ASYLUM, COMMITMENT, AND PSYCHIATRIC TREATMENT
IN HISTORICAL CONTEXT

by

ANDREW PAUL LIBBITER

B.App.Sci., Phillip Institute of Technology, Melbourne, 1989
B.S.W., The University of British Columbia, 1993

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SOCIAL WORK

in

THE FACULTY OF GRADUATE STUDIES
(School of Social Work)

THE UNIVERSITY OF BRITISH COLUMBIA

August 1994

© Andrew Paul Libbiter, 1994
In presenting this thesis in partial fulfillment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the head of my department or by his or her representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

(Signature)

Department of Social Work

The University of British Columbia
Vancouver, Canada

Date 28th August 1994
ABSTRACT

This thesis was a sociological, historically informed, study of the interactions between three key variables over a two hundred year period. These variables were the changing nature of asylum-based care of the mentally ill, the epistemological and professional dominance of the psychiatric profession, and changing periods of mental health legislation. Specifically, the study examined how historical and contemporary tensions between the perspectives of psychiatry and law have been manifested in British Columbia, and with what consequences.

Two qualitative methodological approaches were utilised. Data was obtained principally by historical analysis. A secondary component of the study was four exploratory-descriptive, in-depth interviews with mental health consumer-activists. These interviews were conducted to explore their beliefs regarding involuntary detention and treatment.

The origins of the asylum were traced in the U.K., America, and Canada. Changes in nineteenth and twentieth century strategies concerning the management of the mentally disordered were examined in terms of the dialectical interaction between the identified variables. Using British Columbia as a case study, reasons for the discontinuous decline of the asylum in the twentieth century were analysed. In particular, the emergence and consequences of a
contemporary dichotomy in the mental health discourse, summarised as "rights" vs "treatment", was examined.

Findings showed that mental health legislative reform is initiated in order to facilitate major changes in the management of the mentally disordered. Such changes were shown to have centred around attempts to manage the enduring consequences of the asylum. The influence of the psychiatric profession was shown to be relative to the over-arching economic and social control objectives of the State. The dichotomy of treatment vs rights was suggested to be the latest manifestation of the historical tension between psychiatry and law. The contention was made that the dichotomy is essentially false. Implications for social work and social policy were discussed and suggestions for further research made.
# TABLE OF CONTENTS

Abstract  
Table of Contents  
Acknowledgements

| Chapter One. | Introduction: Asylum, Commitment and Psychiatric Treatment in Historical Context | 1 |
| Chapter Two. | Theoretical Perspectives. | 13 |
| | The Social Control Perspective | 13 |
| | The Psychiatric Paradigm | 17 |
| | Anti-Psychiatry Theories: Societal Reaction and Civil Libertarian Perspectives | 25 |
| | The Critical Perspective | 34 |
| Chapter Three. | Methodology. | 40 |
| | Specific Methodological Procedures | 43 |
| | Qualitative Interviews Methodology | 49 |
| Chapter Four. | Social Control of Mental Disorder in the Nineteenth Century: Asylum, Medicalization of Insanity, and Legalism. | 64 |
| | Changing Conceptions of Sanity and Madness | 66 |
| | The Institutional Response: The Rise of the Asylum | 73 |
| | The Decline into Custodialism | 94 |
| | Epistemological and Commercial Origins of the Psychiatric Profession | 97 |
| | The Emergence of Legalism | 108 |
Chapter Five. Contradictory Forces: Mental Hygiene and the Asylum, 1900-1950.

Antecedents to Early Twentieth Century Reform

The Mental Hygiene Movement

Changing Strategies to Manage the Mentally Disordered

Legislative Changes in Canada


The Emerging Crisis of the Asylum

The Impact of the Development of the Welfare State

The Impact of Psychoactive Medication

Initial Responses to the Crisis of the Asylum in B.C.

The Adoption of a Long-term Strategy

The Initiation of a New Cycle Mental Health Law Reform

Chapter Seven. Pressures for Reform: The Decline of the Asylum, 1970-Present

The Economic Context of Health Care in Canada: The Fiscal Crisis of the State

The Ideological Context: The Anti-Psychiatry Challenge to Psychiatric Legitimacy

Deinstitutionalization and the Development of Alternative Community Services
I have significant debts of gratitude to a number of people, without whose help I could not have completed my studies.

I am indebted to my supervisor, Dr. Richard Sullivan, whose encouragement, insightful comments, and benevolent pressure ensured this study was finished. I am also grateful to Dr. Peter Ward, who welcomed a naive and neophyte historian into his graduate class, and willingly shared his enthusiasm for history.

I also owe thanks to Andrew Larcombe, who listened with a keen ear and much patience.

Thank you also to my friends and in-laws, Sam and Marian McDowell. No acknowledgement can adequately express my gratitude. To my parents, Vera and Derek, who have always found it within themselves to support my decisions, and to encourage me in my varied endeavours. That has been a real gift.

Most of all, my thanks go to my partner Meryl, and son, Ben. They endured more than was reasonable. Thank you both so much.

This study is dedicated to my father.
CHAPTER ONE

INTRODUCTION: ASYLUM, COMMITMENT, AND PSYCHIATRIC TREATMENT IN HISTORICAL CONTEXT

The conundrum of mental illness contains an enduring dilemma: How to provide psychiatric treatment to those who do not recognize a need for it or who explicitly refuse it, while at the same time, safeguarding the individual rights of people from unwarranted detention and treatment. The construction and various historical manifestations of this dilemma has resulted in a contemporary situation characterised by uncertainty and ambiguity. In British Columbia, deinsitutionalization and "downsizing" of the province's largest psychiatric institution, Riverview hospital, is scheduled to be completed by the end of the century. Many anxieties exist amongst psychiatric service providers, families of the mentally ill, and some mental health consumers themselves, regarding the type and size of, and access to, specialist tertiary facilities and replacement services in the future. At the same time, the recent breakdown of a consultative process created to forge a new Mental Health Act has exposed deep divisions among stakeholders regarding the purpose, extent, and design of legal provisions concerning involuntary detention and treatment. These divisions have created
a dichotomy in the mental health discourse that can be summarised as "rights" vs "treatment".

This study, seeks to trace and explain how these dilemmas have developed historically. It is therefore timely. By positioning the current dichotomy in a historical context, this study aims to identify the historical relationships and dynamics between key variables that have given rise to the current dilemmas.

Historical and contemporary attempts to achieve a balance between social control of the mentally ill, and the protection of individual rights, have given rise to an enduring tension at the interface of psychiatry and the law. This study examines the epistemological origins of this tension, how it has been historically manifested in British Columbia, and with what consequences. In particular, the study seeks to explain how the mental health discourse, as it pertains to the provision of involuntary commitment and treatment, has developed into a dichotomy. To achieve this broad objective, the study examines the historical relationship between psychiatric medicine and the law. Specifically, the relationships and interactions between asylum-based involuntary care, the psychiatric profession, and changing periods of mental health legislation are analysed. These three variables are indissolubly connected. Historically, the asylum has been, and continues to be the principal site of long term involuntary care. The asylum has provided the psychiatric profession with an institutional power base which has only recently been eroded. Acting in the role of "gatekeeper", the psychiatric
profession has been granted varying amounts of power over time by the State to commit and treat people against their will. Mental health law has provided the legal authority for the fulfilment of this dual social control and therapeutic function.

A number of specific questions arise in consideration of the issues above. For organisational convenience these questions have been ordered into four clusters, however, it is emphasised they are not posed as discrete question areas. Rather, they are interconnected to the extent they assist in providing an explanation for the changing relationships between asylum-based commitment, psychiatric professional practice, and mental health law. These clusters relate to the central themes of the thesis: the provision of asylum-based involuntary care, the influence and practices of the psychiatric profession, the changing periods of mental health law, and the contemporary dichotomy in the mental health discourse of treatment vs rights.

Four questions are posed in relation to asylum care: How did the large custodial asylum develop as the principal form and site of psychiatric treatment? Why has, what is essentially a nineteenth century innovation and edifice, been so extraordinarily difficult to dismantle and replace with alternatives? What social, political and economic factors account for it’s conceptual and literal decline in the late twentieth century? What has been the relationship between the rise and decline of the asylum and involuntary care and treatment as manifested in mental health law?
The second cluster of questions refers to the relationship between the psychiatric profession, and the asylum and law: How has the psychiatric profession achieved and maintained its professional and epistemological dominance in mental health? Why have competing epistemologies largely failed to disturb that dominance? To what extent have traditional demands for medical autonomy and clinical discretion affected mental health law with relation to involuntary committal? What factors account for the erosion of psychiatric authority in the late twentieth century?

The third cluster of questions address issues connected to mental health legislation itself: Given that there have been identifiable periods of change in mental health law, what accounts for periods characterised by the imposition of restrictions on psychiatric practice related to involuntary detention, and periods where medical autonomy and discretion has been facilitated? Have legislative practices authorising involuntary committal, treatment and continued detention been reconciled with advances in patients’ rights in the late twentieth century? To what extent, if any, are periods of mental health legislation cyclical?

The final cluster of questions address the contemporary dilemmas of achieving a balance between individual rights and involuntary committal and treatment: Why has the current impasse in mental health reform developed in British Columbia? Why has the government been reluctant to "impose" a solution to the impasse? What are the difficulties that confound a future resolution of the dilemmas addressed in the wider thesis?
A brief description of the research presented in each chapter will now follow.

Chapter Two explicates four theoretical perspectives that inform the thesis. A brief summary of how each perspective pertains to the study is given. Theories of social control and the State are explored. The two major theoretical perspectives of the mental health domain are described. These are the psychiatric paradigm and theories conflated under the "anti-psychiatry" label. Fourthly, the utility of the critical perspective to make visible the historical effects of obscured power relationships between various institutions and groups is examined.

Chapter Three provides a detailed explication of methodological issues and study design.

Chapter Four provides a sociological and historical context for the major themes of the thesis. The first half of the chapter traces radical shifts in concepts of insanity and practice of managing the mentally disordered in the nineteenth century. From a position of undifferentiation with other deviants, it is shown that within a period of fifty years, insanity was transformed into a medical construct, and the insane were swept up into a network of state run asylums. The reasons for the development of the asylums are explained in relation to the conjuncture of two forces. The first, the Enlightenment period, provided the intellectual and philosophical seedbed for a fundamental reconception of human behaviour and insanity. The industrial revolution and development of a market economy are shown to have provided the material reasons
for the introduction of a large scale institutional response to insanity in order to meet the changing social control objectives of the state. The concomitant rise and dominance of the psychiatric profession is described and principally explained as a result of the jurisdictional vacancy created by the management of the new asylums.

The second half of the chapter outlines the origins of tensions between psychiatry and law. It is shown that the decline into custodialism of mammoth asylums combined with periodic revelations concerning the treatment of the insane, produced a widespread fear and distrust of such institutions and those who administered them. Paradoxically, it is argued that the nineteenth century solution was not to question the viability of large institutions, but to ensure that the sane were not committed. It is shown that the consequent development of mental health law characterised as "legalism", sought to restrict the autonomy of doctors, principally through judicial overview, particularly in relation to admission and detention. Chapter Four focusses initially on the United Kingdom. Parallel developments in America and Canada, and the reasons for them are discussed. The reasons for the introduction of mental health law predicated on the tenets of legalism are discussed specifically in relation to British Columbia.

Chapter Five examines the relationship between contradictory ideological and institutional forces from the turn of the century until the mid-1950's. From Chapter Five onwards, the research
focus is on British Columbia, though pertinent national and international trends are discussed. It is shown that a shift in perspective, away from an exclusive focus on asylum-based, institutional care to a broader focus on prevention and early treatment, occurred partially as a consequence of the pervasive ideological influence of the emergent mental hygiene movement. It is contended, however, that institutional forces, combined with the failure of the mental hygiene movement to offer any viable treatment for mental illness, effectively halted the evolution of service provision outside of the institutional domain. It is suggested that the two most significant institutional forces were the escalating institutional population, and the discovery and wide-spread utilisation of a series of radical somatic treatments. These competing forces exerted a significant impact on the direction of Canadian and British Columbian mental health legislation. In particular, it is shown that the legalism of the nineteenth century was perceived to be incompatible with the shift in focus toward early treatment, and the delineation between the acute, treatable mentally disordered and those judged to be refractory, institutional cases. As a consequence, it is contended that a new process of legislative reform was instigated in order to dismantle limited legalism, in favour of increased medical discretion regarding commitment.

Chapter Six examines the confluence of forces that initiated a reversal in the historical incarceration of people with mental illness to warehouse asylums from the 1950’s until 1970. The major
focus of the chapter is on British Columbia. In British Columbia, as in other jurisdictions, it is demonstrated the asylum increasingly became a fiscal and political liability. It is shown that the situation reached a point of crisis by the 1950's, primarily because of remorseless annual increases in the institutional population. To resolve the crisis, the government authorised hospital officials to instigate a policy of embryonic deinstitutionalisation in the mid-1950's. It is argued that the advent of the Keynesian welfare state and, to a lesser extent, the discovery of psycho-active drugs, provided the conditions necessary for accelerated deinstitutionalisation and the development of alternative services in the following decades. It is contended that the interests of the State and the psychiatric profession temporarily converged during this period. In exchange for overseeing the shift in strategy of managing the mentally disordered, the government largely accepted a vision of future mental health services that secured the unequivocal dominance of the psychiatric profession. This included the removal of the last vestiges of legalism, thereby ensuring that involuntary detention and treatment became primarily a matter of medical discretion. It is argued that this further shift in the direction of mental health legislation away from legalism towards professional discretion facilitated the government's objectives of dismantling the warehouse asylum in favour of alternative, cheaper ways of managing the mentally disordered.
Chapter Seven examines pressures for the reform of mental health services in British Columbia from 1970 until the present. The final stages of the decline of the large custodial asylum in British Columbia are outlined. At the same time, potential future roles of the asylum, reconstructed as a specialist, tertiary service are discussed. The continuing decline of the asylum is explained in relation to two forces. It is argued that the principal explanation was located in the escalating costs of institutional health care. The federal and provincial context of Canadian health care is outlined in the context of the fiscal crisis of the state. It is demonstrated that the search for cost containment and later restraint provided the impetus for accelerated deinstitutionalisation. This process involved the complex establishment of alternative services in the community. It is contended, however, that deinstitutionalisation and the decline of the asylum has not occurred as a linear process, but rather has unfolded in three over-lapping phases. As part of this process, it is argued the authority and influence of the psychiatric profession was eroded, primarily due to the loss of the central power base of the institution.

The second, ideological, force that gave momentum to the decline of the custodial asylum and the deinstitutionalisation process was the emergence of the so-called "anti-psychiatry" critique. It is demonstrated that the ambit and the influence of the anti-psychiatry movement was wide-ranging, particularly in relation to the noxious elements of institutional care, and the
philosophical, moral and legal basis of involuntary commitment and treatment.

Chapter Eight examines the pressures for, and consequences of the parallel development of mental health law reform in British Columbia that emerged in response to the developments outlined in Chapter Seven. It is shown that the shift in strategy for managing the mentally disordered has been paralleled by pressures for mental health law reform. These pressures include the emergence of the patients' rights movement, the activities of civil libertarian lawyers, and the impact of the Canadian Charter of Rights and Freedoms. It is contended that the direction of mental health law reform has been toward the principles of what has been characterised as the "new legalism". This shift away from medical discretion has facilitated the process of expedited deinstitutionalisation and redevelopment of tertiary services outlined in the previous chapter. It is shown that part of the government's strategy in this regard has been to pursue statutory reform of the Mental Health Act. Subsequently a lengthy consultation process with all stakeholders instigated by the government is shown to have had the effect of bringing to the surface polarised perspectives, particularly relating to involuntary detention and treatment. As a consequence, it will be demonstrated that reform of the Mental Health Act is at an impasse. A qualitative study undertaken as a component of this thesis is discussed. Four in-depth interviews with mental health consumer-activists regarding their beliefs about the involuntary detention
and treatment reveals possible reasons for the adoption of polarised views, and suggests that reconciling these within the context of a new mental health act will not be an easy task.

Chapter Nine concludes with findings of the study. Implications for social policy are discussed.

There are a number of important definitions. The terms "madness", "insanity", "lunacy", "mental disorder" and "mental illness" selectively appear throughout this thesis. They do not all describe exactly the same thing, but rather refer to the accepted medical and cultural construction of disordered thought or behaviour at different historical junctures. Many theorists have emphasised that the conscious or inadvertent use of objectifying or pathologising language maintains hegemonic oppression of marginalised groups (e.g. Drover & Kerans 1993). As Jones (1993), points out, virtually all terms connected to disorders of thought or behaviour carry negative connotations, yet the constant invention of acceptable euphemisms is unsatisfactory. With reservations, the author has therefore elected to use the above terms only as they were used in specific historical contexts. The term "asylum" has a general meaning of sanctuary or refuge, as well as a historically specific meaning that refers to mental institutions. Even though efforts were made in the late nineteenth and twentieth centuries to change the names of asylums to "hospitals" to reflect their supposedly medical nature, the author has chosen use to the term throughout most of the thesis. This is intended to reflect the author's perspective that such name changes
did not signify the end of what was an essentially nineteenth practice, that of consigning large numbers of people to warehouse institutions, until well into the second half of the twentieth century. The term "patient" is utilised to signify people identified as suffering mental illness, and receiving care from the services of the day. "Mental health consumer" is a relatively new term which, although now widely accepted as meaning a consumer of mental health services, remains problematic. Everett & Steven (1989) point out that mental health consumers are cognizant that they differ fundamentally from other consumers as they lack the financial power to take their business elsewhere. Other people prefer the term "psychiatric survivor" (Chamberlain 1993), a term that connotes their survival of the system, as opposed to the illness. Although no term is entirely satisfactory, the term "mental health consumer" is used to connote all contemporary users of mental health services. The term "mental health consumer-activist" refers to any mental health consumer/survivor currently active in a mental health consumer organization, association, or provincial/regional consumer advisory council.
CHAPTER TWO

THEORETICAL PERSPECTIVES

This chapter will discuss four major theoretical perspectives that inform this study. The social control perspective is discussed as it relates to neo-Marxist, Gramscian theories of the State. The two major theoretical perspectives of the mental health discourse are examined. These are the psychiatric paradigm and theoretical perspectives conflated under the "anti-psychiatry" label. Critical theory is examined in terms of its utility to make visible obscured historical constructions of power.

The Social Control Perspective

Social control theory has traditionally been associated with deviancy-derived models (Pfhol 1985), although Rothman (1983) asserts American sociologists first used the term with regard to notions of social cohesion. The difficulty with a social control perspective derived predominantly from concepts of deviancy is that attention is excessively focussed on coercion. This can be problematic when attempting to trace processes that are not always easily visible, such as the changing relationships between mental illness and the maintenance of the social order. Mayer (1983) argues recent scholarship has revised and broadened the parameters of social control theory to account for more subtle, "soft"
apparata of social control. In particular, revisionist historians have sought to explain changing social control strategies in the context of the evolution of capitalism (Foucault 1965; 1978; Ignatieff 1978; Scull 1979; 1984).

The social control perspective and the State.

The linking of social control and the exigencies of capitalism has created a recently renewed interest in the relationships between the State and its apparatus of social control, in both history and sociology (Cohen & Scull 1983). The State functions primarily as a mediator. It is not an unbiased mediator however, as it contains an inherent bias towards the accumulation of capital. Therefore, even though the State is autonomous, its autonomy is relative to the economic base of society (Poulantzas 1978). The State is also relatively autonomous in the sense it is receptive to pressure from the ruling elite and will tend to act on their behalf, but not at their behest (Carnoy 1984, p.235). The State actively seeks to socially control the behaviour of classes, groups, or individuals to the extent they represent a destabilising phenomenon that threatens to potentially disrupt the status quo, in particular the continued accumulation of capital. Ralph (1983) argues the State exercises its social control functions in four ways. These are through overt coercion via the police, legal structure, and bureaucratic regulation, secondly, through ideological conditioning, thirdly, via co-option of mass grievances and fourthly, by moulding the labour force to the needs of capital. Ralph points out that:
it is not necessary to postulate that anyone consciously conspires to create these multiple social control functions. Rather, capitalist State organization implicitly assumes, depends on, and enforces capitalist values. (p.36).

Social control functions are delegated (in order to maintain the autonomy and legitimacy of the State), to components of the State such as the legal system and psychiatry. Gramscian theory asserts that social control is mediated through "hegemony". Hegemony involves attempts by the dominant class "to use its political, moral, and intellectual leadership to establish its view of the world as all-inclusive and universal, and to shape the interests and needs of subordinate groups" (Carnoy 1984, p.70). Gramscian theory asserts there are two aspects to social control, coercion and consent. Consent (hegemony) is given primacy in Gramscian theory, though it is recognised that hegemony is "protected by the armour of coercion" (Gramsci 1971, p.263). The consent relationship is not static however, but is constantly shifting in order to "accommodate the changing nature of historical circumstance and demands and reflexive actions of human beings" (Giroux 1981, p.418).

Langman (1980) contends that both law and psychiatry, as adjunct extensions of the State, collude to enforce the ideological hegemony of the State. Psychiatric and legal jargon are, in Langman's view, the codes by which dominant ideology is translated into social practice. Poulantzas (1978), in his analysis of how the locus of "class struggle" has shifted from the economic to the political sphere, offers a valuable insight into how the State
mediates social control through professional practices, such as those in the legal and medical systems. An important element that characterises the shift from the economic to the political sphere of "class struggle" is the relationship of knowledge and power. The State uses science and technology to rationalize power. A relationship between knowledge and power is derived from the separation of manual and intellectual work. By the control of professionals and scientists via mechanisms of widespread direct or indirect financial dependence, the State is able to integrate new and existing knowledge into its mechanisms of power. Thus the State is not only able to influence the generation of new knowledge, but also how such knowledge is used. It is in the State "where an important part of the strategies for maintenance and expansion of dominant-class hegemony - based on "expertise" - are developed" (Carnoy 1984, p.114). Knowledge, including new technology, (such as expanding psychiatric knowledge and treatment innovations), has to be understood therefore, in relation to the exercise of power.

Studies such as Scull's 1977 study, Decarceration, link changes in the strategy of the management of the mentally disordered with the economic concerns and functions of the State. Poulantzas (1978) argues that in the early stages of competitive capitalism, the State had only general economic functions such as taxation, infrastructure development and so forth. In advanced capitalism, however, the State has assumed expanded economic functions. This is because, according to Poulantzas, the
separation between the economic and political domains has been modified, and differences between the economic arena and politics and ideology have become increasingly unclear. As contradictions in capitalism multiply and produce periodic crises, the State is increasingly compelled to intervene. Here, Poulantzas goes beyond Gramscian theory which contends that the action of the State is essentially negative, as manifested through prevention, control and exclusion. Poulantzas argues that "the State also acts in a positive fashion, creating, transforming and making reality" (p.30). Thus, for instance, the interventions of the State can be analysed with relation to the macro-economic context of health care. Likewise, in mental health, changing State strategies for managing the mentally disordered can be examined at the macro-sociological level.

In summary, neo-marxist and Gramscian theoretical perspectives facilitate an examination, at the macro-sociological level, of why and how social control functions in mental health and the law have changed at different historical junctures.

The Psychiatric Paradigm

For nearly two centuries psychiatric medicine has conducted an energetic and, for the most part, successful campaign to assert that it's practice is based on the ideological foundations of mainstream medicine, namely, science, benevolence, and disinterested altruism (Busfield 1986). Scull (1989) contends that such claims to scientific credibility have provided the psychiatric profession with "a privileged ontological status, safe from even
moderately searching scrutiny" (p.6). Locating the core theoretical constructs that underpin psychiatric practice is problematic however. Mechanic (1989) argues that psychiatry has broad theoretical occupations that range from genetics to psychodynamics. Pressman (1993) contends that the psychiatric profession sits uneasily within the domain of medicine. Pressman states:

That the discipline lacks a set of internal standards by which to differentiate unequivocally the correct theory from the false, or the efficacious therapy from the useless, is an open secret (p.59).

What then, are the theoretical characteristics of the knowledge base of psychiatry that have enabled it to achieve and maintain dominance of the mental health domain?

The psychiatric paradigm/medical model derives it’s theories and ideas from the principles of the objectivism inherent to the scientific method. The historical origin of the tenets of objective rationality and logical positivism occurred with the advent of modernist era in the seventeenth century (Gorman 1993). Gergen (1985) argues that the two basic epistemological orientations to knowledge are exogenic, which perceives the source of knowledge to be in the objective, real world, and endogenic, which perceives the world as socially constructed, primarily through the medium of our senses. Gergen contends that the exogenic orientation is deeply embedded in the Western conception of knowledge as being objective, individualistic and ahistoric. Fischer (1991) states that objectivist epistemology sees reality as
having an independent existence comprised of verifiable facts that can be known through the scientific method. Behaviour is deterministic and can be explained if the relationships between the variables are fully known. These objectivist traditions of science, as exemplified in the medical model, have endowed psychiatry with its legitimation.

"Science is, then, viewed as the lynchpin of psychiatric practice; it is science that permits the boundary to be drawn between the normal and the pathological; it is science that creates the accurate identification of the mentally ill; it is science that provides sound knowledge of the causes of mental illness; it is science that provides the effective methods of cure" (Busfield 1986, p.17).

Despite this, the psychiatric paradigm does not enjoy the same degree of immunity from challenge experienced by many fields of mainstream medicine. Guze (1992) affirms that continued acceptance of essentialist definitions of emotional problems as disease are the foundation upon which the practice of psychiatry rests. If the scientific and biological approach to mental illness is significantly weakened, the hegemony of the psychiatric paradigm becomes endangered. In response, many theoretical defences of the medical model in psychiatry have sought to establish the theoretical and clinical superiority of the medical model over competing explanations and treatments (Guze 1992; Pearlman 1992; Rezneck 1991; Siegler & Osmond 1974). A principal theme in these arguments is that other mental health professionals, particularly psychologists but also social workers, nurse practitioners and others, are less than ideally qualified to provide comprehensive
treatment to the mentally ill. Historically, the tactic of policing theoretical and practice borders by the consistent reiteration of the importance of the bio-medical perspective, has left the psychiatric profession periodically vulnerable to the predations of mainstream medicine itself. Pressman (1993) argues that once a valid biological model is established for a psychiatric condition, (Pressman uses the examples of syphilis and general paresis), it is moved out of the purview of psychiatry. Over time, as another medical discipline establishes it's right to diagnose and treat the condition (such as neurology), and it ceases to be considered to be a psychiatric disorder.

Adherence to the medical model has been a double edged sword for psychiatry. The reductionism of the medical model has offered a coherent, logical and internally consistent schema for the explanation (diagnosis) and intervention (treatment) of mental illness. Few other competing theories have attempted or been able to effectively link explanation and intervention. Psychiatry has struggled, however, to satisfactorily explain, (let alone do anything about), the enmeshment of structural, social and cultural issues and mental illness. The challenge for psychiatry has been to protect the integrity of the medical model while, at the same time, offering credible explanations for non-biological phenomena. The adaptive response by psychiatry has been to incorporate diverse theoretical concepts into the medical model whereby the person's biological, psychological, and social situation are all taken into account (Siegler & Osmond 1974; Clare 1976; Guze 1992). A close
examination of the integration of a holistic approach within the psychiatric paradigm reveals that, in practice, the somatic orientation remains dominant, and the social, structural, and psychological situation of the person is, at best, of secondary consideration. Baruch & Treacher (1978) argue that claims to embrace psychological and social factors are never framed in terms of relative emphasis. The biological emphasis remains paramount, but this is obscured by the apparent consideration of other factors. The reason for a (camouflaged) primary emphasis on the biological is, according to Baruch & Treacher, directly connected to the continued dominance of psychiatric medicine. Medical practitioners can claim to be the only people qualified to work properly within the model, and all other professionals are relegated to ancillary status. Engel's (1987) call for a new medical model based on a "biopsychosocial" approach is characteristic of the claim that the medical model is suited to provide a holistic context for assessment and treatment. Engel argues that this expanded approach would encompass consideration of the social and cultural elements of the human experience of disease whilst not losing the valuable contributions of the biochemical and neuropathological concepts of disease. Most contemporary psychiatrists and mental health professionals would probably state they philosophically subscribe to this approach. It is in the practice situation that the emphasis and political dominance of the medical model is revealed. Seigler & Osmond (1974), for instance, propose three major models of "madness" (their terminology). These
are the medical, moral and impaired models. The authors argue that these models are discontinuous in that they do not explain everything, the inference being that in combination, all contribute to a comprehensive understanding. They then state:

Once the schizophrenic person has been installed in the sick role and brought under the care of the medical model, techniques derived from the moral and impaired models can be brought to bear on the secondary effects of the illness (p.41).

Roth & Kroll (1986) and Guze (1992) acknowledge the medical model could be renamed a biopsychosocial model to theoretically reflect the social context within which the organism exists. The authors reject the renaming of the medical model, however, claiming the original term is preferable, not to connote ownership by the medical profession, but to maintain continuity with it’s roots.

The motivation for maintaining a semantic and theoretical connection with medicine has powerful political implications. Medicine has a lengthy history of using it’s complex construction of knowledge to exert power politically and in the marketplace. Foucault (1980) casts light on the political importance of maintaining a hierarchy of knowledge and theory when he states: "Knowledge and power are integrated with one another...It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power" (p.50). It follows that it is prudent for the profession to assiduously promote the linguistic dominance of medicine terminology. Guze (1992) advises that psychiatry is, in essence, the medical model applied to psychiatric conditions. He states:
This means simply that the concepts, strategies, and jargon of general medicine are applied to psychiatric disorders: diagnosis, differential diagnosis, etiology, pathogenesis, treatment, natural history, epidemiology, complications and so on (p.4).

Adherence to specialist language can be understood to have a significance that goes beyond the usage of a commonly understood (within the profession) technical terminology. Foucault (1970), among others, has argued that it is through language that the world is known. Leonard (1990), in discussing Foucault’s ideas on language and power, argues that to impose a "scientistically conceived regime of truth" (p.64), language must be reconstructed to meet the demands of the scientific enterprise. If language, (representing ideas), does not comfortably fit within this framework, then it must either be made meaningless or discarded (op cit). The incorporation of ideas under the rubric of the medical model offers another way to maintain the dominance of the biological focus. Ideas that may present an implicit critique of psychiatric practice are rendered essentially harmless to the pre-eminence of the psychiatric paradigm through co-option into it’s hierarchy of knowledge. If one accepts that the social arrangements of capitalist societies generate, in part, immiseration and deviance, the claim to take account of structural and social factors while keeping a focus on individual pathology, represents a powerful method of stabilising the status quo.

The hallmarks of science, as applied to medicine and psychiatry, are reductionism and a focus on individual pathology. These approaches are congruent with theories embedded in the order
perspective and the liberal paradigm. Busfield (1986) emphasises that individualism permeates every aspect of medicine from the doctor-patient relationship to its explanations of illness and the treatments it offers. Mullaly (1993) contends that order theorists perceive social problems as located in the individual and, because they represent a potential threat to societal equilibrium attempts are made to return them to normal functioning through social institutions like psychiatry. Recent events in psycho-pharmacological and genetic research have moved psychiatry further towards a somatic orientation (Pressman 1993). Guze (1992), for instance, speaks of his hope for scientific advances emerging as the primary force in shaping the future of psychiatry. He states:

Growing knowledge of the brain's functions in carrying out mental processes and behavioral tasks, within an adaptive genotype-environment interaction that allows for individual variation, will make the difference in the long run (p.128).

Such views raise an important question as to whether the increasing theoretical shift towards biology is likely to further decontextualise the lived realities of mentally ill people as clinical attention correspondingly turns to individual biological etiology and treatment. Baruch & Treacher (1978) argue that this is a distinct possibility because, if doctors become increasingly preoccupied with the disease process, the social problems and the problems of daily living of the mentally ill person are liable to fade into insignificance.

In summary, a central theme of this study is the examination of the ascendance and influence of the psychiatric profession. It
is important to understand, therefore, from a theoretical perspective, how the psychiatric paradigm has achieved and maintained its dominance of the mental health domain. The psychiatric paradigm has been effective in demonstrating that it can offer both explanation and treatment of mental illness. The paradigm is derived from the epistemology of objectivism and scientific reductionism. As such, the paradigm is characterised by a theoretical focus on the individual. The paradigm incorporates other contextual perspectives into the biomedical model. The biomedical focus remains paramount however, though the addition of other perspectives obscures this to a degree. The reasons for claims to theoretical eclecticism are directly connected to the continued survival of the dominance of the paradigm. In this way, the psychiatric paradigm has dual functions. While offering explanation and treatments for individual distress, it serves as an instrument of order and social control through the medium of moral authority, medical expertise, and officially sanctioned legal power.

Anti-Psychiatry Theories: Societal Reaction and Civil Libertarian Perspectives

In the 1960's and 1970's the appearance of a theoretical literature critical of the psychiatric enterprise emerged. Prior to the 1960's, psychiatric orthodoxy - that mental illness is essentially an illness like any other, which is most appropriately treated within the parameters of the medical ideas of the day - encountered few theoretical challenges that were sustained over
time. The critical literature has been associated with sociologists such as Goffman (1961) and Scheff (1966; 1984), psychologist Rosenhan (1973), the polymath philosopher-historian Michel Foucault (1965), psychiatrists such as Laing (1967; 1969) and Szasz (1961; 1970; 1984), and lawyer-advocates such as Ennis (1972) and Kittrie (1971). Although the views, and certainly the politics, of these and other critics have manifested wide differences, they have tended to be conflated as advocates of the so-called "anti-psychiatry" movement (Cavadino 1989). Other writers such as Brown (1985) have suggested an even broader definition of anti-psychiatry, arguing it embraces patients' rights, Marxist and other radical critiques of psychiatric practice, and contributions from feminist theory and therapy. Some however, most notably Thomas Szasz, have vehemently refuted the validity of the label and concept of anti-psychiatry (Szasz 1976, p.48-49). Chamberlain (1990) also sharply distinguishes between the patients' rights movement and critics under the anti-psychiatry rubric whom she casts as academics and dissident mental health professionals, engaging in a largely academic exercise. Anti-psychiatric theorists have offered a wide ranging critique of psychiatric orthodoxy. Their questions gravitate around three main areas: the nature of institutions, the efficacy and effects of psychiatric practice, and the legitimacy of psychiatric power in relation to civil rights. It is not the intention here to give an exhaustive overview of this prolific literature but rather to briefly sketch the main tenets of the pre-eminent writers in each
of the three categories, and to summarize their impact on the field of mental health.

The critique of the institution.

Erving Goffman’s *Asylums* (1961) offered a polemical, trenchant critique of the "total institution", a term that he asserted could be applied to any institution where inmates lives were regimented on a full-time basis, including mental hospitals, prisons, concentration camps and closed religious institutions. Using a methodology of participant-observation at a large state mental hospital in Washington, D.C. in the mid 1950’s, Goffman drew a compelling picture of the effects of institutionalisation. Inmates, Goffman argued, were subordinated in a highly structured, hierarchical situation of staff and inmates. They were subjected to a monotonous, dehumanising regime which inexorably eroded individualism and produced an apathetic, acquiescent conformity. Daily activities occurred within the context of "batch living", whereby all inmates were treated the same according to rigid regulations, in-situ largely for bureaucratic convenience. Continual surveillance, a powerful process of "disculturation", and objectification by staff eventually caused inmates to become withdrawn and completely dependent on the institutional regime, to the point that the individual became incapable of survival in the world outside of the institution (op cit). Goffman’s seminal work has been roundly criticised on a number of fronts. Some of these criticisms relate to the fact that like many other writers in the anti-psychiatric tradition, Goffman was "...cited by many and
examined by few" (Ditton 1980). Goffman, for instance, was careful to state that not all institutions were total institutions, nor did all institutions share the same characteristics. Nevertheless, many people ascribed the pejorative connotations of Goffman's "total institution" to all mental hospitals and prisons (Jones and Fowler 1984). Goffman has been castigated for including no account of reforms introduced at the time of his research, such as "open door" policies. Furthermore, he failed to refer to the introduction of psycho-active medications which ameliorated the need for some of more brutal forms of social control within the institution. Goffman has also been criticised for the "unusual" site for his primary research. St. Elizabeths hospital in Washington was a segregated institution of 7,000 inmates catering to a largely black community (which Goffman did not mention), and while Goffman's thesis exposed similarities between institutions, it did not allow for the exploration of differences (Issac and Armat 1990; Jones and Fowler 1984).

The critique of psychiatric practice: labelling theory.

Five years after the appearance of Asylums, sociologist Thomas Scheff (1984) articulated a radical critique based on the epistemological perspective of societal reaction theory. Societal reaction theory derives from the epistemological tradition of social constructivism. In this epistemology, reality is socially constructed in the dynamic of experience that occurs between the observer and the observed. Truths about reality are considered multiple and relative, and knowing and science are seen as ongoing
processes of interpretation (Fischer 1991). The major theoretical stream of the societal reaction perspective is labelling theory. Labelling theory asserts that deviant behaviours have no inherent value qualities in themselves, but rather it is the reactions of others that ascribe values: "...deviant behaviour is behaviour so label" (Becker 1963). Scheff (1984), the preeminent labelling theorist, defined mental illness as a type of residual deviance, a variety of behaviours which violate everyday social interactions. Crucially, Scheff made the observation that not all people who engage in residual deviance are labelled mentally ill. To account for this, Scheff contended that it was the act of being labelled by others that locked the residual rule breaker into a stereotyped career of deviance as a mentally ill person. Although Scheff refrained from refuting the concept of mental illness altogether, he clearly held the psychiatric enterprise responsible for the deviancy it projected onto others. Scheff outlined nine propositions, the ninth stating that labelling is the most important single cause of careers in residual deviance" (Scheff 1966, p.92-93). Scheff later moderated his stance when he acknowledged that: "In recent years, there has been a tendency in sociology to overstate the claims of labelling theory" (p.x). Consequently Scheff reframed the crucial ninth proposition to read that "...labelling is among the most important causes of careers of residual deviance" (Scheff 1984, p.69). Certainly, studies of the relative effects of labelling and social rejection have been somewhat equivocal, with some supporting the theory, and others not
(Liska 1987). Liska concludes this may be due, in part, to labelling theorists over-stating their case, though he acknowledges the theory has provided a useful critique of psychiatric practice. Pfohl (1985) contends that the most important criticisms of the theory come from the structural critique. This critique contends that the theory has not been adequately concerned with the structural causes of deviancy. Pfohl suggests that the preponderance of micro-level studies of the effects of labelling may have encouraged this omission. Liazos (1972) concurs with this conclusion. In his examination of studies concerned with the power to label others Liazos contended that the insight, while important, was not well developed. He discovered that studies tended to focus on the micro-level, exploring the deviancy as identity or they focussed on the middle level agents of social control (for instance, mental health professionals). Liazos surmised this focus was misdirected and the larger structural causes of deviancy were minimised as a result.

Serious doubts were raised by another labelling theorist about the accuracy and validity of psychiatric practice, in particular the ability of mental health staff to accomplish the most crucial and basic of clinical tasks; differentiating the sane from the mentally disordered. In Rosenhan's (1973) classic study, *On Being Sane in Insane Places*, eight "pseudopatients" gained admission to twelve different hospitals through the presentation of a single, minimal symptom, that of experiencing a possible auditory hallucination (an unclear voice saying "empty", "thud" and
Following admission, the pseudo-patients ceased completely to manifest any behaviour liable to be interpreted as evidence of psychopathology. All patients were diagnosed with schizophrenia except one who was diagnosed with manic-depressive disorder. Hospitalisations ranged from 7 to 52 days and all were discharged in remission. In addition to what Rosenhan saw as a confirmation of labelling theory, his study revealed that powerlessness, depersonalization and other negative aspects of institutionalisation were unequivocally counter-therapeutic. The Rosenhan study brought a renewed attention to the potential problem of people being unnecessarily committed as Himelfarb & Lazar (1981) point out:

....the failure of the unnecessarily committed patient to engage in violent behaviour will not be taken as a sign of mistaken diagnosis, but more likely a sign of successful intervention. Here one can see the vicious circle, the Catch-22, of diagnosis and commitment. A patient, once committed to a mental institution, may not be able to disprove or challenge his diagnostic label. Even if he (sic) exhibits no more bizarre or violent "symptoms", this may be taken as proof of the validity of the course of treatment and commitment more generally. At best, the patient may hope to be re-categorised as "in remission" (p.8).

Although Rosenhan's study has been methodologically criticised (Spitzer 1975), its effect at the time on a public already sceptical about the psychiatric profession was "devastating" (Issac & Armat 1990). Although the claims of some societal reaction theorists that psychiatric practice causes mental illness have been undoubtedly overstated, the scholarship in this area has extended
knowledge of mental illness and psychiatric practice from a deviancy and social control perspective.

The civil libertarian perspective.

The civil libertarian critique holds that the right to physical liberty is of over riding importance. Gordon (1988) contends that civil libertarians have taken particular exception to the widespread imposition of treatment of people against their will on the premise that treatment might work, particularly given the imprecise nature of psychiatric practice, and the unimpressive historical track record of therapeutic efficacy. Thomas Szasz, an American psychiatrist/psychoanalyst, has occupied the extreme end of the civil libertarian continuum for over thirty years. Szasz has been described as the intellectual heir of a "flint-hearted" nineteenth century liberalism that asserts personal autonomy and individual liberty represent the highest good (Sedgewick 1982), as well as a "...kind of Milton Freidman of the political economy of mental disorder" (Unsworth 1987, p.347). Szasz's sustained attack on psychiatry has been influential, in part because he has focussed on psychiatry's ties to mainstream medicine which, as has been demonstrated, have been historically and conceptually tenuous. Szasz's work can be viewed in two major components; a theory of personal conduct and a critical analysis of the social functions of psychiatry. Szasz's views have rested on his original premise that mental illness is a myth (Szasz 1961). The term "mental illness" is, Szasz contends, a metaphor that simultaneously conceals moral problems in daily living as illness, and justifies coercion as
treatment. Those who cannot or will not conform to consensual societal norms are "scapegoated" by being labelled mentally ill and "punished" by involuntary detention and forced treatment (op cit). He asserts that mental health legislation empowering such action is entirely unjustifiable. If mental illness is truly like a physical illness (Szasz argues that the absence of evidence such as organic brain lesions refutes this claim), then it must be logically treated as such. Since special laws pertaining to diabetes, for instance, are an absurdity, so should they be for schizophrenia. If, on the other hand, mental illness is a metaphor, mental health legislation and psychiatric power are equally untenable (Szasz 1961;1963). Thus Szaszian logic dictates the sole purpose of psychiatry, outside of a private "contractual psychiatry", is oppressive social control by the "therapeutic state", as Szasz describes in characteristically polemic prose:

The fact that psychiatric imprisonment is called "civil commitment" is...simply a part of the linguistic deception characteristic of the mental-health system. Since civil commitment results in the loss of liberty, and subjects the victim to health hazards at the hands of medical criminals whose ostensible healing function is legitimised by the state, it entails far greater deprivation of rights than does incarceration in prison, a penalty carefully circumscribed by...judicial safeguards (Szasz 1984, p.69).

Not all civil libertarian activists adhere to Szaszian orthodoxy which has been roundly and repeated criticised. The civil libertarian position does, however, tend towards a marked scepticism of the legitimacy of the psychiatric enterprise. Sedgewick (1982) asserts this relates to the "crucial defect" of having to maintain a focus on the mis-use of medical power. Thus,
civil libertarians are compelled to act as reactive protestors.

Consequently, Sedgewick asserts:

A further move beyond this partially negative stance is...that of complete negation of negation of the legitimacy of any psychiatric intervention whatever. Rather than taking confinement and ill-treatment as the misuse of therapies that are basically sound, we are bidden to see them as the normal use of an authoritarian power which is basically evil. Defensive libertarianism in the mental health field...into an all-round condemnation of the psychiatric enterprise itself (pp.217-218).

In summary, the anti-psychiatry critique has been highly influential in raising questions in the academic and public mind about all aspects of the psychiatric enterprise. These include questions about the potentially noxious effects of asylum-based care, the negative effects of diagnostic labelling, which has poor reliability, and the legitimacy of removing fundamental rights and freedoms in order to provide medical treatment.

The Critical Perspective

Critical theory facilitates the examination of the historical construction of power relationships between macro-societal structures, institutions, and individuals. Mullaly (1993) contends that critical theory concerns itself with social transformation, moving from societal relationships based on exploitation and inequality to relationships predicated on emancipatory participation and freedom from domination. Pfohl (1985) argues this view is essential because as long as the reproduction of power hierarchies are endlessly reproduced, there is little chance that deviance and social control can be anything more than continual
conflict concerning who has the power to control whom. Critical theory pays close attention to the exercise of power in social relations and suggests that structures of domination and subordination are socially constructed over time. Critical theorists critique objective, logical-positivist knowledge as ignoring the effects of power. Quinney (1979), for instance, argues that positivism induces an intellectual inability to be reflective. Thus the psychiatric enterprise finds it difficult to acknowledge its own historical relationships to power or its ideological foundations. Craib (1984) argues critical theorists are specifically concerned with the construction of power. The Frankfurt school, for instance, understands power as a historical process. Craib states: "..it [ critical theory ] puts our present society and views back into their historical context, showing they are not fixed for all time, but are part of a long and difficult process in which we are all engaged" (p.189). Luske (1990) adds that critical theory also offers the promise of alternative conceptions that would otherwise be invisible to us, of how social life can be organised and social problems defined, when he states: "It’s [ critical theory ] historic project is to de-reify the future by challenging the power of pre-definition and the definitions of the powerful" (p.5).

There have been many criticisms of critical theory (op cit). These include that it is empty speculation, it is empirically untestable, and that it only produces abstract generalisations. Recent critical theorists have refuted some of these criticisms.
Leonard (1990) states the defining characteristic of critical theory is its ability to link social theory with political practice. Leonard argues there are three criteria that must be met to be considered critical theory. These are the ability to locate sources of domination in actual social practices, the ability to offer some notion of an alternative vision and the prescription of tasks to work towards that vision, expressed in such a way that they are meaningful to the oppressed. Pfohl (1985) argues that inequitable power relationships, such as those that exist between professional and client can be ameliorated utilising a "power-reflexive" methodology. This methodology has utility for the theorist, the practitioner, and the person experiencing oppression. Using Foucaultian analysis, Pfohl establishes the fundamental inter-connectedness of power and knowledge. With this in mind, the power-reflexive theorist is encouraged to always ask what any theory or study says about how power is organised in society in general. At a practice level, power-reflexive practitioners are directed to perceive their own biographical experiences of power (for instance, race, gender, education, sexual orientation, class), and the exercise of knowledge in hierarchical settings, (such as mental health centres) as reproducing relationships of domination and subordination, even if this is unintended. To ameliorate this the practitioner must be willing to critically ask him or herself how their actions, at the micro or macro level can help further social justice. The person who is oppressed, is encouraged to identify and name the oppression, to
perceive the links between knowledge and the exercise of power, and to organize collectively against structures and relationships based on domination and subordination.

Drover & Kerans' (1993) recent work on a "claimsmaking" approach to welfare theory offers a framework for analysis of how "claims" by marginalised groups, such as the mentally ill, are articulated and responded to by the institutional order. This approach has specific utility for this study as it pertains to the understanding of claims for, among other things, enhanced "rights" by mental health consumers. Drover & Kerans' claimsmaking approach, which is derived from a critical perspective, attaches importance to individual subjective experience and meaning. Everyday experience is understood to be a legitimate standpoint from which claims can be identified, named, and articulated. Drover and Kerans emphasise that "claims" involve much more than demands for resources. For instance, claimsmaking can involve a struggle for a reformulated identity. The process of pursuing a claim involves organising collectively and impacting on the hegemonic discourse so that a reframed identity, free of negative connotations that contribute to continued marginalisation, can be accommodated. For many people who have experienced mental illness this has meant renaming themselves and their experience so that they can "narrate one's genuine autobiography, to be the judge with respect to the meaning and coherence of one's life, to secure one's own identity" (Drover & Kerans 1993, p.9).
Once a group of marginalised individuals publicly articulate a claim arising from a collective recognition of private dissatisfactions, it is adjudicated in the domain of the political. To publicly articulate a collective demand, personal experiences of oppression have to be linked with some understanding of the hegemonic nature of the dominant discourse, and how, on a practical level, things need to change. Drover & Kerans point out that the preservation of the institutional order is procured largely through hegemonic consensus that ensures compliance to dominant values. Furthermore, the underlying purpose of any institutional response is biased towards the continued legitimation and preservation of the existing social order. Claims that do not threaten the dominant group (or are made by elements of it), are likely to be accommodated. A claim articulated by a marginalised group, however, is likely to be presented in terms that represent a radical critique of the existing social order. This is because the claim invariably involves demands for increased autonomy and self-actualisation that cannot be met until the existing relationships of domination and subordination are changed. Resistance is highly likely as claims represent conflicts "over the power to give meaning to the world by defining legitimate participants, issues, alternatives, and alliances" (Jenson 1989, p. 74). Drover & Kerans (1993) contend while claims can be completely rejected or accepted without modification, in reality these polarities of response rarely occur. Rather, the institutional response is usually to
divert, dilute, or co-opt and manage the claim in order to make it more acceptable to the maintenance of the established order.

In summary, Drover & Kerans' work offers an analytical framework with which to understand the process and potential outcome of claims making in the mental health. Possession of such an analytical framework is important because the institutional response to claims will occur over time and evolve as a discontinuous process.

In conclusion, the critical theoretical perspective offers an analytical framework for the examination of the historical construction and mediation of institutional power relationships. It does not explicitly endorse either the psychiatric paradigm or anti-psychiatric perspectives as having an intellectual or moral ascendancy. Instead, it focuses on the historical matrix of domination and subordination within which the mentally ill and mental health professionals find themselves. Critical theory advocates the radical restructuring of these relationships and offers some practical suggestions as to how this process may occur in political practice.
CHAPTER THREE

METHODOLOGY

This thesis is a sociological, historically informed, study of the reasons for, and interaction between, the provision of involuntary, asylum-based care, professional practices, and associated phases of mental law reform at different historical junctures. In particular, it seeks to explain the historical development of the epistemological and professional division between psychiatry and law which is reflected in the contemporary dichotomy that can be summarised as "treatment" vs. "rights". As such, this analysis is within the domain of historical sociology. Smith (1991) defines historical sociology as the investigation of:

the mutual interpenetration of past and present, events and processes, acting and structuration. [Historical sociologists] try to marry conceptual clarification, comparative generalisation and empirical exploration (p.3).

This study therefore moves beyond an attempt to explain contemporary events through the provision of an understanding of the past. Abrams (1982) emphasises that analysis within the historical sociological domain is not:

merely a matter of recognising the historical background to the present. It is the attempt to understand the relationship of personal activity and experience on one hand and social organization on the other as something that is continuously constructed in time. It makes the continuous
41

process of construction the focal concern of analysis (p.16).

A combination of three methodological approaches was utilised to address the questions outlined in Chapter One. These approaches are: thematic literature review, archival analysis, and qualitative interviews. Methodologically, the utilisation of three approaches was intended to improve the verification of findings from multiple sources and thus improve validity.

The origins of this study are located in personal and academic experience. Having been originally trained in the psychiatric paradigm as a psychiatric nurse, the author worked in a variety of institutional and community mental health settings in the U.K., Australia, and Canada. It was the author's observation that the moral, legislative, and policy dilemmas pertaining to involuntary detention and treatment were similar, regardless of country or site of practice. Having witnessed different stages of decline of various large custodial facilities, it appeared to the author that the social control and therapeutic dilemmas of the psychiatric enterprise were brought into sharp relief by the process. Study of historically isolated elements of the process (such as media perceptions of deinstitutionalisation, during nursing and social work undergraduate degrees), provoked larger questions. It was apparent that the issues concerning involuntary detention and treatment could not be examined in isolation from a range of contextual forces including the complexities and difficulties of dismantling asylum-based care, the powerful influence of the medical profession, the impact of new treatment technologies, the
anti-psychiatry critique, and, most recently, the emergent political status of the patients' rights/mental health consumer movement. Given the complexity of the development of these issues over time, a sociological, historically informed approach was adopted. A retrospective analysis would allow the researcher to make an assessment of the significance of various historical variables and their relation to contemporary dilemmas. Scull (1989) contends that:

One of the virtues of a historical perspective that extends beyond the ideas and events of the past quarter century is that it makes us properly skeptical about claims of intellectual breakthroughs and the discovery of utopian solutions to the complex and extraordinarily recalcitrant problems we label mental illness. It also leaves us better placed to assess just how novel and original our current enthusiasms really are (p.29).

Given an informed understanding of the consequences of certain historical dynamics, the study would illuminate the constraints and possibilities of future developments in mental health legislation and services that embrace the needs of all stakeholders.

This study has several limitations. A major limitation of the study is the restriction of in-depth research to British Columbia. A comparative study of different provinces was beyond the scope of this thesis. Thus, while it is asserted that British Columbia was subject to trends that impacted on other jurisdictions, (for instance, deinstitutionalisation), it cannot be assumed that developments were, or are representative of other Canadian provinces or North American jurisdictions. As such, the focus on British Columbia represents a "case study" and further research is
needed to understand the extent to which developments were paralleled elsewhere. A second limitation was the exclusion of an examination of forensic psychiatric care and treatment, and mental health legislation concerned with the mentally disordered offender. This area is excluded due to the specialist and somewhat divergent nature of forensic psychiatric issues, legislation, and practice. A specific limitation refers to the volume of archival research undertaken. To the extent that validity can be judged by the scope and volume of data analysed, the validity of this study is correspondingly limited. The purpose of this study, however, was not to undertake an exhaustive examination of all aspects of involuntary care and treatment in British Columbia. Rather, the intention was to position the debate in a historical context, and discuss key events and processes that provided a representative indication of pertinent trends through different historical junctures.

Specific Methodological Procedures

Organization of the study.

The organization of this study is based on a chronological progression from the nineteenth century to the present. Chapters are organised into discreet time frames. The strength of this organisational structure is that it facilitates the description of complex historical events. This structure is somewhat problematic, however, in the presentation of a coherent analysis of historical processes (such as deinstitutionalisation) and themes (such as periods of mental health law reform), neither of which fit neatly
into discreet temporal categories. The choice of how each chapter is delineated by time period therefore represents a compromise. The time frame of each chapter was chosen to facilitate, in the researcher's judgement, the most coherent discussion of the interaction between concrete historical occurrences, ongoing processes, and developing themes. Occasionally, this gave rise to organisational anomalies, as processes or themes, and even specific events, were followed in a way that does not conform precisely to the temporal organisational structure of the chapter. The researcher has made every effort, however, to minimise these organisational inconsistencies.

The historical and thematic focus of the study moves from the broad to the specific with relation to place. The historical origins of the major issues and themes are examined with relation to pertinent developments in the U.K., the United States, and Canada in the nineteenth century. The manifestation of the pertinent themes in British Columbia in the late nineteenth century is discussed. In the period covering the first half of the twentieth century, the focus is narrowed to British Columbia, although reference is made to influential developments in the United States and Canada. An in-depth examination of developments in British Columbia is offered in the period covering the second half of the twentieth century.

To maximize validity, this study utilised multiple types of data from three main source areas. The first source area involved a systematic and thematic review of the literature. The second
involved a review of archival data pertinent to the themes and questions in the literature. The third utilised in-depth qualitative interviews with mental health consumer-activists concerning their beliefs about the involuntary detention and treatment.

**Review of the literature.**

A systematic and thematic review of the literature pertaining to asylum-based care and mental health law was undertaken. This entailed a systematic review of book and serial holdings. Major psychiatric journals were reviewed as they pertained to the provision of asylum-based care, psychiatric treatment and mental health policy, as well as those that addressed issues at the interface of psychiatry and law, such as the right to refuse treatment. Examples include *The Canadian Journal of Psychiatry, Canada's Mental Health*, and the *International Journal of Law and Psychiatry*.

Two main streams of scholarship dominate the historical mental health literature. These streams are scholarship that falls within the "march of progress" school, and study within the historically revisionist, social control tradition. Congruent with the theoretical perspective of this study, the review of the literature was influenced by the perspective offered by revisionist historians who have grounded their work within a social control paradigm (e.g. Cohen & Scull 1983; Foucault 1965; Rothman 1971; 1980; Scull 1979; 1993). Prior to the relatively recent emergence of this revisionist historical scholarship, changes in the treatment of the
mentally ill were explained as generally incremental episodes of benevolent reform (e.g., Alexander & Selesnick 1966; Grob 1973; Jones 1955; 1993; Zillboorg 1941). In this tradition, change is generally synonymous with progress, motivations are invariably interpreted as benevolent, and negative consequences of change understood as the unfortunate intrusion of unforeseen variables. Thus, the treatment of mental illness was seen to have moved from "barbarism to enlightenment, from ignorance to expertly guided intervention, from cruelty and vindictiveness to scientific humanism" (Cohen & Scull 1983, p.2). A social control perspective provides an analytical framework which encourages:

- scepticism about the professed aims, beliefs and intentions of professed reformers; concern with analysis of power and its effects; curiosity about the relationship between intentions and consequences; determination to locate the reform enterprise in the social, economic and political contexts of the period (Cohen and Scull 1983, p.2).

A comprehensive review of the literature using a social control perspective therefore questions the notion of benign progression in the reformist trajectory. Literature is not examined with the intention of identifying individual or institutional agents of change in order to ascribe wilful negative motivations. Rather, the perspective facilitates an examination of the literature that identifies the effects of contradictions inherent in institutions that interact in the context of capitalist society. Thus, the liberal scientific and humanitarian ideology of psychiatric services is examined to make visible the mechanisms by which social control is mediated through ostensibly therapeutic functions.
Other, macro-sociological phenomena can be similarly analysed. For instance, the dual functions of the welfare state can be revealed to simultaneously facilitate the redistribution of resources while ensuring the quiescence of the workforce in economic downturns, and the availability of a readily available reserve pool of cheap labour.

**Archival documents.**

Archival information was obtained primarily through the U.B.C. library system, Riverview hospital library, and publicly available government documents. Data was extracted from a variety of sources including Royal Commission reports and transcripts of proceedings, asylum/hospital annual reports, reports of non-governmental inquiries (e.g. Canadian Mental Health Association), and publications containing provincial and federal government statistics. For the purposes of analysis official government reports were placed in two categories: those primarily related to assessing the state of services at a particular historical juncture and recommending future developments (e.g. *Mental Health Planning Survey 1979*), and those that had a more issues based focus (e.g. Ombudsman’s (1994) report, *Listening: A Review of Riverview Hospital*, into administrative fairness at Riverview hospital). At the same time, both types of reports were examined for commentary that revealed or confirmed trends about the direction of mental health services. This reflected the researcher’s dual objectives of tracking historical events on a chronological basis, while developing an understanding of themes and interactions between
forces that were not chronologically anchored. A specific problem concerning the availability and quality of archival data was encountered with relation to the annual reports of provincial mental health services. These reports were comprehensive to the point of exhaustion from the 1930's until the late 1970's. Annual reports were complete with statistical and written descriptions of all aspects of the activities of the provincial mental health services. Perhaps surprisingly, this not infrequently included candid commentary by government officials on the difficulties facing the system and government. During the 1970's, the progressive reorganisation of departments combined with the tendency to condense information, meant that the informational quality of reports diminished dramatically. By the 1980's, annual reports were brief documents which, due to their "promotional" nature, were of little analytical value.

A selective review of the provincial media was undertaken and utilised in two ways. First, searches of British Columbian media reports were scanned to provide a background to reactions to specific mental health issues at different historical junctures. Secondly, and more significantly, media reports were used was to locate material about why official inquiries were instigated, or what the reactions to findings were. In British Columbia, an absence of daily Hansard recordings prior to the 1970's, creates difficulties in obtaining official political background to particular developments.
A review of specific qualitative methodology for the in-depth interviews with four mental health consumer-activists will now follow.

Qualitative Interviews Methodology

The intent of this component of the thesis was to explore the beliefs of mental health consumer-activists regarding the right to refuse treatment. The integration of qualitative interviews into this broader historical sociological study, was intended to provide a link between the micro-sphere of personal experience and the broader historical sociological themes in order to inform and enrich the overall study. Increasingly, it has been recognised that policy analysis should be informed by seeking the input of those whom the policy ultimately affects. Mass (1993), for instance, contends that policy analysis could benefit from the perspectives of sociology and psychology, and that macro-social processes of policy-making need to be informed by person-focused enquiry. Jennings (1983) contends that qualitative research may indicate new social policy objectives and reveal "a deeper, more sensitive comprehension of the sociological, cultural, and psychological ramifications of governmental action" (p.27). Denzin (1982) argues that qualitative research can embrace history because past events and processes influence current perspectives, feelings because they reflect valid perceptions of reality, and power because it permeates all structures of society. Lord, Schnaar and Hutchinson (1987) argue that understanding the consumer perspective has tangible advantages for both the researcher and the mental
health professional. They state: "The consumer perspective personalizes our understanding of needs and issues, and helps us grasp dilemmas and contradictions faced by powerless people" (pp. 33-34). This section of the thesis aims, therefore, to take note of consumers' reality as a primary source of information, in order to inform others why their perspective is central to historical and contemporary dilemmas discussed throughout the wider thesis.

Mental health consumers have an emergent political importance in relation to mental health policy and service planning. The mental health consumer perspective has been historically ignored however, (Kopolow 1981; Lord 1989), and their subjective experience has been traditionally discounted as unreliable despite evidence that people with direct experience of the mental health system have a unique knowledge and can effectively articulate their concerns (Estroff 1981; Hutchinson, Lord, Schnarr, & Savage 1985; White 1989). As a consequence, existing knowledge of consumer activity remains largely fluid and informal (Church 1989), and there continues to be significant barriers to the effective expression of the consumer perspective and their meaningful participation in all aspects of the mental health system (Colom 1981; Everett & Steven 1989). It is the author's perspective that mental health consumers are those most directly affected by changes to mental health services or mental health legislation. As such, given the relative lack of knowledge about their beliefs and issues, it is essential to actively seek and embrace their perspectives.
The design of the qualitative interviews was exploratory-descriptive. Rubin & Babbie (1989) advise that exploratory research is useful when the research issue is relatively unstudied, as is the case with the beliefs of mental health consumers. The qualitative interviews were descriptive in that they sought to elicit lived experience. In the hermeneutic tradition of inquiry (Bouchard 1991; Orcutt 1990), the interviews elicited the subjectively endorsed realities of mental health consumers and linked those views to the historical sociological themes explored in the wider thesis.

A qualitative approach utilising an interview format was adopted because it most ably facilitated the exploration of mental health consumers' beliefs. In-person interviews are a highly suitable method for eliciting personal information. Such interviews also facilitate audio-taping which ensures the accuracy of the raw data that is collected. Qualitative interviews gave respondents a context in which they could describe at length, and in their own words, their beliefs as they related to personal experience. Patton (1990) states that qualitative measurements "....find out what people's lives, experiences and interactions mean to them in their own terms" (p.22). To obtain the data, qualitative, open-ended interviews with key informants were conducted. Gilchrist (1992) describes key informants as individuals who possess special knowledge and who have access to perspectives denied to the researcher. Mental health consumers are key informants, in that it is increasingly recognised that
experience of mental illness and of the mental health system represents a form of expert knowledge and unique perspective.

**Sampling**

A purposive sampling strategy involving politically important cases was utilised. Patton (1990) defines purposive sampling as the selection of information-rich cases for in-depth study. Politically important case sampling is defined as attracting attention to the study by sampling politically important cases (pp.182-183). Mental health consumers, in the context of the stalled Mental Health Act Review process, and in terms of their emergent political status, represent politically important cases. In addition, snowball sampling was employed. Discussions with mental health consumer-activists, mental health professionals, and lawyers employed by the provincial government and a civil rights legal organization, resulted in suggestions about possible key informants who might be willing to be interviewed.

The major limitation inherent in this sampling strategy is that it is not known if the participants are representative of the consumer population. It cannot be presumed therefore that the findings are representative of anything other than the individuals beliefs. As the study is exploratory-descriptive, it would require further research to determine the applicability of the respondents beliefs, and their generalizability to the overall mental health consumer/survivor population. The strength of the sampling strategy, however, is that the key informants provide an information-rich perspective that is well developed due to their
involvement with mental health consumer organisations, as well as their own personal experiences.

The inclusion criteria was the mental health consumer be active in mental health consumer politics, either by virtue of their affiliation to a mental health consumer organization, or their position on a representative structure or committee that concerns consumer input into policy or service development. Exclusion criteria was mental health consumers who were not affiliated with a group as described above, and anyone who had not had direct experience with the mental health system as a client.

To ensure, with a reasonable degree of certainty, that the respondents views would reflect both sides of the dichotomy, the following steps were undertaken. Contact was made with Mr. Gerret Clements, a lawyer employed by the Provincial government who acted as a special legal consultant to the Mental Health Act Review Committee. He was therefore in a position to know the positions of various high-profile consumers and organisations. Mr. Clements advised me to contact a consumer known to hold generally "pro-treatment" views. This consumer, who agreed to be interviewed, had been involved in the Mental Health Act Review process, and currently held a position of influence, both in the consumer movement and in relation to advising the government on mental health issues. Mr. Clements also advised contact with Mr. Bill Trott, a lawyer with the Community Legal Advocacy Service (CLAS), an organization which strongly favours and promotes civil rights for mental health consumers and others. Mr. Trott agreed to make
some preliminary inquiries with consumers on my behalf to gauge their interest in being interviewed. Contact with Mr. Trott was not maintained however and no interviews resulted. Discussions occurred with a number of mental health professionals in the Provincial Mental Health System and Greater Vancouver Mental Health Services. From these contacts approaches to three consumer organisations were made; one organization was publicly known to be "pro-treatment", one "pro-rights", and the third to encompass a range of opinion. All contacts resulted in interviews. The gender of the respondents resulted in an imbalance of three men and one woman. Attempts were made to arrange a fifth interview with a female consumer, however after showing initial interest, the respondent declined to participate and time constraints did not allow for further recruitment.

Recruitment Procedure.

Recruitment occurred by writing an introductory letter (Appendix 1) explaining the study and seeking participation. This was addressed to individuals if they were known at the various organisations. If no-one was known by name, as occurred in one case, the letter was addressed to the Executive Director. A follow-up telephone call was made at an appropriate interval following the letter to discuss their participation and to make arrangements if appropriate.

Four in-depth interviews were undertaken. As this study is part a larger thesis, a primary consideration was to ensure a manageable sample size. The event was open-ended interviews with
mental health consumer-activists to elicit what they believe about the right of mentally ill people to refuse treatment. The social process was how mental health consumer-activists perceived the wider debate about mentally ill people having the right to refuse treatment. A subtext was how mental health consumer-activists came to evolve their own views on the right to refuse treatment.

The setting of the interviews was potentially very important in this study. Mentally ill people have historically been enmeshed in relationships characterised by the exercise of implicit and explicit power when dealing with mental health professionals. From an ethical perspective, it was important to ameliorate the negative legacy of unequal power and ensure it was minimised as a factor in the research situation. Attempts to meet this objective were made in a number of ways. First, the researcher indicated a willingness to meet wherever the respondent felt comfortable. All interviews actually occurred in the offices of the various consumer organisations. Secondly, it was conveyed to the respondent that their views were genuinely valued for this study. The researcher did this by indicating an awareness of the historical absence of consumers' voices and emphasising that their views represented an important part of the writer's thesis. When the interviews were completed the writer sent a thank-you letter to all informants (see sample letter, Appendix 5). Thirdly, attempts were made to ameliorate the negative effects of any perceptions of a power imbalance. Pfhol (1985) states that a power-reflexive methodology demands that researchers analyse their own biographical power
relations and be aware that they help to define the questions the researcher asks, and the way that he or she asks them (pp.357-360). With this in mind, the writer took the following steps to minimise the degree to which the interview situation was contaminated by power issues.

1) No technical or pathologising language was utilised in the questions.

2) No information about psychiatric diagnosis was solicited. If this information was volunteered, the researcher did not specifically refer to the persons condition, nor discuss it in terms of his professional knowledge.

3) The researcher briefly discussed his own professional biography as a mental health professional. This was to ensure the respondents were aware of whom they were dealing with, i.e a graduate student and someone who has worked as a mental health professional. This entailed some risk that the consumer would negatively associate the researcher with the mental health system, but the writer felt it would have been unethical to not clearly reveal his professional background.

4) The researcher was sensitive to the question of dress. The writer did not dress as a "professional". This required an element of judgment. At one interview for instance, the writer dressed in casually smart clothes, in the knowledge the key informant was a middle aged professional person. At other venues, the writer took care to wear appropriately casual clothes (jeans, sweater etc.).
5) Notes were not taken during the interviews. Most consumers have experienced clinical interviews where a mental health professional has asked about their personal lives whilst recording such information in files. In light of this, it is possible that note-taking has connotations of situations of unequal power for many consumers.

**Feedback to respondents.**

All respondents were offered written or personal feedback. One respondent and the Executive Director of his/her organization requested written feedback (a copy of the study prepared for the author's MSW research class). This study was duly mailed with a written offer to respond to any questions raised following receipt of the study.

**Development of the interview guide.**

The interview guide was composed of 6 questions (see Appendix 3). The questions centred around the issue of the "right to refuse treatment". This focus was developed for three reasons. First, questions about the right to refuse treatment automatically refers to involuntary treatment, as voluntary patients have the unequivocal legal right to refuse any procedure. Secondly, the right to refuse treatment issue is known to be a source of controversy (Issac & Armat 1990). Psychiatric professionals have raised the spectre of involuntarily detained patients refusing treatment, thus resulting in potentially open-ended periods of detention without treatment for the patient, and reducing professional care givers to the role of jailers (Fleming 1993).
Patients' rights advocates have replied that, where a right to refuse treatment has been implemented, no "epidemic of treatment refusals" has occurred (Valentine, Waring & Giuffrida 1992). Consequently, as Brown (1985) suggests, "the right to refuse treatment is a dividing line in the patients' rights arena" (p.181) and therefore tends to elicit unambivalent responses. It was assumed, therefore, in discussing the right to refuse treatment, respondents would also discuss their beliefs about the context of refusing treatment, i.e., involuntary detention under the MHA. Thirdly, it had been informally told to the researcher by a participant in the Mental Health Act Review process, that the right to refuse treatment issue was perhaps the singularly most difficult issue to attempt to reach consensus on.

Upon feedback received as a result of pre-testing, the questions 2 and 3 (Interview Guide, Appendix 3) were reworded to provide an opportunity for respondents to reflect on both sides of the dichotomy. This was effectively achieved by requesting respondents to articulate what they considered the arguments to be that opposed their stated beliefs. Questions 2 and 3 were therefore used interchangeably, to elicit the opposite argument to the position the respondent articulated in response to question 1.

Data collection.

Data collection was undertaken through in-person interviews utilising an interview guide. The benefits of an interview guide are that it provides a structured focus for the interviewee, while at the same time allowing for flexibility. It also allows the
respondent to express their views in their own terms and language. The structure and flexibility of the interview guide was particularly important in regard to mental health consumers. Mental illness, and the psychotropic drugs used in treatment, frequently interfere with cognitive functions at different times. This can range from things like an inability to concentrate to symptoms such as "thought blocking" in schizophrenic illnesses.

The researcher had no knowledge of the respondents history of mental illness as previously discussed, nor whether the respondent was, or was not, taking psychotropic medication. It was therefore the possibility of the effects of mental illness or medication that determined the interview guide as the instrument of choice. Respondents were given written assurances of confidentiality and anonymity in the introductory letter and consent form (see Appendices 1 and 2 respectively). All information that identified respondents as individuals, or the mental health consumer organization with which they were affiliated, was stripped from the data.

It is important to note that while the interview guide was utilised to provide focus to the interview, it served as a guide only. Not all questions were asked in the same order or in the same language. This allowed the researcher flexibility to use the language and conceptual constructs of the respondent. This flexibility enhanced the instrument's internal validity which reflects the extent which the measure "reflects the real meaning of the concept under consideration" (Rubin & Babbie 1989, p.146).
Interview procedures.

Following introductions, the consent form (Appendix 2) was discussed, which the respondent then signed and was given a copy for their own records. The consent form outlined obligations concerning confidentiality and anonymity, and the need to audiotape the interview. The interview was prefaced with a short introductory statement (Appendix 4). Respondents were encouraged to speak from their own experience. The interviews were audiotaped, and no notes were taken during the interview. The length of the interviews was remarkably consistent, all taking between 45-50 minutes.

Reliability and Validity.

Problems with qualitative research are frequently identified to occur with reliability (Hudson 1982). Reliability is addressed in qualitative research through explicit reporting of research procedures, precise documentation of sources, self-analysis, and acknowledgement of theoretical perspective and biases (Berreman 1966). In addition to documentation of personal perspective, self-analysis, and research procedures previously described, process notes were kept documenting each stage of the study. As soon as was practical after each interview, notes were made recording pertinent impressions and information. Reliability was also addressed by the utilisation of single interviewer and interview guide which increased the likelihood of similar presentations of questions to each respondent. The audiotaping of interviews helped to reduce interviewer bias in recording data.
All interviews were transcribed verbatim. Inference from the data was supported by verbatim quotations.

Validity refers to the concept that an instrument measures what it is supposed to measure (Rubin & Babbin 1989). Validity was addressed in a number of ways. The interview guide was pre-tested for clarity and focus on fellow students and two mental health professionals. Questions in the interview guide were open-ended to avoid leading participants in the range of their responses. Seidman (1991) asserts that the purpose of an in-depth interview is not to generalize findings, but to present the experiences of participants in such a way that an audience can acquire a deeper understanding of the issues that the experiences reflect. The results of the study are reported in the context of the articulated parameters of the study and inclusion criterion.

**Data Analysis.**

Grounded theory was used to examine the data. Grounded theory, in its pure form, aims to build theory. Strauss (1987) states that it is not a specific technique, but rather a style of qualitative analysis that embraces a number of distinct guidelines "..such as the making of constant comparisons and the use of a coding paradigm, to ensure conceptual development and density" (p.5). The advantage of the grounded theory approach is that it examines meaning and context. A further significant advantage of the approach is that it allows for a range of perspectives to emerge from the data.
Data analysis involved the following steps. Each interview was transcribed verbatim. A coded transcript is included (Appendix 6). Each transcript was open coded line by line, and tentative elements and themes were identified. This process was also reversed: identified elements and themes were compared to the open codes and checked to ensure they were supported by verbatim evidence. For example, when one respondent discussed his experience of mental illness he stated:

I was absolutely bizarre. I thought the third World War was starting in Europe and I was in control of all the armies....I could have been off the balcony that night, I could have had a heart attack in my high state of excitement.

This statement was coded as "mental illness as potentially catastrophic experience". The code represents the respondents statement at an abstract level while not eroding the essential meaning of his experience. Where there was conceptual confusion or theoretical questions that emerged in the data analysis, the writer recorded memos in the transcripts. Strauss (1987) describes theoretical memos as:

Writing in which the researcher puts down theoretical questions, hypotheses, summary of codes, etc. - a method of keeping track of coding results and stimulating further coding.. (p.22).

Thus, data analysis involved continual revision and modification. This process would normally continue until theoretical saturation had occurred. Strauss (1987) defines theoretical saturation as occurring "when additional analysis no longer contributes to discovering anything new about a category" (p.21). A limitation of this section of the study was that theoretical saturation was not
achieved and the analysis only progressed to the point of identifying themes and the links between them. The purpose of this component of the study was not, however, to proceed to the "stage" level of analysis in order to build theory, but rather to illuminate and enrich the macro-sociological analysis with the lived experience of people affected by the issues of the wider study.
CHAPTER FOUR

SOCIAL CONTROL OF MENTAL DISORDER IN THE NINETEENTH CENTURY: ASYLUM, MEDICALIZATION OF INSANITY, AND LEGALISM

This chapter explores the changing nature of psychiatric practice from the late eighteenth century until the end of the nineteenth century. The chapter is divided into four sections. The first three sections explore inter-related phenomena that radically altered the care of the insane in the nineteenth century and were transformational due to their scope and their break with, or reversal of, previous thought and practice. These phenomena can be summarised as the changing conceptions of the nature of insanity, the rise of the asylum as an institutional response to insanity, and the medicalization of insanity and emergence of the psychiatric profession. The fourth section discusses the genesis and development of tensions inherent in the relationship between the profession of psychiatry and law.

The first section offers a brief analysis of how the Enlightenment period provided the intellectual and philosophical underpinning to material changes in the response to the insane. The second section proposes that the principal explanation for the subsequent institutional response to insanity was located in the changing social control objectives of the state, as a consequence
of industrialisation and the emergence of a market economy. The role and significance of social reformers in this process is examined. The third section analyses the medicalization of insanity and the epistemological and commercial origins of the psychiatric profession in relation to the rise of the asylums. The challenge of "moral treatment" is explored as a catalytic agent in the emergence of the psychiatric profession’s successful domination of the mental health domain. The fourth section examines the development of the period of mental health law reform characterised as "legalism". Focussing on the issue of involuntary commitment, this discussion examines how and why the epistemological and practical tensions inherent to the interface between psychiatry and law developed. The situation in British Columbia will be specifically discussed in this regard. It is concluded that the enduring legacy of the nineteenth century response to insanity was the large, custodial asylum and an emerging tension between psychiatry and law.

The chapter focuses primarily on British developments during this period, although parallel developments in America and Canada will be integrated. The most important characteristics of nineteenth century psychiatry, which were changing social control strategies and the medicalization of mental illness, occurred as parallel international developments (Rothman 1971; Scull 1989). The rationale for the focus on the British experience in the nineteenth century is divided into three principal reasons. First, changes to psychiatric practice occurred on a truly national scale.
Second, the rapid upheavals of the Industrial Revolution, in which Britain led the way, initiated changes that later occurred elsewhere. Third, the development of Canadian society is closely linked to Great Britain. The imperial influence of Britain was particularly significant during the nineteenth century, although events in the United States have become increasingly dominant during the twentieth century (Allodi and Kedward 1977).

**Changing Conceptions of Sanity and Madness**

The Enlightenment period of the eighteenth century provided the seedbed which gave rise to the intellectual and philosophical impetus for social and structural changes in the response to insanity in the nineteenth century. The Enlightenment was a complex phenomenon that exerted a dramatic impact on religious and secular institutions and thought in Europe and British North America. Leonard (1990) stresses that The Enlightenment connotes more than a way of identifying the late seventeenth and eighteenth centuries of the West. He states:

> It is rather a way of understanding the hopes and desires of those who thought a new era of civilization and progress was emerging, one that would replace superstition and dogma as the basis of social and political life (p.10).

Contemporary scholarship has produced conflicting historiographical perspectives on the nature and legacy of the Enlightenment. These perspectives range from sympathetic accounts that perceive the Enlightenment as broadly progressive and the source of modern liberal humanism (e.g Gay 1966-1969), to critiques that locate within the Enlightenment, the origins of authoritarian and
repressive scientific, political, cultural and social practices (e.g. Adorno & Horkheimer 1972; White 1970). A brief consideration of these polarised perspectives on the Enlightenment generally, and its significance to responses to insanity will follow.

The intellectual exponents of Enlightenment were a group of (mostly) men who were essentially critics of the existing order. Their work was characterised by scientific scepticism combined with a relativist attitude toward belief, particularly religious belief. Although many developments in scientific, philosophical, and political thought were attributed to their work, they searched not so much for new knowledge "as for new attitudes toward knowledge" (Marsak 1972, p.3). Gay (1966) has described the philosophes and scientists of the Enlightenment as an intellectual unity. Enlightenment thinkers frequently knew each other, or were at least familiar with each others ideas. The major figures of the time shared an assumption that there existed a body of truths about human and physical nature that could be known and utilised for the benefit of all (Lively 1966). Porter (1990), commenting on Gay's (1966) "...generous collective portrait" (p.5) of the Enlightenment philosophes suggests:

They shared a general commitment to criticising the injustices and exposing the inefficiencies of the ancien regime; to emancipating man (sic), through knowledge, education and science, from the chains of ignorance and error, superstition, theological dogma, and the dead hand of the clergy; to instilling a new mood of hope for a better future and to practical action for creating greater prosperity, fairer laws, milder government, religious tolerance, intellectual freedom, expert administration, and not least, heightened individual awareness (p.5).
The belief in individual awareness and the upholding of the supreme value of Reason, placed many Enlightenment thinkers at distinct odds with prevailing religious dogma. These writers reasoned that emancipation was impossible if a person was not in possession of him/herself, but was beholden to a "tyranny" of mystical and religious explanations and strictures. Although individuals such as Voltaire and Hume declared themselves as unbelievers and, in the case of Voltaire, conducted an iconoclastic crusade against organised religion (Porter 1990), there was no consensus about what should replace it (Marsak 1972). Nevertheless, Enlightenment thinkers represented the emergence of a secular intelligentsia large enough to significantly erode the credibility of the clergy. Religion remained an enormously powerful force, (inspiring, for instance, many nineteenth century social reformers, which will be discussed later in the chapter), however the secularization of European thought represented a radical challenge to the authority of religious epistemology of the world.

In the secular domain, Enlightenment principles instigated, and were manifested in, significant changes in a range of human endeavour. Positivism, rationality and the principles of the scientific method gave rise to optimism that nature could be controlled and human problems solved. Risse (1993), for instance, contends that advances in medicine such as Jenner's successful development of a smallpox vaccine caused governments to increasingly design social policies to protect or improve the health of the general populace. At the same time philosophers,
political theorists, and legislators were confronting changes to the socio-economic and political landscape which rapidly escalated in response to the pressures of industrialisation. For instance, in response to increasing secularization and moral diversity, Bentham's influential theory of utilitarianism attempted to provide an empirical framework for the making of political decisions and solving of human problems (Manning 1968).

Prior to the mid-eighteenth century no one conception of insanity prevailed. Although historically, the idea of madness had been entertained since Greek times (Simon 1978), this conception was not privileged and was frequently subordinate to, or overlapped with demonological, theological and astrological explanations (Pressman 1993). Madness became, within the context of the changing philosophical and intellectual ideas of the Enlightenment, a matter of heightened scientific and cultural concern. Enlightenment ideology advocated that the most intractable of human problems could be solved with the application of reason and science. Ingleby (1983) argues that the "old" paradigm of insanity hypothesised that the lunatic had lost his or her reason and, in doing so, had become less than human, a brute. The "new" paradigm contradicted this view in that it was believed that all nature, including human nature, could be controlled and moulded. It followed therefore that the insane could, with the appropriate application of scientific treatment, have reason restored.

The view of the Enlightenment as an incrementally progressive movement that promoted liberation from tyranny, ignorance and
superstition, and offered the promise of scientific progress and freedom of thought, has been refuted by many contemporary social philosophers such as the Frankfurt school. Adorno & Horkheimer (1972) have suggested that reason was intimately connected to absolutism. Enlightenment thought denied the possibility of a pluralist diversity of values, but rather made absolute distinctions between concepts such as right and wrong, true or false, and mad and sane. Foucault (1961), in *Madness and Civilization* argues that such absolutism was used to first differentiate the mad, then organize them in the name of rational administration. Foucault asserts that historically, madness and sanity had not been consciously separated. As reason came to subjugate unreason however, madness was differentiated from sanity. What was previously merely a lack of reason became reconceptualised as "unreason". Foucault states:

"A culture like that of the Classical Age, so many of whose values were invested in reason, had both most and the least to lose in madness. The most because madness constituted the most immediate contradiction of all that justified it; the least, because it disarmed madness entirely, leaving it quite powerless. This maximum and minimum of risk accepted by Classical culture in madness is perfectly expressed in the word "unreason": the simple, reverse side of reason; and this empty, purely negative form, possessing neither content nor value, which bears the imprint of a reason that has just fled, but which remains for unreason the raison d'être of what it is" (p.31).

Madness as unreason therefore had a direct relationship to sanity as reason. The mad person was no longer an object to be viewed at a comfortable distance, he or she had become more domesticated and,
in doing so, was more fearsome. The condition of insanity was capricious and could strike anyone, any time. The traditional explanations for affliction such as possession or evil spirits, which ironically offered a measure of reassurance, no longer held sway. If sanity as a cultural construct was to be protected, it was imperative to control insanity. Foucault (1965) refutes the pre-eminent icons of Enlightenment humanitarianism in mental health symbolised by Pinel’s liberation of the insane at Bicetre, and moral treatment at Tuke’s York Retreat. Foucault reframes such "advances" as the imposition of a pervasive moral imprisonment more oppressive than former practices of brutal confinement because they operated on the mind, rather than just on the body (Sarup 1989). Foucault concludes that the true legacy of the Enlightenment was the delegation of the mad to physicians, the result of which authorised:

"...a relation only through the abstract universality of disease;...the man (sic) of madness communicates with society only by the intermediary of an equally abstract reason which is order, physical and moral constraint, the anonymous pressure of the group, the requirements of conformity (Foucault 1965, p.x).

As a consequence of this relegation of the mad to a realm of non-communication, "....the language of psychiatry, which is a monologue of reason about madness, has been established.. on the basis of such a silence" (pp.x-xi).

Although the mentally disordered were relegated to a realm of figurative and literal silence (through incarceration) in the nineteenth century, they were not removed from public
consciousness. On the contrary, the changing conceptions of insanity and the mammoth nineteenth century effort to confine the insane, brought the mad to greater public attention. Doerner (1981) contends that a tension became generated between the humanitarian hopes of the Enlightenment and the harsh realities of the Industrial Revolution. According to Doerner, this produced a crisis of self perception in society. As it became increasingly evident that the lives of the poor were constrained by the demands of industrialisation with its attendant long hours of stultifying work, appalling standards of housing, poor public health and widespread poverty, the potential for social unrest grew. For the bourgeoisie, the spectre of the French Revolution and bankruptcies caused by early cyclical upheavals of unfettered capitalism evoked a sense of an uncertain world. Doerner argues that pauper lunatics came to represent the embodiment of the ills of the time. At the same time, the first of the many mental breakdowns of the English monarch in 1788 added to the sense that insanity was potentially universal and required universal regulation. Doerner argues that as the insane came to be swept up into the rapidly expanding asylum system, rather than disappearing figuratively as well as literally, they actually moved closer to public consciousness as they became part of the debate about civil rights. Doerner concludes that "...in a special sense, the insane remained visible and functionally related to the social structure because the socio-economic and moral order of bourgeois society defined itself by their uniqueness". (p.70-71). Simply put, the "Exclusion of a
deviant class is necessary for the remainder to feel included" (Langman 1980). In summary, the Enlightenment produced a redefinition of the boundaries of insanity, it held out the promise of a solution, and at the same time provoked public anxiety about the etiology and nature of madness.

The Institutional Response: The Rise of the Asylum

Changing ideas about the nature of sanity and insanity provided an abstract underpinning which provided a partial justification for a new societal response to the insane. These changing ideas were of course intangible and did not, in themselves, directly prescribe the material nature or design of a new response. Prior to the mid-eighteenth century those suffering from mental disorders were generally assimilated in society. If they were not too behaviourally troublesome and could be supported by their families, they remained within their communities. In Britain, if domiciliary care could not, or would not be provided by relatives, the insane were subject to the provisions of the Elizabethan Poor Law system. To this end they were indistinguishable from the poor, the unemployed, the indigent, the handicapped, and other members of the dependent populace. Within the space of one hundred years, Scull (1979) reports a change of radical proportions. By 1850 the insane were clearly classified as a separate category of deviants, the etiology of their condition was regarded as medical, and their incarceration, diagnosis, and treatment was in the hands of a nascent psychiatric profession sanctioned by the state. Moreover, in less than fifty years the
majority of the insane "...found themselves in a specialised, bureaucratically organised, state supported asylum system which isolated them physically and symbolically from the larger society" (p.14). To account for this transformation in the response to the insane, several questions have to be addressed. These include: what confluence of ideas and circumstances occurred to persuaded the state to make such a significant capital and political investment? How was the prevailing nineteenth century ideology of laissez-faire economics reconciled with the large scale intervention of the state? How was the ideological belief in individual self-reliance reconciled with the provision of a national state-run system for the mentally disordered?

**Institutional antecedents to the rise of public asylums.**

Prior to addressing these questions in detail, a brief discussion of the institutions that existed antecedent to the rise of the asylums in Britain is warranted. These institutions were important for two reasons. First, they offered an embryonic template of institutional care. Secondly, their commercial basis attracted competing professions and groups to what was, undeniably, socially unattractive work, (this will be discussed in more detail later in the chapter). Only two types of separate institutions for the insane existed prior to the nineteenth century; private, for-profit madhouses, and a small number of public, charitable institutions. Only one charitable institution, Bethlem hospital, infamously known as Bedlam, existed prior to the eighteenth century (Jones 1955). A handful of charitable institutions for the insane
were developed in the eighteenth century, such as Bethel hospital in Norwich and St. Lukes hospital at Moorfields in London, in 1713 and 1751 respectively (Busfield 1986). Private madhouses remained the principal source of distinct institutional care for the insane in the seventeenth, eighteenth and the early nineteenth centuries (op cit). In 1774 there were 16 licensed metropolitan private madhouses, by 1807 English provincial and metropolitan licensed madhouses numbered 28 and 17 respectively. By 1837 the total number of licensed provincial and metropolitan madhouses numbered 117 (Parry-Jones 1972). Private madhouses accepted both private and pauper patients, the latters' fee being paid by the parish. The lucrative "trade in lunacy" consequently flourished throughout the eighteenth century. Provincial licensed madhouses increased steadily throughout the first half of the nineteenth century and only declined as pauper lunatics became absorbed into the emerging public county asylum network (op cit, p.30). Even combined, public and private institutions never accounted for more than a fraction of the total population of the mentally disordered. Despite this, Scull (1979) contends their symbolic importance overshadows their numerical size, as they facilitated the legitimation of a vastly expanded institutional response in the nineteenth century.

The impact of industrialisation and development of a market economy.

The remarkable changes in the management of the insane in the nineteenth century - the specific separation of the insane as deviants, their incarceration in a burgeoning national network of
public institutions as the response of choice, and the associated emerging medicalization of insanity - were the result of powerful philosophical, political and social forces of change. In Britain, Mayer (1983) suggests that the social control paradigm, in the context of rapid industrialisation, has emerged as the dominant explanation. Mayer states:

According to this interpretation, the transitional stage of industrialism, with its breakdown of communal and deferential authority patterns, its economic and residential separation of classes, its disjunction between people's actual behaviours and the new behaviours needed for a modern industrial society, led to a sense of crisis among elites, generalized as a fear of the lower or dangerous classes. (p.17).

Mechanic (1979) contends families became increasingly incapable of caring for their unproductive dependents, due to large scale emigration to the industrial centres, increased urban poverty as a result of unplanned and uncontrolled urbanisation, and the effects of the division of labour on the family unit. As a consequence, deviants of all types became "visible" and appeared, to the bourgeoisie at least, to be a potential threat to the social order. Mechanic concludes some form of segregative control was therefore an inevitable consequence of these changes. Scull (1979), whilst not disagreeing that segregative control was related to changes wrought by the industrial revolution, suggests such structural determinism is too simplistic and lacks important empirical evidence to support it. Scull argues, for instance, that an examination of the population shifts from rural areas to the cities does not support all of Mechanic's contentions. Scull points out
that at the turn of the nineteenth century only 17% of the population lived in cities with 20,000 people or more. By 1841, this percentage had still only risen to 29%. So while the phenomena of rural to urban emigration undoubtedly created massive changes to family organization, the impact was limited to specific geographical areas. Scull proposes that an alternative explanation can be located in the impact of the market economy and commercialisation of social life. This phenomena was well underway at the end of the eighteenth century and, crucially, it knew no geographical boundaries. The emergence of market capitalism undermined traditional rural and urban societal structures alike, and made the parochial system of poor law relief increasingly ineffective. Ingleby (1983), commenting on Scull's work, contends the Elizabethan poor law system of parochial relief was distinctly at odds with the demands of a market economy, primarily because relief given to the able-bodied poor undermined the mobility of the labour pool. It became essential therefore to differentiate between the deserving and undeserving poor. The new entrepreneurs also viewed the poor law situation with alarm. With one in nine people receiving some kind of relief (Perkin 1969), it was concluded that relief promoted indigence rather than relieved it. Thus, philosophical and material conditions were ripe for the introduction of an institutional response firmly encased in the residual mould. Such a response offered the advantages of being economical, of removing potentially troublesome populations from society, and conforming to the imperatives of the new social order.
In all three major institutions of social control, the workhouse, the gaol, and the asylum, the virtues of self discipline, personal industry, punctuality and compliance could be inculcated (Mayer 1983).

The insane were also segregated into institutions for reasons of economic expediency and administrative pragmatism. Scull (1979) points out that maintaining the insane in the community at a reasonable standard of care, would have meant investing funds at a level that would have totally undermined the symbolic and practical intent of the residual mould of welfare. Crudely put, the pauper insane could not have better conditions than those in the workhouse. Secondly, Scull asserts that the continued assimilation of the insane in the workhouse population created significant problems. Normal inducements and punishments often had no effect on the mentally disordered, thus undermining the structure and discipline of the institution. The rationale that supported an institutional solution to the problems of poverty and indolence, appeared to be just as valid in regard to the problem of pauper insanity.

**Significance of the 1845 Lunacy Act.**

The Lunatic Asylums Act of 1845 represented the pivotal legislation in the rise of the asylums. Previous legislation had failed to include the element of compulsion on a national scale to respond to the problem of insanity. For instance, the Lunatics Act (1808) had authorised, but not compelled, counties to provide institutional care for pauper and criminal lunatics (Hunter &
MacAlpine 1963). The 1845 Act mandatorily compelled all local authorities in England to provide separate public institutions for the insane and established a permanent, centralised regulatory body (Busfield 1986; Butler 1985; Jones 1955). It thus endorsed the creation of a national network of public institutions, and reflected the commitment of the state in the support and regulation of institutions for the insane. Following the Act, county and borough asylums spread rapidly. In 1850 there were 24 such asylums, this rose to 50 by 1870, and 77 by the end of the century (Busfield 1986). The 1845 Act was only one component of a range of legislation that signalled the previously unprecedented involvement of the state. This increasing intrusion included legislation to regulate various industries and to improve public health and introduced in an attempt ameliorate social problems, and to secure the conditions necessary for the continuation of production and capital accumulation (Busfield 1986).

Parallel developments in America and Canada.

In North America, similar dramatic developments paralleled those occurring in Britain. Prior to the Jacksonian period from 1820 onwards, the majority of the insane were given outdoor relief and left in the care of their families. Some were incarcerated in general institutions for the deviant such as gaols. In the colonial period however, only a few such institutions existed. All were located in large centres and were regarded as places of last resort (Rothman 1971). The scale of the reversal of American colonial practices of social control, specifically the separate
incarceration of the mad in institutions as the place of first resort, was of such magnitude that Rothman labels the Jacksonian period the "age of the asylum" (p.xiv). By 1850 almost all northeastern and midwestern legislatures supported a public asylum and, by 1860, only five states out of thirty three did not have a public institution for the insane (Rothman 1971).

In Canada, the development of a national institutional response to insanity followed a similar pattern, although the timing and progress of the response was shaped by specific national and geographic factors, such as the isolation of the north and the later development of the West. As in Britain and America, the insane were immersed in the general population prior to the development of an institutional response. Until the mid-nineteenth century, if the pauper insane caused no difficulties to public order they were not actively persecuted. Those with sufficient finances were frequently sent to private madhouses back in Britain or the United States (Francis 1981). The first provincial insane asylum, a converted cholera hospital, was established in New Brunswick in 1836 (Allodi & Kedward 1977). A series of public and private asylums were established in Ontario in the mid-nineteenth century and by the end of the century, all provinces had established specific institutions for the insane (Hurd 1917). In the Northwest Territories, which included Alberta and Saskatchewan (as they were not constituted as provinces until the early twentieth century), the mentally disordered had to make their way, usually in the company of Royal North West Mounted police, to
provincial asylums in Manitoba (Hurd 1917). For a while, British Columbia sent the insane to the nearest asylum which was located in California, a practice the Americans eventually and inevitably resisted. In 1872, the previously abandoned Royal Hospital was remodelled as an insane asylum.¹ A purpose built provincial lunatic asylum was built at New Westminster in 1877 and initially admitted 38 patients (Hurd 1917). By the end of the century the expanded and renamed Provincial Hospital for the Insane held 258 patients.²

Explanations for the institutional response in America and Canada.

In America and Canada, although the development and outcome of an institutional response to the question of insanity paralleled those events occurring in Britain, it has been contended the reasons were somewhat different. Rothman (1971) in particular asserts the rationale for the new Republic’s response was uniquely American. Rothman locates the crucial variable as the Jacksonian view of the etiology of insanity. The causes of insanity were believed to arise from what was perceived to be a dangerously fluid and open social order. This was understood to create structural instability of a magnitude that predisposed the republic’s citizens to insanity. Rothman states that the Butler Hospital Annual Report for 1853 declared that all citizens struggle:

...to make, or greatly advance their fortunes, by some happy stroke or skill...chance, or some daring speculation. Sleepless nights, fear of failure, and extraordinary stress accompanied these efforts rapidly consuming mental energies and thus strongly predispose the mind to insanity (op cit,p.116).
This conception combined with a number of other factors, such as the "cult of curability" (Caplan 1969; Deutsch 1949), (which will be discussed in more detail later in this chapter), led reformers to propose an institutional approach as the treatment response of first resort. Asylums, the reformers reasoned, would have the dual advantages of caring for the insane while providing a model which could be an antidote for the new republic's ills, one that exemplified order, structure and stability. Rothman (1971) argues that proponents of the asylum perceived its symbolic value would exert an influence beyond the practical value of containing deviants within the boundaries of its walls. He states:

Thus the insane asylum, like other corrective institutions in the Jacksonian period, represented both an attempt to compensate for public disorder in a particular setting and to demonstrate the correct rules of social organization. Medical Superintendents designed their institutions with eighteenth century values in mind. They would teach discipline, a sense of limits, and a satisfaction with one's position, and in this way enable patients to withstand the tension and fluidity of Jacksonian society (p.154).

In Canada, the pre-institutional laissez-faire attitude to the care of the insane became subject to significant strain within a relatively short period of time. Katz (1975), for instance, in a quantitative historical study of the citizens of Hamilton in the mid-nineteenth century, tracked the population movement into and out of the city. Based on his findings, Katz hypothesised that Canadian society at this time was characterised by the structural rigidity of its social institutions, combined with significant social transiency. For instance, between 1851 and 1861, over half
the population left Hamilton. Other factors such as the impact of European migration, and rural migration to increasingly industrialised cities made the system of maintaining the insane in the general community increasingly redundant (Allodi & Kedward 1977). Faced with the increasing prominence of social disorganization, and with the example of developments in Britain and America, Canadian provincial legislators were persuaded of the necessity of the establishment of separate institutions for the mentally disordered.

The role and influence of social reformers on the rise of the asylum.

The role of human agency, within the context of the macro-societal changes previously discussed, is significant in the rise of the asylums. The impact of the reformers is however closely entwined with these broader changes. Their work cannot therefore be attributed solely to uncomplicated altruism, although some historians have attempted to argue this (e.g. Zillboorg 1941; Alexander & Selesnick 1967).

Social reformers in Britain and America were heavily influenced by the philosophical orientations of Evangelicalism and Utilitarianism. Butler (1985) suggests that in Britain, these approaches were significantly divergent with the Evangelicals tending to focus on the plight of individuals, and the Benthamites using state intervention in the name of efficient government to achieve their objectives. As a consequence, the methods of the reformers were often in conflict. The Evangelicals, like Lord
Ashley in Britain and Dorothea Dix in America, were imbued with a paternalistic moral fervour whilst the Benthamites were motivated by the tenets of reason and a desire for administrative order (Armour 1981). Mercantilism had powerful adherents and Scull (1979) contends the ideology of utility with its rational focus on primitive cost-benefit analysis made the Benthamites more effective reformers on balance. He states:

The Benthamite, with his emphasis on providing institutional mechanisms to uncover as well as to eliminate social evils, was in many ways a more effective moral entrepreneur than his equally self-righteous Evangelical contemporary. The Benthamite formula - inquiry, legislation, execution, inspection, and report -proved a fertile source of new laws and institutions throughout the nineteenth century, nowhere more so than in the area of lunacy reform. (p.58).

It was however the Evangelical focus on the plight of individuals that was used to most effect in promoting the need for early reforms. Public disquiet about the conditions of the insane led to a series of Parliamentary Select Committees in 1806, 1814-1816, 1827 and 1839 (Jones 1955). Reformers on these committees found much to support their contention that lunacy reform was imperative and that a new response to the insane was essential. The lengthy investigations and four reports into asylum conditions by the 1815-1816 Parliamentary Select Committee was most significant in that it established beyond doubt that both asylums and madhouses were in urgent need of reform. In numerous visits to private madhouses and public institutions, the reformers found appalling conditions and abusive treatment were endemic to the private and public sector alike (Busfield 1986; Jones 1955). Individual examples of abuse...
were used to dramatically publicize the plight of the insane. A particularly notorious (and for the reformers a politically powerful), example of abuse concerned an American seaman, William Norris. Norris was discovered during the committee’s visit to Bethlem to be constrained by an iron apparatus around his neck, shoulders and body which was attached to the wall. His right leg was also shackled to his sleeping trough. This unfortunate man was thus able to adopt two positions only (standing and lying). He was unable to move more than twelve inches away from the wall. The committee members were understandably shocked to further find that Norris had been confined in this condition for twelve years without respite (Butler 1985).

The English reformers reasoned that the solutions to these problems were two fold; the establishment of separate public institutions for the pauper insane financed by the state, and the creation of a centralised inspectorate to supervise both public and private enterprises (Scull 1979). It was believed that this strategy would achieve two purposes, according to Scull. First, a compulsory asylum system for paupers would erode the trade in lunacy and its concomitant abuses such as overcrowding, lack of staffing, and poor conditions, all of which it was reasonably believed were principally motivated by profit. Secondly, an inspectorate independent of the asylum system would ensure institutions adhered to proper standards, and did not slip back into the practices of systemic abuse (op cit). This explains, in part, how the reformers, particularly the Benthamites, were able to
reconcile their laissez-faire economic beliefs with the contradictory promotion of a more centralised and expanded state.

The reformers' proposals represented a formidable investment for the state, particularly in light of the fact that parsimony imbued the existing Poor Law system. For example, the first nine county asylums established by 1827 incurred capital costs ranging between 10,000 pounds for a 52 bed asylum at Bedford to 60,000 pounds for a 170 bed asylum at Lancaster. Per capita costs ranged from 192 pounds to 367 pounds at Gloucester county asylum (Jones 1955). By way of contrast, Butler (1985) reports that the average per capita cost of poorhouse construction prior to 1845 was 40 pounds. Running costs were also higher: in 1837, the weekly cost of maintaining a pauper lunatic in a county asylum was 6 shillings and 6 pence, compared to a weekly cost of 3 shillings and 6 pence for indoor or outdoor relief (Hodgkinson 1967, p.181). Calculations of average weekly wages offer a poor comparison due to the complexities of different types of labour, defining wage rates with actual wages earned, hours at work and so on (Benson 1989). Benson advises that in 1850 the "normal" weekly wage of the highest paid workers (cotton spinners) was 23 shillings, while the lowest (agricultural labourers) was only 10 shillings (op cit, p.41).

Given the significant capital and recurring costs of establishing and running asylums, and the strength of political will required to establish centralised state supervision in an era when laissez-faire beliefs prevailed, it is perhaps surprising the reformers were successful to the degree they were. Two principal
explanations can be advanced to account for the reformers' success. First, as previously discussed, a series of Select Committees and Lunacy Commissioners' Reports effectively demonstrated the manifest inadequacy of public and private institutions for pauper and rich alike. Although this caused genuine concern, only the most naive historical accounts suggest that this was enough to persuade the state to act from humanitarian motives, and establish asylums as a way to counter these abuses. The second, more compelling reason relates to the longer term social and economic advantages the state envisioned from investing in a large scale institutional response. The reformers were aware of the need to marshal a convincing argument that would demonstrate such advantages to the state. The situation in the early nineteenth century facilitated the making of such a case. The insane represented an increasingly visible social problem, they were chronically dependent and often unemployable, and were capable of causing considerable social and institutional disruption. Thus the possibility of a cure, particularly in a setting which required only short-term dependency, was an attractive proposition which could ameliorate pecuniary anxieties about capital costs (Busfield 1986). The reformers were therefore able to use the exposure of appalling conditions and brutal treatment of the insane, and contrast them to the advantages of a network of public asylums. Central to this line of argument was the ability to provide empirical evidence of the therapeutic efficacy of the institutions (Scull 1981). These claims, which were wildly exaggerated, were essential to the reformers case. To
advance their case the reformers, with the support of medical men, sought to establish that asylums represented the hope of cure. Implicit in this contention was the notion that asylums should be designated as places of first resort. Medical men cautioned that treatment should not be delayed and asylums should be "first in time as well as the first and preferred location for cure" (Busfield 1986, p.247).

In America, reformers marshalled similar arguments in support of state asylums. Unlike Britain, the task of the reformers in America was complicated by the federal system of government which meant that reformers had to convince individual state legislatures of the case for public asylums (Armour 1981). Dorothea Dix, the most famous of the republic's reformers, had a standard presentation which she tirelessly pitched to legislators "from Massachusetts to Mississippi" (Rothman 1971, p.132). There is also evidence that Dix's efforts extended north of the forty ninth parallel and that she was influential in the establishment of asylums in Nova Scotia and Newfoundland (Allodi & Kedward 1977). Dix's formulaic presentation comprised of describing the appalling conditions of the insane in general institutions for the deviant like poor-houses and gaols, and then contrasting them with the promise of asylum efficacy. American science and republican humanitarianism would, the reformers assured legislatures, make soluble the social problems of insanity (Rothman 1971). As in Britain, central to the reformers' argument was the provision of compelling data on recovery rates. These claims became so wildly
exaggerated in America, that they have been dubbed the "cult of curability" (Caplan 1969; Deutsch 1949; Rothman 1971). Rates of cure supposedly ranged from 82.5% according to the Worcester, Massachusetts asylum superintendent in 1834, to claims by Doctors’ Galt and Awl in 1842 and 1843 in Virginia and Ohio respectively, that 100% of their patients were cured. Such statistics were frequently manufactured or manipulated by crude devices such as "curing" patients several times over, as at the Pennsylvania Friends Asylum where 87 patients made 274 recoveries (Rothman 1971).

Despite exaggerated claims of cures, periodic investigations of scandals at asylums throughout the first half of the nineteenth century demonstrated an embarrassing therapeutic bankruptcy. The reformers were able to sidestep the potential difficulties this posed by promoting the promise of asylums based on the principles of moral treatment. The essence of moral treatment comprised of a structured environment, the inculcation of orderly habits, firm kindness and an emphasis on self discipline that would restore lost reason (Digby 1985). The York Retreat, established in the late eighteenth century, became an icon of the moral treatment movement and its influence spread throughout the Western world. In his 1813 book, A Description of the Retreat, Samuel Tuke explained that moral treatment sought to appeal to the "unimpaired" portion of the mind, in order to assist the person to regain self control, although the sparing use of the "jackcoat", straps and the "dark room" remained available (Cherry 1986), presumably for refractory
cases. The example of moral treatment thus provided the reformers with a "positive institutional ideology that justified and legitimated the development of separate institutions for lunatics" (Busfield 1986, p.363). Reformers could continue to expose the sins of institutions in order to further their objectives, and in clear conscience promote a solution which advocated a dramatic expansion of the same.

Explanations for the reformers' success.

In light of the above, it can be contended that the most significant factor in explaining the reformers success is located in the convergence of their objectives and the needs of the state at a particular historical juncture. The institutional solution to the problems of insanity, and deviancy generally, were attractive to the state which was rapidly facing social problems generated from the pressures of industrialisation. Industrialisation compelled the state to expand its apparatus and influence to ameliorate social problems in the interests of a stable social and political environment, to ensure undisturbed production and continued wealth accumulation. Integral to this process was a radical over-haul of the Poor Law system in which administration was moved from the parish to more centralised forms of control and planning. Thus the State's preference for an institutional response to replace the old Poor Law system, combined with it's related reluctance to fund outdoor relief, was integral to the creation of a "demand" for the phenomenon of the asylum alternative.
The motivations of the reformers have been the subject of heated historical debate. Mayer (1983) advances three explanations within the social control paradigm. First, one school contends that reformers and others involved in social control enterprises were inspired by a nostalgic search for the security and authority of an evaporated social order. A second school asserts that industrialisation produced a new social order, one in which capitalist owners demanded a compliant workforce and a stable environment, to facilitate continued production and wealth accumulation. A third school argues that an emerging professional middle class was:

....attempting to stake out areas of expertise and authority so that, while involved in addressing perceived social problems, they were also engaged in enhancing their own status, power and security. (p.18).

This latter perspective offers support to the contention that the societal elites including the new bourgeois capitalists, the reformers, and rising professional classes such as doctors, had many common class interests. Both reformers and physicians were engaged in activities whose parameters were largely defined by class. Nineteenth century social reformers tended to be upper middle class philanthropists mostly, but not exclusively, men, whilst the subjects of their attentions were predominantly the poor, the mad and the criminal lower classes. A similar class dynamic also operated between the insane and their physicians, who increasingly came to be drawn from the upper middle classes. Butler (1985) offers an example of how insanity was defined in
practice, as a class phenomenon. Butler quotes D. H. Tuke's (Chapters in the History of the Insane in the British Isles) comparison of asylum admissions in Britain in 1844 and 1859. In this period, the number of private lunatics committed rose from 3,790 to 4,762. Pauper admissions for the same period rose from 16,821 to 31,230. Butler points out that although the commitment was projected as an individualistic process of objective scientific examination, diagnosis and certification, doctors were clearly diagnosing insanity predominantly on an economic and class basis. Mayer (1983) cautions, however, that such social control motivations by the upper middle classes is often asserted, but has not been convincingly demonstrated. Mayer asserts that many writers rely on the polemical ascription of malign motives of the reformers, casting them as hypocritical and repressive agents of social control. The social control school has also been vigorously attacked, most notably by Gerald Grob (1973; 1983), the most prolific of chronicler of American psychiatry. Grob contends that it is simplistic to categorise the motives of the reformers within the confines of the social control paradigm. Grob insists most reformers were unaware of the wider ramifications of their efforts, and that the negative consequences of their work, like the decline of asylums into custodialism, were unforseen and accidental by-products. He states:

From an ideological point of view it is equally difficult to categorise activists in any simple manner....A few saw reform as a conservative phenomenon in that it would diminish class rivalries and antagonisms and thereby preserve a fundamentally sound and moral social order. But
many more were primarily concerned with uplifting the mass of suffering humanity and were not particularly aware of political or economic considerations.

Their intentions were, he argues, essentially humanitarian but they were defeated by a combination of an onslaught of lower class patients, the unexpected chronicity of insanity, and insufficient fiscal resources to adequately respond.

What can be deduced from these competing explanations of the reformers' motivations? Certainly the motives of the reformers were more complex and ambiguous than they first appear. The influence of class was a defining characteristic in the work and objectives of the reformers. Reformers and physicians frequently had occasion to engage in conflict, particularly when reformers attempted to investigate physicians' practices or limit their powers. It can be conjectured however, the commonalties of their class interests may have been instrumental in preventing differences from becoming irreconcilable. Finally, social control was undoubtedly the outcome of the reformers' plans, whether or not they were consciously inspired. Ingleby (1983) contends that the reformers, genuine humanitarian motivations notwithstanding, fundamentally misunderstood the nature of insanity in relation to the changing social order. He argues the reformers:

...failed to offer a radical diagnosis of the evils of incarceration, still less of the system of wage labour that led to it: in the end, their efforts only subordinated the needs of the insane to the demands of the economy (p.151).

The consequence for the insane meant committal to institutions that were increasingly characterised by systemic problems of
overcrowding, grossly inadequate care, and brutal management practices carried out by untrained staff, who were themselves subject to appalling working conditions. The outcome of the lunacy reformers' labours was to endow the twentieth century with a legacy of massive institutions, and practices of confinement that would prove socially and economically difficult to resolve.

The Decline into Custodialism

The promise of the asylums, as envisioned by the reformers, were completely unrealised in Britain and North America. Although the lunacy reformers on both sides of the Atlantic had promoted a vision of institutions based on the principles of moral treatment, asylums quickly degenerated into mammoth warehouses of abject human misery. Asylums quickly developed into large, highly regimented, inadequately staffed institutions where there was little or no attempt at therapy or rehabilitation (Busfield 1986). Several reasons for this decline have been proposed. The principal reason was the sequelae of gross overcrowding. Inmate populations increased dramatically from the inception of public institutions. The House of Commons reported a total of 2,248 people (2.26 people per 10,000), officially identified as insane out of a total population base of nearly 10 million in Britain in 1807. In 1860 the Commissioners in Lunacy Report listed 38,000 insane people (16.5 per 10,000) out of a total population of 19 million and by 1890 these numbers had increased to 86,000 (29 per 10,000), out of a total population of 29 million. Between 1844 and 1860, whilst the overall population rose by 20%, the insane population nearly
doubled (Scull 1979, p.225). Scull contends the reasons for this increase were two fold. He states: "Very early on in the history of the asylum it became apparent its primary value to the community was as a place to consign the awkward and unwanted, the useless and troublesome" (p.240). This led, Scull contends, to decreased family and community tolerance for deviance and an expanded conception of what constituted insane behaviour.

The degeneration of asylums into mammoth custodial institutions in North America followed an identical pattern to Britain. Rothman (1971) contends there was no one inherent defect in the concept of the American asylum that was responsible. After 1850 incarceration reversed traditional colonial practices of social control for all categories of deviancy, such as deportation to other jurisdictions, physical punishments and fines. In the case of insanity a combination of an overwhelming rise in admissions, the unexpected and unplanned for development of a chronic population, and the withering of government funds to cope with the new demands, resulted in a similar picture to Britain. The situation in Canada appears to have been no different. In 1845 the Ontario provincial asylum was compared unfavourably to English institutions, many of which were certainly not paragons of enlightened care. J. H. Tuke, a member of the Yorkshire Tuke dynasty, on a visit to the Toronto asylum recorded in his diary:

Visited the lunatic asylum. It is one of the most painful and distressing places I have ever visited. The house has a terribly dark aspect within and without, and was intended for a prison. There were, perhaps, 70 patients, upon whose faces misery, starvation, and suffering were indelibly impressed.
The doctor pursues the exploded system of constantly cupping, bleeding, blistering and purging his patients; giving them the smallest quantity of food, and that of the poorest quality....The doctor, in response to my questions, and evident disgust, persisted that his was the only method of treating lunatics, and boasted he employs no restraint and that his cures are larger than those in any English or Continental asylum. I left the place sickened with disgust, and could hardly sleep at night, as the images of the suffering patients kept floating before my mind's eye in all the horrors of the revolting scenes I had witnessed (Tuke 1885, p.215).

In British Columbia, the Medical Superintendent of the Provincial hospital for the insane included in his 1901 Annual Report a historical review of provincial services for the insane. This review states that the Provincial Asylum was overcrowded from its inception in 1878 with "...dayrooms, corridors and lavatories...all being used as sleeping rooms". (p.467). The report refers to the gloomy prison like structure of the building, with barred windows located at such a height that one had to stand on a table to see out of them, an activity which the Superintendent observed, inmates indulged in for hours at a time. This, combined with the frequent use of brutal restraint, applied both "therapeutically" and arbitrarily as a punishment by attendants, undoubtedly made the Provincial Asylum a place of abject misery, indistinguishable from hundreds of other asylums in North America. Rothman (1971) concludes that: "The promise of reform had built up the asylum; the functionalism of custody perpetuated them" (p.240). The rise of the asylum had dominated psychiatric care during the nineteenth century; the mentally ill, policy makers, and society in general
were going to be dealing with its legacy throughout the twentieth century.

Epistemological and Commercial Origins of the Psychiatric Profession

The success of the psychiatric profession in securing dominance over the domain of insanity is due to several interrelated factors. The principal reason relates to the expansion of public institutions for the insane, the administration and control of which, psychiatrists successfully competed for. The rewards for professional dominance in terms of monetary compensation, status and power are significant, and professions rarely are able to stake a claim without conflict. The psychiatric profession was no exception and had to overcome a number of internal weaknesses in its theoretical and organisational position, in order to defeat external threats to its claims to dominance. Consequently, it did not secure a position of dominance until the middle of the nineteenth century (Scull 1979).

The institutional antecedents to the asylum (private madhouses and charitable institutions), played an important role in the process of professionalisation of psychiatry. These institutions served a number of functions. They provided sources of employment for medical men as specialists in the treatment of the insane and offered ready access to a growing clinical population. In turn, practice and research with this clientele facilitated increased opportunities to claims of expertise (Busfield 1986). The involvement of prominent medical men and the formal association of
medical infirmaries with many charitable institutions for the insane, formed an association in the public's mind between insanity and medicine (Scull 1993). The private madhouse system was also important. As was previously discussed, although the private sector served a relatively small percentage of the total population of the insane, it was expanding and was perceived to be profitable by medical entrepreneurs and others. Initially, the profitable and unregulated nature of the "trade in lunacy" attracted a range of speculators from a variety of different occupational and business backgrounds including medicine. Physicians of varying training and expertise became increasingly involved in this trade, both for entrepreneurial reasons and to help improve the condition of inmates (Scull 1979). Even as this trade slowly became subject to increased regulation, the expanding nature of the institutional response and the concomitant increase in the clinical population provided a guaranteed market which was commercially attractive, and bound to cause competition for control. The growth of a significant institutional base on which a new profession could establish itself was, however, slow to develop. It was not until the national system of public asylum care was compulsorily mandated in the mid-nineteenth century that the profession was able to secure dominance by fully exploiting the state's need for a specialist occupation to administer the burgeoning enterprise.

Initially no one occupational group was able to monopolize the market for the exclusive provision of services to the insane (Scull 1979). Abbott (1988) contends that professional competitions for
dominance are, in effect, jurisdictional disputes, and it is such disputes that comprise the determining history of individual professions. Abbott notes that it is jurisdictional vacancies, rather than the actual professions which are the principal determinants in the process of claims for professional dominance. Jurisdictions can be vacated if an existing profession loses control, if it is voluntarily vacated, or if a jurisdiction is newly created. As previously noted, the free market in lunacy ensured competition but provided no mechanisms or grounds whereby any one group could assert dominance. The rise of the asylums in the nineteenth century, or more precisely the management of them, provided such a mechanism by creating, in effect, a new jurisdiction. This jurisdiction - asylum management - allowed the psychiatric profession, in a decisive manner, to consolidate their position from one of increasing dominance to monopolistic control.

Freidson (1970) states that the core characteristic of any profession is autonomy based on special knowledge which is denied others. Only when this is legitimately established can a profession declare that external supervision of it’s training, education, and particularly its work, to be unwarranted. Given the persistent epistemological and conceptual vulnerability of medical knowledge about insanity, however, the assertion of exclusive knowledge alone is an inadequate explanation for the profession’s rise to dominance. Usually, once a new jurisdiction is created, professions that aspire to dominance have to establish credible claims of exclusive expertise and efficacy. Medical claims to such
expertise, much less demonstrable therapeutic efficacy, were manifestly not much more than rhetoric framed in the scientific language of the day. Perkin (1989) notes however that it is not specialised training per se that yields comprehensive professional dominance. Instead he argues that: "The transforming device is professional control of the market" (p.7). Thus the success of the medical men did not rest solely on their claims of therapeutic expertise being verified. Light (1980) asserts that "Technically, a profession's greatest need is for a better expertise in the form of knowledge and skills, but sociologically, a profession's greatest need is for control" (p282). The creation of the jurisdictional vacancy of asylum management created an opportunity for a bid for monopolistic control. The new profession was assisted in this regard in that the orientation of asylums toward order and structure was congruent with the medical approach to madness with its emphasis on rationality and self-control (Scull 1979). Having gained sufficient control of the market a profession is able to use other mechanisms of professional dominance such as licensing and mandatory training to drive out competitors and create an artificial scarcity for its service. The origins of the dominance of the psychiatric profession are intimately connected to its capture of an institutional base, as opposed to undeniable evidence of particular expertise and knowledge. Scull (1993) contends that, paradoxically, the reluctance of psychiatry to relinquish it's institutional base in the asylum was a significant factor in it's continued dominance of mental health during the late
nineteenth and well into the twentieth century. As long as the asylum retained symbolic and practical primacy, the psychiatric profession was assured of its monopoly and a guaranteed market (pp.382-383).

Disputes over ownership of knowledge frequently occur prior to the success of one profession establishing its control of a designated intellectual territory. Abbott (1988) states: "Control of knowledge and its application means dominating outsiders who attack that control. Control without competition is trivial" (p.2). Despite the profession's claims to special knowledge, it remained vulnerable to challenge in the first half of the nineteenth century. Scull (1979) points out that a principal weakness of the medical position was that its theory base and the "therapeutic" application of medical knowledge had become incongruent with contemporary thought. Medical treatments continued to be grounded in the pre-Enlightenment paradigm of the mad as inhuman. Although couched in therapeutic rhetoric, the standard medical treatments of the eighteenth and early nineteenth century were principally aimed at control of the animalistic impulses of the deranged. They included bleeding, purging, the administration of emetics, chaining, whirling in rotary devices and so on. In 1810, three years prior to Tuke releasing his famous book proclaiming the humanity of moral treatment, the famous American physician Benjamin Rush described his latest therapeutic invention:

I have contrived a chair...It binds and confines every part of the body. By keeping the trunk erect, it lessens the impetus of the blood toward the brain. By preventing the muscles from acting, it
reduces the force and frequency of the pulse, and by the position of the head and feet favors the easy application of cold water or ice to the former, and warm water to the latter. Its effects have been truly delightful to me. It acts as a sedative to the tongue and temper as well as to the blood vessels. In 24, 12, 6, and in some cases 4 hours, the most refractory patients have been composed. I have called it a *Tranquillizer* (Bynum 1974).

The emergence of moral treatment presented a major threat to the medical profession's claims for dominance. A brief examination of its influence will follow.

**The challenge of moral treatment.**

The significance of the challenge posed by moral treatment was that it did not simply offer an alternative, competing service to traditional medical practice but, by its very existence, offered a dramatic contrast to the inhumanity of the majority of medical treatments. In so doing, moral treatment implicitly raised the question of the validity of medical theory and practice, and explicitly threatened the role of the medical practitioner in the treatment of insanity.

Moral treatment derived from the paradigmatic shift in the conception of insanity, whereby the mad person was perceived to retain human qualities and for rehabilitation to be possible. The pre-eminent advocates of moral treatment, Phillipe Pinel in France and William Tuke in England, perceived the insane to be suffering primarily from a lack of internal self control and self discipline (Bynum 1974). Congruent with this non-organic diagnosis, it followed that treatment should be psychological in nature. Moral treatment thus provided a sharp contrast to prevailing medical
theory and practice which persisted in seeing the patient as animalistic in nature. Moral treatment was the source of more anxiety, however, than that arising from a simple epistemological dispute. The non-medical nature of moral treatment explicitly threatened to relegate the role of physician to a secondary position of attending only to physical complaints. Clearly, this had serious ramifications for the profession:

If physicians could do nothing for the lunatic except treat his (sic) bodily afflictions, then medical men had no special claims to a unique place in the treatment of mental illness. Their income, prestige and medical theories were all threatened (Bynum 1974, p.325).

The medical profession was also frequently challenged publicly to defend the theoretical underpinnings and clinical practice from other sources. Public disquiet about the condition of madhouse and asylum inmates led to a number of Select Committees in the early nineteenth century as previously discussed. Called to give evidence, prominent medical men repeatedly struggled to justify their practices. Scull (1979) reports Thomas Munro, physician to the York Asylum, in giving evidence before the 1815 enquiry, admitted the principal justification for mass treatment was tradition. Munro advised the Committee members that inmates:

"....are ordered to be bled about the latter end of May...and after they have been bled they take vomits once a week for a certain number of weeks, after that we purge the patients.." (p.136).

Following this, the depleted patients were, Munro advised, chained to their beds for several days a week. In the minds of many physicians, treatment remained so intimately connected to coercion
that they felt no need to be strategic in their justifications, even when called upon to do so publicly. Appearing before the 1839 Select Committee on Hereford Lunatic Asylum, Dr. W.L. Gilliland was requested to explicate the theory underpinning his practice of ordering inmates be immersed in cold baths.

Chairman, J.Barneby: You state that you did not use the bath as a punishment.

Dr. Gilliland: Probably if I give you my idea of the bath as a punishment and a remedy, it would answer that question; I have always used the bath as a cure, at the same time that I have impressed upon my patients that it was a punishment.

Chairman: When patients have torn their clothes, have you ever put them into the bath upon that account?

Dr. Gilliland: I have done so...so that I could impress upon their minds that it was a punishment, but I have used it as a cure...but I impressed upon the patient in nine cases out of ten that it was a punishment.

Lord Ashley: ...Then it is not a curative process?

Dr. Gilliland: Always. (pp.163-164).

The medical response to moral treatment.

Medicine was prevented from becoming permanently marginalised by several factors. First, the threat of moral treatment ironically acted as a catalyst and galvanised the medical profession to articulate its case more forcefully. Scull (1993) reports a plethora of medical treatises on the etiology, nature and cure of insanity appeared from 1815. These treatise were written partly in an attempt to persuade the public of the organic etiology of insanity. Scull states:
The most single effective response [was to]... demonstrate that insanity was in fact caused by biophysical variables. A somatic interpretation of insanity would place it beyond dispute within medicine's recognised sphere of competence, and make plausible the assertion that it responded to medicines's conventional remedies for disease (op cit, p.217).

Scull points out that the advocates of moral treatment were not well positioned or possibly even disposed to articulate a theoretical defence; moral treatment lacked a developed model of insanity, it had failed to develop it's own jargon and continued to use essentially medical terminology. In addition, moral treatment advocates asserted an honest but strategically naive belief in the amelioration of mental illness as opposed to cure. All of these factors left moral treatment vulnerable to a vigorous attack by medical men. Scull states they originally reacted with frank hostility and simply tried to reassert their traditional claims based on medical "expertise". William Nesbit, a prominent London doctor asserted in 1815:

The disease of insanity in all its shade and varieties, belongs, in point of treatment, to the department of the physician alone....the medical treatment....is that part on which the whole success of the cure hangs (Scull 1993, p.191).

The doctors could not fail to notice however, that influential reformers were thoroughly persuaded of the benefits of moral treatment. As previously discussed, over and above the humanitarian appeal of moral treatment, it suited the reformers to champion the moral treatment model in pursuance of their own objectives. The solution for the medical profession was to
effectively assimilate moral treatment by arguing that it's specific treatments, such as warm baths, be administered only under medical supervision. Scull (1979) reports the 1854 Asylum Journal editorial asserted that "...the moral system of treatment can only be properly carried out under the constant superintendence and by the continuous assistance of a physician". Those who argued against this were accused of denying patients the benefits of medical and moral treatment (Scull 1993). The psychiatric profession has continued to effectively employ the strategy of incorporation until the present day. Potential threats to its dominance, whether in the form of ideas or other professions, are subsumed under its ideological and organisational authority. Busfield (1986) argues this has endowed the biomedical model with an enduring flexibility. She states:

Undoubtedly...both the selective incorporation of psychological ideas and the incorporation of new mental health professionals have served to contain and cover over the tension arising from the contradiction of a specialism whose expertise and ideas have come increasingly to be drawn from the natural sciences, which attempts to deal with a broad range of disorders, the origin and character of which are linked to a diversity of structural and cultural features of society. (pp.368-369).

The success of the psychiatric profession's claims for dominance.

By the late 1830's, the doctors were gaining ground in their struggle for professional dominance. The 1828 Madhouse Act compulsorily mandated asylums to engage the consultative services of a doctor on a regular basis, and compelled asylums with inmate populations exceeding one hundred, to employ a medical
superintendent (Scull 1979). The 1845 Lunacy Act entrenched the expansion of the medical profession principally by requiring all public asylums to appoint medical superintendents. In addition, the national inspectorate, the Commissioners in Lunacy, were comprised of the three dominant groups in the arena of insanity: three medical practitioners, three members of the legal profession and five laymen. This latter group largely represented the ongoing interests of reformers, with the first lay Commissioners including the high-profile reformers Lord Ashley, Robert Gordon, and Lord Seymour (Butler 1985). The Commissioners were not infrequently criticised for their lack of effectiveness. The Lancet openly castigated the Commissioners, on one occasion describing two of them as old and bedridden, and another, so blind he mistook a male patient for a female (Bean 1980). Despite these organisational and personal criticisms, the appointment of doctors to the Commission was highly significant for the medical profession, as from that point on the Lunacy Commissioners:

....manifested a steadily growing hostility to non-medically run asylums. With the help of elite sponsorship, the asylum doctors were now able to drive competing lay people out of the same line of work, and to subordinate those who stayed in the field to their authority (Scull 1979, p. 163).

Despite the success of the medical men in gaining monopolistic control of the public asylums, their therapeutic impotence continued to hinder the public's acceptance of the profession. Abbott (1988) contends that:

....psychiatry was a kind of profession in reverse. It controlled an important jurisdiction with a steadily growing demand but could use little more
than administrative knowledge in its activities. Of its treatments, only incarceration had any effect, and that made psychiatrists little different from the jailers they had replaced, despite their legitimation by reference to the medical model of science, treatment, and cure. (p.295).

Psychiatry thus emerged as both a dominant profession in the nineteenth century, but marginalised due to its tenuous connections to mainstream medicine and science, despite its vigorous claims to the contrary. After 1845, insanity was accepted as a medical condition both legally, and in the public mind. At the same time, the asylum was materially and conceptually entrenched as the principal site of treatment. This emerging hegemony exerted a significant effect. Scull (1989) points out that even when the systemic weaknesses of the asylums were periodically exposed, the only thought was how to apply remedial correctives. The questioning of the concept of the asylum, had become effectively unthinkable. Likewise, although the continued therapeutic impotence of the psychiatric profession was frequently the subject of concern, their professional dominance was no longer open to a serious challenge.

The Emergence of Legalism

The impetus for a slow progression toward greater controls on commitment of the insane in both Britain and America, arose from continued revelations about systemic cruelty of the asylums, and the periodic but widespread public fears of wrongful detention (Butler 1985; Caplan 1969). Out of these concerns developed an increasing tension between medical and legal interests, a tension
which increasingly defined the boundaries of the insanity discourse.

Significant contradictory public attitudes existed concerning the necessity for asylums and the incarceration of people within them. McCandless (1981) relates that Victorians were strongly in favour of involuntary detention in asylums due to their abhorrence of the spectre of lunatics at large. On the other hand, they were equally horrified by the possibility of the sane being wrongfully incarcerated. These fears occasionally erupted into "lunacy panics", often fuelled by highly publicized suits for wrongful detention, as well as popular fiction describing the horrors of wrongful detention in asylums. Central to this contradiction was the belief, vigorously supported by doctors, that a clear demarcation existed between the sane and the mad. McCandless contends that this led to occasional vigorous attacks on asylum operators and doctors, while the system itself remained untarnished. He states:

Most Victorians could not or would not see any contradictions between their concerns for the liberty of the sane and their insistence on the incarceration of the insane. And, if one accepts their belief that distinguishing between the two was an easy matter, the contradiction largely disappears. From their perspective, if a sane person were confined, it could only be because the greed, stupidity, or malevolence of those responsible for his (sic) commitment had perverted the asylum from its true course (p.341).

Of course, it remained in the best interests of the doctors to assert that only they could properly diagnose insanity. At the same time, McCandless states that Doctors steadfastly refused to
concede the obvious limitations of their knowledge. Despite the legal sanctioning of the doctors as arbiters of sanity, the public never fully accepted their claims and "....many people remained suspicious of the doctors' abilities and intentions even as reliance on them increased" (p.341). McCandless concludes however, that empirical evidence to support a conspiracy theory of wrongful confinement remains insubstantial. Nevertheless, public anxiety was real and, given the state of psychiatric knowledge and the conditions of the asylums, not unreasonable. As Robitscher (1978) points out, contemporary society (no less than nineteenth century society), has an awareness that:

Only a very small percentage of the population is ever directly threatened with commitment, but everyone in society - except the most deranged and the most committable - understands that if you overstep certain lines the penalty may be either police power or commitment - and sometimes both (p.188).

Attempts were made to introduce more stringent certification procedures, and supervision of private madhouses and public asylums prior to 1845. Despite consistent opposition, some modified legislation was successfully passed, such as the Madhouse Act and County Asylum Act of 1828, both of which marginally improved licensing and treatment procedures, and tightened committal criteria (Busfield 1986; Jones 1955). Hervey (1986) contends these administrative controls remained woefully inadequate, and that in practice, were often simply ignored. For instance, asylum
inspections were usually highly perfunctory, and madhouse owners continued the practice of certifying their own inmates.

McCandless (1981) suggests that the issue of wrongful confinement may have been primarily a middle and upper middle class concern. Certainly, prominent reformers like Lord Ashley focussed their concerns primarily on private asylums. Commitment procedures continued to differ on class lines, with generally less stringent criteria being applied to pauper lunatics (Bean 1980). These ongoing concerns led to the formation of reform groups such as the Alleged Lunatics' Friend Society (ALFS) in 1845, later to be renamed the Lunacy Law Reform Association in 1873 (McCandless 1981). The ALFS was co-founded by J.T. Perceval, a British army officer and the son of an assassinated Prime Minister. Perceval, who Brandon (1991) describes as the first "lunatic reformer" (p.18), published two volumes of his experiences of institutional brutality during three years of incarceration called *A Narrative of the Treatment Experienced by a Gentleman, during a State of Mental Derangement* (see Peterson 1982, p.92-94). Dain (1980) quotes Perceval as stating his aim was to:

> ....stir up an intelligent and active sympathy, in behalf of the most wretched, and the most oppressed, the only helpless of mankind, by proving how much needless tyranny they are treated [with]....by men who pretend indeed their cure, but who are in reality their tormentors and destroyers (p.89).

These early, energetic civil libertarian organisations, such as the ALFS, expressed sentiments similar to those that are articulated in the latter half of the twentieth century. Hervey (1986) states
that the ALFS proclaimed certain inalienable rights of the individual, advocated that every patient should have a say in his or her confinement and treatment, and have access to appropriate legal representation. The ALFS specifically campaigned for tighter committal procedures including jury trials prior to admission, and the establishment of an appeals and review process in regard to confinement and continued detention. Hervey suggests the ALFS were often perceived as an irritant by the Lunacy Commission, which frequently resented its intrusion and adopted an obstructionist attitude to the Society’s objectives. Like contemporary critics who advocate increased restrictions on the psychiatric enterprise, Hervey concludes that the ALFS’s most significant impact was to "....continually challenge the parameters of mental illness laid down by others" (op cit, p.275).

In America, as in Britain, prominent court cases and popular fiction also heightened public fears about commitment. Caplan (1969) relates that one of the most significant of the American cases concerned Elizabeth Packard, who won a suit against her husband and an asylum superintendent for false commitment in Illinois in the mid-1860’s. In 1867, the Illinois Personal Liberty Law, popularly referred to as the "Packard Law" was passed, requiring a jury trial before committal. Caplan points out that doctors resented what they perceived as attacks on their autonomy and often resisted changes. Aware of public fears, many states adopted legislation that sought to limit or curb the practices of doctors and asylum operators (Rothman 1980; Grob 1973; 1983).
By the late nineteenth century, fears concerning the improper management of the insane, and the chaotic state of lunacy legislation and administrative procedures, prompted the English Parliament to introduce the **Lunacy Act 1890**. This legislation has been described by Jones (1972) as the epitome of "legalism". Legalism, at this time, referred to the attempt to replace medical and social discretion with the imposition of a framework of legal technical processes and regulations. Lengthy and complex, bearing the "heavy impress of the legal mind", it contained "Every safeguard which could possibly be devised against illegal confinement.." (Jones 1993, p.111). Jones (1972), a long standing critic of historical and contemporary legalism, characterised the Act as "....piling safeguard upon safeguard to protect the sane against illegal detention, delaying certification and treatment until the person in need of care was obviously (and probably incurably) insane (p.153). Furthermore, the Act reflected a determination to "....draw a firm legal boundary between the sane majority and insane minority" (Jones 1993, p.112). Bean (1980) observes that the preoccupation with liberty was driven by an overarching ideological thrust of "....pure nineteenth century liberalism, the basis of which was that the rule of law must provide a minimum level of protection against personal interference" (p.35). Butler (1985) points out that as a consequence of the concern with the protection of liberty of the subject above all else, the medical perspective inevitably became an adjunct to the legal view.
The 1890 Lunacy Act established four procedures for admission to the asylum or madhouse. These procedures were again influenced by underlying class and economic considerations, with three procedures applying to private patients and one to pauper lunatics. All required judicial authority for commitment (Bean 1980). The 1890 Act, while uncomprising in terms of the legal framework it established, was in another important sense a compromise between medicine and law, and the desire to protect civil liberties whilst ensuring the treatment of those adjudicated to be properly insane. The 1890 Act clearly established asylum detention as a judicial process in the name of civil liberties, whilst granting legal recognition for the independent expertise of the medical profession in treating insanity (Jones 1960). Butler (1985) concurs with this analysis and points out that while the 1845 Act had affirmed the medicalisation of insanity, the 1890 Act legitimised psychiatric practice on the basis of legal detention. Butler highlights the nature of the compromise; admission became a legal issue but said little about the treatment of the insane post-admission. That was to be left to the expert ministrations of the asylum doctors. Despite their considerable irritation with the imposition of legal constraints on their autonomy concerning admission, such arrangements were probably partially welcomed by Medical Superintendents, who no doubt wished to engage in their profession without constant critical scrutiny. This would be facilitated in that legalism sought to allay the gross anxieties of the public of incarceration of the sane. With this achieved and responsibility
for the mad delegated to the doctors, there were (and continue to be) distinct advantages to decreased public anxiety about the realities of asylum life, as Scull (1993) asserts:

By not inquiring too deeply into what went on behind asylum walls, by not pressing too hard to find out what superintendents actually did with their patients, and by not being too sceptical of the officially constructed reality, people were (are) rewarded with a comforting reassurance about the essentially benign character of their society and the way it dealt (deals) with its deviants and misfits (p.382).

The impact of legalism in Canada.

The imperial influence of the English Lunacy Act of 1890 on Canadian Lunacy law, reflected Canada's position as a Dominion within the British Empire, although its impact was not immediate or evenly distributed to all provinces (Gordon 1988). Gordon explains that provincial lunacy procedures for the management of dangerous insane were consistent across the country, while statutes dealing with the non-dangerous insane varied. In New Brunswick, Ontario and Quebec the commitment of non-dangerous insane was undertaken by Doctors, but their treatment and continued confinement was subject to quasi-judicial supervision. In B.C., Nova Scotia, Prince Edward Island and Manitoba, the judiciary were central to the commitment process.

Public anxiety about the unwarranted incarceration of the sane in British Columbia was similar to other jurisdictions. Despite medical rhetoric about the underlying scientific principles of diagnosis and treatment, knowledge about the causes of insanity, much less its effective treatment, was extraordinarily basic and
subjective. The 1892 *Annual Report on the Asylum for the Insane* lists the "supposed" causes of insanity for the 64 patients admitted that year. Etiological categories include political excitement, self abuse (sexual), uterine disorders, intemperance in drink, love affairs, fright, jealousy, and unknown (p.417).

Significant momentum to adopt a judicial framework in British Columbia similar to that embodied in the English Lunacy Act, was provided by the *1894 Royal Commission into the Provincial Lunatic Asylum for the Insane.* The investigation by the Commissioners over fourteen days, revealed a litany of systemic abuse that was reminiscent of the early nineteenth century Parliamentary Select Committee investigations into English asylums and madhouses. The Commissioners, Edward Hassell and Charles Newcombe, in their extensive report to Parliament, specifically referred to the "infinite difficulty" they encountered in getting patients to give evidence for fear of retribution. The Medical Superintendent, Dr. R. Bentley, assured the Commissioners that punishment was never imposed and restraint only used by special order. The evidence unearthed by the Commissioners was to the contrary:

....we were astounded at hearing patient after patient telling the same stories of inmates being thrashed with straps, of their being kicked, handcuffed for trifling offences, struck with the fist, ducked in cold water until nearly suffocated, of their being tortured by semi-strangulation by means of the strait-jacket, and of one man being crippled for life by the prolonged use of a leather "mit", followed by inflammation and abscess."

The transcribed proceedings of the Royal Commission reveal an arbitrary and unrestrained reign of terror. For example, a patient
named Richard Hughes, an American citizen, revealed the process of "cold ducking".

....I was stripped stark naked and hand-cuffs were put on me....and put face down in the water, and then they kept me there for a second or two, and then they pulled me out, and then they dumped me down again....and Williams got one leg and held me up like that (illustrating) with my face under water so that I could not shout, so I had to hold my breath....and then they took me again and butted me against the taps that come out of the side of the bath with my head here, and they kept me there for five or six times and then took me out, and then when I came out from the bath....they took the strap to me and hustled me off, and as soon as they got me out they told me if I ever spoke about that I would have to walk a bee line into the cellar - into the black hole."

The Commissioners noted a staffing ratio of one to thirteen (a total of 158 patients and thirteen staff). This compared unfavourably with English asylums which, the Commissioners stated, maintained a ratio of one staff member to eight patients. Staff worked from 6 am until 7 pm, seven days a week, with one half day off. Under these conditions, with negligible or no training and manifestly inadequate supervision, systemic abuse was almost inevitable. The Commissioners asserted, perhaps optimistically, that many of the methods of restraint used at the Provincial asylum had been redundant in Britain for forty years, and they recommended their abolition except when necessary for the "protection" of the patient, as: "To reject its use when necessary would be to sacrifice the patient to a sentiment". The Commissioners concluded their report with the ethnocentric observation that asylum records revealed the national origins of nearly all of the inmates to be
British, therefore "...there is no reason why they should not be treated as humanely as their brothers and cousins at home".

The Commissioners squarely laid responsibility for their findings with the Medical Superintendent. Bentley's culpability offered the Commissioners a useful scapegoat, in that it relieved the Commissioners and the province of any responsibility to address the question of the nature of the asylum itself. As previously discussed, this was not surprising; the hegemonic concept of the asylum had become such a constituent part of reality in the late nineteenth century, that alternatives were unthinkable. Dr. Bentley, rebutted the allegations in a bitter defence to James Baker, the Provincial Secretary. This correspondence was replete with evidence of restraint practices elsewhere, as well as enthusiastic testimonials regarding Bentley's management of the asylum from a locum physician and the Chaplain. Dr. Bentley was particularly keen to highlight the therapeutic effect of weekly concerts which he personally had instituted. All this was to no avail and Dr. Bentley felt compelled to offer his resignation in the New Year. This was accepted, no doubt with some relief, in a reply by the Provincial Secretary, who tersely reiterated Bentley's personal responsibility.¹⁰

The Commissioners had made no specific recommendations concerning the process of incarceration of the insane. It is likely however, that the findings of the Royal Commission, combined with the imperial influence of the English Lunacy Act of 1890 in Canada generally, prompted the province to act. The resulting
legislation, the *Hospitals for Insane Act 1897*\(^{11}\), was the first provincial statute to adopt the legalistic model and judicial procedures of the English Lunacy Act (Gordon 1988). This legislation repealed and consolidated the original Provincial *Insane Asylums Act 1873* which was a brief statute that allowed for the committal of a lunatic on the basis of two certificates from medical practitioners, who examined the patient in the presence of each other, a practice unique to B.C. at the time.\(^{12}\) The provisions of the Act allowed a (non-dangerous) person to be admitted following examination of two Doctors establishing insanity and a commitment order signed by a judicial official. In emergencies an Urgency Order signed solely by a judicial officer was sufficient, although the regular certification process referred to above had to be completed within two weeks.

The new Act emulated the English legalism in that commitment proceedings were attended to in detail, but the treatment of inmates, including continued detention and discharge, was left as a matter of medical discretion. In deference to the Royal Commission findings, penalties were stipulated for ill-treatment, although no body equivalent to the English Commissioners in Lunacy were established to oversee the treatment of inmates. Gordon (1988) asserts that while the emergent "legalism" inherent in the English statute was influential in Canada, in no province was it embraced in entirety and it is more accurate to designate the Canadian legislative situation as one of "limited legalism".
The legalism of the late nineteenth century lunacy law and the limited legalism of its Canadian counterpart, marked the origins of deeper tensions that have persisted at the interface of law and psychiatry. Jones (1980) argues that legalism represented a triumph of rigidity over flexibility, and the origins of a tension between "....systems founded on the application of a body of law within an institutional framework and systems based on the flexible interpretations of human needs in given situations...."(pp 1-2). Unsworth (1987) contends that the tension between nineteenth century legalism and medical discretion was of a "collision of perspectives" (p.21), the consequences of which continue to be played out today.

Legalism emerged to protect civil liberties partly out of fear of what occurred beyond the asylum walls. Legalism served to satisfy concerns that only those who were insane were incarcerated. Beyond that, legalism was incapable of guaranteeing improvements in asylum treatment or administration, even if that had been the intention. The almost universal poor conditions of asylums and the climate of therapeutic nihilism, overseen by a dominant but medically marginalised profession, painted a depressing picture as the century drew to a close. The medical approach inherently tends towards reductionism, and the law, no less so. While the reductionism of medicine was crudely reductionist in it's approach to insanity in the nineteenth century, legalism likewise reduced the systemic problems of the asylum to that of protecting the sane. In the following chapters the reasons for, and the manner in which
tensions between psychiatry and law in relation to asylum commitment and treatment have developed and been mediated, will be explored.

In summary, this chapter has analytically traced the changing responses to insanity through the nineteenth century. It has been proposed that changing ideas about human nature in conjunction with socio-economic pressures generated by the rapid development of a market economy, produced an institutional response to insanity. The purpose of this response was primarily social control. The rise of the asylums was instrumental in the emergent dominance of the psychiatric profession. Limitations in medical knowledge about psychiatric treatment, combined with inherent faults in the asylum concept, gave rise to efforts to balance the need to socially control the insane with the need to protect civil liberties, particularly of the sane. The resulting legalism of various lunacy statutes in England and Canada reflected an emerging tension between law and medicine. This tension, together with the figurative and literal symbol of the asylum, represented the dominant legacy of the nineteenth century, which contemporary mental health workers, policy makers, and mental health consumers continue to grapple with today.
CHAPTER FIVE

CONTRADICTORY FORCES:
MENTAL HYGIENE AND THE ASYLUM, 1900 - 1950

This chapter examines the relationship between contradictory forces from the turn of the century until the mid-1950’s. It is shown that the emergence of the mental hygiene movement, with its emphasis on the prevention and early treatment of mental disorder, produced an impetus for a shift away from institutional, custodial care. At the same time, it is contended that other forces, most notably the escalating institutional population and the discovery of a series of radical somatic treatments, counterbalanced and effectively halted the evolution of the shift towards a community focus. The impact of these contradictory forces on Canadian, and specifically British Columbian, mental health law will be examined. It will be shown that a trend to replace nineteenth century legalism with medical discretion was set in train.

The antecedents of the shift in focus away from institutional care, including mounting criticisms of institutional psychiatry and the advent of the progressive era in the United States, will be outlined. It is contended that the original aims of the mental hygiene movement - the reform of the asylum - was reframed and diverted towards the more amorphous objective of prevention. It is
suggested that the pervasive influence of mental hygiene ideology was reflected in official commissions of enquiry into how to respond to perceptions that the incidence of mental disorder was escalating. While the mental hygiene movement was broadly progressive, it is argued that it also contained authoritarian, social Darwinist elements which were manifested by, most notably, eugenics advocates. It is contended that this aspect of the mental hygiene movement reflected, in part, its inability to offer viable ways to actually prevent or treat mental disorder. Nevertheless, it is shown that the influence of the movement did give rise to facilities to provide early treatment, most notably in the form of "psychopathic" hospitals. It is argued, however, that the effects of these progressive developments were diluted by the inexorable rise in the institutional population. At the same time, the advent of a series of radical somatic treatments that appeared to have some therapeutic efficacy, produced a reorientation back towards the asylum as the principal site of treatment.

The chapter concludes with an examination of legislative developments in British Columbia. It is shown that the shift in focus toward early treatment initiated a trend of eroding legalism in favour of medical discretion, primarily in order to facilitate the changing strategies of managing the mentally disordered.

Antecedents to Early Twentieth Century Reform

Institutional psychiatry became subject to increasing criticism from a number of quarters in the late nineteenth and early twentieth century. Rothman (1980) points out that asylums
had not only failed to live up to the ideal of their nineteenth century advocates, they had manifestly degenerated into warehouses of human misery: "Failure to do good was one thing; a proclivity to do harm quite another - and yet the evidence was incontrovertible that brutality and corruption were endemic to the institutions" (p.17). As will be shown, the most effective criticism came from non-professional sources, however, dissent was evident even within the medical profession. In particular, neurologists levelled a wide-ranging critique of institutional practices. Medical Superintendents of asylums were castigated for their adherence to diffuse management roles (typically this included everything from clinical treatment to farm management), their lack of clinical research, their isolation from mainstream medicine, and their continued reliance on restraints, and inability to control systemic abuse of inmates. S. Weir Mitchell, a prominent neurologist delivered a stinging rebuke concluding:

You have far too long maintained the fiction that there is some mysterious therapeutic influence to be found behind your walls and locked doors. We hold the reverse opinion and think your hospitals are never to be used save as a last resort....upon my word, I think asylum life is deadly to the insane (op cit, p.295).

The impact of such criticism was diluted by the fact that it was based, in part, on professional rivalry and motivated by professional self-interest. Neurologists, as a nascent medical specialty, perceived themselves to be in competition with the Medical Superintendents both for access to the clinical population and resources. Both groups stood on very different epistemological
ground. The neurologists believed the etiology of insanity was solely organic and treatment solutions lay in the laboratory and autopsy room. Consequently, they viewed the asylum doctor's diffuse conceptions of insanity with little more than contempt. While the cogent criticisms of the neurologists were frequently devastatingly accurate, they offered negligible constructive alternatives. In the absence of realistic alternatives to asylum care, the asylum superintendents were only moved to respond with denials, rationalisations and, for the most part, effective defences of asylum practice (Rothman 1980).

Despite such criticisms, the psychiatric profession did not concede the underlying charge that it remained almost totally ineffectual in it's understanding or treatment of insanity. On the contrary, Scull (1993) argues that despite the fact madness remained largely intractable and unamenable to "treatment", no admission of therapeutic impotence was made, still less any uncertainty about it's ability to intervene. No thought was given to relinquishing the institutional power basis of psychiatry. The psychiatric profession was, however, prompted to consider a diversification and expansion of it's activities. In addition to retaining "the central mission of institutional psychiatry" (p.384) of acting as guardians of the incurably insane, the profession sought to shift it's focus. By moving the point of intervention to one of prevention and early treatment, it was hoped that the decline into intractable madness could be prevented. This shift in focus represented the first phase of a "rapid proliferation of the
sites and targets of intervention" (p.384) which has characterised the development of twentieth century psychiatric practice.

This shift in focus was facilitated by the advent of the Progressive era in the United States. Just as the Enlightenment had produced a confidence that social and human problems could be solved, the "Progressive" movement of the first decades of the twentieth century produced a similar, though less wide-spread optimism. Rothman (1980) states: "The Progressive era marked a major divide in attitudes and practices toward the deviant, creating new ideas and procedures to combat crime, delinquency and mental illness" (p.43). Grob (1983) points out that Progressive thinking encompassed a wide range of analyses of human problems, from notions of environmental causality of delinquency, to inherited predispositions to insanity. Proposed solutions were similarly spread across a wide political and moral continuum from the imposition of eugenic measures such as sterilisation to transforming the social environment. The essential characteristic that linked progressive activists, regardless of ideological persuasion, was a belief in discretionary responses to each problem and each case (Rothman 1980). This flexibility represented a critical shift in thinking, and was in contradistinction to nineteenth century belief and practice, which had authorised and legitimated the massive sweeping up of people designated as insane into warehouse institutions, regardless of condition, chronicity, or treatability. The Progressive era thus produced a climate
conducive to innovation and reform, which in the field of mental illness, was symbolised by the Mental Hygiene movement.

The Mental Hygiene Movement

The origins of the mental hygiene movement are synonymous with the life and work of Clifford Beers. Beers, born in 1876, was educated at Yale. Following a serious suicide attempt, Beers spent three years committed to mental hospitals, mainly in the Connecticut Hospital for the Insane. Discharged in 1903, Beers emerged with a lifelong, passionate conviction that structural and organisational change to the asylum system was essential (Grob 1983). Beers subsequently wrote a book *A Mind That Found Itself*, based on his experiences of mental illness and incarceration. Beers' lucid and convincing account of asylum life "combined the desire to expose, reform and inform" (Dain 1980, p.89). Beers not only offered further evidence of institutional brutality (there were numerous accounts of such maltreatment), but his analysis extended beyond descriptions of mere individual malice, to reveal that such behaviour was symptomatic of profound systemic problems.

Beers' career replicated the strategy of the first "lunatic reformer", J.T. Perceval, who had written of his own asylum experiences and had gone on to found a national advocacy movement, the ALFS in Britain (see Chapter 4), seventy years prior to Beers' own incarceration. At the same time Beers was, in some important respects, a forerunner of late twentieth century mental health consumer-survivor activists. In particular, rather than obscuring the fact he was mentally ill, Beers openly promoted his experiences
of mental disorder and the institutional response to it, as a form of unique and expert knowledge. Rothman (1980) notes that much of the power of Beers’ analysis lay in his admission of mental illness and the manifest inadequacy of the asylum to do anything to help him (p.299). Following the critical claim of his book, Beers worked energetically to form a state, then national advocacy movement. The American National Committee for Mental Hygiene (NCMH) was subsequently formed in 1909 (Grob 1983). Within a dozen years the movement had spread to become international with national committees inaugurated in England, Canada and other countries (Armour 1981; Dain 1980; Griffin 1967).

The diversion of mental hygiene from Beers’ original vision.

The mental hygiene movement held the potential of being an extremely effective critic of institutional psychiatry. Despite the undeniable significance of the mental hygiene movement, the original aims of its founder were never realised. Beers’ original intention was to improve the conditions, care and treatment of the institutionalised mentally ill although, despite his well argued charges against the inhumanity of the asylum, he was not prepared to advocate for their abolition (Rothman 1980). Why was this compelling demand for reform of a system that was demonstrably therapeutically and morally bankrupt diverted to the more amorphous goal of prevention? An examination of the early development of the movement lends some support for the conjecture that Beers’ original vision was co-opted and reframed, principally by organised psychiatry. Beers’ strategic approach prior to publishing, was to
seek a stamp of approval from the psychiatric establishment to ensure his book was credibly received. Encountering mostly indifference, Beers' book attracted the sympathetic attention of Adolf Meyer, the internationally known neurologist and psychiatrist, later accepted as the "dean of American psychiatry" (Valenstein 1986, pp.15-16). Writers such as Rothman (1980) argue that Meyer was responsible above all others, for developing and popularizing the principles of mental hygiene and leading psychiatry out from the confines of the asylum into a broadened vision of mental illness prevention and education. Meyer clearly perceived himself as instrumental in expanding the vision of the movement "...away from mere reform of psychiatric hospitals and mainly official legislative investigations" (Dain 1980 p.101). Given the appalling systemic problems of the asylum system and the need for wholesale reform, it can be conjectured that Beer's original mission of institutional reform was diverted, principally by Meyer. Meyer, whose actions clearly revealed his implicit, and sometimes overt, representation of the interests of organised psychiatry (Grob 1983), manouvered to neutralize aspects of Beers' critique that were unacceptable to the psychiatric establishment and their supporters. Dain (1980) points out that Meyer took particular offence at criticisms of hospital physicians and accused Beers of being "hypercritical" and exercising unbalanced judgment which, he implied, was attributable to his mental illness. Beers, in an effort to gain establishment acceptability, and no doubt to avoid alienating his prestigious sponsor and advisor, took Meyer's
"constructive" criticisms seriously and ".... tried to temper his condemnations, eliminate hostile remarks, and modulate his absolute judgments, [though] he continued to believe what he had first written" (op cit, p.82).

While Beers undoubtedly gained credibility from his productive, though often conflictual relationship with his esteemed sponsor, Meyer's involvement was instrumental in diverting Beers' original intentions for the mission of mental hygiene. Drover & Kerans' (1993) claims making approach to welfare theory assists with this proposition. Drover and Kerans point out that the essential purpose of any response to a "claim" is to preserve the hegemonic order. Any claim by an individual or group, subordinate to the dominant group, is likely to articulated in terms that represent a radical critique of the existing order. This is because, in part, the claim cannot be met unless existing relationships of domination and subordination are fundamentally altered. The limits of response are either outright rejection, acceptance or, more usually, reframing or diversion. *A Mind That Found Itself* represented a damning indictment of institutional psychiatry, particularly as it was such a critical success. The momentum of the mental hygiene movement as it rapidly spread from a local reform venture in Connecticut to an international movement ensured Beers' claim could not simply be ignored or marginalised. The diversion of Beers' original mission involved a fundamental shift from a radical critique of the institutional status quo, to the more amorphous goal of mental health education and prevention.
Reframing the aims of the movement away from a "negative" focus on the systemic problems of the asylum, to a "positive" focus on prevention that potentially opened up new opportunities for practice, was undoubtedly attractive for organised psychiatry. Grob (1983) states:

"To psychiatrists hygienic concepts opened up new vistas and shifted attention away from their custodial role and inability to cure admittedly vague disease entities. Prevention also had the virtue of hastening the reintegration of psychiatry and medicine, since it provided psychiatry with the mantle of a biologically oriented specialty and put it in step with other medical prevention movements (pp.150-151)."

Whilst psychiatry probably had the most to gain from the expansionary vision of mental hygiene, other groups were also potential beneficiaries. For instance, Grob (1983) points out that the nascent profession of social work, also perceived advantages. The outward focus of mental hygiene into the community, as opposed to the gaze inward to the asylum, shifted attention away from the exclusive doctor-patient dyad to include larger social groupings and environmental factors, thus offering social workers a wider scope for their work and more equal collaboration with physicians.

Changing Strategies to Manage the Mentally Disordered

The influence of the Mental Hygiene Movement in the United States spread rapidly to other countries, including Canada. Although mental hygiene societies were reported in South Africa, Australia and Mexico by 1914, Dain (1980) reports that Beer's considered his direct contribution to the organization of the Canadian National Committee in the spring of 1918 to have been the
true beginning of an international movement (op cit). This was due in part, to Beers' close collaboration with Clarence Hincks. Hincks founded the Canadian National Committee, the forerunner of the highly influential Canadian Mental Health Association (Canadian Mental Health Association, 1959). Hincks, a Canadian doctor shared much in common with Beers. He also suffered debilitating periods of mental illness and, like Beers, his motivation was born out of an abiding sense of the injustice of institutional practices. In 1918 Hincks was invited to undertake a survey of provincial mental facilities in Manitoba. He uncovered multiple abuses. During one visit, Marjorie Keyes, a social worker, found a naked woman confined to a bare, unilluminated linen closet. When she and Hincks enquired how long she had been there, they were told two years. She had apparently been released for ten minutes during this time, but had become restless, so the attendants explained they felt compelled to put her back. These experiences left a deep impression on Hincks and he maintained a lifelong commitment to mental health reform (Hincks, 1962). Hincks continued a long association with Beers, and from 1930-1938 acted, at Beers request, as the Executive Director of the U.S. National Committee for Mental Hygiene (Chalke 1962; Dain 1980).

By the advent of World War Two, all provinces had adjusted their strategies for managing the mentally disordered to reflect the prevailing mental hygiene belief in early treatment and prevention. This was achieved primarily by identifying and segregating chronic, refractory cases from persons with acute
conditions believed to be treatable. New institutions, primarily psychopathic hospitals, were proposed. Some were established, and where they were not, psychopathic wards acted both as short-term treatment centres and "clearing houses" for longer term institutions. In the tertiary institutions for refractory cases, the mentally retarded were distinguished from the mentally disordered, and generally, segregated into institutions built specifically for their care and management. The imposition of eugenic measures through sterilisation, marriage and immigration restrictions were also widely proposed. These developments will now be examined in the context of British Columbia.

In British Columbia, the 1920 Mental Hygiene Survey of the Province of British Columbia utilised arguments borrowed directly from the Mental Hygiene Committee of New York to recommend the establishment of a psychopathic hospital, an innovation that was being widely introduced in the United States (Grob 1983 p.236-239). The purpose of the proposed hospital was to be three fold: (i) to check the perceived rapid increase of mental illness in the province by (ii) to provide early treatment, and (iii) to save the province money by diminishing long term dependency on the provincial mental hospitals.

The 1920 report was followed by the Royal Commission on Mental Hygiene in 1927. The appointment of the Commission appears to have been primarily motivated by the widespread and growing impression in the minds of doctors, politicians and the public that mental disorder was not only escalating out of control, but that
the increase was occurring at a rate disproportionate to the rest of the country. Newspapers ran several articles with this theme with headlines such as "Insanity Increase in B.C. Startling" and "Mental Patients Form Increasing Menace in B.C." The Hon. William Sloan, the Provincial Secretary in Charge of Asylums, called for "drastic measures" to halt the spread of insanity, including sterilisation of mental defectives and "strong eugenic marriage laws". Sloan contended to the Legislature that whereas the population had multiplied seven and a half times since 1886, "mental cases" had increased twenty seven and half times. Furthermore, the majority of the insane were, he asserted, non-British Columbians, and worse, many were non-Canadian citizens. These anxieties were reflected in the Commission's mandate which required the investigation of the fact that 66% of Mental Hospital inmates were not Canadian born, and 90% were not "natives" to the province. The Royal Commission eventually refuted assertions that the incidence of insanity was disproportionate to the growth of the general population, although it conceded that increases in incidence, and the numbers of foreign born insane represented a serious problem for the province.

The Commission received numerous national and local witnesses who all attested to the need and advantages of the establishment of a psychopathic hospital. The hospital would, it was claimed:

....help check the present rapid increase in the number of insane by heading off the stream at its source; by preventing and curing cases of mental disease in incipient and early stages, it will prevent a considerable proportion from becoming chronic insane patients, and it will save the State
the expense of continuous care of chronic cases for a long term of years in regular Provincial Hospitals."

The Commission expressed their optimistic belief that a psychopathic hospital could limit treatment to only ten days and thus prevent long-term institutionalisation. Furthermore, the hospital could act as a clearing house for the tertiary institutions, it could provide social service and outpatient services, and travelling clinics to other parts of the province. The siting of the hospital at a general hospital (the 1920 Report had suggested Vancouver General Hospital), would erode some of the stigma associated with provincial mental hospitals. Indeed, Dr. Bell, Superintendent of the Vancouver General Hospital was so sanguine on this latter point, that he asserted, based on his knowledge of the Winnipeg Psychopathic Hospital, that there was "...no distinction in the public mind between the psychopathic and the General". These recommendations, particularly regarding the suggestion of short term intensive treatment, represented a dramatic change of thinking. The vision of the Royal Commission was, however, not to be matched by reality.

The fate of the Commission's recommendations mirrored a general trend elsewhere in North America. Rothman (1980) points out that despite multiple proposals to establish psychopathic hospitals in the United States, only a handful ever came into existence. More critically, Rothman suggests that such hospitals never developed autonomous clinical identities or services, but rather became "handmaidens of the asylums" (p.325). In British
Columbia, despite the two enthusiastic endorsements of the psychopathic hospital concept by the Canadian National Committee for Mental Hygiene (CNCMH) and the Royal Commission, the government did not act until the late 1940's (Foulkes 1961), a delay it was to regret as will be discussed in the following chapter. Furthermore, when the psychopathic hospital, Crease Clinic, did open, it was not located in the community attached to a general hospital, but centrally on the Essondale campus. By this time, Essondale was an institution of truly massive proportions with over four and a half thousand inmates. Thus the psychopathic hospital was important conceptually but did little to erode the centrality of the asylum. The government did implement some recommendations piecemeal, particularly where such innovations did not require special legislation. These included a social service department in 1932, a Child Guidance Clinic in 1934, and travelling psychiatric clinics to Chilliwack and Nanaimo in 1935 (Mental Health Branch 1970).

Consistent with the pervasive ideological influence of Mental Hygiene ideology, the Commission was preoccupied with the prevention of insanity. The terms of reference commissioned a study into the cause and prevention of insanity, and a survey was undertaken of all case records of patients admitted to the Provincial Mental Hospital at Essondale and the Provincial Hospital for the Insane between 1916 and 1926. The study was seriously confounded by several factors, including the integration of "mentally deficient" inmates with the general psychiatric
population. The conclusions were that "hereditary taint" was the cause of insanity in up to 30% of cases. The extent to which the etiology of mental disorder remained largely a matter of informed speculation is revealed in the discussion of the remaining 70% of the population. Only vague approximations of incidence were reported, and it was contended mental disorder was caused by factors including syphilis, alcohol, toxic infections, and some evidence of psychogenic factors.

In the absence of reliable biological markers, diagnosis remained largely a matter of subjective clinical judgment. There were two exceptions. Syphilis could be detected through the Wassermann test and combatted through public education and the inculcation of moral principles. Secondly, "hereditary taint" could be identified and predicted, albeit inaccurately, through anecdotal family history. In the face of escalating costs of expanding institutionalisation, the possibility of preventing the genetic transmission of insanity and mental deficiency was undoubtedly highly attractive to policy makers and the public. A reliable and scientifically sound eugenic "solution", in the absence of any cure, was irresistible. Grob (1983) points out that the mental hygiene movement had, in effect, two sides. The relatively optimistic and benign side looked forward to an eventual cure, and in the meantime, emphasised prevention as the most effective way of dealing with the problem, given the apparent intractibility of the condition itself. Others were less sanguine about a cure and proposed a range of intrusive interventionist
measures. In the United States, a social Darwinist attitude had gathered momentum since the late nineteenth century. Immigration restrictions, marriage regulation and involuntary sterilisation all were popular proposals, finding their way onto statute books in several states (Grob 1983). These ideological developments were influential in Canada and British Columbia. The Royal Commission sought submissions from Canadian and international sources concerning the sterilisation of mentally disordered and mentally handicapped patients. The Commission noted objections could be based on moral grounds and invasion of personal rights, however they felt this was countered by the observation that eugenic sterilisation had attracted little criticism elsewhere. For instance, the Commission was "impressed" by the lack of opposition to sterilisation in the United States. Between 1907 and 1940, 18,552 mentally ill persons were sterilised in state hospitals (Grob 1983, p.173). California had passed an early and permissive eugenic statute in 1909, resulting in 5,000 sterilisations by 1925. Indeed, many bodies, including the California Conference of Social Work, had enthusiastically endorsed the practice. Dr. Butler, Medical Superintendent of the Sonoma State Home for the Feeble Minded reported:

> In California we think the law permitting sterilisation of the insane and mentally deficient is one of the best things that has been done to prevent the unfit from reproducing their kind and adding to the State's burden of caring for the same.\(^\text{11}\)

The Commission was further comforted by the fact that any sterilisation in British Columbia would only be authorised after
careful consideration by the Provincial Board of Control, which was a proposed (public service) body with advisory and supervisory powers concerning Provincial mental institutions. Additionally, sterilisation would only be performed with the consent of the parent\guardian, husband\wife, or patient themselves, if "capable". In spite of these dubious safeguards, the Commission’s recommendation on this issue implied a strong element of coercion:

Sterilisation of such individuals in mental institutions as, following treatment or training, or both, might safely be recommended for parole from the institution and trial return to community life, if [emphasis added] the danger of procreation with its attendant risk of multiplication of the evil by transmission of the disability to progeny were eliminated (p. 6-7.)

Sterilisation measures attracted much support between the Royal Commission and the passage of the Sexual Sterilisation Act in 1933. Numerous doctors and politicians spoke to the benefits of sterilisation in the newspapers, probably in an attempt to mute criticism. Nevertheless, despite the widespread enthusiasm for the measure, the Legislature anticipated (correctly) that religious organisations, particularly Catholic women’s groups, would protest. The Members therefore elected to clear the galleries and meet in-camera to debate the bill. The Sexual Sterilisation Act 1933 mandated only voluntary sterilisation, a fact that eugenicists were to deplore. The power of the Act was limited to patients detained in public mental hospitals, and institutions for "mental defectives". Medical Superintendents could recommend to a Board of Eugenics, comprising of a psychiatrist, judge and social worker, that an inmate be sterilised prior to discharge. The Board could
recommend sterilisation, however written consent first had to obtained from the patient (if "capable") or their guardian or relative. These "safeguards", much lauded at the time, are clearly inadequate today, and it can be conjectured that considerable pressure would have been applied to both patients and relatives to ensure the Board's recommendation was carried out, prior to release from hospital. Provincial Mental Hospital Annual Reports, which statistically reported all aspects of asylum life, including all treatments administered during the 1930's to 1950's, never referred to sterilisations. The Board of Eugenics also appears to have deliberately conducted its work with a very low profile. Between 1933 and 1941 fifty sterilisations were reported. In 1963, a journalist investigating sterilisation, found a senior government legal expert did not even know of the existence of the statute. Upon investigation it was revealed that the 1933 statute and the Board of Eugenics were still in operations and that 35 sterilisations had occurred in the previous seven years. Despite the inadequacy of safeguards for the rights of mentally ill people under the terms of the British Columbian legislation, it did offer protection compared to other jurisdictions. Alberta was noted to have taken a "unique approach" to mental disorder with its permissive 1928 eugenic statute for instance. By the mid-sixties over 2,000 people were reported to have been sterilised in Alberta (McKerracher 1966).

Although it is important not to over-state the significance of the eugenics component of mental hygiene, it does have a
significance that goes beyond the number of people who were directly affected. It points to both an understandable desire for a solution to a seemingly intractable problem and, at the same time, reflects the reality that mental hygiene, as a clinical therapy, had little to offer that was effective in the treatment of serious mental illness. Thus, although the movement undoubtedly succeeded in developing a focus on early treatment and prevention, in the absence of effective treatment innovations, the existence of other powerful, parallel forces halted the evolution of any move to implement services outside of the asylum. Two of these most significant forces, the escalating growth of the institutional population and the development of radical somatic treatments will now be examined.

The escalating growth of the institutional population.

The institutional population of Canada and British Columbia continued to increase significantly on an annual basis for the first half of the twentieth century. Between 1932 and 1950, it was noted that first admissions to mental institutions Canada-wide, increased at a faster rate than the general population.\(^9\) In British Columbia, the resident population at Essondale rose to the point that it was described in 1955 as British Columbia’s twelfth city by the Medical Superintendent.\(^9\) In 1928-29, 2,347 inmates were reported as resident.\(^20\) With re-admissions, the total number of cases treated was 2,914. A decade later, these figures were 3,612 and 4,471 respectively.\(^21\) In 1948-49 4,355 patients were reported as resident, with the total number of cases treated reaching
No decrease in the resident population was recorded until 1956-57, when for the first time ever, the trend was reversed with 78 fewer patients, followed by a reduction of a further 90 the following year (Foulkes 1961). At that point, in common with other North American jurisdictions and Western countries, the historical rising tide of asylum incarceration peaked, and the process of deinstitutionalisation began to slowly develop. This phenomenon, and the reasons for it, will be discussed in detail in the following chapter.

The renewal of therapeutic optimism: radical somatic treatments.

Faced with rapidly increasing institutional populations, and escalating problems of overcrowding, North American psychiatrists readily embraced new somatic therapies developed in Europe during the 1930’s. These treatments were both radical and intrusive as Simmons (1990) describes:

Psychiatrists injected patients with insulin, inducing a coma which often brought the patient close to the point of death until it was relieved with an injection of glucose; they administered a camphor-based drug called metrazol which provoked spine-cracking convulsions; they indiscriminately administered forty, fifty, or even hundreds of shock treatments and, in lobotomy operations they drilled holes in patients’ skulls and excised portions of their brain (p.15).

The export of these treatments to North America signalled the end of a long cycle of therapeutic impotence. Somatic therapy offered a number of distinct advantages. It was based on science, although as will be shown, frequently very poor science. Therefore, to the psychiatric profession it offered the opportunity to move closer to
mainstream medicine. To patients it held out the promise of release from the asylum with their conditions cured, or at least ameliorated.

Most of the new treatment innovations were based on dubious science and/or supported by insubstantial theory. Valenstein (1986) points out that:

All the theories attempting to explain how these treatments worked proved to be wrong and, as they were stated, so vague as to be impossible to take seriously. Yet, as soon as reported, each of these therapies was put into practice, and hailed enthusiastically and energetically by the medical profession and the public (pp.45-46).

Manfred Saskel’s accidental discovery of insulin coma therapy offers an illustrative example. Saskel discovered insulin coma therapy when he accidentally injected a morphine addict with insulin and induced a coma. Saskel noted that the cravings for morphine disappeared when the patient was revived. After accidentally (again!) injecting a mental patient and noting a similar diminution of symptoms, Saskel concluded that insulin coma was effective in treating schizophrenia (Simmons 1990, p.15). Saskel advanced an implausible theory to explain the apparent therapeutic mechanism. The Medical Superintendent at Essondale, in reporting the employment of intensive treatment with insulin and metrazol shock, offered an explanation derived from Sakel’s theory as to how insulin works:

Stimuli travelling over the body tend to follow the same route each time, so that the body may have many reflexes working unconsciously as well as consciously. We walk in a crowd, wending our way and, at the same time, give our attention to other matters also. These paths in time of mental illness
let messages run over, more or less at random as
time goes on. Stimuli from the eye may roam over
and be received as messages from the ear and, as a
result, auditory hallucinations are heard which
produce delusional ideas. It is thought that in
"insulin shock" these newer paths give way and the
messages are gradually routed to the old and normal
paths. In time they are all re-established and the
mental disease passes out of the picture as sanity
is restored.\textsuperscript{23}

Initially, the therapeutic efficacy of new treatments was
invariably reported to be good. The reliability of such reports
were highly suspect however, particularly as the clinical criteria
and categories connoting success or failure remained obscure and
difficult to assess with any empirical confidence. Statistical
analyses in Mental Hospital Annual Reports in British Columbia, for
instance, usually reported treatment efficacy under the categories
of "markedly improved", "improved" or "unimproved".

Of all the radical treatments, lobotomy was the most
intrusive, inducing irrevocable personality and behavioural changes
of varying degrees. The effects of the surgery were contingent on
a complex interaction of factors, including the amount of brain
tissue destroyed, severity of the mental illness, length and
effects of institutionalisation, and pre-morbid personality and
intelligence. Some patients undoubtedly experienced relief from
their most troublesome symptoms, particularly those involving
chronic anxiety and agitation. Post-operative impairments for
those who survived surgery (the procedure carried a 5% mortality)
ranged from the tolerable to the devastating, producing "zombie"
like behaviour. Most patients suffered intermediate deficits that
curtailed their capacity for abstract thought, emotional experience
and spontaneity. Furthermore, their ability to plan, to make appropriate social judgments and to retain insight were damaged (Valenstein 1986). In short, many patients suffered incapacities that precluded an independent and autonomous life. Between 1936 and 1951, 18,608 people underwent the surgery in the United States (op cit, p.173). In Britain, Butler (1985) reports 12,000 psychosurgical operations were performed between 1935 and 1954 (p.161). There are no national figures collated on the incidence of lobotomy for Canada. Simmons (1990) states that the numbers of operations in Canada began to decline in the mid-1950’s and the operation had disappeared entirely by the late 1970’s. Between 1944 and 1967, Simmons estimates that 1,000 lobotomies were performed in provincial mental hospitals in Ontario (p.210). In British Columbia, the numbers were small relative to the overall institutional population, but nevertheless significant. The first operations were undertaken in 1945-46. Following "encouraging" results, 45 lobotomies were performed the following year. A further 51 operations were then undertaken in each of the following two years. Following small rises from 1953-55, 1955-56 signalled a dramatic decline:

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Lobotomies</th>
</tr>
</thead>
<tbody>
<tr>
<td>1945-46</td>
<td>9</td>
</tr>
<tr>
<td>1946-47</td>
<td>45</td>
</tr>
<tr>
<td>1948-49</td>
<td>51</td>
</tr>
<tr>
<td>1949-50</td>
<td>51</td>
</tr>
<tr>
<td>1950-51</td>
<td>39</td>
</tr>
<tr>
<td>1952-53</td>
<td>20</td>
</tr>
<tr>
<td>1953-54</td>
<td>27</td>
</tr>
<tr>
<td>1954-55</td>
<td>30</td>
</tr>
<tr>
<td>1955-56</td>
<td>10</td>
</tr>
</tbody>
</table>

(Source: Mental Hospital Reports 1948\49 - 1949\50; Mental Health Services Reports 1950\51 - 1955-56).
It has been suggested that the operation was frequently used for other than purely therapeutic reasons, such as to control troublesome behaviour in institutions, for research purposes and even idle curiosity (Simmons 1990; Valenstein 1986). There is some evidence that lobotomies were conducted in British Columbia to facilitate the institutional management of behaviourally difficult patients, as well as to effect clinical improvement. Mental Hospital Annual Reports statistically divided lobotomised patients into two categories. These were: (i) "Patients Operated on for the Relief of Symptoms" and (ii) "Patients Operated on for Improved Hospital Adjustment". The percentage of patients undergoing surgery for improved hospital adjustment exceeded, for several years, those receiving lobotomy for reasons of clinical improvement of symptoms. For instance, from 1948-49 to 1950-51, the percentages of lobotomy performed for reasons of improved hospital adjustment were 53%, 64.5% and 62.5% respectively. It is perhaps not surprising in light of this that the majority of patients who underwent lobotomy in British Columbia were not discharged but remained in hospital, even if categorised as "improved". The Clinical Director at Essondale, Dr. F. McNair, was quite comfortable to state in the 1952-53 Mental Health Services Report that: "The majority of patients treated by this method [lobotomy] have been those who have presented disturbing and troublesome problems of adjustment in hospital". By 1957 however, a growing disquiet was evident about this drastic method of institutional management when the new Clinical Director at Essondale, Dr.
Kenning, advocated that behavioural control of patients through psychosurgery should cease. Noting the decreasing incidence of surgery, he argued that the previously higher rate reflected:

....a more desperate staff using radical procedures to control chronically disturbed people when there was less in the way of treatment resources. Let us not return to that former state.28

Assessing the impact of radical somatic treatment.

Two major consequences were derived from the development of radical somatic treatments. The first was that psychiatric treatment in asylums became lodged in the popular imagination as oppressive and cruel, and later provided considerable ideological ammunition for the "anti-psychiatry" critique. Secondly, radical treatments focussed attention back into the asylum as the principal place of treatment.

Issac & Armat (1990) argue that criticisms of radical somatic treatment have been exaggerated and distorted and their use has not been considered with a sufficiently balanced perspective. They acknowledge that the theory behind the treatments was, like many "major medical discoveries" (p.195), frequently wrong. They also acknowledge that, in the initial burst of therapeutic enthusiasm, treatments were frequently applied indiscriminately and overused. In turn, they charge that critics refuse to acknowledge the subsequent refinements in technique which, particularly in the case of psychosurgery, ECT, and drug therapy, improved therapeutic efficacy and safety. Undoubtedly, it is a simple task to mount a polemical attack on the imposition of radical somatic treatments.
It is equally understandable that many psychiatrists and psycho-surgeons, faced with huge warehouses of institutionalised patients, felt that, in the words of Valenstein (1986) "anything that holds out hope should be tried". Some of the treatments, in particular E.C.T., which remains in use today albeit in modified form, clearly benefitted some patients. Nevertheless, the fact remains that it was known that the treatments carried significant iatrogenic consequences, and they were given with scant regard for the patients' wishes, much less their consent. In addition, the scientific rhetoric assembled to legitimate each new discovery, appeared to have more to do with the profession's desire for respectability with mainstream medicine, and the public's desire for a cure, than any respect for the hippocratic principle of "first, do no harm". As a consequence, radical somatic treatment became lodged in the popular imagination as an object of repulsion. All of the treatments required an institutional setting and trained staff to administer them. As a consequence, one of the most significant effects of the radical treatments was the consolidation, in the public and professional communities mind, that the asylum was the proper and principal site of psychiatric treatment.

**Legislative Changes in Canada**

Legal changes in Canada reflected the general shift in the management of the mentally disordered that was occurring in other countries such as Britain and the United States. New legislation was introduced in all Canadian provinces that progressively reduced
the supervisory role of the judiciary in favour of increased medical domination. This shift in legislative strategy supported the emphasis on early treatment. As with the impact of legalism, these changes were not distributed equally or universally across all provinces. Nevertheless, the general trend was toward an erosion of legalism. Gordon (1988) outlines the unfolding of this process by describing a series of amendments to existing acts and new statutes dealing with the mentally disordered. The cycle of legislative change began in 1912 with the introduction of provisions for voluntary admission in Nova Scotia, and was completed in 1939, with Prince Edward Island being the last province to institute reforms similar to those in the rest of the nation. These legislative changes differed in detail from province to province, but generally authorised the mentally disordered to be admitted to new facilities like psychopathic hospitals or wards, for short periods of time on the basis of medical certificates. As previously described, an important aspect of these new facilities was to act as clearing houses. Once admitted, a patient could be transferred, on a voluntary or involuntary basis, to a tertiary institution on the authorisation of a medical practitioner. Once transferred, the patient became subject to the discretion of the medical superintendent who could order detention, treatment or discharge. In only three provinces, Quebec, Saskatchewan and Alberta, could patients access a judicial review of their confinement. Such a review was not automatic however, and had to be specifically requested (Gordon 1988, p.73).
In British Columbia, the recommendations of the 1920 Mental Hygiene Survey of the Province of British Columbia reveal the shift in attitudes concerning mental illness and the relative involvement of the legal and psychiatric profession. Specifically, the report refutes the underlying basis for legalism, that is, the concern to protect the sane from improper incarceration. The report states:

The only argument we heard urged in favour of the system in vogue is that it provides a proper safeguard against sane persons being improperly placed in confinement. The argument is a fallacious one, as magistrates are just as prone to make mistakes as physicians. Theoretically scandals might be possible in private sanatoria, but in public institutions they are practically unheard of. In the first instance, the magistrate would not be able to make a fine medical diagnosis; in the second, his usefulness would be doubtful, and the officers at the hospital would be the persons to correct the abuse. Such cases, however, exist largely in the minds of a credulous public.

This statement appears to reverse the logic that underpinned legalism. The impetus for legalism was a fear that sane people may be incarcerated without cause. The various legal controls surrounding admission were designed to provide sane citizens with a measure of protection from unjustified committal to the horrors of the asylum. The statement above implies that magistrates, not doctors, may be the ones to incorrectly incarcerate a sane person, if only through lack of diagnostic expertise. Furthermore, the report suggests that hospital psychiatrists would be the agents to provide an adequate safeguard and correct the abuse if necessary. This reasoning was directly connected to the influence of mental hygiene. Rothman (1980) points out that it no longer seemed
reasonable, to mental hygienists and other Progressive reformers, that only doctors dealing with mental illness be compelled to comply with numerous legal procedures prior to treatment, when their colleagues in general health did not. Rothman states:

To equate commitment with deprivation of liberty for the insane seemed to make as little sense as equating hospitalisation with deprivation of liberty for the tubercular. The entire thrust of the mental hygiene movement, after all, was to make insanity into a disease like all others, to make asylums into hospitals and psychiatrists into doctors - and hence it seemed unfair, punitive, and retrogressive to single out mental illnesses for special restrictions (p.327).

The Mental Hygiene Survey report[^3] stressed therefore, that if insanity was to be seen as a disease and not a crime by the public, mechanisms for voluntary admissions were essential. The Committee therefore recommended legislative change to allow voluntary admission. This innovation was placed firmly within the purview of medical practitioners. Voluntary admission should, it was recommended, be authorised by two physician certificates (pledging the patient to give the Medical Superintendent "...at least ten full days' notice in writing....of intention to leave the said Hospital for the Insane" (p.9).

In 1920, the Mental Hospitals Act[^3] was amended to permit voluntary admissions to the provincial mental hospitals at New Westminster and Essondale (later to be renamed Riverview Psychiatric Hospital). Gordon (1988) states that in Alberta, British Columbia and Nova Scotia, elements of limited legalism were retained with the judiciary continuing to supervise the commitment of non-dangerous persons. Gordon asserts, however, that the
authorising of voluntary or involuntary admission of patients for short-term treatment on the basis of medical certification still represented a significant concession to the medical profession. As will be discussed in the following chapter, the trend of eroding the remnants of limited legalism was completed over the next three decades in favour of a return to medical autonomy and professional discretion.

In summary, legislative developments began a trend that eroded legalism in favour of increased medical power and discretion. The medical profession gained the power to admit people to new facilities for the purposes of short term treatment. This strategy was buttressed by the authorisation of voluntary admissions to all facilities. The judiciary retained authority, however, for the apprehension and initial commitment of dangerous mentally disordered persons. These legislative developments reflected wider attitudinal changes to mental disorder as a medical condition, and changing strategies for management and treatment. In particular, the management strategies aimed to distinguish between and segregate the acute, "treatable" mentally disordered, from the refractory, "untreatable" cases.

In summary, this chapter has examined the emergence and influence of the mental hygiene movement on the development of early twentieth century mental health services and mental health law in British Columbia. It was contended that the original aims of the mental hygiene movement were diverted from a radical critique of the asylum system to one of prevention and early
treatment, primarily by organised psychiatry. This shift in focus away from the asylum was counterbalanced by the pressures of an escalating institutional population and the advent of the first somatic treatments that had some therapeutic efficacy. The legalism of the nineteenth century, with its emphasis on legal safeguards against unwarranted commitment was seen to be incompatible with the shift toward early treatment and the delineation between the acute, treatable mentally ill and refractory, institutional cases. As a consequence, it was contended that a process of legislative reform was instigated to dismantle the elements of limited legalism in favour of increased medical discretion and autonomy.
CHAPTER SIX


This chapter examines the initial stages of the decline of the large, geographically isolated asylum. The decline of the asylum in most Western industrialised countries - principally through the process of deinstitutionalisation - represented an historic turn-around in the management and treatment of the mentally ill. Concomitant to this change, a new cycle of mental health law reform was initiated which had significant ramifications for the civil rights of the mentally ill. These changes are examined in detail.

It is demonstrated that by the early 1950’s, the mammoth asylum had surpassed the zenith of its utility. The trend of persistent annual increases in institutional populations had continued unabated in industrialised countries since the inception of the asylum. In Canada, overcrowding in many provinces reached a point of desperation. Traditional reactive measures, such as the grafting of new buildings onto existing ones, were no longer effective. Furthermore, the concept of the asylum itself as the principal agent of treatment was becoming increasingly discredited. Radical somatic therapy had manifestly failed to reduce the institutional population and had not assisted to return people in
large numbers to the community. The effects of long term incarceration itself became recognised as pathogenic. In short, the management of the mentally disordered in the post-war period represented a growing crisis for both federal and provincial governments. As a consequence, it is suggested that the State was compelled to develop a proactive strategy of long-term management to resolve the crisis. It is argued that the convergence of two factors - the structural development of the welfare state and the advent of psychoactive medication - facilitated the process of deinstitutionalisation and the partial establishment of mental health resources in the community.

The decline of the asylum had significant implications for the civil rights of people with mental illness. In particular, a new cycle of mental health law reform, initiated to facilitate the implementation of the long term strategy, eroded the remnants of legalism. Admission and discharge from hospital subsequently became largely a matter of medical discretion. It is contended that the long term strategy was largely based on a vision that reflected the interests of the psychiatric profession, and that this occurred due to a period of temporary convergence of the interests of the State and the psychiatric profession.

The analysis of developments in this chapter is focussed on Canada generally, and British Columbia specifically. The temporal period of analysis covers the post-war period until the beginning of the 1970’s.
The Emerging Crisis of the Asylum.

By the early 1950's it was manifestly apparent that the structural flaws inherent in the large, geographically isolated asylum as the principal strategy of management of the mentally disordered, were no longer amenable to minor reform. Internationally, there had been a century and a half of persistently escalating admissions to asylums which had become grossly overcrowded and were rapidly decaying. By 1954, the English institutional population in mental hospitals peaked at 148,000 people, 33.45 per 10,000 people (Scull 1984, p.65). At the same time, the United States' public mental hospital population reached 558,022, with state and county mental institutions accounting for two out of every five hospital beds nationally (Chu & Trotter 1974, p.13). In Canada a series of reports on mental institutions revealed a similar national problem which was acutely mirrored in British Columbia. In British Columbia, mental illness became recognised as the principle cause of hospitalisation. In 1951, the Deputy Director of the Provincial Mental Health Services, R. A Pennington, tried to document the extent of the problem for the government. He reported that at any given moment, 5 out of every 1,000 British Columbian citizens were in a mental hospital. On March 31st 1951, 6,028 British Columbians occupied general hospital beds of all types province-wide, whereas 5,394 were in mental hospitals. Pennington pointed out that nearly one quarter of the entire provincial civil service was engaged in the care of the mentally ill, and that running the Essondale campus entailed
the twenty four hour administration of a community the size of Nanaimo or Nelson. Of all the problems facing asylums, the fiscal and humanitarian consequences of overcrowding most acutely reflected the paucity of long-term strategic planning in mental health. In 1939 a national report on public health prepared for the Rowell-Sirois Commission specifically emphasised the need for additional mental hospital accommodation (Richman 1966). Piecemeal additions to mental institutions had been a traditional coping response across Canada for decades, indeed it was estimated that four fifths of all mental hospital construction authorised under the Federal Hospital Construction Grant Program between 1948 and 1961 represented additions to existing institutions (op cit, p.43).

Reviewing national mental health statistics Richman concluded that:

For well over a century the history of Canada’s mental hospitals has been....a record of bed shortages with respect to the needs of the general population and to overcrowding within the institutions (op cit, p.39).

Lack of strategic planning combined with relentless annual rises in admissions culminated in the problem of overcrowding reaching the point of crisis. The Department of National Health and Welfare reported that overcrowding reached its peak in the late 1940’s with institutions being 28% over-capacity, a deficit of 11,928 beds (op cit, p.39). In British Columbia, the provincial government had been adding temporary and permanent additions onto existing structures since the opening of the first Provincial Lunatic Asylum in New Westminster in 1877-88. By the 1950’s construction of new facilities and additions to existing ones, was unable to keep pace
with demand. In 1951, the Director of Mental Health Services pointed out that the basements and attics of all buildings at Essondale were being used to house patients. In some buildings, overcrowding was so severe that conditions for patients and staff alike bordered on the intolerable. The worst facility in terms of overcrowding, Centre West Lawn for men, contained room for 143 beds. An additional 117 beds had been added, creating an 81.8% rate of overcrowding. The women fared little better. The East Lawn building had a bed capacity of 921 with 1,445 beds in situ, an excess of 524 patients or 56.8% rate of overcrowding.² By 1958 continued increases in new buildings and beds (funded partially through the federal National Grants program to be discussed later), had reduced overcrowding to 14% nationally, but an additional 8,391 beds would still have been required to eradicate the problem (Richman 1966, p.39). By 1960, the percentage occupancy of public mental hospitals was reduced in some regions, but remained a problem of significant proportions. The highest percentage occupancy was in Saskatchewan with 156% occupancy, the lowest Prince Edward Island with 79%, while British Columbia was running at 115%.³

British Columbia, in common with other jurisdictions, was faced with a problem that was derived from a vision belonging to the past. The mammoth asylum remained an enduring concept in the absence of feasible alternatives, but one that was increasingly untenable. The almost exclusive reliance on custodial care for the mentally ill meant that, even with the best of humanitarian
intentions, systemic abuse was inevitable. There appeared to be few immediate, workable solutions. A convergence of several factors resulted in an historical turn-around in Canada and other industrialised nations. Within a relatively short period of time - twenty years - the historical trend of custodial care was completely reversed and patients were being progressively returned to a new site of care and treatment, the community. This process has continued until the present day, with Riverview (the renamed Essondale hospital) reducing its available beds to just over 900 since 1990 (Canadian Mental Health Association 1993). Prior to considering how decisions regarding this change in strategy occurred in British Columbia, and what the consequences were for the civil rights of the mentally ill, it is necessary to consider some of the significant factors that underpinned and facilitated a change of such momentous import. In particular, the advent of the welfare state and the introduction of psychoactive medication will be discussed in detail.

The Impact of the Development of the Welfare State

From the end of the Second World War until the early 1970’s, Canada adopted Keynesian economic policies and developed comprehensive systems of public health and welfare services (Guest 1985). The "welfare state" was based on a mixture of Keynesian economic policies of state intervention to ensure high levels of economic activity and employment, combined with social interventionist policies to protect citizens from social and economic contingencies inherent in a modern industrial society
(Mishra 1984). Versions of the welfare state simultaneously developed in most Western industrialized nations.

**Federal developments.**

A number of reports of enquiries related to social welfare occurred from 1940-50. These reports included the Heagerty report on Health Insurance in 1942, the landmark Marsh report the following year, and the Dominion Provincial Conference on Reconstruction (Green Book) proposals in 1945 (Armitage 1975; Guest 1985). While the general objectives for the Canadian welfare state were established during this period, and a number of statutes related to unemployment, family allowance and housing were introduced, the effect on the problems faced by institutional mental health services was limited. The federal government had no legal jurisdiction over provincial mental health services. Ottawa did recognize however, that health, education, and welfare services had been badly neglected due to the Depression followed by the Second World War. In an attempt to demonstrate leadership, the federal government instituted a series of National Health Grants in 1948. These grants-in-aid were to be allocated annually on an ongoing basis primarily for specific health problems such as tuberculosis and venereal disease control, as well as hospital bed construction and professional training purposes. The size of the mental health grant relative to other health areas reflected the seriousness with which the federal government perceived the problem of mental illness. The mental health grant was one of the largest commencing at four million dollars annually rising to seven million
mental health grant relative to other health areas reflected the seriousness with which the federal government perceived the problem of mental illness. The mental health grant was one of the largest commencing at four million dollars annually rising to seven million dollars over a period of years (Department of National Health and Welfare 1962; Williams & Luterbach 1976). In order to ensure effective utilisation of the grants, a series of surveys of provincial mental health services were undertaken. These surveys, completed between 1950-51, revealed the "....deplorable state of mental illness in Canada" (Richman 1966, p. 6). Each provincial survey made recommendations. In the main, these recommendations advised a shift away from further consolidation and reform of the asylum system. Recommendations included establishing community mental health clinics, integrating mental health services with mainstream health services, and grounding psychiatric treatment and professional training in the scientific tradition provided by universities (op cit). Between 1948 and 1959, 20,000 new beds were provided through the grants program. Approximately 7,000 beds were created in institutions for the mentally retarded and 12,000 in public mental hospitals. Despite this assistance, the problem of overcrowding was not significantly reduced (Williams and Luterbach 1976).

An incremental extension of the emerging welfare state occurred between 1950 and 1960, although the impact on provincial health and psychiatric services remained limited. Important general developments during this decade included legislation
concerning cost-shared income assistance for people with various
disabilities, federal cost-sharing concerning provincial social
assistance payments, and the 1957 Hospital Insurance and Diagnostic
Services Act which implemented cost sharing of provincial hospital
insurance programs. Mental health services were explicitly
excluded from the latter development, a move bitterly resented by
the psychiatric profession which will be discussed later in this
chapter. All provinces had joined the provincial hospital
insurance program by 1961 (Williams & Luterbach 1976). Between
1960 and 1970 the contemporary Canadian welfare state was expanded
and consolidated. Armitage (1975) notes that by the end of the
1960’s, housing was the only social welfare objective formulated in
the 1940’s that had not been legislated. Notably, the Saskatchewan
government introduced the first universal medical insurance program
in North America in 1962, a development of considerable symbolic
significance for the nation. This provincial initiative was
followed by the Hall Commission’s recommendations for a national
universal medical plan leading to the Medical Care Act in 1966. In
the same year, the Canada Assistance Plan extended federal cost-
sharing in provincial social welfare programs including
unemployment assistance, old age assistance, child welfare measures
and disabled persons insurance (Armitage 1975; Guest 1985). Thus,
although federal interventions in the health area had only a
limited impact on the problems faced by provincial mental
institutions, the federal government did provide both the policy
framework and fiscal mechanisms for the development and
implementation of a contemporary national and provincial welfare state.

Provincial developments.

By 1939, British Columbia could be considered a provincial welfare state (Irving 1987). Irving offers a number of related explanations for the advanced state of the province’s social welfare system. First, there had been an urgent need to achieve social stability by the harnessing of a functional welfare system to the needs of the province’s burgeoning economy. Secondly, successful agitation by organised labour, the unemployed, and women’s groups had created a climate of pressure for social reform in an era of devastating depression. In addition, progressive politicians and bureaucrats, most notably the ex-social work professor Harry Cassidy, had shaped and influenced many of the province’s social welfare policies (op cit). The passing of the Hospital Insurance Act in 1936 and the introduction of comprehensive social assistance legislation in 1945 represented significant advances for the time (op cit). Federal cost sharing arrangements through the 1950’s and 60’s stimulated and further consolidated the expansion of the provincial welfare state.

In summary, as Scull (1984) points out, only as viable welfare services were developed, did alternatives to the costly and increasingly unmanageable system of segregative control become realistic to consider. The emergence of the contemporary welfare state provided the structural conditions necessary for the gradual deinstitutionalisation of thousands of people who had significant
rehabilitation, housing, income assistance, employment and generic welfare needs. Furthermore, the climate provided by the emergence of the welfare state was favourable to the development of specific services in the community for the mentally ill, such as community mental health centres, to both support those who had been released and prevent the admission of new cases.

The Impact of Psychoactive Medication

The discovery and clinical introduction of psychoactive drugs in the early 1950's (Swazey 1974), was hailed by psychiatrists as another "revolution" in psychiatric treatment. The historical penchant of the psychiatric profession for embracing technological innovations reasserted itself and permissive prescribing followed in the belief that the new drugs would offer a cure (Jones 1993). Gradually it was realised that the drugs offered only an alleviation of symptoms, and this was achieved often at the cost of side effects that ranged from the tolerable to the severe. In British Columbia, it appears that the limitations of the new drugs were recognised fairly early on. Favourable reports of the effects of chlorpromazine and reserpine first appeared in 1955. Dr. Kenning, the Clinical Director at Essondale, acknowledged in 1957 that the drugs were not a cure but made the patient more accessible to the resources of the hospital. By 1964, it was advised that efforts had to be made to control "...untoward behaviour by means other than chemical, with the recognition of certain insidious side effects due to administering atataric drugs over long periods in fairly high dosage". Of all the historical therapeutic
innovations however, psychoactive drugs most warranted the optimism that accompanied their introduction. The new drugs did have a real, though variable, anti-psychotic action which ameliorated the distress of psychosis while simultaneously lessening the debilitating effects of social withdrawal commonly associated with conditions such as schizophrenia, and dangerous excitement associated with manic depressive disorders. The drugs also offered significant benefits to mental health professionals. The potent sedative effects of the drugs meant that they could be employed for clinical and administrative convenience within the institution, particularly to control behavioural problems (Crane 1973, p.125). Scull (1984), reviewing the historical significance for the psychiatric profession of the drug "revolution", polemically states:

....one must acknowledge that in this period they were given a new treatment modality which enabled them to engage in a more passable imitation of conventional medical practice. In place of acting as glorified administrators of huge custodial warehouses, and instead of relying on crude empirical devices like shock therapy and even cruder surgical techniques like lobotomy to provide themselves with an all too transparent medical figleaf, psychiatrists in public mental hospitals could now engage in the prescription and administration of the classic symbolic accoutrement of the modern medicine man - drugs (p.79).

The conventional explanation of deinstitutionalisation holds that the new drugs opened the asylum doors and therefore were the principal factor in promoting the return of mental patients back to the community. As Scull (1984) has shown, the simplicity of this explanation is attractive but flawed for a number of reasons.
These reasons include evidence of new patterns of release prior to the introduction of the new drugs, the failure of research to demonstrate any correlation between those receiving phenothiazines and improved rates of release, and the fact that the drugs did not cure but only offered an alleviation of symptoms, and then only if they were taken consistently, which frequently they were not.

In summary, the introduction of psychoactive drugs was important, but their significance related to the initiation of a strategy of deinstitutionalisation has been over-emphasised. They did however, serve to buttress the State's strategy of deinstitutionalisation, both by facilitating clinical and behavioural management within the institution, particularly by making chronically disturbed patients more available to rehabilitative programs, and in the community by controlling undesirable behaviour.

Initial Responses to the Crisis of the Asylum in British Columbia

Throughout the 1950's, British Columbia, like other provinces, had to deal with the asylum crisis primarily with its own resources in the absence of any direct policy or material assistance from Ottawa. As previously discussed, the exception was the money provided through the National Health Grants program, and more broadly through the development of the welfare state infrastructure. The strategy to deal with the crisis comprised four interlocking phases which were progressively implemented under the stewardship of Dr. A. M. Gee, who was the Director of Mental Health Services throughout most of the decade. The first and
crucial phase was to delineate the mentally ill from the mentally retarded and elderly. This was essential to break up the practice of simply warehousing masses of people whose problems ranged from acute psychosis to senility to congenital mental retardation. By segregating each category of patient, it became feasible to actively treat people according to the specific needs of their condition. The second phase involved the creation of acute treatment facilities in an attempt to slow or prevent the consignment of patients to long-stay incarceration. The third phase was to begin to rehabilitate members of the institutionalised long-stay population in order that they could begin to be returned to the community supported by newly created resources (the fourth phase). In short, the new strategy signified no less than the beginnings of the erosion of the foundations of the warehouse asylum in British Columbia.

It was doubtless a matter of regret for the British Columbian government that they had not implemented the recommendations of the National Council of Mental Hygiene and the Royal Commission on Mental Hygiene (see Chapter 5). The first two stages of the new strategy were a revival of two key recommendations made in the 1920's. In 1951, Dr. Gee announced:

"Future organization must more clearly delineate these three groups - the psychotic, the mental defective, and the senile - so that each may be admitted to their respective institutions.

Gee added that special legislation for the retarded would be required and more accommodation built for the elderly." Plans were instituted to transfer mentally retarded patients from Essondale to
a new 300 bed facility at the old Provincial Hospital for the Insane site in New Westminster. By 1952, additional construction had raised the bed capacity of the newly named Woodlands School to over a thousand (Mental Health Branch 1970), and the Schools for Mental Defectives Act 1953 allowed for direct admission, bypassing the previous necessity to admit through the provisions of the Mental Hospitals Act. The aged, senile population also began to be removed from the general psychiatric population. The government undertook the renovation of military hospitals at Vernon and Terrace. These facilities quickly filled to capacity causing the construction of an additional 100 beds at the Coquitlam Home for the Aged in 1952 (op cit). The second phase principally involved the creation of a psychopathic hospital. A four storey, three wing building, the Crease Clinic, was established in 1951 on the Essondale campus. The hospital's mandate was to provide early admission, intensive treatment and rapid discharge. By acting as a clearing house for the Provincial Hospital (situated conveniently across the way), it was hoped to block the automatic admission of patients with conditions that were potentially responsive to treatment, and therefore ameliorate the overcrowding in the main institution. R.A. Pennington was so optimistic about this development he was moved to write in his annual report of 1951, that the day of the proclamation of the enabling legislation (the Clinics of Psychological Medicine Act), was an "epoch". Early results being attained from the psychopathic hospital in fulfilling its mandate were sufficiently impressive, Pennington asserted, that
he recommended to the Provincial Secretary the putting "on ice" of already developed plans for the building of a second large mental institution for chronically psychotic patients. His optimism concerning the ability of Crease Clinic to relieve the crisis, however, was unfortunately not to be borne out.

The need for the adoption of a long term strategy to counter the crisis was dramatically reinforced by an external source. In 1951, the American Psychiatric Association had been appointed to undertake an "accreditation" survey of all aspects of the province's mental health services operation. The accreditation team subsequently down-graded the province to the status of provisional accreditation. Dr. Gee, in his annual report, observed that it was essential that the province recover full accreditation in order to win the trust of the public (a task of considerable proportions given the reputation of mental hospitals), but that the most difficult obstacle to overcome in regaining full accreditation remained overcrowding. Gee wrote that it was now necessary to proceed with plans for a new mental hospital site as soon as possible. As will be discussed later in the chapter, comments by Gee later in the decade revealed his growing antipathy to the concept of the large institution, so it is difficult to know whether he genuinely believed construction of another mental hospital was a desirable option. Whatever the case, Gee and the government began to implement plans to reverse the increase in the hospital population through non-institutionalisation and deinstitutionalisation.
Deinstitutionalisation is a process embracing a complex convergence of political, legal, fiscal, human rights, and social planning issues. Lerman's (1982) definition of deinstitutionalisation advises that it is a multi-dimensional process that involves prevention of what are deemed to be unnecessary admissions to institutions. Where patients are admitted, a policy of minimal retention in terms of length of institutional stay is instituted. Furthermore, deinstitutionalisation involves the establishment and provision of alternative housing, treatment and rehabilitation services in the community, and the improvement of care and conditions for those who remain in long-term institutional environments (op cit). It is not the intention here to exhaustively analyse every aspect of deinstitutionalisation which has been comprehensively covered elsewhere and produced a wide range of often conflicting views (for example see: Bachrach 1983; Barnes & Toews 1983; Lerman 1982, Scull 1984). Rather, the focus on deinstitutionalisation is to explain how and why decisions were made about shifting the locus of care and control from the institution to the community in British Columbia, and what were the subsequent ramifications for the discourse on the civil rights of the mentally ill.

To consider implementing any form of deinstitutionalisation, Gee and his officers had to first face up to a significant problem in terms of the nature of the institutional population itself. The asylum was increasingly being acknowledged to contain properties that were pathogenic. It was recognised that lengthy incarceration
produced an iatrogenic syndrome of "institutionalisation" characterised by "...apathy, lack of initiative, loss of interest, submissiveness, apparent inability to make plans for the future, and loss of individuality (Richman 1966, p.113). Whereas such behaviour was previously seen solely as an integral component of mental illness, it now became understood that it could also be a consequence of prolonged hospitalisation. Both the causes and the extent of the negative effects of what British psychiatrist Russell Barton (1959) later termed "institutional neurosis" were reflected in statistics concerning the median length of stay in mental institutions. In 1960, a review of provincial statistics of public mental hospitals (which contained 78% of patients), revealed that overall the median length of stay ranged from 22 months in P.E.I., to over ten years in Saskatchewan. The median length of stay in British Columbia was 113 months for men and 81 months for women (Richman 1966, p.110-111). Over 52,000 patients of all ages nationally, were reported to be more likely to leave the asylum for reasons of death than discharge in 1960, while over 15,000 patients were reported to have been under continuous hospital care for more than 20 years (op cit, p.124). The authorities therefore had to devise a way to counter the deleterious effects of the asylum itself, if mentally ill people were ever to be moved back into the community in significant numbers.

In 1953, Gee recounted the historical and contemporary advances in psychiatric treatment. These advances had led to the creation of a "...programme of "total push", which has utilised
The reactivation programme was highly significant for the effect it had on the hospital generally. Simply put, custodial practices of locked wards and physical restraint became incompatible with a policy of rehabilitation. Accordingly, McNair announced that as of 14th August, 1952, physical restraint was formally abolished and furthermore, he noted that seclusion rooms were being employed with diminishing frequency. From the initiation of two "open" wards in 1952, the policy was progressively expanded, so that by 1960, 15 of 20 men's wards and 17 of 24 women's wards were unlocked. In 1955, Dr. Gee stated:

Hospital wards which were previously double locked, on the inside to keep the public out and on the outside to keep the patients in, are now shedding some of their locked doors. Mental hospitals are
now becoming respectable places to visit your
friends and relatives, even respectable enough to
consider admitting yourself as a patient if the
need arise.\textsuperscript{16}

Despite these laudable changes, the actual discharge of long-stay
patients remained slow. Gee had acknowledged that "...much of the
burden for rehabilitation planning falls upon social workers".\textsuperscript{17}
Retention of staff was a problem throughout the entire mental
health service with staff turnover reaching a high of 35% in 1957.\textsuperscript{18}
Indeed, serious shortages of appropriately trained personnel were
revealed to be a national problem in a 1955 survey undertaken by
the federal government. Psychiatrists for instance, were reported
to be 60% under established staffing guidelines of the time and 70% off the "optimum" psychiatrist/patient ratio. Social workers were
36% below established guidelines and 67% under "optimum"
conditions.\textsuperscript{19} The social services department at the provincial
mental hospital, although increasingly important to the new
strategy, was severely constrained in its operations due to
chronic, gross understaffing throughout much of the decade. This,
combined with the broad demands placed on social workers ranging
from social history "work-ups" on admission to discharge planning,
diffused the department's ability to focus on efforts to support
rehabilitation and discharge. In particular, the department appeared to find it difficult to move away from carrying large
caseloads with a focus on individual "casework", in order to adopt
more of a planning and consultative role that the current strategy
appeared to demand. In 1954, the Social Work Supervisor, Alice K.
Carroll, pointedly expressed her frustration. Ms. Carroll stated
that the department's ability to provide social work services had become severely curtailed due to lack of staff. She then proceeded to refer to the American Psychiatric Association standards, a tactic that was likely to draw attention, given the A.P.A.'s recent embarrassing withdrawal of full accreditation. She stated:

At no time during the past three years have the appointments to the Social Services staff at the Provincial Mental Hospital or Crease Clinic approximated the standards established by the American Psychiatric Association.\textsuperscript{20}

Ms. Carroll emphasised that A.P.A. standards recommended one social worker for every 80 patients in residence and one social worker for every 60 patients on supervised discharge. Her staff consisted of a combined total of 12 social workers for thousands of Essondale and Crease Clinic inpatients alone. A decade later the Royal Commission on Health Services echoed Ms. Carroll's sentiments. At that point the provincial mental health services employed 71 social workers, a figure the Royal Commission considered inadequate. The Commission observed that psychiatric social workers continued to focus on individual casework when they may have been more profitably employed in a consultative capacity (McKerracher 1964, p.139). These difficulties notwithstanding, 50 long-stay patients were discharged by 1959 to private licensed boarding homes in the Lower Mainland and the Fraser Valley. These types of discharges continued to increase: in 1962 the Provincial Supervisor of Social Work reported that 317 patients were in supported accommodation and 448 by 1965.\textsuperscript{21}
The fourth phase of the strategy was the development of specific support and treatment services in the community. The Burnaby Mental Health Centre opened in 1957. The enabling legislation, the Provincial Mental Health Centres Act 1955 allowed for the development of such centres throughout the province. Admission was solely on a voluntary basis. The mandate of the centre was to economically offer a full range of intensive interdisciplinary psychiatric treatment on an outpatient and day hospital basis, thereby preventing admission and readmission to Essondale. The centre quickly demonstrated its value in this regard. The A.P.A. accreditation visit in 1960-61 (to be discussed later) praised the centre as an "outstanding" model facility (Ross 1961). In the same year that the Burnaby Mental Health Centre opened, the vacated Child Guidance Clinic in Vancouver was converted into "Venture", a rehabilitation centre for men (Mental Health Branch 1970). Follow-up services were established for discharged patients from Essondale and Crease Clinic with the opening of the Rehabilitation and After Care Clinic in Vancouver in 1961. The clinic was quickly working to capacity with 457 patients on the books within the first four months of operation. By the early 1960's a full-time community mental health centre was operating in Victoria and another was planned in Kelowna. In addition 26 travelling clinics in the Lower Mainland and 5 on Vancouver Island offered secondary consultation services to a variety of primary agencies and practitioners (McKerracher 1966).
The year prior to his retirement, Dr. Gee reflected on recent changes in mental health in Canada and internationally. His experience appeared to have both disillusioned him of the therapeutic utility of the large mental hospital and convinced him that non-custodial alternatives were the only viable basis upon which a humanitarian and therapeutic mental health service could legitimately survive. To make his point Gee reproduced a speech by Dr. Harry Solomon, President of the A.P.A., in which he had written:

America's large mental hospitals are bankrupt beyond remedy and should be liquidated. The large mental hospital is antiquated and outmoded and rapidly becoming obsolete.

Gee went on to state his own view that:

....it is obvious that the former idea of isolating the mentally ill in a remote mental hospital..is now outdated. Future treatment facilities should be located in conjunction with medical centres and in the main streams of life, in small units and close to the patient's home surroundings.

Gee's reflections were publicized and quotes from his annual report were reported in the media. Dr. Gee and his political superior and ally, the Provincial Secretary R.A. Pennington both retired the following year, having steered the State through a significant crisis of legitimation.

In summary, as a consequence of a paucity of sufficient human and material resources, progress in relieving the crisis was undeniably sluggish throughout the 1950's. Despite the slow rate of progress, the government's commitment to change occurred during this time and allowed mental health planners and staff to establish
rehabilitative programs in the institution and new resources in the community. These innovations provided the seedbed for the policy of accelerated deinstitutionalisation in the following two decades. Events in the coming decade would entrench the long term strategy of managing the mentally disordered in ways other than through the medium of institutional incarceration.

The Adoption of a Long Term Strategy

The foregoing description of changes in the management of the mentally disordered became entrenched as a long term strategy of deinstitutionalization and the development of alternative community services throughout the 1960's. The success of the implementation of the long term strategy rested on three factors. The first was the development of the structure of the contemporary welfare state as previously discussed. Secondly, the shift in the locus of management and treatment of the mentally disordered had to be authoritively managed at the level of day to day operations. Thirdly, a new, flexible, legislative framework was required to facilitate the implementation and further development of the changes. Two key inquiries, both dominated by the psychiatric profession, the national Tyhurst report and the provincial Ross report, recommended and facilitated the adoption of a long term strategy. Through its support of the long term strategy, it will be contended that the psychiatric profession hoped to achieve three things. First, the profession wished to realize its long standing desire of effecting an integration with mainstream medical practice to shake off its lack of scientific and public acceptability.
Secondly, the profession wanted to erase the last vestiges of legalism which it had long felt was unwarranted and interfered unnecessarily in the provision of expeditious treatment. Thirdly, the profession wished to ensure that through the change process, psychiatrists emerged as the dominant figures in clinical, fiscal, and administrative policy pertaining to mental health care. The process of adoption of a long term strategy and the new cycle of mental health law reform will now be examined in detail.

The national context of reform: the Tyhurst report.

In 1955 the Canadian Mental Health Association (C.M.H.A.), previously known as the Canadian National Committee for Mental Hygiene, elected to attempt to capture a greater influence over mental health policy by writing its own report. A committee was formed, under the chairmanship of Dr. James Tyhurst from British Columbia and met regularly over the next five years. This arrangement had the tacit approval of the federal government. Crichton (1973) contends that because mental health services were a provincial responsibility, it was easier in the 1950's to set up de-facto national commissions through voluntary organisations than through federal government mechanisms (p.69). Gordon (1988) has offered a sophisticated and complex explanation of the relationship between the C.M.H.A. and the federal and provincial levels of government. Like Crichton, Gordon contends that it was to the State's advantage to "use" the offices of an apparently autonomous body like the C.M.H.A. to undertake a national enquiry. This not only obviated the need for federal funding for such an enquiry, but
also protected government from possible direct criticism of its failure to assist the provinces to resolve the crisis posed by provincial asylums. At the same time Gordon contends that the C.M.H.A., dominated by senior psychiatrists, was in a position to promote its own objectives through its close links with the State.

The work of the Tyhurst Committee was undoubtedly facilitated and influenced by international developments. In England, the Percy Royal Commission had reported in 1957 and recommended that mental illness be considered in the same light as medical illness. This was to be reflected in a de-emphasis on custodialism in favour of community treatment. The Royal Commission’s recommendations repudiated the principles of legalism of the English 1890 Lunacy Act in favour of a legislative framework based on medical discretion. These recommendations were subsequently entrenched in the English Mental Health Act 1959 (Armour 1981; Jones 1993; McKerracher 1964). In the United States, the Joint Commission on Mental Health undertook a lengthy six year consultation with a broad spectrum of stakeholders and produced a weighty report of eleven volumes. The report, Action for Mental Health, was completed in 1961. The report made numerous recommendations. As in Britain, it was recommended that no new large mental hospitals be built and that community mental health alternatives be developed. Liberalisation of the legislative framework concerning admission to hospital was advised. General hospital psychiatric units and regional psychiatric treatment centres of limited size were recommended to supplement community services. Multi-
disciplinary personnel were to be increased and better trained (Grob 1991; McKerracher 1964).

The Tyhurst Committee released a set of interim reports on every aspect of mental health policy in Canada in 1960 followed by a synthesis of the reports, More for the Mind in 1963 (Canadian Mental Health Association 1963). Key shortcomings in Canada's mental health services were identified as the lack of strategic planning, the isolation of psychiatric services from mainstream medicine and the community, the size of mental hospitals, personnel shortages, exclusion from federal hospital insurance, and the remnants of legalism complicating admission to hospitals. Proposals to combat these deficiencies included the integration of psychiatry with mainstream medical services, decentralisation of services administered under regional and local corporate boards of management, and improved continuity of care and co-ordination. An extension of the Hospital Insurance and Diagnostic Services Act to fund mental health services was recommended. Mental health services had been specifically excluded from this arrangement originally, a fact resented by the psychiatric profession which felt it entrenched the segregation of mental health services and, by association, stigmatized psychiatrists with diminished status relative to their general medical counterparts (op cit, p.3). The provincial government was advised to relinquish responsibility for mental health services except in terms of funding through the federal-provincial Hospital Insurance program (op cit, pp.201-202). Psychiatrists were to be employed sessionally rather than salaried
government employees. Through a diversification in their sites of practice (which, like their general medical specialist counterparts would allow a greater role for private practice), the profession would consolidate its autonomy from government (op cit, pp.156-159).

The Tyhurst Committee was exclusively comprised of (male) psychiatrists, and this led to complaints upon the release of the interim reports in 1962. The Committee acknowledged its disciplinary exclusivity and attempted to soften criticism by noting in the foreword to the report:

....it became obvious that many psychologists and other social scientists were concerned lest psychiatrists, as specialists within the medical profession, should pre-empt the whole mental health field or at least assume the sole authority in it (Canadian Mental Health Association 1963, p.i). The committee insisted that the report should not be considered a review of the ".... whole field of mental health as defined by the psychologist, the sociologist, the educationist or social worker" (op cit, p.i). This "limitation" may have had an empty ring in light of the fact that the committee had acted on "explicit" terms of reference to examine all of the mental health services in Canada and bring down recommendations that reflected a "radical new concept of treatment and care" (Griffin 1989, p.180). Undoubtedly both the C.M.H.A. and individual psychiatrists believed only significant reform could erode the custodial status quo of the asylum. The chief device to achieve this, according to the Tyhurst committee, was to structure services for the mentally ill so that they mirrored those for the physically ill. This was to occur
through integration with mainstream medicine. This had been a long standing desire of the psychiatric profession. The report strenuously advocated that medical integration be accomplished. It emphasised that all of the report's 57 recommendations rested on the pivotal assumption of mental illness as equivalent to physical illness. The organisational, administrative and professional framework of response was to reflect that assumption. The report stressed unequivocally that "....the mental patient is a medical patient" (Canadian Mental Health Association 1963, p.39). From this principle it followed that mental health policy should reflect the dominance of psychiatrists in all aspects of the system. Clinical leadership was a given from overseeing the treatment of the patient in the acute stage of his or her illness in an institution, to directing rehabilitation in the community. Indeed, it was pointed out that the psychiatrist was ideally placed to administer to his or her subordinates in order to facilitate change:

The psychiatrist....with the greatest power of decision and greatest responsibility, is in a particularly important position to explore the causes of insecurity in team function, the way relevant groups may provide mutual security, the sources of resistance to employment of these means and ways of dealing with these causes of resistance. Persons in a dependent position are less able to initiate such action and to create a climate for accepting change (op cit, p.153).

The ambit of psychiatry went further however to include administrative tasks such as "budget, personnel policy, plant development, maintenance etc. [which] have therapeutic implications
which bear directly on patient care" (op cit, p.152). Budgets had "profound therapeutic implications" and consequently:

....the specific allocation of funds...should be a matter for medical policy rather than decision by a business manager, who may have no knowledge of the therapeutic issues involved. The psychiatrist should have final responsibility and authority (op cit, p.153).

The Tyhurst report, while offering a new vision for Canada’s mental health services, unequivocally promoted the interests of the psychiatric profession in order to consolidate and expand its dominance.


As the Tyhurst Committee was engaged in it’s work, a provincial enquiry into the province’s mental health services was undertaken. Despite earlier reforms which had eased the crisis temporarily, the government found itself under political pressure to hold an inquiry into the province’s mental health services. At first the government refused to bow to such pressure. The opposition Co-operative Commonwealth Federation (C.C.F.) demand for an inquiry was dismissed in early 1958. By the fall, however, the government, under pressure from the opposition and the British Columbia Medical Association, agreed to a full inquiry. It is apparent from the introduction to the Ross report that the government decided to use the survey as the basis to consolidate and expand it’s long term planning strategy for mental health services (Ross 1961). The comprehensive report, submitted to the government in 1961 restored full accreditation to the province’s mental health services. The report validated the government’s
strategy of de-emphasising custodial care but advised that the strategy had to be consolidated and expanded (op cit).

The Ross report made 50 specific recommendations, many of which were more broadly expressed in the Tyhurst committee reports, though the partisan championing of the psychiatric profession was not in evidence as in More for the Mind. To replace custodial care, Dr. Ross and his team recommended the provision of simplified access to early, efficacious treatment in the patient's locale combined with a policy of rapid discharge back to the community. To achieve this the province was urged to regionalise psychiatric facilities, expand community mental health resources, and ensure an increase in the employment of adequately trained staff. Additionally the government was urged to expand the provision of acute psychiatric unit beds in general hospitals. In recognition that social workers were "....essential to all clinical and preventative mental health programs" it was recommended that "every attempt" be made to increase the social work staff (op cit, p.27). New, "small" mental health facilities were proposed such as 500 bed mental health centres in Victoria and the Okanagan Valley. These were to be based on the "model" mental health centre exemplified by the Burnaby facility. The report emphasised that combatting mental illness required a multi-disciplinary effort, although it was stressed that psychiatrists should provide clinical and administrative leadership in all provincial mental health facilities (op cit).
The C.M.H.A. was able to gain significant input into the Ross report (Drs. Griffin and Jones were official representatives from the C.M.H.A. to the Ross team, and Dr. McKerracher representing the Canadian Psychiatric Association was a former chairperson of the National Scientific Planning Committee of the C.M.H.A.). Despite this influence, the final report was not to the C.M.H.A.'s liking and it formally disassociated itself from it. What was missing for the C.M.H.A. was sufficient emphasis on integration with general medicine. Dr Tyhurst explained to the media that: "The Ross report is a bad report. It is badly written....The sooner the report is pushed out of the way the sooner we can get on with a lot more modern development". Dr. Tyhurst went on to express his concern that the recommendations, particularly the building of regional mental health centres in Victoria and Kelowna, would lead to "further segregated psychiatric services".

Gordon (1988) has offered a convincing explanation for the adoption of the long term strategy in terms of the State's cardinal functions of order maintenance, legitimation and ensuring conditions for continued capital accumulation. Gordon contends that the precipitant crisis of the asylum represented a crisis in the State's order maintenance function. The A.P.A. report which withdrew the province's accreditation in 1951 added a crisis of legitimation in terms of public and professional confidence. Gordon suggests that the initiation of deinstitutionalization measures developed in the 1950's temporarily relieved the State's order maintenance problem. These changes prompted the reinstatement
of A.P.A. accreditation thereby resolving the State's legitimation problem. The emergence of the welfare state, which was designed in large part to satisfy the State's third cardinal function of reproducing conditions favourable for continued accumulation of capital, served to facilitate the consolidation of the State's long term strategy of deinstitutionalization and development of community services.

The Initiation of a New Cycle of Mental Health Reform

The adoption of a long term strategy that encompassed deinstitutionalization as a central principle, necessitated a more flexible legislative framework. British Columbia's various statutes related to mental health were still focussed on the asylum as the principal agent of management and treatment. Furthermore, these statutes retained elements of legalism which, as has been previously discussed, were designed primarily to safeguard against unwarranted commitment to an institution. The long term strategy demanded simplified, flexible admission procedures for early, active treatment, preferably on a voluntary basis. Just as importantly, mechanisms for rapid discharge were required, although this had to be balanced against the State's obligation for order maintenance in terms of safeguarding the public and property from people perceived to be actively mentally disordered and unstable.

The Tyhurst Committee was anxious to remove the remnants of legalism contained in Canada's mental health statutes (Canadian Mental Health Association 1961). The committee expressed their belief that medical, clinical criteria and discretion should guide
the admission and discharge process. The committee proposed that admission should be voluntary whenever possible and based on one medical certificate. Only one consent form would be signed on admission which would allow the administration of all treatments the psychiatrist saw fit. If voluntary admission was not possible, the patient would be admitted against his or her will on the basis of two medical certificates for 2-3 weeks. A new certificate would then be completed and review and re-certification would occur at two weeks, four weeks, five months, six months and then annually (op cit).

The Ross report singled out the province's legislative framework as "...inadequate, archaic, unnecessarily complicated and sometimes degrading to the mentally ill individual" (Ross 1961, p.157). Compounding the problem was the fact that the province's statutes relating to mental illness and mental retardation were contained in a number of pieces of legislation including the Lunacy Act, the Mental Hospitals Act, the Clinics of Psychological Medicine Act, the Provincial Mental Health Centres Act, the Provincial Child Guidance Act, the Schools for the Mentally Deficient Act and the Sexual Sterilisation Act. Ross based his recommendations on a University of British Columbia, Faculty of Law analysis of the province's mental health legislation undertaken in 1959 (op cit). To support medical integration and to reduce stigma, Ross and his team advised that admission of a mentally ill person should, as much as possible, resemble the admission of physically ill patient to a general hospital. Therefore voluntary
admissions were to be encouraged. Although voluntary admissions had been steadily rising as a form of admission through the 1950's, the majority of admissions still occurred on an involuntary basis. An examination of legal status on admission over a ten year period reveals that involuntary admissions declined from 59.7% in 1955 to 51.5% in 1964.\textsuperscript{28} The procedure for involuntary admissions was recommended to be certification by two physicians, one preferably a psychiatrist. Judicial review would only be invoked if a patient felt he or she was unjustly detained. Patients, even if still mentally ill, were not to be endlessly detained if some kind of therapeutic progress was not possible and alternative supports could be arranged. Discharge was to be further facilitated by granting hospital authorities the power to release patients on "convalescent leave" for up to one year (renewable), although certain conditions could be attached to the leave which, if breached, could result in a return to the hospital. Commitment and incompetence procedures were to be separated. Dr. Ross and his team felt: "Loss of civil rights is usually unnecessary, humiliating and a barrier to rehabilitation" (op cit, p.147). "Civil rights" had only a limited meaning in the report however, referring primarily to control of estate and affairs.

The provincial \textit{Mental Health Act} was passed in 1964\textsuperscript{29} and proclaimed the following year. The Act consolidated the various statutes affecting mental illness and mental retardation. If anything the Act extended more discretion to medical practitioners than either the Tyhurst or Ross inquiries had recommended.
Admission and discharge were to be based solely on the basis of medical discretion. In the case of involuntary admissions, two medical certificates signed by physicians (not necessarily psychiatrists) were to be completed within 14 days of each other in order to allow detention. Within two months a physician was required to undertake an examination of the patient and, if it was judged necessary, formally state the reasons why the patient should be subject to continued detention. The authority for continued detention had to be renewed yearly for two years, then every two years thereafter. The only judicial involvement retained in the Act was the ability of anyone, including the patient, to apply to a judge prior to, or following admission, for an order prohibiting admission or ordering release. It was recognised, however, that to make an informed adjudication the judge would probably have to rely heavily on medical evidence. The judge was therefore authorised to order a medical report within ten days that stated the reasons for the detention of the patient. After 3 months detention, any person, including the patient, could apply to have the patient’s case reviewed by two members of a review panel. This panel, comprised of psychiatrists, was expected to review the case "without delay", i.e. by the end of the month following the month in which the application was made. In 1966 the Director of Mental Health Services noted that fourteen patients had requested a review of their involuntary detention resulting in one discharge. The Director further noted that 45% of admissions to Provincial mental health facilities were voluntary, and the other mostly involuntary
admissions were completed with medical certificates but without formal committal documents. The Director concluded that the ease of both voluntary and involuntary admission: "....clearly demonstrates that the public and the medical profession have welcomed this forward step in the case of the mentally ill..".\(^{31}\)

The passing of the Act represented the culmination of a cycle of reform that had begun in the 1920's in an attempt to erode the legalism that had originated with the passing of the provincial 1897 Hospitals for the Insane Act. The new Mental Health Act completed not only the reversal of the legalism inherent in the original provisions surrounding commitment but also the philosophy that had underpinned them. The perception of the new Act in British Columbia was similar to the U.K. where similar legislative developments had been passed into law in the late 1950's. The British Mental Health Act 1959 was:

...perceived as a highly liberal measure: the rhetoric of liberalism which had formerly attached to the deployment of legal safeguards was now transferred to the process of facilitating the relief of suffering by their removal. This redefinition of humanitarianism and liberalism temporarily submerged the issues of civil liberty which were at the forefront of the debate about the treatment of the insane in the late nineteenth century..(Unsworth 1979, p.107).

Reaction in the press to the B.C. Act was generally favourable. The Vancouver Sun, with perhaps unconscious irony, ran an article with the headline, "B.C. Mental Bill Changes 'What Psychiatrist Ordered'".\(^{33}\) Some minor disquiet was expressed about the expanded responsibilities given to medical superintendents however, with New Democratic Party health critic Gordon Dowding complaining that the
admission of patients now rested on "whims of hospital officials". The Canadian Mental Health Association perceived that More for the Mind, and the later Royal Commission on Health Services (McKerracher 1966) had established good planning principles for the development of modern psychiatric services in Canada (Swadron & Sullivan 1973). The C.M.H.A. retained some concern however that the issue of "civil rights" (used in the broadest sense) of the mentally disturbed had not been adequately addressed by these enquiries. Undoubtedly, in doing this the C.M.H.A. was acting in its capacity as a pre-eminent national organization with a broad mission to improve conditions for people with mental illness. Granting rights to mental patients similar to those enjoyed by citizens hospitalised due to physical illness also made good sense in the context of the C.M.H.A.'s desire to erode the isolation of psychiatric services and to increase integration with mainstream medicine. Consequently the National Scientific Planning Council of the C.M.H.A. appointed a committee to comprehensively examine federal and provincial laws as they pertained to mental health. The committee produced three reports on hospital care, civil rights and criminal process in 1964, 1967 and 1967, later collated and revised as The Law and Mental Disorder (Swadron & Sullivan 1973).

The committee raised important civil rights issues that would be picked up and developed by patients' rights groups and their supporters in the following decades. For instance, it was pointed out that past practice had judged people either incompetent or competent. A judgement of incompetence resulted in the wholesale
removal of liberties, a judgement of competence kept them completely intact. This decision rested on one criterion, whether the person was committed to a mental hospital or not (op cit, p.34). The committee argued that involuntary committal to a mental hospital was a crude criterion for adjudicating competency, and that commitment should no longer be automatically equated with incompetency. This raised the enduring problem of a paucity of commonly agreed and reliable tests upon which to adjudicate competency.

Despite this problem, the committee strongly recommended that rights should be temporarily removed only when specifically indicated. In the case of involuntary patients, a review board was recommended as the mechanism of adjudication. The issues raised in *Law and Disorder* were destined, however, not to lead to further legislative change. The advent of a new cycle of mental health reform beginning in the 1970's, namely the "new legalism", overwhelmed and expanded the concerns of the C.M.H.A. as will be discussed in the following chapter.

In summary, the warehouse asylum became an increasing liability throughout the first half of the twentieth century. In an attempt to achieve a long term resolution of the crisis that the asylum came to represent, the interests of the State and the psychiatric profession temporarily converged. The proposed solution was to reverse the historical trend of custodial care and to shift the locus of social control and treatment to the community. Institutionalised patients were to be rehabilitated and
progressively returned to the community. New patients were to be discouraged from long term custodial detention by the provision of early, active treatment. These objectives were facilitated by the structural development of the welfare state on one hand, and new methods of control and treatment, primarily psychoactive drugs, on the other. The long standing ambition of the psychiatric profession to integrate with the medical mainstream, and to escape the cumbersome and resented judicial safeguards associated with legalism, was forcefully expressed in a series of inquiries dominated by psychiatrists. Decentralised community services, new methods of funding and a new legislative framework based on clinical criteria and medical discretion were recommended. The psychiatric profession made it clear that it would facilitate the implementation of the new strategy in return for unequivocal dominance in all aspects of the mental health field. This gained tacit approval from the State which was anxious to entrench the strategy initiated in the 1950’s.

During this time the mentally ill themselves remained largely "...mute observers of their situation precisely because they lacked political cohesion and influence" (Butler 1985, p.213). The influence of diverse forces in the 1970’s, 80’s and into the 90’s, not the least of which was the advent of the patients' rights movement, would create further changes to the delivery of mental health services and initiate another cycle of mental health law reform. These developments will be discussed in the following two chapters.
CHAPTER SEVEN

PRESSURES FOR REFORM: THE DECLINE OF THE ASYLUM

1970 TO THE PRESENT

This chapter examines pressures for reform of the mental health system in British Columbia from 1970 until the present. Specifically, the conceptual and literal decline of the large, custodial asylum and the development of alternative community services is described. The explanation for this process is attributed to the confluence of two forces. It is contended that the principal explanation was a response to the economic forces of escalating health care costs in the context of the fiscal crisis of the state. It is argued that the second, ideological, explanation relates to the emergence of the critical "anti-psychiatry" literature, which did much to undermine the legitimacy of institutional care and involuntary commitment and treatment.

The global economic context that gave rise to the fiscal crisis of the state is described. It is demonstrated that the search for cost containment, and later restraint, provided the rationale for a policy of accelerated deinstitutionalization and non-institutionalisation. It is shown that in British Columbia, deinstitutionalization did not progress as a linear process but rather developed in three distinct phases. At the same time, it is
contended that the combination of a lack of planning for an integrated mental health service, and the inadequate development of community alternatives to institutional care hindered, and continues to hinder, the finalisation of the deinstitutionalization process. It is argued that as a consequence of the development of diverse alternative services in the community, the central institutional power base of the psychiatric profession was weakened. As a result, it is suggested that the psychiatric profession's administrative dominance and policy-making influence has been significantly eroded. Brief reference is also made to the secondary, but significant ideological impact of the anti-psychiatry critique.

The Economic Context of Health Care in Canada: The Fiscal Crisis of the State

The period of post-war Keynesian economic expansionism, upon which versions of the welfare state had been built in advanced capitalist countries, was brought to an abrupt end in the mid-1970's. Major structural changes, most notably international competition induced by the development of global consumer markets, the O.P.E.C. oil crisis, new work and communication technologies produced general economic recession, rising unemployment, and inflationary pressures (McNiven 1987). The resulting shortfall in government revenues and increasing expenditures, in the context of demands from business to cut spending and pressure from workers to offset declines in wages from labour with social wages, has been described as the fiscal crisis of the state (Moscovitch and Drover
196

1987). Despite the decline in revenues creating genuine problems for social policy, it has been suggested that the reasons advanced for the fiscal crisis rest on political perceptions more than economic reality. Despite international evidence accounting for the global recessionary tendencies, right wing intellectuals and economists have argued, for the most part successfully, that the root cause of the fiscal crisis has been rising public expenditures and borrowing (Hill & Bramley 1986; Moscovitch & Drover 1987). As a consequence, public services in Canada, most notably those provided under the umbrella of the welfare state, have been successfully scapegoated in the same manner as Mishra (1984) described in the United Kingdom.

By the early 1970's inflation in Canada posed a significant threat to business interests. The continuation of Keynesian policies were viewed with hostility by business interests because it was perceived they would contribute to and exacerbate inflationary pressures (Calvert 1984). By the mid-1970's the government elected to abandon the post-war Keynesian compromise between capital and labour and adopt a strategy of incremental monetarism (Wolfe 1984). This strategy involved the deflation of the economy through a number of interlocking strategies in order to attack inflation and contain public expenditures. These strategies included control of the money supply, lowering public spending, controlling wage increases, raising interest rates and allowing unemployment rates to rise to dampen demand (Calvert 1984). The social interventionist component of Keynesian strategy was placed
under attack as a result of the shift in economic priorities: 
"Social justice" was dropped from the political vocabulary. Terms such as "belt tightening", "sacrifice", and "restraint" became fashionable" (op cit, p. 26). Although this fundamental change in strategy did not herald the immediate withering away of the welfare state, a process of welfare state erosion was put in train. This process would have (and continues to have), variable but serious ramifications for the future of all types of health services in Canada.

The effect of the fiscal crisis on the Canadian health system.

Prior to the onset of the fiscal crisis of the state and the government's response of gradual monetarism, it was feared that health care costs were escalating. During the post-war period until 1971, health care costs expanded significantly both in dollar terms and as a percentage of gross national product (G.N.P). Costs as a percentage of G.N.P. stabilised (at around seven to seven and half per cent) throughout the following decade, however, the impression left by the numerical size of increases in dollar terms gave weight to the impression of "spiralling" costs (Evans 1984b). In 1961 for example, national health expenditures absorbed 6% of G.N.P., an outlay of $2.375 billion. By 1971, these figures were 7.5% and $7.122 billion respectively. By the end of the decade the percentage of G.N.P. had fallen to 7.2% while the dollar amount had risen to $19.067 billion (op cit, p. 9). By the late seventies, hospital care, which accounted for the largest component of health care spending, had stabilised though other sectors, notably
continuing care, continued to expand (op cit). Guest (1985) has argued that the government's failure to develop alternatives in the way health care was delivered, particularly via expensive physician oriented, acute in-patient care, was primarily responsible for increased costs. Guest quotes Evans (1984a) who contends this reflects a national trend of achieving cost containment of Canadian health care with "blunt instruments" such as various fiscal controls, rather than developing less costly but more efficient forms of health care delivery. The federal government did make some effort however, to consider alternative means of health care delivery. The federal 1970 Task Force examination of national health care expenditures and the 1972 "Hastings Report" on Community Health Centres were both concerned to find ways of cutting costs and improving health care delivery (Hastings 1972; Task Force 1970). The reports recommended the establishment of community health centres which would, amongst other things, reduce the pressure for expensive acute in-patient care. Decentralisation of mental health services was once again recommended, and that community mental health clinics be incorporated into the interdisciplinary community health centres (op cit). The government had always considered however, that the main problem of health care costs was open ended cost sharing (Crichton, Hsu and Tsang 1990). In 1977, in an effort to restrain social spending generally, and Medicare specifically, the federal government sought to alter the funding arrangements. The resultant changes contained in the Federal-Provincial Fiscal Arrangements and Establishment Programmes
Financing Act (EPF), freed the government from their fixed 50% contribution to a block funding arrangement that was sensitive to economic cycles (Guest 1985). As a consequence federal contributions from Ottawa were dramatically reduced in times of economic downturn as was quickly realised with the onset of the 1981 recession (op cit).

Acting on suspicions that the provinces were exploiting the more flexible nature of EPF to divert funds to other program areas, the federal government appointed the Hall committee to investigate (Crichton et. al. 1990). While suspicions were proved to be unfounded, the government was left in no doubt by opinion polls that Canadians valued universal medicare and opposed the extra billing and user fees highlighted by the Hall Committee (Guest 1985). Indeed, Hall stated his commission could find no-one in government or the medical profession that was overtly opposed to medicare. Support amongst consumer groups, organised labour was noted to be particularly strong (Hall 1980). Subsequently the introduction of the Canada Health Act 1984 sought to preserve universal medical coverage through a carrot and stick approach, whereby federal funding was contingent on meeting five criteria, (accessibility was added to comprehensiveness, public administration, universality, and portability, previously included in the original Medical Care Act 1966). In addition, penalties were introduced for extra billing and user charges, a measure some provinces only reluctantly accepted (Guest 1984).
Cost stabilisation measures of the 1960's, such as the termination of National Health Grants to provinces to deter further capital investment in buildings (Crichton, Hsu & Tsang 1990), gave way to the adoption of gradual monetarism in the 1970's which significantly eroded elements of the welfare state. In recent times, however, the welfare state has come under concerted attack. In particular, an idee fixe of the neo-conservative agenda has been the extrication of the federal government from fiscal responsibility for provincial social programs. In terms of health care this was clearly manifested through the provisions of Bill C-69, which proposed to allow the federal government to incrementally off-load it's funding responsibilities for health care to the provinces as specified in the E.P.F. arrangement. (Canadian Council on Social Development 1991). The subsequent Government Expenditures Restraint Act which came into force in early 1991, has raised concerns that the Act will effectively mean the end to Canada's national health system. Progressive reductions in transfer payments to the provinces will eventually cease altogether, thereby releasing the provinces from the provisions of the Canada Health Act. While most provinces will continue to receive (diminishing) transfers into early next century, Quebec will be entirely reliant on provincial revenue-raising by 1995/96 (British Columbia Royal Commission on Health Care and Costs 1991).

Concerns have also been raised about a less direct attack on the nation's welfare programs through the unfolding pressures to "harmonize" Canadian social programs with it's trading partners in
the North American Free Trade Agreement (N.A.F.T.A.) (Hum 1988). Some critics of N.A.F.T.A. have suggested that the agreement provides the means to institutionalise and extend the pursuance of neo-conservative ideology of deregulation and privatization (Gainor 1992; Shifrin 1987; Willette 1990). Willette (1990) suggests for instance, that an extensive list of services can be legitimately offered for private management by U.S. or Mexican corporations including general and psychiatric hospitals, mental health centres and nursing homes. Although provincial services are currently excluded from such measures, Drover (1992) advises that services under provincial jurisdiction will be subject to negotiation in the future.

In summary, Canada, like other Western industrialised countries, has witnessed an increasing erosion of the welfare state. This erosion is underpinned by the fiscal crisis of the state and has been given ideological momentum by neo-conservative critics. The neo-conservative prescription has included a return to free market principles, privatization, unrestricted mobility of capital, decreased government spending, and a labour pool inculcated with the discipline of the market through the roll back of employment and social wages (Mishra 1984). The provinces are likely to become enmeshed in a deepening funding crisis as the nineties progress, as federal funding transfers progressively dry up. Although health care, including mental health care, is a politically sensitive area, it is subject to significant pressures to contain or reduce costs, including through such measures as
privatization. As such, these pressures have significantly constrained and shaped mental health policy as will be discussed later in the chapter.

The impact of the fiscal crisis on the British Columbian health care system.

The foregoing would suggest that at the provincial level, universal health services have been incrementally and persistently eroded. A closer examination reveals a more complex picture, encompassing elements of cost stabilisation and restraint in some areas and growth in others.

Health care has been, and continues to be, expensive. In 1978 health care provided under the auspices of the B.C. Ministry of Health cost $1.3 billion, 7.09% of the Gross Provincial Domestic Product (GPDP). By 1985 these figures had risen to $3.1 billion accounting for 8.57% of GPDP. By 1990 B.C. was spending $4.8 billion on health care (percentage of GPDP statistics were not available) (British Columbia Royal Commission on Health Care and Costs 1991). Similarly, long term mental health care provided through institutionalisation is very expensive. In 1977 the Riverview budget, excluding salaries was over $26 million. Out of a total health budget of over $976 million, Riverview alone accounted for nearly 2.7% of the province’s health budget. By 1985, Riverview had a bed capacity of 1,306 (906 in the Adult Division and 400 in the Geriatric Division), a full time staff of 1,654, and a budget of $73 million (British Columbia Royal Commission on Health Care and Costs 1991). In 1990 the bed
capacity of Riverview and Valleyview (the geriatric wing) had fallen to 907, though the budget had risen to $79 million (op cit).

Following the emergence of the fiscal crisis in the mid-seventies, governments generally sought to tighten their grip on health care costs in all aspects from budget projections to service delivery. This was achieved through a variety of measures, including not allowing costs to rise disproportionately to the G.N.P., the imposition of zero budgeting practices in health care institutions and, in some provinces such as Ontario, the contracting out of services such as hospital management services (Crichton, Hsu & Tsang 1990). Toews (1980) notes that cost containment measures that result in a failure of funding to keep pace with inflation are a "...subtle and widely practiced method of cost cutting" (p. 2) that obviate the need for government to make politically unpopular overt cuts.

In British Columbia, a period of rapid expansion, both in absolute terms and relative to the provincial economy, was followed by the imposition of restraint policies by the Social Credit government in response to recession of the early 1980’s (Evans 1986). Despite the imposition of restraint policies on the public sector, the government consistently sought to reassure the electorate that health care would be protected. Evans, in answer to the rhetorical question, "was health care given special treatment or special language?", concluded that health care was, in fact, subject to restraint. While the system was not allowed to grow in real terms however, the degree of restraint, relative to
other sections of the public sector, was as not severe and suggests that the government sought to preserve essential elements of the health system, even through a period of restraint (op cit).

The British Columbia Royal Commission on Health Care and Costs (1991) report recognised that British Columbia has persistently lacked an overall plan for an integrated mental health system, despite the numerous reports that have recommended integration. In setting out a number of broad objectives to achieve an integrated system, the government is prepared to increase mental health financing. It appears, however, that such increases will occur within a context of cost containment, and permanent global increases to the mental health budget will not be forthcoming. Rather, increases will be time limited and tied to specific policy objectives, such as the downsizing of Riverview hospital and support of mental health consumer projects (op cit). Prior to examining in detail how the foregoing economic contingencies shaped the deinstitutionalization process generally and the continued decline of the large custodial institution specifically, the ideological context of the "anti-psychiatry" critique will be briefly explored.

The Ideological Context: The Anti-Psychiatry Challenge to Psychiatric Legitimacy

In the 1960's and 1970's the appearance of a literature critical of the psychiatric enterprise exerted a significant and influential impact both internationally and in Canada. Prior to the 1960's, psychiatric orthodoxy - that mental illness is
essentially an illness like any other, and is most appropriately
treated within the parameters of the medical ideas of the day -
encountered few serious theoretical or ideological challenges. The
challenges that did arise were not sustained over time, either due
to inherent theoretical weaknesses in the critique, or because they
were successfully out-manouvered by the dominant psychiatric
profession. For instance, as has been previously discussed, the
nineteenth century concept of moral treatment was theoretically
weak and it’s proponents were ideologically ill-disposed for a
sustained attack on the medical profession. Consequently it was
successfully subsumed under the medical rubric. The threat posed
by the early mental hygiene movement and it’s embryonic critique of
institutional psychiatry was successfully diverted toward a focus
on the more amorphous and benign (in terms of consequences for the
dominance of the psychiatric profession), area of "prevention" of
mental illness.

The contemporary challenge of the "anti-psychiatry" critique
has echoed many of the original concerns of nineteenth century
critics; that is, a profound scepticism about the efficacy of
psychiatric treatment, and concerns that the detention and
treatment of people against their will represents such a serious
infringement of civil rights, it should not be applied without
stringent checks and balances, primarily of a legal nature.
Ironically, as Grob (1991) points out, the critique appeared at a
time when mental health professionals, in particular the
psychiatric profession, were imbued with an optimism about the
future of the psychiatric enterprise. Recent therapeutic developments such as psychoactive drugs, the hopeful beginnings of deinstitutionalization, and the unequivocal dominance of the psychiatric profession in the mental health field all lent support to such confidence. The attack on psychiatric legitimacy occurred precisely at a time when multiple challenges to previously accepted orthodoxies and authorities occurred in all aspects of life, and civil rights arguments were expanded to new claimants (op cit).

Deinstitutionalization and the Development of Alternative Community Services

Within the economic context of fiscal restraint, and the ideological context of the "anti-psychiatry" critique that brought renewed attention to real and perceived problems in psychiatry, the decline of the large mental institution progressed. The following section will examine the faltering but continuing decline of Riverview Hospital in British Columbia. It will be shown that the process of deinstitutionalization has occurred in three related phases from 1970 until the present. An accelerated period of deinstitutionalization reached a plateau in the late 1970’s and was followed by a period of status quo where the institutional population remained relatively stable. In the mid 1980’s, in response to a number of pressures, attempts were made to reactivate and finalise the deinstitutionalization process. This third stage has met with variable success and continues today.

To adequately examine the process of the decline of the large mental institution, it is essential to understand the extent to
which alternative community services were established. This is because, in the initial stages of deinstitutionalization at least, institutional and community support services are engaged in a symbiotic relationship. The institution cannot discharge people without adequate support services, at least not without running the risk of creating legitimation problems for the state, as has occurred for example in many jurisdictions in the United States (Scull 1984). Likewise, embryonic community services need the institution as a tertiary back-up service, and, in the case of British Columbia, look to the institution for a reallocation of it’s funding to establish replacement services. It is necessary therefore to assess the degree to which the development of alternative community services has occurred, and how this development has shaped the continuing decline of the central institution. For this reason, a number of key reports which have examined the interface between the institution and the community will be examined in order of their chronological release. These reports include the Foulkes Report (1974), the Mental Health Survey Planning Report (1979), the Mental Health Consultation Report (1987), and the British Columbia Royal Commission on Health Care and Costs (1991).

The process of deinstitutionalization which had been initiated in the 1950’s, was accelerated from the mid-1960’s until the end of the 1970’s when it became apparent that the institutional resident population had stabilised. Admissions to Riverview hospital also began to decrease, from 288 per 100,000 of the general population
in 1966\67 to 139 per 100,000 in 1971. The trend of declining admissions was found to be the reverse of the experience of most large psychiatric hospitals which actually saw admissions increase as their institutional populations declined. This was due to a prevailing treatment philosophy of "revolving door" which dictated short and, if necessary, repeated admissions and rapid discharge as opposed to lengthy hospitalisation. The Mental Health Planning Survey Report found that Riverview had engaged in a practice of artificially restricting admissions (Ministry of Health 1979). This was achieved through a section of Mental Health Act which tied a patient's admission to the provision of suitable accommodation. The survey team found that this section had been flexibly interpreted to include "adequate staffing", a concept which the team pointed out has tended to increase over time (op cit).

At the end of the fiscal year in 1966 the resident population was 2,815. By 1976 this population had been reduced to 1,244. During the early 1970's, criticisms first began to emerge about the fate of deinstitutionalized patients in the United States and Canada (e.g: Murphy 1972; Scull 1984). Toews (1980) suggests that such criticisms could have initiated further development of community resources if the economy had been able to support such an expansion. As has been discussed, the changing economic conditions prevented any such attempt at reworking plans for a more integrated, comprehensive system of community supports. As a consequence, Toews contends that many deinstitutionalized patients were caught "....in limbo, inadequately fitting into the static
By 1981 active deinstitutionalization policies had further reduced the resident population to 1,097. It was apparent, however, that the deinstitutionalization process had reached a plateau when the Director of Mental Health Services reported that this represented "...a relatively stable figure with little change over the last three years". Over the next decade, the status quo pertaining to the size of the resident population was maintained with the hospital providing 1,032 beds with approximately 90% occupancy. There are two related explanations that account for the effective levelling off of the deinstitutionalization process. First, the historical development of Riverview hospital meant that it inevitably contained a residual population of the most persistently and seriously disabled, mentally ill persons in the province. Secondly, the role of Riverview hospital was adjusted through the 1980's as community services and general hospital psychiatric units effectively treated more people with acute conditions that responded quickly to treatment. At the same time these facilities increasingly relied on Riverview hospital as a tertiary treatment centre for their most seriously ill and difficult to manage clients. The physical location and position of many psychiatric units in general hospitals made it difficult to deal with persons who manifested extremely difficult behaviour as a consequence of their condition. Indeed, by 1977 the Superintendent of Riverview noted that the hospital was receiving
an increasing number of urgent, acute referrals from that source. In 1982, Dr. Goresky "clarified" the ministry's position concerning the role of Riverview hospital. While acknowledging it remained a primary referral source for many outlying areas in the province, the hospital was "...increasingly used for those cases that require prolonged treatment, extreme security or specialised care" (Goresky 1982, pp.316-317). A study of the 106 GVMHS clients transferred from the Vancouver General Hospital Psychiatric Assessment Unit (PAU) to Riverview hospital in 1992 lends support for Riverview hospital's role as a specialist tertiary referral centre (GVMHS-Vancouver General Hospital-Riverview Hospital Research Team 1993). In addition, the study also suggests that a population exists for whom the concept of "asylum" remains applicable. The level of violent behaviour in the context of psychotic disorganization of patients transferred to Riverview hospital was found to be well above the level of violence for other PAU psychiatric patients. The study group also noted:

Many of the RVH-Transfer patients are seen as chronically and severely disturbed and as requiring a substantially longer inpatient stay than other PAU patients. For a significant number of these patients, Riverview Hospital is seen as providing asylum rather than acute intervention or psychosocial rehabilitation (emphasis added), (op cit, p.17).

The study concludes with a question as to how the unique needs of this particular group of patients will be met as the downsizing process occurs, noting that the mental health system is not currently able to manage these patients in any other way.
The expansion of community mental health centres.

The provision of an expanded network of community mental health centres was an essential component in the strategy for deinstitutionalization. In addition to supporting discharged patients, mental health centres were expected to facilitate a policy of non-institutionalisation whereby patients would be treated in the community, preventing if possible, the need for admission to Riverview. In December of 1970, 17 mental health centres carried a caseload of 4,931. By 1976 the province had established 30 mental health centres which in that year accepted 9000 new cases and carried over 4,000 cases from the previous year. Unfortunately, the foregoing statistical records may not accurately reflect the increasing amount of direct service delivered through mental health centres. In 1979, a comprehensive report on the provinces mental health system revealed widespread practices of poor record keeping, in particular the practice of delivering services without engaging in the bureaucratic process of "opening" a case (Ministry of Health 1979). The report found that in one month, for instance, central office records showed nearly 40% of all direct service time was given to unregistered clients for whom no case was opened and whose demographic and diagnostic characteristics went unrecorded. Despite such record keeping problems, it was evident that the caseload of the provincial Mental Health Centres progressively increased throughout the 1980’s to over 31,000 in 1987, although a decline to 26,725 had occurred by the end of the decade.
The expansion of psychiatric unit beds in general hospitals.

The policy of expanding the provision of acute psychiatric unit beds in general hospitals was derived from recommendations of the Ross report in the 1960's. By the late sixties, 149 such beds had been established, psychiatric unit construction was under way to provide another 285 beds and a further 397 beds were in the planning stage (Mental Health Branch 1970). There was also evidence that general hospital psychiatric units were providing more acute short term care and assuming an increasing portion of active treatment for hospitalised patients. In the first national quantitative study of involuntary admissions to appear in the Canadian or international literature, it was revealed that between 1970-1978, 22% of involuntary admissions were to psychiatric units of general hospitals (Riley and Richman 1983). Another unpublished study showed that 53% of patient-days under four months were spent in general hospitals (Richman 1981). By 1987 general hospitals provided psychiatric services in 27 designated psychiatric in-patient units for 627 patients. Most beds were for the provision of acute general psychiatric conditions, though some units were developed as specialist areas (e.g. affective disorder units) (Mental Health Services, British Columbia 1987).

The establishment of Greater Vancouver Mental Health Services.

The ongoing process of deinstitutionalization added to local pressures pertaining to alternative community mental health services. During the early 1970's a crisis developed in Vancouver which led to a period of rapid planning and implementation
resulting in the creation of the Greater Vancouver Mental Health Service (GVMHS) (Cumming, Coates, & Bunton 1976). Although mental health clinics and psychiatric unit beds had been incrementally developed throughout the province, such developments had not been paralleled in the metropolitan area. The paucity and poor integration of public psychiatric services in metropolitan Vancouver degenerated into a state of chaos by 1972. Vancouver General Hospital was over-burdened causing low morale, and large numbers of patients accessed psychiatric treatment only on an involuntarily basis following involvement with the criminal justice system. The "desperation" of the situation in Vancouver was reflected in high rates of suicide, substance abuse and, most dramatically, by the shooting of a female psychiatrist by a disturbed patient (op cit). The election of a N.D.P. government ideologically committed to the Hastings report facilitated the planning process. U.B.C. professor of psychiatry Dr. John Cumming, was appointed as a full-time program consultant to work with community agencies and institutions to develop a plan for co-ordinated community mental health services in Vancouver (op cit). A Plan for Vancouver, released in late 1972 led to the establishment of the comprehensive, multi-disciplinary G.V.M.H.S the following year.

The mandate of the GVMHS community care teams was, like the provincial community mental health clinics, to support deinstitutionalization and to implement a policy of non-institutionalisation where possible. It quickly became apparent
that the establishment of GVMHS was an important component in this regard. In 1974 the service carried a caseload of 994, by the end of 1975, 6 Community Care Teams carried a caseload of 2,116 patients and the Riverview outpatient department was transferred to GVMHS management. Throughout the following decade the community care teams carried an average caseload that has stabilised around 3,500 patients. An early internal evaluation of the service estimated that the service was preventing 85% of admissions amongst it’s clientele, and that the cost of maintaining a GVMHS client was $160 per month compared to institutionalisation costs of $125 a day (Bigelow & Beiser 1977).

As will be shown, the development of these alternative services, laudable as many of them were, were undermined by the province’s lack of an overall vision of an integrated mental health service. Successive governments were certainly aware of this problem as report after report from the 1960’s onwards emphasised the point. The inability to plan and develop services that derived from an integrated vision did not appear to be a uniquely British Columbian problem however, as Goering, Wasylkeni & Grisonich (1992) pointed out in discussing the process of deinstitutionalisation in Canada:

Lack of coordination between the three major sectors of treatment services is a major impediment to service planning and delivery. Provincial psychiatric hospitals, psychiatric units in general hospitals, and community mental health centres operate in isolation from one another, resulting in a situation best described as the three solitudes (p. 27).
Undoubtedly, the political and fiscal problems of reorganising psychiatric and general health services to conform to a master plan to deliver integrated services throughout the province, was daunting and not suited to the relatively short-term perspectives of government. The failure to do so, however, continues to hinder the development of cost-effective, comprehensive services providing continuity of care today.

*The Foulkes report.*

In 1972, another of the periodic media exposes of conditions at Riverview hospital reported that the hospital had developed a reputation among professionals for being the "...worst hospital in Canada". Persistent problems included underfunding, inadequate staffing, continued over-crowding, and a shortage of psychiatrists. The underlying charge of such intermittent reports reflected the growing belief amongst many professionals and the public that institutionalisation itself gave rise to pernicious consequences. Attacks on institutionalisation of all sorts had become increasingly common, partly as a result of the academic legitimacy accorded such views with the publication of studies such as Goffman's *Asylums*. These concerns were forcefully reflected in *Health Security for British Columbians*, a comprehensive report commissioned from Dr. Richard Foulkes by the new N.D.P. government. Using Goffmanesque terminology, Foulkes referred to the "...destructive and inhuman characteristics of the total institution". Foulkes advocated that what was required was:

....a real change to [a] community orientation by attacking psychiatric domination of the system and
Foulkes concluded that the "...present mental health service is the most inefficient, ineffective, out-dated and discriminatory of all our existing social and medical programmes". According to Foulkes, the domination of the psychiatric profession had resulted in a prevailing combination of "punitive" and "medical" models of mental health care. Foulkes advocated that, in light of the new government's commitment to community mental health services and the "new regard for human rights", "the supporting elements of the displaced regime" (p. 11) had to be changed. Foulkes dramatically recommended the urgent demolition of Riverview, which he advised could be achieved unit by unit as patients were relocated into community facilities. Only this would facilitate a genuine overhaul of the whole system and moreover would act as a symbolic "ceremonial salute to the beginning of the end of barbarism". Not surprisingly, reaction to the Foulkes report was not unanimously positive. Dr. William Brown, chairman of the psychiatry section of the British Columbia Medical Association released a statement which "deplored" the report as it related to psychiatric services. Dr. Brown's comments received support from former N.D.P. MLA and psychiatrist, Dr. Kay Parkinson, who described the report as "callous, degrading and irresponsible". The Foulkes report was written and released in an ideologically receptive climate. Indeed, in early 1973 the N.D.P. Minister for Health, Dennis Cocke, had stated to the media that mental health facilities were to be...
provided in the community, adding that: "As an institution, Riverview will no longer exist". A year later, the political realities of such an undertaking had the minister reassuring mental health employees that "...there is no way in which comprehensive psychiatric care can be provided...without the specialised services of Riverview Hospital". With the return of the Social Credit government the radical recommendation of demolishing Riverview hospital, or even of replacing it quickly, became effectively redundant and the new Health Minister, Bob McClelland, moved to further reassure mental health professionals that there was no plan to phase out the hospital and that "Riverview has an important role to play in the delivery of health care".

The mental health planning survey 1979.

During much of 1978, the province’s mental health services were subject to a comprehensive survey under the chairmanship of Dr. John Cumming (Ministry of Health 1979). The Cumming report generally endorsed the government’s strategic direction of developing community alternatives to institutional care. In support of the government’s direction, the authors quoted Judith Turner, Community Support Program Director at the U.S. National Institute of Mental Health:

Reliance on hospitals for long term care will continue to diminish. The costs of hospitalisation are too high; the human and civil rights issues too complex; and the negative side effects too great to maintain the old pattern of institutional care (op cit, Appendix 4).

Having delivered an endorsement of the strategic government’s direction with regard to mental health services, the report clearly
demonstrated that entrenched in both institutional and community service systems were a number of significant deficiencies that would, if not addressed, seriously obstruct the government's plans. These deficiencies included a lack of inter-disciplinary cohesion in community mental health centres, and community services that were generally unfocussed, poorly evaluated, and inadequately regulated. Serious systemic problems were also noted in the entrepreneurial, for-profit boarding home sector. Consequently, the report made sweeping recommendations based on an incisive critique of the shortfalls and lack of co-ordination and integration of both institutional and community services (op cit). In addition, the report made recommendations regarding a reconstruction of the Mental Health Act. These latter recommendations will be dealt with in the following chapter.

The survey team delivered a trenchant critique of institutional practices at Riverview hospital which focussed on the residual effects of the large custodial institutions nineteenth century heritage. The survey team found the hospital to be an isolated institution engaged in minimal "boundary spanning activity" between itself and the community. As a consequence, the insular institutional climate fostered incoherent planning, a paucity of rehabilitative programs, extremely poor budgeting and accounting systems, obsolescent work practices that needlessly consumed clinical time, an unjustified adherence to obstructive admission policies, and inadequate discharge planning. The historical tradition of pervasive medical authority in large mental
institutions continued despite evidence that it was antithetical to efficient, contemporary clinical practices. For instance, virtually all decisions regarding patients required physician authorisation, from the granting of grounds privileges to referrals for occupational therapy. As a consequence, the survey team found hospital services were characterised by a lack of coherent coordination:

There is no clear delegation of authority or responsibility to anyone at any level for the development of programmes in Riverview. Supervision of the patients is almost entirely medical, in the sense that almost every part of the patients' treatment and privileges must be medically authorised....The hospital operates traditionally, that is, is in the pious hope that if each discipline does that which is appropriate to it the resulting whole will be a therapeutic programme (op cit, p. 54).

In addition to the foregoing criticisms, the survey team produced evidence that the hospital was caring for a significant minority of patients who did not require (expensive) institutional services. Utilising a level of care survey administered to patients resident on June 18th, 1978, the team found that of the 1,077 patients surveyed, 230 patients (21.3%) required no psychiatric care at all (their level of care needs ranged from independent living to extended, non-psychiatric care). Acute psychiatric care was required by 299 patients (27.8%), and a total of 847 patients (77.7%) required some level of psychiatric care on the day of the survey (op cit).

To counter these problems Cumming forcefully emphasised that Riverview's "historic norms and attitudes" which had led to a
"miasma of pessimism" had to be eradicated. A "renaissance" of the hospital required a thorough rationalisation of its fiscal and administrative structures to improve its cost-effectiveness. Other recommendations included improved co-ordination of clinical and rehabilitative programs, increased integration with the community, and expanded roles for non-medical staff, particularly psychiatric nurses (op cit).

The report did not receive unequivocal approval from all professional quarters. The British Columbia Association of Social Workers (BCASW) (1980) criticised the methodology of the report and reproached Dr. Cumming for his perceived criticism of social work competency, training and practice in mental health centres. The BCASW took particular exception to perceived charges that social workers practiced according to their own interests and professional bias and called for a "balanced" mental health service that accommodated "both the biological and social-behavioral models" (p. 5). Miles (1982), a psychiatrist, also alluded to the underlying tensions between proponents of the medical model and those who favoured a social-behavioural approach. Miles felt that the "complex problem" of role blurring and the perceived diminution of authority of psychiatrists was poorly addressed. As psychiatrists "know more than anyone else about serious mental disorder" (op cit, p.27) and are patients' advocates, it was deemed essential that psychiatric authority be restored clinically, and in terms of policy consultation with government, not only for the sake of the profession but also for the mentally ill. Miles also criticised
the report's methodology, particularly it's failure to sample private psychiatrists, whom he claimed, "treat the vast majority of psychiatric disorders" (op cit, p. 25).

Despite these professional complaints the government moved to institute remedial measures, although it declined to institute large scale, systemic change with any elements of the system. Arrangements were made to expedite short term, acute admissions to Riverview, fiscal control mechanisms were implemented, and the hospital was encouraged to liaise effectively with community agencies such as mental health centres. Provincial boarding homes were upgraded and efforts made to adjust their emphasis from custodialism in the community to rehabilitation (Gordon 1988).

The erosion of the psychiatric profession's administrative authority as a consequence of deinstitutionalization.

In the 1960's the Tyhurst report had emphasised that psychiatrists must retain administrative as well as clinical domination of all mental health care, regardless of treatment setting (Canadian Mental Health Association 1963). As the process of deinstitutionalization produced pressure for the development of alternative community resources, it became apparent that aspects of the dominance of the psychiatric profession in public sector psychiatric services were being significantly eroded for the first time. In the past, the power base of the psychiatric profession had been derived from it's institutional origins. Dickinson & Andre (1988) contend that in Saskatchewan an institutional bifurcation occurred as the centrality of the large institution was
eroded in favour of community services. A number of factors including cost-effectiveness of non-medical professionals relative to psychiatrists, the autonomous nature of community work and the increasing unwillingness of non-medical professionals in community services to unquestioningly accept a psychiatric division of labour premised on medical domination, led to a changing balance of power (op cit). As a consequence of similar tensions in British Columbia, psychiatrists have largely vacated the fields of community mental health administration, and to a lesser extent mental health service planning, in both the provincial mental health system and GVMHS. As has been previously discussed, jurisdictional vacancies are a key determinant in the struggle for, and maintenance of, professional dominance (Abbott 1988). The erosion of the institutional power base of the psychiatric profession, combined with a failure to effectively dominate the emerging field of community mental health planning and administration, has resulted in a significant erosion of two avenues through which the psychiatric profession's exercised its traditional dominance, that of administrative leadership and policy planning. Dickinson & Andre (1988) point out that although the shift in power in community mental health is significant, whether it has translated into better treatment for persons with mental illness remains uncertain. Both medical and non-medical mental health professionals continue to perpetuate an individualistic approach to the diagnosis and treatment of mental illness as it is not in their professional interests to focus on "problem-producing
social conditions and relations" (p. 306) that certainly exacerbate, and possibly produce, mental disorder (op cit).

The reactivation of deinstitutionalization: "downsizing" Riverview Hospital.

The plateau reached in the deinstitutionalization process by the end of the 1970's presented an increasing dilemma for the government. The high costs of institutional care for an apparently stable population which contained some of the most seriously and persistently mentally ill persons in the province, were exacerbated by the recession that commenced in the early 1980's. In addition, Riverview inevitably showed serious signs of physical dilapidation. In mid-1985 the government put in train a consultative process to develop a new mental health plan for the province to resolve the dilemma. The subsequent Mental Health Consultation Report (A Draft Plan to Replace Riverview) was released in 1987 (Ministry of Health 1987). The report stated the intention of the government to re-expedite and finalise the deinstitutionalization process. Community support and treatment facilities were to be enhanced to buttress small acute, in-patient units located throughout the province. Although Riverview was to be closed by 1992, the report recognised that there would be a core population requiring medium and long-term inpatient care though it was felt this population could be reduced and adequately served by the provision of 550 beds. The distribution of these beds was to be 300 in the Lower Mainland, 200 beds divided equally between Vancouver Island and the Okanagan, and 50 beds located in Northern B.C. The fiscal strategy
developed to facilitate these changes was "overshadowed by the awareness of escalating health care costs" (op cit, p. 19). It was emphasised that the then current level of funding for Riverview hospital ($73 million) be maintained though reallocated to facilitate the objectives of the plan (op cit). Despite the plan, the government found itself repeatedly embarrassed through consistent criticism in the media for not underwriting the plan with sufficient funds to provide adequate support services to those discharged from Riverview. Media reports reflected what many citizens could see and experience for themselves: a visible increase in the homeless mentally ill, difficulties getting acutely disturbed patients into Riverview, and grossly inadequate housing for the mentally ill. In addition, opposition to downsizing itself periodically appeared in the media, but such opposition had no organising focus and was not able to gain momentum in terms of a full scale attack on government policy. 

In 1990 the government announced the Mental Health Initiative, which was described as an "enhancement" of the 1987 Mental Health Consultation report. The time frame for the implementation of the report was doubled, an additional $20 million was allocated to the mental health budget on an annualised basis until 1995/96, $26.5 million in transitional funding was to be provided for 10 years, and capital funds of $60 million distributed over the following decade for the provision of 110 acute psychiatric beds to replace facilities at Riverview hospital (Royal Commission on Health Care and Costs 1991). The Strategic Mental Health Plan for 1992
confirmed these goals, and set out a five year plan to transfer 170 Riverview Hospital beds to acute psychiatric care units in general hospitals around the province.28

While a fiscal commitment of this magnitude reflected a genuine desire to finalise deinstitutionalization, the funds were provided in a policy vacuum in the sense that the province still lacked an overall plan for an integrated mental health system. The indirect consequences of the lack of integration for the smooth implementation of a reactivated deinstitutionalization process were revealed by the 1991 Royal Commission on Health Care and Costs. While the Mental Health Consultation Report was recognised to be an ethical and effective plan, it was found that "action ha[d] not followed policy" and, in particular, funding had not been tied to policy objectives to successfully implement the process (British Columbia Royal Commission on Health Care and Costs). Although the mental health budget had been increased to provide enhanced community services, neither the budget, staff, or resident population at Riverview hospital had substantially declined. Indeed, the Riverview hospital budget had actually increased to $84.5 million for the fiscal year 1989/90 (op cit). In addition the Commissioners found that there was no evidence to demonstrate that enhancement funds were either needed at all or, if they were, that they were sufficient. For instance, the transitional funding arrangements did not appear to be tied to policy objectives (at least not publicly), and there was no stated evaluation process to assess their impact (op cit). As a result of these concerns the
government commissioned a value-for-money audit of downsizing process (Auditor General of British Columbia 1994). The audit reviewed the transfer of patients during the first year of formal downsizing (April 1st, 1992 - March 31st, 1993). The audit found that the transfer of 67 patients had been adequately planned, implemented, and evaluated in line with "Closer to Home" principles. During this period 105 beds had also been closed. The success of this reactivation of the deinstitutionalization process was consequently reflected in a significant reduction in bed capacity as well as population numbers. In March/April 1993, the hospital reported a capacity of 922 beds while housing 819 patients, 265 of whom were in the Geriatric Division (Ministry of Health and Ministry for Seniors 1993; Ombudsman 1994). The audit team also found that funding had moved with patients, although it was noted that negotiations between the British Columbia Mental Health Society (the quasi-independent society formed in 1988 to administer Riverview Hospital) and community service providers had been "challenging" with Riverview arguing that it could not give up resources until the cost of establishing tertiary facilities in the community had been established, and the community looking to the hospital for money to upgrade services required in the community (Auditor General of British Columbia 1994).

**Strategic planning for the future role of Riverview hospital.**

Some commentators have argued that once the major process of deinstitutionalization has been "completed", there will still remain a need for institutional care. The smaller, redesigned
psychiatric hospital will retain a viable and crucial role. Visions of the role differ, however, with some advocating the provision of some kind of "asylum" care and others promoting specialist tertiary programs (e.g. Bachrach 1992; Dudley, Gorrie, Gove & Shreiber 1992; Glick, Freund, & Olfson 1992). Bachrach (1992; 1986), one of the most influential North American commentators on deinstitutionalization contends it is a fallacy to perceive mental hospitals as stagnant and moribund. In support of her contention Bachrach points out that statistics showing a decline in the institutional population over a given temporal period do not reveal the whole picture which properly includes readmissions, new programs and the emergence of new patient populations. She states mental hospitals "...continue to be vital service delivery settings with a great deal of busy activity and a constant turnover of patients" (Bachrach 1992, p.227). There is evidence that Riverview hospital is planning and consolidating its reorientation as a specialist, research oriented service, although it still provides some traditional institutional care. In the release of it's first annual report following its reorganisation as a non-profit society, the hospital stated its mandate as a "third level referral hospital....for the most intractable illnesses". The 1994-1996 Draft Strategic Plan for Riverview hospital consolidates the hospital's planning for a specialist, tertiary role within the context of continued "downsizing". Clinical services are organised into eleven specialist programs. These include acute assessment and treatment (including Psychiatric
Intensive Care), continuing treatment, neuropsychiatry, treatment of refractory psychosis and aggressive behaviour rehabilitation. In addition, a Community Psychiatry Division facilitates community reintegration, and a geriatric division offers a range of specialist services to the elderly mentally ill. While the BCMHS clearly envisions an evolving specialist role for Riverview, the Ombudsman (1994) points out that it presently offers both specialist and institutional "asylum" services. With continued "downsizing" and a proportional reduction in resources, the hospital may not be able to continue to do both in the future (op cit).

In summary, three identifiable phases can be associated with the process of deinstitutionalization since the mid-1960's. The first phase involved accelerated deinstitutionalization followed by a second phase of status quo in which declines in the core institutional population effectively ceased. The third phase, which is currently in still in progress, involved a reactivation and expediting of the deinstitutionalization process. This latter phase currently involves a concerted effort being made to finalise the deinstitutionalization process by the end of the decade. These phases occurred in the context of, and in response to, a number of pressures. Principally, the process was driven by the need for cost stabilisation and later restraint following the fiscal crisis of the state. Deinstitutionalization and the decline of the large custodial institution was given additional momentum by the ideological attack of the so-called "anti-psychiatry" critics which
focussed on the pernicious effects of institutionalisation, raised questions about the legitimacy of involuntary confinement, and questioned the etiology of mental illness itself. The government now appears committed to oversee the eradication of the "asylum" as it was conceived in the previous century, by the end of the present one.
CHAPTER EIGHT

RIGHTS VS TREATMENT: CURRENT DILEMMAS IN
THE PROVISION OF INVIDIUNTARY PSYCHIATRIC CARE

This chapter examines pressures for mental health law reform that developed parallel, and in response to the process of deinstitutionalization and non-institutionalisation outlined in the previous chapter. Specifically, this chapter will seek to describe and explain the development of an increasing polarisation of perspectives within the mental health discourse that can be summarised as a dichotomy of "treatment" versus "rights".

It is contended that the shift in the strategy of managing the mentally disordered described in the previous chapter, was facilitated by the implementation of a new wave of mental health law reform which has been characterised as the "new legalism". The development and conjuncture of a number of complex forces that initiated and gave ideological momentum to this reform are examined. These forces include the partial success of a loose amalgam of patients' rights groups, legal aid lawyers, and civil libertarians in pursuing law reform through court challenges and administrative review mechanisms. In particular, the impact of the Canadian Charter of Rights and Freedoms is examined. It is argued that the government moved to instigate statutory reform of the
Mental Health Act (MHA) in order to further facilitate its strategy of expediting deinstitutionalization, and in response to the pressures described above. It is suggested that instead of drafting new legislation and submitting it for comment and review by interested parties, the government was compelled to conduct a lengthy consultation process involving all stakeholders. This process allowed the expression of polarised views which have relate to the fundamentally divergent causes and treatment of mental illness. It will be shown that the subsequent failure of the consultation process has resulted in an impasse. This impasse is compounded by the diversity of beliefs among mental health consumers about the legitimacy of promoting more legal rights that limit the discretionary powers of psychiatry. The chapter concludes with an examination of four exploratory-descriptive qualitative interviews with mental health consumer-activists. These interviews offer an illustration of some of the factors that contribute to the development of polarised positions amongst mental health consumers.

**The New Legalism**

Parallel to the implementation of deinstitutionalization and non-institutionalisation described in the previous chapter, the collective civil rights of persons with mental illness underwent significant change. This period of mental health law reform which commenced in the mid-1970's and continues today, is characterised by elements of what has been called the new legalism. The term, the "new legalism", has been variously attributed to Larry Gostin,
an American lawyer prominent in Britain concerning civil liberties issues for the mentally ill (Gordon 1988; Gostin 1983), and Clive Unsworth, a British legal academic (Jones 1993; Unsworth 1987). The term "new" legalism connotes its connection to the "old" legalism of the late nineteenth century. Professor Kathleen Jones, a long-standing opponent of legalism in both its traditional and contemporary forms, contends that the new legalism once again "...demands that the treatment of mentally ill people should be viewed primarily as a problem of the deprivation of liberty, and hedged with legal safeguards and precautions" (Jones 1993, p.203). Gostin (1983) agrees with Jones that the technical legal formalism of the nineteenth century did little to foster advances in psychiatry. Gostin contends, however, it is a mistake to assert, as some critics of legalism have done, that the legal profession is attempting to erect a cumbersome legal framework to control mental health professionals, or that the legal profession wishes to substitute legal discretion for that of mental health professionals (op cit). Gordon & Verdun-Jones (1988) advocate that the new legalism does more than simply protect patients' rights but rather seeks to advance them in a number of ways.

The "new legalism" encompasses such trends as the introduction of a right to effective mental health services, protection against unjustifiable deprivation of liberty, and the prevention of discrimination by maintaining the civil and social status of patients. In particular, the term reflects an approach that embodies a central role for law in ensuring that the state provides effective health services for patients, effective facilities and resources for mental health professionals and protections for patients by placing clear limits upon such psychiatric
procedures as compulsory treatment and admission (p. 834).

Gordon (1988) argues that the new legalism provided provincial governments with the means by which to implement changes in the strategy of managing persons with mental illness. The new legalism embraced the dual purpose of promoting fundamental civil rights while at the same time restricting hospital use. This was principally achieved by reducing the autonomy of doctors in regard to their utilisation of costly institutional resources. Barriers to commitment were combined with checks and balances that mitigated against the unwarranted continued detention of those judged to be mentally ill. The new legalism thus allowed the government to pursue its objectives while simultaneously minimising attacks that it was simply cutting politically sensitive services (op cit). Gordon’s analysis extended to 1988. Events in the intervening years have lent support to his conclusions. As was discussed in the previous chapter, the government has reactivated and expedited deinstitutionalization. Despite opposition from some quarters, the government has for the most part managed to escape criticism that it is wantonly cutting an essential part of the welfare state. Rather, it has largely been able to justify it’s actions as a rationalisation and modernisation of services that are being brought "closer to home".

Prior to the examination of how pressures for mental health law reform developed in B.C., and what have been the consequences, a brief review of the underlying epistemological perspectives of "pro-treatment" and "pro-rights" advocates is warranted.
The epistemological dichotomy of "pro-treatment" and "pro-rights" advocates.

"Pro-treatment" advocates, who include organised psychiatry, family advocacy organisations and some mental health consumers, generally believe that major mental illness has an organic etiology (Guze 1992; Roth & Kroll 1986). The lack of insight associated with untreated major mental illness is understood to erode a person's awareness of a need for treatment, even when in acute distress (Toews, Prabhu & el-Guebaly 1980). The "pro-treatment" perspective contends that without "sanity", the enjoyment of liberty is inconceivable (Hoaken 1986; Nelson 1982). Hoaken (1986) states since "....psychotic people are without psychological freedom it is meaningless to respect their apparent liberty at the expense of allowing them to go untreated" (p. 222). Given the above premises, under the doctrine of parens patriae and using the police power of the state, it is seen as inherently justifiable to detain and treat people for their own protection and/or the protection of others, even if such detention and treatment is against their expressed wishes. Thus, in the "pro-treatment" perspective, the liberal democratic paradox inherent in many functions of the welfare state of balancing a person's right to self-determination against the need to deny civil liberties in their, or others best interests, is settled in favour of commitment and control (Weistubb 1980). By extension, only a "treatment" driven model is logically consistent (Applebaum 1988). Since the sole justification of denying a person their liberty is to treat
them, it makes no sense to allow them to refuse such treatment, as is proposed in a "rights" driven model (op cit). The imposition of legal methods to advance patients' rights is resented and frequently perceived as "....obstructive, unscientific, and downright counter-therapeutic: the substance of healing should not be sacrificed to the form of safeguarding abstract liberties" (Unsworth 1987, p. 4).

"Pro-rights" advocates, who include anti-psychiatry theorists, civil libertarians, and some mental health consumers and lawyers, are less sanguine about the biological determinism inherent in the medical model of mental illness. They emphasise that psychiatric practice is based on imprecise science at best. Consequently, the diagnostic and therapeutic efficacy of psychiatric practice is frequently open to question (eg: Rosenhan 1973). No major research has yet defined with precision when involuntary detention is necessary (Spenseley & Werme 1982). In light of therapeutic and diagnostic uncertainty, the involuntary detention of people on the basis that they are potentially treatable is seen as questionable.

As Gordon (1988) points out, "pro-treatment" advocates argue:

The blanket imposition of treatment has dominated the delivery of mental health services for many decades and has not resulted in the successful treatment of patients. Indeed, it has resulted in many abuses; such as, the "warehousing" of indigent and "incurable" persons, the widespread us of harmful treatments, and inappropriate confinement. In the view of many civil libertarians, it has been necessary, therefore, to limit the "therapeutic orgy.." (p. 20-21).

Other critics have contended that psychiatric practice itself is a contributory factor in the etiology of mental illness (Scheff
1984), and even that the whole psychiatric enterprise is scientifically and morally illegitimate (Szasz 1961;).

Pressures for reform: The emergence of the mental health patients' rights/consumer movement.

The history of mental illness has been remarkable for the resounding silence and absence of the collective voice of mentally ill people. While there have been notable exceptions, they have invariably been individuals, such as J.T. Perceval and Elizabeth Packard in the nineteenth century, and Clifford Beers in the twentieth century (see Chapters 4 and 5). Since the 1970's the collective voice of mental patients has progressively emerged as one of, if not the most effective critics of the mental health system.

The counter-culture of the 1960's created a cultural context that gave rise to challenges to the paternalistic authority of all professionals by new, active and increasingly informed consumers. This phenomenon has been clearly manifested in the general health field (Guldemond 1977; Siler-Wells 1987). Siler-Wells (1987) states;

If trends continue, we will move beyond patient role into a more egalitarian and empowered partnership role with professionals...Consumers expect to be partners and to share in the planning and decision-making process of the health care system (p. 8), (original emphasis).

In the U.S., the climate produced by the counter-culture led to remarkable wave of mental health consumerism:

For the first time in American history ex-patients created their own organisations; they openly expressed their anger and hurt; they denied that
the therapies offered to them were either effective or appropriate; they insisted that they were best qualified to pass judgment on how they were or should be treated; they sought to establish their own programs as alternatives to hospitals and community mental health facilities (Dain 1989, p. 10).

By the late 1980's between seventy to a hundred ex-patient organisations were in existence in Canada, the U.S., South America, and Europe (op cit).

With the establishment of the Mental Patients' Association (M.P.A) in 1971, British Columbia became one of the first of two original formal patients' rights and advocacy movements in North America (Chamberlain 1979). Drawing on the critique offered by the critics identified with the "anti-psychiatry" tradition, members of the fledgling M.P.A. initially sought to offer each other the support they perceived to be missing in traditional psychiatric services, and to express their dissatisfactions with the medically oriented paternalism of the system (op cit). Within six years the M.P.A had obtained funding from all three levels of government and was operating a drop in centre in downtown Vancouver, running five co-operative residences, and advocating for mental health law reform (op cit). Throughout the following two decades, self-help and advocacy organisations and associations have flourished. Today, such organisations include M.P.A., West Coast Mental Health Network, Unity Housing, and the B.C. Mood Disorders Association. The C.M.H.A also began to adjust it's political position in the mid-1980's, renewing it's commitment to persons with long term mental disability while distancing itself from the medical model,
principally through the adoption of a consumer advocacy orientation (Griffin 1989; Savage & McKague 1987). Chamberlain (1990) makes a distinction, however, between mental patients' liberation organisations and "reformist consumerism" groups, which, Chamberlain contends, developed as the psychiatric establishment began to fund ex-patient organisations. The former organisational category of ex-patient activity has focussed on the right of the individual to not be a patient, to refuse treatment etc., rather than the latter organisational category which has principally focussed on procedural safeguards concerning involuntary commitment (Chamberlain 1990; Savage & McKague 1987). The more radical, political agenda of some patients' rights organisations is reflected in their statements of philosophy. The U.S National Association of Psychiatric Survivors philosophy statement, (undated), states the intention to achieve an end to psychiatric intervention which involves any form of involuntary commitment or treatment against one's will (Chamberlain 1990). In Canada, a 1982 conference in Toronto attended by patients' rights groups which included MPA representatives, endorsed a "Declaration of Principles". These principles included "opposition to the psychiatric system because it is inherently tyrannical" and a belief that "....the psychiatric system cannot be reformed and must be abolished" (Savage & McKague 1987, p. 238). A brief review of the current relationship between government and the consumer movement does show however, that the mental health consumer/patient's rights movement have recently moved into a
position of mainstream acceptability. As mental health consumer
groups and organisations become increasingly drawn into funding
relationships with government, the possibility for co-option may
increase. In 1990 the government established the Provincial Mental
Health Advisory Council to provide advice directly to the Minister
of Health regarding the nature and quality of mental health
services.¹ This was followed in the spring of 1992 by the
establishment of the Consumer Advisory Council to advise the
Director of Mental Health Services on service priorities and to
administer the consumer involvement budget initiative.² The 1992
Strategic Mental Health Plan³ projected a policy target of one-
third consumer involvement for all mental health advisory
committees, boards and councils at local, regional and provincial
levels. Arnold Skulmoski, Director of Alternate Care (Provincial
Mental Health Services) stated in a talk at Riverview Hospital in
early 1994 that consultation with consumers was no longer
considered to be a pilot project, but rather a core component of
the mental health policy development process.⁴ Reflecting the
status accorded consumer involvement was a budget envelope of
approximately $4 million to increase citizen involvement in the
planning, delivery, management and evaluation of mental health
services.⁵ The Canadian Mental Health Association (CMHA) has
recently recommended that mental policy groups be composed of a
minimum of 50% consumers.⁶
The impact of the Canadian Charter of Rights and Freedoms.

The introduction of the Canadian Charter of Rights and Freedoms in 1982 produced new pressures for mental health law reform. The Charter represents the supreme law of Canada and all federal and provincial law must be in compliance with its provisions (Grant 1991). The courts are the agencies empowered to adjudicate whether any given law is unconstitutional due to violation of Charter provisions. This effectively means potentially unconstitutional laws remain valid until such time as they are successfully challenged in court (op cit). Mandel (1989) points out that an important consequence of the Charter is that political, social, and moral issues are increasingly submitted for judicial resolution. It is within this context that dilemmas in mental health care are being similarly presented as legal controversies (Segall, Tefft, & Trute 1991). Certainly, it has been feared by the provinces that many aspects of provincial mental health legislation would be open to successful challenge under the Charter (Gordon & Verdun-Jones 1988). Charter safeguards that mental health legislative provisions potentially violate include protection from arbitrary detention (section 9), the right to expeditious retention and instruction of legal counsel upon detention (section 10), the right to due process if detained (section 11), the right not to be subjected to unusual treatment or punishment (section 12), the guarantee of equality under the law and the right to not be discriminated against on the basis of mental disability. Some provisions within the current B.C. Mental
Health Act are vulnerable to a Charter challenge which, if successful, would undermine the working of the entire Act. One example pertains to the sensitive and fundamental issue of involuntary treatment. Currently if a person is involuntarily detained, they cannot legally refuse treatment. Section 25.2 of the MHA reads: "Where a person is [involuntarily] detained in a Provincial mental health facility...treatment authorised by the director shall be deemed to be given with the consent of the person" (p.11). This so-called "deemed consent" has been interpreted by hospitals to mean that involuntary patients, whether capable or incapable (of giving consent), may be given treatment against their will. Section 7 of the Charter guarantees "life, liberty, and security of the person". Section 25.2 is potentially in violation of this Charter safeguard because it effectively means the competent, involuntary patient has no right to consent to, or refuse, treatment. At this point, however, no challenge of section 25.2 has been instigated.

Partially as a consequence of concerns about such challenges, the British Columbian government moved to develop proposals for statutory reform, a development that will be discussed shortly.

Tensions inherent in the interface of psychiatry and law: the examples of the Mental Patients' Advocacy Project and the McCorkell test case.

Following the success of civil libertarian lawyers using test case litigation to promote patients' rights in the United States, most notably that of the right to refuse treatment, Canadian
lawyers with a special interest in civil liberties and mental health became increasingly active in litigation to create law reform (Savage & McKague (1987). Many of these lawyers were influenced by arguments articulated under the anti-psychiatry umbrella. This was understandable because, as previously discussed, important elements of the anti-psychiatry critique were shaped by the political liberal heritage with its emphasis on individual rights. The Patients’ Advocacy Project (MPAP) at Riverview hospital was the earliest Canadian experiment of providing free professional legal advice to mental patients on the grounds of a major institution, but independent of it (Himelfarb & Lazar 1981). Gostin (1983) acknowledges that: "The tension between "legalism" and "professional discretion" is probably the central cause of controversy at the interface of psychiatry and law" (p. 47). The MPAP does provides an illustrative example of the potential for tension and polarisation occurring as a result of the interaction of medical and legal perspectives. As will be shown, both perspectives premise and justify their actions on divergent interpretations of the same situation.

The MPAP was established in 1977 following major input from the Mental Patients’ Association. The project was operated under the auspices of the Vancouver Community Legal Assistance Society (VCLAS), an organization whose mandate included the promotion of law reform through test case litigation (Himelfarb & Lazar 1981). Likewise, in addition to providing legal advocacy for people in relation to their status as mental patients, the MPAP also sought
to raise issues with the objective of making new law or reforming existing legislation (op cit). The largest component of work undertaken by the MPAP lawyers related to involuntarily committed clients seeking release. MPAP lawyers advocated for 465 patients in their first three years of operation. Two options for appeal were available under the Mental Health Act at the time. The first option involved an appeal to a Review Panel under Section 24 of the Act, the second, a more costly and time consuming appeal to the Supreme Court of British Columbia under Section 30 of the Act (op cit). The MPAP was remarkably successful. Of all patients seeking release via either avenue of appeal, 81% received full discharge or were placed on extended leave. Only 3% of cases resulted in continued commitment. In evaluating the MPAP, Himelfarb and Lazar commissioned an unpublished study of hospital staff attitudes to the project, the results of which revealed the underlying problems of perception that exist at the interface of the paternalism of the medical/therapeutic model and the adversarialism of the legal model. The study found that staff generally understood, respected, and supported the concept of patients' rights, although they were "....taken aback when these rights are operationalized" (op cit, p. 39). Staff concerns related to perceptions that the adversarial model of dispute resolution intruded with negative consequences on what they understood to be a therapeutic relationship. Staff believed they were acting for the patient in the name of their "best interests". Consequently, the role of being cast as their patients' adversaries was "foreign and unwelcome" (p. 35). These
views suggest that while talk of "rights" generally have a compelling quality against which most people are reluctant to argue, tolerance for the rights of the mentally ill have a definite threshold. This threshold is underpinned by a understandable reluctance to acknowledge, let alone attempt to reconcile, the social control and healing functions of psychiatry. Unsworth (1987) argues:

"Soft" apparatuses of control, precisely because they function by ideology, moral suasion, the generation of consent, images of healing, beneficence and paternalism, may be said to require an acute legal scrutiny if the threats they pose to civil liberty are to be successfully deflected. It is this role of law in relation to psychiatry which has been central to the confrontation between the guardians of professional discretion and the partisans of patients' rights, and which, when pressed beyond a certain minimal recognition, is liable to attract accusations of "legalism" (p.10).

The legal perspective asserts that the status of "involuntary" patient indicates the existence of a dispute, which, if the patient remained unrepresented, will invariably be settled in the hospital's favour. Therefore, while the mental health professional view tends to perceive formal legal advocacy as an often unnecessarily "legalistic" intrusion into what is a therapeutic situation whose parameters have traditionally been defined by professional discretion, proponents of the legal model perceive such advocacy as simply adding a necessary balance (Himmelfarb & Lazar 1981).

The most recent examination of legal mechanisms regarding commitment and detention was undertaken as part of the Ombudsman's review of administrative fairness at Riverview hospital. The
Ombudsman acknowledged that compulsion remains the legal context within which many services are provided at Riverview hospital and similar settings, "which creates a fundamental imbalance between those providing the services, and those receiving services" (Ombudsman 1994, p. 4-1). Despite the lack of statutory reform, the Ombudsman’s report found that administrative reforms of, and amendments to, the MHA have shifted the working of the Act in the direction of the new legalism. For instance, guidelines for review panels were developed in 1992 in response to the charge that the MHA contains only a paucity of (vague) criteria regarding the operation and decision making principles of review panels. The Ombudsman found that these guidelines had improved the fairness of panel decisions and concluded that Riverview patients were generally well served by existing legal processes. Underlying reservations and concerns, similar to those expressed about the imposition of the legal model by the MPAP in the 1970’s, were found to be undiminished by the Ombudsman in the 1990’s:

We heard many people, other than patients, suggest that the Review Panels apply excessively narrow criteria for "protection of self or others", and thereby discharge too many patients. The Panels are thought by some to be an impediment to the treatment of patients in serious need, and to contribute to the number of seriously mentally ill people on city streets, without support or follow-up care (op cit, p. 4-5).

The Ombudsman’s office was reassured by the consistency of Review Panel decisions which, over the previous three years (1990-1992 inclusive), had discharged 36 patients (18%), 49 patients (25%), and 39 patients (22%) respectively. The Ombudsman asserts that if
discharges were significantly higher than 20% on average, it would indicate a serious discrepancy between hospital psychiatrists and panel members regarding interpretation of committal criteria. Conversely, the Ombudsman states that a discharge rate significantly below 20% on average would possibly be an indication of ineffectiveness of the Panel in preserving individual rights (op cit). The Ombudsman did think that a significant gap in fairness existed in relation to how patients' decisions to refuse treatment were overridden. The Ombudsman therefore recommended (in the absence of a reconstructed Act), amendments to the MHA to include procedural, quasi-legal protections. These recommendations included independent review of patient competency in regard to treatment consent and an independent review of medical decisions to impose treatment without consent (op cit).

Segall, Tefft & Trute (1991) state there are divergent opinions concerning the potential of the Charter to clarify and advance mental health law. Savage & McKague (1987) contend that because it is so difficult to achieve consensus positions on what provincial mental health laws should be, the principal vehicle for mental health clarification and reform will be through interpretations of the Charter. An important and most recent test case brought under Charter provisions,McCorkell v. Director of Riverview Hospital et al7 (1993), challenged the constitutional validity of involuntary committal and detention under the B.C Mental Health Act. The action, sponsored by the Community Legal Assistance Society (CLAS), sought to narrow the criteria for
involuntary committal. Specifically, CLAS aimed to limit the criteria specifically to one of physical dangerousness. The criteria for involuntary detention specified in the current legislation refers to a mentally disordered person who "requires medical treatment or makes care, supervision and control of the person necessary for his protection or for the protection of others". Upon the completion of two medical certificates by two physicians stating that the person meets the criteria above, they may be detained against their will for an initial period of one month. The plaintiff argued that he was denied his liberty contrary to section 7 of the Charter, and that as a consequence he was subject to arbitrary detention contrary to section 9. CLAS lawyers contended that underpinning the alleged Charter violations was the excessively vague nature of committal criteria. In partial support for this contention, counsel for the plaintiff showed that an external evaluation of the hospital in 1989 criticised the excessive number of patients who were involuntarily committed (over 90%). Within two years the Director had reduced the number to 60% by means of discharge and reclassification of patients to voluntary status. Such a dramatic reversal in the ratio of involuntary committals could, the plaintiff’s counsel asserted, only have been achieved in the context of poorly defined criteria for committal. Witnesses for each side in the case reflected the polarisation that exists between civil libertarian views of committal, and those committed to a "need for treatment" perspective. Several mental health consumers for the defence
testified to their own histories of mental illness and the negative and potentially catastrophic consequences of lack of insight into their need for treatment.

The present MHA survived the constitutional challenge brought by Mr. McCorkell and CLAS. Basing his decision on a previous and similar constitutional challenge in Manitoba, Mr. Justice Donald found that physical dangerousness was not the only criteria. Instead, he affirmed a broader criteria stating that committal could be authorised for "...harm that relate to the social, family, vocational or financial life of a patient as well as to the patient's physical condition". Furthermore, Mr. Justice Donald implicitly endorsed the view of organised psychiatry and its allies:

I reject the plaintiff's argument that because the mentally ill are innocent victims of disease they should have their liberty interfered with as little as possible. Culpability has nothing to do with the question. The extremes of the civil libertarian view have been painfully documented in the United States where one learned commentator observed that the authorities leave the mentally ill to "die with their rights on".

Reactions to the McCorkell case further reflected the polarisation that has developed around reform of mental health legislation. The British Columbia Schizophrenia Society (BCSS), the major organization representing parents and relatives of the mentally ill in the province, called the decision a "significant victory for our cause". BCSS contended that further litigation from CLAS and other patients' rights groups had to be expected and that an emergency litigation fund would be set up to respond to such
challenges. Bill Trott, a CLAS lawyer recently stated in an article entitled "Are you in or out? Only your doctor knows for sure", that the McCorkell decision continues to leave doubt about where the "bottom line" exists in decisions to commit people to hospital. Despite the failure of the CLAS action to have the court establish a "bottom line" on criteria for admission and detention, Mr. Trott cautioned that "...it cannot be presumed that this case provides authority to sweep the street and forcibly detain and treat people with mental illness". Further test cases designed to clarify and narrow committal criteria, (particularly in the event of a continuing absence of statutory mental health law reform), remain a distinct likelihood.

**Attempting statutory reform: the failure to restructure the Mental Health Act (MHA).**

The first evidence of a formal shift in the direction of legislative reform towards the new legalism occurred with the "Cumming Report" (Ministry of Health 1979). In order to facilitate the shift from institutional to community services, the report recommended that the MHA be subject to a complete overhaul. In particular, the survey team found that: "The grounds for certification are probably too broad for consonance with modern concepts of civil liberties" (p.111). The government declined, however, to undertake the considerable task of statutory reform of the MHA at that time, preferring instead to introduce reform through the mechanism of regulations pertaining to a fairer and more efficient administration of review panels (Gordon 1988).
Despite periodic amendments, the original Mental Health Act proclaimed in 1964 remains in effect today. It is generally recognised as a legal anachronism and the need for a reconstructed Act to reflect contemporary contingencies is generally accepted. In 1990 the government mandated a review of the Mental Health Act with a view of implementing statutory reform to rationalize and modernise the Act. The government was placed in a difficult position with relation to developing the new legislation. Undoubtedly, it would have been a relatively simple process to draft a new MHA which suited the government’s objectives and took into account, as far as possible, the competing views of stakeholders. The draft legislation could then have been modified based on community response. It can be conjectured that the government chose not to do this for two possible reasons. First, if the government was to implement a workable Act that facilitated its objectives of continued deinstitutionalisation and development of less costly alternative community resources, it was preferable to achieve a high degree of consensus amongst stakeholders. Secondly, the government was almost certainly aware of the divisive nature of many issues surrounding the balance between the provision of involuntary psychiatric treatment and protection of civil rights. Understandably, it wished to avoid an attack for being too permissive and "pro-rights" or conversely, being too authoritarian and denying the mentally ill basic civil rights and due process. The election, in 1992, of a new government ideologically oriented to citizen consultation further endorsed the consultation process
and restricted the role of government to that of "honest broker". The MHA review occurred in two stages, the first through the distribution of an Issues and Options paper, and the second through the striking of a Consultation Committee. The committee was comprised of representatives of all stakeholders, including consumers, health care providers, advocates, representatives of affected ministries, and individuals with expertise in mental health legislation. The Committee submitted a report in early 1992 which was subsequently circulated to stakeholders. In addition, a series of regional public meetings were held to elicit community feedback. Despite this considerable effort, the process was abandoned following the repeated failure of the various interests to reach and present a consensus position to government. Although the Ombudsman (1994) has recently "strongly urged" the Ministry of Health to show leadership and renew a process of consultation, no such intention has been announced by the government and the situation remains at an impasse.

The Mental Health Act Review consultation produced proposals that clearly reflected elements of the new legalism, particularly in regard to the substitution of discretionary power by psychiatric professionals for processes of independent administrative review. For instance, three scenarios were envisaged where a person may have legally refused treatment. So-called "capable treatment refusers" would be held for three days (during which time attempts would be made to persuade them to voluntarily accept treatment) before having their decision to refuse treatment adjudicated before
a Review Board. "Incapable treatment refusers" with advanced
treatment directives (such as Ulysses agreements\textsuperscript{19}), would have
their agreements adjudicated upon by a Riverview Board to determine
their validity. Treatment refusal by a "substitute decision maker"
(a representative appointed by the patient or possibly by the
courts) would result in an adjudication by a Review Board.\textsuperscript{20}
Despite the efforts of many individuals and agencies the
consultation process was unable to generate consensus, particularly
in relation to involuntary detention criteria and the right to
refuse treatment. To some extent this mirrors the experience of
other jurisdictions. Wherever right to refuse treatment proposals
have been proposed or implemented, controversy and polarisation
have followed (Gutheil 1986; Hermann 1990; Issac & Armat 1990).
Community reaction to the initial MHA Review Consultation Committee
report revealed a dichotomy of views. For instance, on the "pro-
treatment" side of the debate, critics saw that the proposed
criteria for assessing persons suffering mental or physical
deterioration for involuntary commitment were too restrictive and
that many people in need of treatment would not receive it. On the
"pro-rights" side of the debate critics saw the same criteria as
too permissive. Unfortunately, though perhaps understandably, the
media was rarely able to portray the complexities of the arguments.
For example, under the inflammatory headline of "Lunacy in New
Rights for Mental Patients", readers were advised to:

\begin{quote}
Just consider the possibility that scores of
mentally ill patients - homicidal, suicidal or
severely demented - could be abandoned by the
\end{quote}
system, left to make their own judgment calls, left to kill or die.\textsuperscript{21}

The collapse of the Mental Health Act Review consultation process and the entrenched polarisation of views that it reflected resulted in an impasse. The government has been silent up to the present time on plans to restart some form of consensus building exercise concerning the issues that stakeholders are unable to agree on. Understandably, the government does not wish to be seen to impose a "solution" by drafting new legislation itself. This impasse has led to a situation which Gordon (1993) describes as:

\textit{...the source of considerable internecine warfare primarily between organised psychiatry and allied groups such as Friends of Schizophrenics,\textsuperscript{22} and allied groups representing the "consumer" perspective. These two groups clash primarily because of their competing visions of what is in the patients' "best interests". Tragically, this frequently involves the use of a false dichotomy - care and treatment vs. rights and liberties.} (p. 42).

It is not a case, however, of a unified movement of mental health consumers pitched against organised psychiatry and other concerned agencies like family advocacy organisations. Bean (1986) offers a reminder that the potential for paternalistic assumptions exists on both sides of the debate. He states for instance:

\textit{We cannot assume, as some lawyers and others do, that all patients may welcome more rights....It remains an all-too-common fallacy to think that because I or others believe something to be good, and believe it to be good for people generally it will be accepted as such} (p.168).

Bean suggests that patients may not welcome more rights for a variety of reasons including indifference, beliefs that enhanced rights are wrong in principle, or fears they may interfere with the
psychiatrist-patient relationship. Qualitative interviews undertaken by the writer with four mental health consumer-activists (see Methodology, Chapter Three), suggest that beliefs on either side of the "rights vs treatment" divide are formed partially as a result of intense personal experience of mental illness and of the psychiatric system. The findings and discussion of these interviews will follow.

What Do Mental Health Consumer-Activists Believe About Persons With Mental Illness Refusing Treatment?

Data analysis.

Data transcribed from four interviews was condensed into five themes, which reflect a range of beliefs of mental health consumers about involuntary detention and the right to refuse treatment debate. These themes were:

1) Need for Treatment vs Need for Right to Refuse Treatment
2) Mental Illness as Distressing and Dangerous
3) Medical Model vs Alternative Explanations of Mental Illness
4) Positive vs Negative Experiences of the Mental Health System
5) Optimism vs Pessimism About Mental Health Reform.

Need for treatment vs need for right to refuse treatment

Respondents were asked initially "What is your position regarding the right to refuse treatment debate?" As discussed in Methodology (Chapter 3) the purpose of this question was to gauge the parameters of any polarisation that existed in consumers beliefs. Responses to this first question suggested a significant polarisation of views. Two respondents, Malcom and Ron, (all names
are pseudonyms), advocated positions strongly in support of involuntary commitment and treatment.

I guess my personal position would be that for me, if I were to get ill again to such an extent that I would require hospitalisation, I would rather be committed and treated against my will for a short period of time to get me well again. (Malcom).

I really am a strong advocate for committing people who are clearly mentally ill and need help and I don’t believe we need to wait until they are dangerous, I think the McCorkell case last July said, serious harms are sufficient and serious harms are the loss of your wife, your house, your reputation etc. (Ron).

Neither respondent believed a right to refuse treatment should be legislated except in very limited circumstances.

If you have a person who is suffering from schizophrenia and he’s had all the medications and he’s been in the system for, say, 15 or 20 years and nothing seems to be working for him, I think at some point you have to make a medical decision....if you’re committing a person when there doesn’t seem to be any apparent benefit, then is it really worth it to take away his freedom, unless he’s a danger to himself or others....but it should be from a humanitarian, not a rights point of view. (Ron).

A third respondent, Hannah, contended that the psychiatric system was oppressive to the point that, in practice, a right to refuse treatment did not exist for anyone, including voluntary patients.

I don’t think it [the right to refuse treatment] exists...the Mental Health Act right now, it says if you are a voluntary patient in hospital you can refuse treatment. If you’re involuntary you cannot refuse treatment. Its not even worth the trees that were grown for the paper to print that on...the trees were more valuable than that piece of paper. You don’t have a choice...you can legislate, you can use up all the forests in this country making big legislation, you make the decision to go to hospital and you cross that invisible line and you’re in the hospital...that’s all gone.
A fourth respondent, Garth, argued strongly that involuntary treatment was fundamentally misused under the doctrine of parens patriae to incarcerate people on the premise that they were potentially treatable.

What the system has done with involuntary treatment is use it as the first line of defence, rather than the last line of defence. When you involuntarily treat someone, when you incarcerate someone, then that needs to be a last resort scenario and not used in the guise of prevention. I think all too often, families and professionals tend to equate the kind of behaviour we would tolerate from mainstream society - say you get someone acting out on the street, say you got some punk on the street that’s spitting on the sidewalk, maybe hasn’t had a bath for a couple of days and looks dishevelled - we let them go. Yet when you start applying that same sort of behaviour to a mental health consumer, they start talking deterioration and they represent a danger to themselves...Like if someone doesn’t want to wash or if someone wants to beg on the streets, whether you consider them to be a social nuisance...there are a lot of nuisances walking out there free and we tolerate them. I don’t think that’s any reason to take someone off the street and treat them against their will..

Garth believed this misuse of parens patriae power was compounded by the sweeping nature of loss of rights under the M.H.A.

....the minute they invoke the Mental Health Act in terms of involuntary status, you cease to have rights as a citizen of this country. Now there’s something wrong with that because we don’t apply that to anyone else. When you take a look at it, people like Clifford Olsen have more rights, more human rights than people with mental illness do.

Hannah articulated the most "radical" position. She stated she saw no justification for involuntarily detaining or treating anyone. Garth was unequivocal that the use of police power, if a consumer was a danger to others, was justified. He continued, however, to question the way in which the system provided involuntary treatment
was therapeutic. Neither thought the doctrine of parens patriae was sufficient justification to deprive someone of their fundamental rights. For instance, Garth stated:

I still believe in my soul in the rights of the individual to call their own shots. There could be a case to be made about diminished capacity with Sue Rodriguez if you stretched it right? O.K., now if a consumer decides they’ve had enough of this system and they want to die because the pain has gotten too much for them, then why is that different to what Rodriguez did? She was physically dying, but I mean if someone is in the depths of despair and there are no resources available to them and the traditional mental health system has given up on them because they are difficult to handle or hard to house because of their psychotic episodes, then I have a problem with the criteria that focuses on them as a danger to themselves.

These positions reflected some significant polarisation, however it cannot be asserted that these positions represent a simple dichotomy. The parameters of the polarisation can be identified by Malcom and Ron’s "pro-treatment" views at one end, and Hannah’s belief that the system is oppressive at the other. Garth’s position was clearly inclined to a "pro-rights" orientation, however, he agreed there were limited circumstances where involuntary detention and treatment was warranted. All respondents clearly based their positions on personal experience. Malcom and Ron both stressed personal experience as the critical factor, whilst Garth and Hannah articulated their positions partially based on critiques of the system.

Mental illness as distressing and dangerous.

Mental illness itself appeared to be a major component of personal experience in shaping the positions of all four
respondents. Malcom and Ron repeatedly described the experience of mental illness as intensely distressing and dangerous. For example, Malcom stated:

It's pretty frightening to be in a state of psychosis and losing control, losing touch with reality, losing control of your behaviour and doing things impulsively...doing things that are so bizarre that you could injure yourself or injure others possibly, just being in that state of mental anguish for weeks or months is not a healthy thought for me, I wouldn't want to go through that again, I'd rather be locked up for two weeks....

Ron described his personal experience of mental illness as terrifying and devoid of freedom:

[Its]...a complete scramble of thought, complete delusional pattern, complete sense of paranoia, a total inability to read or concentrate or formulate any meaningful ideas...where is the freedom there? It isn't freedom, it's the biggest, most hopeless, deepest, darkest prison there is.

The potential for psychic, social, financial and physical catastrophe dominated the experience of mental illness for both Malcom and Ron. For instance, Ron described a number of negative financial and social consequences he had suffered himself, and which he had also witnessed occur to others through his consumer advocacy work. He stated:

Both of these conditions [depression and manic depression] are usually eminently treatable, and yet untreated the damage can be tremendous...loss of life and everything leading up to that - reputation, wife, house, money, job, friends, the whole works goes, and in the final scenario when people realize the extent of their losses, often they do kill themselves.

Malcom and Ron both emphasised the potential for injury or loss of life. Malcom stated:
I’ve been ill enough to the point where I’ve lost insight...I remember one time I was delusional thinking I could fly and if I had encountered a tall building with an open stairway I may have just climbed up and jumped off thinking I could do that, luckily I got treated before I could test that hypothesis.

Hannah and Garth also emphasised the intense suffering of mental illness. Hannah described the pain of chronic suicidal feelings:

I’ve been suicidal from the minute I’d open my eyes in the morning and the only thing I’d want to do was to go to sleep, to forget, to not have to participate. It was so painful for me.

Whilst both Malcom and Ron specifically volunteered having suffered major mental illnesses in traditional psychiatric diagnostic terms (schizophrenia and bipolar disorder respectively), Garth and Hannah identified the origins of their suffering, at least in part, in relation to wider social problems. For instance, Garth stated:

I don’t have a major mental illness, I was treated for psychosis and never had a psychotic episode in my life. I’m the victim of serious sexual and physical abuse when I was a child.

Although intense suffering was common to all respondents experience of mental illness, two distinctive differences were evident. Malcom and Ron emphasised repeatedly the potential for catastrophe that they believed timely intervention could prevent. The origin of their mental illness was perceived to be organic and largely unconnected to the social world. Hannah and Garth, on the other hand, understood the origins of their suffering to be principally located in the external world and forced upon them. Furthermore they did not make such an unequivocal connection between their experience of mental illness and the potential for
catastrophe. Rather they emphasised that (their perceptions of) the paternalistic and, at times, abusive responses by the system greatly exacerbated their problems and those of other mental health consumers.

Medical model vs alternative explanations of mental illness.

During the course of the interviews all respondents indicated some conception of mental illness as a theoretical construct. Significant differences were observed. Consistent with their "pro-treatment" orientation, Malcom and Ron articulated theoretical conceptions of major mental illness which were generally congruent with the traditional medical model; that mental illness has an organic etiology, it is characterised by loss of insight, and is most amenable to bio-medical intervention. For instance, Malcom emphasised his belief in the underlying organic nature of mental illness:

With mental illness I think your brain is impaired, your mind is affected by the actual illness and its impaired, your reasoning is impaired.

In sharp contrast Hannah rejected the notion of mental illness as illness entirely.

I disagree with the whole idea of mental illness....I have no belief at all in the medical model....with the biological model I always felt they would cut off my arms to make me fit the diagnosis.

When asked what function "mental illness" served, if it had not bio-medical basis, Hannah replied:

It's very convenient for a society to think that other people are crazy right....where do you put the misfits? Men who have dysfunctional lives end
up in jail, so the psychiatric system is a place for women....

The meaning of insight in mental illness.

Mental health professionals assert the phenomenon of "lack of insight" associated with major mental illness necessitates the imposition of involuntary treatment from a clinical perspective. Both Ron and Malcom's beliefs were congruent with this assertion.

But with mental illness it's clouded, the mind itself is clouded by the illness itself and people lose...insight and sometimes it takes forced treatment to get them thinking straight again. (Ron).

I know when I am ill, I lose all insight that I am ill and that I need help and that I need treatment. (Malcom).

Hannah and Garth, on the other hand, both rejected the clinical argument regarding insight and how it is used to justify involuntary treatment. They did not dismiss the concept of insight altogether, but rather offered different interpretations. Their view was that consumers invariably retain insight in terms of being aware of one's own suffering. Garth contended that many professionals misuse the concept to further their own agendas regarding treatment compliance. He argued that insight, for the mental health professional, principally means the consumer is willing, (i.e. has the insight) to comply with the treatment.

The whole argument about insight, you can debate that until...its like a psychiatrist will tell you there's no real pain associated with mental illness. Well let me tell you, when I was going through all those ECT [Electro-convulsive therapy] treatments and I tried to commit suicide 5 or 6 times before I was 18, what do you think I was going through? I had insight to know I didn't want to live on this planet anymore. I mean it might not
be the sort of positive insight that they would like you to have which means come in, get your injection, go yes sir, no sir, thank-you sir, and all that stuff, but who's to say psychiatrists are Gods?

These polarised views reflect the two major conceptions of mental illness in the literature. Malcom and Ron's beliefs about mental illness are congruent with the psychiatric paradigm. Hannah's beliefs are congruent with the sociological interpretation of mental illness as a labelling phenomena, which scapegoats people with problems in living. The literature reveals these conceptions are mutually exclusive and a major contributor to the development and enduring nature of the dichotomised debate.

Positive vs negative experiences of the mental health system.

The third major theme that emerged in the articulation of respondents' beliefs about the right to refuse treatment was the experience of the psychiatric system itself. This theme was comprised of two major elements: experience of intervention involving the psychiatric system, and experience of psychiatric treatment in terms of perceptions of administration and therapeutic efficacy.

Experience of psychiatric intervention.

Congruent with their beliefs that untreated mental illness was intensely traumatic and potentially catastrophic, Malcom and Ron perceived intervention by the psychiatric system to be positive. Malcom and Ron both pointed out that there are many unpleasant aspects to psychiatric treatment, particularly if it is against one's will. On balance, however, they emphasised that treatment,
even against one's will, was preferable to the suffering and dangers of non-treatment. The motives of friends and the system insisting on treatment were perceived, in retrospect, as supportive and humanitarian.

I'm glad that [hospitalisation] happened...and I was put into a ward that had restrictions...it wasn't locked but it was hard to get in and out of, there were nurses observing people coming and going and so forth, so it was a safe setting. I find that when I'm not well, and I've been hospitalised about 5 times in 20 years, that its nice to go to an environment where it feels safe and where the nurses are understanding and supportive, know you're not in touch with reality all the time and can give you some support. (Malcom).

I've been helped by my friends when I was full of denial and resistance and they simply took me to care and I'm very thankful they exerted this force over me...in one situation, it was in the middle of the night and I was phoning some of my rugby friends, and eventually some of them came over to my place. I was absolutely bizarre, I refused all sensible arguments to go to hospital, and so one of them was talking to me and the other one knocked me out...and they carried me in to the hospital and I'm very pleased for it, I mean it was a small price to pay, I could have been off the balcony that night, I could have had a heart attack in my high state of excitement. (Ron).

These generally positive views were in sharp contrast to the perceptions of Hannah and Garth. They perceived commitment and hospitalisation as frequently anti-therapeutic, not only because of the removal of civil rights, but also because mental health practice, in the involuntary context, inevitably infringes basic human rights.

Involuntary treatment should be something that goes beyond getting someone in a squad car in the back seat where they can't get out because they are caged there, and then you're shuffled off to the hospital and no-one advises you of your rights
because the minute they invoke the Mental Health Act...you cease to have rights as a citizen of this country.... (Garth).

When I was in hospital last time, they tied me up on this bed. I couldn’t believe it...All of a sudden I’m on this bed and I thought "My God, I’m in Central America" you know. Once I’d calmed down a little bit, I soon found a way out of the straps, I walked into the ward and made a grand gesture....and the shrink came back in and said "You know if you don’t behave yourself..." you know because I was disturbing the routine of the ward, ",..we’re going to have to restrain you". (Hannah).

These beliefs revealed a sharp dichotomy. Practices that removed all control from people were considered to be antithesis of a therapeutic response according to Hannah and Garth. For Malcom and Ron on the other hand, the means potentially justify the ends, i.e. the short term loss of autonomy for restoration of sanity and physical freedom.

**Experience of psychiatric treatment.**

Experiences of treatment, in terms of therapeutic efficacy and the manner of administration were also clearly dichotomised. Malcom and Ron saw traditional bio-medical psychiatric treatment as generally appropriate and efficacious. Both related stories that revealed considerable discomfort pertaining to psychiatric treatment, but they articulated an acceptance of the current limitations of things like psychopharmacology. For example, Malcom contended:

When someone’s in psychosis I think no amount of talk therapy is going to solve it, I think medication is the answer...luckily I’m one who responds to medication. I’ve had to work through the side effects for years...I don’t hold a grudge against the doctors...I think that’s just the nature of the beast, that’s where medication is
right now, its a bit of a hit and miss thing with medications. (Malcom).

I am very, very pro-treatment, we have modern medications that do work and to live in the past with the memory, say, of the heavy duty shock therapy of the sixties - which I did have - the modern ones are much more efficient and they don’t have the side effects, so let’s not scaremonger, let’s go with what the current situation is. (Ron).

This optimistic view of treatment stands in stark contrast to Hannah’s and Garth’s perceptions that all too often, psychiatric treatment controls people, but does not make them better.

The institutions pride themselves on fact they get people better. Institutions do not get people better, they maintain the status-quo. They keep people medicated, they keep people dysfunctional, they maintain them.... (Garth).

For Hannah and Garth, personal negative memories of previous treatments were not relegated to an unenlightened past. Their sense of injustice was compounded by the fact that the treatment they had received was frequently perceived to have been unwarranted and ineffective. This reflected a deeper view that the system rarely makes any effort to address the person’s underlying concerns. Garth related that:

From the time I was eleven until I was fifteen, I had ECT, thirty five treatments and I was a child, I was still legally a child, totally against my will and I remember the outrage I felt....They would strap me to the table and zap me and do whatever they wanted. I would ask questions and they would just pat me on the head and say well, this is the best thing for you.

I didn’t have any belief in the system then, I just felt instinctively it wasn’t good for me eh? So I would quit taking the medication, quit going to see the psychiatrist and then whenever later I would go back in and be drugged and everything else right? They believe if they just give me a pill that it
would just totally change my life you know, and if they give me a shock treatment its going to change my life...but how can it because they don't even know what I was going through because I was too terrified to tell them, because I figured if I told them, they'd whack me more right? (Hannah).

The experience of the psychiatric system appeared to be a significant factor in the development of respondents' beliefs. No respondent felt that intervention by the system or the traditional bio-medical interventions were unequivocally positive. Malcom and Ron's reservations about the system and treatment were always overshadowed, however, by their concerns about the effects of untreated mental illness. Garth, whilst having trenchant criticisms of how the system responds and the care it offers, did not totally reject the system. Of all the respondents, only Hannah perceived it as a completely illegitimate enterprise. A significant factor in seeking to account for why some respondents do not reject the system, despite negative experiences, was the establishment of positive, respectful relationships by professional caregivers with consumers. These relationships facilitated the sharing of information which was perceived to be very empowering:

I think I had a relationship with my doctor in that he could point out the shortcomings and say "Well I'm sorry but this is the state of the art now, the medication isn't clean, it has a lot of side-effects....so I guess my rapport with the doctor was important in my recovery, and some people don't have that, they may get a doctor that isn't willing to spend the time with them to explain those things or to answer their questions and they get turned off by it all. (Malcom).

I've got an exceptional physician and I just sort of think everyone has exceptional physicians and, you know, maybe if I was exposed to some of the
more average treatments, it would be difficult for me to be as pro-treatment. (Ron).

Garth believed he had been lucky in having relationships with caregivers that facilitated him getting information, but emphasised that this is not the case for many consumers.

I take medication....because I demanded to know what I was taking and I was lucky I had access to psychiatrists and psychologists that didn’t mind talking to me. There’s a reason why people resist treatment, they resist treatment not because as the psychiatrists say they are psychotic....most of the time its that they dread the fact they remember the last time, their last experience with side-effects and the fact they were locked up and incarcerated.

On the other hand, the absence of such relationships appeared to compound Hannah’s sense of alienation from the system. For Hannah, questioning was not only taboo but was dangerous.

So I asked the psychiatrist right.... and he said to me, if I asked any questions I would be in the hospital a long time.

The experience of the system and treatment appeared to be the most significant determinant in shaping respondents’ beliefs. For Malcom and Ron, the fear of the consequences of untreated mental illness dominated their perceptions. In addition, both perceived treatment as efficacious. Respectful, caring relationships with professional caregivers empowered them. Garth, despite his profoundly negative experiences of the system and treatment, also managed to access such relationships. This appeared significant for him in preventing the degree of alienation from the system articulated by Hannah.
Optimism vs Pessimism about Mental Health Reform.

All respondents were asked to consider in what ways, if any, the divisions that had become apparent amongst consumers and other stakeholders as a result of the failure of the MHA process may be resolved. This question caused all respondents to comment on the future and revealed a dichotomous split amongst those who felt optimistic about reform and those who felt the system was not serious about meaningful legislative or policy reform. Ron exuded optimism about the future of psychiatric treatment generally, and believed the system was changing in a positive way. Ron had strong beliefs about where the effective force for change was occurring.

It's changing right, and rather than the radicals shouting and screaming and charging the ramparts, I don't think they are really creating the change. I think change is being created by sensible television shows that talk about recovery, I think its about thoughtful newspaper articles, I think its by people who have recovered talking to Kiwanis or the Rotary Club....

Malcom also expressed his belief that the system was changing positively, although he felt that change would be understandably slow.

Consumers or survivors are starting to be heard by the people that decide policy, the government is listening....Things are happening that are more progressive, but it's going to take a while because, ingrained in the structure of the institution, it's been there for 80 years, is a "We know what's best for them" sort of attitude and that has to change in the staff and management and it's hard for someone who's been working with severely ill patients for 40 years to be suddenly told that the patient knows better than they do.

When asked about whether the polarisation between consumers' views can be reconciled, Malcom felt that it was unlikely, and believed
that the minority (as he perceived them to be), of pro-rights consumers would gain ground in the future.

....there's always going to be that split, there's some radical consumers, some moderates, some pro-treatment....I don't think that's going to change over time. In fact I think if anything, the pro-civil libertarian, the pro-right side, because its very vocal may get even stronger because as consumers are listened to, those who shout the loudest are listened to the most.

Garth's view of the future for the "pro-rights" lobby directly contradicted Malcom's belief. Garth had become increasingly suspicious about the government's original sincerity in reviewing the M.H.A and pessimistic about future legislative reform.

I don't think it's [legislated right to refuse treatment] is going to happen in this province, the latest word out of Victoria is...I mean the deck was stacked against us from the beginning, they never had any intention of reforming the Mental Health Act. We've been told informally now that "if you bitch about us holding onto the old one [the existing MHA], then what you're gonna get is an even more regressive one". So we're basically being told, informally, to keep our mouths shut and don't bitch about it.

The Deputy Minister is saying that "I don't want this to happen because its a pain in the ass and because you have opened up the process to too much scrutiny"....six months ago I would have told you I was much more optimistic about the government's role, but since the Ministry reshuffle, since Cull [Elizabeth Cull, the former Minister of Health] left, I'm not convinced we're on the same page anymore.

Garth was keen to stress that the right to refuse treatment represented only one issue of needed reform, but that he believed the erosion of professional power would continue to be resisted.

The psychiatric profession is a profession that likes the traditional relationship between the professional and the client, its that authority
thing....some people are resisting levelling the playing field. They don’t like it because it takes away power. It empowers consumers for a change, what you’re really doing is threatening people where they live....It’s still very much controlled by old dinosaurs like psychiatrists and by people used to having things done their way and not having to answer a lot of questions.

Hannah remained the respondent most alienated from the mainstream psychiatric system. In contrast to Malcom’s belief that "radicals" would progressively exert more influence, Hannah believed the psychiatric system was too powerful to even consider approaching to give up power in favour of consumers.

I mean its very, very powerful. Its like immigration is more powerful than the police right, psychiatry is more powerful than the police....Psychiatry is not gonna give up its power right? To me that’s stupid to even go after that....you don’t make frontal assaults on systems you know, because they’re just gonna pound you in the dust....I don’t see any hope, I mean they’re not going to change, why should they? (Hannah).

Discussion about the future exposed the greatest degree of polarisation amongst respondents. These responses were congruent with where each consumer considered him/herself to be in relation to the system. Malcom and Ron generally perceived themselves as aligned with a system that required reform and was making slow but significant progress in this regard. Garth, continued to perceive that change was possible, however, his political experience had made him suspicious of the ideological agendas of those opposed to genuine change. Hannah’s deep alienation from the system was dramatically illustrated in her belief that attempting to change the system was futile and potentially exposed her to punitive sanctions.
Emergent Themes and Implications

It is emphasised that this study is exploratory-descriptive, therefore implications and links between themes are tentative. Furthermore, the presentation format of the links between the themes is for purposes of explanation only. It is not implied that there is a linear development of consumers beliefs concerning the right to refuse treatment.

Emergent themes.

It appears that a dichotomy summarised as "rights" vs. "treatment" is reflected in respondents' beliefs. It is not, however, an absolute, oppositional dichotomy. Certain aspects of respondents' beliefs, such as their experience of the system or their vision of the future of mental health reform, reflect a greater degree of polarisation than other areas. The emergent themes appear to be linked as follows: The experience of mental illness + Conceptual belief about what mental illness is + The experience of the psychiatric system = The major determinants in the formulation of respondents beliefs about the right to refuse treatment.

A complex interaction of factors related to personal experience appears to determine how respondents' beliefs are developed and articulated. Emphasis appeared to be differentially placed on experience. "Pro-treatment" respondents emphasised the experience of mental illness as a major determinant in the development of their beliefs, whereas "pro-rights" respondents emphasised the (negative) experience of the psychiatric system
itself. Respondents' beliefs about the right to refuse treatment tend to one of two polarities, with some marginal overlap. On one side, "pro-treatment" respondents tended to support involuntary treatment and the medical model approach as the principal avenues through which to access treatment efficaciously. Conversely, "pro-rights" respondents expressed major criticisms of the psychiatric system, and advocated a "rights" approach to guard against misuses of psychiatric power. Respondents' beliefs revealed a sharp dichotomy with regard to the future of mental health reform generally, and mental health law reform specifically. Respondents with "pro-treatment" orientations were optimistic about ongoing reform of the system, but feared that more "radical" voices would exert an influence beyond their numbers due to the forceful way they present their case. Conversely, respondents with an orientation to "rights" currently feel somewhat pessimistic about reform, particularly in light of the breakdown of the MHA review process.

Implications.

Two related implications can be drawn from the interviews. The first relates to the possibilities for solving the current impasse by further attempts at generating consensus. Although respondents' beliefs generally reflected the epistemological medical/legal divide in the literature, supporting rights or involuntary treatment, they were developed from intense lived experience. The failure of the MHA review process to generate consensus is perhaps more understandable in light of the depth of
feeling that exists on each side of the dichotomy. Clearly, any further attempt to generate consensus about a new MHA that provides for blanket provisions concerning involuntary detention and treatment, is going to be extremely difficult. This raises a second implication. Is it time to consider ways of reducing the elements of the legislation to a bare minima as they relate to compulsion? Undoubtedly, this would be a difficult task, replete with definitional problems about what constitutes "bottom line" criteria for compulsion. Mental health consumers who feel alienated and embittered toward mainstream psychiatry may only be persuaded to accept the necessity of compulsion, however, if a concerted effort is made to consider individually expressed wishes regarding detention and treatment. Similarly, consumers who feel enhanced rights may be potentially personally catastrophic, may only accept their legitimacy if their own rights to treatment, including involuntary treatment if necessary, are protected. Advanced treatment directives (such as Ulysses agreements), written while the person is well, could potentially serve both groups. This would require, however, the adoption of writing and regular revision of such agreements with clients into mainstream mental health practice, as well as their recognition in law. Although innovations such as Ulysses agreements are no panacea to the difficult problems reflected in the interviews, they may go some way to settling the understandable anxieties about future mental health legislation that has been generated on both sides of the dichotomy.
Limitations and strengths of the study.

As discussed in Methodology (Chapter Three), theoretical saturation was not achieved. The construction of the interview guide sought to elicit personal beliefs and experience. It became clear during the study that the respondents had well constructed political analyses of the issues surrounding dichotomy between "rights" and "treatment". A future study that took notice of this point would likely elicit insights into the political nature of the issues. The strength of the study was that it revealed well developed insights into how the personal and political nature of beliefs about involuntary detention and treatment. The utilisation of qualitative in-person interviews was a sensitive measurement tool that facilitated respondents to link personal experience with broader, political analyses. Furthermore, qualitative interviews were a respectful, sensitive methodological approach to utilize with a group that has been traditionally subject to overt paternalism.

In summary, this chapter has argued that the process of deinstitutionalization and non-institutionalisation has been paralleled by an incremental shift in the orientation of provincial mental health law towards the principles of the "new legalism". The emergence of the new legalism signifies a dramatic shift, within a relatively short span of time, of societal attitudes to psychiatry:

How quickly fortunes change. In the late 1960's and early 1970's psychiatry promised everything - whether it be through insights gained by psychotherapy or by technical achievements through
the pharmacological revolution. Psychiatrists were given the power to transmit these promises into action. Now things are different. Psychiatrists must forever justify themselves and are forced to give reasons for their decisions, whether they be for admissions, types of treatment, or continued detention (Bean 1986, p.168).

A number of forces account for this shift in the balance between medical discretion and autonomy and legal restrictions. These forces include the emergence of patients' rights/mental health consumer organisations as an increasingly politically significant constituency. In addition, a loose coalition of patients' rights groups, legal aid lawyers, and civil libertarians have sought to challenge mental health decisions in behalf of individuals, while at the same time seeking to clarify the law and move it towards an increased emphasis on legal safeguards and rights. The impact of the Charter has been particularly significant in this regard, although it's long term ability to refine mental health law in relation to patients' rights remains, at present, unclear.

Overarching these considerations, the government has been able to successfully utilize the shift toward the new legalism to reduce medical domination and autonomy, particularly in regard to the control and utilisation of institutional resources. In response to pressures to modernise the provincial MHA, and in order to further facilitate it's objectives in reactivating and completing deinstitutionalization, the government instituted a process to reconstruct the Act. The government attempted to achieve this through a lengthy and difficult consultation process with all stakeholders. This process brought to the surface polarised views
regarding the balance between treatment and social control of persons with mental illness, and safeguards to protect fundamental human rights and freedoms. Consequently, the current position in B.C. is one of impasse in relation to statutory legislative reform. Four qualitative interviews tentatively suggest that polarised views may develop from profound personal experience of mental illness and the mental health system.
CHAPTER NINE

FINDINGS AND IMPLICATIONS FOR SOCIAL POLICY AND SOCIAL WORK

The final chapter will summarize the findings of the study, and will discuss implications for social policy and social work. Findings will be presented as they relate to the connections between the asylum, the role of the psychiatric profession, and mental health law reform. Suggestions for further research are briefly outlined.

Findings of the Study

The rise and decline of the asylum.

Two images from different centuries stand in counterpoint to each other; the nineteenth century asylum inmate languishing for years in the inhumane, regimented conditions of the warehouse institution, and the late twentieth century plight of the homeless person with a serious mental illness, whose sole possession is physical freedom. These two extreme, contrasting, images derive from a mental health discourse whose parameters have been largely dominated, in both centuries, by the consequences of the asylum.

The major historical changes in the strategy of managing the mentally disordered - the rapid rise of the asylum in the nineteenth century, and its discontinuous decline, combined with the development of alternative services in the twentieth - have been principally initiated by structural forces. As such, these
changes have had, to borrow Rothman's (1980) felicitous phrase, less to do with conscience than convenience. The antecedent to the rise of the asylum and the medicalization of mental disorder, was a philosophical reconceptualisation of human nature during the period of the Enlightenment. During this time insanity ceased to be considered synonymous with a loss of humanity. It was thought that the restoration of reason, the defining marker of sanity, became possible with appropriate treatment. The astonishing rapidity of an institutional response to insanity on two continents was initiated principally in response to the profound pressures that nineteenth century societies found themselves subject to. Chief amongst these was the emergence of industrialisation and the development of a market economy. The support of unproductive family members became increasingly difficult in societies progressively characterised by geographic mobility and division of labour. New social control objectives arose that were derived directly from the needs of the emergent capitalist state. The asylum, along with the penitentiary and the workhouse, provided a triumvirate of ideal social control mechanisms. Qualities valued by the new order, namely, adaptation to routine, self-discipline, and obedience could be inculcated. Confining cognitively disorganized, behaviourally troublesome, and economically non-productive citizens to the asylum was found to be cost efficient, despite the high initial capital outlay.

Similarly, the convergence of the crisis caused by a burgeoning institutional population, and the fortuitous emergence
of new social control methods, facilitated a historic reversal in the management of the mentally ill in the post-war period of the twentieth century. Remorseless annual increases in the institutional population combined with increasing costs of institutional care to produce a crisis of legitimation for the State, at both the federal and provincial levels of government. As asylum care ceased to make fiscal and political sense, the emergence of the anti-psychiatry critique made large scale asylum care increasingly ideologically indefensible. At the same time, the crucial structural development of the Keynesian welfare state, and to some extent, the discovery of neuroleptic medications, facilitated the support and supervision of a large proportion of the mentally ill population in non-institutional settings.

The endurance of the custodial asylum is testament to the constraints on the ability of reformers of both centuries to develop viable alternatives to institutional care. This is due, in part, to the hegemonic nature of both the concept and the edifice. Once asylum networks were established at considerable capital cost, alternatives became conceptually, and certainly materially unthinkable. In addition, asylums worked to the extent that they were efficient mechanisms of social control. Forces, such as the mental hygiene movement, which attempted to reorient the focus of psychiatric care away from an institutional basis, were undermined, principally by an inability to provide effective social control outside of the institution. Nineteenth century society was clearly cognizant of abuses within asylum walls. As has been shown,
however, the nineteenth century impulse was to reform through increased regulation and supervision, while leaving intact the integrity of the overall asylum concept and system. The twentieth century impulse has also been to reform, and isolated attempts to advocate radical change, such as Richard Foulkes' call to demolish Riverview hospital as a "ceremonial salute to the beginning of the end of barbarism" have been met with little more than incredulity.

It is evident that economic imperatives have been a principal factor for the initiation of strategies to change the management of the mentally disordered. What is also apparent, is that when initiatives like deinstitutionalisation are put in train, the long term nature of the ensuing process makes the evolution of the initiative subject to changing economic contingencies. To this extent, the outcome and consequences of long term strategies are not entirely predictable when they are initiated. The process of deinstitutionalisation has not unfolded smoothly, but has rather evolved in three phases in British Columbia. The policy of accelerated deinstitutionalisation during the 1960’s and 70’s was slowed in the late 1970’s and then largely halted during the first half of the 1980’s. This occurred as a consequence of federal and provincial neo-conservative measures introduced in response to the fiscal crisis of the State, and the economic recession in the 1980’s. The current, reinvigorated push for the completion of deinstitutionalisation and the redevelopment of tertiary services
is driven by a number of forces, the chief of which continues to be the search for cost-containment.

The influence of the psychiatric profession.

The psychiatric profession's overall dominance of the mental health domain has been closely connected to the asylum as the principle site of treatment. The struggle for the capture of the nineteenth century market regarding the provision of administrative and treatment services to the insane was vigorously contested by the nascent psychiatric profession, despite an unenviable public reputation and serious deficiencies in it's knowledge base. It was shown, however, that the profession's eventual success was as much due to the need for efficient institutional administrators than it was to any credible claims of therapeutic success in treating mental disorder. Claims to the scientific basis of psychiatry have continued to be a point of vulnerability. In particular, continuing doubts about inter-clinician diagnostic reliability, and the inability of psychiatry to accurately predict behaviour, particularly dangerousness, continue to give opponents a standpoint from which to legitimately question psychiatric decisions. The progressive medicalization of insanity in the nineteenth century was facilitated by four factors, all of which continue, to a greater and lesser extent, to protect the profession's dominance today. These factors were the lack of a sustained, effective, theoretical and clinical challenge of alternatives to medicalization, secondly the nascent medical profession's ability to subsume challengers into it's own gaze of authority and
knowledge base, thirdly the association with mainstream medicine (even though it was and remains tenuous), and fourthly, the humanitarian justification that medicalization gave the social control aspect of the institutional response. For instance, neither moral treatment in the nineteenth century, nor mental hygiene in the twentieth, were able to offer effective treatment services that could be implemented on a large scale basis for serious mental disturbance. Psychiatric knowledge and practice has, however, been periodically subject to vigorous attack. The anti-psychiatry critique has been particularly effective in this regard. The critique did much to erode psychiatric hegemony and the increasing trend toward medical discretion which had developed through the twentieth century, prior to the advent of the new legalism. Anti-psychiatric critiques have been essentially reactive and negative, however, effectively pointing out faults and problems but offering little that is therapeutically constructive. Szasz’s contractual psychiatry is available for those willing to pay, and R. D. Laing’s experiments at Kingsley Hall with patients with schizophrenia have been discredited. Even Erving Goffman’s trenchant critique of the total institution contained the admission that he knew of no alternative to the asylum, and that if it did not exist, society would have to invent something like it. Mental disorder is therefore largely accepted as an illness today. Those who deny the concept of mental illness totally are in a minority. Controversy and uncertainty continue to exist in abundance however, concerning the extent to which the course of mental illness is
sensitive to, and perhaps even determined by, social forces. The current, so-called "biological" revolution, particularly as it relates to genetic research and "new" pharmacological agents such as Clozapine, is likely to reinforce the theoretical dominance of psychiatry although, as has been suggested, sustained success has not always correlated with the initial optimism and enthusiasm that has invariably accompanied therapeutic innovations.

In spite of continued epistemological dominance, the administrative authority and policy influence of the psychiatric profession has diminished over the last twenty five years. This is most clearly manifested in community mental health centres, the majority of which are now operationally administered by non-medical professionals. These personnel are primarily social workers, but also include psychologists and nurses. The principal reason for the erosion of authority by psychiatrists in public mental health is related to the loss of the institutional power base of the asylum. Not only has the asylum diminished in importance due to its progressive reduction in size, but it has also lost its position as the central focus of mental health service provision. A discussion of the relationship between the influence of the psychiatric profession and changing periods of mental health law reform will follow in the next section.

Mental health law reform.

This study has shown that mental health law reform is instigated by two factors. Principally, mental health law reform is initiated to facilitate major changes in the management of the
mentally disordered. Permissive commitment laws that contained an inherent bias against the poor and destitute facilitated the large scale incarceration of the pauper insane in the second half of the nineteenth century. Conversely, restrictions on medical autonomy to commit and continue detention of mentally ill persons have proven an effective way to contain the cost and size of institutional asylum services in the late twentieth century. Secondly, there is evidence to suggest that mental health reform is also initiated by the State in response to changing community attitudes toward mental disorder and the nature of psychiatric services.

Three major overlapping phases of mental health law reform were identified in the study. The first phase, "legalism", developed in response to growing concerns about the nature of asylum care in the United Kingdom in the late nineteenth century. The 1890 Lunacy Act in Britain, the epitomy of legalism, was influential in the drafting of similar legislation in Canadian provinces, including British Columbia. The intent of legalism was not to disturb the provision or nature of asylum care but rather to protect the sane from unwarranted detention. The second phase of reform involved the progressive removal of restrictions on medical discretion and autonomy in terms of compulsory and voluntary admission. This gradual shift away from legalism toward medical discretion began in the 1920’s and culminated with the passing of the Mental Health Act in 1964. The third phase of reform, which is continuing at this time, has involved a progressive reintroduction
of contemporary restrictions on medical autonomy and discretion which have been characterised as the "new legalism". With the benefit of a longitudinal perspective, these developments reveal that the power and influence of the psychiatric profession in the mental health discourse has been relative to the extent that the profession's objectives have synchronised with those of the State. For instance, the psychiatric profession was able to influence both the federal and provincial components of the State through a series of reports in the late 1950's and 1960's. The psychiatric profession's claims for unequivocal dominance and broad autonomy in the mental health domain, increased integration with mainstream medicine, and the removal of the last remnants of legalism, were all unopposed by the State which was anxious to entrench the strategy of deinstitutionalisation. The State was therefore prepared to harness the position and dominance of the psychiatric profession to facilitate the accelerated implementation of deinstitutionalisation. The State has also shown, however, that it is prepared to reverse the gains of the profession (or any other professional group) in order to achieve its long term objectives. Various legislative provisions and regulations pertaining to compulsory admission, continued detention, and treatment have specifically restricted the autonomy granted to psychiatrists in their gatekeeping and other functions. By restricting the autonomy of psychiatrists to commit and continue to detain persons with mental illness, the State has effectively been able to first limit admissions, and then facilitate the reduction of costly
institutional services. This strategy has provided the provincial government with an inherent justification for promoting civil rights thereby avoiding possible charges of unjustified cost-cutting, or the inadequate provision of replacement services.

The State is sensitive to prevailing community demands and attitudes. Segall, Tefft and Trute (1991) state that "Laws are codified expressions of community attitudes and values dominant in a particular socio-historical context" (p.11). From this point of view it is contended that community attitudes, as reflected in mental health law, follow the movement of a pendulum, moving from pressures to grant the psychiatric profession liberal powers to efficiently mediate the social control of the mentally disordered, to demands that the powers of psychiatrists be restrained. The impetus for movement in a given direction is provided by changing community attitudes toward mental illness and psychiatry. In turn, these attitudes are formed as a result of community perceptions of psychiatric practice at different times. Community attitudes are (obviously) not reflected immediately in mental health legislation. Therefore the consequences of psychiatric practice at a particular historical juncture, in terms of community reaction, may be manifested at a later juncture, in changes to mental health legislation. For instance, in the nineteenth century, the large scale incarceration of the mentally disordered into asylums which invariably degenerated into warehouses of human misery, gave asylum care and those responsible for it, an unenviable reputation. Public suspicion of lax commitment practices, fuelled by periodic
"lunacy panics" and stories of illegal incarceration, led to legislative reform characterised as "legalism". The express purpose of legalism was to respond to community fear and protect the sane from unwarranted committal. In the late 1950's and 1960's, the push by the medical profession was for integration with general medicine and a diminution of the differences between the physically and mentally ill, which had for so long stigmatized the psychiatric patient (and the psychiatric profession according to the Tyhurst Report). The physician-patient relationship inherent to the medical model was, according to the psychiatric profession, to predominate. A crucial difference remained, however, between general and psychiatric illness. This was that the psychiatric patient, particularly when involuntarily detained, was presumed to be incompetent and incapable of making decisions, including those concerning consent to treatment. The resulting pervasive paternalism reflected in the 1964 Mental Health Act was not compatible with changing community attitudes which were already extending claims for civil rights to new constituencies. The subsequent reaction produced demands for reform, some of which have been manifested in the principles of the new legalism.

If the "downsizing" of Riverview hospital is not matched by adequate replacement services, including housing, the visibility of acutely disturbed mentally ill persons, many of whom may be homeless will increase. Should this occur, community tolerance may be exceeded (there is already some evidence that such tolerance is brittle). Pressures may then be created for increased social
control and the State may be compelled to erode patients' rights gained under the new legalism, as a drift back to medical autonomy and discretion is put in train with regard to commitment and enforced treatment.

Mental health law and the current dichotomy of rights vs treatment.

As has been shown, the process of deinstitutionalisation was paralleled by a shift in attitudes toward a mental health legislative orientation that embraced principles of the "new legalism". Given ideological momentum by the anti-psychiatry critique, patients' rights groups and civil libertarian lawyers have sought to incrementally reform the operation of the current mental health legislation in the direction of patients' rights. Mechanisms to achieve this objective have included individual court challenges to psychiatric decisions, Charter challenges to the constitutionality of mental health law, and Review Panel mechanisms. These reformist objectives have not been met with opposition by government as they have been generally congruent with current government objectives to complete the "downsizing" of Riverview hospital and to provide cost efficient services on a non-institutional basis wherever possible, or where it is not, to limit the length of institutional stays. It is likely, however, that the State, while ideologically supportive of enhanced patients' rights, will be able, through the mechanism of funding and sponsoring mental health consumer activities, to control consumer demands in the future if they exceed the government's tolerance for change, or
if they diverge significantly from State objectives. The provincial government, in seeking to construct a modernised MHA, employed the strategy of a lengthy consultation process with and amongst stakeholders in order to achieve a consensus position on the major provisions to be included in the MHA. This tactic held two significant advantages. The government remained ideologically congruent with regard to its commitment to consult with citizens and, more importantly, by not imposing a solution it avoided accusations of being too permissive with regard to rights, or too oppressive with regard to involuntary detention and treatment. It is unfortunate that the inability of stakeholders to reach a consensus position, despite much effort, brought the review process to an impasse. What this impasse has done is to reveal, in a tangible way, the latest manifestation of the enduring, underlying tension between law and psychiatry. Additionally, the unintended consequence of the consultation process has been to erode the middle ground by compelling stakeholders to adopt polarised positions in order to respond to the opposing views of the other. This study shows that the polarisation is more than a simple "collision of perspectives" by two powerful professions, both claiming to represent the best interests of the patient. Interviews with four mental health consumer-activists provided tentative evidence to suggest that the dichotomy dividing adherents of pro-rights and pro-treatment positions is complex, and not simply a case of a unity of mental health consumers against organised psychiatry, families and others. Beliefs about
involuntary detention and treatment were shown to be formed, in part, as a result of intense personal experience. Consequently, the discourse exists on more than a theoretical or intellectual plane. The qualitative interviews suggest claims for both rights and treatment, even on an involuntary basis, have inherent legitimacy. Arguing, therefore, that one should prevail at the expense of the other, suggests the dichotomy between rights and treatment is essentially false.

It will not be a simple matter to resolve the dichotomy, as it is presently constructed. If further attempts at reconciliation prove to be fruitless, how are decisions to be made with regard to the balance between rights and compulsory detention and treatment? These issues will be discussed in the implications of the study for social work and social policy.

Implications of the Study for Social Policy

The simple emptying of traditional asylum edifices cannot eradicate the historical legacy of oppression and control that has unfortunately done much to make fear and stigma synonymous with mental illness. Neither will it mean the need for "asylum", in the sense of periodic and perhaps ongoing sanctuary, will cease to exist for a minority of the most seriously and persistently mentally ill patients. Rather the questions for social policy are what should be the nature and meaning of asylum, for whom and where should it be provided, and for how long? How should it be connected and integrated with other services, and should there be differing forms of asylum for different populations? The asylum
continues to be extraordinarily difficult to dismantle. The "downsizing" process has to be completed but managed in such a way that it is not allowed to degenerate into an inhumane cost-cutting exercise, where disabled patients are either literally cast onto the street, or given over to an insufficiently regulated for-profit private system, as has been alleged in many jurisdictions in North America (Issac and Armat 1990; Scull 1981; 1984). There are enormous complexities in redeveloping tertiary psychiatric services with relation to size, location, clinical focus, appropriate client population, and integration with other services. What is clear is that, in order to establish a symbolic and literal distance from a traditional asylum legacy that stretches back to the nineteenth century, tertiary services of the twenty first century must reposition themselves. To do this, tertiary psychiatric care must develop specialised clinical foci, must be closely integrated with other hospital and community services, and must occupy one position on a continuum, rather than standing as an isolated, central focus of mental health care.

The limitations of the new legalism.

The limitations of the ability of the new legalism to produce progressive change in mental health social policy and services needs to be acknowledged. An over-reliance on the promotion of rights will not necessarily improve the quality or range of psychiatric treatment, it certainly cannot provide redress for the injustices of the past, and it cannot satisfy the significant needs of the mentally ill that exist in addition to freedom from
unwarranted or unwanted compulsory detention and treatment. The major effects of the new legalism have been to narrow the criteria for committal, and ensure that continued detention is not imposed without quasi-judicial review. The new legalism has not been manifested as a right to refuse treatment in British Columbia at this point in time, though this has been achieved in some other North American jurisdictions, particularly in many parts of the United States. The impact of the new legalism has been largely reactive, imposing restrictions on psychiatric power. There is no evidence to suggest that the new legalism has proven an effective strategy for ensuring the effective provision of mental health services, as Larry Gostin argued it should (Gostin 1983). Nevertheless, the new legalism has played an important role in advancing patients' rights. Expectations of the new legalism to induce progressive change, must be tempered, however, with an awareness that the pursuit of rights is only one avenue by which to advance the overall well-being of persons with mental illness, as Sedgewick (1982) points out:

> If the resources of court action really did represent the high road of hope for the average institutionalised psychiatric patient, one might imagine that the United States would by now possess the finest mental health system that legal and libertarian reason could invent (p.216).

That it manifestly does not, reflects, in part, Sedgewick's assertion that "law is, at best, a crude instrument for promoting social policy" (p.281).
Deconstructing the dichotomy of rights vs treatment.

This study has shown that the construction of the current dichotomy, whereby rights and treatment are viewed as antagonistic and possibly mutually exclusive, is a major block to progressive legislative change. What is urgently required is a deconstruction of the current dichotomy. This assertion rests on the premise that the concepts and language of law and psychiatry have reached the limits of their utility to move the debate forward. Indeed, continued debate within a discourse defined predominantly by the concepts and language of psychiatry and law is likely to merely reinforce the positions of those on either side of the dichotomy, thereby constraining the ability of stakeholders to hear the legitimate aspirations and demands of others, and in turn, to be heard. Other, non-pathologising and non-legal language and ways of considering the issues need to be integrated into the discourse. The aim of a broadened discourse would not necessarily be in the expectation of producing new, concrete solutions, but rather to impact on the process of reaching a compromise, without requiring consensus. To achieve this objective, a more flexible, less defensive view of each side of the dichotomy is required, so stakeholders can begin to consider ways to ensure essential elements of their agenda are accommodated without having to marginalise the demands of others. Jonsen and Butler (1975) contend there is a role for the integration of public ethics into the policy making process in order to assist in the elucidation of policy options. They advise that ethicists, who usually have no
particular constituency, can help discern in the problem, or the debate around the problem, the moral principles around which policy discussion occurs. Once a ranked order of moral options for policy choices is developed, it is possible to demonstrate to policy makers (and presumably others) what different policy options look like, and what the respective "trade-offs" to each option will be.

One example of how ethical and moral perspectives have broadened a discourse and informed social policy is found in the field of general health. This field has witnessed a relatively recent mainstream acceptance and inclusion of a burgeoning bioethical literature and debate. The emergent importance of bioethical perspectives has contributed to a vigorous and fluid philosophical and legal debate, as well as focusing attention on specific social policy dilemmas, such as the use of new biomedical technology and euthanasia. The widespread publicity given to individual stories, such as Sue Rodriguez's challenge of the constitutionality of the prohibition of physician-assisted suicide, has increased public awareness of the profoundly human nature of the key social policy dilemmas. The increased attention given to ethical and moral considerations has moved the discourse and relevant social policy forward, in a way that a singular reliance on clinical medical and legal aspects of the issues cannot be expected to do. Practical developments, such as the increasing use of advanced treatment directives related to death and dying, have been derived from this broadened discourse (King 1991).
Implications of the Study for Social Work

Social work, as a profession, has a valuable contribution to make both in a broadened discourse and in moving towards resolution of the social policy dilemmas outlined in this study. The real value of this contribution will only be manifested if it meets two general criteria. First, it must be perceived as logically and coherently derived from fundamental social work values and ideology, and secondly, it must be independent of the hegemony of the psychiatric and legal models that underpin the current dichotomy. Social work espouses values based on humanitarianism, egalitarianism, self determination, acceptance of difference, and the promotion of social justice (Mullaly 1993). In practice, social workers aim to promote the autonomy, dignity, and right to self determination of individuals and groups (Hepworth & Larson 1990; Mullaly 1993). Furthermore, social work aims to legitimately intervene at multiple levels of society from policy development to individual casework. This broad focus of intervention derives from the social work perspective that capitalist societies produce multiple contradictions that give rise to structural inequities that cause, or exacerbate, private troubles.

Regardless of where social workers practice, or at what level of intervention, cardinal social work values direct social workers to advocate for those who suffer disadvantage, vulnerability, and lack of power. Social work values indicate, therefore, that the social work profession should support those elements of the new legalism that offer protection against detention and treatment
based solely on clinical discretion in the context of a grossly inequitable power relationship. Two caveats, derived from the findings of this study, are advanced. First, while generally supporting legislative change based on the new legalism, the social work profession should monitor the progression of mental health law reform. As this study has shown, mental health law reform is unlikely to remain static. The social work profession needs to actively voice opposition to a drift to either end of the spectrum of mental health law reform; a return to the unreconstructed legalism of the late nineteenth century, or a return to broad powers of committal and detention without external avenues of appeal. Secondly, the social work profession must not support legislative change based on the new legalism, if rights to legal protection are imposed at the expense of rights to treatment, including on an involuntary basis. Social workers should therefore support legislative innovations that accommodate both rights and treatment.

The complex issue of competency to consent to, or refuse, treatment illustrates how social work can and should respond in a way congruent with the values outlined above. Currently, as has been shown, a person involuntarily detained under the provisions of the MHA is presumed to be legally incompetent to consent to, or refuse, treatment. There is a widespread, though not unanimous agreement that some involuntarily detained persons may be competent to give or withhold consent to treatment. Conversely, some patients voluntarily admitted, may be incompetent though are not
automatically legally presumed to be so. Valentine, Waring and Guiffrida (1992) point out that people who both deny they have a mental illness and those that acknowledge it "...may, nevertheless, have valid reasons for disagreeing with their physician's treatment recommendations" (p.21). No formal avenue of appeal or review mechanism currently exists in British Columbia for the patient upon whom treatment is imposed without his or her consent. This inevitably gives rise to considerable insecurity for some people and may actively be a factor that leads persons with mental illness to avoid seeking treatment within the mainstream mental health system.

Cardinal social work values assist the social worker to constructively confront this problem at both the policy and practice level, and in a manner that does not automatically become entangled in the dichotomy of rights vs treatment. Congruent with the social work value that maximum self determination is desirable in itself, including when there is doubt or dispute about the competency of the individual, the social work profession can and should vigorously argue for the establishment of external review mechanisms of all enforced treatment decisions. Arguments against the implementation of such an innovation, such as the potential deleterious effect of procedural delays, should be countered with the assertion that such procedural difficulties are the responsibility of the system to solve. Social workers must assert that such arguments cannot be allowed to negate the practical as well as symbolic fairness of ensuring patients have an avenue to
express their perspective. Furthermore, the social work profession should advocate that, to ensure credibility, mechanisms for review should be funded and operated independently from the psychiatric establishment. The social work profession also needs to argue coherently for flexible mental health and/or guardianship legislation that embraces, wherever possible, individual preference and avoids blanket provisions. Advanced treatment directives, such as Ulysses agreements, are promising in this regard, particularly as they can encompass "negative" preferences (for instance, not to be given certain forms of treatment), and "positive" requests (for instance, the request to be involuntarily detained and treated against the person's will if substitute decision makers and/or professional caregivers judge the individual to have lost insight). Social workers need to actively support efforts to give such agreements legal recognition in mental health and/or guardianship legislation. In the workplace social workers can encourage discussion and organize education about the utility and current limitations of advanced treatment directives. At the level of practice, social workers need to acquaint themselves with the formulation of advanced treatment directives, and actively inform their clients of how they can be used to ensure their wishes and preferences are respected when, and if, they should be actively unwell in the future.
Suggestions for Further Research

Three broad suggestions for further research are made.

With regard to future tertiary psychiatric services, research is needed to inform policy-making decisions in three areas. Questions in these areas include: (i) who are the future demographic and clinical population(s) that will require tertiary services?, (ii) what specialised clinical foci need to be developed to best meet the needs of these populations?, and (iii) how can post-downsizing tertiary services can most efficiently be integrated into a continuum of mental health services? A mix of empirical and qualitative research is required that can elicit data concerning the perceived needs of mental health consumers and their families, the perceived needs of governmental and non-governmental care providers, as well as other legitimate stakeholders (e.g., general health services, police etc.).

Secondly, there is a need for comparative studies of other Canadian jurisdictions which have introduced mental health legislation based on the principles of the new legalism. Research that can determine the extent to which the dichotomy of rights vs treatment has been exacerbated or assuaged by new legislation, would be useful in developing social policy in British Columbia. Specifically, this will require data on the outcomes for mental health consumers and professional service systems. Have they been able to access/deliver treatment and advocacy services efficaciously? What clinical/legal/procedural problems have been encountered concerning mental health consumers seeking review of
psychiatric decisions to impose detention and treatment? Have some consumers been legally detained under Mental Health Act provisions, yet been found competent to refuse treatment? If so, how many consumers have been detained without treatment, and how are such situations usually resolved? Comparative studies would also be useful to examine the impact of new, non-institutional social control methods, such as in Ontario, where controversial proposals have been made to introduce compulsory community treatment orders.

Thirdly, further macro-sociological analysis will be required to track and assess the consequences of changing social control strategies. A number of broad research questions arise in this regard. As the availability and utility of the tertiary institution declines as an instrument of social control for all but the most seriously disturbed and disabled, how will social control be mediated in the future? Will the current trajectory of mental health law reform in the direction of the new legalism continue, or will it be eroded with demands for an increase in psychiatric power to detain and treat people with mental illness against their will? What will be the effect of continuing demands for cost-containment and possibly a reintroduction of restraint in the future?

Conclusion

In conclusion, the suffering caused by mental illness is profound, both for those who experience it, and for those who witness its effects in their loved ones. Responding with compassion and justice to the conundrum of mental illness represents an ongoing challenge of enormous complexity. The legacy
of the nineteenth century response continues, remarkably, to exert a residual impact on the contemporary problems faced today. Reformers and professional caregivers of the past have faced enormous constraints and often appalling conditions. For the first time, a new dimension has been introduced into the mental health discourse. The voices of mental health consumers, and those of their families, are being heard. This new, previously unparalleled development may offer the best hope for the development of just, equitable psychiatric services in the twenty first century, where treatment and rights are synonymous.
CHAPTER THREE

1. The State, or political society, is defined as the instruments of overt social control (the police and military) together with state funded bureaucracies such as the public service, judicial, welfare, and educational institutions as well as federal and provincial governments (Bocock 1986; Ralph 1983). Another important term in Marxist theory refers to civil society. Civil society refers to other institutions and organisations which are not part of the means of material production or state-funded bureaucracies. Examples may include voluntary organisations, elements of the media, religious organisations and interest groups. The border that separates State and civil society is not rigid, however, and is subject to frequent adjustment and negotiation (Bobock 1986).

2. Gramsci did not settle on one theory of the State or model of hegemony (Carnoy 1984; Bocock 1986). While Gramsci’s theory of the State emerged from Marxist theory, he did not accept the Marxist-Leninist notion of a single coercive state apparatus. Rather: "Gramsci rejected..crude dialectical materialism and..attempted to reformulate doctrine of historical materialism in such a way as to allow room both for the influence of ideas on history and for the impact of individual will" (Joll 1978, p.16). Of Gramsci’s three models of hegemony, Carnoy (1984) argues that Gramsci’s second model is the most useful as it pertains to analysis of advanced capitalist society. Here, hegemony is expressed both in civil society and the State.

CHAPTER FOUR


2. Ibid.

3. Ibid.

5. Prominent examples included: Wilkie Collin's *The Woman in White*, 1860 and Charles Reade's *Hard Cash*, 1863. Caplan (1969) advises that although these books were published in England, some, like *The Woman in White* were widely read on both sides of the Atlantic.


8. **Commission Appointed to Enquire into Certain Matters Connected with the Provincial Lunatic Asylum at New Westminster.** 1895. **Proceedings.** Ibid. (pp.504-505).

9. **Ibid.** Proceedings. (pp.504-505).

10. **Ibid.** Return. Correspondence between Dr. Bentley and James Baker, Provincial Secretary. (pp.659-662).

11. **Hospitals for Insane Act.** 1897. R.S.B.C. c.17, s.1.


**CHAPTER FIVE**


3. Times, April 2, 1921, p.21.

4. Colonist, November 19, 1925, p.5

5. "Insanity Check Strongly Urged Before House" Vancouver Sun, 1925, November 19, p.1.


8. Ibid., p.16.


11. Ibid., p.17.

12. Ibid., pp.6-7.


14. Prior to the passage of the bill, Dr. L. Borden argued in the Legislature that sterilisation was misunderstood by the "lay mind" and that the Essondale population of 2,600 would have been 600 if eugenic measures had been previously introduced. Reginald Hayward, a member of the 1920 Mental Hygiene Commission bluntly proclaimed: "Laws were passed for the improvement of livestock. Why not legislate for the benefit of the human race?". Asked if the House was ready to receive such a bill, "members pounded their desks". "Sterilisation Misunderstood", Victoria Daily Times, April 1, 1933.

16. "50 Sterilisations are listed in B.C.", Province, April 26, 1941, p8.

17. "I'd Shudder to Think We Had a Law Like That. But We Do!" Colonist, Dec. 11, 1963, p1.


21. Ibid.

22. Ibid.


30. Ibid., p.8.

31. Ibid.


**CHAPTER SIX**


2. Ibid. p.24.


26. The pressure that the government perceived itself to be under was indicated by the fact the Provincial Secretary was reported to be hastily dispatched to the American Psychiatric Association (A.P.A.) convention in Kansas to negotiate a contract for the study to be undertaken. "Black Orders Full Probe of Mental Health Services". Victoria Daily Times, October 14, 1958, p.1.

27. Province, October 14, 1961, p.3.


30. Ibid.


33. Vancouver Sun, March 6, 1964, p.10.

34. Colonist, March 5, 1964, p.1.
CHAPTER SEVEN


6. Ibid.


21. "Foulkes bid to demolish Riverview 'like pulling plug to sink ship'". Vancouver Sun, January 21st, p.18.

22. Ibid.


**CHAPTER EIGHT**


2. Ibid.


15. For amendments see *Mental Health Act R.S.B.C. 1979 c.256.*

17. *ibid.*

18. *ibid.*

19. For an example of a Ulysses agreement, see Appendix A in Gordon, R.M. 1993. *Out to Pasture: A Case for the Retirement of Canadian Mental Health Legislation*. *Canadian Journal of Community Mental Health*, 12, (1), 37-55. Ulysses agreements are written when the consumer is well and can take account of a variety of factors related to the consumer’s wishes regarding action to be taken if he/she should become unwell in the future. These factors are based on the consumer’s knowledge of his/her own illness, and previous experience with professional systems of care. The agreement specifies trusted members of the consumer’s professional and non-professional support team and how they can be contacted. Details of the consumer’s psychiatric history including diagnosis, symptoms when becoming unwell (including any propensity to lose insight), and action to be instituted are outlined. The consumer’s wishes and preferences with regard to treatment are specified. Other, social, aspects pertaining to the care of the consumer while unwell may be included (e.g. arrangements for continuing to ensure rent is paid).


22. In B.C., the Friends of Schizophrenics are now known as the British Columbia Schizophrenia Society.

**CHAPTER NINE**

2. Two reports, one federal and the other provincial were most influential. These were: More for the Mind. A Study of Psychiatric Services in Canada (1963), and Survey of Mental Health Needs and Resources of British Columbia, (1961) respectively.

3. Compulsory community treatment (CCT) orders are a controversial legislative innovation that has been introduced in virtually all parts of the United States. CCT refers to the legal compulsion on persons who allegedly have mental disorders to undergo treatment in an outpatient setting. CCT has not been proposed as an option in British Columbia at this point in time, however, this may change in the future. For a discussion of the issues involved in CCT as they pertain to the Canadian context, see Boudreau & Lambert (1993; 1993).
BIBLIOGRAPHY


Mental Hospitals Act. S.B.C., 1940. c. 27


Shifrin, L. 1987. Free Trade in Social Programs: the level playing field is not an empty field In, Canada Not For Sale: The Case Against Free Trade. Toronto: General Paperbacks.


Dear <Name of key informant>,

My name is Andy Libbiter. I am a graduate student at the University of British Columbia School of Social Work. As part of my Master's degree, I am undertaking an historical analysis of mental health policy in B.C., in order to examine the contemporary issues raised by the proposed changes to the provincial Mental Health Act. My research thesis reflects my long-standing interest and involvement in mental health policy and practice having worked in different mental health settings in the U.K., Australia, and Canada over a fourteen-year period.

An important piece of my thesis involves seeking the in-depth views of people involved in mental health consumer activity, regarding the debate on the "right to refuse treatment". I am writing to ask if you would participate by sharing your views with me. Your participation would be entirely voluntary and you can, of course, refuse to participate with no consequence to yourself. You may also withdraw your consent to participate at any time or refuse to answer any questions.

The research would take the form of an in-depth interview that would take approximately 1 hour. If you agreed, I would make an audiotape of the interview. The tape would be accessible only to myself and would be destroyed following completion of the project. Alternatively, I would be happy to forward the tape to you for your own records. The information collected in the interview would be used for the purposes of my thesis only, and would not be used for any other reason or purpose. All information that identifies you or any mental health consumer group will be erased from the final report. The completed thesis becomes the property of the University. It will be kept in the Library and so, in effect, enters the public domain. I would be happy to give you some preliminary feedback of this portion of my research, either in writing or in person.

Thank you for considering this request. I will telephone you in one week to see if you would like to participate. In the meantime, if you have any questions or would like to discuss any aspect of this request, please feel free to call me at 536-1447, or my thesis supervisor, Dr. Richard Sullivan at 822-2255. Thank you.

Yours sincerely,

Andy Libbiter.
APPENDIX 2: INTERVIEW CONSENT FORM

Title: Mental Illness and Civil Rights: Contemporary Dilemmas of Legislating Rights for the Mentally Ill in Historical Context.

Researcher: Andy Libbiter, University of British Columbia, School of Social Work.

This research project is part of a graduate thesis exploring contemporary dilemmas involved in the legislation of civil rights for people with mental illness. The 1 hour interview I am participating in is investigating my beliefs about the rights of people with mental illness to refuse psychiatric treatment.

The purpose of this interview has been clearly explained and the researcher has answered any concerns or questions to my satisfaction. I understand that my participation in this study is entirely voluntary and that I may choose not to answer any questions or withdraw my consent to participate at any time, with no consequence to myself.

I agree to the researcher making an AUDIOTAPE of this interview. I understand that this tape will be erased following completion of the study. All information that I choose to provide will be held in confidence by the researcher. All individual information, including information which identifies any mental health consumer group with which I am affiliated, will be omitted in the final document.

If I have any questions or concerns prior to or following the interview, I may contact the researcher, Andy Libbiter, at 536-1447 or his thesis supervisor, Dr. Richard Sullivan at 822-2255.

My signature is acknowledgement of receipt of a copy of this form for my own records, and my consent to participate in this study.

Respondent’s Signature: __________________________ Date: __________

Researcher’s signature: __________________________ Date: __________
APPENDIX 3: INTERVIEW GUIDE

1) Can you tell me what is your position on the right to refuse treatment issue?

2) Could you tell me what you consider to be the arguments for involuntary treatment?
   Probes: acute psychiatric illness, suicide, danger to self/others

3) Can you tell me what you consider to be the arguments for legislating a right to refuse treatment?
   Probes: autonomy/self determination, right to physical and psychic integrity

4) Can you tell me how you came to develop your position on the right to refuse treatment issue?
   Probes: personal experience, literature/research, consumer advocacy, philosophical orientation.

5) The Mental Health Act review is currently at a standstill. I understand the right to refuse treatment issue has been a particular cause of division amongst people. What do you think will help to resolve the issues at this point?

6) Is there anything else you would like to add, or you think is important for me to know?
Thankyou very much for agreeing to be interviewed by me. Before we start the interview I would like to go over some things that were discussed in my letter to you and that we also discussed briefly on the telephone.

First of all, I would like to tell you that this interview is part of my thesis for my Master of Social Work degree which I am undertaking at the University of British Columbia. This thesis is concerned with the historical development of mental health policy and legislation over the past two hundred years. Part of this research involves interviewing consumers/survivors as who are active in the mental health consumer movement.

I am particularly interested in seeking your personal views on the issue of involuntary commitment and the right to refuse treatment. The reason I have chosen to ask people about this issue specifically is two-fold:

1) Involuntary commitment and the right to refuse treatment has caused contention and division in most, if not all jurisdictions where it has been debated or implemented and secondly,

2) the issues raise many of the philosophical, legal and medical dilemmas that are central to my wider historical thesis.

I have prepared five open ended questions that seek your personal views and position on this issue. I want you to answer the questions as you see fit. If any of them are unclear, please ask me to clarify them for you.
APPENDIX 5: THANKYOU LETTER TO RESPONDENTS

< Address of Respondent >

< Date >

Dear < Name of Respondent >,

Just a quick note to thank you for your time and consideration yesterday. I really appreciated you being willing to share with me, not only your thoughtful and articulate views, but also your personal experiences. The interview was very valuable for my research. As we discussed, if you have any questions or issues that you would like to discuss concerning the interview or the study, do not hesitate to contact me. Thanks again.

Yours sincerely,

Andy Libbiter.
# Certificate of Approval

<table>
<thead>
<tr>
<th>PRINCIPAL INVESTIGATOR</th>
<th>DEPARTMENT</th>
<th>NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sullivan, T.R.</td>
<td>Social Work</td>
<td>B93-0793</td>
</tr>
</tbody>
</table>

**INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT**

UBC Campus

**CO-INVESTIGATORS:**

Libbiter, A., Social Work

**SPONSORING AGENCIES**

**TITLE:**

Mental illness and civil rights: Contemporary dilemmas of legislating rights for the mentally ill in historical context

**APPROVAL DATE**

JAN 14 1994

**TERM (YEARS)**

3

**AMENDED:**

CERTIFICATION:

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Dr. R. Corteene
Dr. I. Franks, Associate Chairs

Shirley A. Thompson
Dr. R. D. Spratley
Director, Research Services

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.