce science.” Superintendents only “borrowed from science” to “disguise” or justify the institution and their therapies. He argues that their authority and their practices remained “of a moral and social order.”⁷ While outwardly superintendents increasingly borrowed from medicine and science their underlying philosophies about insanity and asylum-based care remained within the social-moral realm. Nevertheless, by the early twentieth-century superintendents throughout Canada and the United States were divided about the nature of insanity. Grob contends each had developed their “own set of assumptions and beliefs. Conflict rather than harmony was the norm.”⁸ They were willing to embrace a medical focus, but due to lack of innovative therapeutic options many still held to older practices of moral treatment.

The pervasiveness of moral treatment did not spread to all new western institutions. In his book, *So Far Disordered in Mind*, historian Richard Fox argues that California mental asylums differed from their eastern counterparts “in a fundamental way.” While institutions in the east

⁴ The name change from AMSAII to AMPA came in 1892. In 1921 the profession changed its name again, that time to the American Psychiatric Association.

⁵ Gerald Grob, *Mental Illness and American Society, 1875-1940*, (Princeton, Princeton University Press, 1983), 70.

⁶ Grob, *Mental Illness and American Society*, 71.

⁷ Michel Foucault, *Madness and Civilization: A History of Insanity in the Age of Reason*, trans. by Richard Howard (New York: Vintage Books, 1965), 271-272.

⁸ Grob, *Mental Illness and American Society*, 110.

declined from therapeutic to custodial, California never underwent such a devolution.

Washington and Saskatchewan institutions both began as custodial asylum and then by adopting medical language stressed the curative nature of insanity and became therapeutic. “From their very beginnings in the 1850s,” argues Fox, California asylums “were clearly understood to be not simply treatment facilities for the mentally disturbed, but also detention facilities” for people whose condition required a lifetime of care. “The efforts of superintendents in the 1850s to establish a humanitarian ‘moral treatment’ regime – modeled after earlier eastern efforts – were futile...In California ‘custody’ was paramount from the start.”⁹ The author claims that from the asylum’s inception, government meddling was too strong and patient populations were too high, thereby hindering superintendent’s attempts at adopting therapeutic practices.¹⁰ He maintains that Californian superintendents had every intent of implementing moral treatment. Yet a closer reading of his work explains that the system “was [little] more than an idea – an idea whose time had passed.”¹¹ Some western asylums, instead of striving to medicalize insanity began as custodial institutions that offered little hope beyond lifelong incarceration for people deemed insane.¹²

When Dr. James MacNeill accepted his position as Saskatchewan’s first asylum superintendent, he had no provincial model of care from which to draw. He adapted traditional practices and increasingly defined insanity within a medical framework that reaffirmed his authority over it. At times, however, his efforts were concerned less with improving the patient experience within the hospital. A close examination of MacNeill’s actions show that he was

⁹ Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978), 17-18.

¹⁰ According to Fox, in 1880 “one in every 489 Californians was insane, compared with a national average of one to 1031.” (18)

¹¹ Fox, *Disordered in Mind*, 18, footnote 2.

¹² Fox, *Disordered in Mind*, 14-15.

worried about public and political opinion the asylum because it affected how people perceived his own professional standing. As will be shown, he was often intent on securing and improving his expert medical position to the extent that the patients sometimes fell secondary. Nevertheless, similar to what Washington superintendents had assumed decades earlier, MacNeill believed that medicalizing the institution and insanity was progressive.¹³ This chapter examines how in the first half of the 20th century, Superintendent MacNeill of the Provincial Insane Asylum in North Battleford, Saskatchewan, worked towards decriminalizing insanity and improving the public opinion of the institution and its residents by adhering to medical principles; a process that was well trodden by other superintendents. Despite AMPA's official dissociation with moral treatment and its more "scientific" understandings, when the government of Saskatchewan planned for an asylum near the city of North Battleford, old ideas about asylum therapies lingered.

Though MacNeill shied away from using outdated language of moral treatment, he adopted its fundamental principles as redefined insanity in medical terms. Indeed, there was little else from which he was able to choose when establishing a daily inmate regimen at his institution near the city of North Battleford. After MacNeill had travelled to hospitals throughout eastern Canadian provinces and American states, he returned to Saskatchewan armed with the firm believe that these practices encouraged a different view of mental illnesses; a conceptualization that allowed for an image of patients as sick rather than criminal. This meant that other physicians introduced him to practices that exhibited "elements of moral treatment."¹⁴

¹³ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1924*, Saskatchewan Archives Board (SAB), Public Works (PW). 2, (Regina: J. W. Reid, King's Printer, 1924), 67.

¹⁴ Reaume, *Remembrance of Patients Past*, 11.

The Criminal Nature of Insanity

In 1879 the Northwest Territories (NWT) government, operating under jurisdiction of the Federal Dominion, drafted a law titled *An Act Respecting the Safekeeping of Dangerous Lunatics in the North-West Territories*. As described in chapter one, this law provided how Saskatchewan initially defined and treated insanity. The NWT law stipulated that once a person was judged “insane” they were “detained... until discharged by law.” To refine this further, the NWT lieutenant governor passed an “Ordinance Respecting Dangerous Lunatics,” stating that people were to be brought before a justice of the peace to be judged for being “insane” and a “danger to society” – two conditions that the government defined as being closely associated. To the NWT government insanity corresponded to criminal behavior. The government adopted a policy that utilized few alternatives apart from removing people from their communities for their own sake and for the safety of others. Overall, this approach put a strain on the prison system that saw many insane inmates incarcerated in penal institutions.

In her book *Moments of Unreason*, historian Cheryl Warsh examined psychiatry at the private Homewood Retreat in Ontario, Canada. In her study she argues that “mental illness, by its very nature, was not seen as curable in the home. At the point that an individual’s behaviour became intolerably disruptive to the family, or dangerous to the community... families were willing to identify a member as insane, neurotic, or addicted and seek outside accommodation for them.” Warsh explains that because “the patient’s environment was partially responsible for the mental disorder and... removal to a new, controlled environment was the first step towards recovery.”¹⁵ By the late nineteenth century regions throughout Canada were building dedicated asylums; nevertheless, the initial step of Northwest Territorial government was simply to remove

¹⁵ Cheryl Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923*, (Montreal: McGill-Queen’s University Press, 1989), 10.

people who were disruptive, dangerous, and insane and place them in penitentiaries. In 1906, the new provincial government in Saskatchewan drafted *The Insanity Act* which kept the committal process in the hands of its justice department, retained the term “insane and dangerous to be at large,” and treated all those accused as personally incompetent.¹⁶

Saskatchewan’s *Insanity Act*, which remained active until 1919, made inmate committal contingent upon the accused shown to be insane and a danger to those around them to a Justice of the Peace. After hearing or seeing proof, the officer then took the person before a magistrate who then pronounced them sane or insane. If the judge declared the individual insane, then a friend or relative, or more typically “a constable of peace officer,” removed them to a jail, penitentiary, or an asylum.¹⁷ The reasoning behind an armed guard, according to an article in the *Battleford Press*, was for the protection of others should the person’s “violent symptoms” suddenly arise.¹⁸ Saskatchewan kept the process a legal prerogative and insanity was analogous to a criminal offence. All the same, instead of relying only on a penitentiary the new government altered the law to amalgamate penal and mental institutions. Many of the insane inmates from Saskatchewan ended up at the Brandon asylum in Manitoba until the Saskatchewan government built its own facility.

The move to a system that relied on a mix of prisons and asylums did not improve care for insanity. Similar to Washington Territory up to 1876, the provincial government did not require administrators of the various institutions to treat insanity. The institutions they used were, in effect, custodial. Not exclusively relying on penitentiaries and jails to incarcerate insanity, however, began the process of disassociating it with criminality.

¹⁶ Saskatchewan Legislative Assembly, *An Act Respecting Insane Persons*, Chapter 22, Section 1, 1st Legislature, 1st session, (Regina, 1906) p. 104-109.

¹⁷ Saskatchewan Legislative Assembly, *An Act Respecting Insane Persons*, chapter 22, section 1, 1st Legislature, 1st session, (Regina, 1906),105.

¹⁸ “Patients Have Arrived at Asylum,” *Battleford Press*, February 5, 1914.

Saskatchewan's evolution of care for insanity in the early twentieth century followed a similar path laid out by Quebec in the 1830s that ultimately saw medical professionals emerge as experts over insanity within a new asylum system.¹⁹ According to historian James Moran, the government in that eastern region reluctantly moved away from the state-backed *systeme des loges* that saw insane people frequently housed in prisons. In its place, Quebec adopted the increasingly popular asylum system in which to treat insanity. In the asylum, he argues, institutionalization became a means to separate people deemed "disruptive and unhealthy" from the rest of society in an attempt to "re-establish social order in the post-rebellion Canadas."²⁰ In Saskatchewan, seventy years later, institutionalization was an effort to separate insane people from mainstream society and maintain social order while the province established itself.

Washington Territory constructed a new mental hospital on the eve of becoming a state in 1889. As discussed in chapter one, the Board of Trustees and Superintendent John Waughop argued the new building was one way to promote the strength of the government and ensure the safety of society, while also celebrating social, medical, and scientific advancements of the region.²¹ Waughop argued that the modern hospital and its moral treatment practices were characteristics of a "civilized world."²² By stressing its innovative system of care, the Washington public came to view the hospital and its patients in a more sensitive manner.²³

Saskatchewan, as Washington and Quebec had before, initially embraced the asylum as an institution that promulgated social stability. The government utilized the institution in a

¹⁹ James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal: McGill-Queen's University Press, 2000), 17.

²⁰ Moran, *Committed to the State Asylum*, 18-19.

²¹ Territory of Washington, *Report of the Board of Trustees of the Hospital for the Insane of the Territory of Washington, 1883*. (Olympia: C. B. Bagley, Public Printer, 1883), 5.

²² Washington State, *Report of the Board of Trustees of the Western Washington Hospital for the Insane 1890*, (Olympia, Wash.: O. C. White, State Printer, 1890), 14.

²³ "Hospital Proves Tacoma: Fort Steilacoom Institution Spends Most of \$230,000 Annually in this City," *The Daily Ledger*, May 28, 1916 Tacoma, Washington.

manner that overlooked therapeutic ideals and focused on people who had shunned their social and moral responsibilities and were believed to be “dangerous” to others.²⁴ Efforts to modernize the asylum were limited to attempts to bring order, by way of medicalization, to the chaos of understanding and diagnosing insanity.²⁵ Nevertheless, up to the 1920s the standard etiology of insanity and the uses of the asylum remained connected within social-moral understandings of what constituted deviant behavior.

Saskatchewan built its asylum at a time when people accepted nonmedical views of insanity, but also at a time when superintendents, and others in their psychiatric profession, were beginning to integrate themselves more explicitly into medicine.²⁶ By incarcerating people defined as “insane and dangerous to be at large,” as the provincial law defined them, the government removed people from the community who did not subscribe to acceptable values and were believed to be a danger to those around them.²⁷ Under a carceral ideal similar to Washington Territory, this process helped the Saskatchewan government solidify its protectorate role over its citizens and secured their new provincial status.

MacNeill Needs a Transformation

When the Saskatchewan Provincial Asylum for the Insane was still under construction in 1913, the provincial government announced James MacNeill, a physician turned brief politician, as its first superintendent. In an effort to overcome old prejudices, he worked to establish a medical atmosphere in and around the institution. MacNeill shaped his practices to highlight the

²⁴ Saskatchewan Legislative Assembly, *An Act Respecting Insane Persons*, 104; Michael J. Clark, “‘Morbidity introspection’, unsoundness of mind, and British psychological medicine, c. 1830—c. 1900,” in *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III, The Asylum and its Psychiatry*, eds. W.F. Bynum, Roy Porter, and Michael Shepard, (New York: Routledge, 1988), 83.

²⁵ Reaume, *Remembrance of Patients Past*, 16. In *The Mad Among Us: A History of the Care of America’s Mentally Ill*, (New York: The Free Press, 1994), Grob argues that between 1880 and 1940 the whole profession underwent a shift that sought to align psychiatry, as he terms it, with medicine. Psychiatrist “identified new careers outside of institutions; articulated novel theories and therapies; expanded jurisdictional boundaries to include not on mental disorders but the problems of everyday life’ and defined a preventive role.” (p. 130)

²⁶ Grob, *Mad Among Us*, 130.

²⁷ Saskatchewan Legislative Assembly, *Act Respecting Insane Persons*, 104.

curability of insanity, but he did so in a manner that allowed him to continue to reform patients along Saskatchewan's normative-social lines. This largely meant inducing self-control and emphasizing a work ethic that mirrored Saskatchewan's prairie identity that leaned on the agriculture and natural resource sectors.

MacNeill wanted to care for and, if possible, cure his patients instead of treating them as criminals, despite the enduring laws that defined patients as inmates. As a physician he believed that insanity was a medical condition that if treated swiftly and properly, allowed people a chance "to return to their homes either in a perfectly normal condition or very greatly improved."²⁸ His "training" also influenced his opinion about the medical nature of insanity. As part of his preparation to become superintendent, the Saskatchewan government sent MacNeill on a five-month trip to study treatments and ideas employed throughout mental hospitals in eastern Canada, the United States, and Europe.²⁹ During these trips, according to one report, he "gathered a fund of information as to the methods adopted for the treatment of mental patients in the most up-to-date institutions in the world."³⁰ Aside from his medical degree, this was the only formal training MacNeill had to prepare for his post as head of the provincial insane asylum.

The medical ideals MacNeill adopted upon taking his post as superintendent helped to ensure that he followed eastern practices. He took up his post and found himself in a situation similar to that of eastern superintendents of the early to mid-1800s, who had set about to medicalize insanity in their respective regions. MacNeill did this in part by emphasizing he was a medical professional whose opinion reigned supreme in the asylum. He took issue with anyone who questioned his methods and used every opportunity to increase his authority while

²⁸ *Saskatchewan Provincial Hospital Battleford*, prepared and published under the direction of Hon. A. P. McNabb, Minister of Public Works, (SAB) PW 2, Special Publications, (Regina, Saskatchewan, Date unknown), 24.

²⁹ *North Battleford News*, September 25, 1913.

³⁰ *North Battleford News*, September 25, 1913.

positioning himself as the medical expert over the institution and his patients. MacNeill actively worked at curbing political meddling that he believed adversely influenced his practices and undermined his authority; at times this approach put him at odds with provincial ministers and local bureaucrats.

MacNeill's asylum

In the first annual report MacNeill refrained from discussing his treatments. He wrote that he had “difficulties...organising our service,” and had a challenging time establishing and maintaining hospital “routine and regulations.” He explained this was due to the “many workmen” who were “necessarily conflicting” with the daily routine of the asylum.³¹ Although he had difficulties establishing a routine, MacNeill wrote “that many good results of treatment are to be seen, and we are laboring on, hoping for greater results in the future.”³² The lack of “good results” was not indicative of his efforts nor the value he placed on the therapies. Part of the therapeutic regimen MacNeill had adopted required that he establish order in the lives of the patients. The problems stemmed from the workmen whose schedules fell outside of his control. Their daily disruptions caused the therapies to lose their effectiveness.

MacNeill believed his therapies were effective despite the early troubles. In late 1915, a year and a half after taking his post at North Battleford, he found himself at odds with politicians concerning his treatments and hospital practices. When the deputy provincial treasurer and the provincial auditor sent a memo to the superintendent questioning his expenditures and staffing decisions, MacNeill took it as an affront to his professional opinion. He defended himself to the

³¹ MacNeill did submit a report that covered the 1913-1914 term. Since the hospital accepted its first large group of patients in February 1914 and the financial year ended in April, it was a very condensed report. The quote comes from Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1914-1915, Ended April 30, 1915*, SAB, PW. 2, (Regina: J. W. Reid, Government Printer, 1915), 62.

³² *Annual Report of the Department of Public Works, 1914-1915*, 62

Public Works Deputy Minister J. M. Smith. He argued that he was the ultimate authority in the institution and claimed that he had support from other medical professionals.

MacNeill complained that he did not need “to be harassed by a bunch out of the Auditor’s Department, who could not give themselves a bran mash three times a day if they were not in the Government service.” If this “harassment” was to continue he threatened he would leave his post. He viewed the criticisms, as he called them, “not much short of an insult.” Political bureaucrats, he wrote, did not have a place in dictating the policies within his institution, only MacNeill held that authority. All matters concerning hospital practices, therapies, and the hiring and firing of nurses, he argued, was “my business and mine entirely.” His letter made minimal reference to patient care, its primary concern focused on politicians challenging his professional position and authority. He concluded his letter with, “in so far as the care of the patients is concerned you can make up your mind that I am going to have the say.”³³ When MacNeill finally mentioned patients in the letter it was in reference to him having the final say on matters concerning the asylum.

Smith attempted to subdue MacNeill’s anger. In a reply letter the deputy minister wrote that bureaucrats did not hold to the “ideal of transferring any of the authority of the Superintendent to the Bursar or any one [sic] else.” As far as the politician was concerned, his “own idea was and is yet that everything in relation to the running of the Institution must and should be done and only with the consent of the Superintendent.”³⁴ Smith conceded that MacNeill was the indeed the ultimate voice in the asylum. The deputy minister did not concern

³³ Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 1 Oct., 1915, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95, 132S.

³⁴ Deputy Minister of Public Works J. M. Smith to Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, Province of Saskatchewan, 25 Nov., 1915, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95, 132, Private.

himself with how decisions affected the asylum patients. Similar to MacNeill's initial letter, Smith understood that the source of contention was the authority of the superintendent.

It appears MacNeill was unsatisfied with Smith's concession, because he continued to complain to the deputy minister. In a second letter to Smith he discussed the "very important therapeutic measures" of his practices and how they served "the best interests of the unfortunate patients" at the asylum.³⁵ Nevertheless, this letter, like the first one, focused largely on MacNeill's professionalism and how the opinions of other physicians, all of whom resided in eastern Canada, United States, and Europe, validated his medical opinions. These professional views meant more to him than those expressed by politicians. "When such men as [William Alanson] White of Washington, Adolf Meyer of Baltimore, Sir Thos. Clouston of Edinburgh, Dr. Maybon, Supt., of the Ward's Island Hospital New York and Dr. Burgess of Verdun Hospital, Montreal., tell me, and when I find in the literature so much consideration paid to the therapeutic value of music in institutions of this kind by the greatest authors of America and in Europe," he wrote, "I am inclined to follow their verdict rather than the verdict of people who, with all due deference to their ability, I am inclined to think have not the experience of these men."³⁶ MacNeill revered medical knowledge from professionals and allowed the writings and opinions of men such as Meyer, White, and Burgess, all of who had intimate knowledge of insanity, to shape his practices, not local bureaucrats.³⁷

³⁵ Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 27 Nov., 1915, Public Works Department: Deputy Minister's Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95.

³⁶ MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 27 Nov., 1915.

³⁷ For more on the influential works of William Alanson White please see, Matthew Gambino, "These strangers within our gates': race, psychiatry and mental illness among black Americans at St Elizabeths Hospital in Washington, DC, 1900-40," *History of Psychiatry* 19 no. 4 (2008): 387-408; for Adolf Meyer please see, Susan Lamb, "The Most Important Professorship in the English-Speaking Domain': Adolf Meyer and the Beginnings of Clinical Psychiatry in the United States," *Journal of Nervous and Mental Disease* 200, no. 12, (December, 2012): 1061-1066.

In yet another letter, MacNeill wrote to Smith arguing that his treatments helped achieve the real objective of the asylum. “I do not think you are satisfied to let this Institution be just an institution for the housing of these peoples and not an Institution to treat them,” he wrote. He continued to suggest that by effectively treating patients he was upholding the asylum’s true purpose. He highlighted the need to distinguish from practices that incarcerated people rather than treating them as patients. Yet, he once again invoked other physicians in order to justify his actions.³⁸ MacNeill’s letters highlight what he believed was really at issue. While he eventually brought attention to how his methods improved the care of his patients, the fact that he first focused on his professional position underscores how MacNeill placed professionalization above medicalization and patient care.

Smith’s response, which was the final letter on the matter, reiterated his stance from the previous letters. In it he wrote that in “reference to the therapeutic treatment given patients at all the Insane Hospitals, and I feel quite satisfied that any treatment given...would be very beneficial to the patients.” He closed by admitting to MacNeill that as politicians, he and his colleagues were “inclined to look more at the financial” aspects of the institution than the benefits “derived from the treatment given.”³⁹ This cemented MacNeill’s position; at the provincial asylum his word was final.

The superintendent’s correspondence is replete with examples of his confrontational approach. He was not afraid to communicate with politicians, especially on areas of competing interpretations of expertise. For instance, MacNeill once again became belligerent, almost

³⁸ Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 27 Nov., 1915, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95.

³⁹ Deputy Minister of Public Works J. M. Smith to Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, Province of Saskatchewan, 29 Nov., 1915, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95, 132I.

truculent, when, in 1916 Smith questioned why he was not transferring patients “in the most economic manner possible.”⁴⁰ Although the law permitted family members to escort people to and from the asylum, the government preferred more expensive method of transporting patients under armed guard, typically by the North West Mounted Police [NWMP]. MacNeill, however, disapproved. “Any patient leaving this Hospital that needs custodial care will be accompanied by some person who is responsible to me for the welfare of that patient, when that policy is departed from I won’t be here.”⁴¹ Although it was the law, he resented the reliance on police who did not answer to him directly.

Smith unsurprisingly did not share the superintendent’s view. He believed that patients travelling to and from the institution should be under the care of the NWMP. The “Police” had, he argued, escorted many patients “and we do not hear of any great objection to them doing so.”⁴² MacNeill, by contrast, argued he had examples of the police treating his patients roughly while transferring them to the hospital. “I can say that I am not personally satisfied with the way they handled these patients coming here,” he began in his reply. The police, whom the minister seemed to “have such a high opinion of,” handled the patients “roughly” and gave one an “infection of the arm” due to his shackles being “so tight.” The more he wrote the more irate the superintendent became. “Now I would take it from your letter that you set yourself up as a Judge as to who shall handle these cases after they come here,” he continued. “While I was satisfied that you had a great opinion of yourself as to your versatility, I did not know that you set yourself up as having any great knowledge of medicine, it is unfortunate that it is just yourself that has

⁴⁰ Medical Superintendent MacNeill to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 27 Nov., 1916, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95.

⁴¹ MacNeill to Smith, 27 Nov., 1916, SAB, Collection no. R-195.2, File no. 1.95.

⁴² Deputy Minister of Public Works J. M. Smith to Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, Province of Saskatchewan, 30 Nov., 1916, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95.

that opinion of your capabilities.”⁴³ MacNeill’s anger stemmed from the fact that the government did not transport patients in a manner approved by him.

MacNeill did not oppose using restraints altogether. Indeed, by 1916 he used restraints on the wards, for instance through the use of “restraint jackets” made by the patients in the asylum sewing room. As Nancy Tomes indicates, non-restraint in the hospital was a “utopian” ideal but proved less than practical when early psychiatrists faced the realities of asylum life. “The philosophy of non-restraint required an extremely labour-intensive style of asylum management,” Tomes wrote; “without ample resources to provide co-operative attendants... and the like, restraint had to remain an integral aspect of treatments.”⁴⁴ MacNeill’s continued use of restraints in the asylum is reflective of a lack of resources more so than adherence to a principled use of restraints as therapeutic. Moreover, the overcrowded institution, as Tomes suggests, necessitated practical measures to cope with staff shortages.⁴⁵

MacNeill remained infuriated with the harsh methods the police employed, even if they mirrored his own, because the context and authority differed. Smith understood that the superintendent did not have “a very high opinion” of the NWMP. However, he noted, MacNeill’s claim was “the first intimation we have had that the patients have not been treated right by them.” Smith concluded the letter with some advice for MacNeill. “With regard to the latter part of your letter, I realize that you have taken another bad turn. I think I could prescribe for your case, but in the meantime I would suggest that you get a prescription from Dr.

⁴³ Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 2 Dec., 1916, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, collection no. R-195.2, file no. 1.95.

⁴⁴ Nancy Tomes, “The great restraint controversy,” in *The Anatomy of Madness: Essays in the History of Psychiatry, Volume III, The Asylum and its Psychiatry*, eds. W.F. Bynum, Roy Porter, and Michael Shepard, (New York: Routledge, 1988), 217.

⁴⁵ *Annual Report of the Department of Public Works, 1914-1915*, 62

Campbell. I shall forget you wrote this.”⁴⁶ By claiming to be able to “prescribe for your case,” Smith mocked what MacNeill claimed was his medical prerogative. MacNeill appears to have received the underlying message because he let the exchange end with the deputy minister’s note.

Similar to how he had done with his therapies, MacNeill used this correspondence to assert his authority and ultimately move patients under his medical purview. Instead of placing himself between the institution and politicians, he placed himself between patients, politicians, and the police. He believed his authority was not confined to the asylum, as it extended to the care of people coming into the institution, and indeed insanity throughout the region.

Neither Smith nor MacNeill discussed the police’s motivations, yet neither believed the escorting officers were being deliberately cruel because they were accompanying people considered insane. Perhaps they did not view the people as medical patients, but rather as inmates who were “dangerous,” like any other criminal in their custody. This prejudiced opinion informed their actions and revealed the criminal undertones embedded in the system. As MacNeill wrote, society “shunned and despised [these people] because insane.”⁴⁷

MacNeill quarreled with politicians in order to affirm his professional authority free from political meddling. He also acted this way inside the hospital where his “stubborn” attitude, demands of respect, and assertions of authority became notorious among his staff.⁴⁸ His demeanor generated some hyperbole, though. For example, he once sent a letter to Smith

⁴⁶ Deputy Minister of Public Works J. M. Smith to Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, Province of Saskatchewan, 4 Dec., 1916, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, collection no. R-195.2, file no. 1.95.

⁴⁷ *Annual Report of the Department of Public Works, 1914-1915*, 62.

⁴⁸ Veryl Margaret Tipliski, “Parting at the Crossroads: The Emergence of Education for Psychiatric Nursing in Three Canadian Provinces, 1909-1955,” *Canadian Bulletin of Medical History* 22, no. 2 (2004): 261, Tipliski also describes MacNeill’s attitude as “tyrannical.” (p. 260) See also “A Hard Hit Wife to the Hon. J. F. Bryant Esq., Minister of Public Works” Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95.

claiming that if the staff did not comply with the rules that MacNeill had established then the “organization [of the asylum] will be wrecked in the course of a very few months.”⁴⁹ His stubbornness, while emphasizing his authority, does underscore his tenacity in asserting a medical model of care and improving the quality of care at North Battleford. MacNeill believed stigma negatively influenced the way society viewed the institution and its patients. Even as he and Smith referred to the institution as a hospital, it was still legally named Saskatchewan Asylum for the Insane, a name that MacNeill fought against. As he wrote, the words “insane” and “asylum... are not received with favour throughout the country.” People wrote him letters expressing their willingness to receive treatment for their or their loved ones’ condition, but, he argued, they would rather be “sent to any place but the Asylum or the Hospital for the Insane as this place is called.” The superintendent frequently implored the government to rectify the situation by changing all legal acts to “eliminate the words ‘insane’ and ‘lunatic’ altogether,” though he grew frustrated by the lack of progress.⁵⁰ MacNeill adamantly believed that a name change was the first step in improving the institution in the eyes of the public. Changing the name “may be a small matter to the average person,” he wrote in 1917, “but those interested find it looms very large.”⁵¹ While calling on the government to make those changes, he banned his staff from using the words “insane,” “lunatic,” and “asylum” in their official correspondence and while on the asylum grounds.⁵²

⁴⁹ Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 14 Jan. 1920, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95.

⁵⁰ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1915-1916, Ended April 30, 1916*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1916), 38.

⁵¹ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1916-1917, Ended April 30, 1917*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1916), 39; see also Cecilia Wetton, “The First superintendent: MacNeill, The Man Who Gave Hope to the Hopeless,” in Delores Kildaw, *A History of the Saskatchewan Hospital North Battleford, Saskatchewan* (Saskatoon: Health Care Administration, University of Saskatchewan, College of Commerce, 1990-91), 15.

⁵² *Saskatchewan Provincial Hospital Battleford*, 8.

The Canadian National Committee for Mental Hygiene visit of 1920

While MacNeill fought to improve the image of the asylum, others, particularly psychiatrists in the east began questioning the institution's effectiveness in treating what they increasingly conceptualized as mental diseases.⁵³ In 1918, just four years after Saskatchewan had opened the doors of one of the "most modern" and "up-to-date institutions," as two local papers reported, the newly formed Canadian National Committee for Mental Hygiene (CNCMH) aspired to reshape the national mental health discourse and standardize mental health practices throughout Canada.⁵⁴ The national Committee pushed mental hygiene in a direction that sought to improve therapies through medical interventions but also explored preventative measures to keep patients out of large mental hospitals.

According to their confidential statement of purpose, the CNCMH drafted goals similar to those adopted by their American counterparts in the National Committee for Mental Hygiene. The Canadians wanted to "improve the brain-power of the nation" so that "society will have less need than now for sanatoria, asylums and prisons."⁵⁵ Naturally, they reasoned, there would always be an "irreducible minority" that would fail to accept their role in the heightened Canadian society and thus there will always be a need for the mental asylum, the prison, and the sanatoria.⁵⁶ Even as they argued there was a continued need for "custodial" asylums, the CNCMH wanted provincial governments to move past their overreliance on what they viewed as "inadequate" and "antiquated" institutions that no longer improved upon the care of Canada's mentally ill, and had failed to provide an adequate setting in which to cure mental diseases. In light of these failures, the CNCMH advocated for smaller psychopathic hospitals. Located within

⁵³ Canadian National Committee for Mental Hygiene (CNCMH), "Confidential Report," ND, Saskatchewan Archives Board (SAB), Scott Fonds I. 153, (40,716 – 40,905), Social Welfare: Mental Defectives, 1917-1921, M4. File no. 40,743 – 40,750, p. 1-3.

⁵⁴ *Regina Leader*, Dec. 23, 1911; *North Battleford News*, August 28, 1913.

⁵⁵ CNCMH, "Confidential Report," p. 1.

⁵⁶ CNCMH, "Confidential Report," p. 1.

urban settings, they were expected to focus on “scientific research” and offer a community centered approach to treating mental diseases.⁵⁷

Beginning in 1919 the CNCMH embarked on a nation-wide tour to inspect Canada’s mental hospitals and promote the Committee’s new objectives. As they explained to Saskatchewan Premier William. M. Martin in 1920, the purpose of their tour was to conduct a study of those who were a “burden or a menace to society” and “ascertain” from the provinces their “present manner of diagnosing and treating cases of mental abnormality.” If they found the system of any particular province lacking, the Committee would, accordingly, “suggest a better programme.”⁵⁸ For his part, Martin, who became a member of the CNCMH, welcomed the visit, which was initially planned for the summer of 1921. According to Martin, the province had “kept fairly well abreast of the work connected” to mental health but nonetheless appreciated any forthcoming recommendations from the Committee.⁵⁹

After first touring Manitoba and British Columbia the Committee found, somewhat unexpectedly, that it had time to tour Saskatchewan. In the summer of 1920 they sent a telegram informing Martin of the situation. The Premier replied, “it is probably better that it should be done now in view of the fact that we are building a new Mental Hospital at Weyburn,” in southern Saskatchewan. Any advice from the CNCMH, he believed, might “be of material assistance.”⁶⁰ Unaware of the Committee’s intent and seemingly ignorant of the fact that physicians in eastern Canada questioned the effectiveness of the traditional mental hospital system, Saskatchewan’s politicians had recommitted the province to the traditional system by

⁵⁷ CNCMH, “Confidential Report,” p. 3.

⁵⁸ Letter from C. M. Hincks, Mental Hygiene Committee Director to W. M. Martin Premier of Saskatchewan. April 16, 1920. SAB Scott Fonds I. 153, (40,906 – 41,032). Social Welfare: Mental Defectives, 1917-1921, M4. File no. 40,919 – 40,920.

⁵⁹ Letter to C. M. Hincks, Mental Hygiene Committee Director. April 22, 1920. SAB Scott Fonds I. 153, (40,906 – 41,032). Social Welfare: Mental Defectives, 1917-1921, M4. File no. 40,921.

⁶⁰ Letter to C. M. Hincks, Mental Hygiene Committee Director. June 2, 1920. SAB Scott Fonds I. 153, (40,906 – 41,032). Social Welfare: Mental Defectives, 1917-1921, M4. File no. 40,926.

erecting a new custodial institution. In fact, the new hospital at Weyburn was on track to be bigger than the building at North Battleford. During the CNCMH's visit the government hoped to gather information, or perhaps even earn praise for this development.

Clarence M. Hincks, the associate medical director and secretary of the CNCMH, and prominent Canadian psychiatrist Dr. Charles K. Clarke oversaw the Committee's survey of Saskatchewan. Under the recommendation of Premier Martin, MacNeill conducted the survey with them "for the purpose of gathering information which will be useful to him."⁶¹ The report was favorable to the Battleford institution and its superintendent; it commended MacNeill and the government on their efforts in dealing with mental diseases throughout their region.⁶² The Committee report noted that the government showed "a deep interest in the affairs of the insane," and had kept "abreast of the time and even [led] in many things."⁶³ It commented on how the government was "lavish in its expenditure to provide accommodation for patients."⁶⁴ Throughout the report, however, underneath the Committee's praise, there was a heavy dose of criticism leveled at the government's disinclination to move away from the custodial hospital system and their refusal toward adopting a more community-based approach to treating mental diseases. For example, they applauded the construction of the new hospital in Weyburn, but framed their praise within the observation that its greatest benefit was to address the overcrowded conditions of the North Battleford asylum. With the "lavish expenditure" in Weyburn the government did little more than provide additional "custodial care" for the insane. According to the Committee, a

⁶¹ Letter to C. M. Hincks, Mental Hygiene Committee Director. June 2, 1920.

⁶² Harley D. Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: University of Regina, 1989), 41. Dickinson also claims that despite its being favorable the report "was never published." In correspondence with Martin, Hincks stated that none of the mental hygiene reports would be made public "until sanction for publication is officially given." (April 16, 1920, correspondence) The Saskatchewan government must have given sanction because the report was published: Canadian National Committee for Mental Hygiene, "Mental Hygiene Survey of the Province of Saskatchewan," *Canadian Journal of Mental Hygiene* 3, no. 4 (Jan. 1922): 314-99.

⁶³ CNCMH, "Mental Hygiene Survey of the Province of Saskatchewan," 342; 317.

⁶⁴ CNCMH, "Mental Hygiene Survey of the Province of Saskatchewan," 342.

new “hospital at Weyburn will relieve the situation for the present, as far as the chronics are concerned, but will not meet the needs of all classes.”⁶⁵ Here they more than subtly argued that the province was committing to a system that did not attend to the needs of all people deemed insane. The hospital was, accordingly, little better than an institution to care for people with incurable conditions.

Mental hospitals, the CNCMH argued, were good for chronics and incurables – people whose mental diseases presented little hope of allowing them to return back to society. The Committee believed that within this system of asylum-based care the other patients, those who responded to treatment, were prone to getting lost within the overcrowded population and “become one of a herd,” their conditions worsening until there was little hope of recovery.⁶⁶ They argued that this outcome was typical of patients placed in the mental hospital setting. North Battleford was no exception. Originally planners built the asylum to care for 600 people, but at 1,100 patients it was “so overcrowded” that despite their best abilities “the officials cannot be expected to produce the best results.”⁶⁷

The CNCMH advocated preventative measures that kept people out of the hospital. One proposal was to create a stronger vetting process for immigrants coming into the region.⁶⁸ They argued that a considerable number of people who exhibited a “mental abnormality” were foreign immigrants or people of foreign heritage. By monitoring those who came into Saskatchewan “the influx of mental defectives and insane would be reduced” thereby reducing the number of people

⁶⁵ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 391.

⁶⁶ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 391.

⁶⁷ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 342; *Saskatchewan Herald*, “New Provincial Hospital for the Insane Receives First Patients,” Feb. 6, 1914; Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1919-1920 Ended April 30, 1920*, SAB, Pubic Works (PW) 2, (Regina: J. W. Reid, King’s Printer, 1920), 51.

⁶⁸ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 379.

needing to go to the asylums.⁶⁹ Another measure included “early diagnosis and early treatment of mental disorders,” an undertaking the Committee insisted was possible with smaller community-based psychopathic hospitals.⁷⁰ Lastly, the report suggested the government establish a “Division of Mental Hygiene.” This department would hire psychiatrists and psychologists to work in “public schools, courts, gaols, reformatories, homes for dependents, maternity hospitals, etc.,” and diagnose early mental abnormalities in people.⁷¹ These recommendations were intended to help the government establish a better, more efficient mental health system. The CNCMH wrote the proposals were “based on a consideration of local conditions,” but were in “conformity with accepted ideals in various parts of the world.”⁷² They presented their findings in a manner that is consistent with Fredrick Jackson Turner’s argument.⁷³ The Committee did not expect Saskatchewan to “imitate” the east. They wanted the region to evolve and adapt, to improve practices and to “conform” to those held by other areas. Local officials were to accept these advances based on regional conditions.

In their report the CNCMH concluded that Saskatchewan failed to adopt “an efficient mental hygiene policy,” thereby forcing them to rely on the “custodial care” of the mental asylum.⁷⁴ Although they assumed a critical view of the North Battleford institution, MacNeill, according to the Committee, was a “capable and enthusiastic” superintendent. The report cast him as an expert physician working in a difficult situation. He had, they wrote, assembled quality staff at North Battleford, all of who were “willing and anxious to do the most advanced work”

⁶⁹ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 379.

⁷⁰ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 379.

⁷¹ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 379.

⁷² CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 316.

⁷³ Fredrick Jackson Turner, “The Problems of the West,” *Atlantic Monthly* 77 (September 1896), quoted from *Rereading Fredrick Jackson Turner: “The Significance of the Frontier in American History” and Other Essays*, with commentary by John Mack Faragher (New York: Henry Holt and Company, Inc., 1994), 62.

⁷⁴ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 316, 384.

and had a “keen interest in the scientific study and care of their patients.”⁷⁵ The superintendent was anxious to advance the care and understanding of mental hygiene and surrounded himself with capable people to achieve those successes. Nevertheless, he faced a government that was interested in long-term care, which hindered the physician’s efforts in establishing better acute care for his patients.

Despite the many praises over the superintendent’s efforts, the report noted MacNeill’s continued use of mechanical restraints, which they saw as non-therapeutic and backward. Assistant Superintendent A. D. Campbell, who led the tour due to MacNeill being ill with diphtheria, justified their use on the grounds that the staff did not use them “under normal conditions.” They were necessary, he argued, due to “overcrowding” and a reduced staff owing to high military enlistments during World War I. The CNCMH also opposed the asylum airing courts; areas where patients were able to obtain some fresh air but that were enclosed by mesh cages and bars. They described these places as “repulsive” and “gaol like.” In the Committee’s estimation, the courts and the restraints were non-therapeutic and served to create a prison-like atmosphere within the asylum. In a very real sense, these concerns reinforced the CNCMH’s belief that the asylum was little better than a custodial institution. Because they did not offer any therapeutic value the Committee urged MacNeill to stop using them.

The unnecessary use of restraints and the airing courts was less a critique of the superintendent’s methods, as he was a “capable” physician working within “meagre and crude surroundings.”⁷⁶ It was, however, indicative of the lack of support the hospital received from the government. The CNCHM already viewed the asylum as a custodial institution. What they saw at North Battleford were patients living in conditions that, due to underfunding and

⁷⁵ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 343.

⁷⁶ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 343.

overcrowding, favored control over therapy. “Any scheme which to a great extent ignores the questions of prevention and early treatment,” they wrote, “falls far short of modern requirements.”⁷⁷ Under the heading “Desire for Progress,” the Committee argued Saskatchewan, with its asylum system, had “clung to methods” that were old if not quite “obsolete.”⁷⁸ The provincial government, accordingly, perpetuated a cycle of long-term care and incarceration that represented an outdated conceptualization of insanity and its care.

There were greater criticisms leveled at the asylum, however. Specifically the CNCMH found fault with the manner in which the government committed patients to the asylum. This process had changed little from before Saskatchewan was a province. By maintaining older methods they continued to relegate the role of medicine to the fringes of asylum care. Until 1919, when administration of the insane was transferred to the Minister of Public Works, the asylum and its patients fell under the jurisdiction of the Attorney General. The transfer had come under *The Dangerous Lunatics Act*, which altered the label of the insane from “dangerous and insane” to “dangerous lunatics.” While still maintaining connections between insanity and criminality, or dangerousness, the shifting of the institution and its patients to the public works revealed the government’s responsibility toward people judged insane shifted from being strictly a legal issue to a custodial one.⁷⁹ Transferring political oversight to public works also emphasized the government’s attention toward the asylum centered on the building and the grounds, not the patients or their care.

Many of the laws adopted under the 1906 *Insanity Act* remained intact in the 1919 *Dangerous Lunatics Act*. While the jurisdiction of the patients shifted, the committal process continued to go solely through the legal system. According to the CNCMH report, other

⁷⁷ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 391.

⁷⁸ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 317.

⁷⁹ Kildaw, *History of the Saskatchewan Hospital North Battleford*, 4.

provinces had by 1920 allowed people to be committed to the asylum based on the written opinions of two physicians and by “voluntary admission.”⁸⁰ Saskatchewan’s sustained practices showed its resistance in following this national trend. Under provincial law, physicians submitted evidence to support or refute accusations, but a non-medical magistrate made the final ruling and people were only committed upon a legal ruling.

The CNCMH also took issue with the government’s continued practice of having an armed escort accompany insane patients and detain them in prisons while they made the long trek to the asylum. Saskatchewan was (and still is) made up of a far-reaching rural areas and sending patients from one distant locale to the mental hospital often required a multi-day trip. The Committee sympathized with the necessity of this lengthy journey. They questioned why the government delayed or detained patients in local prisons as they made their way to the asylum; there was, they wrote, no “excuse for the perpetuation of a method of admitting the insane that is manifestly an anachronism.”⁸¹ As convenient as it was to rely on the prison system for support, it perpetuated stereotypes that maintained links between insanity and criminality and, just as distressing, was “prejudicial to recovery.”⁸²

The “anachronistic” methods of admitting patients “through the order of magistrates,” having them escorted in restraints by a peace officer, and “pass through gaol prior to admission,” the CNCMH lamented, served only to reinforce the public stereotype that all insane people were dangerous.⁸³ Public prejudices surrounding the institution, they argued, were “founded on the old tradition which made it a species of disgrace or even crime to be insane and to require legal

⁸⁰ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 344.

⁸¹ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 344.

⁸² CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 386.

⁸³ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 346.

commitment.”⁸⁴ These stereotypes damaged the image of the institution and prevented many who needed care from seeking it due to fear of public “disgrace” exacerbated by a demeaning commitment process. These acts not only affected the public perception of the North Battleford Hospital and its inmates, it placed a legal wall around insanity in Saskatchewan that kept out medicine – much to the CNCMH’s dismay and MacNeill’s frustration. If the institution was to become a hospital (especially in the eyes of the public, which MacNeill repeatedly claimed it had not) and if the government wanted to improve the image of people deemed insane, than these methods needed to change.⁸⁵ As it were, insanity legally remained a non-medical issue.

The Committee saw these as adverse actions that harmed the image of the asylum and its patients. However, they did not advocate for a strict departure from the established committal process. Instead they recommended the introduction of “voluntary admission and for the acceptance of patients by certification of two physicians” to help expedite commitments and to strengthen the ties between medicine and insanity outside the institution.⁸⁶ According to the CNCMH these changes would also mean “the disappearance of the unfortunate detention of the insane in gaols.”⁸⁷ The inclusion of voluntary admissions opened a way for people to assess for themselves, or at the recommendation of a physician, if they needed to go the North Battleford asylum. By bypassing the legal proceedings and the attention that is sometimes associated with

⁸⁴ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 391.

⁸⁵ For a few examples of MacNeill’s claims about the public holding unfavorable opinions of insanity see *Saskatchewan Provincial Hospital Battleford*, 8; *Annual Report of the Department of Public Works, 1913-1914*, 38; *Annual Report of the Department of Public Works, 1914-1915*, 61; MacNeill’s reply to Deputy Minister Smith about the “Great War Veterans complaining about patients,” Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 17 June 1919, Public Works Department: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, Saskatchewan Archives Board (SAB), Collection no. R-195.2, File no. 1.95.

⁸⁶ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 386.

⁸⁷ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 343.

it, it expedited commitment and allowed for early diagnosis and treatment, which the Committee repeatedly argued was essential for the successful treatment of mental diseases.⁸⁸

The Mental Hygiene Committee concluded that there were “so many delightful and admirable features at Battleford.”⁸⁹ They agreed there was still a need for custodial institutional care, yet they suggested building smaller psychopathic hospitals throughout the province to better serve the needs of individuals while allowing them to remain in or close to their communities.⁹⁰ This shift reflected the ideals proposed in the CNCMH’s confidential statement of purpose. Instead of calling for radical changes and encouraging Saskatchewan to move past the asylum system altogether, the Committee offered minor proposals – building psychopathic hospitals and allowing for voluntary admissions – two changes that did not depart radically from Saskatchewan’s existing mental hospital system. Building smaller, community-based facilities, however, moved closer to achieving preventative care than the more traditional methods.⁹¹

At the time of the national inspection the province’s mental hygiene services lagged behind Manitoba, British Columbia, and Ontario, all of which had adopted more lenient laws and practices aimed at helping patients and saving the government money. The CNCMH stated that in Manitoba, people went to the new psychopathic hospital by voluntary admission, general admission, and order of Magistrate, the last method, according to the report, was the least common. The Committee claimed that due to a combination of voluntary examination and admittance and a psychopathic hospital, Manitoba patients only averaged 29-days under

⁸⁸ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 321, 344, 379, 385, 392.

⁸⁹ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 345.

⁹⁰ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 385.

⁹¹ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 391.

treatment.⁹² Saskatchewan's methods not only perpetuated an erroneous link between insanity and criminality, it perpetuated and required expensive, extended care.⁹³

In the wake of the visit MacNeill adopted a somewhat uneven approach to the CNCMH's recommendations and criticisms. He focused on the Committee's praise while ignoring any mention of the traditional mental hospital being antiquated or custodial. Overall he appreciated the CNCMH's visit and used it as momentum to introduce stronger medical language in connection to mental diseases and the hospital. In his 1920 annual report, he praised the visiting doctors for their medical insight and at the same time used the opportunity to criticize the provincial politicians for maintaining control of something they did not comprehend. "We were visited by the Mental Hygiene Committee of Canada," he stated,

We enjoyed their visit very much, and we hope to benefit by the suggestions which we received—and I think the province will benefit by the suggestions which Doctor Clarke has to make... I am inclined to think that if we had visits from people frequently, who are qualified to know how an institution of this kind *should be run*, it would be better for everybody concerned. It is certainly a great advantage to an institution of this kind to get suggestions from people who have had wide experience in this kind of work.⁹⁴

MacNeill felt frustrated at being politically constrained in his position. He wanted to work with or at least discuss mental hygiene matters with like-minded individuals who understood mental diseases and the hospital. In many ways his words reflected the opinions of the Clarke and the rest of the CNCMH: the government, which continued to control many aspects related to the institution, restricted his professional authority and failed to adopt progressive or modern ideals concerning insanity. He believed that the province needed to embrace a policy that took dramatic steps towards medical control. With some heightened public

⁹² CNCMH, "Mental Hygiene Survey of the Province of Saskatchewan," 393.

⁹³ The report did not offer comparable figures for Saskatchewan do to it not having a psychopathic hospital. MacNeill did not report the average stay of the patients at North Battleford. However, from 1916 to 1921 the hospital averaged a 12% parole rate from year to year.

⁹⁴ *Annual Report of the Department of Public Works, 1919-1920*, 22. Emphasis added.

and political awareness, due to the visiting Mental Hygiene Committee, MacNeill began transposing Saskatchewan's mental health policy, advocating legally redefining insanity as mental disease.⁹⁵

In 1923 MacNeill announced that he had removed the airing court "to the satisfaction of everyone concerned, especially the patients." The court, he wrote, invited attendants to adopt "careless" methods and were "only used by the *most backward of mental hospitals*."⁹⁶ By removing them he was showing that his hospital was not "backward," it was, in his estimation, progressive. He improved the institution so that it remained at the forefront of mental health practices. At the very least, as MacNeill wrote, he had attended to the "only criticism which Dr. Clark [sic], president of the Mental Hygiene Committee, did make that was not in our favor."⁹⁷ This claim was erroneous, the airing courts were not the only criticism from the CNCMH report. During their visit, the Committee also noted the staff's continued use of restraints. The superintendent also addressed that issue, but without the same pomp as the courts and in a manner that focused on him and his "successful" treatments.⁹⁸

In 1920 leading up to the CNCMH's visit, MacNeill had written about the patients who had manufactured 30 restraint jackets to use in his hospital. After the visit he stopped having the patients produce the jackets, claiming that at that time, "we have no patient in any restraint of any kind."⁹⁹ He linked this achievement to his physical activity program, which helped patients achieve control over their conditions. When MacNeill made drastic changes and needed support for them, he justified his actions based on the CNCMH's recommendations thereby linking his

⁹⁵ Dickinson, 42.

⁹⁶ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1923*, SAB, PW. 2, (Regina: J. W. Reid, King's Printer, 1923), 63.

⁹⁷ *Annual Report of the Department of Public Works, 1922-1923*, 63.

⁹⁸ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1922*, SAB, PW. 2, (Regina: J. W. Reid, King's Printer, 1922), 50.

⁹⁹ *Annual Report of the Department of Public Works, 1921-1922*, 50.

actions to the group that the government approved and invited. On the other hand, when he did something important but did not need political approval, such as ending the reliance on restraint, he overlooked the Committee's criticism and instead linked it to his own efforts. In this manner he was able to emphasize his own medial efforts and stress the asylum's therapeutic successes without admitting his motivation came from external sources.

In 1924 MacNeill, once again aligned his practices with the CNCMH recommendations, arguing that "research into medical diseases is the quickest and surest way to economically handle the problem of the insane."¹⁰⁰ He carefully framed this development within the continual use of the mental hospital as a way to improve upon Saskatchewan's existing interventions in mental hygiene. To adopt "the quickest and surest way to economically handle the problem of the insane" was to effectively treat them with the aim of curing and releasing them; it was a matter of economic importance that the government support the swift hospitalization of people after exhibiting the earliest sign of a mental disease.¹⁰¹ MacNeill still believed his institution was still *the* most effective place to treat patients. Instead of replacing the "antiquated" and "custodial" mental hospital with smaller community-based psychopathic clinics, he wanted to improve the care of people with insanity within the existing framework of Saskatchewan's system.

Due to the opening of a second mental hospital in Weyburn in 1921, MacNeill was unwilling to call on the government to adopt a system that all but ignored its heavy investment and instead finance new facilities. Such requests would make him extremely unpopular with politicians and the people who relied on and utilized the new hospital. It would politically weaken his position and could have potentially resulted in people fighting against him and his

¹⁰⁰ *Annual Report of the Department of Public Works, 1923-1924*, 67.

¹⁰¹ *Annual Report of the Department of Public Works, 1923-1924*, 67.

efforts to improve the care of people judged insane. Instead of blazing a new mental hygiene path in Saskatchewan, MacNeill restricted his calls to improving the existing one.

The government also began to comply with some of the CNCMH recommendations. In 1922 the province introduced the *Mental Diseases Act*, which stopped referring to insane patients as “dangerous lunatics.” The new law excised “insanity” and “lunacy” and in their place inserted the term “mental disease.” It officially changed the name of the institution to “The Mental Hospital, Battleford” and dropped all uses of the word asylum. Lastly it modified the commitment process.¹⁰² While the act still favored sentencing through a magistrate, the revised procedure allowed a patient to be committed under two medical certificates, thereby extending power to the general physician, and for voluntary admissions.¹⁰³ Although, as psychologist John Elias, who researched the legal changes of mental health services in Saskatchewan, argued, this was “not truly voluntary as we now understand the term, as ‘voluntary patients’ were detained and required to serve up to five days’ notice before discharge.”¹⁰⁴ By comparison, just after becoming a state in 1889, the Washington government altered its commitment laws from its 1877 law. Although commitment remained a legal process still overseen by a judge, the government allowed “two reputable physicians” to interview the accused person who then gave their medical opinions to the judge, in addition to the to the “one or more respectable [general] physicians” who initially submitted their opinions in writing to the judge before the trial.¹⁰⁵ The

¹⁰² Saskatchewan Legislative Assembly, *An Act respecting the Care and Treatment of Mentally Diseased Persons*, chapter 77, 5th Legislature, 1st Session, (Regina, 1922), 191-211.

¹⁰³ See CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 386, for these recommendations from the Committee.

¹⁰⁴ John W. Elias, “Continuity and Change in the New Mental Health Services Act,” presented at the Annual Clinical Conference of Psychiatric Services Branch, Saskatchewan Health, Regina, SK, October 9, 1985.

¹⁰⁵ Washington State Legislature, *Providing for the Management of the Hospitals for the Insane*, Session Laws of the State of Washington Enacted by the First State Legislature, Session of 1889-90, Chapter XVI, Compiled in Chapters with Marginal Notes and Index by Allen Weir, Secretary of State, (Olympia, O. C. White, State Printer, 1890), 486; Washington Territorial Legislative Assembly, *An Act to Amend an Act Entitled ‘An Act Defining the*

state, however, did not allow for voluntary admissions until 1931 in that respect Saskatchewan was more progressive.¹⁰⁶ In 1922 the Saskatchewan government legally expanded the patient commitment process to include both a form of voluntary admission and medical opinions. As MacNeill maintained, “The regular mode of procedure” continued to go through the Saskatchewan’s court system.¹⁰⁷ Nevertheless, he believed the changes would help bring a more nuanced public understanding of mental illnesses.¹⁰⁸

These alterations to the law came partly in response to the construction of the new larger provincial mental hospital at Weyburn. Although in 1921 the original institution was overcrowded with a population of 1,253 patients, there was little chance that transferring 457 patients to Weyburn was going to fill the institution.¹⁰⁹ Changes in the law helped emphasize the medical nature of the hospital and reduced some of the associated stigma. The government made these legal changes so that the public would be more willing to take advantage of the hospital and thereby justify their investment.

The *Mental Diseases Act*, which adopted many of its changes from the CNCMH report, marked a new era for mental health in Saskatchewan. Yet administrators were keen to reform the public understanding of mental diseases and the mental hospital. In 1922 MacNeill still believed politicians regarded the hospital as a center for incarceration. This was a view that led to hindered medical care and led to economic problems. “If we are expected to effect cures of

Jurisdiction and Practice in the Probate Courts of Washington Territory, Enacted by the Legislative Assembly in the year 1877, Sec., 327. (Olympia: C. B. Bagley, Public Printer, 1877), 210.

¹⁰⁶ Washington State Legislature, *Admission to State Hospitals to Determine Sanity*, Session Laws of the State of Washington Twenty-Second Session, Convened January 12, Adjourned March 12, 1931, Chapter 77, S. B. 231, Compiled in Chapters by J. Grant Hinkle, Secretary of State, Marginal Notes and Index by John H. Dunbar, Attorney General, (Olympia, Jay Thomas, Public Printer, 1931), 237-238.

¹⁰⁷ *Saskatchewan Provincial Hospital Battleford*, 10.

¹⁰⁸ *Annual Report of the Department of Public Works, 1921-1922*, 49.

¹⁰⁹ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1918-1919 Ended April 30, 1919*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1919), 46.

mental illnesses,” MacNeill wrote, “sufficient help, and especially sufficient medical help to give the individual adequate medical care, is the one and only way to bring about that much desired result... The place of detention must give way to the hospital, and to the up-to-date, well-equipped hospital, if the state is going to be relieved of the economic burden imposed upon it, even to a degree.”¹¹⁰ The superintendent was not expected to treat patients with the goal of paroling and sending them back to their communities. This, in part led to overcrowding conditions and required the government to invest more funds to provide daily care for institutionalized people, in addition to constructing more buildings and hiring more staff. The superintendent continued to advocate for change, but framed the necessary changes as pecuniary imperatives.

In 1929, the hospital population was once again nearing 1,000 people. In response, MacNeill began articulating a clear need for prevention, suggesting that “more attention should be paid to the prevention [and] to the early recognition” of mental diseases – another point of the Mental Hygiene Committee.¹¹¹ Making such a recommendation on the eve of the economic crisis, however, soon fell down a list of more pressing political priorities. MacNeill pressed on, illustrating how prevention functioned as a cost-saving measure, he argued that “Another matter of economic importance is the early recognition and early hospitalisation of mental cases.” He did not argue recognition and prevention went hand-in-hand, rather it was recognition and early hospitalization that led to better chance of recovery, and consequently shorter hospital stays. Repeating his pleas of reaching out to families and encouraging early commitment, he stated that “Many cases are left too long at home without treatment, because of the foolish and mediaeval [sic] notion of mental diseases being a disgrace. Much valuable time is lost in the way of

¹¹⁰ *Annual Report of the Department of Public Works, 1923-1924*, 67.

¹¹¹ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1929*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1929), 68.

treatment, because of this much to be regretted prejudice among our people.”¹¹² If people were going to be effectively cured, then the families needed to be willing to bring their loved ones to the hospital earlier, with the expectation that those patients would return home and perhaps resume their roles as functioning members of society.

The government responded to these changes and commissioned the publication of a small booklet that worked to assuage public fears toward the newly renamed mental hospital and its patients.¹¹³ Overall, the booklet, titled *Saskatchewan Provincial Hospital Battleford*, highlighted the facility as a modern, curative institution. It emphasized how the government consistently invested in this facility, which had now risen to over a million dollars. It stressed that the “very large expensive building” was there for the benefit of all, it was a piece of state apparatus.¹¹⁴ MacNeill used this publication to link the ownership of the hospital to the Saskatchewan residents, arguing that the institution was a product of the local economy, a testimony to a caring society, and a service for everyone.¹¹⁵

MacNeill opened the booklet questioning why people were still holding “to the old, cruel idea that it is disgrace to become insane or to have a relative suffer from a mental break down?”¹¹⁶ He argued this view tended to delay commitment and made “recovery so difficult or hopeless.”¹¹⁷ Throughout the asylum’s initial years, MacNeill played an important role in stimulating change away from these ideas by adopting a stronger medical language in relation to

¹¹² *Annual Report of the Department of Public Works, 1923-1924*, 67.

¹¹³ Although there is no date on the booklet *Saskatchewan Provincial Hospital Battleford*, many of the issues and the personnel mentioned put its date in the early to mid-1920s.

¹¹⁴ *Saskatchewan Provincial Hospital Battleford*, 9, 5.

¹¹⁵ Although the booklet is not attributed to any author, the medical tones suggests that MacNeill had a heavy hand in writing most, if not all of the material.

¹¹⁶ *Saskatchewan Provincial Hospital Battleford*, 3.

¹¹⁷ *Saskatchewan Provincial Hospital Battleford*, 8; André Cellard and Marie-Claude Thifault, “The Uses of the Asylum,” in *Mental Health and Canadian Society: Historical Perspectives*, eds. James E. Moran, and David Wright, (Montreal: McGill-Queen’s University, 2006), 101.

mental disorders and insisting that his institution was a “hospital not an asylum.”¹¹⁸ The booklet further helped him highlight these changes to the public. MacNeill understood that in order for him to successfully treat and parole his patients, he needed to instil acceptable behaviors befitting the local culture. This meant adapting therapies to instil the normative values of the region, something the superintendent wanted to show the public first-hand.

MacNeill frequently encouraged for a close association between the public and the institution. He consistently advocated for family and friends of patients and interested parties to visit the hospital so that people could directly witness his therapies in action.¹¹⁹ Many early asylum advocates argued the pressures borne of increased urbanization caused insanity. Therefore they believed it was critical to isolate an insane person from their frenzied social and family environment. MacNeill did not favor this interpretation, as isolation had already posed myriad problems for the people who lived in remote locations on the prairies. He maintained that seclusion of his patients only served to exacerbate insanity. As early as 1916 he wrote that the “isolation” of the rural settlements caused “mental depression and mental confusion” in many of the patients, or it aggravated a mental imbalance borne of an “apparently unimportant circumstance.” In that same report he noted there was a “steady increase in our population; especially... from the rural districts.”¹²⁰ The isolation that people had to bear, the separation of social contact was what triggered their breakdowns. MacNeill, therefore, believed that it was important to preserve any established family or social contact the patient had before going to the hospital, and to facilitate a patient’s reintegration if paroled.

¹¹⁸ *Saskatchewan Provincial Hospital Battleford*, 8.

¹¹⁹ *Annual Report of the Department of Public Works, 1915-1916*, 38; *Saskatchewan Provincial Hospital Battleford*, 8; Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1927*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1927), 65.

¹²⁰ *Annual Report of the Department of Public Works, 1915-1916*, 38.

MacNeill argued that many rural families did not have the time, money, or in some cases interest to make their way to the hospital when they needed help. This situation meant that not only were families reluctant to rely on the hospital for care, but that some patients languished in the institution longer than necessary because they had become estranged from their families.¹²¹ The superintendent did not want to exacerbate those issues by advocating for total isolation from family or society. Instead, breaking from tradition, MacNeill needed his patients to feel as though they were still part of society and strove for a strong affiliation between patients, public, and the asylum.

In her book *Prisons, Asylums, and the Public*, historian Janet Miron highlights the relationships that developed between Canadian asylums and society in the late 1800s and early 1900s. “[R]ather than working outside the parameters of public opinion, officials tended to be very concerned with how their institutions were perceived by society and vigorously sought to implement measures that would bolster popular support.” Therefore, she adds, a “number of administrators strove to foster close ties with the communities beyond their walls.”¹²² Public opinion became increasingly important for superintendents. By the late nineteenth century hospital and patient seclusion was an outdated notion. Into the twentieth century physicians worked to solidify, rather than dissolve links between the mental hospital, the patients, and the community. MacNeill exemplifies this trend: borne out of an openness toward society, community-patient interactions, however regulated, were important features of his administration. Because strong hospital-public relations were vital, MacNeill wrote, the staff was working in “several ways to bring [their] work to the attention of the people at large.”¹²³ A closer

¹²¹ *Annual Report of the Department of Public Works, 1914-1915*, 61.

¹²² Janet Miron, *Prisons, Asylum, and the Public: Institutional Visiting in the Nineteenth Century*, (Toronto: University of Toronto Press, 2011), 34; 36.

¹²³ *Annual Report of the Department of Public Works, 1914-1915*, 61.

relationship between the institution and the community also served to increase public support of the hospital, the superintendent, and his methods.¹²⁴

MacNeill advertised “visitors to the institution [were] always cordially welcome.” This helped him to emphasize community engagement and unrestricted transparency.¹²⁵ Allowing the public to see “insane” individuals as people facilitated the dissolution of links between criminality and insanity, and allowed people to see firsthand that his patients were valuable hard-working individuals. He believed that public tours of the hospital dispelled notions of the mental hospital being a secretive “insane asylum.”¹²⁶ Visiting, he believed, served to eradicate many common misconceptions about harsh treatments, callous interactions within the hospital, and dangerous patients.

At the hospital MacNeill provided a strict daily schedule for the patients. “Regularity, order and cleanliness are three cardinal rules of the Provincial Hospital,” he wrote in the public relations booklet.¹²⁷ Every day, the patients awoke at 6:30 am. From then until the retiring hour of 7:00 pm (9:00, if the individual was “paroled” but still resided in the hospital or was doing “fairly well”) the staff busied the patient’s day with work, recreation, and other treatments. The booklet emphasized the “splendid discipline” maintained at the hospital; a feat that MacNeill stressed was undemanding. Patients, he explained, were “abnormal on only a few points [but] think and act as normally as the average person outside the institution,” they were willing to follow hospital rules and help the staff when needed.¹²⁸ For example, when a flu epidemic swept through the hospital in 1918 and again in 1919 the patients “took full charge and managed” all

¹²⁴ Miron, *Prisons, Asylum, and the Public*, 35.

¹²⁵ *Saskatchewan Provincial Hospital Battleford*, 8.

¹²⁶ The *Saskatchewan Provincial Hospital Battleford* booklet stated that MacNeill was “a man of infinite patience and good nature” except when the “thoughtless visitor” called the hospital “an ‘insane asylum.’” p. 8.

¹²⁷ *Saskatchewan Provincial Hospital Battleford*, 17.

¹²⁸ *Saskatchewan Provincial Hospital Battleford*, 19.

the areas of the hospital they were capable of working.¹²⁹ Even before MacNeill granted patients parole, he tailored his approaches with them to adopt a work ethic that mirrored that of the average citizen. These hard working attributes, while allowing the superintendent to maintain discipline in the hospital, exemplified the normative behaviors exhibited by patients.

When discussing the nature of patients and socio-normative hospital activities, MacNeill regularly touched upon patient labor, as it was important to the hospital and to Saskatchewan society. “As many as possible of the patients are kept employed,” he stated. Many, he stressed, wanted to work outdoors “especially in the garden or on the farm.”¹³⁰ According to MacNeill, patients wanted to work at these activities because farming and gardening were familiar, indeed they were reassuring normalizing activities.¹³¹ If weather or physical restrictions prohibited outdoor labor, then patients worked indoors. Overall, the staff ensured people were “kept busy at some occupation or another” throughout the day.¹³² Catering to a large patient population “from the rural districts,” the superintendent adapted a daily regimen that privileged agricultural, construction, ranching, and household activities for women with the aim of matching these activities with the local culture and economy.¹³³

In spite of the emphasis on work therapy, he also acknowledged the need for recreational activities. He wrote in the booklet that “‘All work and no play,’ no matter how interesting the work, would never do in a modern hospital of this kind.”¹³⁴ People needed recreation, entertainment, and diversions to offset a day of chores. MacNeill contended that entertainments and recreation had the added benefit of preventing “patients from brooding over real or

¹²⁹ *Saskatchewan Provincial Hospital Battleford*, 19.

¹³⁰ *Saskatchewan Provincial Hospital Battleford*, 12.

¹³¹ *Annual Report of the Department of Public Works, 1914-1915*, 64.

¹³² *Saskatchewan Provincial Hospital Battleford*, 17.

¹³³ *Annual Report of the Department of Public Works, 1915-1916*, 38; 61.

¹³⁴ *Saskatchewan Provincial Hospital Battleford*, 15.

imaginary worries.”¹³⁵ He reasoned that if left to themselves patients were liable to fixate on their delusions. Therefore if they were not working then patients were participating in some other mental distraction, such as listening to a phonograph or enjoying live music from a piano. Every Tuesday evening, the staff chaperoned a dance for the patients, and Friday evenings were “moving picture” nights.¹³⁶ Protestant church services were held on Sunday afternoons and Catholic services Monday mornings.

Discharging patients served as a reminder that the mental hospital was capable of restoring health to patients. MacNeill explained that he did not discharge people “as cured, but as improved and on parole, although a large proportion are permanently restored.” His use of “parole” was not an allusion to patients being criminals. MacNeill used it, he argued, because it followed the “same course [of] tuberculosis sanitariums, where patients are discharged with disease arrested instead of discharging them as cured.” He continued in this manner – using medical language to create links between mental and physical conditions – maintaining there is no “reason to be ashamed of a disease of the brain than any other disease.” A person “would not dream of making light of an attack of pneumonia or typhoid fever.”¹³⁷ He wanted to solidify the image of one going to the mental hospital as someone seeking medical care at a general hospital.¹³⁸ The Saskatchewan Provincial Hospital, North Battleford was, MacNeill argued, “primarily...a hospital for the treatment of cases of insanity.”¹³⁹ He maintained that insanity was treatable and his therapies were successful enough that “at least fifty per cent. [sic] of the cases

¹³⁵ *Saskatchewan Provincial Hospital Battleford*, 18.

¹³⁶ *Saskatchewan Provincial Hospital Battleford*, 17.

¹³⁷ *Saskatchewan Provincial Hospital Battleford*, 9.

¹³⁸ *Saskatchewan Provincial Hospital Battleford*, 8; 9; 27.

¹³⁹ *Saskatchewan Provincial Hospital Battleford*, 24.

admitted may be expected to return to their homes either in a perfectly normal condition or very greatly improved” from their mental diseases.¹⁴⁰

Despite MacNeill’s assurances, his promised cure rate, while not as high as the 80% advocated by some of the early AMSAII members, never materialized.¹⁴¹ Claiming a 50% expected cure rate was more than hyperbole as the hospital reports show that the highest MacNeill ever achieved before and after he made that claim was a 15% parole rate.

By 1929 the patient population at North Battleford Hospital was once again “crowded.” MacNeill attributed this to a steady increase in the general population and claims of mental disorders rising proportionately. He did not believe that his ineffectual therapies were the cause. In response, MacNeill recommended new buildings, specifically designed to siphon the “old men” and “chronic women patients” off the regular wards, and still continued to treat his patients with his social-moral based therapies.¹⁴²

Conclusion

In his 1927 report, MacNeill explained why a positive public opinion was essential for the proper care of people with mental diseases. “Without the sympathy of the community and the Public in general,” he wrote, “Mental Hospitals, any more than any other Hospital, or any other Institution, cannot do their best work.” Public support, or as he framed it, sympathy toward the mental hospital was crucial if it was to be fully proficient. “I am persuaded,” MacNeill continued, “that nowhere in America have Mental Hospitals the sympathy and the good wishes of the community to such a large degree as have the Mental Hospitals in this Province.” These developments, according to him, were not unfounded claims. Based on the judgments of those

¹⁴⁰ *Saskatchewan Provincial Hospital Battleford*, 24.

¹⁴¹ Thomas S. Kirkbride, *On the Construction, Organization, and General Arrangements of Hospital for the Insane with some remarks on insanity and its Treatment*, 2nd ed., (Philadelphia: J. B. Lippincot & Co., 1880), 23.

¹⁴² Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1929*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1929), 29.

who visited the institution, the superintendent argued, he was “convinced that the Public has no other wish than that the Mental Hospital shall be a Hospital in the best sense of the word.”¹⁴³ As Janet Miron argued, officials believed that the institution was ineffective if it operated outside the purview of public opinion.¹⁴⁴ MacNeill linked public opinion to improved image. While holding to the concepts of the region, he bolstered public support of the hospital by adopting and promoting therapies that emphasized humane practices and local circumstances.

Nancy Tomes has argued that the AMSAII used the asylum “to convince the public that insanity was a curable disease, best treated in” their institutions.¹⁴⁵ MacNeill exemplified this advice when it came to managing his own institution. He played a key role in medicalizing insanity in the region by developing a psychiatric science and inserting himself between politicians and his patients. In the wake of the Mental Hygiene Committee visit, MacNeill faced the opinion that Saskatchewan mental health program, which favored the asylum, was archaic and encouraged incarceration over effective care. Nevertheless, he worked to present a system of care that retained the asylum at the center of Saskatchewan’s mental health program and ensured its longevity.

Although the AMPA had stopped promoting moral treatment in the 1870s, its ideals were ingrained into asylum practices by the time Saskatchewan had opened the North Battleford hospital in 1914. By adopting moral treatment ideals and practices in his own institution and presenting them as a humanistic approach to caring for insanity, MacNeill utilized a system of asylum-based care that stressed the therapeutic nature of his hospital. While not invoking the term moral treatment, he promoted aspects of it in an effort to redefine insanity from a dangerous disorder that required incarceration into a curable medical disease. He merged these established

¹⁴³ *Annual Report of the Department of Public Works, 1926-1927*, 65.

¹⁴⁴ Miron, *Prisons, Asylum, and the Public*, 34.

¹⁴⁵ Tomes, “A Generous Confidence,” 122-123.

practices with the CNCMH's medical language and presented a system of care that helped to publically alter and the image of the asylum and insanity along medical lines.

To MacNeill moral treatment principles highlighted the medical nature of insanity and the asylum, and solidified his place as the expert over both. In a process that resembled the early struggles of early eastern superintendents, it allowed him to present a system of asylum-based care shaped by regional ideals of normality. His efforts, however, underscore how highly he valued his own expert opinion, especially when non-medical people questioned his methods. His confrontational attitude underscores how he was acutely concerned about his professional standing, at times relegating patient care secondary to asserting his authority.

By the late 1920s, MacNeill believed that Saskatchewan residents had developed a "more sensible and scientific attitude towards the patients suffering" from mental diseases. He believed these attitudes were "better for the patient, better for the Hospital, and which, in the last analysis will be better for the people themselves."¹⁴⁶ This change allowed him to advance the notion that mental diseases were treatable and he was able to return patients back to their homes. The transformation began when the government made revisions to the insanity laws. Building on momentum generated from the CNCMH visit, politicians had altered the legal definitions of insanity.

Although MacNeill was successful at enacting changes outside of the institution and inserting medical dialogue into mental disease, not much changed inside the hospital. He continued to treat his patients using a social-moral therapeutic regimen that sought to instill regionally acceptable skills and reorient the behaviors of his patients. While reflecting an appropriateness for the agrarian society of Saskatchewan, his therapies did not effectively treat mental diseases. Despite adopting medical language, the moralistic composition of the

¹⁴⁶ *Annual Report of the Department of Public Works, 1926-1927*, 65.

MacNeill's therapeutic system ensured it remained unable to solve the medical complexity of insanity.

Chapter Four

What is and What Never Should Be: Patient Labor in Washington

In 1905 Washington State's Board of Control devised a strategy for Western Washington Hospital for the Insane (WWH) to expand its pasture grounds and save the institution money in the process.¹ The Board had "borrowed temporarily" \$900 from the patients' fund, a holding account for patient's personal finances, and \$500 from the contingent fund, an account that the hospital paid into from the selling of patient made goods, produce, and farm animals, in order to purchase 93 additional acres of land. The Board justified this use of funds by claiming that there was enough "timber on the land purchased to more than repay the purchase price."² Absent from the discussion were the patients' opinions on allowing the administration to "borrow" their personal money for such an undertaking. The patients' contribution were not, however, restricted to their finances; they also supplied the physical labor to raze the trees, cut the timber, and cultivate the land.

Owing to the patient funds and labor the Board was able to sell 500 cords of wood back to the hospital at \$2 a cord, which was, they claimed, "45 cents less than the contract price for wood." The money went to repaying the patients' fund, with "remaining sufficient timber to more than repay the contingent fund." The state secured "93 acres of pasture land without cost."³

¹ Washington's Board of Control was a group of men appointed by the governor of the state, who was also the *ex officio* chair of the Board. They oversaw the state's various institutions, including its mental hospitals, penitentiaries, and reform schools. The mental hospital at Fort Steilacoom underwent many name changes. Under the law it started as the Territorial Asylum for the Insane and Idiotic. In 1877, its name was changed to the Hospital for the Insane in Washington Territory. When the government opened the Eastern Washington Hospital for the Insane in 1891, it also changed the name of the first hospital to Western Washington Hospital for the Insane and then finally to Western State Mental Hospital in 1915.

² Washington State, *Third Biennial Report of the State Board of Control for the Term Beginning October 1, 1904, and Ending September 30, 1906*, (Olympia, Wash. C. W. Gorham, Public Printer, 1907), 24. Ostensibly, this was what the contingent fund was there for – although any land purchase needed to come through a legislative appropriation. As for the patients' fund, that was supposed to be patients' personal money to which only they had access.

³ *Third Biennial Report of the State Board of Control, 1904-1906*, 25.

As this transaction highlights, with some creative accounting and investing, the hospital procured additional land by relying directly on resources supplied by patients.

In 1905, Western's new superintendent, A. P. Calhoun, argued that occupation and amusement, presented in the form of "*light work* and plenty of fresh air," were some "of the best aids to recovery."⁴ Calhoun sustained this perspective over his ten-year period as superintendent, though he gradually came to resent the use of patient labor as a cost-saving measure for the institution. He believed that labor was generally therapeutic, but if it did not reflect a patient's skillset it was not necessarily beneficial to their recovery. At those times, he discouraged work, even if it was advantageous to the institution. To illustrate his position, he argued patient labor was *strictly* a therapeutic measure. For example, patients who were farmers before entering the institution might maintain their skills by farming or gardening as part of their institutional routines. Correspondingly, Calhoun argued, the non-farmers needed to work in areas that matched their previous work experience, exposing them to skills that held therapeutic value for them, which would then later facilitate their return to work outside the hospital. To accomplish this, he introduced industrial therapy workshops into the hospital.

Industrial therapy was a program that became popular in the United States in the early 1900s. It exposed patients to work services that aligned with their individual skillsets and the regional economy. These skills were potentially beneficial to people after they left the hospital and pursued employment, further underscoring the relationship between insanity and inability to work.

This chapter examines the impact and meaning of patient labor at Washington's first insane hospital. Emerging as part of the Association of Medical Superintendents of American Institutions for the Insane's (AMSAIL) moral treatment regimen in the 1840s, many North

⁴ *Third Biennial Report of the State Board of Control, 1904-1906*, 37. Emphasis added.

American mental asylums maintained patient labor programs into the mid-20th century, and the Fort Steilacoom mental hospital was no exception. Many factors influenced how superintendents embraced patient labor, defined then redefined, and sometimes exploited it. The course that each institution took and the opinions expressed in support of or against work therapy are illustrative of the relationship between the hospital and society and the interplay between the cost of running the institution and the state funds devoted to it during recession economies or periods of regional economic growth. Most significantly, work therapy highlights the relationship between politicians and hospital administration, medicine and money, the superintendent and his patients.

Patient labor at Western Washington Hospital was a complicated program that politicians, oversight committees, and superintendents used for much more than simple financial benefits shrouded under a rhetoric of therapy.⁵ Not having a consistent superintendent for any significant period of time, different physicians, psychiatrists, administrators, and elected officials influenced the work therapy program. Although superintendents often separated work therapy from clinical medicine, it was, nonetheless, a key aspect of a patient's daily regimen.⁶ The hospital's files are replete with physicians voicing their opinions as to the medical nature of insanity. Although superintendents offered different opinions, there was considerable consensus around the idea that a patient "recovered" after accepting the routine of the asylum, including the

⁵ By listing these works, my intention is not to diminish the author's overall arguments. Yet, in each of the works, the authors conclude or make the statement that finances strongly motivated patient labor. See: Geoffrey Reaume, "Patients at Work: Insane Asylum Inmates' Labour in Ontario, 1841-1900," in *Mental Health and Canadian Society*, ed. James E. Moran and David Wright (Montreal & Kingston: McGill-Queen's University Press, 2006), 77; David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown, 1971), 146; Harley D. Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: University of Regina, 1989), 30; Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (Los Angeles: University of California Press, 1989), 262; Cheryl Warsh, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923* (Montreal: McGill-Queen's University Press, 1989), 117-118. Warsh's argument is interesting in that she claims the administration introduced occupational therapy at the Homewood Retreat to dispel "notions that patient work was an institutional cost-saving scheme." By 1925, however, it devolved into a department with two goals: a therapeutic goal and a "utilitarian goal – to reduce the operating budget."

⁶ Territory of Washington, *Report of the Resident Physician at the Insane Asylum of W. T.; Ordered Printed by the Legislated Assembly*, (Olympia: Prosch & McElroy, Printers, 1871), 5.

daily working regimens.⁷ Superintendents offered work therapy to maintain order (in the asylum and a daily schedule) to counteract “prolonged idleness,” which they believed was “detrimental” to people living in institutions.⁸ From those beliefs the program evolved into something that benefitted the state and the institution regardless of how it helped the patients. Superintendents used it, in large part, to justify the existence of the hospital.

Hospitals typically delineated their patient labor program along the lines of farming, ranching, and other agrarian activities. Washington’s superintendents, however, confronted an environment with poor soil quality, restrictive land and water rights, and a changing economy and culture that redefined what constituted acceptable work in the region. In light of these issues, some superintendents questioned the value of maintaining a large agrarian-focused labor program. Adopting new asylum-based activities was not always straightforward, as outside forces, either political or economic, pressured superintendents to work patients in traditional areas. For example, when the United States entered World War I in 1917 it stopped mattering if one was a farmer, a lumberjack, or a toymaker in the asylum. Although Calhoun believed that he should not be in the practice of using patient labor to ease hospital finances, politicians and the Board of Control grew more austerity minded during the wartime economy of World War I. They expected everyone, especially patients in state institutions, to contribute to the war effort, whether that included maintaining a garden, raising livestock, sewing and mending clothes, or limiting gas and coal consumption.

Superintendents also had to coordinate with politicians and political appointed members of oversight committees who wanted to expand patient labor for reasons of fiscal responsibility.

⁷ Washington State, *Report of the Board of Trustees of the Western Washington Hospital for the Insane of the State of Washington, 1891-92*, (Olympia, Wash.: O. C. White, State Printer 1892), 11.

⁸ Washington State, *Second Biennial Report of the Department of Business Control for the Term beginning October 1, 1922, and Ending September 30, 1924: To the Governor and the Legislature of the State of Washington Nineteenth Regular Session, 1925*, (Olympia: Frank M. Lamborn, Public Printer, 1924), 48-49.

Nowhere was this more prevalent than during and after the economic austerity measures brought on by World War I, wherein the Board of Control, under the recommendations of the government implemented a trade system among its state institutions (i.e., Hospital for the Insane, Reform Schools, Penitentiaries, etc.,) in order to cut their state budget. Within this arrangement, the Board selected psychiatric hospitals to produce the majority of the food wares for the other institutions. These political reasons sometimes conflicted with trends articulated by the AMSAII, which recognized farming, ranching, and gardening as the more efficient forms of therapy.

The Growing Popularity of Work Therapy

Work therapy has its roots in concepts of labor and productivity as markers of social normality. The Association of Medical Superintendents accepted the principle as part of their moral treatment ideology, because it meshed well with the ideal of a productive farming household and the hardworking urbanite being the foundation of the American way of life.⁹ “Inactivity,” wrote one early 20th century psychiatrist, was “the root of all evils;” society saw “idleness” as a “vice” and an “unsocial characteristic.”¹⁰ The Association had adapted work therapy based on the notion that it was, according to one asylum advocate, “efficacious” and “preferred, both on a moral and physical account.”¹¹ It helped increase a patient’s self-esteem, which greatly influenced their behavior and personal conduct.¹² Through work, people could resist the “irregular tendencies of their [insane] disease” and “conceal and overcome their morbid

⁹ Daniel Feller, *The Jacksonian Promise: America, 1815-1840*, (Baltimore: Johns Hopkins University Press, 1995), 122.

¹⁰ Hermann Simon, *Aktivere Krankenbehandlung in her Irrenanstalt* (Berlin: Walter de Gruyter, 1929), 6-7, excerpt taken from, *From Madness to Mental Health: Psychiatric Disorder and its Treatment in Western Civilization*, ed. Greg Eghigian, (New Brunswick: Rutgers University Press, 2010), 272.

¹¹ Samuel Tuke, *Descriptions of the Retreat, an Institution near York for Insane Persons of the Society of Friends*, (York: Alexander, 1813), p. 156.

¹² Tuke, *Descriptions of the Retreat*, 157.

propensities.”¹³ Viewed as part of a medical therapy, yet informed by morality and religion, work therapy helped to encourage regular “normative” habits in people.

On the surface, work was a way for people in the asylum to engage in physical activities, but it also provided them with the means to demonstrate that they had accepted a principled moral order. When treating an affliction that was borne of disorder, as early reformers believed insanity was, regular habits demanded from work was advantageous because it showed that the patient had accepted the hardworking principles of American society. Superintendents believed they were instilling in the patients a set of behaviors and traits that helped them repress their “irregular” impulses and instead behave in a manner that was not “obnoxious,” as asylum advocate Samuel Tuke had infamously argued.¹⁴ By adopting work therapy superintendents directed people who had lost their moral way; people who were no longer part of “normal” society and subsequently been deemed “immoral,” “abnormal,” or “mentally ill.” The AMSAII, however, did not initially endorse this approach.

Early prominent members of the AMSAII admitted that patient labor was something superintendents could ostensibly use to cure or treat patients, however, support of the program varied from member to member. In 1847 Horace Buttolph published an article titled “Modern Asylums” in the Association’s professional periodical *American Journal of Insanity*.¹⁵ In it he wrote that patient labor offered “the advantage of free exercise in the open air.” Employment, he continued “is of so much importance to the welfare of the insane in asylum” because it satisfied the “want of mental and bodily occupation” necessary to treat insanity.¹⁶ Advocates, such as

¹³ Tuke, *Descriptions of the Retreat*, 157.

¹⁴ Tuke, *Descriptions of the Retreat*, 157.

¹⁵ H. A. Buttolph, “Modern Asylums,” *American Journal of Insanity (AJI)* 4 (April, 1847): 364-78.

¹⁶ Buttolph, “Modern Asylums,” 377.

Buttolph, believed work was essential to the milieu of the therapeutic hospital. Others, however, were more hesitant in their support.

Three months after Buttolph's piece, the AMSAII published another article that was more tentative in its sponsorship of work therapy. In "The Moral Treatment of Insanity," Amariah Brigham wrote that the Association only tolerated work therapy. "Bodily labor as a measure for benefiting and curing the insane is generally recommended," yet they "express[ed] the hope that better arrangements for this purpose will be made."¹⁷ In the 1840s superintendents had utilized physical labor to provide activity to patients. The Association, however, believed there were better options. Patient labor, Brigham wrote, was "undoubtedly useful of itself in some cases, but it rarely cures."¹⁸ The Association failed to reach consensus on the issue and encouraged superintendents to decide for themselves as to whether to use labor and how. Nevertheless, seeing the program's popularity increase throughout the hospital, the AMSAII tempered their position. "But however useful bodily labor may be to some, we regard it as less so generally as a curative measure." The Association considered physical activity as adequate, yet they wanted therapies to offer a new approach: treating the mind, not simply the body. While physical labor was useful, they argued, it did not work as well as "mental occupation or the regular and rational employment of the mind."¹⁹

American superintendents wanted to follow the principles established by Phillipe Pinel, which combined a focus on the mind with established physical practices.²⁰ Nevertheless, they reworked his theories to justify their own medical and physical therapies.²¹ They believed that

¹⁷ AMSAII, "The Moral Treatment of Insanity," *AJI* 4, (July 1847): 10.

¹⁸ AMSAII, "The Moral Treatment of Insanity," 11.

¹⁹ AMSAII, "The Moral Treatment of Insanity," 11.

²⁰ Carla Yanni, *The Architecture of Madness: Insane Asylums in the United States*, (Minneapolis: University of Minnesota Press, 2007), 24.

²¹ Anthony Brandt, *Reality Police: The Experience of Insanity in America* (New York: William Morrow and Company, Inc., 1975), 30-34. For the conflation mental and physical ideals stemming from moral treatment see also:

“the curative class are more benefited by the regular and rational employment *of the mind*, by pursuits that engage the attention, and tend to the enlargement and the improvement of the mental and moral powers.”²² Owing to the growing popularity of work therapy, however, they argued it was also possible to treat the mind through corporeal means, suggesting that in many cases physical labor helped “focus the attention” more than “books, maps and apparatus illustrative of different sciences.”²³ Brigham’s article advocated that superintendents first use therapies which focused the mind, as insanity, which originated as a “mental disturbance... left the brain and faculties of the mind in a torpid state.”²⁴ The Association’s compromised view argued that effective asylum-based care ought to first focus on the faculties of the mind and then the body.

By the 1860s work therapy had developed into an essential asylum program that had superintendents praising its merits. This development compelled AMSAII founding member Isaac Ray to publish an article entitled “The Labor Question, and Hospitals for Incurables” in 1866 that clarified the Association’s position on patient labor. Part of the reason the AMSAII was cautious about initially supporting work therapy, Ray explained, was that it was an untested “theory”²⁵ After 20 years of experience, however, superintendents began to see its significance as “a remedial and a financial measure, in the care of the insane.” Its dual benefits led asylum administrators to “strongly insist” for it, and saw it become a “controlling element” in the institution.²⁶ The program gained acceptance because it offered fiscal advantages, yet it also

Robert Castel, “Moral Treatment: Mental Therapy and Social Control in the Nineteenth Century,” in *Social Control and the State*, ed. Stanley Cohen and Andrew Scull (New York: St. Martin’s Press, 1983), 248-251.

²² AMSAII, “The Moral Treatment of Insanity,” 12. Emphasis added.

²³ AMSAII, “The Moral Treatment of Insanity,” 12.

²⁴ AMSAII, “The Moral Treatment of Insanity,” 13.

²⁵ Isaac Ray, “The Labor Question, and Hospitals for Incurables,” *AJI*, 22, (April, 1866): 441.

²⁶ “The Labor Question,” 440.

failed because it catered to large groups while depriving individuals of their unique therapeutic requisites.

Ray argued people were “bred to work” and to that end work therapy was an ideal program. Even so, patients were “not slow to tell [him] that [they] did not come to the hospital to work; or that if [they] can be paid for [their] labor, [they were] willing to take hold, but not otherwise.” He explained complaints such as these came from “indolent and listless” people unwilling to work for the “love...it can furnish.”²⁷ Ray’s article reveals the contemporary commitment to a Protestant work ethic as a significant characteristic of mainstream American values, and it also underscores the significance that society placed on work in general as a measure of one’s self worth. Restoring one’s mental balance or health, therefore, required reconnecting with these values and performing labor, even if it was not remunerative, as was the case within the institution.

Ray’s article depicts the rise in the program’s popularity coinciding with the political and administrative realization of its financial potentiality. He admits that the therapy made “the labor of the patients defray, wholly or partly, the cost of their support.”²⁸ While he argued the practice is not as “remunerative as is here supposed,” it was because it had “never been developed to its fullest extent.”²⁹ He felt that superintendents needed to develop the program further to realize its full promise before they could incorporate remuneration into the program.

Ray maintained it was he, not politicians, who intensified patient labor at his New York asylum. Nevertheless, both politicians and superintendents embraced work therapy as an effective cost-saving measure. The rise of work therapy, therefore, was not explicitly due to either its financial or therapeutic benefits – even as neither had fully proved itself by the 1860s. It

²⁷ “The Labor Question,” 454.

²⁸ “The Labor Question,” 446.

²⁹ “The Labor Question, and Hospitals for Incurables,” 447; 441.

emerged as an amalgamation of both of these principles. This was in spite of Ray's assertions of it not being "so remunerative as... supposed."³⁰ Because it had the potential to produce so many "benefits" superintendents appear to have forgotten Brigham's opinion that it "rarely cures."³¹ The Association nonetheless altered their recommendations, thus allowing work therapy a more prominent place in the asylum under their moral treatment regimen. As work therapy became "entrenched" in the asylum, historian Geoffrey Reaume writes, "the stated therapeutic aims...became less important than maintaining a system that put the economic well-being of the institution ahead of any idea of work acting as a curative agent."³² Over time the fiscal benefits overshadowed any therapeutic goals.

By the 1870s the AMSAII had transformed patient labor into a key therapy that saw patients receiving treatment in a way that turned them into an unpaid workforce in the institution. In the face of rising costs, superintendents started promoting the financial benefits of patient labor to politicians and other oversight committees in an attempt to demonstrate fiscal responsibility. Patients became cogs within government's bureaucratic machine. Asylums administrators and politicians overlooked the original purpose of work therapy as they increasingly became aware that patients could essentially work for the state to keep hospital costs down.

Washington's Patient Labor Program

The AMSAII had originally established firm guidelines outlining acceptable asylum practices. Over time, however, the Association recognized that superintendents often had to amend their methods based on the needs of their patients, the opinions of local supervising

³⁰ "The Labor Question, and Hospitals for Incurables," 447.

³¹ AMSAII, "The Moral Treatment of Insanity," 11.

³² Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940*, (Toronto: University of Toronto Press, 2000), 180.

bodies, and the economy of the region they served.³³ Nevertheless, many Canadian and American superintendents had continued patient labor as an important component of their therapeutic arsenal. When the Insane Asylum of the Washington Territory opened at its permanent location in 1871, Resident Physician Stacy Hemenway looked favorably upon patient labor, but because the Washington facility had suffered from public exposure to alleged abuses, including the exploitation of patients, it prevented him from employing work as a therapy. When Hill Harmon assumed the position of superintendent that same year, Hemenway sought out alternatives to implementing a strict labor program, as the asylum's contract system combined with its historical reputation of abuse made it difficult for him to implement a full-scale work routine.

Although the AMSAII and some of its prominent superintendents, such as Ray, had endorsed patient labor as a therapy, under Washington's two-contract system it fell under Harmon's jurisdiction. Harmon held the contract to provide for the physical needs of both the institution and the patients, while Hemenway looked after their medical and moral needs. As the head superintendent, Harmon employed patients to help ensure low operating costs, additionally he used work therapy as a means to increase his personal income (the government paid him \$.91 a day per patient). Utilizing the free labor of patients as cooks, landscapers, gardeners, etc., freed him from having to hire hospital staff. For example, in early 1875, H. C. Willison (who replaced Hemenway in 1873) recommended that the "Board of Inspectors" (the Hospital Trustees) discharge three male patients, as, he maintained, "none of them having exhibited symptoms of insanity for a long time previous."³⁴ The Trustees contacted Harmon on the matter, and

³³ Orpheus Everts, "The American System of Public Provision for the Insane, and Despotism in Lunatic Asylums," *American Journal of Insanity* 38 (1881): 114; 126.

³⁴ Members of the Medical Society of Washington Territory, *A Supplement to the Late Asylum Controversy*, (Olympia, W. T., Printed at the Olympia Transcript Job Rooms, 1875), 22.

subsequently denied the request. The reason for the denial was that one of the men recommended for discharge worked as Harmon's personal cook, a type of butler, and errand boy, while another worked in the asylum kitchen. Not only did these men make Harmon money by remaining in the asylum, but they also, according to Willison, saved "the contractor the wages of a Chinaman."³⁵

The manner by which Harmon and his attendants worked the patients and punished them if they failed to do so, led to sustained accusations of abuse and administrative mismanagement.³⁶ To distance himself from these methods, Hemenway was reluctant to support patient labor at the asylum. Instead of advocating for a program that forced patients to toil in terrible conditions, he encouraged a physical program that combined elements of work and recreation, but leaned heavily on the latter. In his first report of the Insane Asylum of Washington Territory, Hemenway asked the legislature for a "special appropriation to provide means of amusement and recreation for the insane." He believed this appropriation offered "healthful gymnastic exercises in the open air, carriage and horseback riding, etc., for both male and female patients."³⁷ He rationalized that recreation had the potential to deliver the same physical and mental stimulation provided through labor. When making his case for amusement and recreation, Hemenway defined the activities as therapeutic so that they came under his medical authority. They were a good and important investment, he argued. Indeed, he believed they were better than medicine. "In many cases these amusements would do more good toward [mental] restoration than medicines. In fact it should form a part of the treatment" offered at the asylum.³⁸ Hemenway established a line of reasoning that had succeeding physicians at the

³⁵ *Supplement to the Late Asylum Controversy*, 22.

³⁶ See chapter 2, specifically pages 110-111, for more on Harmon's methods and Hemenway's position against them.

³⁷ Territory of Washington, *Report of the Resident Physician of the Asylum for the Insane of Washington Territory, For the period commencing: October 1, 1871, and ending September 30, 1873*, (Olympia: P. T. Gunn, Public Printer, 1873), 5.

³⁸ *Report of the Resident Physician at the Insane Asylum of W. T.*, (1871), 5.

institution following his lead and advocating for recreation, lighter tasks, and work therapy rooms, the latter of which had the benefit of aligning with patients' skillsets. These activities were not unique to the Washington asylum, yet the amount of support its superintendents placed behind them, had physicians at times advocating for these alternate activities over traditional tasks such as farming, ranching, gardening, and construction.

Hemenway found himself in a peculiar situation. Knowing that work was increasingly accepted in American asylums, he wanted to embrace it as other physicians had, yet in doing so it might appear that he supported Harmon and his practices that had shaped the local reception of patient labor. In his first report to the government in 1871 he requested for a farm "to lessen the expense of carrying on, and maintaining the operations of the Hospital."³⁹ The request overlooked what, if any, therapeutic benefit might have for the patients. Perhaps to garner support from the fiscally-minded politicians, he acknowledged that it contributed to maintaining low operating costs. Hemenway acknowledged that patients or their relatives often failed to "pay their expenses" incurred while in the asylum.⁴⁰ Having the patients maintain a farm would defray the cost of patient care and hospital maintenance.

Hemenway saw work strictly as a financial measure. In his estimation, patients were able to receive the same therapeutic advantages via recreation. While he never wrote of the therapeutic benefits of labor, he argued "Amusements, diversions, or recreation daily in some form are indispensable in the...treatment of the insane." They were, he believed, "a very important remedial agent" in any physician's therapeutic arsenal against "mental disorders."⁴¹

³⁹ *Report of the Resident Physician at the Insane Asylum of W. T.*, (1871), 19.

⁴⁰ Washington Territorial Legislative Assembly, *An Act Defining the Jurisdiction and Practice in the Probate Courts of Washington Territory, Chapter XVIII, Relating to Idiots and Insane*, Enacted by the Legislative Assembly, 1873, Together with Joint Resolutions and Memorials, Sec. 329, (Olympia: C. B. Bagley, Public Printer, 1873), 322, Washington State legislature website: http://www.leg.wa.gov/CODEREVISER/Pages/session_laws.aspx, accessed on March 11, 2016.

⁴¹ *Report of the Resident Physician, 1871-1873*, 19.

Early superintendents adopted work because it offered a mental diversion while instilling proper work habits. Hemenway overlooked the concept that work acted a means to reorient patients' behavior. He believed that any patient physical activity was important as it offered a mental diversion for the patients. Despite his efforts, Hemenway never implemented strong alternatives during his two year contract term.⁴² His successors did not fare well either, as with each contract the resident physician's authority diminished and Harmon's increased while patients continued to work for the superintendent's pecuniary advantage.

After Harmon's contract in 1875, the government changed the law mandating that a physician be the principal authority *within* the hospital and as the only superintendent he had complete control over the care of the patients.⁴³ This provided Superintendent Rufus Willard, who followed the brief tenure of F. S. Sparling, with limited influence on recasting the place as a curative institution, albeit under the approval of the hospital's Board of Trustees.⁴⁴ Superintendent Willard, however, solidified patient labor as an important therapeutic program. Building on Hemenway's initial arguments he maintained that physical pursuits helped patients, but moved away from the discourse of recreation and replaced it with labor. Willard also strengthened the connection between work and therapy by underscoring its financial potentialities.

⁴² Throughout the biennial reports Hemenway frequently complained about Harmon's growing non-medical authority, but did so in a subtle manner as Harmon had the power to terminate his contract. When he left the asylum, Hemenway and his predecessor, H. C. Willison, who also left in frustration, became vocal advocates against Harmon and his practices. I covered this in detail in chapter 2. See also: "The Asylum Investigating Committee," *Puget Sound Dispatch*, Jan. 28, 1875; and *A Supplement to the Late Asylum Controversy* by Members of the Medical Society of Washington Territory. (Olympia, W. T., Printed at the Olympia Transcript Job Rooms, 1875), for examples.

⁴³ *An Act to Establish a Hospital for the Insane in Washington Territory*, Sec. 5, p. 86.

⁴⁴ From 1875-1877, the years between the end of Harmon's tenure and the beginning of Willard's, Dr. F. S. Sparling was named superintendent. However, having quit before submitting a biennial report and not producing much in writing, I found next to nothing about him in the archives.

One year into his position as superintendent, Willard explained that due to the “limited force... of patients who were either capable or willing to perform manual labor” he had to contract out for 100 cords of wood.⁴⁵ Notwithstanding the patient workforce, the territorial government had to pay the full expense of that contract, implying that under different circumstances patient labor would have saved the government money.

Willard also lamented the farming situation at Western. The land surrounding the hospital was not suitable for farming or gardening which proved to be a constant source of concern for the asylum administration. As he explained it, the “gravelly, sandy nature” of the land plus the “cost of fertilizing” prevented it from “being profitably cultivated.” With just “a few good acres of good land” Willard believed the asylum “can diminish very materially [its] current expenses.”⁴⁶ He made the case that patient labor was financially attractive to the government. Part of what the superintendent needed was a larger sampling of patients willing to work in areas that required paid employees. He explained, “the greater the number [of patients], the less will be the cost for the care and treatment of each.”⁴⁷ With a larger population of patients in the asylum and increasing numbers of them willing to work, the more the institution could reduce its overall expenses. The Trustees agreed with this logic. They agreed that the hospital needed more land for agriculture in the hope of “saving hundreds of dollars to the Territory.” Moreover, they declared the hospital orchard was “progressing nicely” and generated so much produce that it not only furnished “all the fruit required for the Hospital but will [also] be a source of revenue.”⁴⁸

⁴⁵ Territory of Washington, *Report of the superintendent of the Hospital for the Insane of the Territory of Washington from August 15, 1876, to August 15, 1877*, (Olympia: C. B. Bagley, Public Printer, 1877), 5.

⁴⁶ *Report of the Superintendent of the Territory of Washington, 1877*, 7.

⁴⁷ *Report of the Hospital for the Insane, 1876-1877*, 7.

⁴⁸ Territory of Washington, *Trustees' Report of the Hospital of the Insane of the Territory of Washington, 1879*. (Olympia: C. B. Bagley, Public Printer, 1879), 5.

Willard tempered the financial view as the Trustees increasingly endorsed this approach. He started adopting a medical tone when discussing work therapy, arguing that while patient labor provided financial benefits, it ultimately needed to be therapeutic.⁴⁹ Willard did not want the hospital administration to abuse labor as it had in the past, which brought shame to the institution. Defining work therapy and its benefits in strict financial terms made that possibility.

Willard was apprehensive about committing patients to tasks that did not help them personally or proved too physically demanding. He wrote that many of the patients “are already broken down by hard work. Hence it is not so much work, hard work, that is needed as easy employment.”⁵⁰ In response to the Trustees’ claims, Willard modified his opinion about the farm, stressing that therapeutic benefits were more important than financial ones. While work therapy operated “at a very small expense to the institution,” its greatest benefit, he argued, arose from providing “healthful and useful employment to [the] patients.”⁵¹ In this regard, he, unlike the Trustees, altered the purpose by placing the salutary needs of the patients at the forefront. Exercise was important, but how patients achieved it was secondary to the fact that they were engaged in activities at all.

Hemenway had explained that recreation and amusements provided the necessary exercise and diversion needed for therapeutic purposes, and therefore administrators did not exclusively need to rely on labor per se. Willard had overlooked that notion and at first only advanced work therapy as a practical alternative. He went so far as to maintain the importance of labor “cannot be estimated in dollars and cents.”⁵² In 1879, two years after becoming superintendent he included an “amusements” section in his biennial report in an attempt to

⁴⁹ Territory of Washington, *Report of the superintendent of the Hospital for the Insane of the Territory of Washington from August 15, 1876, to August 15, 1877*, (Olympia: C. B. Bagley, Public Printer, 1877), 7-8.

⁵⁰ *Report of the Hospital for the Insane, 1876-1877*, 7-8.

⁵¹ *Report of the Hospital for the Insane, 1879*, 24.

⁵² *Report of the Hospital for the Insane, 1879*, 24.

balance the “occupation” section that described patient labor activities. Willard explained that relying on the “limited” amusements the hospital offered, patients “enjoyed exercise in the open air” and received mental stimulation through “music, singing, dancing and games of various kinds.”⁵³ He downplayed the pecuniary aspect of work therapy and presented a more balanced observation of how patients achieved positive physical and mental incentives through active stimulation. Positive results, he suggested, were not achieved through work activities alone, amusements and recreation were also viable options as they offered similar therapeutic goals. In this manner, he attempted to reposition the discussion by placing the therapeutic needs of the patients at the center. Despite his more nuanced position, patient labor under Willard, encouraged by the Trustees, expanded in the asylum.

In 1881 following Willard’s modified stance the Trustees acknowledged the benefits of recreation. They deemed it “wise” to offer a variety of amusements to “interest and entertain the patients,” because these services provide “good, wholesome bodily exercise.” The Trustees then confused the issue, by immediately adding, “As many of the patients as are able to work, at light or heavy work, are utilized for that purpose, and the bulk of the labor is performed by them.”⁵⁴ The manner in which the Board presented their opinion showed that they favored work over recreation. Patients were going to work in the hospital, performing “the bulk of the labor” whether it was therapeutic or not.

In 1881 Dr. John Waughop replaced Willard at Western. With this new superintendent, the Board of Trustees had someone who used labor for both its therapeutic and financial benefits. Waughop maintained that recreation and work were equally important as they offered different therapeutic benefits. According to him, “employment” made the body weary and secured

⁵³ *Report of the Hospital for the Insane, 1879*, 23.

⁵⁴ Territory of Washington, *Report of the Board of Trustees of the Hospital for the Insane of the Territory of Washington, 1881*. (Olympia: C. B. Bagley, Public Printer, 1881), 4.

“refreshing sleep, healthy appetites and strengthened bodies, all of which help to restore the unbalanced mind.”⁵⁵ On the other hand, “amusements” only served to “relieve the...monotony of hospital life,” but provided a diversion, which ultimately benefited the patients.⁵⁶ One activity benefited the mind at night by providing sleep and rest, the other afforded a distraction during the day; together they were helpful tools in treating insanity.

Waughop delineated the advantages of each program but argued in favor of expanding the farming program. He wrote that the farm provided a great source of therapeutic activity to the patients and thus should be “materially enlarged.”⁵⁷ Waughop adopted a more political approach to patient labor than his predecessor had. By admitting patient labor supplied a financial advantage to the hospital he earned increased political support from the Trustees. By emphasizing its therapeutic qualities he contended the benefits borne of physical labor were important enough to ensure work remained a viable option in the hospital. Moreover, by situating it as a therapy he retained medical authority over the work projects.

Waughop’s merging of therapeutic and financial discourse combined to assuage fears of exorbitant costs for a new building. He explained, “All the brick necessary for building could be made with hospital help, employing such of the patients as are able and willing to assist.”⁵⁸ He justified that physical employment was “conducive to [patient] recovery.”⁵⁹ While the patients helped with construction preparation, farming, sewing, gardening, and raising livestock remained the principal patient activities. In 1885 the women manufactured 579 flannel drawers, 554 canton flannel undershirts, 254 flannel shirts, and 482 flannel skirts, among other items. The farm and

⁵⁵ *Report Hospital of the Hospital of the Insane, 1881*, 14.

⁵⁶ *Report Hospital of the Hospital of the Insane, 1881*, 14, 15.

⁵⁷ *Report of the Hospital of the Insane, 1881*. 15.

⁵⁸ *Hospital for the Insane of the Territory of Washington, 1883*, 15.

⁵⁹ *Resident Officers of the Hospital for the Insane of the Territory of Washington, 1885*, (Olympia: C. B. Bagley, Public Printer, 1885), 28.

garden produced 12,989 pounds of beets, 11,814 bunches of onions, 21,810 bunches of squash, 8,809 pounds of strawberries, and more.⁶⁰ This escalation in patient made goods and produce came during Waughop's increased calls for a new hospital. Knowing that it was going to be a considerable investment, he intensified his patient labor program to show that people in the asylum, who he had proved to be productive, were able to assist with construction and lessen the overall expense.

When construction on the building began in 1886, Waughop was true to his word: the patients helped build their own hospital and, as he believed, worked for their own recovery. The reports only credited the patients with excavating the basement, but the Building Commissioners stated that they were pleased with the "*vast amount of labor... performed by the employes [sic] and patients connected with the Hospital.*"⁶¹ While conceding that they helped, Waughop presented an opaque picture of patients' accomplishments, taking their work for granted as part of their therapy rather than as a skilled set of accomplishments.

As work increased, recreation and amusements, which previous superintendents struggled to provide as alternatives to work, became, under Waughop something the patients "indulged in at the close of the labors of the day."⁶² The superintendent (who the Board of Trustees called "wise, safe, and *economic*") explained amusements were still prominent in the asylum as a therapy, yet he only offered them "in the evening" for about two hours before bedtime."⁶³ By 1887, while still claiming it was therapeutic, he restricted amusements to only "one evening in

⁶⁰ *Hospital for the Insane of the Territory of Washington, 1885*, 62-63.

⁶¹ *Hospital for the Insane in the Territory of Washington, 1887*, 56. Emphasis added.

⁶² *Hospital for the Insane of the Territory of Washington, 1885*, 6.

⁶³ *Hospital for the Insane of the Territory of Washington, 1885*, 29; *Hospital for the Insane of the Territory of Washington, 1883*, 8. Emphasis added.

the week.”⁶⁴ More than any asylum physician before him, Waughop favored patient labor as a means to help patients recover from insanity.⁶⁵

The Trustees were pleased with the increased patient productivity, linking it to decreased hospital expenses. They explained that while the population increased in the hospital, the cost per patient fell as they cultivated more land, raised more produce, and the existing staff managed more patients without hiring additional employees.⁶⁶ The asylum became such an industrious institution that the state Board of Control, which replaced the Board of Trustees in 1897, felt compelled to explain that while they (not the superintendents) provided “employment for the inmates of the institutions” they ensured it conflicted “as little as possible with the free labor of the State.”⁶⁷

Beginning hesitantly with Willard but increasing under Waughop, the superintendents of the Washington Hospital for the Insane defined its “exercise and diversion” therapy as labor, resulting in patients farming, gardening, caring for livestock, sewing, and performing chores around the hospital. These were subsidies of which the Board members greatly approved. Through these outlets, the patients supplied the hospital with many of its own goods, saving the state, and ultimately the taxpayers, money. Washington’s superintendents enjoyed the financial benefits but also recognized that farmers and ranchers made up the basis of the economy and for a time the bulk of the patient population at the asylum.

When A. P. Calhoun became superintendent of the renamed Western Washington Hospital for the Insane (WWH) in 1906, he criticized the institution’s continued focus on

⁶⁴ *Hospital for the Insane in the Territory of Washington, 1887*, 20.

⁶⁵ *Hospital for the Insane of the Territory of Washington, 1885*, 28.

⁶⁶ *Hospital for the Insane of the Territory of Washington, 1885*, 5.

⁶⁷ Washington State, *Second Biennial Report of the State Board of Control for the Term Beginning October 1, 1902, and Ending September 30, 1904: To the Governor and the Legislation of the State of Washington Ninth Regular Session, 1905*, (Spokane: Inland Printing Company, 1904), 34.

agrarian-centered labor. In his 1907 report, he argued against hospital's farm, once again, as Willard had, explaining that the soil surrounding the institution was unfit for heavy agricultural cultivation. "Any one at all familiar with the character of the soil here knows that it is out of the question to cultivate it and expect to get back as much as the seed cost."⁶⁸ He reasoned, "it is impossible for us to employ the number of patients who would like and who would be benefited by outside work."⁶⁹ Calhoun suggested the government build a new smaller hospital in "some good farming district" and "transfer a portion of [his] patients who would be benefited by outdoor employment."⁷⁰ He maintained that the meagre returns did not justify sustaining a farm at WWH.

The problem with relying on the farm extended beyond poor soil. Calhoun reasoned that a labor program was only therapeutically beneficial when the staff assigned a patient to a task that improved, or at the very least matched their skillset. When farmers made up the bulk of the population it was fitting to assign them to agrarian tasks. For the superintendent it was also simpler to put patients to work at familiar tasks upon entering the hospital. As Geoffrey Reaume argues, matching patients to tasks to which they were accustomed before entering the hospital "improved efficiency and reduced the need to train inmates."⁷¹ Accordingly, assigning patients to the farm was appropriate during the hospitals' initial decades, but the administration's continued support of agrarian practices did not match the hospital's changing patient demographics during the late nineteenth century.

⁶⁸ Washington State, *Fourth Biennial Report of the State Board of Control for the Term Beginning October 1, 1906, and Ending September 30, 1908: To the Governor and the Legislation of the State of Washington Eleventh Regular Session, 1909*, (Olympia: Jay Thomas, Public Printer, 1909), 36. Despite buying more land and draining the lake to get at the bottom soil, the hospital owned land was never suitable for extensive farming. The soil remained an area of soreness for the superintendents. Even by 1926, things had not improved, leading Superintendent C. E. Taylor to call the "sand and prairie" land a "joke." See page 23 of the 1926 biennial report.

⁶⁹ *Fourth Biennial Report of the State Board of Control, 1906-1908*, 36.

⁷⁰ *Fourth Biennial Report of the State Board of Control, 1906-1908*, 36.

⁷¹ Reaume, *Remembrance of Patients Past*, 152.

Before Calhoun became superintendent, the Puget Sound region experienced an economic shift: the increasingly urban area was developing a more consumer-based economy. Farming as an occupation was once ubiquitous, but after 1890 “laborer” had replaced “farmer” as the top occupation of male patients. In 1879, when Willard first reported the occupation of patients, “farmer” as a vocation held the top spot with 28 of the 61 men admitted during 1877-79 biennium; in contrast, there were only 8 “laborers.”⁷² By 1890, however, laborer replaced farmer as the number one occupation, and in the 1908-1910 biennium report, only 55, or 4%, were listed as farmers, whereas carpenters and laborers totalled 302, or 25%, amounting to just over half of all incoming male and female patients.⁷³ Horace Buttolph advised in his 1847 “Modern Asylums” article that “The employments of the insane should be varied according to their previous habits and professions.”⁷⁴ This ideal was not lost on Calhoun, nor were the changing economic realities of the region. With inmate demographics shifting away from agrarian-based activities the majority of the tasks people were willing and able to do in the hospital needed to alter also. Due to occupation changes and the poor soil of the immediate area surrounding Western hospital the superintendent pushed to put in place labor practices that reflected the needs of his patients and, as mentioned above, encouraged the state to build a new smaller mental hospital in an area that was better suited for extensive farming.⁷⁵

Calhoun did not want a large farming program at Western, although he still had patients work on the “farm, garden, lawn, [and in the] green-house.” He expanded labor offerings so that male patients had the option of working indoors at trade-based tasks found in the “engine room,

⁷² *Report of the Hospital for the Insane, 1879*, 31.

⁷³ Washington State, *Fifth Biennial Report of the State Board of Control for the Term Beginning October 1, 1908, and Ending September 30, 1910: To the Governor and the Legislation of the State of Washington Twelfth Regular Session, 1911*, (Olympia: E. L. Boardman, Public Printer, 1910), 92-93.

⁷⁴ Buttolph, “Modern Asylums,” 377.

⁷⁵ *Third Biennial Report of the State Board of Control, 1904-1906*, 36.

carpenter shop, tinshop, blacksmith shop, etc.,” while the females worked in the “sewing room, dining rooms, laundry, etc., and... allowed to do fancy work if they care.”⁷⁶ He supplemented the existing work program with a strong industrial therapy department. These areas offered skills that aligned better with the regional economic needs, and had the potential to help patients become productive members of society once paroled. Overall, he believed labor needed to teach, or maintain, a trade or craft that benefitted the patient upon returning to his or her community.

Calhoun wrote the work was never “compulsory” nor was it “hard, [or] allowed to become tedious.” Those who chose not to work obtained “their exercise from...daily walks.”⁷⁷ Calhoun also expanded the hospital’s recreation offerings, introducing activities such as weekly dances and baseball games to provide patients with additional physical pastimes. He wrote that his new expanded program “had a great beneficial effect” on the individual patient.⁷⁸ Once again merging recreation with labor, Calhoun believed that any activity, whether it was daily walks, writing letters “to friend and relatives,” or “amateur theatricals” provided a mental stimulant for the patients.⁷⁹

The Board of Control still wanted a large patient labor. Despite Calhoun’s new focus the Board appealed to the government for other ways to gain support for and expand Western’s agrarian activities. In 1909 the state legislature passed *An Act establishing the Western Washington Hospital Farm for the Harmless Insane*.⁸⁰ Although it was in the northern region of the Puget Sound and not physically connected to Calhoun’s hospital, it was for a time technically

⁷⁶ *Fourth Biennial Report of the State Board of Control, 1906-1908*, 38.

⁷⁷ *Fourth Biennial Report of the State Board of Control, 1906-1908*, 38.

⁷⁸ *Fourth Biennial Report of the State Board of Control, 1906-1908*, 38.

⁷⁹ *Fourth Biennial Report of the State Board of Control, 1906-1908*, 38.

⁸⁰ Washington State Legislature, *Establishing Western Washington Hospital Farm*, Session Laws of the State of Washington, Eleventh Session 1909, Compiled by Sam H. Nichols, Ch. 222, H. B. 145, (Olympia: E. L. Boardman, Public Printer, 1909), 754.

part of it.⁸¹ The Board of Control was pleased with this development. In their excitement, the Board expressed gratitude that political attitudes had improved concerning “those unfortunates who [had] become *charges upon the tax-payers*.”⁸² The image of the patient, accordingly, had transformed from someone who needed assistance from the state, to one who was a ward of the state. In the eyes of the fiscally-minded Board members, the people receiving treatment at the hospital were not patients so much as they were “financial charges.” They solidified money’s place within the patient-care equation, thus turning a medical or humanitarian situation into a financial one.

In the same report the Board of Control expanded on Washington’s patient labor program, this time overtly linking it to maintenance and finances. They argued, “No reason exists, save a lack of enterprise on the part of the state lawmakers, why the institutions should not be producing [sic] major part of their own subsistence.”⁸³ Here the Board, overlooked both the authority of the superintendent and the notion that in the hospital patient labor was intended to be therapeutic. As it were, the Board only saw the program in economic terms. They believed that “enlarging immediately the agricultural and pastoral areas of the state institutions is one that should engage the closest attention of the legislative body.”⁸⁴ To them a lack of suitable land approximating the institution, not the therapeutic needs of the patient, prevented the asylum from being self-sufficient.

The Board continued to link patient labor to fiscal benefits by arguing that the state taxpayer invested in the mental hospital and the best return on their investment was not the return of a family member, humanitarianism, or the altruistic notion of the improved mental health of

⁸¹ Eventually the government renamed the “Farm for the Harmless Insane” to The Northern State Hospital, making it the third, and last, mental hospital in the state.

⁸² *Fifth Biennial Report of the State Board of Control, 1908-1910*, 12. Emphasis added.

⁸³ *Fifth Biennial Report of the State Board of Control, 1908-1910*, 28.

⁸⁴ *Fifth Biennial Report of the State Board of Control, 1908-1910*, 30.

the state; the best return was more land. “[N]o investment of the taxpayers tends more to economy and to the betterment, money and physical, of the...charges of the state, than the early purchase of sufficient lands for institution sites to meet all future needs for agricultural and pastoral purposes.”⁸⁵ This financial focus reflected the Board of Control’s jurisdiction over all state institutions, including the penitentiary and training schools. In the hospital, work was a form of treatment and rehabilitation but in the other facilities it was a form of punishment masked as rehabilitation. Production became a visible way to chart if and how institutions were effectively rehabilitating their respective inmates. Despite their situation, that is to say whether they were a patient or a criminal inmate (labels the Board did not differentiate between), the “charges” at the various institutions were cared for at the taxpayer’s expense. These men believed that in order to ease the taxpayer’s burden, all institutions should expand their farming programs – this included Western. To this end there was much, the Board members argued, that “might be accomplished along economical lines by the adoption of a more liberal land-purchasing policy.”⁸⁶ They adopted an explicit fiscal attitude concerning the management of Washington’s inmates, regardless of the goals of the institution.

In spite of this economic mandate, Calhoun worked at doing what he believed was therapeutically best for his patients. Unlike Waughop, who merged economic with therapeutic to increase support for his practices, Calhoun was hesitant to link patient labor with hospital finances. Doing so meant losing the main objective of the program. To him work was, above all, a therapy; once politicians and the Board allowed money to influence its purpose then treating the patients fell second, and became subject to exploitation.

⁸⁵ *Fifth Biennial Report of the State Board of Control, 1908-1910*, 28.

⁸⁶ *Fifth Biennial Report of the State Board of Control, 1908-1910*, 29.

Calhoun adopted an alternate strategy and maintained that Western Hospital as a modern therapeutic institution and Washington as a young state had yet to emulate their modern eastern counterparts. “I would again call your attention to the need of establishing an industrial department. This branch of asylum work is becoming very popular in the East.”⁸⁷ In the east it was already a proven success and had shown to have a positive therapeutic return on any investment. Calhoun first adopted this type of comparative argument in 1909 when successfully asking the state for hydrotherapy facilities. He appealed to state politicians and brought his therapeutic milieu in line with national trends. By invoking the east both times Calhoun contended that Washington had yet to evolve to the status of other states, specifically in terms of medical advances and treatment of people with mental diseases. If the Board of Control or the legislature accepted industrial therapy as a viable treatment and put their budgetary concerns aside, Washington State would be at least striving to adopt the latest mental health advances.

As it was, WWH *was* ultimately a state institution that fell under the direction of politicians and was funded by the taxpayer. If the superintendent made expensive decisions based on medical advances, such as creating an industrial therapy department, the politically appointed members of the Board and politicians often stymied these developments due to the misunderstanding of whom to prioritise first: the patients or the tax-payers.

Calhoun, who was aware of his limited decision making authority, argued that if implemented, the industrial therapy program consist of many “profitable occupations” that benefitted the hospital.⁸⁸ He added that it helped many patients with acute disorders “grow to take an interest in their work.”⁸⁹ Western needed to have a variety of treatments. Agrarian

⁸⁷ *Fifth Biennial Report of the State Board of Control, 1908-1910*, 86.

⁸⁸ *Fifth Biennial Report of the State Board of Control, 1908-1910*, 86.

⁸⁹ *Fifth Biennial Report of the State Board of Control, 1908-1910*, 86.

options were limited to the needs of fewer and fewer patients. The government agreed with this reasoning and Calhoun officially adopted an industrial therapy department.

In 1913 Calhoun proclaimed that the new industrial department was the most beneficial improvement at the hospital.⁹⁰ In it the hospital staff taught a new variety of skills to the patients and, according to Calhoun, many of the acute patients were taking an “interest in this work and appear to enjoy it.”⁹¹ The following year he extended the industrial offerings outdoors leading to “a gradual extension of privileges and liberties,” spelling greater opportunities for and appreciation from the patients. He maintained that the primary function of work therapy “was to provide employment as a form of treatment, and *not as a money-making proposition.*”⁹² Nevertheless, he conceded, “we owe it to the taxpayers to conduct [the departments] in as economical a manner as possible.” Therefore, to emphasize that it was a financial success he stressed even as patients had “enjoyed and profited from the work...each department has shown a comparatively large profit” over its maintenance cost.⁹³ The department proved to be both therapeutically advantageous to the patients and financially beneficial to the state and taxpayers.

With the new unit in place, Calhoun admitted there was little incentive for the hospital to rely on patient labor as it traditionally had. This decision came after the hospital lost access to its “contingent fund” – a fund that permitted any institution that generated money, via the selling of products and patient made goods, to hold that revenue on site and reinvest it as needed. The Board of Control closed all the funds and instead had the money sent to the state’s general

⁹⁰ Washington State, *Sixth Biennial Report of the State Board of Control for the Term beginning October 1, 1910, and Ending September 30, 1912: To the Governor and the Legislation of the State of Washington Thirteenth Regular Session, 1913*, (Olympia: E. L. Boardman, Public Printer, 1912), 85.

⁹¹ *Sixth Biennial Report of the State Board of Control, 1910-1912*, 85.

⁹² Washington State, *Seventh Biennial Report of the State Board of Control and Fourth Biennial Report for the Board of Managers Washington State Reformatory for the Term beginning October 1, 1912, and Ending September 30, 1914: To the Governor and the Legislation of the State of Washington Fourteenth Regular Session, 1915*, (Olympia: Frank M. Lamborn, Public Printer, 1914), 54. Emphasis added.

⁹³ *Seventh Biennial Report of the State Board of Control, 1912-1914*, 54-55.

maintenance fund, which in turn folded the excess money into the following year's general budget. Under the new system, Calhoun argued, "there is no incentive to build up these different [labor] departments" as the hospital had to use part of its own general budget to maintain farms, gardens, and care for the livestock.⁹⁴ Continuing those agrarian activities meant investing money in areas that saw little reward for the patients. Calhoun instead shifted his focus to remedially rewarding programs. As it was, the budget situation remained the same, forcing the superintendent to cope with the restrictions while continuing a farming program.

Superintendents at WWH developed a practice of recording the improvements to the hospital, in addition to listing the various work achievements. This practice originally had a threefold purpose: it highlighted the upkeep of the institution. At the same time, it showed how this work helped save the state money. Finally, it demonstrated that patients were not idle. The reporting procedures emphasized that patients were performing normalizing tasks that ostensibly contributed to their personal improvement and that of the institution.⁹⁵ Despite these intentions, from the beginning, the superintendents failed to attribute the work to particular patients, or to differentiate between staff and patients. This process effectively attributed the savings and the work to the hospital as an entity. It also had the effect of marginalizing the patients by the system of reporting. Geoffrey Reaume argues in the case of the Toronto asylum that superintendents made similar efforts at Ontario's insane asylums; they praised individuals by name but avoided discussing labor in relation to groups of patients.⁹⁶ Superintendents at Western purposely did not attribute the tasks to the patients, thereby avoiding charges of mistreatment, exploitation, or more cynically, genuine recognition of patients' efforts. While the list became a way to identify

⁹⁴ *Seventh Biennial Report of the State Board of Control, 1912-1914*, 53.

⁹⁵ For more on how work became a normalizing marker in the asylum, please see chapter 5.

⁹⁶ Reaume, "Patients at Work," 76-77.

savings, the problem of marginalizing patients in favor of focusing on the hospital in general placed fiscal responsibility in front of the patients.

Listing patient work was a common practice in insane hospitals. Yet the justifications varied. In contrast to Washington, which placed the accomplishments in front of the patients, when Superintendent James MacNeill started presenting lists on the tasks completed at North Battleford, he made clear that they came from the labors of the patients. In Saskatchewan the work also took on a gendered tone. MacNeill and the asylum matron made sure to note the women worked at traditional female tasks, such as clothing manufacturing, sewing, and various gardening activities, while they attributed construction, farming, and livestock work to the male patients. As will be shown in the next chapter, this was to emphasize the *work of the patient*, not the work itself. By placing the patients at the forefront they, unlike their counterparts in Washington, emphasized their normative practices and skills. The superintendents at Washington made no such attempt, and never explained who was behind the work being done.

Listing the tasks in the official reports without attributing them to any group continued under Dr. William Keller, who replaced Calhoun as superintendent in 1914. Keller reported that he had introduced a “new system of landscaping” to the hospital, but failed to mention who the landscapers were, continuing the practice of non-attribution. Near the bottom of the section titled “Grounds, Roadways, Lawns, Etc.,” he boasted that at a regional flower show, “we” had won first prize in first and second classes, and second place for the “best exhibit made at the show.” He continued, “wherever allowed to compete, *our* garden products took first prize.”⁹⁷ His report does not reveal the role of patients. Superintendents assigned patients to work at landscaping

⁹⁷ Washington State, *Eighth Biennial Report of the State Board of Control and Fifth Biennial Report for the Board of Managers Washington State Reformatory for the Term beginning October 1, 1914, and Ending September 30, 1916: To the Governor and the Legislation of the State of Washington Fifteenth Regular Session, 1917*, (Olympia: Frank M. Lamborn, Public Printer, 1916), 75.

jobs, in the garden, and on the farms because they were generally unskilled tasks that patients often requested. In the report, however, Keller kept the workers anonymous, opting instead to use the term “we,” as though he and the staff worked them also. Through this process he continued the practice of marginalizing the patients from their accomplished tasks and from the fiscal savings of which they contributed. In Keller’s 1916 report, he listed 28 extensive improvements, in addition to repairing of all the surrounding fences, assisting on the new highway running through the property, trimming of 3,020 trees, and the planting of 7,216 feet of bushes.⁹⁸

WWH superintendents never reported where or even if the patients were specifically working. This practice highlights how much the program had changed at Western and in asylums in general. Work, or rather the products of work, indicated a person’s worth to society. Historian Richard Fox argues that society committed people to the asylum upon realizing they were “*both* bothersome and unproductive, a threat not just to familial or public tranquility, but also to canon of conduct characteristic of bourgeois society. Sanity was equated with rationality and rationality was identified...with capacity for and devotion to efficient labor.”⁹⁹ The desire to be productive was a way to measure one’s social worth and a way to determine their mental state. Superintendents established work therapy using this philosophy but over time their opinions in this regard became distorted. In the 1800s, work was for the benefit of patients – not the state. Even then there was confusion about its benefits. Historian Joel Braslow argues that in California, “superintendents could not separate the social benefits—‘more acceptable to

⁹⁸ *Eighth Biennial Report of the State Board of Control, 1914-1916*, 73-74.

⁹⁹ Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978), 174-175.

society’—from the therapeutic ones—‘hastens the recovery.’”¹⁰⁰ By the early 1900s, the concepts of work and therapy comingled and became inextricably connected.

Keller and his predecessors were keen to demonstrate that their hospital or asylum was productive, and were less concerned with proving that their patients were successful, industrious, or healthy. Keller equated productiveness with being a worthwhile member of society; by attributing many of the accomplishments and savings to the hospital he was proving the institution’s worth to the government and to Washington society. By framing it in that manner, however, he minimized the contributions of the patients as they spent their days working in the hospital under the principle of therapy only to have their efforts diminished in favor of institutional improvements completed under the premise of savings.

Cure rates and humanitarianism were supposed to be the focus of the hospital, but under Keller the more the “institution” as an entity achieved the better the hospital was and the more the state benefitted. He was not above embellishing the results of the farms to make himself and the institution appear more efficient, leading to an official rebuke from Washington’s Bureau of Inspection and Supervision reminding him of the importance of keeping “proper records” of “subsistence, heating, farm activities, etc.”¹⁰¹

When America entered World War I in 1917, Western’s burgeoning industrial program ended in favor of intensifying agricultural production at the hospital. The reports of that era from Keller and his wartime replacement, Dr. J. B. Laughart, (an assistant physician who served as interim superintendent while Keller served in the army) assumed a different tone. Their

¹⁰⁰ Joel Braslow, *Mental Ills and Bodily Cures: Psychiatric Treatment in the First Half of the Twentieth Century*, (Berkeley: University of California Press, 1997), 31.

¹⁰¹ “Correspondence from C. W. Clausen, Ex-officio Chief of the Bureau of Inspection and Supervision of Public Office, Olympia, Jan. 6, 1916, to Dr. Wm. N. Keller, Supt., Western Hospital for Insane,” Washington State Archives (WSA), Group: Western State Hospital, Sub: Farm & Dairy, 1896-1987, Accession no.: 95-A-213, box: 48.

descriptions of patient affairs or treatments were greatly reduced, while reports increasingly stressed patriotism and wartime efficiency. The Board of Control members joined this trend and often stressed economic efficiency as critical to the war effort.

Due to wartime economic restrictions, the Board explained that it had established an internal exchange system that benefitted all of the state's reform institutions. The Board claimed that it became apparent early in 1917 "that unless the most rigid economy were exercised and all resources conserved a deficiency of huge proportions would be created long before the close of the fiscal period." They opted to purchase items that cost less, but, as they claimed, did not impair "the efficiency of the institutions."¹⁰² Moreover, they established a "close co-operation between institutions in the matter of exchanging products" and ordered that "every foot of tillable ground" be cultivated "to increase the productive powers to the highest degree."¹⁰³ It did not matter that Western's superintendents continually argued that the land surrounding the institution was of low quality for extensive farming; in the face of an aggressive war economy the Board took steps to ensure the staff and the patients grew whatever the ground could bear.

To reduce costs further, the Board developed an internal economy where one institution focused on particular goods and traded their surplus with another. The level of efficiency that they established led them to boast there was no excess and "nothing has been left unused."¹⁰⁴ This level of frugality and focus was not new, they claimed. "It has always been the policy to secure the maximum amount of food-stuffs from the different institution farms" in order to

¹⁰² Washington State, *Ninth Biennial Report of the State Board of Control and Sixth Biennial Report of the Board of Managers Washington State Reformatory for the Term beginning October 1, 1916, and Ending September 30, 1918: To the Governor and the Legislature of the State of Washington Fifteenth Regular Session, 1919*, (Olympia: Frank M. Lamborn, Public Printer, 1919), 33.

¹⁰³ *Ninth Biennial Report of the State Board of Control, 1916-1918*, 33, 36.

¹⁰⁴ *Ninth Biennial Report of the State Board of Control, 1916-1918*, 33.

maintain an economical “per capita cost of maintenance.”¹⁰⁵ Once again, fiscal responsibility reigned in the institution.

In the aftermath of the war, the Washington government overhauled the bureaucracy that oversaw and handled its state institutions. In 1921 the legislature passed the “Administrative Code” that ultimately affected Western’s administration, its patient labor program, and set forward the process that allowed it to become more medically oriented. Before the Act, the Board of Control directly oversaw the hospital administration. Many of the changes, and all of the major ones, had to gain the Board’s approval before the superintendent could put them into practice. With this change in the law, a newly created Director of Business, who oversaw the new Department of Business Control, supplanted the Board of Control. According to the Act, the director and his department had all the same powers as the Board, “except the supervision of the custodial care and treatment of the inmates of the...state hospitals for the insane” – that responsibility the government finally gave to the superintendents.¹⁰⁶ The new department, however, was in charge of five sub-divisions surrounding the *maintenance* of state institutions: administration, purchasing, farm management, industrial management, and public buildings.

The Administrative Code also created a Director of Health position, which, along with the “head physicians of the women’s industrial home and clinic, the state custodial school and each of the state hospitals for the insane, and one woman physician,” made a Council that the government tasked with visiting the various institutions from “time to time.”¹⁰⁷ The main duty of this new Council was to advise the individual superintendents on the care, treatment, and dietary

¹⁰⁵ *Ninth Biennial Report of the State Board of Control, 1916-1918*, 36.

¹⁰⁶ Washington State Legislature, *Administrative Code*, Session Laws of the State of Washington Seventeenth Session, Convened January 10, Adjourned March 10, 1921, H. B. 11, Compiled in Chapters by J. Grant Hinkle, Secretary of State, Marginal Notes and Index by L. L. Thompson, Attorney General, (Olympia, Frank M. Lamborn, Public Printer, 1921), 24.

¹⁰⁷ *Session Laws of the State of Washington Seventeenth Session*, 35-36.

needs of the patients/inmates. The Act gave the superintendents of each institution, who had the “exclusive care and charge of the custodial treatment of the inmates” and the authority to “adopt the suggestions of the institutional board” or reject them.¹⁰⁸ It also specified that the director of business had to answer to the director of health on matters pertaining to “health and sanitation at the institutions.”¹⁰⁹ Overall, the act gave the superintendents “exclusive care and charge” of the patients at their institution, at Western Keller, who had returned from service, had the authority to adopt and redefine any routines to align with his own medical ideals.

Keller may have had the final say over the *care* and *treatment* of the patients, but his authority did not extend to the hospital’s farm and industrial management divisions, giving him limited say over the existing labor program. Politicians did not define these areas as therapeutic, allowing the state a way to keep patients at work. The superintendent, however, continued to provide input about the program. In 1921, Keller wrote to the Department of Business Control lamenting that the dairy farm was “least profitable in dollars and cents of all our departments on the farm... If we had been obliged to pay of our labor we would have been way in the red.”¹¹⁰ The correspondence from the 1920s concerning patient labor does not discuss therapy, the Business Control only wanted to hear about finances.

The state gave up any pretence it had about farming being a form of therapy in 1921. As outlined in the Act, the farm management division was motivated strictly by finances. Its director was required “To make a survey, investigation, and classification of the lands connected with the state institutions [to] determine which thereof are of such character as to be *most profitably* used for agricultural, horticultural, dairying, and stock raising purposes.” Under this rubric, the state

¹⁰⁸ *Session Laws of the State of Washington Seventeenth Session*, 36.

¹⁰⁹ *Session Laws of the State of Washington Seventeenth Session*, 24.

¹¹⁰ “Correspondence from Superintendent Keller to Department of Business Control, Olympia Wash., Apr. 24, 1921,” WSA, Group: Western State Hospital, Sub: Farm & Dairy, 1896-1987, Accession no.: 95-A-213, box: 48.

expected the farm to meet “the needs of all the state institutions for the food products that can be grown or produced,” to “establish or carry on suitable farming operations” in order “to exchange with, or furnish to, other state institutions, food products at the cost of production.”¹¹¹ After that the institutions had to option to sell or dispose any surplus goods. The state did not want goods furnished from the private sector, mainly because they did not want to pay the cost. What they did want was to have products grown, harvested, and finished at the cost of production, but in the most profitable manner.

Over the years, farming had become increasingly important to the state and the asylum for its financial benefits more than its therapy. Not all work had to be lucrative. Under the 1921 Administrative Code, the state admitted there was a place for industrial work in the asylum. Similar to the farming department, this branch established and maintained “such industries and industrial plants as may be most suitable and beneficial to the inmates.”¹¹² Yet, in contrast to the farm manager’s responsibility to make the farm profitable, the industrial manager had to operate the plants “at the least relative cost and greatest benefit to the state.”¹¹³ The Act explained that the farm and industrial departments had to be beneficial to the “inmates” and as such they had to take “into consideration the *amount and character* of the available labor of inmates at the...institutions.”¹¹⁴ The state judged its benefits in terms of money, nevertheless politicians realized that insisting on a work program that favored agrarian activities was not in the best interest of the increasingly non-agrarian patient population.

In 1923, the newly formed Department of Business Control reported on their industrial management division. They explained that the government secured \$100,000 to expand the

¹¹¹ *Session Laws of the State of Washington Seventeenth Session*, 26. Emphasis added.

¹¹² *Session Laws of the State of Washington Seventeenth Session*, 27.

¹¹³ *Session Laws of the State of Washington Seventeenth Session*, 27.

¹¹⁴ *Session Laws of the State of Washington Seventeenth Session*, 27. Emphasis added.

program at the various state institutions. The industrial department manager wrote, “It was assumed that the appropriation was made for the dual purpose of teaching the inmate [or patient] population useful trades and to permit a reasonable production of manufactured articles.”¹¹⁵ While still hoping to make a profit off its inmate/patient population, the people at the department wanted the industrial program to teach the population “useful trades” that prepared a “number of men” for “self-support [with] the knowledge acquired in the shops”¹¹⁶ In the report there was no reference to the program’s impact on women, apparently only men needed to learn “self-support.” Despite its gendered shortcomings the results were pleasing and the Business Control argued that \$100,000 was a sufficient investment. The division proved itself, they claimed, “not alone as a financial saving to the state, but of primary importance in its effect on the morale of the institution and the *opportunity afforded for useful instruction.*”¹¹⁷ The members of the Business Control understood the importance of the program and vowed to write a “special report” to the state legislature.

By 1923 Dr. David Livingstone had replaced Keller as the new superintendent of Western and for a time he maintained Keller’s enthusiasm concerning the farm. In a unique development, once the Board started seeing the value of industrial therapy, the superintendent highlighting how strong the farm program had become at the hospital. Western’s orchard and garden had done well enough that in 1923 it opened a canning plant for the surplus fruit and vegetables. In just two months of operation, the patients had canned 705 tins of vegetables, 402 tins of fruit, 633 jars of berries, and 1,041 jars of jellies – the estimated value being \$2,063.74. Minus the cost of staff labor and supplies (\$1,353.79), the hospital made a profit of \$709.95.

¹¹⁵ Washington State, *First Biennial Report of the Department of Business Control for the Term beginning October 1, 1920, and Ending September 30, 1922: To the Governor and the Legislature of the State of Washington Nineteenth Regular Session, 1923*, (Olympia: Frank M. Lamborn, Public Printer, 1922), 11.

¹¹⁶ *First Biennial Report of the Department of Business Control, 1920-1922*, 12.

¹¹⁷ *First Biennial Report of the Department of Business Control, 1920-1922*, 12. Emphasis added.

This led Livingstone to believe it “should be developed on a larger scale.”¹¹⁸ Much like his predecessor, he maintained a farming program that relied on patient labor. The farm and ranch produced \$8,844.11 worth of goods with an estimated \$3,857.50 still to be harvested. Additionally, the vegetable garden produced \$47,847.20 worth of goods, with an estimated \$4,000.00 still in cultivation.¹¹⁹

Industrial therapy, now under the new heading “occupational therapy,” made a resurgence in Western’s 1925 report. As mentioned in chapter one, historian Gerald Grob argues that despite its new heading, “occupational therapy was by no means a new idea.”¹²⁰ Livingstone was utilizing a term that was popular in the east to describe a program that assumed more than a passing resemblance to the one Calhoun implemented 10 years earlier. Livingstone explained, this program, which opened in 1923, had “proved to be the remedy excellence [sic] in the treatment of mental disorders.”¹²¹ The therapy offered daily “classes” for those with low-functioning mental disabilities, from there it utilized a graded system wherein patients moved to new areas based on their abilities and learned experiences. Instructors worked at arousing and maintaining the patient’s attention by having them perform tasks that were suited to their capabilities. Once the patients proved they were adept, the instructor promoted them to the next level and so forth. The overall goal was to take a “patient who formerly sat in a chair staring into space” and make them “an expert at...some...useful occupation.”¹²² On average, the process took 3 months for a patient to acquire a skillset.

¹¹⁸ *First Biennial Report of the Department of Business Control, 1920-1922*, 48.

¹¹⁹ *First Biennial Report of the Department of Business Control, 1920-1922*, 50.

¹²⁰ Gerald Grob, *Mental Illness and American Society, 1875-1940*, (Princeton: Princeton University Press, 1983), 258. See chapter one, page 65-64.

¹²¹ *Second Biennial Report of the Department of Business Control, 1922-1924*, 48.

¹²² *Second Biennial Report of the Department of Business Control, 1922-1924*, 48-49.

Livingstone was only superintendent for three years but during his time he reaffirmed the goal of the institution. As Hemenway wrote, “The primary object of placing persons of unsound mind in an asylum is their permanent cure.”¹²³ Western was a therapeutic mental hospital. The Department of Control started their 1927 report on Western by stating, “It will be our aim to report, not how cheaply we are operating this institution, but what we are doing with the patients.”¹²⁴ Although economic efficiency remained important, the discourse had shifted to emphasize the welfare of the patients over the finances of the state.

Conclusion

The farm, garden, and ranch were fixtures at Western from the late 1870s until 1965 when they finally closed and the mental hospital focused its treatments exclusively on helping patients restore their mental health through clinical interventions. During its formative years the concept of patient labor engaged politicians and medical authorities in a debate over responsibility within the institution. The hospital administration treated patients interchangeably as contributing members of a hospital economy, while the justifications for their work differed as part of their upkeep or therapy.

From 1871 to 1875 Hill Harmon utilized patient labor ostensibly as a way to save money. In truth, however, he used it for personal monetary gain. He kept patients in the asylum long after the superintendent cleared them for parole, thereby reducing the number of workers he needed to hire and pay to maintain the institution. The reduced paid staff allowed Harmon to keep a large share of the money the government paid to care for the patients. Despite this abuse, Rufus Willard, who became superintendent in 1877, retained a strong work therapy program. He

¹²³ *Report of the Resident Physician, 1871-1873*, 8; See also: *A Supplement to the Late Asylum Controversy*, 4-5.

¹²⁴ Washington State, *Third Biennial Report of the Department of Business Control for the Term beginning October 1, 1924, and Ending September 30, 1926: To the Governor and the Legislature of the State of Washington Nineteenth Regular Session, 1927*, (Olympia: Jay Thomas, Public Printer, 1927), 18.

believed physical activity was an important factor in treating insanity. He favored work over recreation and stressed the financial potentialities it had on the hospital finances. In this manner he solidified it as a cost saving measure.

Notwithstanding his deep commitment to patient labor, Willard took a nuanced approach in advertising it to politicians. He believed the activities needed to match the patient's physical capabilities and established skills in order to be of the best therapeutic value to the patient. Nevertheless, beginning in the 1880s, under Superintendent Waughop, finance overshadowed therapy in the hospital's reports as the most notable benefit of patient labor. By focusing on areas such as farming, gardening, livestock, and construction the various Board members and superintendents sought to emphasize institutional efficiency. Their political aim was to underscore the hospital's value to the government, society, and the taxpayer.

By the twentieth century superintendents, specifically Calhoun and Livingstone began advocating for a more nuanced justification of patient labor. Echoing the ideals espoused by Willard they argued work and physical activities needed to benefit the patient over the hospital. They borrowed some principles from eastern experiences and their concept of therapeutic work evolved to match the economic environment of the Puget Sound region.

The Washington government made positive strides when they passed the 1921 Administrative Code, which gave the superintendent the final say over the care and treatment of the patients in the hospital, and effectively medicalized mental health in Washington. The superintendent answered to an institutional Board of Health, but he had the authority to reject their recommendations. Even so, their advice came from a medical point-of-view, not a political one as it had under the Board of Trustees and the Board of Control. Consisting of politicians or people with political aspirations most of the men on these former Boards were favored politics

over medicine.¹²⁵ This resulted in them arguing in favor of economics and institutional efficiency. The 1921 Code changed that and brought medicine to the forefront. While the Act was a progressive step, by adding that the farm must operate at the greatest “benefit to the state” and that occupational therapy had to run “at the least relative cost and greatest benefit to the state” state legislators again placed the needs of the state and the taxpayer above those of the patients.

¹²⁵ Ernest Lister, who Governor John Rogers appointed as the first chairman of the Board of Control, later became Governor of Washington from 1913-1919. All members of the Board of Control were political appointments and it was not uncommon for the members to be replaced following state elections.

Chapter Five

Wearing and Tearing: MacNeill Showed Patients Could Still be “of some value”

In mid-June 1919, Superintendent James MacNeill, received a telegram from Saskatchewan’s Deputy Minister of Public Works, J. M. Smith. The message was succinct and straightforward, “Great War Veterans complaining about patients working on your summer cottage— Better have them returned.”¹ Smith did not explain why the veterans had complained. MacNeill, however, did not believe that a few patients working off asylum grounds with minimal supervision was cause for complaint.

As a physician and brief politician MacNeill understood how to maneuver in order to prevent political opinions from influencing his practices. He wrote a lengthy response questioning the telegram. Perhaps, he speculated to Smith, the veterans believed the superintendent did not have the authority to have patients on his property, let alone put them to work. Alternatively, it may have been the type of work: that improving a house was not therapeutic and MacNeill was abusing his authority by utilizing the patients for his personal affairs. Lastly, the superintendent wrote, the veterans might view the patients as a “menace to the Public and should be kept within the confines of [the asylum].” MacNeill held steadfast in his position. He told to Deputy Minister Smith, “the Great War Veterans evidently propose to dictate to your Department the policy of this Hospital.”² “The trouble is,” he wrote to Smith, “people think they know something of mental diseases, when, as a matter of fact, they know less about them than any branch of Medicine.”³ MacNeill did not write that in reference to himself. He

¹ Correspondence, Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 17 June 1919, Public Works Department (PWD): Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, Saskatchewan Archives Board (SAB), Collection no. R-195.2, File no. 1.95.

² Correspondence, Superintendent MacNeill to Deputy Minister Smith, 17 June 1919.

³ Correspondence, Superintendent MacNeill to Deputy Minister Smith, 17 June 1919.

believed that with his training and experience as head of Saskatchewan's Provincial Insane Asylum, he was an expert on mental diseases.

MacNeill justified his actions to Smith by arguing that it was necessary to have patients do repairs on his cottage. Indeed, he needed to make his summer home livable because he was removed from his rental home and the government had not yet found him a suitable place in which to live. He explained to Smith that he “did not wish to embarrass your Department of the government” by having the family of the superintendent be homeless. Therefore he had sent patients up to his summer home to prepare it for year-round living until the Department was able to obtain a more permanent place for his family.⁴

MacNeill further defended his actions by arguing that everyone working at his home “was there at his own request... they all wished to be left there;” moreover, “they enjoyed the outing immensely.” He continued “the best authorities in the United States are of the opinion that a place where a semi-official supervision of patients can be obtained is of great value to them.”⁵ Working under minimal supervision allowed the patients to recapture a sense of personal freedom. He surmised that the chief concerns likely stemmed from the possibility that patients might escape. MacNeill, however, impressed upon the deputy minister that the people at his cottage were “trust patients” – individuals who, as he explained, had improved under his care and were able to practically come and go from the institution as they pleased. According to MacNeill, no one had complained about them in the past.⁶ The superintendent did not recall the patients back to the asylum before they had completed their “outing.”

As highlighted in the previous chapters and the opening example, MacNeill was a stubborn man who despised unsolicited advice. He did not easily bow to governmental pressure

⁴ Correspondence, Superintendent MacNeill to Deputy Minister Smith, 17 June 1919.

⁵ Correspondence, Superintendent MacNeill to Deputy Minister Smith, 17 June 1919.

⁶ Correspondence, Superintendent MacNeill to Deputy Minister Smith, 17 June 1919.

nor did he appreciate when non-medical people attempted to “dictate” hospital policy. He typically became upset when he felt challenged by people who lacked his level of expertise. There are more than a few instances when the superintendent adopted a belligerent position against residents and politicians or became angry when political actions and opinions affected his patients or the quality of care for his patients.⁷ For example, in 1932 “a hard hit wife” of an attendant sent a letter to the Department of Public Works asking when the superintendent was going to stop using hospital funds to send patients and the hospital’s official painter to his summer home to improve it.⁸ She feared that his “orgy of spending” would negatively affect her husband’s pay. Deputy Minister Smith forwarded the letter to the superintendent. MacNeill once again defended his use of patient labor, while at the same time demeaning the opinion of the “hard hit wife.”⁹

He replied with, “the letter is a tissue of lies coated over with certain facts that exist.” He explained that he personally assigned patients to clean, paint his house, and, as it turned out, plant his garden, none of which he saw as a problem. Using patients in this capacity “is a privilege which had always been extended to any member of the staff if there is any particular work to do... It is a privilege which is extended to the Superintendent and...staff in any...Institution of this kind.” He continued by stating, “I am not a believer in the doctrine that the employees are the best judges of how an Institution or an Industrial Plant should be run. I believe that there must be a Management, and the Manager must be experienced and qualified to run the place – the time may come when the employees will be qualified enough to know how an

⁷ There are more examples in chapter 3 “North Battleford Hospital and Changing Public Opinion in Saskatchewan.”

⁸ A Hard Hit Wife to the Hon. J. F. Bryant Esq., Minister of Public Works. Saskatchewan PWD: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95.

⁹ Hard Hit Wife to the Hon. J. F. Bryant Esq.

Institution should be run, but certainly not the class of people I have around me.”¹⁰ While MacNeill was cordial to his medical colleagues, he was often belligerent when others outside questioned his authority.

MacNeill’s responses also provide insights into how he viewed patient labor. Of all the issues he anticipated when writing his reply about the veterans’ complaints, he failed to consider that their objections might have stemmed from the fact that the patients were working at his residence when they should have been cared for at the asylum. In MacNeill’s estimation, even as the “trust patients” were working on his home, they were still receiving care. Echoing the opinion of other superintendents throughout Canada and the United States in the early 1900s, he believed patient labor in any form was an advantageous therapy.

Even though MacNeill was not above promoting its financial benefits to gain political support, he initially validated work therapy due to its therapeutic applications. At the Western Washington hospital, most of the superintendents bowed to political influences of the various departments of the government, who, in their own ways, ensured patient labor remained a program dictated by finances rather than therapy. The provincial hospital at North Battleford, by contrast, did not encounter the same issues.

In the *Saskatchewan Provincial Hospital Battleford* booklet published in the 1920s, MacNeill’s Assistant Superintendent, A. D. Campbell, outlined the hospital administration’s philosophy behind its patient labor program. His perspective is reflective of mid-nineteenth century justifications for the program. “It is bad for a normal, healthy person to be idle. It is even more important that any person affected with mental trouble should have his or her time

¹⁰ Medical Superintendent, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works, Province of Saskatchewan, 3 August 1932, PWD: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, 132.P.

occupied as far as possible.”¹¹ Campbell and MacNeill believed, as did Western Washington’s David Livingstone who made similar arguments in his 1924 report, that idleness was evil and any healthy person who was idle was damaging their physical and mental health.¹² Work provided a way to remedy that. Not only did patients work to stave off and potentially overcome their mental troubles, it also highlighted their worth to others, including the staff, people who visited the hospital, and society. At North Battleford Hospital labor was very much an outward manifestation of therapy in action and mental health achieved.

MacNeill justified expanding the work therapy program based on its therapeutic benefits. In the hospital’s official reports and his correspondence with politicians, he framed patient labor as a marker of normality. Through patient labor MacNeill presented to the public the relatable image of a productive working patient being a “normal” resident of the province. Through the hospital bazaars and provincial exhibitions, where patients sold and exhibited their hospital made goods and livestock to the public, and through public tours, and interviews he extended this image into the community. The more frequent and harder the patients worked, the more they solidified their reputation as productive people completing relatable tasks. This view of labor, which MacNeill presented in medical language, spoke to the working people of the province. It was a concept the public came to accept.

Under the superintendent’s direction, the hospital purchased and cultivated nearby tracts of land for farming and patients built or assisted in erecting many of the asylum structures; they painted buildings, landscaped the property, and cared for livestock. If the weather proved to be too inclement the superintendent had them work indoors helping in the kitchen, doing laundry,

¹¹ *Saskatchewan Provincial Hospital Battleford*, prepared and published under the direction of Hon. A. P. McNabb, Minister of Public Works, (SAB) PW 2, Special Publications, (Regina, Saskatchewan, Date unknown), 18.

¹² *Second Biennial Report of the Department of Business Control for the Term beginning October 1, 1922, and Ending September 30, 1924: To the Governor and the Legislature of the State of Washington Nineteenth Regular Session, 1925*, (Olympia: Frank M. Lamborn, Public Printer, 1924), 48-49.

cleaning the wards, or working in one of the hospital's many occupational therapy rooms. While these developments are typical of early 20th century North American mental hospitals, MacNeill took to patient labor with great enthusiasm while downplaying or relegating other medical advances.

MacNeill's firm belief in the therapeutic results of patient labor explains its longevity at North Battleford while he remained superintendent. Historian Cheryl Warsh outlined a similar experience at the Homewood Retreat in Ontario. Under the administration of its superintendent, Albert Hobbs, the Retreat adhered to moral treatment, which she attributes to Hobbs' firm belief in the active treatment. Once Hobbs went into "semi-retirement," patient care became a system of overused "hypnotics and sedatives."¹³ The personality of the head physician dictated the livelihood of some therapies and methods.

In Saskatchewan, while MacNeill remained head physician of the North Battleford mental hospital, work therapy remained a constant feature of daily life for patients. Other mental hospitals, such as Western Washington, underwent numerous changes in hospital administration and developed a more varied approach to patient labor. With an average tenure of approximately 5 years, each superintendent utilized a singular technique, and some even questioned its benefits all together.¹⁴ The circumstances at Washington, however, were more indicative of national changes in asylum therapies: despite varying degrees of acceptance by superintendents, once politicians saw its financial benefits, hard labor (i.e. farming, construction, and various patient led agrarian activities) became mainstays in the mental hospital.

¹³ Warsh, *Moments of Unreason*, 125.

¹⁴ To clarify: Hard labor is a specific term that I will use to denote more physically demanding tasks some patients were required to do, e.g., farming, landscaping, raising livestock, construction. However, that does not necessarily exclude these activities when I use the term patient labor or work therapy.

The case of Western Washington reveals how superintendents, sometimes in contrast to national trends, resisted hard labor activities as therapy. In their own way superintendents Stacy Hemenway, John Calhoun, and David Livingstone questioned the inherent value of patient labor. Due in large part to the personalities of the superintendents, Western and North Battleford differed in their approaches to patient labor. When MacNeill accepted his first patients he immediately set them to work improving the grounds and preparing for the farming season.¹⁵ In Saskatchewan there was little debate over patient labor and MacNeill deferred to few critics.

Work therapy underlines the diverse influences that shaped western North American asylums. Washington and Saskatchewan illustrate that while their first mental hospitals followed similar paths – that being they both defined patient labor practices as farming, gardening, ward work, and raising livestock – a closer inspection reveals the nuanced goals of the individual programs. Work therapy provided the vehicle to demonstrate how, at times, superintendents and politicians defined the practice as a financial benefit while at other times the superintendent shaped it to be a culturally acceptable practice that validated the social value of the patients. Walking the line between these two concepts allowed MacNeill to gain both political and public support for the program. Emphasizing its financial value ensured political support for a program that he believed was therapeutically advantageous. During the times when he underplayed its financial value in favor of stressing its therapeutic benefits MacNeill was presenting patient labor in a manner that helped him gain public support while hoping to avoid any accusations of it being exploitative.

¹⁵ “The Patients Have Arrived at Asylum,” *Battleford Press*, February 5, 1914; “New Provincial Hospital for the Insane Received First Patients,” *Saskatchewan Herald*, February 6, 1914.

The Changing Theoretical Justification of Patient Labor

According to Andrew Scull, superintendents developed work therapy based on the notion that it reawakened rational thought and compelled people in the asylum to internalize the acceptable social standards of hard work and individual productivity.¹⁶ If successful, the program allowed people to leave the institution to once again “compete in the marketplace.”¹⁷ The founding members of the Association of Medical Superintendents of American Institutions for the Insane (AMSAMI), believed in this concept, though they did not justify it in such economic terms. They allowed their personal conceptions of social-morality to dictate their understanding of insanity and the individual’s perceived place in the community.¹⁸ They increasingly relied upon patient labor to inculcate acceptable social behaviors into their patients, thereby teaching them an appropriate work ethic as defined by their social values.

Historian Geoffrey Reaume contends that patient work, while justified by superintendents as instilling normative social values, was never as therapeutically advantageous as they declared. Without the superintendent’s propaganda clouding the issue, he argues it was an exploitative practice used to improve the asylum and save the government money. The escalation of work therapy in mental asylums was motivated by “the need to pay for the maintenance” of the institution.¹⁹ Under the guise of therapy, the staff assigned people in the institution to complete tasks that benefitted the institution more than the patient. Accordingly, the “reality of patient labor and the impetus for pushing it forward...was quite different from the theory that justified

¹⁶ Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective*, (Berkeley: University of California Press, 1989), 52.

¹⁷ Scull, *Social Order/Mental Disorder*, 94.

¹⁸ Gerald Grob, “The State Mental Hospital in the Mid-Nineteenth-Century America: A social Analysis” in *The American Psychologist* 21, no. 6 (1966), 512.

¹⁹ Reaume, “Patients at Work: Insane Asylum Inmates’ Labour in Ontario, 1841-1900,” in *Mental Health and Canadian Society*, ed. James E. Moran and David Wright (Montreal & Kingston: McGill-Queen’s University Press, 2006), 69.

it.”²⁰ Validated in terms of providing quality physical activities while keeping the mind focused on a task and away from morbid thoughts, the program was in effect a way to mitigate high institutional costs.

Under the pragmatic economic application, patient labor steadily grew in popularity throughout North America insane asylums, as highlighted in the Western Washington Hospital. Historian James Moran agrees with Reaume and argues a “more practical aspect of patient work” was to “offset the costs of asylum maintenance.”²¹ The money saved from labor helped administrators justify the asylum to the government. Moreover, the program became central to daily patient activities, as superintendents argued there was a “close diagnostic relationship between mental and physical condition[s].”²² In effect, they believed, by working the patient’s body they were also improving their mental state. Most significantly, perhaps, the repetitious activities helped, according to Moran, instill “regular and sober habits that medical superintendents considered essential to patient recovery.”²³ In this capacity superintendents merged medical understandings with physical labor and productivity.

MacNeill believed that personal management and the ability to work with minimal supervision were key indicators of patient recovery. He understood that both of these markers were possible to obtain through his various work therapy programs. From occupational therapy rooms to outdoor work activities, MacNeill sought to enrich a patient’s work ethic and teach them skills that once paroled improved their social standing, or at the very least provided them with essential skills to re-enter the workforce. For him to teach these essential skills he had to look outside his institution in order to shape his program along regionally appropriate lines.

²⁰ Reaume, “Patients at Work,” 70.

²¹ James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal: McGill-Queen's University Press, 2000), 93.

²² Moran, *Committed to the State Asylum*, 92.

²³ Moran, *Committed to the State Asylum*, 92.

Historian Matthew Gambino argues that as part of the “new psychiatry” of the 20th century, superintendents began looking “beyond the walls of the asylum” and defined mental health as a “combination of personal responsibility and civic engagement.”²⁴ Physicians focused on providing activities that strove to enhance an individual’s worth within their community. This perspective, accordingly, developed a different “therapeutic paradigm: reintegration of the patient into a largely secular order whose dominant relations were among the citizen, the family and the state.”²⁵ Social assimilation and an individual’s value to the community solidified themselves as new secular therapeutic markers. Through work superintendents sought to restore within their patients principles that stressed a hard work ethic, order, and social responsibility. At the North Battleford hospital MacNeill based his treatments on Saskatchewan’s predominantly agrarian social and work values; he constructed work therapy to reflect what many people in the province did on a daily basis, tasks they had come to define as “normal.” He turned to the society he served and defined patient labor in ways that ensured its cultural acceptability to Saskatchewan residents and the provincial government. Moreover, by adapting treatments to local standards, he taught skills to ensure the reintegration of patients into Saskatchewan’s social order once, or if they were paroled.

According to historian Bill Waiser, in the early 1900s the Canadian government “sought out immigrants who had a history of working the soil, settlers who possessed the determination to survive on their own and bring the prairies under cultivation.”²⁶ In its early years as a province, 80 per cent of Saskatchewan’s population consisted of rural farmers. Years later, during World War I, when the government failed to secure federal contracts for munitions and

²⁴ Matthew Gambino, “‘These strangers within our gates’: race, psychiatry and mental illness among black American at St. Elizabeths Hospital in Washington. DC, 1900-40,” *History of Psychiatry*, 19 no. 4 (Dec. 2008): 387-388.

²⁵ Gambino, “These strangers within our gates,” 388.

²⁶ Bill Waiser, *Saskatchewan: A New History*, (Calgary: Fifth House Ltd., 2005), 64.

manufacturing, many urban dwellers left the province to seek industrial jobs elsewhere. Those who stayed, according to Waiser, “had to survive on business mostly generated by the agricultural sector.”²⁷ From its origins, due to its rich prairie soil, agriculture was a pillar of the Saskatchewan economy and culture. It has supported the province even as other economic areas struggled to expand in the same capacity. With farming and other similar hard labor tasks (i.e., construction, raising and slaughtering livestock, etc.), MacNeill focused in on activities that were regionally appropriate but also economically viable for the asylum, though he vocally argued that work therapy benefitted the patients first.

MacNeill always used work therapy at the asylum, yet he promoted his use of occupational therapy before actively advertising hard labor practices. It was not until after the Canadian National Committee for Mental Hygiene (CNCMH) visited in June of 1920 that he switched focus. Under his labor program, MacNeill was not shy about attributing many farming, livestock, and construction accomplishments to the patients. Western Washington, on the other hand, did not praise, acknowledge, or attribute any of “accomplishments” to their patients (save their assistance in building the new asylum structure). While Washington’s superintendents kept the patients at arm’s length, Saskatchewan Hospital, North Battleford, or more appropriately MacNeill, embraced and even praised their efforts.

MacNeill and the Construct of the Valuable Patient

Before it became a province, the Canadian prairie region that was to become Saskatchewan saw an influx migrants attempt their hand at farming. Waiser explains, “Saskatchewan was the land of opportunity” according to Canadian immigration literature. “The new province,” he continues, promised “two things that gave it an edge over other Canadian destination: good farmland and lots of it;” the promise of which incited “tens of thousands of

²⁷ Waiser, *Saskatchewan*, 209.

people” to migrate to this “agricultural wonderland.”²⁸ Most came driven by the promise of 160 acres under the *Dominion Lands Act* of 1870. “The Homesteaders Act,” as the 1870 act came to be known, promised 160 acres of prairie land to any male (excluding First Nations) if they cleared and cultivated at least fifteen of it, constructed a dwelling, and resided there six months of the year. As part of the agreement, the homesteaders needed to demonstrate that they had improved the land and increased its overall value with minimal government assistance. The federal government designed these markers in such a way that ensured homesteaders were, as the Canadian interior minister Clifford Sifton believed, according to Waiser, “sturdy, independent [people] who placed individual progress and achievement above everything else.” They were to be “the best settlers... who persevered and succeeded on their own.”²⁹ These feats proved difficult for many, 40 per cent of the migrants cancelled their contracts between 1871 and when the program ended in 1930.³⁰

Leading up to 1905 and thereafter, even through a post-war recession and drought of the 1920s and 30s, the province developed an economy and culture dominated by agriculture.³¹ Successful farming, ranching, and related activities became a way to gauge progress and personal achievement. For his part, Superintendent MacNeill took these cultural labor ideals, based around farming, and fashioned them as markers of normality in his hospital. His patients were not necessarily poor or failed farmers.

MacNeill used work as a means to “re-instil” acceptable behaviors in order to compensate for the irregular ones exhibited by insanity. He argued that with proper therapies

²⁸ Waiser, *Saskatchewan*, 102.

²⁹ Waiser, *Saskatchewan*, 105.

³⁰ Waiser, *Saskatchewan*, 105. Waiser notes that “Two out of every five homestead applications in the three prairie provinces between 1871 and 1930 were cancelled; the failure rate actually climbed above 50 per cent during the last two decades of the program.” (105)

³¹ Waiser, *Saskatchewan*, 101-38; 209-221; 256-67.

“enthusiasm and a correct habit of thought can be cultivated amongst our people” at the asylum.³² To create “enthusiastic” patients and help them adopt “correct thoughts” the superintendent used relatable work practices with which many of the patients were already familiar. Delores Kildaw, in her short history of the Battleford hospital argues “Most of the patients were farmers, so the farm always generated a ready supply of skilled labor.”³³ This was not lost on MacNeill, who made that connection early in his career. “[O]f course, it would be expected,” he maintained, “that, as our’s [sic] is an agricultural province entirely, we should have a large proportion of farmers and farmers’ wives.”³⁴ According to the superintendent, patients were more than willing to work at tasks such as planting, growing, and harvesting crops, or raising livestock in the summer, when the weather permitted such activities.³⁵

The idea of patient labor in Saskatchewan’s mental hospital began before the government selected a location for the asylum. When Dr. David Low sent his report to the provincial government recommending a building style and location for Saskatchewan’s insane asylum, he prefaced it with unsolicited proposals relating to the employment of the asylum’s inmates, wherein he stressed the hospital be located on “an abundance of land, and let it be of the very best and richest of farming land.” He believed “employment in the open air had been found one of the most efficient methods of bringing about recovery in the insane; and the various employments of agriculture constitute the most easily provided means of supplying this essential

³² Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1919-1920 Ended April 30, 1920*, SAB, Pubic Works (PW) 2, (Regina: J. W. Reid, King’s Printer, 1920), 21.

³³ Delores Kildaw, *A History of the Saskatchewan Hospital North Battleford, Saskatchewan* (Saskatoon: Health Care Administration, University of Saskatchewan, College of Commerce, 1990-91), 42.

³⁴ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1915-1916 Ended April 30, 1916*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1916), 38.

³⁵ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1916-1917 Ended April 30, 1917*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1917), 39.

in the pleasantest and most acceptable way to the patients.”³⁶ Before the government settled on a location, Low justified a patient labor program because farming offered, as he believed, the easiest means of curing the insane in the “pleasantest and most acceptable” manner.

Low noted that the climate in Saskatchewan did not allow for year round farming. To keep the patients working, he advised the government build workshops to keep patients “employed at various trades” such as “shoemaking, tailoring, broom making, fancy carving,” and weaving “rag carpets.”³⁷ The women can work year-round making floor mats, rugs, brushes, and mattresses for the institution. With this arrangement, he argued, the asylum and the government could save money by ensuring all the “repairing and mending [was] done in the workshops.”³⁸ Low presented the argument in favor of work therapy in a manner that stressed its therapeutic benefits but ended by noting the financial advantages of the system, thus ensuring the attention of fiscally skeptical politicians. This was a tactic adopted by MacNeill who sometimes extolled the financial gains patient labor afforded the asylum thereby stressing the program’s value to politicians. Nevertheless, because he saw his asylum as a curative institution, he often underplayed finances in favor of promoting therapeutic benefits.

Low’s opinions reflected the broader practices of Canadian and American mental hospitals.³⁹ He proposed Saskatchewan’s new provincial asylum within the accepted discourse of North American institutions. He suggested adopting relatable practices favored within the broader public sphere of Saskatchewan, highlighted most notably by his proposal to establish a

³⁶ “The Low Report,” Dr. David Low to The Lieutenant Governor in Council. May 1, 1907. SAB T. C. Douglas Papers. Collection no. R 33.5. File no. III, 127. (14-8)g, Folder 2 of 8, pg. 2. See chapter one for a closer look at “The Low Report.”

³⁷ “The Low Report,” 5.

³⁸ “The Low Report,” 5.

³⁹ “The Low Report,” 1.

strong farming program. Although the government rejected much of Low's report, they accepted the recommendations to include patient labor.

On February 5, 1914, the day after the first patients arrived by train at North Battleford from Brandon, Manitoba, the *Battleford Press* ran an article announcing their arrival. At the end of the article, the reporter remarked on what a beautiful place the asylum was going to be. Explaining that a landscape engineer was already on the hospital grounds demarcating roads and drawing up plans to beautify the surrounding land, the article reported, "Practically all this manual work will be performed by the patients, as well as the farm work."⁴⁰ Despite the newspaper's information about the type of work, MacNeill abstained from explicitly linking patients to hard labor activities, both in official reports and to the public. Although he revealed that he utilized certain tasks to help patients feel comfortable in the hospital, he primarily focused on lighter activities offered through his occupational/industrial therapy program (i.e., sewing, cleaning, crafts, laundry, etc.) in order to illustrate to politicians and the public the therapeutic benefits work had on the patient.⁴¹

In the first annual report, MacNeill explained that he had "employed" 68.8% of the females and 56.5% of the males "in some form of work." He presented both a male and female list of "patients employed." Recognizing that many of the patients were laborers, farmers, and house workers before arriving at the asylum, he had them work at relatable tasks that allowed them to do something familiar. He kept the females working indoors doing "ward work" (cleaning the wards), "fancy work," laundry, sewing, and cleaning employees' quarters. While the males also performed ward work (the wards were separated by gender) and assisted in the laundry and kitchen, they also worked as clerks in the hospital store, graded the land, worked on

⁴⁰ "The Patients Have Arrived at Asylum," *Battleford Press*, February 5, 1914.

⁴¹ In his annual reports, MacNeill often switched between "occupational" and "industrial" when describing his work therapy program.

the garden and farms, assisted with carpentry tasks, and raised livestock. As the male activities expanded the following year to include more construction and outdoor activities, the female activities remained the same. MacNeill justified this gendered work offerings on the basis that “it is wise in order that the individual may feel himself placed in surroundings more like that to which he is accustomed.”⁴² With this discourse he framed patient work as normalizing activities. To the patients they worked and made their time in the hospital feel more akin to their life before they were institutionalized. To the public, the tasks were relatable to their own everyday activities and knowing that patients worked at relatable activities made the patients themselves more relatable. From the outset, MacNeill constructed the concept that working patients were normal people, despite being affected by mental diseases.

MacNeill expounded on his occupational therapy program. Utilizing phrases such as “light and pleasant,” “very beneficial,” and “desirable” he argued that this work was valuable for the patients, as it “diverts their thoughts” and acts as a “mental stimulant.”⁴³ Labor kept patients interested in something other than their “delusions.” The hospital did have a farm and raised livestock. However, when MacNeill discussed these labor-intensive tasks, the descriptions were initially restrained and separate from sections describing the therapeutic value of work.⁴⁴ Because his medical background shaped his goals as a superintendent, therapeutics and the benefits they provided to the patients quickly became a priority in MacNeill’s reports. The financial benefit they yielded was of lesser concern, but nonetheless it was something worth promoting from time to time. He was, however, careful to announce these claims, perhaps in an

⁴² Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1914-1915 Ended April 30, 1915*, (Regina: J. W. Reid, Government Printer, 1915), 64. In the text of the report MacNeill gives the approximate 68.8 and 56.5 percentages. However, when he lists the tasks (separated by gender) he claims 70% of females and 73% of males were working. For the males it was quite an increase.

⁴³ *Annual Report of the Department of Public Works, 1914-1915*, 73.

⁴⁴ *Annual Report of the Department of Public Works, 1914-1915*, 73.

effort to avoid family members accusing him of exploiting patients. Nevertheless, the cautious melding of therapy and finances allowed the superintendent to gain wider acceptance for his program. But by first emphasizing the therapeutic rewards work had for the patients, he claimed that the financial advantages were a secondary, almost unintended consequences of the original purpose.

In the reports, MacNeill presented a patient labor program that focused on occupational therapy and catered largely to women. Owing to the “sale of work done” by the female patients at the Christmas Bazaar, MacNeill noted, the hospital “realised a sum of money [\$500] which considerably added to the Christmas cheer of our patients.”⁴⁵ Here the superintendent merged the therapeutic and financial benefits of labor. Female patients, he wrote, were already working at activities that he believed provided them with a “mental stimulant.”⁴⁶ They crocheted, did “solid and eyelet embroidery, drawn thread work and plain sewing,” or as he termed it “pick up work” – work that the female patients were able to partake in during their free time.⁴⁷ Due to their efforts the hospital had an abundance of patient-made goods to sell to the public at its bazaar. The profits of the patient made goods allowed the staff to purchase holiday gifts for patients who had little or no outside support. Although a secondary advantage, the financial bonus yielded from the items became indirectly therapeutic as they improved the hospital atmosphere and contributed to patient cheer.

The positive results encouraged MacNeill to increase the number and range of patient manufactured goods. He stated it was the “endeavour [of the hospital] to manufacture *everything* that is used by the women on the premises.”⁴⁸ The activities were therapeutically beneficial for

⁴⁵ *Annual Report of the Department of Public Works, 1916-1917*, 39.

⁴⁶ *Annual Report of the Department of Public Works, 1914-1915*, 73.

⁴⁷ *Annual Report of the Department of Public Works, 1914-1915*, 73-74.

⁴⁸ *Annual Report of the Department of Public Works, 1916-1917*, 39.

the women as all “occupations aid to divert the patient’s attention from themselves and have very beneficial results.”⁴⁹ Expressed as a “therapeutic benefit” the superintendent nonetheless expanded his “diversional occupations or industrial arts” program for the financial advantages.⁵⁰ He was quick to dedicate larger rooms for sewing patient clothes, attendants’ uniforms, and making mattresses. His “hope” was to “extend this department so as to manufacture all the clothing used in the institution.” MacNeill did not limit the patients to clothing; he also had the patients manufacture “restraint jackets and strong suits.”⁵¹

The asylum’s matron, who remained unnamed in the reports, echoed these sentiments. She explained that the “modest” success from the Christmas bazaar was due to the industrial arts program being in “its infancy” and the women only working on a small number of projects. By next year, she hoped to expand to include many more projects. Nevertheless, she maintained that work had a therapeutic effect in that it helped distract patients from his or her issues.⁵² Like MacNeill, the matron walked the line between financial and therapeutic when presenting patient labor to politicians. While the “modest” \$500 was a financial benefit, she maintained, the real success of labor was the therapeutic advantages it afforded the patients. With the superintendent and the matron focusing on the female work, due its “therapeutic benefit” and generating a modest financial return, they presented the hospital’s limited industrial therapy offerings as successful. Its success, however, was restricted to the hospital setting as both administrators failed to link it to patients leaving the institution.

With the extreme low temperatures and bouts of heavy snowfall, the winters in Saskatchewan became an obstacle for MacNeill as he strove to establish an outdoor labor

⁴⁹ *Annual Report of the Department of Public Works, 1916-1917*, 47.

⁵⁰ *Annual Report of the Department of Public Works, 1916-1917*, 39.

⁵¹ *Annual Report of the Department of Public Works, 1915-1916*, 44-45.

⁵² *Annual Report of the Department of Public Works, 1916-1917*, 47.

program. He wanted something for the men that proved as advantageous as the occupational program had for the women, but remained under the parameters of acceptable male occupations. He did not assign men to the sewing room, nor did he have them crochet or do embroidery. Although he initially asked to expand the industrial rooms to include male oriented activities, such as shoemaking, he ultimately wanted the men to work at outdoor activities. He desired more farming land, a greenhouse to garden year-round, a bigger barn, and more construction projects; to offer more activities that were traditionally considered appropriate for male laborers.

He requested funds from the government to first expand the hospital to build workshop for the men, in order to employ them “to their own advantage.” Because he understood promoting the financial advantages helped ensure political approval, he added the work would also benefit “the hospital in many ways.”⁵³ MacNeill’s solution differed from the problem. The dilemma, as the superintendent presented it, was that the male patients were idle during the winter months, they were not participating in, nor were they receiving the “beneficial” and “desirable” work therapy. With space for a workshop, he believed he was able to rectify the situation. To gain political approval, however, MacNeill stated that the shop would benefit both the patient *and* the hospital. His combining of the benefits was an approach that he adopted with the women’s program: the benefits of the program extended to both the hospital and the patients, albeit in a tenuous manner. When asking for an expansion of offerings for the male patients he assumed a similar tactic. As a physician MacNeill wanted to place the wellbeing of the patients above all else.

While MacNeill advertised the dual benefits of patient labor to politicians, the program sometimes put him in direct conflict with the public. In late August of 1917 S. Brackett sent a

⁵³ *Annual Report of the Department of Public Works, 1916-1917*, 39. Emphasis added.

letter to the superintendent concerning his friend N. Castle who was a patient at the asylum.⁵⁴ The letter stated that Castle had been “confined” in the asylum for almost a year and “has been working painting for some months.” According to Brackett, there was nothing allegedly wrong with the patient yet he was “held there still.”⁵⁵ When MacNeill forwarded the letter to the deputy minister of Public Works, his addendum stated that he had recently discharged Castle from the hospital and he did not “think any other explanation is necessary.”⁵⁶

Brackett was not concerned with Castle working; he did, however, take issue with Castle remaining in hospital working as a painter despite being “alright...for some months.” Laboring as a painter for MacNeill, Castle was performing a skill that outside the asylum earned him financial compensation. Under the guise of therapy, however, the superintendent abused his position over Castle, as he had with other patients. MacNeill kept him in the hospital months beyond what was necessary in order to improve the asylum while saving the government money. The superintendent, in effect, committed “slavery,” to borrow sociologist Harley Dickinson’s term, to provide cheap labor for the hospital.⁵⁷

Dickinson, in his book on Saskatchewan’s mental hospitals, maintains the staff at the North Battleford asylum exploited the patient labor program in many ways, such as using the patients “as private servants” for the “in-hospital management and medical staff.”⁵⁸ This, according to Dickinson, “gave rise to intermittent charges of slavery and unjust internment by

⁵⁴ All patient and patient family and friend’s names have been changed.

⁵⁵ Letter to “Attorney General, Province of Saskatchewan, 4 Aug., 1917,” PWD: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, SAB, Collection no. R-195.2, File no. 1.95.

⁵⁶ “Medical Superintendent MacNeill, Saskatchewan Hospital Battleford, to Deputy Minister of Public Works J. M. Smith, Province of Saskatchewan, 13 Aug., 1917,” PWD: Deputy Minister’s Personal File, North Battleford Mental Hospital, 1910-1935, (SAB), Collection no. R-195.2, File no. 1.95.

⁵⁷ Harley D. Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984* (Regina: University of Regina, 1989), 28.

⁵⁸ Dickinson, *Two Psychiatries*, 28.

inmates, their relatives and disgruntled hospital employees.”⁵⁹ There were many unintended negative consequences for both the patients and the staff, apart from those outlined by Dickinson. In the 20th century mental hospital, labor was both a therapeutic application and a curative marker. The harder a patient worked the better they purportedly were and the more responsibilities the staff assigned them, sometimes with decreased supervision. Under MacNeill, workers eventually earned the status of “trust patients” and were close to achieving parole.⁶⁰ The harder a person worked to prove their sanity, however, the more valuable they became to the hospital economy, which in many cases lowered their chances for parole. There was a direct correlation between labor as a therapeutic and cost cutting system, and increased operating costs as valuable workers remained in the asylum. Despite this, and despite Dickinson’s other claims that patient labor “had the potential to develop into a ‘political crisis’” and that it became “a continual source of conflict between in-hospital management and the government department to which they were responsible,” MacNeill maintained and continually enlarged his work therapy program during his 30-year appointment as superintendent.⁶¹

From 1914 to 1920 MacNeill developed more “suitable occupations” for the patients in his industrial arts department.⁶² In 1918 he sent an assistant abroad to study occupational programs at other mental hospitals. Despite his zeal for a strong program, MacNeill repeatedly indicated to the government that overcrowding and lack of space hindered his efforts.⁶³ The

⁵⁹ Dickinson, *Two Psychiatries*, 28.

⁶⁰ The patients who were working at MacNeill’s cottage in the opening section, for example, were “trust patients.”

⁶¹ Dickinson, *Two Psychiatries*, 28-29.

⁶² Canadian National Committee for Mental Hygiene (CNCMH), “Mental Hygiene Survey of the Province of Saskatchewan,” *Canadian Journal of Mental Hygiene* 3, no. 4 (Jan. 1922): 343.

⁶³ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1915-1916 Ended April 30, 1916*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1916), 38; *Annual Report for the Financial Year 1916-1917*, 39; Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1918-1919 Ended April 30, 1919*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1919), 46. In his reports to the government, MacNeill consistently used the terms occupational and industrial arts interchangeably.

Canadian Military Authorities agreed, when, in 1918 they visited the Battleford asylum to inspect it for military personnel returning from the European war. They reported that the North Battleford hospital suffered from a “lack of employment and suitable occupations” for the patients, primarily due to overcrowding.⁶⁴

The government struggled to expand space at the North Battleford institution to meet the needs of the growing patient population and the industrial departments. If the government invested in more space, MacNeill reasoned, the number of idle patients would be reduced.⁶⁵ Because he was appealing to politicians, the superintendent took the opportunity to focus on the financial benefits of patient labor. He explained the patient-made wares “is of good quality, and no difficulty has been experienced... in finding sale for the product of the patients’ labour.” A stronger program would mean more patient made goods to sell. Fearing politicians might lose sight of his therapeutic goals within the promise of monetary benefits, MacNeill assured them patients needed to be “kept ‘busy,’” at a “variety” of occupations that appeal their “every variety” of needs. Balancing both, he concluded that if done correctly the expansion would be an “advantage to the patient” and also an “economic advantage of the state.”⁶⁶

The government was not negligent in their efforts to enlarge the hospital, and each time they built additional spaces MacNeill developed his own labor department further. In 1915, a year after opening, the asylum finished construction on a new male ward, which immediately relieved some of the overcrowding. Despite the new rooms, MacNeill warned “if the [patient] receiving service continues as large as at present, our capacity will again soon be overtaxed.”⁶⁷

⁶⁴ As quoted in: CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 343.

⁶⁵ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1919-1920 Ended April 30, 1920*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1920), 21.

⁶⁶ *Annual Report of the Department of Public Works, 1919-1920*, 21.

⁶⁷ *Annual Report of the Department of Public Works, 1915-1916*, 38

The new space, however, allowed the superintendent to open a new patient-run mattress room, placing greater demands on the female sewing workers.⁶⁸

By 1919 he was looking forward to the completion of a small tubercular ward that only held “between 30 and 40 patients.”⁶⁹ Although relatively small (the last addition accommodated up to 200 patients), the new ward expanded their patient work “very greatly,” despite the fact that occupational therapy departments already included “the kitchen, bakeshop, sewing room, mattress maker’s shop, tailor’s shop, laundry, dining rooms, stock throughout the institution, women’s wards and work in industrial therapy.” The added ward provided space for a “new shoemaker’s shop.”⁷⁰ Moreover, to ensure that all the who were able to work did so, MacNeill opened additional rooms in the tubercular wing to include basket, wood, and “toy making” shops, the latter of which he hired a “returned soldier, from Toronto” to supervise.⁷¹ Although designed to isolate and treat patients who developed tuberculosis, the new wing significantly increased the occupational therapy program.

In 1920 the CMHC visited the North Battleford asylum. The Committee, while praising the “pre-eminence” of the institution, wrote that the “most outstanding feature of the work at Battleford is the development in occupational therapy.” Because it “produces the best results” the Committee suggested further extending the program to all the patients. They reasoned that a “fully occupied” population was “easy to manage.” Furthermore, a busy hospital with diverse offerings was a “happy home for inmates.”⁷² They shared MacNeill’s frustration that the

⁶⁸ *Annual Report of the Department of Public Works, 1914-1915*, 74.

⁶⁹ *Annual Report of the Department of Public Works, 1918-1919*, 46. In the 1920 annual report MacNeill revised his estimation to “about 45 patients.” (p. 21)

⁷⁰ *Annual Report of the Department of Public Works, 1918-1919*, 54.

⁷¹ *Annual Report of the Department of Public Works, 1918-1919*, 21.

⁷² CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 344.

institution was at a disadvantage due to lack of space and recommended the government “erect a special industrial building” dedicated to the labor and recreations needs of the patients.⁷³

Feeling emboldened, MacNeill used the Committee’s recommendations to push for an expansion of his patient labor program. In fact, his 1920 annual report largely centred on occupational therapy. It became the superintendent’s primary focus and he vowed to extend the program “at all times.”⁷⁴ His efforts, however, were hindered by a paucity of space and lack of diversity in activities that failed to inspire the patients. MacNeill did not want the politicians to lose sight of the therapeutic benefits of physical activities, but he also stressed the financial benefits. He agreed that housing and not “employing” patients is “expensive from every standpoint,” nevertheless “employment alone is not sufficient” to treat insane patients. He suggested, recalling the CNCMH report, a “recreation building” to house the “Occupational Therapy, gymnasium, skating, swimming pools, drill, etc.” With this new building, MacNeill envisioned his therapeutic offerings including leisure-based activities. These recreational pursuits, he believed, would create a new “interest in life” in his patients and help them be “of some value to society” once again.⁷⁵ Lastly, he reasoned “[r]ecreation and workrooms cost less and are infinitely superior to empirical drugs, so often resorted to.”⁷⁶ By focusing on the financial aspect – that is to say, emphasizing the one-time investment to erect a “recreation building” over the repeated investment of drugs – MacNeill was able to frame the therapeutics borne of physical activities as more advantageous and cheaper than drugs.

⁷³ CNCMH, “Mental Hygiene Survey of the Province of Saskatchewan,” 344.

⁷⁴ *Annual Report of the Department of Public Works, 1919-1920*, 21.

⁷⁵ *Annual Report of the Department of Public Works, 1919-1920*, 21.

⁷⁶ *Annual Report of the Department of Public Works, 1919-1920*, 21; also please see: Territory of Washington, *Report of the Resident Physician at the Insane Asylum of W. T.; Ordered Printed by the Legislated Assembly*, (Olympia: Prosch & McElroy, Printers, 1871), p. 5. In Western’s report, Hemenway was arguing for more amusement, which he defined, in part, as “healthful gymnastic exercises” over the repeated purchase of drugs.

The 1920 report highlighted many of underlining ideals North American asylum superintendents had developed relating to work therapy. MacNeill had established links between labor, exercise, the exorbitant cost of repetitive and ineffective drugs, and proper mental health in his hospital. He advanced work and physical activity as *the* curative marker in his hospital: after a patient adopted a strong work ethic he or she had to potential to become a “value to society.” Through labor, he argued, he was able to cultivate “[e]nthusiasm and a correct kind of thought” within his patients.⁷⁷ As such, if the government funded an expansion to the program he believed he could engage more patients in work, with the ultimate goal of returning them to the community. According to Geoffrey Reaume, this was a nineteenth century bourgeois view, which “judged a person’s worth by whether she or he was a good, reliable worker.”⁷⁸ Although that was an outdated middle-class view of the previous century, it continued in Saskatchewan where a steadfast worker remained a feature of acceptable behavior.

The matron, who once again remained unnamed and whose opinion was confined to the annual reports, also strengthened the links between productivity, usefulness, and work when in the 1920 report she explained why labor was a therapeutic success at the asylum. “Patients employed,” she argued, “are much happier working and creating articles of use than they would be with nothing to occupy their time.”⁷⁹ Beyond extolling the advantages of physical activities had on the mind, the matron underlined the positive effects work had on the patients when they made “useful” items specific to the maintenance of the asylum. Owing to occupational therapy, patients became happier, more productive members of the asylum population and were working toward a cure. Their happiness, she argued, was directly linked to their productivity. The matron further claimed that “some of the cures we attribute entirely to the work done in this

⁷⁷ *Annual Report of the Department of Public Works, 1919-1920*, 21.

⁷⁸ Reaume, “Patients at Work,” 83.

⁷⁹ *Annual Report of the Department of Public Works, 1919-1920*, 31.

department.”⁸⁰ She was the first to explain what ultimate “therapeutic benefit” work had on the patients. Supporting MacNeill in that it ultimately benefitted the patients as much or more than the hospital, she argued that occupational therapy was essential in achieving the hospital’s curative goals.

Work therapy, as outlined above by the administration of North Battleford, had many virtues. It allowed the hospital staff to easily care for the growing population, provided a daily ordered schedule, maintained the hospital on the cheap, and offered the patients activities that inculcated regular habits of thought, leading to their “cure.” It also proved to be an effective public relations tool. Speaking at a public event, MacNeill publicized work therapy as “one of the best agencies to restore mental balance.” Because of his tenacity at developing the department “North Battleford mental hospital,” he argued, “was recognized all over the continent as one of the foremost in the successful application of that treatment.”⁸¹ MacNeill explained to the public that not only did he offer “one of the best” known therapies, his efforts were such that it made the North Battleford asylum, and by extension the province of Saskatchewan, internationally known for its efforts at restoring “mental balance to the afflicted.”⁸²

At a more local level, work therapy provided a way to normalize the asylum patients to the residents of Saskatchewan. Relatable work had the added benefit of introducing familiar activities within a strange environment, thereby easing patients into the hospital setting. Though work also helped develop and maintain patient skills, MacNeill understood that it had the potential to do more if the public was able to witness the results of a patient’s efforts. By

⁸⁰ *Annual Report of the Department of Public Works, 1919-1920*, 31.

⁸¹ This comes from a newspaper clipping without the name of the paper nor a date of the article. However, the clipping can be found in: Public Health Department: The Sask. (Mental) Hospital, Weyburn Corresp. Of Supts. R.M. Mitchell and A.D. Campbell with Supt. MacNeill, Battleford Mental Hospital, 1921-31, SAB, Collection no. PH. 3, File no. A.9.

⁸² Unnamed newspaper clipping, Public Health Department: The Sask. (Mental) Hospital, Weyburn Corresp. Of Supts. R.M. Mitchell and A.D. Campbell with Supt. MacNeill, Battleford Mental Hospital.

exhibiting it to the public, work therapy helped solidify links between patient productivity, understood normality, and public opinion.

MacNeill sponsored a booth that exhibited and sold finished patient-made products at the Saskatoon and North Battleford Exhibitions, in addition to hosting an annual bazaar at the asylum. When examining the products at these events, the asylum matron claimed she repeatedly heard people remark, “surely, anyone who can do such beautiful work cannot be ill.”⁸³ The public reaction suggested that people were impressed with the finished products, believing insane people incapable of producing such “beautiful” work. The quality of the final product defined patients as “not ill;” work directly helped define patients as healthy “normal” or capable people.

It took a concerted effort that lasted many years, but MacNeill and his staff solidified the connection between patient work and normality. The “good results” achieved through the program and the “intense interest” due to “the sale and exhibition of [patient] work,” allowed the superintendent to expand his program into different venues that were economically and culturally relevant, yet consistent with both national medical trends and the economic and culture of the region, thereby allowing him to continue to stress the normalization of patients through their productivity.⁸⁴

As he vowed in the 1920 report, MacNeill’s support of work therapy grew stronger in the years following the CNCMH visit. In 1922 he praised patient labor, placing it above all other hospital therapies. “It is beyond question, to my mind, that no expenditure made at this hospital was of more value than the equipment for the carrying out of our occupational therapy.” By their own admission, he claimed, many patients expressed that if they had not worked “they would

⁸³ *Annual Report of the Department of Public Works, 1919-1920*, 30-31.

⁸⁴ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1922*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1922), 50.

never have gotten well.”⁸⁵ Due almost exclusively to its positive effects, MacNeill argued, patients were able to leave the institution. For the superintendent to parole a patient from North Battleford, or to “get well” as he wrote, meant they accepted order in their habits and developed a strong personal work ethic; it did not necessarily mean they had fully recovered, but that they had gained important skills that placed them on the path to overcoming their illness and reintegrating into the community.

MacNeill wrote in his 1922 annual report, “It has been said by one superintendent in a recent article that the road to recovery is by way of occupational therapy, and this has been our experience.”⁸⁶ He continued in this capacity, further explaining the benefits of patient labor also extended outside of the institutional walls. “Building up the will of the patient and making him again, so that he can adjust himself to society when he is discharged, is the work few are doing by our occupational therapy, and, we believe, successfully.”⁸⁷ He believed more than anything else offered in the hospital work made a person’s body and mind healthy again.

Two years later, MacNeill’s support of the department changed. While the program still produced “good results,” he admitted “no one method of treatment” helped people improve enough for them to be paroled from the hospital. Occupational therapy alone no longer exclusively alleviated mental conditions. But neither did anything else. Together with an enlarged hydrotherapy department, however, work therapy did “produce results which, before their use, were not thought possible.” Hydrotherapy, the means to treat patients with various water activities, grew in popularity during the end of the nineteenth and into the twentieth century. As historian Joel Braslow argues, it was the “first widely acknowledged effective

⁸⁵ *Annual Report of the Department of Public Works, 1921-1922*, 50.

⁸⁶ *Annual Report of the Department of Public Works, 1921-1922*, 50.

⁸⁷ *Annual Report of the Department of Public Works, 1921-1922*, 50.

somatic therapy of the twentieth century.”⁸⁸ He maintains “physicians found hydrotherapy to be a genuinely scientific means by which to act upon their psychiatric patients' biology in order to effect mental cures.”⁸⁹ Echoing the medical literature of 1920s, one psychiatrist from the University of California Hospital in San Francisco argued that hydrotherapy was the most advanced “scientific treatment for acute excitement of the insane.” It helped to “rid the system of toxins and poisonous matter in the constitution.” The application of water on an excited patient, the psychiatrist argued, brought “blood to the surface and relieve[s] the congestion in the brain and spinal cord, which in most cases seems to cause the excitement.”⁹⁰ The therapy provided an alternative to drugs, which at that time consisted almost exclusively of non-therapeutic sedatives.

At North Battleford, hydrotherapy consisted of electric cabinet bathes – temperature regulated steam cabinets heated by electricity – needle spray showers, shower and splash baths, salt baths, etc. According to MacNeill, the most popular and most therapeutic offering were the “continuous baths,” where people reclined in a hammock, were immersed in water with the exception of the head, and had continuous warm water run over them.⁹¹ This, he argued, calmed patients when they became excited. Although he praised the expansion of and benefits from hydrotherapy, MacNeill did not lose faith in the positive effects of patient labor. In his 1924 report he softened the previous elevated position he had given to work and argued that a variety of therapeutics “are essential... one supplements the other” when treating insanity.⁹² In highlighting the innovative hydrotherapy department, MacNeill unintentionally altered the ultimate benefits of patient labor. Whereas in 1922 it was by work alone that people “got well,”

⁸⁸ Joel Braslow, “History and Evidence-Based Medicine: Lessons from the History of Somatic Treatments from the 1900s to the 1950s,” *Mental Health Services Research* 1, no. 4 (1999): 232.

⁸⁹ Braslow, “History and Evidence-Based Medicine,” 232.

⁹⁰ In the Matter of the Investigation of Agnews State Hospital. (1919). California State Archives, Sacramento, California. As quoted from Braslow, “History and Evidence-Based Medicine,” 233.

⁹¹ *Saskatchewan Provincial Hospital Battleford*, 17-18.

⁹² Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1924*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1924), 66-67.

by 1924 hydrotherapy with labor produced “good results” in the patients. His altered opinion shows he was not above redefining the perceived benefits of labor, but only when necessary, and in a manner that retained its professed importance in relation to new therapies.

From 1914-1925 superintendent MacNeill defined work therapy as duties performed by patients, e.g., basket weaving, toy making, etc., that taught skills and potentially prepared people for parole. In 1925, under the heading of occupational therapy, the superintendent altered that definition when he listed activities such as “cleaning, dusting, weeding, road working, shelling peas, or even keeping themselves tidy” in place of activities that the hospital had traditionally used.⁹³ MacNeill explained that while other patients “were given work which requires more initiative and sociability” the staff tasked some patients with these basic undertakings.⁹⁴ In addition to unskilled labor he also included road work under the occupation heading. These variations permitted him to move outside the occupation rooms and broaden what constituted work treatment by suggesting any corporeal activity was advantageous, including maintenance-based tasks and personal hygiene. If a person was incapable of working but was capable of achieving mental health, MacNeill, who predominantly used one’s productivity as a sign of a healthy mind, needed additional markers, such as “keeping themselves tidy.” He expanded the ideal of what represented curative activities by extending it toward patients who were unable to perform physical labor and outdoor activities.

In 1926 overcrowding once again became an issue at North Battleford. The population had been “steadily increasing each year,” MacNeill wrote, “and the day is not far distant when

⁹³ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1925*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1925), 70.

⁹⁴ *Annual Report of the Department of Public Works, 1924-1925*, 70.

further accommodation will need to be provided for the treatment of the mentally ill.”⁹⁵ The superintendent always strove to develop the work therapy program in tandem with the patient population and the expansion of hospital wards. Nevertheless, overcrowding hindered his efforts in that regard. Unlike 1919, when the government built a new ward and then in 1921 transferred many patients to the new provincial hospital in Weyburn, relief from overcrowding at the North Battleford Hospital was not forthcoming. Confronted with these conditions, MacNeill began moving patients into rooms previously utilized for occupational work while also widening his definition of “suitable occupations” by deliberately accentuating agrarian, livestock, and construction practices. According to him, this outdoor work created a “marked benefit” to the patient’s “mental health,” as it had in the workshops.⁹⁶ He moved into these areas to offer patients more opportunities to receive treatment while still remaining within the framework of what constituted normality that he had established over the years at the hospital.

MacNeill deepened his commitment to outdoor activities because they provided him with the necessary areas to extend his therapeutic offerings. “A great deal of work was done,” he wrote in 1926, “both inside and outside the buildings.”⁹⁷ Neglecting the occupational rooms he described the value of patient labor in relation to how it benefitted the hospital structures, while at the same time moving the focus of work outdoors. As he had in the past, after he explained the benefit of patient labor on the institution he emphasized the therapeutic returns afforded the patients. “We have continued our policy of having as many patients as possible employed on the farm and in the Gardens and Grounds and always with marked benefit to their physical and

⁹⁵ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1926*, SAB, PW. 2, (Regina: J. W. Reid, King’s Printer, 1926), 69.

⁹⁶ *Annual Report of the Department of Public Works, 1925-1926*, 69.

⁹⁷ *Annual Report of the Department of Public Works, 1925-1926*, 69.

mental health.”⁹⁸ Without identifying the work under any specific label in the report, MacNeill strengthened the links between therapeutic work and outside activity undertaken by the patients.

Once MacNeill defined outdoor work as a benefit to the patient and the hospital he stopped identifying it as separate from his accepted occupational activities. Instead of focusing only on work completed in the hospital building as therapeutic, he included tasks performed outside, such as construction, farming, landscaping, and raising livestock into that definition. The government recognized his reformed designation of work therapy and promoted it through the *Saskatchewan Provincial Hospital Battleford* booklet. The booklet, emphasized, among other things, what a beautiful place the hospital was. “I had no idea you had such a beautiful place here,” according to MacNeill this was the statement frequently uttered by relatives of patients who have visited the place.⁹⁹ In the booklet MacNeill stressed that the government erected the hospital in a naturally tranquil area, which he had since improved upon. By utilizing patient labor he had transformed the grounds and the hospital into a serene and beautiful place. The existing roads were “kept in splendid repair” and “miles of new roads have been laid out,” all of which was “furnished by the patients.” They did not just work the roads, MacNeill explained, patients also planted trees, grass, and flowers. They worked the farms, gardens, and raised livestock, in addition to building barns and other supplement structures. Most of the 2,236 acres used were “under cultivation.”¹⁰⁰ The superintendent wrote that the patients farmed or worked the land in some capacity. Reaffirming the matron’s opinion from the 1920 report, he argued that the patients who worked were “far happier and easier cared for and their recovery is much more rapid than if they have nothing to do.”¹⁰¹

⁹⁸ *Annual Report of the Department of Public Works, 1925-1926*, 69.

⁹⁹ *Saskatchewan Provincial Hospital Battleford*, 5.

¹⁰⁰ *Saskatchewan Provincial Hospital Battleford*, 5.

¹⁰¹ *Saskatchewan Provincial Hospital Battleford*, 13.

MacNeill was convinced that he was helping people through his work program. However, work affected people in many ways, as highlighted in the following examples. Depending on the circumstances the financial stress of sending someone to the asylum was sometimes more than a family unit could handle. The families on the outside suffered due to a lack of income coupled with the need to pay for their family member receiving treatment, while inside the asylum the government benefitted at the hands of the patients. Even if the patient was not the main source of income for the family, placing a loved one in the institution often times put the family in a situation that adversely affected their own labor situation. For example, Harry G. was a farmer and a husband who, in 1917, went to the asylum. While he was at North Battleford, he left his wife, Ellie, and their shared farm behind. Ellie, it appears, was willing to do whatever was necessary to make sure her husband received the proper care necessary to get him healthy and return home. However, the situation proved difficult because she lost her sole source of income: her farmer husband. Whether Ellie was unwilling or unable to work the farm is never mentioned in the correspondence. Nevertheless, while Harry was institutionalized Ellie went around her hometown “ekeing [sic] out an existence by scrubbing and doing other odd jobs.”¹⁰² For her husband’s stay and treatment, the government billed her \$240, which she was unable to pay. She and her husband had a farm but without Harry working it, it fell into disrepair. Eventually, Ellie had to put the farm under the control of the provincial administrator of lunatics’ estates and, coupled with the \$5 a week she could spare, began paying off her husband’s substantial debt.

Women were not the only ones affected. Men felt the pressure too. Daniel C. sent his wife, Barbara, to North Battleford in the winter of 1918. Four months later, he wrote to Premier Martin, asking for her release. In the letter, Daniel claimed although “she is getting better” he

¹⁰² “Letter from J. Jarrett to Premier Martin, Dec., 18, 1917,” SAB Scott Fonds I. 153, (40,716 – 40,905). Social Welfare: Mental Defectives, 1917-1921, M4. File no. 40,722 – 40,723.

was unable to get a statement from the “authorities of the Asylum” concerning when she would return home. Daniel was not troubled that his wife might spend extra time in the asylum while she was “getting better.” Rather, somewhat self-importantly, he claimed, “I am a very busy man, and have very little time to look after my two boys.” If he knew “exactly” when his wife was to be released, he “could arrange [his] business accordingly.”¹⁰³ Barbara’s stay in the asylum hindered Daniel’s work at home.

Labor, especially gendered notions of it, affected people and families in different ways. While Harry worked in the hospital, perhaps as a farmer, doing the same work he did at home, his wife Ellie suffered and had to take on multiple menial jobs just to “eke out an existence” and eventually gave up control of her farm. On the other hand, without the help of Barbara, “very busy man” Daniel did not have the time necessary to devote to his job while raising his two boys. He needed his wife at home to care for the children so that he could do his work. Having patients in the asylum and constructing a treatment regimen around a normalizing socio-activity such as work often disrupted other people’s idea and efforts of doing their own “normal” work.

Inside the hospital MacNeill espoused ideology about how labor was in the best interest of the patients. Yet these people left jobs in the home or community to perform similar tasks in the institution. On the inside, however, neither MacNeill nor the state compensated them or their families for the labor. In the community or at home a citizen could expect to receive some form of return for their labors; inside the hospital, financial compensation was non-existent. One common argument levied against paying patients was that they worked for their room, Board,

¹⁰³ “Letter from [name redacted], Shellbrook Saskatchewan, to W. M. Martin Premier of Sask. April 16, 1919,” SAB Scott Fonds I. 153, (40,716 – 40,905). Social Welfare: Mental Defectives, 1917-1921, M4. File no. 40,821 – 40,823.

and therapy.¹⁰⁴ Put in more altruistic words, as Deloris Kildaw does when writing about the farming program at Battleford, patients worked for many reasons including themselves, less fortunate patients, the asylum, and the government.¹⁰⁵ To compensate for their labors, the government gave them room and Board while they earned a sense of pride – the latter of which is hardly tangible payment.¹⁰⁶ Nevertheless, the patients did not receive room and Board in exchange for their labors at North Battleford. Despite performing tasks for which anyone in society would rightfully expect to receive payment, the government still charged their families or seized their property to pay their fees while the patients worked for the hospital's benefit.¹⁰⁷

In later reports MacNeill, as William Keller had in Washington, began using the terms “we” and “our” in relation to completed or ongoing hospital tasks. This change subtly extended the definition of laborers to include the staff, despite the patients having done most, if not all of the work. Framing it in this manner the superintendent began to undermine the contribution that occupational therapy made toward hospital maintenance and the quality of patient labor had in general. This type of devaluing was a common practice in North American asylums. According to Moran, superintendents, when faced with increasing “protests and demands for compensation by relatives... de-emphasized the usefulness and value of patients.”¹⁰⁸ This approach allowed superintendents to take advantage of patient labor without the need to pay it. The public in Saskatchewan, however, never leveled accusations of exploitation at MacNeill, perhaps proof that they had accepted work as an essential part of the asylum system.

¹⁰⁴ This was a common argument superintendents made to maintain their program, see Reaume, “Patients at Work,” 89; Geoffrey Reaume, *Remembrance of Patients Past: Patient Life at the Toronto Hospital for the Insane, 1870-1940*, (Toronto: University of Toronto Press, 2000), 160-171; Rothman, *The Discovery of the Asylum*, 146.

¹⁰⁵ Kildaw, *History of the Saskatchewan Hospital North Battleford*, 38.

¹⁰⁶ *Saskatchewan Provincial Hospital Battleford*, 13.

¹⁰⁷ Saskatchewan Legislative Assembly, *An Act respecting Lunatics and their Estates*, chapter 58, 5th Legislature, 1st Session, (Regina, 1919), 4-7.

¹⁰⁸ Moran, *Committed to the State Asylum*, 94.

Despite these issues, MacNeill wanted people to know that mental hospitals throughout North America ordinarily had work therapy as part of their therapeutic agenda. His booklet explained, “Occupational Therapy or Industrial Therapy now has a recognised place in any modern institution for the care...of mental diseases.” At the hospital in North Battleford, however, the superintendent not only recognised its place in his therapeutic regimen, he had placed “increasing importance” on work therapy and wanted to expand the program to offer a variety of tasks.¹⁰⁹ According to Assistant Superintendent Campbell, work also helped keep patients calm. Patients, he argued, tended to give “very much trouble” when “a bad spell of weather interfere[d] with outdoor work” and exercise.¹¹⁰

As Washington’s superintendent A. P. Calhoun had argued in 1906, MacNeill, in his booklet stressed there was no compulsion on the staff’s part to get people working. Patients were, according to him, “eager to work.” To emphasize that latter point MacNeill pointed out that “there is nothing which the male patients so much enjoy as the annual trip out to the haying meadows.”¹¹¹ Although he first listed outdoor labor, it being the most important, he explained that patients also worked indoors, with tasks separated by gender. Both men and women dusted, swept, and cleaned their respective wards, women, however, also assisted in the kitchen, washed the laundry, and worked in the garden, in addition to the occupational room options, where they found “a great deal of pride” in their work.¹¹² This was not an innovative justification, linking work to pride was a way Superintendent John Waughop also rationalized Western’s work program in 1881.¹¹³

¹⁰⁹ *Saskatchewan Provincial Hospital Battleford*, 13.

¹¹⁰ *Saskatchewan Provincial Hospital Battleford*, 18.

¹¹¹ *Saskatchewan Provincial Hospital Battleford*, 12.

¹¹² *Saskatchewan Provincial Hospital Battleford*, 13.

¹¹³ Territory of Washington, *Report of the Hospital of the Insane of the Territory of Washington, 1881*, (Olympia: C.B. Bagley, Public Printer, 1881), 14-15.

The men assisted in many of the same areas, but they also did more physically intensive tasks. They worked in “the power house...as gardeners and farmers, as ward workers, in the [male] dining rooms and kitchen, with a smaller number as carpenters, painters, plumbers...bakers, shoe repairers,” or as basket and toy makers.¹¹⁴ The tasks in the hospital reflected the accepted gendered work stereotypes of 1920s Saskatchewan society. In this manner it helped the public accept the tasks the patients performed, while framing the patients who worked them as “normal.”

MacNeill was keen to keep the discussion of patient labor focused on the benefits it had for patients and ultimately their families. Yet when discussing the program, the topic inevitably turned to finances – as it frequently did at Western Washington. Not wanting money to dominate the discussion MacNeill claimed that work does “contribute a certain amount to the credit side of the hospital ledger”; nevertheless, the majority of patient labor brings “no return in dollars and cents.”¹¹⁵ Nevertheless, he continued it because it brought returns greater than money. With the “thousands and thousands of trees” planted every year and the “miles of new roads” laid out, patient work “adds to the appearance of the hospital and surroundings.” These returns was where the real value of labor resided. Working to improve the hospital was a “benefit to the present inmates... as well as of value to future patients.”¹¹⁶ MacNeill claimed work ensured ones legacy; it was not something easily forgotten, as it created a lasting impact on the hospital.

Even as MacNeill and his staff were advocates of work therapy, they were not the only ones. C.M. Learmonth, who served as Superintendent of Institutional Farms, believed that patient labor was quite effective. He believed it helped with the patient’s physical well-being

¹¹⁴ *Saskatchewan Provincial Hospital Battleford*, 13.

¹¹⁵ *Saskatchewan Provincial Hospital Battleford*, 26, 27.

¹¹⁶ *Saskatchewan Provincial Hospital Battleford*, 27.

while contributing to the maintenance and upkeep of the hospital.¹¹⁷ It is unsurprising that the Superintendent of Institutional Farms supported patient labor, as speaking out against it had the potential of putting his job and financial stability in jeopardy. In her book on the institution, Deloris Kildaw also argues labor was an effective and useful program, claiming it was a “physical outlet for the patients” that offered a chance to work away from the “overcrowded, smelly wards.”¹¹⁸ More than just providing a relief from stale air, however, she maintains that farming allowed many people to perform comforting work, in that they were doing similar tasks to those they had done before coming to the mental hospital. Their work, she maintains, instilled in the patients a “feeling of accomplishment and self-worth in the ability to show their skills and prowess.”¹¹⁹ The public only witnessed these skills at some public events. The rest of the “accomplishments” only benefitted the hospital economy, as many of the patients never left the hospital.

In 1921, E. Schoen’s wife admitted him to North Battleford, where he lived his remaining 48 years. Schoen, a “master stonemason” by trade, completed many construction projects for MacNeill at the institution. While he worked as a plasterer, he also oversaw many stonemasonry tasks, specifically work on the hospital’s small chapel, bridges, retaining walls, and pillars around the grounds.¹²⁰ Patients, such as Schoen and the numerous farmers, did the same or similar tasks to that which they had done before entering the hospital. It was economically practical to assign people to jobs based on their skillset, as evinced by the work done by Schoen and the painter N. Castle.

¹¹⁷ C.M. Learmonth, taken from Kildaw, *History of the Saskatchewan Hospital North Battleford*, 38.

¹¹⁸ Kildaw, *History of the Saskatchewan Hospital North Battleford*, 38.

¹¹⁹ Kildaw, *History of the Saskatchewan Hospital North Battleford*, 38.

¹²⁰ This comes from a photocopy of a newspaper article with no date and no mention of the paper or origin. “Stonemason Emil Schoen Leaves Mark on Saskatchewan Hospital.” See also, Margaret Hryniuk and Frank Korvemaker, *Legacy of Stone: Saskatchewan’s Stone Buildings*, (Regina: Coteau Books, 2008), 174.

After opening his 1927 report with “nothing of a very spectacular nature has occurred at this Institution,” MacNeill continued “our work has been of the usual kind.” This standard work consisted of “considerable construction... by way of improving our outbuildings,” a new hog pen, two new stone bridges, stone walls, as well as expanding the space for the hospital’s large cattle herd. Having gained acceptance for the program, MacNeill, for the first time, advertised outdoor work without linking it to occupational therapy or mentioning any of its curative advantages. Nevertheless, he still stressed the economic benefits it had on hospital maintenance and presented it as the “usual kind” of work.

In subsequent reports, MacNeill itemized all the projects completed at the hands of the patients, a task that was also common at Western Washington. MacNeill catalogued anywhere from 150 to 200 tasks. As explained in the previous chapter, these lists took on a two-fold purpose. One, they publicized the accomplishments of the patients in order to note how capable the people had become; and two, they underscored the money the government saved via the program. Rothman explains that this approach was not new. Many of the early superintendents took pride in keeping asylum “costs down.” As they believed “in the medical value of these tasks,” they often presented their labor related results with a “self-congratulatory tone.”¹²¹

MacNeill’s gradual shift to describing hard labor over occupational therapy came after he had advertised to the public the multiple advantages it presented. Having gained acceptance he stopped stressing its therapeutic benefits and instead, in a “self-congratulatory tone,” listed the accomplished work done at the hands of the patients. Constructed around relatable established skills, such as farming, gardening, construction, and sewing, work therapy used the ideal of labor as a normalizing socio-activity – one which benefited the patients, instilled a sense of self-worth, and, if paroled, allowed former patients to be of “value” to their communities and society. Many,

¹²¹ Rothman, *Discovery of the Asylum*, 146.

however, never returned home, their inculcated labor ethics only ever contributing to the economy of the mental hospital.

Conclusion

Weyburn's first superintendent, Robert Mitchell frequently cited economics as his motivating factor in maintaining a work therapy program. MacNeill, however, initially wanted to achieve more with his farms and workshops beyond creating a revenue stream. To him patient labor was a therapeutic action that highlighted the socio-normative skills of the patients. Yet by increasingly mentioning the savings – something he did more frequently in later years after he had established its therapeutic benefits – he highlighted the program's economic potentialities, often allowing it to overshadow its therapeutic advantages.

Geoffrey Reaume argues that patient labor “when stripped of its therapeutic veneer, was in reality a public works program run on the ‘free’ labour of people confined in insane asylums.”¹²² Offering a more balanced approach, however, Moran believes “The extent to which patient work was therapeutic, profitable, or exploitative was subject to debate.”¹²³ As highlighted in the introduction of this chapter, MacNeill was not above exploiting work therapy for his personal benefit, lending credence to Harley Dickinson claims that the hospital's administration abused patient labor for their own advantage.¹²⁴

Work therapy was a common practice in Canadian and American mental hospitals; it was a national ideal developed in the early nineteenth century to instil order within the inmate. What is telling about North Battleford is that MacNeill deliberately and slowly promoted his patient labor program even as it was a nationally accepted ideal. He did so by first highlighting its therapeutic benefits. Once it was an accepted practice he adopted and maintained a medical focus

¹²² Reaume, “Patients at Work,” 90.

¹²³ Moran, *Committed to the State Asylum*, 93.

¹²⁴ Dickinson, *Two Psychiatries*, 28.

that stressed the therapeutic benefits afforded from it, but did so by defining its success as teaching regionally acceptable skills. By working at appropriate tasks he was able to inculcate order and a work ethic that necessitated minimal oversight within his patients. Once MacNeill believed that a person had adopted these characteristics, and after they had developed or further developed skills that were regionally appropriate, he then paroled them back into Saskatchewan's society.

MacNeill's insistence on framing work therapy first as therapeutic and then linking it to relatable tasks that Saskatchewan residents did helped patient labor gain acceptance in the province. His powerful personality showed that he did not first see work therapy, nor did he allow politicians to frame it as a financial savings program. The regional economy and culture influenced the manner by which MacNeill established his work therapy program. In Saskatchewan, acceptable work drew from ideals established as part of their agrarian economy. Hard work became a marker a productive citizen. In the asylum, by connecting regional agrarian labor practices to therapeutics, MacNeill constructed an image of a hard working patient as a potential valuable resident. Work remained a constant of North Battleford's regimen for many years. Moreover, by increasingly publicizing its financial benefits, even as he initially downplayed them, the superintendent justified it and the institution to the government. The public, for their part, accepted MacNeill's definition of patient labor, because he explained it as effective therapy and aligned it with acceptable or "normal" agrarian work practices.

Western society's values characterized labor as representative of ones' worth to society. The manner in which regions defined these standards, however, was something superintendents took into account. Many came to the North Battleford Hospital as farmers, homeworkers, stonemasons, ranchers, etc. MacNeill turned to what people knew and accepted in order to

highlight the social value of his patients. There is truth in Andrew Scull's argument that mental hospital superintendents applied a social meaning to particular segments of everyday life – in this case, it was the values associated with work. Superintendents adopted work therapy because it afforded patients exercise but also allowed them as mental health experts to instil within the “troubled people” a normalizing socio-activity that many already practiced outside of the hospital.¹²⁵

¹²⁵ Andrew Scull, “From Madness to Mental Illness: Medical Men as Moral Entrepreneurs,” *European Journal of Sociology* 16, no. 2 (1975): 221.

Conclusion: What the Western Asylum Tells Us

Both Western State Hospital in Washington and Saskatchewan Hospital, North Battleford were constructed as state institutions. As each one confronted national trends in mental health and asylum-based care they reshaped them to suit their regional circumstances. When concluding his study of the emergence of the asylum system in Ontario and Quebec, James Moran argued, “In neither province did the asylum emerge out of a socio-therapeutic vacuum. A range of local practices in the treatment and management of insanity had preceded lunatic asylums and continued to exist well after their introduction. These local, non-asylum socio-medical practices are aspects of the history of insanity that deserve more attention.”¹ Moran reasons that asylum histories would benefit from moving outside of the walls of the institution and include a closer look at how local socio-medical concepts influenced the care of insanity within. It is this area, where practices and medical concepts meet social realities, that national trends concerning insanity and the asylum are renegotiated. In a close examination of the institutions in Washington and Saskatchewan, relative latecomers to a western trend towards custodial care, regional cultural identities and economic concerns profoundly shaped the conceptualization of care in the asylum. These factors also influenced how local communities understood insanity.

The superintendents of Washington and Saskatchewan did not develop their ideologies and practices within their own medical or social vacuums. Each functioned within the influence of regional social, political, and national medical standards as they oversaw their respective institutions and advanced what they believed were clinically informed care principles.

¹ James Moran, *Committed to the State Asylum: Insanity and Society in Nineteenth-Century Quebec and Ontario* (Montreal: McGill-Queen's University Press, 2000), 170.

The asylum was a microcosm of the society it served.² While the United States and Canada developed their mental health practices under many of the same influences, the treatment of insanity fell to state and provincial governments. It was upon these regional governments to build, fund, and regulate mental hospitals. National ideas that defined insanity were often negotiated at a state and provincial level, and then again at a more regional level. Examining asylums in the regional context surrounding these institutions presents a more complete understanding of how the social-political environment shaped medical practices.

The Association of Medical Superintendents of American Institutions for the Insane (AMSAAI) turned American Medico-Psychological Association (AMPA) was initially the only entity that attempted to unify asylum practices. Other groups, such as the Canadian National Committee for Mental Hygiene (CNCMH) and the Members of the Medical Society of Washington Territory (MMSWT) had somewhat tenuous relationships with the mental hospital. Despite the AMSAAI/AMPA national organization, which increasingly claimed medical expertise over insanity, regional governments maintained a position that allowed them to adopt or ignore the concepts of most medical groups examined in this study. For example, Saskatchewan politicians overlooked many of the recommendations made by the CNCMH after their visit to the province in 1920. Similarly the Washington government ignored the opinions of the MMSWT when this group came out in support of former resident physicians H. C. Willison and Stacy Hemenway when these men objected to Superintendent Hill Harmon and his management practices. The state and provincial governments often disregarded these organizations on the grounds they challenged traditional understandings and established practices of treating insanity.

² Lynn Gamwell and Nancy Tomes, *Madness in America: Cultural and Medical Perceptions of Mental Illness before 1914* (Ithaca: Cornell University Press, 1995), 56-59.

While sometimes echoing national trends, state and provincial governments drafted and enacted laws that governed asylums. Most changes concerning insanity and the asylum, represented shifts in the regional understanding of insanity as influenced by social and political concepts of criminality, medical care, normality, and the economy. Superintendents adopted concepts based on national standards, typically advanced at professional annual meetings and journals, but then redefined them due to these local influences. It is this area of negotiation that offers greater insight into what shaped the ideals behind medicalization of insanity, urbanization, governance, and what redefined (or sustained) normative social and economic values.

Superintendents did not wait for changes to occur on their own. Most publically repositioned insanity as a treatable, and indeed a medical condition, while the asylum existed as a therapeutic institution. Nevertheless, these authorities were not immune to having external influences alter their own perception of insanity, effective treatments, and what defined parole eligibility. These physicians constructed most of their medical perceptions around the ideal of normality defined at a local level. They took national ideals and adapted them to fit within their own socio-medical landscape, or waited to introduce innovative concepts only when they believed they were able to get support for them. After the CNCMH visit MacNeill wrote that the “province will benefit by [its] suggestions,” yet even he was hesitant to lead the charge to replace the mental hospital with smaller psychopathic clinics, as the Committee advocated.³ It was not until 1929 that he began encouraging for “more attention [to] be paid to the prevention [and] to the early recognition” of mental diseases – another point of the Mental Hygiene Committee that had the potential to weaken the importance of the mental hospital by treating people before they

³ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1919-1920 Ended April 30, 1920*, Saskatchewan Archives Board (SAB), Public Works (PW). 2, (Regina: J. W. Reid, King’s Printer, 1920), 22.

needed extended hospital care.⁴ MacNeill took the recommendations of the Committee and advocated for part of them only after he believed the region was willing to accept and lend its support. Nevertheless, even after he advocated for stronger prevention and early recognition, he still presented the CNCMH's recommendations in a manner that allowed the hospital to maintain its prominent position within Saskatchewan's mental health system.

The negotiation of national versus regional concepts, of social versus medical, etc., began with the physical hospital structure. Both Saskatchewan and Washington adapted their buildings from bygone eastern ideals. The building design emerged from early AMSAII members who advocated for specific structures that they believed were an essential supplement to their moral treatment ideology. Even as that system departed from their professional discourse, the idea that the AMSAII had established an effective and manageable structure remained and continued to influence architectural concepts. When designing and constructing their own structures both western governments adopted the style developed in the east, even as each justified it along regionally specific lines.

In Washington the hospital Trustees and Superintendent John Waughop argued that a new building was necessary in order to replace the decrepit old military buildings and to show to the public the emergence of medicine and science over insanity. The Trustees took it a step further and saw a new structure as an effective means to promote the benevolence of the government. In Saskatchewan, however, politicians reasoned it was a necessary civilizing step in the care of their own citizens. Although utilized as a means to bring insane people to their home province, it was initially a way to ensure the safety of communities by incarcerating people

⁴ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year Ended April 30, 1929*, SAB, PW. 2, (Regina: J. W. Reid, King's Printer, 1929), 68.

judged “insane and dangerous.”⁵ The asylum was a medical institution, but at a local level it was a way to promote the stability of the government and its protectorate role over the public.

Although, as Gerald Grob argued, in the east the buildings became a symbol of the early psychiatric profession, they nevertheless represented different ideas for the western governments that funded them and the superintendents who operated within them.⁶ What it signified to these different governments ultimately influenced how the public viewed insanity and what they expected from the asylum, which in turn influenced the expected level of care offered within the walls of the institution. These western superintendents, as eastern psychiatrists had before them, expected the hospital to become a symbol of medicine and their profession. They ultimately saw themselves as medical experts over insanity. It was upon them to articulate a more sympathetic and medicalized understanding of insanity to the public and politicians. They negotiated between medicine and culture and the public increasingly came to accept their medical expertise. The symbol of their authority became the large mental hospital.

If the asylum represented the psychiatric profession, then its moral treatment ideals defined it. This was true of the superintendents in eastern institutions during the mid-1800s. It remained true when Superintendent John Waughop first advertised moral treatment as a kind and structured system of care that he employed in the Washington hospital in 1883, and when MacNeill outlined the system in his public booklet in the 1920s.⁷

Waughop advertised moral treatment as an effective system of care that underscored the asylum as a humane and curative institution. He did this even as superintendents in eastern

⁵ Saskatchewan Legislative Assembly, *An Act Respecting Insane Persons*, chapter 22, section 1, 1st Legislature, 1st session, (Regina, 1906), 104.

⁶ Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill*, (New York: The Free Press, 1994), 71.

⁷ Territory of Washington, *Report Board of Trustees of the Hospital for the Insane of the Territory of Washington, 1883*. (Olympia: C. B. Bagley, Public Printer, 1883), 18; *Saskatchewan Provincial Hospital Battleford*, prepared and published under the direction of Hon. A. P. McNabb, Minister of Public Works, (SAB) PW 2, Special Publications, (Regina, Saskatchewan, Date unknown).

institutions had begun to turn away from promoting this approach as an active form of treatment in the asylum. Despite national trends, moral treatment practices provided a way for Waughop and other Washington superintendents to legitimize the asylum as a place of care, stress the potential of returning patients back to their communities, and legitimize their profession to politicians and the public. It helped them move the Washington asylum away from its own past that had become mired in accusations of abuse and mismanagement. The timing of Waughop officially advertising moral treatment, leading up to and immediately following Washington achieving statehood, is also reflective of the region advancing from frontier ideals and adopting more so-called “civilized” laws that governed other states. The system, as much as the new building, embodied the civilized traits of a strong and capable, yet humane state.

When Saskatchewan opened its first mental hospital in 1914, superintendents no longer advertised moral treatment, yet its practices had become ingrained within the asylum routine throughout Canada and the United States. MacNeill’s takeaway from eastern superintendents after touring their hospital practices highlights this fact. Although he shied away from using the term, unlike Waughop, he nonetheless presented his asylum regimen to the public as work, relaxation, amusements, and religious services offered within an ordered and regimented environment. This approach allowed MacNeill to present a system of care that helped move Saskatchewan past the notion that insanity required incarceration; it forwarded the concept that insanity was a treatable condition best cared for in the asylum. The regimen allowed MacNeill the opportunity to position himself as an authoritative voice over the Saskatchewan Hospital, North Battleford and its patients, and as the expert over insanity. Yet he still had to do that within the conceptions held by the region.

Despite newspapers describing the North Battleford hospital as “one of the finest institutions of its kind” and a structure “of which any province might well be proud” the CNCMH suggested it was obsolete and encouraged a cycle of incarceration, despite overtly praising Saskatchewan’s mental health system that placed the asylum at its center. Nevertheless, the region’s continued use of the asylum as a place to lock away people, emphasized a desire to retain traditional practices. MacNeill, bolstered by the CNCMH, used the asylum as a means to advance a more humane and medical understanding of insanity to the public. He began adopting the language of the Committee, even as he wanted to keep the institution an active participant in the care of insanity, contrary to their recommendations. By advocating their preventative ideals and calling insanity a mental disease he adopted a language that matched national trends but retained the asylum’s essential place in the care of insanity.

In both regions moral treatment, or more specifically its therapies, presented the superintendents with the opportunity to move insanity into the medical arena. Washington and Saskatchewan initially held views that insanity need only be incarcerated and not necessarily treated. The territory of Washington justified this interpretation by claiming that fiscal restrictions prevented them from demanding anything more. Saskatchewan, on the other hand, did not provide justification, but nonetheless reinforced traditional laws and practices that required the incarceration of insanity. Using moral treatment, superintendents were able to encourage these regions to move past these practices. Early reformers shaped their moral treatment ideology around social philosophies that gauged successful treatment of a patient upon a reorientation of their behavior. Although they adopted medical language when describing insanity and their therapies, they framed their understanding within social concepts.

The struggle of defining insanity between social influences, political beliefs, and medical convictions was not the only area of negotiation. Concepts of regional cultural normality and economic ideals also influenced asylum practices. The Puget Sound moved away from an agrarian-based economy in favor of an increasingly resource-based one that also favored areas such as logging, mining, and shipping finished goods. Gradually the region valued efficient business management and consumer-based items over farm products and agrarian communities. While the Puget Sound underwent that transition, superintendents at Western were starting to develop occupational workshops for their patients, which introduced skills reflective of a new set of occupations. Other mental hospitals such as Eastern Washington Hospital and North Battleford, both of which catered to a large farming population, still maintained a work therapy program with strong agricultural components, as these reflected the normative working conditions of the majority of their patient population. As Western Washington's superintendents strove to adopt practices that mirrored its regional transition, politicians pressured them into maintaining the traditional, yet economically viable, farming, livestock, gardening, and construction practices. In addition to these outside pressures, the hospital had to contend with its own past wherein the staff abused patients who failed to work in these areas. These elements led to Washington superintendents embracing work therapy differently, and sometimes in a manner that saw practices differing among succeeding physicians.

In contrast to the administrative situation at Washington, James MacNeill was the only superintendent at North Battleford hospital during the years examined in this study. And unlike Washington he did not radically change the asylum practices throughout his time there. He did, however, change the way in which he advertised them to politicians and the public. MacNeill developed work therapy in a manner that first highlighted its importance in teaching non-labor

intensive normalizing behaviors to his patients and then, while still maintaining that theme, emphasized its economic value to the hospital and ultimately to the government thereby gaining political approval for the program. Over time he broadened the scope of the program to include more activities. MacNeill first focused on his occupational rooms (a practice that gained popularity in asylums throughout Canada and the United States in the late 1910s and throughout the 1920s) and he emphasized more intensive, albeit regionally appropriate work areas such as farming, raising livestock, gardening, and assisting in construction programs thereby increasing public support. This allowed him to stress that patients who took to these areas were “of some value to society.”⁸

In his study on English mental asylums Andrew Scull asked what, in general, defines normality and proper moral standards?⁹ The superintendents of the Washington and Saskatchewan asylums faced this question when defining parole. While on the surface they answered the question by characterizing a patient on “parole” or their insanity “in remission” against professional nationwide ideals, a closer inspection shows they adopted a more nuanced, regional definition of what those standards were. The effects of time, space, industrialization, agriculture and urbanization changed what was acceptable behavior in the eastern regions from what was culturally acceptable in western United States and Canada. Despite prescribing (inter)national therapeutic ideals to treat insanity, the AMSAII never developed the same national standard of parameters that defined someone as cured. The fact that they did not define the markers for parole at a national level left it to the superintendent to circumscribe their own

⁸ Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1919-1920 Ended April 30, 1920*, (Regina: J. W. Reid, King’s Printer, 1920), 21.

⁹ Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective*, (Berkeley: University of California Press, 1989), 90-91.

markers based on regional social ideals of normality. Moral treatment provided the therapeutic regimen, but by the vagueness of its definition left it open to regional interpretation.

The goals of the farm and the workshops at these two mental hospitals did not always center on money. Lower operating costs motivated Western Washington's superintendents, often at the request of the hospital's Board of Control, to broaden their work therapy program. Nevertheless, Superintendents A. P. Calhoun and later David Livingstone both created occupational/workrooms that focused on patient care despite the low remunerative benefits to the institution. In Saskatchewan, MacNeill first embraced patient labor as a therapeutic measure. Even when he initially mentioned money, it was in relation to the staff using the program's financial benefits to purchase gifts and musical instruments for the patient wards. It was not until the superintendent wanted to expand the program that he frequently brought up the financial benefits for the institution. Nevertheless, expansion, not finances, was the motivating factor, as MacNeill downplayed monetary benefits in favor of therapy.

In Washington, the various superintendents answered to an oversight Board consisting of politically appointed men whose interests concerned keeping an efficient and cheaply run hospital. Ostensibly, these men operated independently of political affairs and kept the needs of the hospital forefront, but they sometimes set their own interests above those of the patients. This system created a different dynamic that allowed a more politically minded administration to overrule the ideals of the superintendent before they reached government officials. Political ambitions and a business-minded administration overshadowed medical practices in most areas save for the occupational therapy programs initiated under David Livingstone and A. P. Calhoun. That system was kept therapeutic in nature and orientation. The superintendents were also political appointments, but the limited duration in which they held their position (averaging five

years) and the fact that they answered to a Board, saw many of them appealing to the will of politicians as they frequently mentioned work therapy's financial benefits.

That society and culture influenced the emergence of practices within the asylum is not an innovative idea. In each region this fact shows in subtle, but not altogether different, ways. In the asylum, the superintendent had to deal with the administrative nightmare of merging new medical ideals with established and sometimes conflicting political-social understandings. With medicine on one side and society on the other, each institution created a unique area of negotiation. Moran argued that the "asylum did in some important respect alter the character of earlier perceptions and responses to insanity," nevertheless "much to the dismay of the medical superintendents, [it] did not quickly replace them."¹⁰ Superintendents in the west initially found themselves in a similar situation. They also believed the asylum was going to change the manner in which people conceptualized insanity, as it had in eastern regions. In Quebec and Ontario, Moran continues, "asylum medicine working at its best was thwarted by the social, economic, and cultural realities of the societies in which the respective lunatic asylums were situated." The institutions "tended to become integrated into the network of pre-existing strategies employed to deal with those perceived to be insane."¹¹ The reality of these eastern regions was that the asylum did not prove to be a catalyst for change. Instead supporters faced strong ingrained social ideals that forced change upon the asylum.

In Saskatchewan and Washington it was the politicians and not advocates who backed the establishment of the asylum. They were the ones who first envisioned the asylum as a place to incarcerate insanity. It was within their established systems that medical superintendents worked for change. Although each region did not undergo swift changes, these men worked within and

¹⁰ Moran, *Committed to the State Asylum*, 99.

¹¹ Moran, *Committed to the State Asylum*, 99.

sometimes against “the social, economic, and cultural realities” of their regions to alter the understanding of insanity and the asylum.

Following the brief public excitement and interest surrounding the opening of the institution in Saskatchewan, MacNeill’s enthusiasm at enacting change grew tepid, nevertheless he “endeavoured in several ways to bring [his] work to the attention of the people at large.”¹² Likewise in Washington, despite the lethargic efforts on the part of politicians to adapt laws in order to improve the asylum and care of its residents, and help alter the understanding of insanity, Hemenway vowed to do his part to develop the areas that had “so seriously occupied the public mind,” and was “deserving of the attention of our several State and Territorial legislative bodies.”¹³ The proper care and understanding of insanity was important to the superintendents in both regions. Although shaped by social, medical, political, and economic influences themselves, these physicians did not entirely concede to these influences. They actively redefined insanity at a local level.

Influential works on Canadian and American asylums are essential in shaping our understanding of these institutions within larger historical narratives. Many of those works, however, center on the eastern regions and confine their studies to their respective nations. While these histories competently provide an account of national trends through the lenses of selective eastern institutions, they would provide a more comprehensive account if scholars not only looked west but also turned their focus to their neighboring North American nation. The asylums in Canada the United States followed a similar path. The process of the medicalization of

¹² Province of Saskatchewan, *Annual Report of the Department of Public Works of the Province of Saskatchewan for the Financial Year 1914-1915 Ended April 30, 1915*, SAB, PW. 2, (Regina: J. W. Reid, Government Printer, 1915), 61.

¹³ Washington Territory, *Report of the Resident Physician of the Asylum for the Insane of Washington Territory. For the period commencing: October 1, 1871, and ending September 30, 1873*, (Olympia: P. T. Gunn, Public Printer, 1873), 8.

insanity was an international process that saw one nation adopting ideals of the other. Both Washington and Saskatchewan adopted a building layout and implemented a therapeutic regimen that resembled one another and that they had established upon early AMSAII ideals. The differences between the two asylums become noticeable when comparing the two regions.

Western regions developed in a manner more consistent with Fredrick Jackson Turner. The west may lose its most primitive features as it assimilates the “older social conditions of the East,” but in doing so it maintains “enduring and distinguishing” marks of its own past. The west is a history of “evolution and adaption,” not straightforward imitation.¹⁴ This argument is illustrated in the history of the mental asylum. Instead of examining these institutions as defined by national trends, or using one institution to speak broadly for others, a close examination allows us to see how the evolution of mental health in America and Canada did not occur evenly across all states and provinces. While the medicalization of insanity was similar when compared internationally between each nation the eastern regions were generally ahead while the later settled regions of the west struggled to achieve the same standards, typically redefined under regionally specific cultural and social influences.

Although sociologist Erving Goffman famously argued that asylums were “total institutions” – environments unto themselves that maintained little contact to the social environment that they served – these asylums challenge that view.¹⁵ The mental hospital is a microcosm of the society and culture that surrounds it. If examined closely and its practices viewed within the framework of the region it served, then it highlights a better understanding of

¹⁴ Fredrick Jackson Turner, “The Problems of the West,” *Atlantic Monthly* 77 (September 1896), quoted from *Rereading Fredrick Jackson Turner: “The Significance of the Frontier in American History” and Other Essays*, with commentary by John Mack Faragher (New York: Henry Holt and Company, Inc., 1994), 62.

¹⁵ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Garden City, N. Y.: Anchor Books, 1961), 17.

the regional social values as reflected within its practices. Oftentimes institutions resisted national trends in favor of regional ideals.

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