The 'New Eugenics:' Psychiatry and Mental Health in Post-World War II Canada

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Any errors remain solely my own.

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List of Abbreviations

CMA	Canadian Medical Association
CMHA	Canadian Mental Health Association
DNHW	Department of National Health and Welfare
ECT	Electro-Convulsive Therapy
EST	Electro-Shock Therapy
HPH	Hamilton Psychiatric Hospital
LSD	d-lysergic acid diethylamide
NCMH	National Committee for Mental Hygiene
NFB	National Film Board
NIMH	National Institute of Mental Health
OT	Occupational Therapy
OAMR	Ontario Association for the Mentally Retarded
OHSC	Ontario Health Survey Committee
TB	Tuberculosis
VD	Venereal Disease

No wonder those poor pre-moderns were mad and wicked and miserable. Their world didn't allow them to take things easily, didn't allow them to be sane, virtuous, happy. What with mothers and lovers, what with prohibitions they were not conditioned to obey, what with the temptations and the lonely remorses, what with all the diseases and the endless isolating pain, what with the uncertainties and the poverty – they were forced to feel strongly. And feeling strongly (and strongly, what was more, in solitude, in hopelessly individual isolation), how could they be stable?

Aldous Huxley
Brave New World 1932

Introduction

> The more scholars explore the history of eugenics in different national, professional, and institutional settings, the more they learn that international eugenics resists any reductive explanation. The standard political interpretation that eugenics was a ruling-class, reactionary, or conservative phenomenon is no longer tenable. National comparisons…indicate that eugenics both respected and crossed national borders, taking various shapes. It followed no particular ideological blueprint. It meant different things to different people in different settings. Racial, gender, and class prejudices were rarely absent, but eugenics was – and is – far more complex than simply a pseudoscientific excuse for indulging these biases.
>
> Ian Dowbiggin
> Keeping America Sane, 1997, p.237-238

In Canada during the 1950s and 1960s, Dr. Ewen Cameron, a psychiatrist at the Allan Memorial Institute in Montreal, experimented on dozens of his patients with a new technique known as 'depatterning.'[1] In the hopes of effecting a cure for schizophrenia, Cameron combined electro-shock therapy, insulin coma therapy, and 'brainwashing' to reprogram psychiatric inmates. The patients received LSD or another drug to induce prolonged periods of sleep, often lasting for weeks or months at a time. During this phase, recorded messages played repeatedly to reduce the patient to an infantile state and to facilitate resocialization. In many cases, the resulting patient suffered increased agitation, an unhealthy dependence upon Cameron, and remained immune to other

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[1] Anne Collins, In the Sleep Room, (Toronto: 1997), p.161.

therapy.[2] These experiments not only remained ineffective but also prevented patients from obtaining help elsewhere. Neither the patients nor family members ever supplied consent for the treatment, or knew the exact details of the program to which Cameron subjected his patients. The work of Dr. Cameron has since been vilified; the nature of his work, its value, and his motivations remain the topic of debate currently.

The desire for professional recognition, the absence of informed consent, and eugenic themes all figure prominently in Cameron's work at the Allan Memorial Hospital. The ability of one psychiatrist to experiment upon patients without consent raises important questions regarding mental health policy, mental health legislation, and the research programs within other psychiatric institutions. Moreover, the motivation behind such experimental treatment requires greater scrutiny since Cameron's idiosyncratic application of medical treatment derived partially from his consistent desire to seek professional status within the medical community.[3] An examination of these themes, specifically in relation to eugenics, is necessary to understand the development of mental health services and the role of psychiatry in Canada's post-World War II years. This thesis will argue that through the haphazard development of Ontario mental health policy, the lack of informed consent legislation regarding psychiatric practice and research, and psychiatric attempts to professionalize, eugenics was permitted to persist in a new format. Human betterment through selective breeding evolved into social progress through environmental intervention.

The desire by humans to intervene physically to create better citizens is not a new

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[2] ibid., p.197.

[3] Cameron sought to become recognized as the psychiatrist who discovered the cure for schizophrenia. He specifically chose schizophrenia due to the long history of frustration, pessimism and impermanent treatment associated with the mental illness. His determination to find a cure and simultaneously secure professional recognition lent considerably to his improper use of drugs and 'brainwashing.' See Anne Collins, In the Sleep Room, (Toronto:1997).

phenomenon. World War II clearly marked the climax of social biology through sterilizations, marriage laws, and ultimately the killing of people with mental and/or physical impairments in Nazi extermination camps. The extent to which eugenic ideology continued to influence post-World War II Canadian medical policy and even determine current conceptions of health, remains a topic of debate. Yet, despite arguments to the contrary, eugenics did not disappear with the end of World War II. As McLaren affirms, "The war in effect put an end to people calling themselves eugenicists, but it did not put an end to eugenic speculation."[4]

This thesis explores the persistence of eugenic ideas in the post-war period. In both application and theory, eugenics never remained a static ideology. As Dowbiggin claims: "It meant different things to different people in different settings."[5] Following World War II the formal eugenics movement was subjected to a public backlash, ushering in a return in medicine to an emphasis upon environmental factors in disease causation. The eugenics of the late 1930s and early 1940s, which prioritized hereditarianism, no longer existed. Modified eugenic arguments - incorporating heredity *and* environmental factors - remained manifest in medical explanations for poor health, intelligence and physical disfigurement. The consistency of an underlying eugenic bias existed in the embracing of the ongoing search for better human breeding, whether through physical or social human intervention. The immediate post-war years did not signal the end of eugenics. Through an examination of government mental health policies, medical and community rhetoric, psychiatric institutions, and legal standards, this thesis will demonstrate that eugenics

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[4] Angus McLaren, Our Own Master Race: Eugenics in Canada, 1885-1945, (Toronto: 1990), p.240.
[5] Ian Dowbiggin, Keeping America Sane: Psychiatry and Eugenics in the United States and Canada: 1880-1940, (London: 1997), p.238.

remained a tangible factor within the shifting paradigm of mental health policy in Ontario, Canada.

The post-World War II years witnessed a reorganization and reorientation of eugenics, not a full-fledged abolition. Despite general acceptance of the Nuremberg Code, which enshrined the principle of consent in medical practice, practical implementation was slow.[6] The 'old eugenics,' centering on the hereditarian make-up of specific individuals, gave way to what Dowbiggin has coined a 'new' eugenics[7] arising from new professional-minded conceptions of "normalcy." The desire to realize better humans socially and physically continued to be put forth largely by medical professionals, particularly among psychiatrists who were attempting to professionalize. And it was permitted by a government unwilling or unable to direct a coherent and protective mental health policy. Professionals working in psychiatry articulated 'new' eugenic ideals through "experimental" treatment options designed to return individuals to social normalcy. The government also continued to support eugenic-like ideals indirectly through slow and 'unbalanced'[8] legislation which allowed the 'new' eugenics to continually evolve. The 'new' eugenics came to envelop social maladjustment, more so than strictly physical disability. Concerns with heredity continued, but to a lesser degree. Moreover, the 'new' eugenics, unlike the old, relied upon the intervention of specific professional groups within society rather than merely deriving from state mandates. Human intervention to create better humans was the mainstay of eugenic philosophy and

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[6] See the discussion below on the Nuremberg Code principles which outline the need for consent and a risk/benefit analysis.

[7] Dowbiggin, Keeping America Sane, p.239.

[8] See Harvey Simmons, Unbalanced: Mental Health Policy in Ontario, 1930-1989, (Toronto: 1990), where he argues that the development of mental health policy in Ontario remained a haphazard and unbalanced process due to the strong implementation of psychiatric units and psychiatric hospitals outweighing the absent and weak integration of community health care services.

genetic postulations. This intervention, however, varied within the cultural constructs, acceptable 'norms,' and role of the state in each society.

The spirit of eugenics, as first coined by Sir Francis Galton, reflected a consistent concern for the 'well-born' and social progress. Although historians have tended to interpret eugenics narrowly – meaning a concern with human breeding, this thesis will continue to use the term eugenics to illustrate that a relationship, albeit varied, existed between the eugenics of the 1930s and that of the 1950s based upon the impetus to perfect humankind. The continuity between the 'old' eugenics and the 'new' eugenics, in the desire for social progress and human betterment, reflected a need to expand the term in assocation with the wide variation of eugenic practices and ideologies. Eugenics represents a spectrum of extreme and moderate responses.

The examination of psychiatry during the post-World War II years and its interactions with both 'new' eugenics and informed consent is an area of study that has not previously received sustained attention. Questions regarding the interaction of consent (specifically for research and treatment), practices within mental institutions, and the prevalence of eugenic ideology after WWII remain largely unexamined by historians. Investigating this interaction may aid in clarifications regarding current ethical and medical dilemmas, specifically issues centered upon genetic research and treatment.

Historiography

The early writing of Canadian medical history was, in the words of one historian, the domain of "'elderly doctors,' amateurs often gifted but, as one of their numbers confessed, 'innocent of the severe disciplines of history.'"[9] Many researchers favoured biographical approaches, resulting in an enduring pattern for Canadian medical historiography.[10] Biographies comprised not only a large number of the early books but continue to provide a framework for more current works[11] – although current biographical examinations are both less numerous and more complex. These biographies of eminent medical men prioritized individual heroes over the social context and implications of disease and disability.[12] Social historians (in the 1970s), however, recognized the absence of social factors within historical narratives. Their research extended into the field of medical history by the 1980s. Subsequently, social historians of medicine have redressed many neglected areas of medical history.[13] The history of medicine no longer records events solely through the history of its profession; new examinations explore relations between health care professionals, society, government and the economy.[14]

Within medical historiography, the history of psychiatry has received significant attention. Its works can be divided into three approaches: humanitarian, social control, and the new social history. The humanitarian approach to psychiatric history centers on the philanthropic motivations of historical actors, and the relentless pace of medical 'progress.' Often illustrated as a response to human suffering, psychiatric historians of this school emphasizes a belief in the curability of humanity and the need

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[9] S.E.D. Shortt, "Antiquarians and Amateurs: Reflections on the Writing of Medical History in Canada," in Shortt's (ed.) Medicine in Canadian Society: Historical Perspectives, (Montreal: 1981), p.2.
[10] ibid., p.4.
[11] ibid., p.6. See also, Michael Bliss, Banting: A Biography, (Toronto: 1984) and Michael Bliss, William Osler: A Life In Medicine, (Toronto: 1999)
[12] Shortt, Medicine in Canadian Society: Historical Perspectives, p.5.
[13] ibid., p.8.
[14] Dorothy Parker, "The Mission of Social History of Medicine: An Historical Overview," Social History of Medicine, 8-3 (1995), p.345-359.

for medical or institutional interventions to aid the mentally ill. Despite the realization that many of the reformers' ideals were never effectively implemented and/or achieved, humanitarian accounts claim that idealistic and altruistic reforms continued to be the central component governing psychiatric advancement.

Cheryl Warsh's perspective on psychiatry falls within the humanitarian approach, as her conclusions regarding the era of the asylum remain positive, despite her recognition of many shortcomings. In her examination of the Homewood Retreat during the years 1883-1923, Warsh's objective was to "document the social and therapeutic functions of the asylum from the perspective of its various human components."[15] Although focusing upon patient perspectives, which largely reflects a new social history, her findings view the asylum as a process, a series of dynamic interactions. Warsh concluded that the asylum fell short of its therapeutic and financial goals but she claimed that nonetheless the asylum fulfilled an important medical and social function for emotionally-disturbed middle class patients in Ontario.[16] Daniel Francis also identifies the process of change within the asylum recognizing the movement from curative hospitals to custodial institutions. He too remains optimistic regarding the transition claiming that "At last it was being recognized that the most important things about the mentally ill was that they were mentally ill, not poor, or violent or criminal, and that they required a specific kind of supervision in a specific kind of institution."[17] Francis' account claims a fundamental distinction was made by psychiatrists between the inmates with mental illness and

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[15] Cheryl Warsh, Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat, 1883-1923, (Montreal: 1989), p.5.

[16] ibid, p.174. See also, Cheryl Kransnick, " 'In Charge of Loons:' A Portrait of the London, Ontario Asylum for the Insane in the Nineteenth Century," Ontario History, where she concludes: "But the belief in the curability of insanity and in the *essential humanity* resulted in treatment which was also benevolent and imaginative." p.104

[17] Daniel Francis, "The Development of the Lunatic Asylum in the Maritime Provinces," in Shortt's, (ed.), Medicine in Canadian Society: Historical Perspectives, (Montreal: 1981), p.93.

inmates with other social or physical deficits. Both historians identify flaws within the system but reaffirm the validity and humanitarian nature of the asylum.

A humanitarian account focusing upon American psychiatry is The Mad Among Us, written by Gerald Grob. Grob illustrates two extremes that governed the management of the mentally ill: confinement in a mental hospital or living within the community. Grob's work includes an examination of the post-World War II years, extending up to the 1980s. The American post-war years reflected a concerted effort to shift care from the asylum to the community, an effort manifested in the development of the National Institute of Mental Health (NIMH) and in the establishment, in 1946, of the National Mental Health Act. While the United States and Canada shared the problems of overcrowding and understaffing in the immediate post-war years, the approach undertaken in each country to resolve the dilemma differed in several important respects. The development of Canadian mental health policy in the post-war years was slow, disorganized and without long-term vision. The absence of strong political lobbying groups and a government committed to mental health reforms (like the Kennedy administration) caused Canada to fall behind. The American Mental Health Act of 1946, by contrast, spelt out the general goals and vision for the future of mental health, an act without parallel in Canada. No new innovations appeared in Canadian Mental Health Acts until 1967 and no portion of the Acts reflected any long-term goals or a future vision. The 1960s brought about widespread civil protest in the United States, a process which further strengthened resolve to improve mental health care by undermining the prestige and faith of the health system in general and psychiatrists in particular. The anti-psychiatry movement questioned the legitimacy of confining people in hospitals and further addressed the issue of "patients' rights." It is here that the discussion of informed consent began to play a fundamental role in the development of mental health legislation in the United States and, to a lesser extent, Canada.

The discussion of informed consent in Grob's work is limited, focusing instead upon the role of the anti-psychiatry movement in reducing the professional image of psychiatrists and weakening their authority through such books as 'One Flew Over the Cuckoo's Nest.'[18] The rise in the civil rights movement initiated changes in the ethics of therapeutic experimentation and informed consent. The creation of the Helsinki Document in 1964, a human rights based accord focusing upon consent in research and treatment, is one example of the United States' initiative in furthering ethics in conjunction with the World Medical Association. The 1940's to 1960's in the United States constituted years of assault upon institutional care, favouring instead community care. When psychiatrists failed to fulfill promises of prevention and cure - both prior to and following the second World War – they blamed the government, the public or an obsolete mental health system.[19]

While Grob's work does not seek to condemn psychiatry, he also does not defend all their actions. Denouncing the illusory belief that mental illness can be permanently cured or at least prevented, Grob blames the abandonment of incapacitated persons upon the unrealistic standards and exaggerated claims which shaped public policy at the time. Yet, Grob also claims that a moral and ethical onus remains upon both the medical profession and society to aid those with mental illness. He states,

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[18] Ken Kesey, One Flew Over The Cuckoo's Nest, (New York: 1964).

[19] Gerald Grob, The Mad Among Us: A History of the Care of America's Mentally Ill, (Toronto: 1994), p.310.

> evidence that programs that integrate mental health services, entitlements, housing and social supports often minimize the need for prolonged hospitalization and foster a better quality of life.[20]

Overall, Grob remains devoted to a humanitarian perspective as he depicts psychiatry with good intentions despite occasionally acting remiss. In support of this, he cites the improvements within and benefits yielded from psychiatric work to date.

The second major school of historical interpretation is the social control historians. The themes of this school are derived in part from Foucault's claims that modern society seeks to control 'deviants,' those who stand outside of, or who deviate from, the cultural 'norm.' Definitions of 'normalcy' determine which members of society require 'modification.' The detection and treatment of 'deviants' however, traditionally requires institutions. Hence, social control theorists focus on the establishment and development of large institutions for housing the sick, criminal or elderly in the nineteenth and twentieth centuries. By implication, these institutions were used to remove and control non-conformists.[21]

The theme of professionalization is also prominent in the works of historians who also investigated the evolution of psychiatry. Tom Brown specifically addresses the relationship between shell shock in World War I and mental health professionals, arguing that shell shock played a decisive role in the professionalization of Canadian psychiatry.[22]

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[20] ibid., p.310.

[21] Andrew Scull, "Museums of Madness Revisited," Social History of Medicine, 6-1, (April 1993); David Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic, (Toronto: 1971). Primary evidence challenges many of the assertions of the social control argument. The examination of population records for insane asylums indicates that no numeral discrepancies in terms of men versus women or poor versus rich exist within the overall numbers of the inmate population. In fact, the division between the sexes and classes is fairly even. Discrepancies in numbers also do not necessarily imply that white, anglo-saxon, protestant, middle-class do-gooders sought to maintain their own place in society. The absence of a welfare state may account for some discrepancy but overall, the middle class enjoyed the same degree of confinement as immigrants and the working class. See both, Gerald Grob, "Marxian Analysis and Mental Illness," History of Psychiatry, 1, (1990), p.229; and Nancy Tomes, "The Anglo-American Asylum in Historical Perspective," in Smith & Giggs' (eds.) Location and Stigma: Contemporary Perspectives on Mental Health and Mental Health Care, (Boston: 1988), p.17.

Terry Copp examines the professionalization of psychiatry during World War II. He claims that the "relationship between the medical profession and army suggests that the medical profession was equal to the task of imposing its own priorities and values on the state."[23] While Copp does not extend his analysis to the post-war period, his argument holds implications regarding the timeframe within which psychiatry was attempting to professionalize and the manner in which that professionalization was occurring.

The theme of psychiatric professionalization occupies a central role in The Two Psychiatries. In this book Dickinson examines the transformation of psychiatry in Saskatchewan between 1905 and 1984.[24] Gleason's work also focuses upon professionalization and prevention, but specifically in relation to psychology.[25] Both works recognize that the movement away from custodial care and towards therapeutic treatment in the post World War II years was accompanied by a desire for psychiatry to achieve greater professionalization and detect early symptoms of mental illness. Community resources were mobilized to establish community psychiatry/psychology, which also extended psychiatrists' and psychologists' sphere of influence. The successful medicalization of psychiatry/psychology necessitated a movement into the community: only recognition within the community would raise their professional status. The introduction of 'mental hygiene,' the need to prevent mental illness, and the desire to

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[22] Tom Brown, "Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War," in Charles Roland (ed.) Health, Disease, and Medicine: Essays in Canadian History, Hannah Institute for the History of Medicine, (Canada: 1982), p.308.

[23] Terry Copp, "The Development of Neuropsychiatry in the Canadian Army (Overseas), 1939-1943," in Naylor's (ed.) Canadian Health Care and the State: A Century of Evolution, (Montreal: 1992), p.67.

[24] Harley Dickinson, The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984, (Regina: 1989).

[25] Mona Gleason, Idealizing the Norm: Psychology, Schooling, and the Family in Postwar Canada, (Toronto: 1999).

educate the public, promoted an increase in psychiatrists' and psychologists' roles in the community which further legitimated professional status.

Scull and Rothman also promote the concept of professionalization as central to our understanding of the relationship between psychiatry and modern North American society. Focused upon the nineteenth century, Scull argues that the pessimism of the era, resulting from an inability to effect cures, resulted in the 'quarantining' of the mentally ill in psychiatric institutions, and the temporary isolation of psychiatrists from mainstream medicine. As a result, Scull claims, "As early as the 1860s, we can observe some members of the psychiatric elite seeking to escape the institution's stultifying grasp, and to carve out alternative career paths outside the walls of the asylum."[26] Moreover, he suggests that the office-based practice which emerged in the present century remained lucrative for psychiatrists who moved outside of the asylum.[27] Bernard Schissel utilizes Scull's social control argument to examine 'psychiatric expansionism' between 1932 and 1975. His findings demonstrate a relationship between professional interests and the expansion of psychiatric control.[28] Rothman's work also supports the argument that professionalization occurred through social control and exploitation of the mentally ill.[29] By housing individuals within asylums, or through deinstitutionalization, the notion of psychiatrist-as-expert remains central to the practices and policies affecting people with mental illness.

The third school of psychiatric historians – social historians of medicine – have

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[26] Scull, "Museums of Madness Revisited," p.22.
[27] ibid., p.23.
[28] Bernard Schissel, "Psychiatric Expansionism and Social Control: The Intersection of Community Care and State Policy," Social Science Research, 26, (1997), p.399-418.
[29] David Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic, (Toronto: 1971).

attempted to search for a middle ground between the 'humanitarians' and those who posit that the rise of the institution was for social control purposes. Social historians of medicine tend to recognize the deficiencies of both the humanitarian and social control accounts by examining the relationship between superstructural factors and human agency. The multiplicity of purposes which influenced and shaped medical developments are recognized rather than claiming that one factor alone was responsible for the manner in which medicine progressed.[30]

Wendy Mitchinson provides an excellent example of this genre. Her articles address the reasons for committal to insane asylums in Ontario. While arguing from a new social history perspective her conclusion acknowledges the imperatives of social control. Mitchinson claims, "welfare and stability were uppermost in the minds of the mid-Victorians. This did not negate their reform impulse but did determine its direction."[31] Thus, while trying to steer a middle course between two approaches, her conclusion supports the social control theory.

Nancy Tomes, an American historian of psychiatry, represents another example of the new social history of psychiatry. She claims that, despite the failure of moral therapy, asylums were not without their own achievements. The asylum removed the burden of insanity from families (this relief explains the popular support of the asylum and custodial care). Since the asylum provided an alternative to the strains of home care, the hospital filled a social need in the absence of the welfare state.[32] The role of family in responding to mental illness and familial interaction with the state is also presented in

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[30] Anne Digby, Madness, morality, and Medicine: a Study of the York Retreat, 1796-1914, (New York: 1985); Tomes, "The Anglo-American Asylum in Historical Perspective," p.2.
[31] Wendy Mitchinson, "Reasons for Committal to a Mid-Nineteenth Century Ontario Insane Asylum," in Mitchinson & McGinnis, (eds.), Essays in the History of Canadian Medicine, (Toronto: 1988), p.109.
[32] Tomes, "The Anglo-American Asylum in Historical Perspective," p.22.

Simmons' works. He addresses the development of mental health policy in the area of mental retardation and mental illness, from the beginnings of a welfare state. In Unbalanced, he argues that mental health policy largely neglected to incorporate aftercare services, thus allowing mental health objectives to remain unachievable.[33] Yet, the theme of professionalization also arises in his work, as the mentally retarded were specifically separated from the mentally ill. The retarded comprised the 'incurables' and thus hindered psychiatry's legitimation.[34] Psychiatry no longer reflected a humanitarian focus with moral treatment, but rather was concerned with the use of science to secure cures and thus to ensure professional legitimation.

Shorter's recent survey, A History of Psychiatry, examines the developments within the psychiatric field from the eighteenth century to the present. Centered specifically on German and American psychiatry, the issue of eugenics is ignored, except in a brief note opposing claims that psychiatrists were among the greatest proponents of eugenic measures during the Second World War.[35] Shorter recognizes that more work needs to occur within the field but he attempts to redress the damaging claims of social control theorists and thus remains supportive of the humanitarian perspective. In writing social history, Shorter seeks to present the facts within the psychiatric field, regardless of country, and illustrate how culture and psychiatry influence each other. Despite clear opposition to the social control position, Shorter does acknowledge claims of patient abuse and other facets supportive of the social control perspective. Overall, the work is a comprehensive overview of the developments in psychiatry from the initial

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[33] Simmons, Unbalanced, p. ix.
[34] Harvey Simmons, From Asylum to Welfare, (Toronto: 1988), p.172-180.
[35] Edward Shorter, A History of Psychiatry: From the Era of the Asylum to the Age of Prozac, (New York: 1997), p.353.

focus upon the biological, to the separation of the biological and psychological, and a return to the biological again.

The history of psychiatry largely remains limited to works addressing the pre-World War II years. The themes of eugenics and informed consent are not consistently or principally represented among the chapters, articles, or major research monographs. Works in psychiatry after 1945 focusing specifically upon Canada are few and far between, as are interpretive connections to informed consent and/or eugenics. The intersection of psychiatry, eugenics and informed consent within Canada historiography remains under-researched.

Eugenics and Informed Consent

Ian Dowbiggin examines eugenics in Canada and the United States in relation to psychiatry during the years 1880-1940. He claims that psychiatry ultimately turned to eugenics as a means of explaining and resolving the disappointments and pessimism within the psychiatric profession. Eugenics explained why the majority of patients remained uncured and legitimated psychiatrists' roles within public health and the community. Thus, "physicians in general and psychiatrists in particular played pivotal roles in the history of these eugenic policies,"[36] such as sterilization laws and immigration policies. Psychiatrists were also drawn to eugenics for professional reasons. Ultimately Dowbiggin, in contrast to Shorter, claims that a belief in the ability to change human nature through social engineering continues to persist.[37]

The topic of eugenics is briefly addressed within Warsh's discussion of psychiatric

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[36] Dowbiggin, Keeping America Sane, p. viii.
[37] ibid., p.240.

treatment. Her examination of gynaecological surgery and ovariotomies reflects an attempt by psychiatrists to control the procreation of people with mental illness. Although both these procedures were utilized as eugenic measures, both were also perceived to have therapeutic value, specifically in reducing the severity of mental illness.[38] Such procedures occurred between the 1870s and 1900s and hence, the interrelationship between psychiatry and eugenics after World War II remains outside the scope of the article.

McLaren's work provides a cohesive examination of eugenics in Canada from 1885 to 1945. While Our Own Master Race, does not extend past 1945, the work does incorporate sources later than 1945 and suggests that eugenic ideology did not terminate with the end of World War II. The last chapter, entitled "The Death of Eugenics?" queries the extent to which eugenics continued in Canada: "Was eugenics dead? The war in effect put an end to people calling themselves eugenicists, but it did not put an end to eugenic speculation."[39] The beginnings of the welfare state supplied eugenicists with their most feared occurrence, the creation of a state which would support those unable to support themselves. Criticism of family allowances, established in 1945, paved the way for the continuance of eugenic thinking along more social and less medical lines. McLaren's final chapter and epilogue supply ample cause for one to question the continuance of eugenics in Canada after WWII and it is from this point that any examination must commence.

Fennell's work, Treatment Without Consent, examines the law, psychiatry and treatment of the mentally ill since 1845 in Britain. The work also broadly addresses

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[38] Warsh, Moments of Unreason, p.55.
[39] McLaren, Our Own Master Race, p.157.

psychiatry in Australia, Canada, and the United States. [In the British Medical Journal,] consent was recognized as necessary as early as the 1890s, requiring permission be given by either the patients or their next of kin. Yet, consent did not seem to be established within the law or within medical circles. Fennell claims, "throughout its history the psychiatric profession has striven to establish, maintain, and expand the legal recognition of 'clinical authority' to treat, if necessary without consent."[40] The assertion that psychiatry continued to expand its authority is an intriguing claim. To suggest, however, that the purpose of this expansion was largely to treat patients without consent is not well-evidenced. It may have been the case that consent interfered with psychiatry's attempts to professionalize through increased cure rates, but that does not translate into an intention to treat without consent. Fennell's argument largely laments the abuses inflicted by psychiatry upon non-consenting mentally ill patients. While rightly critical of psychiatry and the need to obtain consent, particularly during the post-war years, Fennell seems to reject the notion that any patient may be unable to provide consent. His research on consent, however, comprises a valuable resource as it provides a basis for comparison and developmental history.

Sharpe's work examines the relationship between the law and medicine in Canada. The development of informed consent legislation constitutes a significant portion of the work, detailing its origins as a defence against allegations of assault and battery. *Volenti non fit injuria* (to one who is willing, no wrong is done) comprised the defence. A distinction thus existed between negligence and battery. Negligence occured in cases where one was not informed of the risks whereas battery required that no consent was

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[40] Phil Fennell, Treatment Without Consent: Law, Psychiatry, and the Treatment of Mentally Disorder People Since 1845, (London: 1996), p.12.

obtained or that consent was obtained by fraud, under duress or from someone "incompetent." The latter case is especially problematic as valid consent required mental capacity. In addition, it must be voluntary, informed and relate to a specific act. The Reibl v Hughes case (1977) in Canada developed the link between consent and a physician's duty of care. Thus one of Canada's precedents occurred thirty years after the Nuremberg Code, when consent first became an issue.

During the immediate post-war years, little legislation developed in relation to informed consent. Psychiatry allowed for the legal confinement of anyone suffering from a mental disease until 1978 and further allowed for patient status to be altered from voluntary to involuntary at a psychiatrist's discretion. Moreover, until 1967, Ontario permitted the indefinite confinement of a person on the basis of two physicians' certificates which stated the person was mentally ill. Sharpe's work illustrates the problems in attempting to obtain consent from incapacitated persons as well as the disregard of consent regarding confinement and release under Canadian law.

A single work addresses sterilization and consent within Canadian law between 1945 and 1960. Gray, writing in 1955, argued that sterilization for eugenic or economic reasons was illegal, but claimed that no precedent within either Canada, the United States or the United Kingdom existed at the time.[41] As a lawyer Gray provides a coherent and thoughtful discussion of legal principles and medicine but reaffirms the lack of concrete legislation governing issues of consent, capacity, and sterilization. Meredith writing at about the same time also addresses legal liability in medicine, but not specifically for psychiatrists, only for general practitioners and surgeons.[42] Faden and Beauchamp

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[41] Kenneth Gray, Law and the Practice of Medicine, (Toronto: 1955), p.52.

[42] William Meredith, Malpractice Liability of Doctors and Hospitals, (Toronto: 1956).

thoroughly address the development of informed consent but only within the United States.[43] While a great work for comparison, none of the case law extends to Canada. Brackel and Rock's work also focuses solely upon the United States and does not address psychiatry or eugenics in general but only in a few instances when these topics appear within the law.[44] Thomson's work provides the exception whereby he examines the interrelationship between psychiatry, eugenics and informed consent. In The Problem of Mental Deficiency, he attempts to examine how eugenics, psychiatry, social policy and conceptions of normalcy all interconnect with mental deficiency.[45] Although relevant to this thesis in a number of areas, his work solely centers upon England.

An examination of the historiography of psychiatry, informed consent, and eugenics highlights the limited research devoted to each area after World War II as well as the absence of literature addressing any intersection of the three areas. Although works in other countries extend past 1945,[46] the historiography on psychiatry largely remains limited to the late nineteenth and early twentieth century[47] and most eugenic accounts discuss its prevalence during the interwar years. A history of 'informed' consent is entirely absent, as articles tend to focus upon current bioethical issues and the problems associated with obtaining consent currently. The list of such articles is endless, ranging

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[43] Ruth Faden & Tom Beauchamp, A History of Informed Consent, (New York: 1986).

[44] Samuel Brackel & Ronald Rock, The Mentally Disabled and the Law, (Chicago: 1961).

[45] Matthew Thomson, The Problem of Mental Deficiency, (Oxford: 1998).

[46] See Robert Menzies, "Governing Mentalities: The Deportation of the 'Insane' and 'Feebleminded' Immigrants out of British Columbia from Confederation to World War II," Canadian Journal of Law and Society, 13-2, (Fall 1998), p.135-173; Fiona Miller, "Population Control and the Perseverance of Eugenics," University of Victoria, (1993).

[47] For example, see Ian Dowbiggin, " 'Keeping this Young Country Sane,' C.K. Clarke, Immigration Restriction, and Canadian Psychiatriy, 1890-1925, Canadian Historical Review, 76, (December 1995), p.598-627; Ivan Williams, & E. Luterbach, "The Changing Boundaries of Psychiatry in Canada," Social Science and Medicine, 10-1, (January 1976), p.15-22; Frances Frankenburg, "The History of the Confinement," Psychiatric Journal of University of Ottawa, 7-4, (December 1982), p.240-243; and David MacLennan, "Beyond the Asylum: Professionalization and the Mental Hygiene Movement in Canada, 1914-1928," Canadian Bulletin of Medical History, 4, (1987), p.7-24.

from cross-cultural perspectives to reproductive technology. Thus, this thesis is an attempt to address in part the absence in historiography and question the extent, and manner in which, eugenics continued in Canada after 1945. This assessment reflects an intersection of all three areas at a time when the medical paradigm was shifting, mental health policy remained haphazard, psychiatry turned to science for professionalization, and the 'new' eugenics continued to intervene socially as well as physically to effect better humans.

This thesis examines eugenics, psychiatry and informed consent, separately and in conjunction with each other. Chapter one addresses mental health legislation in Ontario, examining the extent to which power resided with psychiatry and tracing the development of informed consent legislation. The absence of informed consent legislation is examined in relation to the power held by psychiatrists to apprehend, admit, detain, treat, and release mentally ill patients. The authority to determine a patient's course of treatment solely resided with psychiatrists due to the absence of any coherent precedent on informed consent.

Chapter two provides the background of Canada's changing health care system and specifically examines the haphazard creation of a mental health policy. Ontario's mental health policy addressed only the most pressing health care needs and thus, through the absence of long-term goals, allowed psychiatry to extend its sphere into the community. First, psychiatry moved into the community with public health initiatives and later through clinical associations with general hospitals. In both cases, psychiatry attempted to increase professional status and legitimation. A review of journal articles and periodicals outlined the themes underpinning the 'new' eugenics, emphasizing a combined attack upon 'defectives' through physical and social forms of intervention.

Chapter three examines the continuation of the 'new' eugenics and social betterment through medical and popular publications. Psychiatry influenced eugenics with professional-minded conceptions of social normalcy and appropriate behaviour which furthered psychiatric legitimacy. Articles in Maclean's Magazine and Saturday Night consistently listed advances in mental health and cited appropriate methods of child training from mental health professionals. An examination of pamphlets from the Mental Health Division of the Department of Health and Welfare reveal one way in which parents were provided with guidance on how to properly raise children to become mentally sound adults. Intervention relied upon upon the manipulation of environmental or social factors to improve humans and an association between physical illness and mental illness, referred to here as the medicalization of mental illness.

Chapter four focuses upon the Hamilton Psychiatric Hospital and investigates the extent to which internal hospital policy remained haphazard allowing treatment to follow an agenda determined more by professional ambition than therapeutic effectiveness. Modes of treatment reflected a scientific progression from electro-shock therapy (EST) to insulin coma therapy, and finally to leucotomies or lobotomies for patients considered to be severe or chronic cases. The differing science-based treatments revealed a desire to better the patients' symptoms in accordance with social norms. Psychiatrists were able to achieve professionalization because of weak internal policies and the use of scientific treatments to obtain higher cure rates. The issue of informed consent also appears, revealing no clear standards or consistency in implementation.

Overall, the absence of a coherent mental health policy, the lack of informed consent legislation, and psychiatric attempts to professionalize allowed eugenics to persist in a new format. All four chapters argue that the professionalization of psychiatry occurred during a time in Canadian history when mental health policy lacked tangible criteria and goals. This allowed a 'new' eugenics to proliferate, as psychiatry both influenced the 'new' eugenics and utilized the 'new' eugenics to become recognized as a legitimate branch of medicine. The 'new' eugenics constituted physical and social intervention, based upon professional constructions of 'mental health,' to better humankind.

Chapter 1

Paternalistic Power: Psychiatry, Consent & the Mentally Ill

Our current criminal laws affecting the mentally ill are woefully inadequate. If anything, they ignore liberty issues and assume a paternalistic stance with regard to mentally ill accused persons.

Gilbert Sharpe
The Law and Medicine In Canada, 1987

The creation of the Nuremberg Code in 1947 required, as its first principle, the voluntary consent of any individual involved as a subject in medical research. The Code further required that research experiments be subjected to a harm/benefit analysis in order to ensure that positive benefits outweighed known or perceived negative results. The allied countries assented to the Code in principle, but legal recognition in many countries was slow. Although the Code solely applied to experimental research, informed consent for medical treatment also emerged, but not equally for all citizens. Indeed, persons with physical or mental impairments were left vulnerable. The delay in legislation protecting the rights of vulnerable people is surprising especially when one considers that the emergence of eugenic measures, in the interwar period, initially targeted individuals with physical or mental impairments. The development of informed consent legislation constituted a slow and uneven process, and remains a subject of debate currently.

Informed consent legislation continues to develop in Canada to this day. In Canada the health care system is largely a provincial jurisdiction, subject to the legislation and policies of each individual province. Thus, any examination of the mental health care system requires a survey of the statutes functioning within Ontario. The acts governing the administration of mental hospitals, and standards for admission, treatment and release, reflected both attitudes towards, and conceptions of, the mentally ill. The continuation of eugenic thought limited the full development of informed consent legislation, perpetuated a system concerned with better human breeding, and extended the power of the psychiatrist beyond the asylum and into the community. Moreover, successive mental health legislation not only reinforced a sense of professionalization and power, but neglected to address issues of competency, consent and the limitation of the authority of mental health professionals in favour of the patients. This chapter illustrates the structure of mental health law and the system of mental health services between 1945 and 1970 in order to demonstrate the inequality in the provision of rights for the mentally ill. The law remained "unbalanced," slow to accommodate a changing medical paradigm, and extended the professionalization of psychiatry.

A History of Consent Law

In nineteenth-century Ontario, informed consent did not exist in any strict medical sense: "Traditionally, consent law served as a defense against allegations of assault and battery" under the clause *volenti non fit injuria*, to one who is willing no wrong is done.[48] Actions in battery cases were confined to cases where no consent was obtained, where the quality of consent was questionable and where the procedure substantially differed

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[48] Kenneth George Gray, Law and the Practice of Medicine, (Toronto: 1955), p.29.

from that to which one assented. Central to cases of battery was the imperative that the medical procedure or surgery undertaken occurred without the patient's knowledge (and thus, consent).[49]

By the twentieth century, the inclusion of informed consent under negligence and tort law rearranged the concept of consent and shifted the onus from the patient to the practitioner. Whereas battery cases based allegations upon the lack of consent for a medical procedure, negligence emphasized the failure to provide the patient with information about potential risks. In 1976, the failure to obtain consent equated legally with a breach in the physician's general duty of care.[50] As a part of a medical practitioner's duties, physicians became obliged to ensure the proper acquisition of consent, including informing the patient of potential risks. Valid consent required competency and/or mental capacity, that consent be given voluntarily, that consent be informed, and that consent be related to a specific act or surgical procedure.[51] Consent applied specifically to surgery due to cultural conceptions regarding the physically invasive nature of surgery.[52]

In A History and Theory of Informed Consent, Faden and Beauchamp address the development of consent legislation in the United States by examining legal cases centered upon the issue of consent and citing case law to support the existence of a standard of

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[49] ibid.

[50] In the 1977 Canadian case, Reibl v Hughes, Judge Haines distinguished between conceptions of consent in battery and negligence linking informed consent and a physician's duty of care. ibid., p.38.

[51] ibid., p.29.

[52] Phil Fennell, Treatment Without Consent: Law, Psychiatry, and the Treatment of Mentally Disorder People Since 1845, (London: 1996), p.149. In 1948 in England, no consent was necessary for coma or shock therapy but obtaining consent remained necessary for psychosurgery due to the risk of mortality. Moreover, proxy consent was widely accepted in psychiatric practice, whatever may have the legal view as to its validity. "Where consent was obtained, it was usually that of relatives who, in the climate of enthusiasm for psychosurgery as a miracle cure, were keen not to stand in the way of their loved ones having access to it." ibid.

consent as early as the nineteenth century. Research conducted in the mid-nineteenth century by Pernick on "medical and surgical case records show that patients' desires to undergo or not undergo surgery were routinely acknowledged."[53] Decisions in nineteenth century law on consent were based upon expert witness testimony to determine the validity of the case as well as the general level of acceptance required by practitioners for consent in specific medical procedures. Thus, despite no legal codification, consent remained a part of legal precedent long before the 1960s and was recognized as a part of the therapeutic process. Yet, the decisional law on consent remained repetitive and incomplete, often reflecting unsettled theory.

The transition from expert testimony to battery cases relied on the absence of consent and a principle of respect for autonomy. Nineteenth-century cases ignored and evaded the issue of self-determination by balancing an individual's wishes with the practitioners testimony that consent comprised an ordinary part of medical therapy. The right to self-determination first appeared in the Scholendorff case (1914) where the court claimed, "Every human being of adult years and *sound* mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."[54] However, the same rights and protection were not clearly extended to individuals of unsound mind. The law remained silent regarding the right and ability of a person of unsound mind to self-determination. Both battery and negligence cases, based in the absence of consent and professional duty, under the law were largely subsumed by malpractice cases where regardless of whether consent was expressed or implied, the doctor remained liable.

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[53] Pernick, "The Patient's Role in Decisionmaking," as cited in Ruth Faden and Tom Beauchamp, A History and Theory of Informed Consent, (Oxford: 1986), p.77.
[54] ibid, p.125.

The evolution of the traditional duty to obtain consent, developed into the duty to disclose information and then obtain consent, occurring between 1957 and 1972. Informed consent further required that the doctor 'inform' the patient of the potential risks. The obligation to ensure the patient was knowledgeable about the procedure rested with the doctor. The Salgo case of 1957 first set forth the extension of disclosure in treatment by basing the case upon whether the consent was informed, not simply obtained.[55] Again, in 1960, the Natanson case further grounded informed consent legally in liability and negligence, rather than battery.[56] The difference between acquiring consent and informed consent relied upon the individual's ability for self-determination, or respect of autonomy. Yet, despite the existence of a consent standard as early as 1841 and the ongoing entrenchment of consent into legal case history, consent by the mentally ill comprised a more complex and less efficient advancement.

In the Law and the Practice of Medicine, Gray, a lawyer and doctor, discussed the existing medico-legal framework in Canada. First published in 1947 and revised in 1955, Gray's work highlighted the post-World War II backdrop against which the medical paradigm began to shift. Gray claimed that judgments and statutes formed the basis of all legal decisions and that legal actions against doctors were based in negligence – a failure to exercise reasonable care. The onus placed upon the plaintiff to prove negligence by either expert medical testimony or *res ipsa loquitur* (the thing speaks for itself) constituted a new application and interpretation of the law. Gray claimed a doctor was

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[55] In the Salgo case, "Martin Salgo suffered permanent paralysis after a translumbar aortography, he sued his physician for negligence in its performance and in failing to warn him of the risk of paralysis." ibid, p.125.

[56] "Mrs. Natanson sued her physician for failure to obtain her informed consent to cobalt radiation therapy, which was administered after a mastectomy. She suffered severe radiation burns and brought a malpractice claim, alleging negligence by Dr. Kline, a radiologist, both in the performance of the new method of treatment and in failure to warn of its nature and hazards." ibid, p.130.

unable to examine a patient without consent but, "It is not even necessary that the consent be in express words; it may be implied from the patient's conduct, and the surrounding circumstance."[57] For example, bringing oneself to a doctor implied consent for an examination. A written notice of consent, usually obtained only for major surgical operations, remained standard but cases arose where consent, even for surgery, could be oral or implied – such as an unconscious person requiring a life-saving operation. Determining the necessity of obtaining informed consent seemed to be broadly construed in Canadian legislation during 1955 and subject to considerable interpretation.

Ontario Laws

The Ontario Mental Health Acts during the period under study consistently authorized the medical superintendent to act on behalf of patients and to retain the power to decide all aspects of hospital policy and procedure. An examination of Ontario provincial legislation largely supported the claims made by Gray and Sharpe regarding the rights accorded to the mentally ill and the securing of consent. The Mental Hospitals Act of 1935 distinguished between mentally ill and mentally defective persons[58] by separating incomplete mental development from a disorder of the mind. Although distinctions between persons with mental illness and persons with mental impairments existed, the same legislation (with minor amendments) affected both groups until 1967. The Mental Hospitals Act and the Psychiatric Hospitals Act prior to and following World War II

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[57] Gray, Law and the Practice of Medicine, p.33.

[58] Mental Hospitals Act 1935, Part I, 2 states, k) "Mental defective" and "mentally defective person" shall mean a person in whom there is a condition of arrested or incomplete development of mind, whether arising from inherent causes or induced by disease or injury, and who requires care, supervision and control for his own protection or welfare or for the protection of others; m) "Mentally ill person" shall mean a person other than a mental defective who is suffering from such a disorder of the mind that such person requires care, supervision and control for is own protection or welfare, or for the protection of others.

remained separate, but complementary entities, specifically in the application and extension of the law. All power for the governance of the hospital, including "regulating the care, treatment, maintenance, conduct, discipline, custody, transfer, probation, release, discharge and apprehension of patients"[59] resided with the Lieutenant –Governor and administration and control of the mental health acts between 1935 and 1967 resided with the Department of Health subject to the authority of the Minister.

The governance of mental institutions by government officials, responsible to administer the act according to the law, required that accountability for the hospital also reside with the government officials and the superintendent, to whom authority had been extended. Yet, the 1935 act prohibited any type of redress or prosecution against the hospital or any employee,

> No action, prosecution or other proceedings shall be brought or be instituted against any officer, clerk, servant, or employee of the Department, or the Public Trustee, or against any other person for an act done in pursuance or execution or intended execution of any duty or authority under this Act or the regulations, or in respect of any alleged neglect or default in the execution of any such duty or authority, without the consent of the Attorney-General.[60]

Moreover, all prosecutions for actions completed or omitted had to be commenced with six months and "no action shall lie against any institution or any officer, employee or servant thereof for the tort of any patient."[61] Such statutes prohibited patients from prosecuting anyone associated with the hospital on the basis of official job capacity which further enfeebled patients rights. A growing tension existed in the post-war years between the façade of medical rhetoric to administer consent and the reality that few

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[59] Mental Hospitals Act 1935, Part I 6 (2)g .
[60] Mental Hospitals Act 1935, Part II 11(1).
[61] Mental Hospitals Act 1935, Part II 11 (2-3).

psychiatric patients held any rights in daily experience. Moreover, the laws regulating the hospital for patient welfare simultaneously prohibited legal action against the hospital officials, the same people in whom the law was vested. The result created a law which authorized individuals to act in all areas of the hospital and then protected the same individuals against the potential for abuse in their position. To essentially forbid the prosecution of anyone associated with the hospital, prevented a patient from filing a lawsuit with any probable success, and thus bolstered the potential abuse of power.

The Hospitals Act of 1935 also permitted the examination of patients and their detention for varied periods of time based upon diagnosis. If a patient voluntarily committed him/herself to a hospital, the patient could leave after five days, once having provided written notice of intent. However, upon examination by two medical practitioners, the voluntary patient's status could be revoked and replaced with that of a certified patient. [62] Hence, even a voluntary patient could have continued as a certified patient despite a desire to leave. Involuntary patients were admitted based upon the directives of a magistrate, or by the certificates of two physicians. In either case, sufficient authority existed to admit and detain a patient, and no legal clause stated when an involuntary patient may be released from the hospital. Thus, the power to release patients resided solely with the administrators of the hospital, regardless of patient status.

Admission and discharge also relied upon the discretion of the superintendent. In 1952, an amendment to the Mental Hospitals Act allowed for application of a patient to an institution with the written or verbal permission of the Superintendent. Once the patient was admitted, the Superintendent possessed all authority with respect to the custody and control of the patient.[63] The verbal approval of all admissions by the

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[62] Mental Hospitals Act 1935, Part II 20 (2), 25 (1).

Superintendent reduced the ability to secure impartial and unbiased access to the hospital. Admission may have been obtained by nepotism or other connections and thus could have possibly undermined the certification process which determined an application's validity. Moreover, during confinement, the Superintendent maintained control over one's custody and care. Treatment, restraint, and examinations all remained subject to the Superintendent's approval, eliminating the possibility of refusal by a patient.

Special legal privileges relating to the mentally ill extended beyond the scope of the institutional workers to other provincial authorities. According to the Mental Health Act of 1935,

> Any person apparently mentally ill or mentally defective and conducting himself in a manner which in a normal person would be disorderly, may be apprehended without a warrant by any constable or peace officer and detained.[64]

A further extension of power to the police to "arrest" individuals who resembled a mentally ill individual created numerous problems. Conceptions of normalcy largely remain a matter of social context. "Community values" and the morals of the era dictated to a large extent whether behaviour could be considered within or outside of the norm. Thus, to allow the detainment of individuals based solely upon disorderly conduct for a "normal" person offered wide latitude in judgement and application for the detainment of individuals. Again, the possibility for abuse remained as the framework to prevent abuses was weak.

In 1954, An Act respecting Mental Health included a provision identifying the legal limits of restraint and detention:

> Nothing in this Act shall be deemed to authorize the detention or

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[63] An Act to Amend the Mental Hospitals Act, 1952, subsection 2 (4) 56(c)2, 56(d)1.
[64] Mental Hospitals Act 1935, Part II 26 (4).

> restraint of any person where such detention of restraint is not authorized by an Act of this Legislature or is not otherwise lawfully authorized.[65]

By identifying the potential for an abuse of power, section eleven attempted to limit the types of actions to be undertaken and remove some confusion from previous acts.[66] The use of detention and restraint remained intact, supporting the previous legal principles; however, the actions had to remain within legal sanctions and apply to specific individuals in specific cases. Little actually changed in relation to the existing legal laws governing treatment of the mentally ill as statute eleven functioned in accordance with previous legislation. Yet, while the possibility for abuse still existed, the principle reflected a desire to ensure proper conduct and differentiate between appropriate and inappropriate forms of detention and restraint. The intent was commendable even if limited in scope.

The 1960 amendment to the Mental Hospitals Act extended the authority of the Superintendent to whomever the Superintendent delegated to act in hospital affairs.[67] The amendment further extended the authority to observe and detain individuals believed to be requiring mental aid by claiming as sufficient either the certificate of ONE medical practitioner or the permission of the superintendent. After a period of thirty days of detention, the patient could be certified as mentally ill and thus required to stay for a further period of time. Subsection 6 (1) of the same amendment also removed the ability of voluntary and habituate patients to discharge themselves based again upon certification

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[65] An Act respecting Mental Health, 1954, 11.

[66] Section 11 states, "Nothing in this Act shall be deemed to authorize the detention or restraint of any person where such detention or restraint is not authorized by an Act of this Legislature or is not otherwise lawfully authorized," which deviates from previous Acts regarding the authority to detain or restrain individuals. An Act respecting Mental Health, 1954.

[67] "Where this Act or the regulations require or authorize the superintendent of an institution to do any act, such act may be done by any person whom the superintendent appoints to do such act." Act to amend The Mental Hospitals Act 1960, subsection 2 (2).

of mental illness by two medical practitioners. [68] Even if discharged, a report from the superintendent claiming the patient to be unable to manage personal affairs retained the placement of a Public Trustee to either dispose of or continue administration of the estate.[69] The 1960 amendment further strengthened the authority and power of the superintendents and those associated with the mental hospital in the detention and treatment, discharge and even "outside life" of the mentally ill.

The right to refuse a mental health examination or not be detained without a warrant continued to be eroded by yearly amendments. On the order of a magistrate "[*any person*]" may be required to undergo a physical or mental examination.[70] The detention of "[*any person apparently mentally ill or mentally defective and conducting himself in a manner that in a normal person would be disorderly*]"[71] may be apprehended without a warrant and taken to a hospital or detained until an examination determined the status of one's mental condition. While it is unknown the extent to which the application of the law reflected the empowerment of mental health officials and the police, the law remained tailored towards such empowerment. Mental health legislation sanctioned the authority necessary in all cases to apprehend, detain, treat and discharge people as appropriate to the standards of mental health professionals. The rights of people with mental illness to determine, refuse and/or relinquish one's own position within the mental health care system clearly did not figure prominently in the legislation. While the issue of competency constituted a real factor in such determination, consent remained notably absent from the legislation – whether from the individual or family members.

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[68] ibid., subsection 4 (1), (2); 6 (1).

[69] ibid., subsection 11 (82).

[70] An Act to amend The Mental Hospitals Act 1962, Part XI (108).

[71] An Act to amend The Mental Hospitals Act 1963, subsection 5 (4).

By the mid-1960s, changes to strengthen patients' rights and account for actions within the hospitals began to appear in mental health legislation. Section 21 of the Mental Hospitals Act of 1965 claimed, "Nothing in this Act shall be deemed to prevent an informal patient from leaving at any time an institution in which he is a patient."[72] Moreover, the 1966 Mental Health Act required that mental health officers "inquire whether any patient is under restraint and, if so, as to the reasons therefor, and shall inspect the documents for the reception and detention of every patient..."[73] "Designated" patients and/or friends and relatives of "designated" patients could petition for a review of the patient's status to determine the necessity of further detainment, or whether placement within family custody or discharge best suited the patient's interests.[74] The change in laws reflected a change in attitudes towards people with mental illness. In the 1960s, activists involved in what is now known as the 'antipsychiatry movement,' pushed for a reorientation in beliefs about mental illness and an increase in patients' rights. The media also aided in the questioning of mental health practices and laws with books such as *One Flew Over the Cuckoo's Nest.*[75] Yet, the changes in the law remained minor and still required continuity with pre-existing legislation as the 1960 Mental Hospitals Act reaffirmed the Superintendent's power and his inability to be prosecuted.[76]

The Mental Health Act of 1967 constituted an "umbrella statute to govern the overall coordination of the mental health programme in Ontario."[77] Many of the minor changes implemented in the early 1960s legislation became consolidated in this important Act.

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[72] An Act to amend The Mental Hospitals Act 1965, subsection 2 (21–3).

[73] The Mental Health Act 1966, subsection 4 (4).

[74] An Act to amend The Mental Hospitals Act 1966, subsection 1 (7).

[75] Ken Kesey, One Flew Over The Cuckoo's Nest, (New York: 1964).

[76] The Mental Hospitals Act 1960, Revised Statutes of Ontario, Chapter 236.

[77] The Mental Health Act 1967, Bill 127, Explanatory Note.

Bill 127, as it was known, became a watershed in the pursuance of equality under the law for the mentally ill despite many issues remaining unresolved or simply not addressed. An alteration from mentally ill and/or mentally defective to "mental disorder" constituted the first important change. Mental disorder was defined as "any disease of disability of the mind."[78] No differentiation between hereditary or environmental factors suggested a separation between the identification of mental illness and mental impairment as well as recognition of the multiplicity of origins in mental illness. For a person believed to be suffering from mental illness, admission to a hospital as an informal patient allowed for observation without labeling the person as an involuntary patient. The categorization of involuntary patient meant the patient would be diagnosed as suffering from a mental disorder and would require hospitalization to ensure the safety of the patient or others. Yet, an informal patient's status could still be altered to 'involuntary' upon the completion of the prescribed form, allowing for forced detention and treatment.[79] Thus, the right of the mentally ill to refuse treatment still lacked legal support.

Detention within a hospital also underwent limited modifications under the 1967 Act. Authorities could still apprehend and detain individuals, but only for a period not exceeding one month.[80] Yet, certificates of renewal allowed detention to continue: the first certificate, two months maximum; the second, three months; the third, six months; the fourth, twelve months; and any further certificates, twelve months.[81] Despite the resolution to limit detainment, individuals could be confined for an unspecified period of time without redress. Moreover, the Lieutenant Governor retained the power to allow

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[78] ibid., 1(f).

[79] ibid., 7, 8 (1a, b), 12.

[80] ibid., 5 (a,b).

[81] ibid., 3 (1-5).

examinations and the detainment of patients; however, the act neglected to address whether the treatment of patients also remained within the Governor's authority. The Act also never addressed the extension of statutory authority to the Superintendent, thus, questioning whether the Superintendent's power had been revoked or simply overlooked.

In Sharpe's examination of the Mental Health Act, he distinguished between the standards of "protection and welfare" and "safety." Prior to 1967, the protection and welfare clause comprised the ubiquitous standard for detention whereas under the 1967 Mental Health Act, the prescribed forms recognized safety as the evaluative standard. Ontario then permitted the enforced confinement of anyone suffering from disease or disability of the mind of a nature...in the interests of his or her own safety or the safety of others. Further amendments to the Mental Health Act in 1978 sought to clarify the grounds for involuntary confinement, thus reducing the wide latitude in judgment by physicians as to what constituted "safety." The "safety" criterion was reconfigured to evaluate only 'serious physical harm' for committal thereby avoiding a more subjective standard of 'psychological/emotional' harm. Civil commitment thus remained a social question whereby "legislators translated community values and policies into operational definitions."[82] In cases where fear of damage to reputation or serious financial loss existed, legislators preferred community alternatives to enforced confinement. Thus enforced confinement continued in Ontario, until the development of tangible criteria for 'safety' in 1978.

Other dilemmas also persisted within the Mental Health Act of 1967. Until 1967 Ontario permitted the indefinite confinement of a person on the certificates of two physicians who stated the person "is mentally ill and a proper person to be confined."[83]

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[82] Gilbert Sharpe, The Law and Medicine in Canada, (Toronto: 1987), p.358-359.

Even until 1978 an application for a psychiatric assessment allowed the detainment and restraint of a person in custody at a psychiatric facility for observation and examination for up to 120 hours; Bill 7 later reduced the length to 72h.[84] While the law allowed for detainment, the authority to treat patients was never extended; until the 1970s, patients could still be "treated" as incompetent under law.[85] The basis for incompetence remained within common law standards which removed any possible right to refuse treatment. Communication "suspected to prejudice the patient or interfere with treatment, may be opened, examined and withheld,"[86] by hospital employees and "No action lies against any psychiatric facility or any officer, employee or servant thereof for a tort of any patient."[87] Despite some movement forward, the 1967 Mental Health Act persisted in allowing for the wide latitude in physician discretion and only a minimal guarantee of patient's rights.

Consent and the Mentally Ill

Obtaining formal consent for treatment and experimentation on the mentally ill remained unnecessary in practice until the 1970s. Nevertheless, there existed a prolonged debate in theoretical ethics and applied medicine beginning in the late 1940s. In 1955 Gray claimed,

> The consent required in the case of a mentally incompetent person is of increasing importance with the rapid development of surgical operations and specialized procedures such as electro-convulsive therapy and insulin

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[83] ibid., p.347 and 441.

[84] ibid., p.361.

[85] "In Nova Scotia, the Public Hospital Act of 1967 required a psychiatrist determine the competency of psychiatric patients' to consent to treatment shortly after admission to the hospital." Although "unrealistic as the appropriate time to consider competency is the time treatment is to be given," at least an attempt was made to determine competency and to receive consent for treatment, an ideal missing in Ontario Acts. Sharpe, The Law and Medicine in Canada, p.75.

[86] The Mental Health Act 1967, Subsection 19 (2).

[87] ibid., Part V, subsection 59.

coma [therapy].[88]

By recognizing the physically invasive nature of treatments, Gray extended the general principle of consent for surgery[89] to the mentally ill. While it remained unclear as to who should give consent (the patient or family members), the necessity to secure consent for the majority of physical procedures, regardless of the type of patient, remained crucial. Gray further recognized the necessity of securing consent when examining a prisoner, despite the fact that the request originated from the police or crown; whereas, in certain provinces, mental examinations or venereal disease examinations excluded securing consent due to statutory authority. [90] In Ontario the law governing mental health extended statutory authority to the Superintendent of a mental hospital to render decisions in all matters. The Superintendent of the hospital retained authority over patients according to the 1950 revised statutes of Ontario for the Mental Hospitals Act in chapter 229 which stated:

> Except as provided by this Act, the superintendent of an institution shall have full control over and the custody and care of the person of every patient in the institution and every patient shall be maintained, cared for, treated in, released and discharged therefrom only as may be provided by this Act and the regulations.[91]

All aspects of patient life emanated from the Superintendent, whose actions, sanctioned

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[88] Gray, Law and the Practice of Medicine, p.35.

[89] The issue of consent only arises in the late 1950s due to legal cases such as Salgo (1957) and later Natanson(1960). While no historical account has been given, excluding Faden's and Beauchamp's work, securing consent for surgery (as we currently understand it) was not a standard practice in hospitals at this time. However, recognition of the new legal emphasis placed upon consent, and due to the existence of disclosure, including risks and benefits prior to surgery, a practice relating to consent was in place. The extent to which consent was enforced cannot be determined but Gray, writing from a legal perspective, was undoubtably aware of the new emphasis upon consent and the general practice of disclosure between surgeons and patients in general hospitals. Faden, & Beauchamp, A History and Theory of Informed Consent, p.88-89.

[90] Further discussion of the rights accorded to the state under mental health acts and laws for the province of Ontario will occur later in this chapter. Sufficient presently is that Ontario provides statutory authority for the examination of those believed to be suffering from mental illness. Gray, Law and the Practice of Medicine, p.33.

[91] The Mental Hospitals Act 1950, Revised Statutes of Ontario, Part II, (14).

by the law, enshrined a patriarchal system of management. Admission, diagnosis, treatment, and release remained under his control. Moreover, the law sanctioned the authority of the Superintendent's competency to determine the capacity of the mentally ill.

Sharpe identified the need to obtain consent specifically from voluntary patients; in involuntary cases, the agreement of the relatives had to be obtained. An administrator could act when no relatives were located; in such a case, the function of the institution extended beyond the hospital and changed into the role of guardian. Sharpe claimed such an extension of the Superintendent's role may be construed as constituting authority for the hospital to then treat patients without consent as well as creating a conflict of interest.[92] Hence, legislation resulted in the continued absence of rights for the mentally ill and ensured the development of an increasingly patriarchal system. The role of the Superintendent and hospital (to treat patients), became blurred with role of the guardian (to protect the patient).

Legislative provision regarding the obtainment of consent from the mentally ill constituted a difficult endeavour due to the prevailing views about incompetence. Incompetence was determined by a single psychiatric examination or two independent statements. If found competent, a patient provided his/her own consent; otherwise a relative's consent, whose ideals presumably coincided with the patient's best interests, was considered sufficient. Yet, irrespective of competence, recommendations within hospitals and by medical professionals persisted to secure a guardian's consent, thereby ensuring the desirability of the medical procedure and reducing liability.[93] Thus, no set

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[92] Sharpe, The Law and Medicine in Canada, p.369.

standard for obtaining consent existed. Not only did the necessity of securing consent remain questionable, but the question of whether one "ought, should, or be compelled" to secure consent seemed central to the debate. Exhortations to obtain consent in all cases, made by commentators such as Gray, perhaps reflected a desire to advance legislation, prevent abuses, or limit litigation based upon malpractice, liability or tort law. Regardless Gray supplied one sample consent form for psychosurgery,[94] suggesting that this author not only correlated the requirements for obtaining consent in general hospitals with those in mental hospitals but also recognized the fundamental principals of equality and self-determination encapsulated by consent legislation.

In The Mentally Disabled and the Law, published in 1961, the rights of people with mental illness, mental deficiency, alcoholism, drug addiction and epilepsy were examined in relation to the laws regulating social, civil and personal rights. Although an Amercian publication, issues of consent corresponding to practices in Canada were discussed suggesting a professional recognition of the issues during the post war years. Admission practices, hospitalized patient rights, domestic relations, incompetency and property rights constituted the topics of the work. Yet, of interest are the abstracts on treatment, specifically psychosurgery and electroshock (the only two treatments addressed), and sterilization.[95]

Again the physically invasive nature of psychosurgery and electroshock therapy seem to explain the elevated level of concern for consent in these procedures. In both cases, competency comprised a central issue and even if the patient was determined to be

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[93] William Meredith, Malpractice Liability of Doctors and Hospitals, (Toronto: 1956), p.140. Also, Hamilton Psychiatric Hospital suggested securing consent from relatives for both lobotomies and insulin coma therapy despite no legal obligation to obtain consent.
[94] Gray, Law and the Practice of Medicine, p.36.
[95] Samuel Brackel, & Ronald Rock, The Mentally Disabled and the Law, (Chicago: 1961), p.155-219.

competent, the freedom to accept or refuse treatment without coercion from hospital staff remained a source of contention. State law was also very vague, but where it existed the law reflected a consistent impetus towards the necessity to acquire consent from the guardian or the patient (if competent). Moreover, in California, the law upheld the patient's right to refuse shock treatment or lobotomy. Although almost no case law existed, the authors claimed consent was partially required for shock treatment. The use had to be solely therapeutic and never punitive, and the physician had to always remain exempt from liability for damages.[96] Although the patient may have been able to refuse treatment, the patient could not file motions against psychiatrists for poor treatment.

Mental health law in Canada recognized voluntarily committal. It also included legal provisions for involuntary committal, thereby preempting the consequent interference with individual liberties. The 1935 Ontario Mental Hospitals Act recognized four classes of patients: mentally ill, mentally defective, epileptic and habituate (drug addicts and alcoholics). Admission procedures for the first three classes varied considerably: two independent medical certificates, the certificate of one practitioner for thirty days, judicial inquiry by a magistrate, the order of judge for sixty days examination and/or by warrant of the Lieutenant-Governor, all constituted acceptable means of entry for all three. Entrance by habituates required voluntarily admission or a petition. Mentally defective persons were unable to be voluntarily admitted.

Attempts to prosecute the mental hospital or the Superintendent for either the enforced committal of a patient or for acting on a patient's behalf failed in the face of the legal authority placed by the statutes of Ontario upon the institution and its administrators.

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[96] ibid, p.161-164.

As Gray explains:

> Thus, if a patient wishes to sue the superintendent of a provincial mental hospital for illegal detention, the patient cannot sue the hospital at all, and he cannot sue the superintendent in his official capacity. The patient's only redress is to bring an action against the superintendent in his personal capacity. [97]

To file a motion *personally* against a psychiatrist for actions committed while under his *professional* care, and succeed, seemed highly unlikely. Thus, no recourse or redress for abuses committed against patients remained readily available. Moreover, the competency of the patient likely would be construed as the central issue in any legal case alleging liability.

Sterilization and Consent

Issues of consent and liability were especially relevant in cases of sterilization. This was so because of the need to ensure the proper use of the surgery in conjunction with the patient's wishes. Sterilization, as has been argued, occurred for therapeutic, contraceptive and eugenic reasons. In the case of therapeutic or contraceptive sterilization, obtaining consent can be equated with the procedure for most surgical operations (a written note verifying the patient's agreement to a specified surgery with all the related risks). Yet, legislation did not address eugenic (involuntary) sterilization; the law remained obscure and no reported legal decision on sterilization for eugenic or economic reasons could be located in the United Kingdom, United States, or Canada.[98] Opinions from the United Kingdom, although not legally binding in Canada, recognized a distinction between therapeutic and eugenic operations, with consensus that sterilization

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[97] Gray, Law and the Practice of Medicine, p.76.
[98] ibid., p.40.

of mental defectives on eugenic grounds was illegal. Yet, Gray claimed, "it is immaterial to discuss whether, if a defective were to be sterilized on eugenic grounds, action might be taken..."[99] The reasoning behind such a statement suggests that the law not only remained unclear but was unlikely to discourage or prohibit the sterilization. In The Problem of Mental Deficiency, Thomson argues that attempts in England in the 1930s to introduce voluntary sterilization legislation targeting high-grade mental defectives and 'overburdened' mothers flourished because of the lack of clarity regarding the legality of the operation.[100] Although efforts to establish a privately-funded sterilization clinic failed, due to the availability of contraception and a reaffirmation of therapeutic purposes, the endeavour reflected the legal uncertainties regarding voluntary sterilization. Yet, voluntary sterilization of mentally sound individuals for eugenic purposes was also considered illegal. The consequences of such an act were more definitive. Medical defence organizations would not indemnify doctors, and Gray claimed almost universal acceptance of the illegality of such a procedure. Awareness of the potential for the filing of lawsuits, even with the full consent of the patient, existed among practitioners. A separate English textbook claimed that voluntary sterilization was illegal, since the State considered it beneficial if all members reproduced.[101] The position of the State coincided with positive eugenic ideology.

The lack of legislation regarding sterilization, especially in relation to consent, constituted a serious omission in the legal system. In the Canadian context, medical journals seem to comprise a major source on the issue, addressing the question in detail:

In a particular sense *sterilization is legal when it is an incidental part*

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[99] ibid., p.41.

[100] Matthew Thomson, The Problem of Mental Deficiency, (Oxford: 1998), p.184.

[101] Gray, Law and the Practice of Medicine, p.42.

> *of a medical or surgical procedure necessary for the preservation of the life or health of the individual.* Under all other circumstances, sterilization is illegal and the doctor who does it under any other circumstances, because he is doing an illegal act, exposes himself to the risk that he may be sued not for malpractice or negligence in a professional sense, but for common assault and battery and he may, therefore, be deprived of the protection of the Medical Act.[102]

Remaining unclear were the circumstances in which sterilization became an 'incidental part' of surgery. One can easily envision a situation in which sterilization could have become necessary to preserve one's life; but to preserve health or as an incidental operation, sterilization remained an unclear medical procedure.

Fennell's work on informed consent identifies an attempt in England in 1952 to broaden the legal acceptance of sterilization to include 'benefits to the individual.' While sterilization occurred frequently during the interwar years under the Lunacy Act for cases of mental defectives or disordered individuals, the introduction of the 1930 Mental Treatment Act reduced the scope of action. Although the Lunacy Act remained in effect, the Mental Treatment Act of 1930 did not extend the same powers to the state, and thus the sterilization debate was forced to gain new perspectives. The right to enable the patient to live a freer life, engage in sexual activity, and marry without fear of conceiving, provided a new basis for sterilization under the guise of 'benefits' to the patient.[103] However, the Bravery v. Bravery case (1954), revealed the legality of sterilization as a method of contraception remained doubtful.[104] Arguments based upon potential benefits to the patient gained minimal acceptance in English case law in the 1980s and 1990s, but the "Ministry was not impressed with the attempt to broaden the concept of best interests beyond medical ones."[105] Even voluntary sterilization still required the medical

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[102] ibid., p.44.

[103] Fennell, Treatment Without Consent, p.105.

[104] ibid., p.105.

legitimacy of a therapeutic purpose.

Canada's position on voluntary sterilization in 1955 derived directly from England's stance, basing the issue on the interests of the State and a refusal to address sterilization in all circumstances:

> Voluntary sterilization of the healthy is a wholly separate and different problem. Excluding from the discussion those cases covered by one or two Provincial Acts allowing sterilization under specific conditions, voluntary sterilization of the healthy must be considered wholly illegal. Under British law it is considered in the best interests of the individual and the state for each individual to retain his or her procreative powers. Requests from healthy individuals, man or woman, for sterilization must be refused, promptly and finally. [106]

Despite the rhetoric of the medical journals and distinctions between voluntary and involuntary sterilization, sterilization that prohibited "healthy individuals" from procreation continued to be illegal; thus, the promotion of procreation among the fit constituted a positive eugenic practice in effect in 1955. Although Thomson cites the voluntary sterilization of the rich in private clinics in England in the 1930s, no discussion of sterilization past 1955 occurs and, moreover, sterilization occurred privately, suggesting a distinction between private and public practice.[107] Under Canadian law, Gray further argued that, "It should be stated again however, that....the courts might decide that a sterilization operation for eugenic or economic reasons is lawful if the patient consents to the operation."[108] While Gray raised the necessity of consent, an absence in legal codification regarding consent and sterilization persisted especially for individuals deemed incompetent.

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[105] ibid., p.105.

[106] Gray, Law and the Practice of Medicine, p.44.

[107] Thomson, The Problem of Mental Deficiency, p.149.

[108] Gray, Law and the Practice of Medicine, p.45.

Sterilization on eugenic grounds is also addressed in The Mentally Disabled and the Law and claimed unjustified; however, a recommendation was put forth to investigate the heredity within a family for several generations.[109] Any sterilization operations were to be voluntary and all necessary precautions were to be taken with the mentally deficient to ensure such a procedure was truly voluntary. Thus, the authors recognized the problems of involuntary sterilization and obtaining valid consent from persons with mental impairments but simultaneously supported an investigation on heredity. The authors concluded by claiming that "Statutes authorizing involuntary sterilization should be repealed. Statutes authorizing voluntary sterilization, especially as applied to the mentally disabled, should afford every reasonable substantive and procedural protection to assure that the sterilization is truly voluntary." Consequently, involuntary sterilization remained problematic, at least until hereditary links could be proven.

Sharpe's work also made similar distinctions regarding sterilization and consent based upon the willingness of the patient and the purpose of the procedure. Sharpe cited Lord Justice Denning's disapproval in 1954 of sterilization (unless justified medically) for fear of injuring public policy and interests.[110] Meredith, a lawyer and author of Malpractice Liability of Doctors and Hospitals, also debated the issue of sterilization and claimed that sterilization, unless beneficial, may be considered criminal even with the consent of patient.[111] Another view representing concerns regarding state interests in reproduction and supporting a positive eugenic ideology.

In Appendix three of Law and the Practice of Medicine, Gray addressed a sample question on sterilization and the mentally ill. While genuinely concerned with securing

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[109] Brackel, & Rock, The Mentally Disabled and the Law, p.211-218.
[110] Sharpe, The Law and Medicine in Canada, p.64.
[111] Meredith, Malpractice Liability of Doctors and Hospitals, p.217.

consent and with the exclusion of eugenic measures, Gray supported a pro-sterilization position. The sample situation presented Miss X as a manic depressive who had already received a lobotomy, thus evidencing the severity of her condition. Miss X was unable to control her conduct during attacks and there was danger she may become pregnant. Gray's response to the scenario claimed that sterilization to prevent hereditary taint or for other eugenic or economic motivations was illegal. Yet, he claimed that in this situation, sterilization would preserve Miss X's mental and/or physical health. Gray suggested that consent be obtained from Miss X and a parent thereby eliminating a potential lawsuit if Miss X was deemed incompetent to consent. A physician should have determined if Miss X was capable of understanding the nature and consequences of the consent form and all findings regarding competency and the doctor's opinion attesting to the necessity of the operation (to preserve her health) should be recorded in Miss X's file. The opinion of an independent physician should also be obtained again emphasizing the necessity of the operation. [112]

Gray claimed that Miss X's ability to safeguard her health during pregnancy and the fear of potential attacks to herself or her child created the basis for supporting the sterilization operation. However, there was no clear reason to be concerned that Miss X would become pregnant. Based upon the evidence provided in the scenario, the entire question of sterilization derived from fear of what may occur, not from events that were pending, nor that had already transpired. Thus, while rightly concerned that Miss X may cause danger to a child, no child existed. Moreover, no explanation was given as to how sterilization would assist in improving Miss X's mental or physical health. While the

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[112] Gray, Law and the Practice of Medicine, p.52.

conduct of Miss X had resulted in her hospitalization and persisted to the extent of requiring a lobotomy, no claims addressed how sterilization would improve her conduct. Also, lobotomies frequently resulted in lowered emotional patterns and apathy for the patient, easier patient management, and the need for social re-training.[113] Thus, if lobotomized, Miss X should be rather calm. Again, the arguments surrounding the safeguarding of her health are based upon potential outcomes. The result is that the operation became a preventive measure against pregnancy and the possible dangers associated with pregnancy. Such preventive measures, unless voluntary, generally constituted a violation of rights - rights that Gray extended to the patient by virtue of requiring her consent.

Gray's response epitomized good intentions confused with preventive measures based on eugenic reasoning. He rightly recognized the issue of competency for Miss X and provided useful and sound suggestions for obtaining consent and specifically demonstrated foresight in obtaining consent from Miss X herself. Yet, Gray neglected to address the outcomes if Miss X refused to cooperate with her parents' and/or the doctors' decision that sterilization reflected her best interest; a problem compounded by the possibility of Miss X's incompetency. If declared incompetent, others determined the outcome and presented their personal interests as Miss X's. Moreover, such preventive measures reflect negative eugenics, specifically by highlighting the concerns regarding the ability of the mentally ill to parent. The implication remained that even if not hereditarily defective, the child would suffer harm, physically, emotionally or psychologically due to the environment in which the child was to be raised.

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[113] "Psychosurgery," Nursing Assistant Program, Nursing Education Department, Hamilton Psychiatric Hospital, circa 1970. p.1.

Professional Association Views on Consent and the Mentally Ill

The debate regarding sterilization, mental illness and consent persisted beyond the 1970s. The Law Reform Commission of Canada examined the arguments for and against sterilization in a working paper entitled, "Sterilization: Implications for Mentally Retarded and Mentally Ill Persons." The conflation of persons with mental illness and persons with mental impairments reflected a consistent theme in the literature. Although legal and social distinctions existed between persons with mental illness and those with mental impairments (as early as the 1940s), lectures/articles frequently included both or refrained from clearly distinguishing between each group. The definition of mental illness included both "arrested and incomplete development of the mind" and "disorders,"[114] emphasizing an association between impairment and illness that specifically extended to treatment policies and translated into a similarly-viewed social problem.

The commission's paper examined sterilization from the perspective of individuals favouring non-consensual sterilization and those in opposition to non-consensual sterilization. The pro-faction cited benefits to society and the state, both economic and genetic, as well as benefits for the "handicapped" themselves. The therapeutic reasons benefiting persons with impairments included a liberation in sexual activity, avoiding the likelihood of still-born babies, and reducing physical health concerns – specifically

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[114] "Moreover, even those doctors who must have been aware of the distinction that separated feeble-minded from mental illness tended to lump together the problems posed by both imbeciles and psychotics." Angus McLaren, "The Creation of a Haven for 'Human Thoroughbreds': The Sterilization of the Feeble-Minded and the Mentally Ill in British Columbia," Canadian Historical Review, 67 (June 1986), p.137. Despite McLaren's focus upon British Columbia, this quotation specifically references doctors from Ontario and although from the 1920s, depicts a theme of association between mentally illness, mental impairment and "solutions" that persisted until 1979 in Canada.

referring to cardiac conditions, for example. The ability or "fitness" to parent, the financial burden of children, and personal hygiene also constituted the putative benefits for the non-consensual sterilization of an individual. Lastly, arguments alluding to the benefits to future generations denounced the uncertain rearing that "normal" children would have by "handicapped" parents and further claimed the conception and bearing of a child with genetic defects was morally irresponsible. The opposition to these non-consensual sterilization arguments relied upon moral and ethical issues and deconstructed the pro-faction's arguments. Objections based upon genetic fallacy, human rights, psychological effects of differing treatment and socio-political problems all emphasized the role of environment, or the hazards of targeting a specific group of people, as well as the fitness of any parent and the need for equality under the Bill of Rights.

Once outlined, the central arguments were situated within the law identifying the problems with state intervention and the variety of medical reasons for sterilization. The law permitted therapeutic sterilization with informed consent, but lacked a standard for contraceptive sterilization or eugenic sterilization – issues raised by Gray's work in 1955. An examination of the role of informed consent identified personal and substitute consent, but neglected to list objective factors in determining competency.[115] The fifth section listed proposals from different organizations regarding sterilization of the mentally handicapped.

The Ontario Association for the Mentally Retarded, a voluntary advocacy organization for the developmentally disabled, rejected non-therapeutic sterilization, opposed any substitute consent in favour of a court decision, and also opposed the validity of consent

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[115] Law Reform Commission of Canada, Sterilization: Implications for Mentally Retarded and Mentally Ill Persons, (Working Paper 24:1979), p.94.

from anyone under sixteen.[116] The Canadian Medical Protective Association claimed that notwithstanding the social, medical or psychological reasons for sterilization, legal problems could still arise. Therefore, consent should be secured from both parents, the operation should occur only at the parent's request, an independent assessment of one's mental status should occur, and an attempt should be made to explain the matter to the individual.[117] The Canadian Medical Association approved of sterilization in 1970 if performed by a qualified doctor, in a public hospital and with the written permission of patient, spouse or guardian.[118] The Ontario Medical Association 'Guidelines for Sterilization of Mentally Retarded Persons' cited benefits to the patient and risk of pregnancy. An examination by three doctors to consider whether the procedure was in the patient's best interest, where the procedure may occur and whether documentation is complete.[119]

The conclusion of the Law Reform Commission Working Paper cited recommendations regarding sterilization by dividing sterilization into four classifications: voluntary therapeutic sterilization, emergency therapeutic sterilization, voluntary non-therapeutic sterilization, and involuntary non-therapeutic sterilization. The conclusion ultimately supported the creation of a board to determine the validity of sterilization on a case by case scenario and recommended that the court determine competency to consent. The right to appeal, to decide without coercion or duress, and to refuse sterilization were all recommended as necessary to ensure equality under the law. While such recommendations appear standard and routine currently, a footnote from the paper

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[116] ibid., p.96.
[117] ibid., p.100.
[118] ibid.
[119] ibid., p.102-103

suggested such was not the case at the time:

> It has been reported by persons who work in institutions for the retarded that this is not an uncommon occurrence. [Explanation of a stomach operation supplanting the true nature of the operation, sterilization.] No attempt is made to explain the medical procedure or the consequences. There is no way of determining how frequent this is, since such operations would be listed as voluntary because they would be carried out with the consent of the parents or guardians. [120]

Moreover, interviews with mentally retarded patients between 1949 and 1958 who were released from institutions showed approximately sixty-eight per cent disapproved of being sterilized.[121]

The Law Commission's references to and recommendations from other associations raises questions regarding the type of information being disseminated to medical professionals regarding not only sterilization but consent. Publications from the Canadian Medical Association included a code of ethics that underwent numerous revisions between 1945 and 1970. The Canadian Mental Health Association also provided two scholarly works addressing the psychiatric system in Canada and the relationship between the law, consent and psychiatry. An examination of both will aid in determining the extent to which consent constituted a professional issue as well as the manner in which the mentally ill continued to be depicted.

Canadian Medical Association

The Canadian Medical Association's Codes of Ethics provided a medical perspective on the issues affecting health care. At the very least, the code identified the "hot spots" which developed over time and at the very most the standard to which presumably many doctors complied. Although not legally binding, the Codes were adhered to in principle,

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[120] ibid., p.76, footnote #178.

[121] ibid., p.50 footnote #123.

and violation of the standards resulted in revocation of one's membership. Between 1945 and 1970, five codes of ethics were published. The first three -1945, 1956, and 1961 - neglected to address the issues of patients' rights and consent. Consent was to be obtained by either the patient or a responsible relative, but only relating to privacy or to the disclosure of medical information on a form. In 1965, an addendum was added to the 1963 code of ethics, addressing sterilization. Only a paragraph in length, the code refused to deal with any legal aspects but claimed sterilization was ethical when performed for 'valid reasons.' Corroboration of the operation and ensuring the operation remained in accordance with the religious convictions of the patient or guardian were the only stipulations. No mention of consent or competency was made. Sterilization was only addressed in the addendum; the 1970 code did not include a reference to it.

The 1970 code did include the right of the patient to refuse treatment. The CMA stated, "when the patient is unable, and an agent unavailable, to give consent, [or] render such therapy as he believes to be in the patient's interest."[122] Emergency consent to save an individual's life constitutes an acceptable practice to this day. Clinical research was also addressed which pointed towards a shift in the medical paradigm. Beginning in 1970, the CMA cautioned members regarding appropriate medical investigations. One must remember that the CMA was not specifically concerned with the mentally ill and thus, no mention of competency nor informed consent relative to competency remains uninformative.

The Canadian Mental Health Association published a report entitled, The Law and Mental Disorder, the sequel in a trilogy addressing mental health.[123] Written in large part

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[122] Canadian Medical Association, Code of Ethics, (June 1970), p.3.

to address the lacunae in More For The Mind,[124] the CMHA decided to publish a work which addressed psychiatry in a legal framework rather than review the psychiatric system and propose changes. The work devoted scant attention to the rights of patients and informed consent due in part to a previous work which relayed information regarding admission and detention. The majority of The Law and Mental Disorder outlined principles which satisfied the basic legal requirements but was limited in both discussion and critical evaluation of the issues. [125]

The right to refuse treatment in conjunction with the right to maintain communication was addressed in chapter two of The Law and Mental Disorder. The former is of primary interest, and thus will only be included. The CMHA cited the complications of competency and involuntary detainment in the determination of the right to refuse treatment. Again, the law remained unclear and vague especially regarding the role of the Superintendent, which the CMHA acknowledged, and thus, presented a principle to aid in deliberations. Principle 36, required consent (for major treatments) either from the individual, if competent, or else from the next of kin. If neither option was available, the CMHA proposed the Superintendent authorize treatment after consulting with another physician to ensure the necessity of the procedure. [126] The work questioned the right of

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[123] A Report of the Committee on legislation and psychiatric disorder; a committee of the National Scientific Planning Council of the Canadian Mental Health Association, The Law and Mental Disorder, Two: Civil Rights and Privileges, (Toronto, 1967). The other two works addressed hospital and patient care, published in 1964, and the criminal process, which was still being researched in 1967.

[124] Canadian Mental Health Association, More For the Mind, (1963). The focus of More For The Mind was solely limited to an examination of psychiatry and treatment for the mentally ill. The review of existing services ignored research and education as well as civil rights.

[125] The work comprised eight chapters on issues as diverse as administration of estates to operating a motor vehicle and sought to address the legal rights of psychiatric patients on each topic in all ten provinces. Thus, the work was limited to factual recitation and little detail, providing only the most cursory information.

[126] Report of the Committee on Legislation and Psychiatric Disorder; a committee of the National Scientific Planning Council of the Canadian Mental Health Association, The Law and Mental Disorder: two: Civil Rights and Privileges, (1967), p.13.

the State to deprive a person of liberty but claimed the right to a hearing would alleviate any unsuitable treatments.

Chapter four of The Law and Mental Disorder discussed domestic relations and included a section on marriage and being a fit parent. The law clearly prohibited the marriage of anyone suffering from mental illness under the Revised Statutes of Ontario, 1960 (chapter 228 section 48) and thus, made discussion of this topic a moot point. Regarding parental fitness, the CMHA was concerned that parents would be unable to provide both physically and emotionally for the child's well-being.[127] The proposed principle suggested that no law be developed, but rather to allow child welfare authorities to continue assessing neglect within the home. While the CMHA clearly did not champion the rights of the mentally ill, significant measures to further limit those rights were also not proposed. The CMHA maintained a conservative standard, and medically-oriented approach to these issues, an approach favouring professionals but, where appropriate, referred to legal precedent.

Conclusion

From examining the Mental Health legislation between 1935 and 1970, the absence of consent legislation and the extension of power to the Superintendent confirms that one could be detained and treated without consent. The absence of consent law adheres to Simmons' theory of "unbalanced" health policy and legislation.[128] The numerous discussions regarding informed consent and competency continued from as early as 1947 to1970, without the development of any concrete legislation to enforce changing

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[127] ibid., p47-49.

[128] Harvey Simmons, Unbalanced: Mental Health Policy in Ontario, 1930-1989, (Toronto: 1990).

medical paradigms, social values and legal precedents. The lack of codification or enforced implementation of any of these ideals allowed for mental health policy, and thus treatment of the mentally ill, to tumble forward haphazardly. The codification existing within the law extended the power of the psychiatrist to all areas of the institution and even beyond, into the community. The reflection of increasing professionalization existed in the law as psychiatrists sought to improve their standing and to address the problems of mental hygiene and prevention. An attempt to resolve the "social" problems in society led to a perpetuation of eugenic ideals. Concern that "healthy" individuals continue to reproduce even if willing to undergo sterilization, constituted a continuation of positive eugenics. Moreover, sincere desires to prevent pregnancy and questioning of the parental "fitness" comprised negative eugenics in a less physical and more social format. Although sterilization, a physical intervention, still constituted the means of prevention, the concept of proper social rearing and prevention itself reflected a social attitude.

The continuation of eugenic ideals, the increasing professionalization, and haphazard policy formation created an atmosphere in which, despite early attempts to secure equality for the mentally ill, a lack of equal rights existed. While further study is necessary to determine if the laws, as written, were also enforced in the same manner, the rights of the mentally ill were left marginalized. The intent of this chapter is not to suggest that abuses were rampant within the mental health system but to evidence the extent to which power and authority was retained by mental health professionals over the mentally ill and to question the slow process of consent legislation. The fact that Gray recognized the increasing importance of consent legislation, specifically for the physically invasive surgeries and treatment used upon the mentally ill, suggests that informed consent constituted a viable principle in medico-legal thought. Moreover, the Hamilton Psychiatric Hospital removed the process of obtaining consent in 1952 for ECT but not for lobotomies and insulin coma therapy.[129] Thus, recognition of the need to obtain consent, even if to prevent litigation, existed long before codification.

The examination of informed consent, both legally and professionally, illustrates an extensive patriarchal attitude pervading all areas of mental health care. The creation of legal principles to solidify the authority of the superintendent, both within and outside of the institution reflected the increasing level of professionalization attained by psychiatry. Eugenic ideals swung away from solely hereditarian arguments to incorporate views on the role of environment and a new social element in the prevention of mental illness. Recognition by health care professionals to obtain consent and by lawyers for the need to implement new legislation governing consent ultimately presented little opposition to a system structured by the professional for the professional. Despite the need for change, no serious pressure came about until the 1970s. Within a changing medical paradigm, the concept of protection remained oriented towards the norm, protection against rather than protection for individuals with mental illness.

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[129] See chapter four.

Chapter 2

Professionalization and Human Betterment

Only if the mental health professionals could convince the government and elite decision-makers that mental illness was in fact an illness, if the ordinary general practitioner could be convinced that he should take mental illness seriously and be trained to identify and even treat certain forms of mental illness, and if the public could be convinced that mental health professionals were engaged in approximately the same kind of endeavour as medical doctors, then the gap between psychological and physical medicine might be bridged, with the mental health system reaping the benefits of enhanced status, improved finances and public standing.

Simmons
Unbalanced, 1989, p37

During the post-World War II years mental health made numerous strides forward in the comprehension and treatment of mental illness, but was equally affected by backward attitudes. Despite public support for equal rights for the mentally ill, and the aftermath from the euthanasia campaigns in Nazi Germany, the subjection of the mentally ill to a patriarchal medical system which disregarded their rights in favour of medical intervention continued. Medical intervention remained justified by appeals to 'human betterment' and desires for psychiatric professionalization. The concept of human betterment relied upon psychiatric and psychological conceptions of 'normalcy' and specifically psychiatric attempts to restore psychiatric patients' behaviours and symptoms to socially-acceptable standards.

The desire to be regarded as a legitimate branch of scientific medicine caused psychiatry to move outside of the asylum and into the community to aid in the fulfillment of better mental health for all Canadians. The purpose and function of mental health policy in the post-war years - to prevent mental illness, sustain mental well-being and restore 'defective' individuals to full mental health - reiterated the desire to improve humans through professionalized intervention. Moreover, only professionals possessed the knowledge and ability to intervene and to realize human betterment. An examination of mental health policy and psychiatry illustrates the haphazard progression of mental health services and policy in post-war Canada which allowed psychiatry to extend into the community and professionalize. The justification for this professional extension was the 'new' eugenic aspiration of human betterment.

Health professionals sought to 'improve' human health through the professionalization of psychology and psychiatry. Psychologists constructed the notion of the "normal" family, thereby extending both the power and influence of psychology.[130] Beginning with involvement in schools, through education and concern over mental hygiene, psychologists reproduced dominant values by generating new definitions of 'normalcy.' The "normal" family became idealized and therefore ultimately unattainable. This attempt by psychiatry and psychology to construct normalcy in accordance with social values and thereby extend power and influence is intriguing.

Psychologists and psychiatrists extended their influence into the public sphere in the ongoing process of professionalization.[131] Medical ideals, legitimized by scientific

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[130] Mona Gleason, Normalizing the Ideal: Psychology, Schooling, and the Family in Postwar Canada, (Toronto: 1999), p. 120.

[131] Harley Dickinson, Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905-1984, (Regina: 1989); Andrew Scull, "Museums of Madness Revisited," Social History of Medicine, 6-1 (April 1993); Ian Dowbiggin, Keeping America Sane: Psychiatry and Eugenics in the United States and Canada:1880-1940, (London: 1997); and David Rothman, The Discovery of the Asylum: Social Order and Disorder in the New Republic, (Toronto: 1971).

knowledge, were extending into many social areas. Behaviour studies began to be promoted, IQ tests revered, and definitions of normalcy applied to all areas of life. Medicalized conceptions of 'normal' behaviour, 'appropriate' social functioning, and 'suitable' environmentals became ubiquitous. However, medical intervention remained largely limited to concern over ensuring this proper "socialized" environment as the pendulum of physical interference to correct heredity was swinging back towards environment.

The emphasis upon environmentalism rather than hereditarianism reflected a new type of intervention combining both eugenic ideals and social conditioning to ensure 'well-born' humans. Previously, emphasis largely rested upon physical intervention but, in response to the Nazi experiments and the subsequent transformation of eugenic goals, social conditioning comprised a 'new' eugenic response. Emphasis upon the environment -how to appropriately raise children - exemplified the desire to create better humans by manipulating environmental factors. Better human breeding could not, in the views of the proponents of the 'new eugenics,' be solely limited to social intervention; physical intervention continued with the sterilization of persons with mental illness or impairments in Alberta and British Columbia.[132] Other forms of physical intervention, such as lobotomies, also sought to redress human deficiency and inappropriate behaviour through physical manipulation. While physical intervention remained, the emphasis upon heredity declined in favour of controlling individual's environment and promoting "social" behaviour.

As this chapter will show, mental health policy in the post-war years addressed three

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[132] Clarence Hincks, "Sterilize the Unfit," Maclean's Magazine, (February 15, 1946); Darcy Henton, "Faith in Eugenics Ran Deep in Alberta," Toronto Star, (February 11, 1996).

constant themes based upon environmental intervention: prevention, education, and the medicalization of mental ill-health. Each aspect of mental health policy interconnected with psychiatry and furthered psychiatry's status as a professional branch of medicine. Prevention encapsulated the trend towards social intervention through community-based mental health programs which accorded mental illness the same 'notions of contagion' as physical illness.[133] Educating the public soon followed, as parents were encouraged to bring children to mental health clinics, visit with psychologists and psychiatrists in the community, read literature on 'normal child' development, and as teachers were prepped to both detect and respond to deviant children.[134] The successful prevention of mental illness, through educating the community, required the general acceptance of the legitimacy of psychiatry as a medical practice with disorders that affected individuals equally, regardless of heredity. Moreover, the status of psychiatrists and general practitioners became equal especially as community treatment was commonly shared. The stigma of large asylums was replaced with mental health clinics and psychiatric clinics – both within the community or general hospitals. Even psychiatry's use of drugs, lobotomies and electro-shock therapy signified an apparently more scientific and medicalized approach to mental illness. Thus, psychiatry's extension into the community obtained increased legitimacy through the creation of a mental health policy seeking to prevent mental illness and educate the public through social conditioning, environment, and by association with physical illness.

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[133] Harvey Simmons, Unbalanced: Mental Health Policy in Ontario, 1930-1989, (Toronto:1990), p.55; M. Chapin, "Mental Illness Need Not Be A Calamity," Saturday Night, 63, (April 17, 1948) p.36; Hincks, "Sterilize the Unfit," p.19; and M. Francis, "Holiday Mental Clinic," Saturday Night, 65, (March 7, 1950), p.12,32.

[134] Mental Health Division, Department of National Health and Welfare, Child Training Pamphlets, 1954-1968; and J. Morgan, "Towards a Health Service Program," Canadian Welfare, 29, (November 1, 1953) p.40.

Post-War Years

In the immediate post-World War II years an increased emphasis on national social services (such as pensions, welfare, and health) occurred with Prime Minister King's green book proposals.[135] As early as 1937, the Rowell-Sirois Royal Commission envisioned the implementation of hospital and medical insurance. Surveys revealing high infant mortality rates and overall poor health among Canadians caused municipal, provincial, federal, medical and even business interests to merge. Yet, the interactions among the federal government, the provincial governments, and the medical community functioned on reluctant concessions and incremental politics. Decision-making transpired through minor decisions addressing particular problems, rather than through comprehensive legislative reform. An indefinite number of minor policy amendments and advancements occurred in accordance with existing agendas, each seeking to alleviate immediate social ills rather than pursue a long-term goal.[136] Thus, the policy process became both endless and unpredictable. Simmons claims the same incremental politics affected the development of mental health policy in Canada: "As is often the case in the history of social policy, a major policy innovation resulted from the slow accretion of minor decisions...In fact, there was no planning: there was no clear statement of goals or objectives to be achieved and no research into alternatives."[137]

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[135] David Naylor, Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance 1911-1966, (Montreal: 1986). William Lyon Mackenzie King put forth a series of proposals in the immediate post-war years reflecting a movement towards the welfare state by introducing Old Age Pensions, Unemployment Insurance and Family Allowances.

[136] See Taylor, Health Insurance in Canada, (Toronto: 1956); J. L.Granatstein, Canada 1957-1967: The Years of Uncertanity and Innovation, (Toronto: 1986); David Naylor, Private Practice, Public Payment (Toronto:1986); Penny Bryden, Planners and Politicians: Liberal Politics and Social Policy 1957-1968, (Montreal: 1997).

[137] Simmons, Unbalanced, p.77.

Slowly, however, psychiatry moved out of long-stay mental hospitals. The initial impetus to prevent mental illness in the community and educate the public about mental illness occurred with the development of the National Health Grants in 1948. The grants, from the federal government, allotted large sums of money to the provincial governments to address pressing health needs. In Canadian Forum, an article titled "Our Shameful Mental Hospitals," argued for increasing the money directed towards mental health, claiming, "we are getting in the way of treatment and care for our mentally sick exactly what we pay for it."[138] Each province initially conducted a survey identifying key health care issues requiring direct attention. The Ontario Minister of Health, Dr. Mackinnon Phillips, appointed the Ontario Health Survey Committee to conduct an examination of the mental health system. The report lamented that, " 'This study of existing facilities for diagnosis and treatment of mental illness in Ontario, and the inadequacy of those facilities leaves no room for complacency.' "[139] The Ontario survey identified mental health as a priority as well as tuberculosis, venereal disease and cancer research and treatment.[140] The current state of Canada's mental health care system required immediate intervention to reduce the number of mentally ill and educate the public regarding mental illness.

The new National Health Grants were widely discussed in journals and the popular media. Canadian Nurse included an article on the "Dynamic Health Program" in 1948, which outlined the different features of the program. Money totaling $625 000 was put aside for surveying existing health needs and extending hospital accommodation. Tuberculosis, venereal disease, mental health, care of crippled children and professional

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[138] D., LeBourdais, "Our Shameful Mental Hospitals," Canadian Forum, 27, (1948), p.226.
[139] Simmons, Unbalanced, p.42.
[140] Author Unknown, "That We May Live…," Saturday Night, 60, (May 16 1950), p.21.

training were all preselected topics for the national grants. Yet, absent from the article were the goals or policies necessary to implement and effect change. In 1950 the Canadian Journal of Public Health noted medical concerns over hospital accommodation due to the constant shortage of beds accompanied by an ever-increasing rate of patients. For mental health services, $5 156 000 was set aside specifically to improve treatment services, develop preventive mental health clinics for adolescents and children, and establish a training course for teachers in primary and secondary schools.[141] Again the means to accomplish these ends were not addressed. In 1953, Canadian Welfare included an article examining the first stage of the National Health Plan and recognized from 1948 to 1953 that the number of infant deaths had been reduced, and that hospital accommodation increased. "Mental health clinics are now open in 77 communities compared to only 17 in 1948, and cancer diagnostic facilities have been provided,"[142] the article concluded. The program was successful in the short-term but no long-term strategy existed. The advancements solved only the most immediate and pressing health care problems.

Mental Health Clinics

In the immediate post-war years a demarcation existed between mental health and the general health care system causing psychiatry to lag behind general medicine in education and research. In 1944, B.T. McGhie, Ontario's Deputy Minister of Health, proposed a radical reform of Ontario's mental health policy based upon two priorities:

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[141] B. Layton, "The Progress of the National Health Grants," Canadian Journal of Public Health, 41, (1950), p.366-367.

[142] Author Unknown, "Across Canada," Canadian Welfare, 29, (June 15, 1953), p.15.

first, to increase bed capacity, and second, to establish preventive health care outside of mental hospitals in conjunction with the public health system.[143] Rather than solely addressing the individual, public health attended to the community. Thus, the role of public health extended from sanitation and preventive medicine to include broader aspects of illness in which the family and community found themselves. In 1950, an article focusing on the teaching of clinical preventive medicine claimed,

> The entire field of health study includes not only activities aimed at the prevention of disease and disability – which suggest the rather negative attitude that health is the mere absence of disease – but also those aimed at developing the maximum of physical and mental fitness in individuals or groups – a more positive concept.[144]

The public health department not only willingly extended its role to include mental health, but sought a mental health program that was preventive, educative and inclusive. Yet a report by the Ontario Health Survey Committee (OHSC) suggested integrating the mental health system with physical medicine by establishing psychiatric wards in general hospitals, extending mental health care into the community through mental health clinics, and increasing additional support staff such as social workers, psychologists and occupational therapists.[145] No proposals from OHSC suggested partnering with public health. As a result, McGhie's proposal that mental health clinics be established as public health centers countered the Ontario Health Survey's proposal of adding psychiatric hospitals to public hospitals and establishing mental health clinics in general hospitals. Despite the conflict, no resolution or compromise occurred. Rather mental health clinics were created and dismantled according to existing needs.

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[143] Simmons, Unbalanced, p.39.

[144] C. B. Stewart, "The Teaching of Clinical Preventive Medicine," Canadian Journal of Public Health, 41, (April 1950), p.157-63.

[145] Simmons, Unbalanced, p.43-44.

Mental health clinics were initially implemented as traveling clinics focusing on assessment and testing, not aftercare. The clinic was generally staffed with one psychiatrist (who acted as the official in charge), one psychologist and one social worker; occasionally a public health nurse also worked with the clinic. The absence of specialized child services within the community caused the clinic to focus specifically upon children. Functioning without any rigid mandate, except to prevent mental illness, the clinics were often imposed upon to administer IQ tests to unmarried mothers (believed to be deficient), or work in schools, or respond to other health related requests not directly associated with the clinic's preventive work. The result was that the clinics became responsible for aspects of mental health outside of the clinic's ability and preventive role. "Thus, despite the declared intention of working to prevent mental illness and to help care for those who were mentally ill, the traveling clinics found themselves motoring up and down every highway and byway on the province's social problem map."[146] The result was that the traveling clinics ended up being absorbed into the psychiatric hospital system and/or psychiatric units. Without a clearly-defined policy and without a long-term goal, the clinics quickly became viewed as a perfunctory establishment which contributed little to the alleviation of mental illness.

The clinics exacerbated their own demise by the large number of recommendations for institutionalization. The clinics were supposed to eliminate referrals, but they were unable to avoid them due largely to the absence of aftercare. Treatment was limited, the function of the clinic convoluted, and high rates of turnover and recidivism attested to the temporary and ineffective service the clinics provided. According to one Report on Community Mental Health Services: "'The clinics lacked a clearly defined function.' "[147]

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[146] ibid., p.52.

Despite the early detection of the need for aftercare services, community care received minimal or no attention until the 1960s when both deinstitutionalization occurred and the number of community care workers increased. The Mental Health Statistics for 1955 claimed the overall rate of patients was declining, but the decline was accompanied by an acceleration of movement by patients between the hospital and the community.[148] The rate of patients on the books (the number of admissions to provincial mental hospitals), steadily increased until 1960, when the rate of patients decreased. Overall, however, higher admission and discharge rates existed. The Mental Health statistics remain consistent with historian Andrew Scull's argument regarding rising admission rates but declining resident rates. He claims, "If the asylum system had its roots in one sort of statistical version of cutthroat competition, its imminent demise seems to have provoked another - only this time, the hospitals, racing to discharge 100 per cent of their intake..."[149] It seems possible that Ontario psychiatrists also joined the deinstitutionalization bandwagon to attest to their ability to cure patients and to evidence legitimation as a medical profession within the community. Despite the overall decline in 'chronic case' admissions, the mental health clinics were unable or unwilling to provide widespread admission reduction.

Since public health represented the center of health education and prevention, it was assumed to play an equally important role in the education and prevention of mental health. Yet, Simmons outlines the problems faced by public health in combating mental

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[147] As cited in Unbalanced, ibid., p.41.

[148] Dominion Bureau of Statistics, Health & Welfare Division, Mental Health Statistics: Trends in Hospital Care and Patient Characteristics, 1955-63, (October: 1966), p.8.

[149] Andrew Scull, "The Demise of the Asylum: Decarcerating the Mad," Decarceration: Community Treatment and the Deviant: A Radical View, (Oxford: 1984), p.67.

illness,

> In 1952, Minister of Health Dr. Mackinnon Phillips told the legislature, 'mental illness is absolutely no different from physical illness... we are going to be able to defeat mental illness the same as we have practically defeated tuberculosis. When we think that fifty years ago tuberculosis...was considered an incurable disease, there was no specific treatment – all they did was really get rest, sunshine and good food. At that time they had a mortality rate of one hundred per one hundred thousand people. Today our mortality rate in Ontario is thirteen last year... If we are going to attack this mental health program...if we are going to attack this, we must attack it at the level of the community with the family doctor being the main person.[150]

Despite the optimistic comparison between TB and mental illness, the direct analogy resulted in elevated expectations the public health department could not meet. The successfulness of the TB program hindered the public health department's participation in preventive mental health due to false analogies which expressed an exaggerated ability to cope with mental illness. By 1966, Minister of Health, Matthew Dymond claimed, "Mental illness is not a communicable disease and does not constitute, necessarily, a hazard to the public health."[151] Yet, not until the 1960s does public health's inability to cure mental illness, and its association with TB or physical illness, become an issue. Public health remained involved in the education and prevention of mental health during the 1950s; however, the poor analogy later reduced the validity of the mental health clinics as comparisons between mental illness and TB were denounced by government officials and psychiatrists.

The mental health clinics failure and public health's exclusion from mental health is not surprising considering the lack of a clearly defined objective, the exaggerated claims about its ability to cope with mental illness and opposing recommendations from the OHSC. Community-based mental health clinics outlived their function and were

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[150] Simmons, Unbalanced, p.55.
[151] ibid., p.56-57.

replaced by clinics integrated with provincial mental hospitals and the general hospitals; local services were transferred to psychiatric units.[152] Yet, the role of the public health department reflected an ongoing concern with prevention and education in mental health. An association with public health was never immediately bypassed and proposals to unite the two movements continued until the 1960s; however, little joint action occurred. From its inception, the public health and mental hygiene partnership lacked direction, "Exactly what form public health centers were supposed to take was not spelled out in the report."[153] As a result,

> In the 1950s, therefore, mental health policy chugged along the same tracks that had been laid down in the nineteenth century...The only major acceptable alternative was to establish psychiatric wards of units in the general hospitals. This appealed to psychiatrists because they believed that psychiatric units would be therapeutically and organizationally beneficial for mentally ill people and because, happily, it suited their professional aspirations to link themselves as closely as possible to general medicine.[154]

Psychiatric Units and Professionalization

The psychiatric unit system was based upon Dr. Cameron's example of the day hospital at the Allan Memorial. From its inception the psychiatric unit system received large support from the OHSC, psychiatrists, the Department of Health, and the Tyhurst Report; however, the creation of psychiatric units as the center of community mental health services comprised a slow process.[155] Initially financed by grants under the National Health Program, the financing ended up coming from within the hospital, which

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[152] ibid., p.54.
[153] ibid., p.38.
[154] ibid., p.44.
[155] ibid., p.69.

as of 1959 fell under the Hospital Insurance and Diagnostic Services Act. Psychiatric treatment itself was excluded from the Act, but due to the association of psychiatric units with the general hospitals, (and specifically the shared locus), psychiatrists benefited as an extension of the hospital. Thus, not only did psychiatrists gain professionally, but financially as well.

The psychiatric units were established with the purpose of preventing mental illness, educating the public to view mental illness like any other disease, and to treat patients promptly. Much like the mental health clinics, however, no serious reduction occurred in the numbers of mentally ill. High rates of turnover and readmission plagued the units. Serious cases still required lengthy admissions to the provincial mental hospitals while the units addressed solely minor deviations in mental well-being. Still missing from the mental health system were the aftercare programs, a long-range plan, and far-reaching goals. Through the process of incremental politics, "the psychiatric unit program came about as a response to existing problems and not as part of a grand design for reform of the mental health system."[156] The psychiatric units structured themselves similarly to the mental health clinics and incurred the same problems. Little changed in the mental health system and a weak policy without long-term goals allowed for the movement from the clinics governed by public health to psychiatric based units within general hospitals. The haphazard policy formation allowed psychiatry to extend into the community initially through public health and later through hospital association. The latter partnership provided the ability for psychiatry to associate directly with physical medicine and to increase legitimacy through scientific innovations in medical research and treatment.

Against the backdrop of incremental politics, mental health policy maintained a

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[156] ibid., p.77-78.

constant focus of extension into the community by directing a program centered upon prevention, education and the equation of mental and physical health. Although the policy remained subject to immediate problems facing Canada's mental health care system, nonetheless the same three themes provided psychiatry with a constant vehicle for integration into society. The failure of the mental health clinics and creation of psychiatric units attest to the limited scope of mental health policy, as does the neglect of aftercare services; however, both treatment centers continuously advanced concern over preventing ill mental health, educating the public on the importance of mental health and correlating mental and physical well-being. Moreover, both centers allowed psychiatry to gain a niche within the community through the same three platforms. Strongly interconnected, an examination of the three platforms of mental health policy reflect the avenues in which policy developed and increased psychiatric status and legitimation despite lacking a central coordinating agenda.

Prevention: Social Ills and Canada's Future Generation

The prevalence of mental illness intensified the need for prevention as mental illness was all-pervasive; 50 per cent of medical patients suffered from both physical illness and psychological problems.[157] In 1950, the Canadian Journal of Public Health cited the magnitude of the mental health task. In addition to the 49 163 mentally ill patients within hospitals were added people who were not mentally ill, but not mentally well. One-third of all military rejections and one-third of service discharges resulted from psychiatric disabilities.[158] The August 14th, 1948 edition of Saturday Night claimed

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[157] ibid., p.36.

one in five children were possibly suffering from personality disorders and poorly adjusted to their environment. The article questioned, "Is the next generation of Canadians being allowed to frolic gaily down the road to instability, which in many instances will lead eventually to serious psychosis and insanity?"[159] As Simmons claims, the variation in estimates of mental illness reflected the lack of uniformity in both the conception of and reporting of mental illness. Next to physical well-being, provincial authorities stated mental illness constituted the major health care crisis in Canada .[160] Mental illness comprised the most pressing problem and the National Health Grants became the vehicle to alleviate poor treatment, increase education and advance preventive principles through mental health clinics and psychiatric units. Yet, as already evidenced, a coherent program for mental health policy remained absent.

The National Health Grants sought not only to prevent mental illness but venereal disease, tuberculosis, and cancer, an indirect association between physical, mental and 'moral' diseases. Yet, mental illness continued to intersect with moral and social factors, combining to avow the need for cure, social conditioning and moral improvement to better humans and ensure all children comprised the 'well-born.' Further, the role of the community clinics encompassed prevention, education, treatment and rehabilitation for anyone manifesting symptoms of mental illness; but, specifically targeted among all citizens were children, the future generation. A mixture of moral, social and physical forces, part social conditioning and part eugenic, prevailed. The "need to anticipate the

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[158] Author Unknown, "Community Health Services," Canadian Journal of Public Health, 41, (September 1950), p.385.
[159] M. Francis & R. Francis, "Mental Health of Canada's Future Citizens," Saturday Night, 63, (August 14 1948), p.22-3.
[160] Simmons, Unbalanced, p.39.

psychiatric breakdown through a preventive approach,"[161] caused recommendations for collaboration with public health. Yet, other proposals suggested mental health partner with general hospitals. The different approaches to establishing community mental health were never reconciled. The legitimation of psychiatry through prevention and education based upon environmental factors within the community raised psychiatry's status and reduced the stigma of mental illness. Prevention itself largely comprised concern with the social benefits offered by environmental intervention to raise better humans and, to a lesser degree, with physical intervention to breed better humans.

Eugenics & Preventive Mental Health

The great concern over mental illness was directly related to the future of Canada - the next generation of citizens. Not only were remnants of eugenic ideology prevalent in immediate post-war publications, but eugenic ideology enhanced the importance of social conditioning and environment. An examination of the Gallup Polls between 1941 and 1966 revealed that social hygiene remained a concern amongst the public at large. The poll of February 6, 1946 headlined, "Public Backs Pre-Marital Tests as Social Hygiene Drive Opens." The drive which the public supported aimed to stop the spread of venereal disease through compulsory pre-marital and pre-natal blood testing. Yet, one of the questions focused only on pre-marital examinations, without addressing venereal disease: "In some provinces there is a law requiring both men and women to take a physical examination and blood test before they marry. Do you approve or disapprove of this law?" Eighty-nine percent approved, six percent disapproved, and five percent remained

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[161] Author Unknown, "Community Health Services," Canadian Journal of Public Health, 41, (September 1950), p.383.

undecided. Again on September 6, 1952, ninety-two percent of respondents approved of pre-marital blood tests but specifically for venereal disease. The social hygiene drive sought to eliminate the spread of venereal disease through familial situations. Husbands and wives were to be protected as were new-born children, and the 1946 poll suggested that prevention (whether for venereal disease or another illness) best occurred through general screening of potential mates. No poll questioned the validity of testing in a routine medical examination, nor testing anyone other than potential mates. While perhaps attesting to traditional values, the same traditional values reflected the importance of safeguarding the nuclear family and increasing quality procreation.

An article discussing the moral and social factors of venereal disease claimed such examinations, "should also include other medical features, such as efforts to discover the Rh (Rhesus) factor in the blood which...appears to make a great difference to the future health of the mothers and to the very possibility of her ability to bear children."[162] Again, concern was familial - the health of the mother, her ability to procreate and the health of future children comprised the basis for the testing. This level of fear and familial concern suggested that the contamination of future citizens needed to be avoided. Thus, pre-marital screening sought to ensure mates remained healthy, compatible and able to procreate.

The issue of sterilization appeared in the Gallup Polls on August 17th, 1966 claiming, "Public Favours Sterilization for Physical and Other Reasons." The highest approval rate coincided with university-educated men and women who approved of the following series of questions.

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[162] C. E. Silcox, "The Moral and Social Factors in Venereal-Disease Control," Canadian Journal of Public Health, 36, (December 1945), p.474-475.

> As you know a sterilization operation makes it impossible for a person to have children. Do you approve or disapprove of sterilization operations in the following situations:
>
> A) Women who have more children than they can provide for properly and ask to be sterilized?
> Approve – 68 Disapprove – 22 No Opinion – 10
> B) Persons who have mental or physical afflictions and who ask to be sterilized?
> Approve – 83 Disapprove – 9 No Opinion – 8
> C) Sterilization in cases where the health of the mother would be endangered by having additional children?
> Approve – 81 Disapprove – 9 No Opinion – 10

The inclusion of the criteria of consent, to be provided by the patient, added a new level of complexity to the evaluation of each case. Yet in the last case, consent was not included. The mother never provided consent to be sterilized, suggesting at least according to popular opinion, that the mother need not give consent if her health may be endangered. Moreover, her own ability to discern what constituted her best interests seemed to be outweighed by poor maternal health. Question C implied that since the woman already had children, her duty resided with raising her family. Consent remained a component in question B, but no comment regarding capacity to provide consent was made, whereas question A suggested the woman was capable of providing consent but unable to cope with the current situation. The questions provided an interesting depiction of societal perceptions in that, these situations revealed instances in which sterilization comprised a viable option. In one, the woman already was a mother and, thus procreation was not necessary - future children would only be a danger. In the other two, an inability to properly provide for children and having a mental or physical impairment suggested that sterilization either offered a personal benefit or else the individual was incapable of raising children. The absence of a situation reflecting more sexual freedom between a couple or a truly therapeutic case suggests that the desire to limit procreation by certain individuals persisted. Moreover, specifically targeted in these questions were women and people with impairments – typically marginalized individuals during this period.

Journals, books and magazines also illustrated concern for bettering the future of Canadian citizens through eugenic ideology and social conditioning. The Revenge of the Cradles, written by C. E. Silcox and published in 1945, examined the role of family allowances in Canada. The work argued that allowances only served to perpetuate the procreation of the unfit as only deficient individuals required aid to support their families. Partially aimed at fears of race suicide among English Canadians due to increasing birth rates among French Canadians, the work nonetheless argued for removing social welfare programs as a deterrent to unfit procreation. The allowances comprised not only a threat to national unity, but "it would seem as if society today were resolved that the morons shall inherit the earth."[163]

Dr. Clarence Hincks, the General Director for and founder of the National Committee for Mental Hygiene, later renamed the Canadian Mental Health Association, wrote articles supporting the sterilization of the unfit and social conditioning of deviants to advance mental hygiene among Canadians. Maclean's Magazine included an article entitled "Sterilize the Unfit," on February 15th, 1946, written by Hincks. The opening claimed increasing rates of mental illness required intervention to halt the upward climb, "For the mentally unfit are apparently breeding faster than the fit, and will continue to do so until we prevent those with undesirable hereditary traits from passing their disabilities on to their children."[164] Although Hincks recognized the need to improve treatment and

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[163] C. E. Silcox, The Revenge of the Cradles, (Toronto: 1945), p.10.
[164] Clarence Hincks, "Sterilize the Unfit," Maclean's Magazine, (February 15, 1946), p.19.

preventive measures, only “a combined attack on mental health problems aimed at both constitutional and hereditary factors and environment [a]nd this means…selective eugenical sterilization,”[165] would markedly reduce deficient procreation. Hincks appealed to the public for support and suggested limiting cases of sterilization to known hereditary disabilities.[166] Sterilization, thus constituted in these instances, a preventive measure to coincide with the creation of community based clinics and programs to educate the public.

According to Hincks, mental defectives caused “social problems and delinquency, dependency, illegitimacy, and the spread of venereal and other diseases.”[167] The correlation of social ills with mental illness suggested that the cause of many of society’s problems, whether based upon nature or nurture, remained fixed in mental illness. While mental illness and social deviance comprise separate issues, conjoining disorders and delinquency constituted a cornerstone of eugenic ideology. Poor breeding resulted in the existence of individuals who perpetuated all societal ills whether immoral, illegal or ill-bred. Moreover, even if inherent defects were not passed on, Hincks argued the remainder of the children would be deficient simply by means of their upbringing. Here arguments between nature and nurture seemed to be conflicting; sterilization remained necessary to prevent the perpetuation of mental illness but mental illness also existed as an external contagion within the environment causing abnormality to occur. The ‘new’ eugenics thus comprised a dual assault, increasing attacks upon environmental factors and continuing a limited targeting of heredity. Hincks also argued that the war

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[165] ibid.
[166] ibid.
[167] ibid.

eliminated Canada's most fit allowing for an increase in the unfit and he attempted to alleviate fears regarding sterilization by outlining the safe and legal aspects of the process. The article appealed not only to arguments of heredity and environment, but fears of race suicide and ignorance regarding the practice of sterilization. Yet, the association of eugenic ideals with social conditioning to improve Canada's mental health remained central to the argument.

In another article Hincks examined the role of mental hygiene over the past twenty-five years and emphasized the new prominence and importance mental hygiene held for ensuring health in the post-war years.

> Prior to the second world war the field of mental hygiene was viewed as interesting and important. It was not, however, until the recent post war years that leaders in many walks of life began to realize that mental hygiene was faced with the most significant challenges and the greatest opportunities in regard to the future of our civilization. The fact began to strike home that mental health was even more important than physical health.[168]

Written in 1949, the attention of mental hygiene became directed towards children and the need to fortify their mental stability. Yet, psychiatrists needed to partner with community officials to extend the therapeutic and preventive value directly into the community. By 1947, the Committee for Mental Hygiene further targeted the mental health of children by preparing a ten-year program aimed at establishing child guidance clinics, providing training for school teachers, and creating long-range children's programs. The emphasis upon children again reflected the need to better Canada's future: "the tremendous task of solving this problem, upon whose solution rests the whole future of civilization."[169] The future of civilization rested in the development of mentally

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[168] Clarence Hincks, "Twenty-Five Years of Mental Hygiene," Canadian Welfare, 24, (January 15, 1949), p.52.
[169] ibid.

sound children.

Hincks was not the only vocal supporter of eugenics and social conditioning as a solution to mental illness. In Saturday Night, 1948, an article entitled, "A Growing Interest in the Mind and Something of What It Does," discussed new publications on mental health. Personality and Its Deviations, written by Dr. Stevenson and Leda Neal, ardently expressed concern over race degeneration, "Some of the case histories are grim affairs. In the situation of a moron where deficiency is *known* to be the result of defects in the genes, sterilization might be recommended."[170] Moreover, both cited the death of the fittest in the war as grounds for supporting preventive medicine and psychiatry. Again sterilization, or selective eugenics, provided the solution for mental weakness. Overall five publications were examined and suggested to be valuable works for public consumption. Thus, psychiatry became more visible in the community through the media and literature and by proposing physical and social intervention to heal society's ills.

The Social Rewards of Intervention

New conceptions of mental illness, the optimism of new cures, and more money all impacted the development of a new mental health program. The new ideal surrounding mental health perpetuated a heightened sense of importance and value in social and physical intervention in order to realize better Canadians. The various facets of mental health not only partially removed the stigma of mental illness, but aided in the realization that sound mental health needed to become a priority due to the resulting benefits. In Saturday Night, an article entitled, "300 New Health Projects Planned By Provinces,"

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[170] J. Yocom, "A Growing Interest in the Mind & Something of What it Does," Saturday Night, 63, (March 27, 1948), p.19.

outlined the optimistic and extensive plans for the health grants. Money was directed towards tuberculosis, more public health nurses and a larger hospital staff; no tangible policies were outlined nor long-term goals. All the plans constituted an immediate response to current situations within Canada and neglected to plan for potential problems. Yet, within the financial plans, the article did forecast the social improvements bound to coincide with better health. The new program "will save lives, keep people out of hospitals while getting more in, restore people to gainful employment who are now permanently on the sick list...improve the health of the nation through attacks on preventable diseases."[171] Mental health remained within the list of preventable diseases such as cancer and tuberculosis. Yet, the emphasis upon returning individuals to the community and to full employment reappeared in another article. In "Bridge to Sanity," on the December 6th, 1952 edition of Saturday Night, the concern with social betterment and community-based living constituted the focus of the article. The 'proper' reception of the patient back into the community from a mental hospital and/or at home remained central to the success of effective treatment. The day hospital at the Allan Memorial Hospital in Montreal, in which patients attended the hospital during the day and returned home in the evening to sleep, encouraged a less disruptive pattern of living, thus reducing the severity of the adjustment from hospital to homelife. The article praised this pioneering work emphasizing that mental illness comprised Canada's number one public health problem.

The optimism of social betterment also existed in statistics claiming 65% of all patients were discharged and did not return and that any patient had a 50% chance of

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[171] Frank Flaherty, "300 New Health Projects Planned By Provinces," Saturday Night, 64, (January 11, 1949), p.9.

recovery and return to ordinary life. The return to the community represented the ultimate goal, and accounted for expensive new treatments and the costly attempts to revise the mental health program. "In the long run it pays, in the restoring of productive ability, in the saving of future cases in preventing insanity when a mild neurosis is cured before it hardens into delusion, perhaps even in saving some child from attack by a sex maniac whose unrecognized feelings of aggression take the most brutal outlet."[172] Psychiatry and the treatment of the mentally ill promised to reduce not only the number of mentally ill but assured the return of hardworking, stable, upstanding citizens to the community who would contribute productively to society at large. Thus, the expense and social and physical intervention were justified by the rewards to society, by the better Canadians who comprised a happier, healthier and well-adjusted population.

Conclusion

Against a shifting medical paradigm, mental health policy and services began to alter in accordance with Canada's most immediate and pressing health care needs. The National Health Grants sought to alleviate the diverse illnesses affecting Canadians, from tuberculosis and venereal disease to mental ill-health. Yet, mental health policy consistently lacked any long-term goals or far-reaching plans. Only the most urgent health issues were addressed, and only within the current circumstances. The development of mental health clinics, later subsumed by psychiatric clinics, attests to the haphazard and unbalanced development of Canada's mental health system. Yet, this inability to create and foster long-term policies with a vision for the future allowed for psychiatry to move into the community in two separate ways.

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[172] M. Chapin, "Mental Illness need not be a Calamity," Saturday Night, 63, (April 17, 1948), p.37.

First, psychiatry's association with public health, although short-lived, began the process of integration with other community-based services and allowed for the general recognition of psychiatry as a vital component of overall health. Secondly, through psychiatric clinics, relocated in general hospitals, psychiatry's extension beyond the asylum increased the status of psychiatry so that it became equal with that of general practitioners. The shared locus allowed for the early detection and treatment of mental illness as well as legitimated psychiatric methods of treatment and cure. The development of new psychotropic drugs, and other treatments based upon physical intervention, lent credence to the scientific nature of psychiatry and identified psychiatry as a legitimate branch of medicine. Psychiatry came to be understood as a scientific discipline and mental health constituted a necessary component of individual fitness and well-being. Other more subtle changes, such as introducing mental health courses in medical school training and psychiatrists' placement as the head of mental health clinics further demonstrate both the extension and raised profile of psychiatry within the community.

Eugenics and social betterment continued to play a part through psychiatry's extension into the community. Reductions in the number of deficient, the amount of crime, associations with physical illness, increased productivity, and a happier and healthier Canada consistently reflected a desire to make humans better. This intervention, to create better humans, based upon both physical intervention (such as sterilization and drug therapy) shared to some degree the spirit of eugenics. While partially hereditarian and partially social conditioning, the spirit of the movement remained grounded in the need for intervention to effect better humans. This intervention continued due to the lack of a long-term plan for mental health services. Without tangible criteria and a set direction to pursue, psychiatry and mental health policy remained able to fluctuate according to circumstances and sustain an agenda that reflected human betterment. A "new eugenics" resulted. The absence of a coherent mental health program in conjunction with psychiatry's desire to professionalize resulted in the persistence of an ideology seeking to better Canadians.

Chapter 3

Preventive Mental Health

It has long been known that the behaviour patterns of later life begin to be established in the cradle, nursery and the elementary school room. Their hates, fears, and prejudices are reflected in this. That is why education for family living in one generation is so essential and so consequential to the mental health of the next.....The prevention of mental illness, which is mental hygiene, may be viewed in three important aspects: as a personal problem, as a family problem, and as a public-health problem. Crucial to all aspects is the recognition that interpersonal relationships and mental health, or illness, are two sides of the same coin.

J. Schifferes
Healthier Living, 1954, p324 & 412

The continuation of eugenics (here termed the 'new' eugenics) and social betterment constitute the focus of this chapter. Recognition of a haphazard mental health policy and concern by psychiatry for professionalization reappears, as each intersects with eugenics. The absence of a well-defined mental health policy allowed eugenics to persist in variable states. Moreover, psychiatry influenced eugenics with professional-minded conceptions of social normalcy which furthered psychiatric legitimacy. Although intervention also relied upon physical means, the 'new' eugenics mostly relied upon the manipulation of environmental or social factors to improve humans. The examination of parenting pamphlets produced by the Department of Health and Welfare, in conjunction with other primary source material relates the concern with ensuring a mentally sound populace. Moreover, mental soundness is equated with physical health which will be referred to here as the medicalization of mental illness. This association furthers the concept of the 'new' eugenics in that these correlations allowed for a new level of seriousness and legitimacy to surround mental illness and thus a new level of concern regarding the importance of environmental factors.

Fighting the Stigma of Mental Illness

The close association made between mental and physical health by the public health department, politicians, psychiatrists and the media constituted an attempt to reduce the stigma associated with the "asylum," the "insane," or "mental illness." Moreover, the 1950s witnessed an increased optimism in the ability to cure the mentally ill. Mental illness was now considered temporary: "Even as matters stand, about sixty percent of those who enter a mental hospital recover wholly or in part."[173] Once the money could be found to properly treat the mentally ill – according to its proponents - the cure rates would rise: "With regard to mental illness we stand where we stood twenty years ago with respect to physical illness which have now been all but eliminated."[174]

Public health officials incorporated mental illness into a medical model of care, often comparing it to tuberculosis. They believed that both were caused or promoted by a poor environment. Thus, prevention could occurr by improving the surrounding environment: "For good mental health one needed a 'wholesome environment...a pathological emotional environment can warp a personality and destroy it, as effectively as

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[173] D. LeBourdais, "Our Shameful Mental Hospitals," Canadian Forum, 27,(1948), p.227.
[174] J. Mather, "Trends in Community Health Services," Canadian Journal of Public Health, 41, (September 1950), p.385.

tuberculosis can destroy the lung tissue.' "[175] Attributing ill health to the environment reflected the concern with social factors in mental hygiene.

Psychiatrists also linked the treatment of mental illness with the treatment of physical illness, but in a subtler manner. The psychiatric units collaborated with physical medicine through a shared locus and similar therapeutic interventions (such as pharmacology). Yet 'milieu treatment,' which emphasized the role of the environment, added an additional dimension. Milieu treatment was expanded to include all factors in the environment which may affect a patient's health. Facilities to produce milieu treatment consisted of "decent human living conditions, privacy, occupational and recreational programs, good food preparation, and social amenities."[176] Milieu therapy gained acceptance in the late 1950s when large provincial psychiatric hospitals were viewed with increasing pessimism and community centers occupied the central force in an environmentally-based mental health care program.

Journals, magazines and newspapers equated mental illness with physical illness. Commentators and doctors throughout the late 1940s and early 1950s relentlessly repeated that the essence of mental illness was the same as physical illness. Recovering from insanity was compared with recovering from TB, claiming that a return to health may take years and attacks may return, "but not as often as do asthma spasms."[177] Psychosis and dementia caused more expense than tuberculosis or cancer, and the prevalence of convulsive disorders was equated with diabetes.[178] Even the cause of

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[175] Simmons, Unbalanced, p.56.

[176] F. Lawson, "Mental Hospitals: Their Size and Function," Canadian Journal of Public Health, 49, (1958), p.189.

[177] M. Chapin, "Mental Illness need not be a Calamity," Saturday Night, 63, (April 17, 1948), p.36.

[178] Hincks, "Sterilize the Unfit," p.19.

mental illness, although requiring environmental intervention, also depended upon physical traits. Medical clinics were to provide for the treatment of both physical and neurological disturbances as mental and physical disorders could not be separated.[179] Moreover, psychiatrists posited the theory that the manic-depressive syndrome may affect many individuals, extending as a widespread contagion and become manifest on a national scale.[180] One doctor, Osmond, claimed that a physical ailment caused mental illness and thus suggested commencing research for the "X" substance, the drug to cure mental illness. Afterall, one commentator asserted, "Diabetes, leprosy and TB were hopelessly incurable fifty years ago, now they're under control. The same thing is about to happen in mental illness."[181] Even, the mental hospital was equated with the general hospital. Mental hospitals were depicted as a place for sick people to regain their health.[182] A movement was underway to reduce the negative associations of mental illness by linking mental and physical health through heredity, environment and medical practice. Comparing mental disorders with physical disorders represented an attempt to both remove the stigma of mental illness and simultaneously legitimate the scientific and medical aspects of mental illness.

The association of mental illness with typical or 'normal' human beings reflected the potential for anyone to become mentally ill and the need for early and proper treatment. The return to milieu therapy advanced the theory that the mentally ill would respond to kindness. One article claimed, " the 'hopeless' responded to humane and intelligent

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[179] M. Francis, "Holiday Mental Clinic," Saturday Night, 65, (March 7, 1950), p.12,32.
[180] John O'Neill, "Manic Traits of Suicides Found in Many 'Fine Type' People," Saturday Night, 64, (September 13, 1949), p.23.
[181] Sidney Katz, "Dr. Osmond's New Deal for the Insane," Maclean's Magazine, 70, (August 31, 1957), p.9-11.
[182] Sidney Katz, "Sidney Katz spends a day in a Mental Hospital," Macleans Magazine, 66, (October 15, 1953), p.26-29.

treatment. Once removed from the horrid conditions of the back ward to the main hospital and treated with EST, 60% of schizophrenics improved."[183] Patients also enlisted in recreational activities and new hospitals were built upon the principles of milieu therapy (a home away from home). The British Columbia director of mental hygiene and psychiatry, Dr. Crease, claimed, "These people aren't lunatics, they are human beings and they should be dealt with as human beings."[184] Even the optimism of drugs faded when compared to social conditioning. Although the "New Wonder Drugs that Fight Insanity," pacified the patient, the patients remained uncured. But the underlying disease could only be addressed once the patient returned to reality so as to undergo social conditioning, to be treated as a human and to respond in kind. [185] Thus, milieu therapy emphasized the role of the environment in curing the mentally ill and the importance of social conditioning to behave "normally."

Education & Community Mental Health

Education within the community comprised the other major facet of Canada's mental health program and acted as the link between prevention and the medicalization of mental illness. Education's role required underscoring the importance of prevention and the similarities of mental and physical illness to the public. It also highlighted the importance of doing so within the community. Dr. Griffin, the General Director of the Canadian Mental Health Association stressed the necessity of moving into the community to prevent mental illness: "As the emphasis in fighting mental illness is

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[183] M. Clements, "New Hope For the Damned," Saturday Night, 67, (July 26, 1952), p.10,28.
[184] M. Franics, "Holiday Mental Clinic," Saturday Night, 65, (March 7, 1950), p.12,32.
[185] Sidney Katz, "The New Wonder Drugs That Fight Insanity," Maclean's Magazine, 68, (November 12, 1955), p.11-13.

placed on the treatment of early cases, it is essential that the battle must leave the hospitals and move out into the community."[186] The concept of mental health education in the community reflected the variety of services, from mental health clinics to psychiatric units, and education programs to training literature. While these new community-based programs increased the visibility of psychiatrists, they also reduced the coordination of a centralized health policy. The program, geared towards informing and directing sound mental development, utilized all mediums to translate the importance of mental hygiene into community consciousness. Interest was "stimulated by psychiatric articles in the press and popular magazines, by radio dramatizations of the mental health approach to problems of human behaviour, and by moving pictures, presenting plays with plots suggested by psychiatric practice."[187]

Through the provision of mental testing in schools, special education programs, parent education in child development, nursery schools, mental hygiene programs from elementary school to college, and public education in regard to mental health principles for self application,[188] education in the mental health program sought to address all aspects of life. The wide variation in and large number of programs addressed two main points: to safeguard the wholesome environment and social development of children, especially through parent education in child rearing; and to "rais[e] the level of the efficiency, the happiness, the wholesome adjustment and the richness and quality of living of all our people."[189] The concern for raising the next generation to be both well-adjusted and efficient remained central to the initiation of a mental health program based

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[186] Simmons, Unbalanced, p.50.
[187] Clarence Hincks, "Conserving Mental Health in Canada," Canadian Journal of Public Health, 38, (July 1947) p.332.
[188] Clarence Hincks, "Mental Hygiene Provisions in Public Health Programs," Canadian Journal of Public Health, 36, (March 1945), p.89-95.
[189] ibid, p.90.

on prevention and education.

The desire to "do something about the widespread prevalence of disturbed children and neurotic and psychotic adults in our communities,"[190] almost came to constitute the motto of the mental hygiene movement. Through education, the mental health program would reduce the number of mentally ill, the inefficient, and the maladjusted. Just as with physical illness, the social benefits to be derived from a mentally sound population were numerous. Just as with physical health, varying degrees of mental illness hindered overall well-being. If prevention were to occur, people needed to accept that physical and mental illness shared traits and that mental illness affected everyone equally. Education's role was to ensure the community became aware of what mental illness was, who it affected, how it could be prevented and what constituted the benefits of prevention and treatment. Moreover, the benefits of a wholesome environment and its relation to society as a whole, portrayed the notion that a better social environment created children who grew up to become happy, well-adjusted and productive adults. Education reflected a corollary between a wholesome mental and physical environment, "The principle for good mental health is not too different, namely, that for optimum mental health and personality development, a wholesome emotional environment is essential."[191] Further, mental health and a pure environment were mutually related: "A perfectly healthy person is one totally adjusted to himself and his environment."[192] Thus, education provided the means to attain a healthy environment for the purpose of raising a sound mental population. Not only would the number of unbalanced individuals be reduced, the

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[190] E. Rosen, "The Changing Attitude of the Community Towards Mental Health," Canadian Journal of Public Health, 51, (September 1960), p.361.

[191] ibid.

[192] J. Morgan, "Towards a Health Service Program," Canadian Welfare, 29, (November 1, 1953), p.40.

productivity and well-being of the entire nation would be increased. Linking mental health with productivity reflected an aspect of 'new eugenic' ideology which claimed that if an individual was not contributing to society, the person then was not a valuable human being.

The importance of recreation for the maintenance of physical health necessitated the importance of recreation for the betterment of mental health. Steps needed to be taken to educate the public regarding the value of recreation in the maintenance of mental health.[193] Recreation and occupational therapy provided both the training and skills necessary to return to the community as a self-sufficient and independent contributor. Recreation also was considered valuable as a preventive measure, as the activity improved personal relationships and (according to professionals) reduced links with crime, social failure, and a loss of manpower. The references to social ills and crime again reflected a reoccurring theme of earlier, traditional eugenic ideals.

One of the most popular mediums to educate and inform the public regarding healthy mental activity, relationships and proper development were film productions. Saturday Night included a review/advertisement of one such film, 'Breakdown,' in which a young woman named Anne Morton, who suffered from schizophrenia, gradually recovered during hospitalization and a treatment program of reversion.[194] Produced by the National Film Board in conjunction with the National Health and Welfare's Mental Health Division, 'Breakdown' was one of at least twenty-one films on mental health put forth

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[193] W. Menninger, "Recreation and Mental Health," Canadian Welfare, 26, (March 1, 1957), p.32.

[194] Author Unknown, "Breakdown," Saturday Night, 66, (June 12, 1951), p.11. Reversion specifically refers to the attempt by psychiatrists to return patients to a child-like state where the patient can then be resocialized or trained to behave in an acceptable manner. The patient's memory and cognitive patterns are disrupted and returned to an earlier state. This process is similar to the 'depatterning' technique used by Dr. Ewen Cameron.

between 1948 and 1958. Concerned with proper development, many films addressed appropriate emotional feelings or reactions. 'Feeling of Hostility,' 'Feeling of Depression,' and 'Feeling of Rejection,' comprised a trilogy of the mental mechanisms series. 'Our School Children's Health,' 'Back Into the Sun,' 'Stigma,' and 'What's on Your Mind,' were other films produced to educate on and prevent mental illness. Some films remained restricted to professional audiences and thus, were considered teaching tools for psychiatrists or examples of various mental illnesses. While the central topic remained mental health, some films also directed parents on proper child rearing techniques and addressed questions of parenthood. 'Why Won't Tommy Eat,' 'Know Your Child,' and 'Mother and Child,' are a few examples of films directed at ensuring the mental health of the next generation.[195]

The Family and the Mentally Ill

The focus of preventive education centered upon the family. One's family not only provided for and created the wholesome environment allegedly necessary to ensure proper mental health, but it also played the key role in teaching proper methods of interaction and relationship building. A direct relationship existed between parents' neurotic tendencies and their children's difficulties[196] due largely to poor parenting skills. Social workers and public health nurses worked "to impress the parents with the most important fundamentals that will lay the foundation for health, [and] normal growth in their children."[197] Yet, all family members were considered to have responsibilities in

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[195] Unfortunately, although many of these films continue to be held by the National Film Board, only purchased copies are made available for consultation; thus, the films remained unviewed.

[196] M. Francis, & R. Francis, "Mental Health of Canada's Future Citizens," Saturday Night, 63, (August 14, 1948), p.23.

[197] M. McLeod, "The Mental Health Program," Canadian Nurse, 45, (August 1949), p.595.

the process of normalization for relatives with mental illness. The rise in "social treatment," a major feature in psychiatry, involved working with the patient's family in the process of readjustment.[198] While the readjustments were considered primarily to be social (requiring specific patterns of behaviour for particular situations), doctors and social workers presented the do's and do not's of familial interaction. Failure to comply with specifications held serious ramifications, "Ineptness on the part of the family can lead to an undoing of much that has been accomplished with the patient."[199] Thus, the family required education to maintain the "cure" performed by psychiatrists. To ensure the effectiveness of social psychiatry, family members and treatment centers required close proximity for instruction and guidance - another impetus for community-based psychiatry.

In one article, published by Macleans' Magazine, Sidney Katz visited a mental hospital. Katz's revelations included admonitions from doctors regarding how family members should interact with mentally ill relatives. One doctor claimed, "Don't be disturbed by harrowing accounts of how your relative is being abused and punished. That's part of the illness."[200] The doctor did not limit the comment to a specific mental illness nor explain how perceptions of abuse and punishment were common among any mental illnesses. While possible to attribute perceptions of persecution to a person suffering from a form of paranoia, other illnesses do not typically manifest symptoms of maltreatment. The comment, in the least remains disturbing and at the most, lends

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[198] F. Lawson, "Mental Hospitals: Their Size and Function," Canadian Journal of Public Health, 49, (May 1958), p.193.
[199] E. Perretz, "Social Work in Mental Hospitals," Canadian Welfare, (November 1, 1958), p.173-177.
[200] Sidney Katz, "Sidney Katz spends a day in a Mental Hospital," Maclean's Magazine, 66, (October 15, 1953), p.26-29.

credence to patients' claims of punishment and abuse when non-compliance occurred.[201]

Articles in popular journals tended to focus primarily upon the need to educate parents, more so than other relatives or family members. Parents comprised the center of a child's environment; the level of cleanliness, nutrition, discipline, behavioural examples and training all constituted the realm of parenthood. The failures of children were often blamed upon poor or ignorant efforts by parents, "Nobody brings up their children perfectly; all of us do the best we can and make failures. Of course you are to blame – not as much as you think, but somewhat. Well then, that is a burden you have to carry, so go on from there."[202] The burden of parenthood thus required the most attention in education and prevention of mental illness. Moreover, "children suffer least when they have the assurance of parental love," and the parent's role was to "try to strengthen family life against the threat of a 'society on edge.'"[203] The role undertaken by the parents assured the proper development of Canada's next generation and therefore required the strictest guidance in proper development both emotionally and physically to ensure optimum mental health.

Parenting & Social Conditioning

Between 1954 and 1968, the Mental Health Division of the Department of National Health and Welfare published over thirty pamphlets, aptly entitled *Child Training*, directing parents on how to appropriately raise children as well as redress various developmental abnormalities. One pamphlet, entitled 'Parent Education,' claimed

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[201] See for example Ken Kesey's book, One Flew Over the Cuckoo's Nest. Other works on the anti-psychiatry movement and works from 'survivors' also include depictions of patient abuse based upon non-conformity.
[202] M. Chapin, "Mental Illness need not be a Calamity," Saturday Night, 63, (April 17, 1948), p.37.
[203] Author Unknown, "Mental Health in a Period of Stress," Canadian Welfare, 27, (June 1, 1951), p.15.

parents required scientific knowledge about the way children developed as well as outside help because, "Many adults live unhappy, maladjusted lives because of the way their childhood went."[204] Parents were thus encouraged to attend meetings, lectures and to seek expert help as necessary. The pamphlets comprised one example of the expert help and informational material available for consultation. Underneath a variety of headings each pamphlet posed questions such as: What can be done about it? What should I tell my child? How can my child be helped? How can my child overcome it? or How can I correct my child's habit? The topics covered a range of diverse issues, from bedwetting, stuttering and destructiveness to obedience, sleep patterns, illness, and shyness. All booklets outlined the actions parents should take to ensure the physical and mental health of their child.

The pamphlets were roughly divided into three categories: emotional development, physical development and behavioural instruction, although the years of publication do not accord with any specific categorization. Within each category the fear of permanent maladjustment reappeared if the behaviour continued without modification. In the pamphlets on emotional development, the behaviour of the destructive child was understood as follows,

> Something has gone wrong in this child's growing-up and unless handled with skill and deep understanding, his attitude can settle into a persistent defiance and destructiveness. [205]

The parents were advised to seek professional help to learn the cause of the behaviour as ignoring destructiveness or the wrong type of discipline would only worsen the situation.

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[204] Department of National Health and Welfare, Mental Health Division, "Parent Education," Child Training, 1954-1968.
[205] Department of National Health and Welfare, Mental Health Division, "Destructiveness," Child Training, 1954-1968.

The picture on the reverse of the pamphlet portrayed a mother taking her young son in hand to the mental health clinic. With her other hand, the mother pointed towards the clinic explaining where they are going as if attending the clinic comprised a typical outing for parent and child.

Other emotional behaviours associated with mental instability included shyness, fear, and temper. Shyness directed attention to the parenting skills. A shy child missed two necessary steps in development, "Your child must always feel that you want him and love him, no matter what," and the child was to feel capable to do and/or be many things.[206] Limiting the experiences of the child needed to be avoided as well as "tying him to your apron strings." Fear also required early parental intervention as, "Fear of this kind can do harm to the young child's developing personality." Symptoms of emotional fear reflected physical deviance, such as thumb-sucking or bed-wetting. Yet, temper provided the most insightful reasoning for intervention, "All of this is highly undesirable if we are aiming at his growing up into a mentally healthy, happy adult who will get along reasonably well with others."[207] Parental education reflected the ultimate goal of raising mentally sound children through the principles of mental hygiene. Children required specific responses from parents to encourage an emotionally healthy development. Moreover, emotional ill health was interrelated to physical ill health and forms of deviance.

The discussion of proper physical development addressed sleeping habits, nervous habits, bed-wetting, baby talk, and stuttering. Again, early intervention by the parent was

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[206] Department of National Health and Welfare, Mental Health Division, "Shyness," Child Training, 1954-1968.

[207] Department of National Health and Welfare, Mental Health Division, "Temper," Child Training, 1954-1968.

necessary to prevent either prolonged or permanent aberrations not only in behaviour but within character development. With baby talk, delays in speech were correlated with the development of personality troubles.[208] In the case of bed-wetting, the family doctor needed to be consulted otherwise, even once bedwetting was outgrown, 'the harm to his character remains.'[209] Although bed-wetting could have a number of causes, faulty parental training was listed as a potential source. For nervous habits, again a visit to the doctor or a specialist was required. The source of the habit likely resulted from poor emotional well-being and thus the parent needed to limit bossing, nagging and scolding within the home, setting instead an example of happy behaviour.[210]

Stuttering also resulted from the close relationship between mental and physical health, "Parents can do a real job of helping to prevent or cure stuttering if they always keep in mind the close tie-up between the child's emotional stability and his speech habits."[211] Poor sleeping habits, including a fuss before bedtime, again resulted from, "faulty training" on the parents' part.[212] The cure was simply to ensure your child received plenty of affection. Physical "abnormalities" were linked to emotional "abnormalities" and the appropriate training by parents either ensured restoration or the perpetuation of maladjustment. Thus, parents needed to be educated on proper child rearing, understand the relationship between mental and physical illness and always

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[208] Department of National Health and Welfare, Mental Health Division, "Baby Talk," Child Training, 1954-1968.

[209] Department of National Health and Welfare, Mental Health Division, "Bedwetting," Child Training, 1954-1968.

[210] Department of National Health and Welfare, Mental Health Division, "Nervous Habits," Child Training, 1954-1968.

[211] Department of National Health and Welfare, Mental Health Division, "Stuttering," Child Training, 1954-1968.

[212] Department of National Health and Welfare, Mental Health Division, "Sleeping Habits," Child Training, 1954-1968.

remember that medical professionals were available for consultation as necessary.

With deviant behaviour, the pamphlets addressed lying and stealing, appropriate forms of play and playmates, preparing a child for school, illness, and instructing a child about sex. In each case the emphasis was placed upon the potential negative behaviour. With illness, the pamphlet warned against children who may try to continue to receive special treatment after recovering, a practice to be discouraged. Illness "can be an emotionally upsetting experience – sometimes with far-reaching effects,"[213] and "Emotional difficulties which aggravate the illness and hinder recovery,"[214] also needed to be avoided. Parents needed to maintain a distinction between pampering the child when sick and not exacerbating the problem. Regarding sex, parents were to answer questions honestly, utilize proper terminology, and discourage masturbation. It was suggested that "such matters are best talked about only in the family circle."[215] Yet, the pamphlet stated one must be careful in the discouragement of masturbation as, "wholly false stories of insanity and blindness resulting from masturbation may worry him to the point of much mental suffering."[216] Thus, again, the importance of assuring mental well-being dictated its priority over all other concerns in parenting and it directed the methods of discipline and training.

Play and playmates comprised an important part of a child's development because, "through it a child is helped to mould a wholesome personality and the character traits so important for a happy and successful life."[217] Play allowed for appropriate interactions

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[213] Department of National Health and Welfare, Mental Health Division, "Illness," Child Training, 1954-1968.
[214] ibid.
[215] Department of National Health and Welfare, Mental Health Division, "Sex," Child Training, 1954-1968.
[216] ibid.
[217] Department of National Health and Welfare, Mental Health Division, "Play and Playmates," Child Training, 1954-1968.

but parents were secretly to observe how their children played to ensure traits of sharing rather than stubbornness were being developed. Children should engage in play before going to school so that new interactions were not stressful nor unknown. Preparing the child for school itself required visits to the doctor, optometrist, and dentist to correct any 'ailments or defects.' The child also required regular rest so as to be alert and a good appearance to increase self-confidence. Overall, children should have sound mental and emotional health,[218] before attending school.

The pamphlets from the Department of National Health and Welfare also examined the manner in which to raise a 'brilliant' child, where to receive parent education, how to understand young adults, helping families in trouble and planning for the later years. The series extended beyond parent/child relationships to offer guidance on ensuring sound mental health throughout the years, even including retirement. In the development of a brilliant child, parents and teachers both played central roles,

> Without realizing it, unsuspecting parents or teachers thwart a child's curiosity, drive and exceptional talents, so that he, or she, grows up to be a mediocre unhappy adult....These gifted children grew up to be superior adults. They had lower death rates, above average mental health, and there were fewer alcoholics, delinquents or criminals.[219]

The association between good mental health, intelligence and upstanding citizenry reflected again the belief in the importance of mental stability, particularly in assuring social benefits and/or societal improvements. Overall, children required good mental health to reduce the number of poor, defective, and/or deviant.

The pamphlet, 'Helping Families in Trouble,' illustrated the views of how family

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[218] Department of National Health and Welfare, Mental Health Division, "Preparing Your Child For School," Child Training, 1954-1968.

[219] Department of National Health and Welfare, Mental Health Division, "The Brilliant Child," Child Training, 1954-1968.

breakdown affected both family members and society. Underneath the heading, 'Everybody's Business,' the pamphlet claimed,

> Home is the core of living. Society is built on family life. Through the bonds of feeling, comfort and strength, through belonging, sharing, learning and in so many other ways, children are helped to develop into well adjusted, mature and responsible citizens. Because it is a living thing, a home requires care and attention, protection and opportunity. It can be harmed through the interruption of parental care...Should it break, it reveals weaknesses in both community and parents. The careful efforts of both are needed if family breakdown is to be reduced. Many broken homes could be prevented, many more could be mended. Those that are broken still need to be helped. In the long run, broken homes are everybody's business.[220]

Broken homes comprised everybody's business due to the potential harm to family members and society as a whole. Implied within the proceeding quotation is that broken families produced abnormal, non-functional children. Children from broken families did not become citizens who lived longer lives and had lower crime rates but rather seemed to be the families in which criminals, alcoholics and delinquents outnumbered the 'healthy.' Broken homes became everybody's business because broken homes did not contribute to societal benefits.

Another category of pamphlets addressed opportunities within the mental health field for psychologists, social workers, registered nurses and occupational therapists. The role of the psychologist centered upon prevention and widespread public understanding of normal development. Psychologists researched the cause of mental breakdown, and thus, focused on preventive techniques. The social worker addressed the needs of the family, particularly interpersonal situations, and attempted to prevent mental illness. Registered nurses also sought to expand services in accordance with preventive techniques whereas occupational therapists understood their role in mental health similar to work with

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[220] Department of National Health and Welfare, Mental Health Division, "Helping Families In Trouble," Child Training, 1954-1968.

arthritis and polio. In all cases, "mental illness may be thought of as a serious variation from normal behaviour,"[221] a variation requiring human intervention to prevent, educate and correct to ensure a healthy nation. The people to intervene comprised psychologists, social workers, nurses and occupational therapists in conjunction with psychiatrists.

The correlation of the previous pamphlets in advancing mental health during the post-war years relied upon themes of prevention, education, social conditioning, eugenics and the equation of mental and physical health. The need to better Canada's future generations comprised the immediate agenda, but no long-term policy to achieve that goal existed. Rather, the focus upon prevention, education and the medicalization of mental illness demonstrated the social benefits that would result through psychiatric extension into the community. The theme of professionalization appeared and reappeared, reflecting the incremental politics of mental health policy but moreso attesting to the general movement within psychiatry towards community care and human betterement.

Conclusion

Although the poor development of mental health policy allowed psychiatry the freedom to extend into the community through various vehicles, three reoccurring themes within mental health identified psychiatry as central to maintaining mental well-being. Prevention, education and the medicalization of mental illness all interconnected and overlapped in the dissemination of mental health care to the public. Each facet of the mental health program further raised psychiatry's status despite reflecting no long-term

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[221] Department of National Health and Welfare, Mental Health Division, Opportunities for Registered Nurses in the Mental Health Field, 1954-1968.

strategy other than to prevent, educate, and medicalize mental illness. While difficult to distinguish and separate the exact function of each facet, prevention largely occurred through the community based clinics and units. The role of the clinics and units centered largely upon early detection and treatment, although other functions such as education also comprised the daily role of the mental health care staff. The association of mental and physical illnesses also occurred through the mental health clinics and psychiatric units, and also centered upon the role of education. Overall, education constituted the central and most vital facet of the mental health program.

Education was necessary to convince the public that mental health was an important aspect of overall health and both could be and needed to be prevented. Moreover, the public required education on the similarities between mental and physical ill health to ensure that prevention would occur. Without recognizing the role of environmental factors in mental illness, prevention would be impossible, and mental illness would continue to ravage society. Education further sought to instruct parents and families in acceptable forms of behaviour and interpersonal conduct as well as correct any deficiencies within recreation, nutrition, and other physical aspects. The goal of education was to ensure proper development both emotionally and physically to produce stable, productive, and well-adjusted adults. The social benefits to be derived accounted for increased work, fewer sick individuals, happier adults, and less crime. The program specifically targeted children, the future citizens, as teachers were trained to respond to different patterns of behaviour and various emotional responses. Education remained the cornerstone for prevention and the medicalization of mental illness, all of which provided consistent and legitimate means necessary for the professionalization of psychiatry.

Attempts to effect better mental health and the psychologization of "norms," relied upon human intervention – either physically or socially. The intervention was designed to perfect human kind as much as possible. Social intervention (such as defining acceptable behaviour and teaching parents proper modes of interaction) largely reflected the 'new ' eugenics by reaffirming the need for intervention to ensure an improved human race. The medicalization of mental illness further supported a 'new' eugenics, as the equalization between physical and mental health lent credence to the importance of mental well-being and the need for environmental intervention. Thus, psychiatry's extension into the community obtained increased legitimacy through professional conceptions of 'normalcy' which educated the public through social conditioning, environment, and the medicalization of mental illness. This process depended upon the persistence of a "new eugenics," an ideal reflecting the necessity of human intervention both physically and socially to effect better humans.

Chapter 4

Professionalism & Pessimism: A Case Study of Hamilton Psychiatric Hospital

> Our population in hospital has risen approximately twenty-five patients which is not great, but which means that this number added to our already terrifically congested wards is reaching saturation point and the point where treatment necessarily suffers. In spite of this I feel that we can be quite proud of our results of treatment. We are using all types of standard treatment and are continually trying to keep before our staff our own belief that shock treatment must not be considered as the panacea of all diseases.
>
> J.N Senn, M.D.
> Superintendent
> Annual Report 1950

Human rights came to the forefront amongst the public after 1945.[222] A desire to ensure equal rights for all humans in society irrespective of race, colour or sex gained momentum following the Nazi war crimes trials. The Nuremberg Code set forth the standard for informed consent, requiring that any participants in research or undergoing medical procedures must agree to the procedure as well as be able to opt out of treatment at any time. The principle of informed consent was designed to ensure the rights of and guarantee the safety of human subjects. Moreover, the risks of the experiment or surgery were not to outweigh the benefits to the patient.[223] For example, innovative surgery with unsubstantiated effects meant the risks constituted a greater threat than the probable benefits to the patient and hence should not occur - irregardless of future benefits. While

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[222] Ruth Frager and Carmela Patrias, " 'This is Our Country, These Are Our Rights:' Minorities and the Origins of Ontario's Human Rights Campaigns," Canadian Historical Review, (March 2001), p.1-35.

[223] A Reprint of the Nuremberg Code, Nuremberg Military Tribunal, "Ethical Requirements for Clinical Research," JAMA, 232-20, (May 24/31, 2000), p.2702.

largely meant to ensure research was properly conducted, informed consent was eventually standardized in hospitals for clinical situations.

Public awareness of the Nazi crimes caused a reexamination of policies and beliefs that supported the exclusion and segregation of people with mental impairments. Simmons argues that the war reoriented attitudes towards mental retardation and mental illness: "People were shocked to realize the deadly potential inherent in some of the arguments that had been used in the 1920s to justify the incarceration and sterilization of mentally retarded people."[224] The same rights and privileges that existed for the general populace needed to be extended to the mentally ill otherwise their very existence was put into danger. The law needed to reflect equality amongst all individuals and especially safeguard the rights of vulnerable persons. For the first time large numbers of people agreed on the need for social reform and a new level of tolerance emerged during the post-war years; tolerance which encouraged a wave of reform but never acceptance.

The focus of this chapter is on the internal operations of the Hamilton Psychiatric Hospital during the years 1945-1970. Located on the scenic Hamilton "mountain," as the hill is fondly referred to by the local community, the asylum was established in 1875 under the principles of moral treatment. The Hamilton Psychiatric Hospital, known alternatively as an Ontario Hospital, was considered to be the best in the region and to have excellent facilities. The history of the hospital is typical of the evolution of most asylums in origin, function and purpose. The hospital typified the process whereby humanitarianism evolved into custodialism. By the 1930s, limited staff, overcrowding by all types of patients, and low cure rates plagued the hospital's ability to function. These

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[224] Harvey Simmons, From Asylum to Welfare, (Toronto: 1982),p.158.

problems persisted in varying degrees into the 1950s and caused great frustration amongst psychiatrists.

While the 1950s and 1960s are of central concern to this thesis, documents from both the late 1940s and early 1970s will be used as well. Evidence is largely based upon documents collected and stored at the Museum office at the Hamilton Psychiatric Hospital. Many archival sources are missing from the collection, either not donated, destroyed or mysteriously disappearing within the hospital system. Yet, the absence of specific documents itself reveals facts about the hospital. Most sources consist of letters, annual reports, memos within the hospital, committee minutes, and lecture-style papers, which help give shape to the examination of psychiatry and human betterment in the post-war years.

A psychiatric hospital was selected because practices involving human betterment are often initially and most easily implemented in places where the inhabitants are vulnerable. The tendency to classify and treat patients as problems that needed to be cured, or returned to normalcy, is greater where the patient population itself is considered not only to be abnormal but unwilling or unable to help themselves. The perceived inability to "will" oneself back to health also presumes one lacks the rationale or understanding necessary to consent to treatment options. Hence the use of heroic measures became necessary and justifiable to psychiatrists and families alike, since anything which will effect a cure or alteration was a positive result for a patient unable to help themselves. Moreover, the psychiatric profession was increasingly pessimistic and desperate in the post-war years. The need to find medical cures and to legitimate the profession medically went hand in hand. Without new medical innovations to treat patients and raise cure rates, the psychiatric profession remained on the fringes of the medical community. Poorly received by general practitioners and surgeons, and excluded from general hospitals, the psychiatric profession still sought professional credibility among its peers and attempted to remove the isolation and stigma surrounding mental illness by integrating psychiatric practice in the community.[225] In response to the desire to professionalize, psychiatrists attempted to reorganize the hospital to achieve a cohesive system of treatment for the mentally ill. Yet, hospital policy was largely haphazard and lacked direction. Without clear functions, committees produced many suggestions, but few modifications. Therapeutic interventions reflected both the physical and social nature of treatment as the desire to return individuals to 'normality' governed research and treatment programs. Disregard of the developing principle of informed consent and a reduced diligence regarding the vulnerability of patients persisted, allowing the portrayal of increased cure rates and professional legitimacy. Hamilton Psychiatric Hospital provides a direct link with human betterment following World War II, a link of professional human intervention to achieve human betterment both socially and medically.

POLICY AND PROCEDURE

Annual reports for the years 1946 and 1947, written by the superintendent, focused upon two subject areas: the care and treatment of patients and staff, and administration and buildings. From 1944 to 1965, the Medical Superintendent of the Hamilton

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[225] Psychiatric practice in the 1950s and 1960s underwent a transition both in terms of locus and visibility. Although the asylum was never replaced, psychiatry extended its sphere into the community through public health and the mental health clinics and later through psychiatric units. Moreover, the initial exclusion of benefits offered in general hospitals to psychiatric patients in 1957, further alienated psychiatry from general medicine and reinforced a sense of lower priority to mental health as well as mental health practitioners.

Psychiatric Hospital was J. N. Senn. To his relief, the end of the war signaled the return of many nurses, doctors and aides to fill the numerous vacancies at the hospital. Of specific concern were the rising admission rates (causing overcrowding), and the number of elderly patients admitted to the hospital:

> You will note that our admission rate is particularly high as we admitted during this year 595 patients. Our death rate is also high, this being caused by the high percentage of admissions in the old age bracket and these patients not long surviving after they are admitted to the hospital.[226]

The report stated that of 595 patients admitted (to all Ontario asylums), 77 were discharged and 492 patients, solely in the category of senile, died.[227] Doctors attributed the high death rate to family members who admitted patients only after diseases were in the last stages, and hence untreatable. Complaints in reports regarding overcrowding, and chronic and elderly cases, emphasized that the hospital functioned largely as a custodial center in the immediate post-war years. Despite newer treatment options, listed in the 1947 report as electro-shock, Narco diagnosis and occupational therapy, a new optimism in psychiatry did not appear until the mid-1950s with the development of psychotropic drugs.

A random sampling of annual reports between 1949 and 1967 provides an overview of program, structural, and procedural policies at the Ontario Hospital. Reports for 1949, 1951, and 1956 share many similarities. Each report complained of high admission rates (particularly for the elderly), overcrowding and high death rates. The coordinating committee minutes for 1959 discussed the problems of overcrowding as well. Treatment varied slightly over the years but ECT and psychotherapy – which

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[226] Annual Report of Ontario Hospitals, (1946), p.12.
[227] ibid., p.13.

suffered due to large numbers of patients and a shortage of staff – were constant. Tranquilizer drugs, insulin coma therapy, lobotomies, and combinations of the former treatments varied year by year. By 1962, overcrowding remained an issue but was not as serious due to deinstitutionalization. The development of more complex drugs coincided with a new focus in the 1960s on community treatment. The redirection of provincial policy towards community-based treatment for the mentally ill resulted in large numbers of inmates being discharged from the hospitals. The simultaneous rise in the numbers of social workers, psychologists, and other medical professions working outside of hospitals provided the necessary community workers. Prevailing treatments in the 1960s were lobotomies (as a last resort), ECT, insulin coma and tranquilizer drugs. The 1966 report made no reference to different types of treatment and noted a slight reduction in admissions and classified the admissions; similarly, the 1967 report mentioned admissions and ignored treatment.[228] However, both reports wrote about occupational and industrial therapy in lieu of any other type of treatment – most likely because the focus in the late 1960s remained grounded in a return to the community and these therapies were most beneficial in achieving that goal.

In 1946, surgery involving psychiatric patients began to be moved to general hospitals, obstetrics being the first area to be handled outside of the Ontario hospital. No documents can be found listing which hospital patients were sent to, nor is there any explanation of the type of surgery undertaken in the obstetrics unit. Further, no records regarding any obstetric surgeries occurring at the Ontario Hospital prior to 1946 can be found. It is unclear why the surgery was moved, what the surgery consisted of, and

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[228] Annual Report of Hamilton Psychiatric Hospital, (1966); Annual Report of Hamilton Psychiatric Hospital, (1967).

moreso, why mental patients initially needed an in-hospital obstetrics program. Not to dismiss the possibility, but the majority of the inhabitants were unlikely to be pregnant as at least half the population were male and post-menopausal females. The complaints regarding overcrowding largely referenced the high numbers of elderly patients, those unlikely to be in the childbearing age range. While some information may be contained in patient files, the law prohibits any further examination without individual permission. The only available information regarding surgery in the 1950s were records discussing lobotomy operations (and it is not clear where these were performed) and dentistry, which continued at the hospital until the 1970s.

A hospital memo from 1959 complained that "certain patients were disregarding the regulations with a resultant co-mingling of the sexes."[229] The fear of sexual interaction between patients with mental illness caused some concern for the staff. Yet, when the memo on patient 'co-mingling' and staff and patient relationships are combined,[230] the HPH seems particularly concerned with preventing any sexual interaction. This is suggestive of a hypervigilance of separation. While difficult to discern what is meant by 'co-mingling,' the manner of interaction not being clearly expressed, interaction between men and women existed. The patients could merely have been conversing or there may have been physical contact. Regardless, the Hospital rightly desired to prevent sexual abuses by staff upon patients or between patients. Yet, the possibility for sexual pleasure was also monitored and prevented by eliminating the potential for heterosexual contact. In this instance, the wards were closed and a more careful selection of patients made for day-wards. One also wonders if lingering concerns of hereditarian traits influenced the

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[229] Co-ordinating Committee Meeting Notes, (June 2, 1959).
[230] See "Rules of Conduct," Hamilton Psychiatric Hospital Memo, p.1.

strict guidelines on relationships.

The Hamilton Psychiatric Hospital's position statement on all hospital policies was written after 1967, most likely in the early 1970s. The statement outlined the purpose and function of the hospital in relation to patient care, education, research and management, and based the statements largely upon the Mental Health Act of 1967. The ultimate goal of patient care was to rehabilitate the patient within the community. Education was meant to ensure quality and up-to-date treatment by skilled professionals. Research evaluated the results of different treatments while securing the individuals' rights in new research projects. Management ensured the appropriate and innovative use of resources, reviewed and assessed all activities, and communicated with all other agencies and the community. In 1974, the Ministry of Health gave full recognition to HPH's Research Department – making it unclear how previous research was viewed by the government.[231] Overall, by the 1970s, a new sense of optimism emerged, policies seemed better organized, the government provided more direction, and psychiatry returned its to biological roots.[232]

The admission and discharge policy for the HPH was fairly static. People could be admitted to the hospital in three ways: 1) a doctor's certificate, 2) by order of the courts, or 3) by voluntary admission. Discharge similarly was by a doctor's certificate, but even voluntary patients could sometimes not leave without a doctor's consent. If a voluntary

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[231] A single sheet entitled, "Taken From Newsletters," provided highlights of developments at HPH between 1972 and 1976. One line reads, "November 1974 – Ministry of Health – full recognition to HPH's Research Department." No further explanation as to what the recognition entailed has been located. It seems likely that HPH received either new monetary support or simply more prestigious recognition.

[232] Shorter argues that the psychiatric movement returned to an emphasis upon biological deficiencies as the cause for mental illness; thus, returning, in a sense, to the fading ideas on genetics germinated during the first biological psychiatry (circa WWI). Inherent within these ideas is the issue of hereditary illness, a major theme within eugenics and human betterment. Edward Shorter, A History of Psychiatry: From the Era of the Asylum to the Age of Prozac, (New York: 1997), p.239.

patient was deemed by a doctor to become a hazard to themselves or others, the doctor could refuse to discharge a patient from the hospital and reassign their classification from voluntary to involuntary. Under the Mental Health Act of 1967, patients were classified as either 'informal' patients or involuntary patients. Informal patients signed themselves in and out, whereas involuntary patients were subject to detention for 30 days after medical certification. Neither the Ontario hospital records nor the Mental Health Act of 1967 provided regulations on informed consent or the signing of waivers to authorize treatment. The earlier 1935 Mental Health Act also does not specify the need for consent nor do amendments in the 1950s. It seems as though the act of committal, whether voluntary or not, embodied an implicit permission for treatment. Yet, from the records of the treatment committee, informed consent did constitute an issue in certain types of medical interventions, specifically for ECT and lobotomies. Even insulin coma therapy needed to be discussed with relatives prior to commencing treatment. But no release forms or waivers existed for patients or relatives to sign upon admittance – this is especially important for involuntary admissions and treatment as well as regarding the problems associated with third party consent.

The policy statements and procedural directives at HPH reflect a focus upon human betterment. The primary goal of the hospital was to restore patients to normal health and return patients to the community. The concepts of restoring and returning the individual to the community suggests an emphasis upon social improvement, specifically by manipulating the patient's behaviour. A desire for reintegration into the community underscored the need for betterment. 'Normality' necessitated acceptance and participation within the community. Thus, while HPH desired to aid the patients, the type of aid centered upon concern for social and physical betterment and moreso, betterment directed at appropriate normalization of social and physical behaviour.

COMMITTEES AND POLICY

Approximately twelve committees were formed from the 1950s to the 1970s to address all aspects of hospital life. One of the committees, the Patients' Councils, was organized on different wards to allow patients to express dissatisfaction and exercise self-discipline. The Patients' Council of 1959 sought self-government for the patients, but this goal became problematic when the patients, in the words of the staff overseer, "consistently elected as President the most vociferous of group, which generally turned out to be a defective patient."[233] The patients otherwise tended to look to the staff for leadership, a move which contravened the purpose of the councils. The biggest demands of the patients concerned hygiene – more soap, deodorant - and sometimes increased amounts of candy. Yet, despite the slow start and extensive consideration of minor details, the councils began to suggest more fundamental improvements (although no example was provided).[234] Also, no comment was made as to whether any suggestions were implemented and only one document regarding Patients' Councils is available.

All other committees were solely staff-directed, including the coordinating committee, pharmacy committee, treatment committee, canteen committee, research committee, volunteer and recreation committee, industrial therapy committee, education committee, committee on voluntary activities, total problem solving committee and management

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[233] Memo from Superintendent Senn to Dr. McNeel, "Patients' Councils," Ontario Hospital, Hamilton, (March 17, 1959).

[234] "Patients' Councils," (March 17, 1959). This is the only set of minutes from Patients' Councils. The minutes discussed points reflective of previous existence of the Council, as well as noting improvements. Yet, explanation of the improvements and earlier or later documentation of the Council is missing.

committee. The coordinating committee generated the most minutes, as all other committees were accountable to it. The pharmacy committee investigated the dispensing procedure for drugs and the availability of various drugs, and ordered all medications. The education committee coordinated the dissemination of medical information to the staff. The canteen committee ensured proper nutrition and health through daily meals as well as recorded the overall food intake. The volunteer and industrial committees engaged patients in sports, work and community activities. For the purposes of this thesis the treatment committee and the research committee require special attention and will be addressed separately.

While each committee had a purpose, often lacking was a clear focus or the exact function. The patients' councils memo stated, "I am afraid we have proceeded with Patients' Councils in rather a blind way as we had little or no guidance from literature or from other sources to assist us."[235] Moreover, as only one memo can be located it seems the council thereafter was left to flounder on its own, which questions not only its ability to function but its ability to survive. The education committee wrote, " Our central problem has been some uncertainty as to the function of our Committee, and any help the Co-ordinating Committee can give us in this regard would be appreciated."[236] The committees were not simply free-wheeling organizations uncertain as to which direction to head, the committees were 'wheel-less.' The Industrial Therapy meeting of February 1967 reported on observations made at Toronto's rehabilitation center while seeking criteria for HPH's program. The therapists from HPH sought selection criteria to aid in the determination of which patients would benefit most from industrial therapy.

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[235] "Patients' Councils," (March 17, 1959).

[236] Memo from the Education Committee to the Co-ordinating Committee, (September 4, 1959), p.2.

The report claims "O.T. [occupational therapy] simply used common sense in their selection, no referral form of any type was used."[237] While other more concrete factors were listed, the overall criteria was vague and left to individual discretion. Despite an attempt to organize, the hospital committees seem haphazard. The committees suggested alterations to hospital policies but it is rarely clear if these modifications occurred. Moreover, many modifications are presented with qualifications, "We would like to emphasize that this proposal is in no way a criticism of the Attendant staff..."[238] thereby reflecting hesitancy within the committee itself. Essentially the committees were without direction and pursued alterations in a haphazard fashion.

The problem does not seem to be isolated to Hamilton. The establishment of an Industrial Rehabilitation Center in London also lacked any long-term direction,

> I have asked Mr. Walker what is meant by an Industrial Rehabilitation Centre, and he concurs in the idea that the entire hospital may be considered a rehabilitation centre, and the activities diffused through it, rather than requiring any specific part of the hospital to be so designated.[239]

Whatever the Industrial Rehabilitation Centre was supposed to be, was never expressed. While the center was to be directly associated with the hospital as part of a macro-industrial therapy center, no explanation of the center itself was made. The problem seems to stem from a lack of provincial and federal initiatives as well as the absence of a concrete mental health policy which made new ideas difficult to implement. The annual report for 1962 provided an account of the new residential units in the hospital but claimed, "Unfortunately we do not seem to have any clear concept for our guidance in the

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[237] Minutes of Industrial Therapy Meeting, (February 27, 1967), p.2.

[238] Miuntes of Education Committee, (September 4, 1959), p.2.

[239] Letter from Dr. McNeel to Wickware at the Ontario Hospital, London regarding Regulations – Industiral Rehabilitation Centres, (September 18, 1964).

type of patient that should or should not be admitted to Residential Units."[240] Hence, despite the new emphasis upon community care in the 1960s, the hospital staff were left without the necessary criteria to determine who should be placed within these open units.

Many committee functions overlapped with each other and supplanted one another over time. Yet, between 1958 and 1970 the number of committees did not diminish greatly nor did major changes occur within the hospital through internal sources. External changes in treatment procedures were the main alterations within the hospital whereas policy formation rarely occurred and when it did, only in an unbalanced and incoherent fashion. Moreover, while the committees reflected ideals of social and physical improvement for the patients, the disorganization surrounding these ideals allowed for experimental techniques aimed at physical and social betterment to proliferate. An examination of treatments addresses the social and physical elements present within the remedies aimed at human betterment.

THE TREATMENT OF THE MENTALLY ILL

The treatment committee at Hamilton Psychiatric Hospital understood its function much better than other committees but defined its mandate in a peculiar fashion. The use of ECT, insulin coma therapy, psychotherapy and lobotomies were not evaluated by the committee. Rather the committee investigated selected issues as diverse as (proper) drug dosages, the benefits of industrial therapy, and "an attempt...with screening, to eliminate possible disease vectors, flies, mosquitoes and rats."[241] In 1961 the treatment committee implemented "the procedure of remotivation" for the staff. [242] The need for staff

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[240] Annual Report of Ontario Hospital, Hamilton, (March 18, 1963), p.2.
[241] Memo from Dr. Morris regarding Treatment Committee Meeting, of April 19, 1959, (May 4, 1959), p.1.

remotivation probably occurred partially in response to the 1959 claim made by the coordinating committee that patient-staff relations have deteriorated. Proof for the statement was that the rate of discharge was the same as thirty years ago when there were "closer relationships; moral treatment of patients obtained as good results as modern methods do."[243] The praise of moral treatment reflects the frustration within psychiatry. The inability to permanently cure patients and even, among many patients, lessen the symptoms lent desperation to the cause. Advancements in medical procedures briefly raised cure rates and testifies to the overwhelming acceptance of new treatments time and time again. Beginning as early as the post-war years and well into the 1970s, psychiatry tried anything with results. Medical innovations received an acceptance that was less critical, the 1950s comprised the "age of experimentation" in psychiatry.[244]

Drugs

In A History of Psychiatry, Edward Shorter acknowledges the excitement surrounding new drug therapies after WWII. Beginning in the 1800s, the use of alkaloids and sleeping compounds represented an attempt to seek out alternatives in response to the desperateness of the times. The reoccurring inability to achieve lasting cures, or even a prolonged absence of symptoms, lent desperation to the psychiatric profession. Alkaloids, such as morphine, produced sedative and hypnotic effects (but only temporarily), and the use of chloral and bromides also realized only minimal effects. The

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[242] Memo from the Chairman of the Treatment Committee regarding the Treatment Committee Meeting of March 30 1961, (April 7, 1961), p.1.
[243] Minutes of Co-ordinating Committee, (March 3, 1959), p.2.
[244] Phil Fennel, Treatment Without Consent: Law, Psychiatry, and the Treatment of Mentally Disordered People Since 1845, (New York: 1996), p.129.

first drugs to create longer durations of relief in the 1930s again followed on the heels of desperation, but at that time, desperation with the custodial asylum. Chlorpromazine in the 1950s addressed schizophrenic's symptoms, and although largely experimental, chlorpromazine's results provided the watershed necessary to renew optimistic ideals of cure and permanent removal of symptoms. "Following chlorpromazine, a veritable cornucopia of antipsychotic, antimanic, and antidepressant drugs poured forth, changing psychiatry from a branch of social work to a field that called for the most precise knowledge of pharmacology, the effect of drugs on the body."[245] The outcomes included not only patient addictions and the usage of certain toxic prescriptions but the output of these drugs into the streets as popular substances of abuse. Lithium and LSD reflect the experimental trend, the dangerous effects, and the new sense of confidence instilled by the "cornucopia" of drugs. By the 1970s biological psychiatry again became the focus replacing notions of environment and faulty child-rearing with genetics – inaugurated in the first biological psychiatry of the early 1920s.[246]

The use of drug treatment began in the 1950s with the development of new psychotropic drugs. The drugs calmed the patients and reduced the symptoms of mental illness. By 1961 the treatment committee was questioning the feasibility of administering all drugs in one dose instead of several times throughout the day.[247] Reasons for the policy change were efficiency and better time management for the staff. The single dosage idea originated from the American Psychiatric Association which claimed many tranquilizing drugs can be given once a day.[248] The staff at HPH wondered if the

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[245] Shorter, A History of Psychiatry, p.255.
[246] ibid., p.239.
[247] Memo from Treatment Committee to Management Committee, (March 7, 1961), p.1.
[248] Memo from Dr. White, chairman of the Treatment Committee, regarding Treatment Committee meeting of June 2nd , (June 9, 1960), p.1.

number of Largactil dosages could also be reduced to one per day. However, certain drug representatives were unable to guarantee the affectiveness of the drug after 12 hours (specifically Stelazine) and issues of safety regarding the large dosages were also raised.[249]

The optimism provided by new drugs and a desire to ensure recognition as a legitimate scientific discipline caused psychiatrists to experiment with new medications. At HPH reminders regarding the treatment of hypotension in the course of tranquilizing therapy were sent to staff. The forwarded memo claimed there was a tendency to become too familiar with drugs and forget they are potent agents - two separate times the hazards of tranquilizing therapy in relation to hypotension was noted. Drugs were also combined with all other forms of treatment, the best illustration of extreme experimentation and abuse being that of Dr. Ewen Cameron, a psychiatrist at the Allan Memorial Hospital, who combined sleep therapy with depatterning and a plethora of drugs to reduce the patient to an infantile state for retraining.[250] The use of thalidomide, as a sedative, in April 1962 further suggests psychiatry was willing to use whatever worked. Recalled by the Food and Drug Directorate in Ottawa, thalidomide no longer constituted an approved product. Senn, however, responded in August by claiming the drug was "very nice" as a sedative since little chance of suicide by overdose existed.[251] Senn further claimed that the drug was never dispensed to pregnant patients inferring the continued value thalidomide held for treating psychiatric patients who were not pregnant.

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[249] ibid., p.2.

[250] Dr. Cameron remained a prominent psychiatric at the Allan Memorial Institute in Montreal where his discouragement with the inability to cure schizophrenia caused Cameron to resort to excessive treatment options. Depatterning essentially comprised a form of brainwashing and occurred without the consent of the patient or family. The results were devastating. Anne Collins, In the Sleep Room, (Toronto:1997).

[251] Memo from Senn on Patient Policy file at HPH, (August 1962).

Psychosurgery

Psychosurgery was one of the most popular forms of therapeutic intervention as it combined 'medical science' with psychiatric treatment. Lobotomies, like the new drugs and ECT, conveyed an aura of scientific legitimacy and technological sophistication, more so than psychotherapy. Accreditation with the new techniques indubitably tied individual psychiatrists more closely to general medicine. The aim of psychosurgery was to reduce anxiety and calm agitated patients. Usually, lobotomies/leucotomies were reserved for the most severe and treatment-resistant patients as drugs could often achieve the same effect in a simpler and in most cases, safer fashion. Specifically cases of schizophrenia and chronic mental illness were considered appropriate subjects, since no lasting cure existed in the treatment of either disease. Indeed, the hopelessness of schizophrenia is exactly what attracted Ewen Cameron to "depattern" patients in the hopes of effecting a lasting cure.[252]

A lobotomy is a complex operation with the potential for serious complications and fatal errors. The Hamilton Psychiatric Hospital required that "the operation is resorted to here only after all other therapeutic measures have failed."[253] In the operation first developed by Moniz, holes were drilled into the skull on each side of the front coronal suture and the white fibers in the center of the brains two lobes were cut across.[254] With a whisk-like leukotome, one would stir back and forth destroying the nerve fibers. For a trans-orbital lobotomy, popularized in North America by Freeman and Watts, one

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[252] Collins, In the Sleep Room, p.132.
[253] Hamilton Psychiatric Hospital, (anon.) Untitled Paper on Practice of Leucotomy/Lobotomy, Archives of Hamilton Psychiatric Hospital, no date. Under Heading: Type of Cases, p.1.
[254] ibid.

inserted an instrument under the eyelid to again destroy the brain's frontal lobe tissue. Complications included hemorrhage, infection and seizures. The result of a lobotomy was entirely unclear; it was thought to not affect intelligence but made patients more quiet and manageable. Social improvement also occurred but many patients regressed and became 'excreta careless.'

> Patients who have undergone this procedure do demonstrate a lowered emotional pattern – flatness and apathy in most cases. Loss of intellectual capacity is usually slight and in many patients appears unchanged, although this varies greatly from patient to patient...Rather, most evidence suggests that a lobotomy produces an individual who is more easily handled, who is less imaginative, who shows a lower activity level, and who may stabilize at this level for a number of years....Many psychiatrists and psychologists believe that such procedures do irreparable damage and make it impossible for any patient thus treated to ever make full recovery.[255]

Lobotomies seem not to be in the patient's best interest but in the interests of the hospital staff. While it will require more time and effort to resocialize and reeducate the patient, subjects of lobotomies are "more easily handled." Post-operative severe regression occurred and resocialization was necessary if the patient was to function independently. Emotionally the patient returned to childhood and needed to be reoriented to the surrounding world, which was successfully achieved with great difficulty. Incontinence, inactivity, apathy, and retardation were symptoms that lasted for a few days or several months. Stroem-Olsen quotes the feelings of a group of relatives regarding lobotomy, "For her this operation has been a miracle, but we wish we had not got to live with her."[256] Whereas the Hamilton Psychiatric Hospital claims, "it is essential that the important people of his world, the relatives have increasing understanding of him and do

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[255] "Psychosurgery," Nursing Assistant Program, Nursing Education Department, Hamilton Psychiatric Hospital, circa 1970, p.1.

[256] E. A. Clark, Prefontal Lobotomy: A Brief Review Of Selected Literature, (September 1949), p.5.

not perpetuate the old stressful situations and reteach the patient the old ways."[257] Here, the tension between nature and nurture is raised. The hospital staff feared the influence of nurture after invading nature to effect a change. Overall, the results observed from lobotomies were inconclusive in 1949[258] and still so in 1978.[259] Controversy regarding psychosurgery continued, especially since the surgery ultimately controlled social behaviour and was not performed due to medical necessity.

Shorter claimed lobotomies faded in the early 1950s and greatly declined by the mid-1950s with the advent of new drugs in both Britain and the United States.[260] At HPH lobotomies continued until 1962 and in 1970, the nursing manual at HPH contained a discussion of the merits and downfalls of psychosurgery.[261] No lasting consensus on the validity of lobotomies could be reached. Recognition of the problems associated with lobotomies were put forth as early as the 1950s. This dissension amongst psychiatrists suggests psychosurgery largely remained an experimental treatment. Without definite confirmation attesting to its beneficial nature, the continued use of lobotomies past 1950, when problems were first recognized, questions the soundness of performing psychosurgery. At a time when ethical constraints remained weak and the decision relied upon doctors, who benefited from the surgery, the proper safeguards were not in place to prevent unnecessary surgery or therapeutic interventions which bordered on the experimental. Amongst some individuals, attitudes towards lobotomies became

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[257] Lobotomy Memo p.3.
[258] Bombard, Stevens, "A Prefrontal Lobotomy Program," American Journal of Nursing, 49-2, (December 1949), p.753.
[259] Betty Lee, "Lobotomy's Robot Image A Myth, Says Doctor," Hamilton Spectator, (Jan 24 1978), p.1. The article requests that past patients of lobotomy volunteer for painless tests to determine the long-term effects of lobotomy.
[260] Shorter, A History of Psychiatry, p.228.
[261] "Psychosurgery," Nursing Assistant Curriculum, Nursing Education Department, (Hamilton Psychiatric Hospital: Unit III).

lighthearted by the early 1950s, suggesting a level of inconsequence was associated with the procedure.[262]

All of the criteria regarding possible complications and post-operative effects needed to be weighed and presented before obtaining informed consent and/or proceeding with the surgery. Yet, there is no evidence that harm/benefit analysis ever occurred, that patients agreed or that third party consent was either informed or obtained. Following so closely from the Nuremberg Code, it is difficult to comprehend why two prevailing principles ostensibly accepted by the medical profession were blatantly neglected. Informed consent for lobotomies was to be obtained, according to a 1953 memo, although the memo actually addressed the issue of obtaining permission for electroshock. In the last sentence, Senn wrote, "Permission will, of course, have to be obtained as in the past for lobotomy;"[263] however, a 1955 letter suggests that informed consent was never obtained from the patient and that the next of kin was never fully informed.

> It is felt that a patient should not be deprived of or denied the benefit of treatment because relatives are disinterested or lacking in understanding. Nor should the patient be denied or deprived of treatment because he has the misfortune to be without relatives. In these cases, it is felt that the patient should be dealt with and treated in accordance with the best judgement of the Superintendent.[264]

The decision was left with the Superintendent, a person likely to be partial or biased in one direction. No mention of patient consent is ever discussed in this memo, which is of concern considering the problems posed with third party consent - familial or otherwise. Although the standard for consent with lobotomies was set, Lewis, the Assistant Director of the Mental Health Division, felt it would be "prudent...to take the extra precaution of

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[262] See Appendix A.

[263] Memo from Senn to Medical Staff, Permission for Electro-Shock and Electro-Stimulation, (August 10, 1953).

[264] Letter from C.H. Lewis to Dr. Senn, Lobotomies, (February 17 1955), p.1.

obtaining a reliable, independent opinion concerning the advisability of proceeding with the operation."[265] Therefore an awareness of the need to take precautions relative to consent existed and began with the emergence of securing a second opinion.

ECT

The process of informed consent, while flawed and incomplete for lobotomies, at least represented an effort to adhere to developing medico-legal ideology; the same does not extend to ECT treatment. On August 10, 1953, two memos regarding "Permission forms for Electro-Shock and Electro-Stimulation" were sent by J. N. Senn. One addressed to Marion Johnston reads, "I received advice from the Department that in future we do not need permission for electro-shock therapy or electro-stimulation. It will not, therefore, be necessary to get this permission in the future."[266] The past process for obtaining informed consent and the person who provided consent for EST are both unknown. A 1953 memo to the Medical Staff advises,

> I have been advised that it is not necessary in future to obtain permission for electro-shock and electro-stimulation. It will, therefore, be in order to proceed with these treatments without permission being received. I would recommend, however, in cases where we are afraid of complications that the matter should be discussed with the relatives prior to instituting treatment. Permission will, of course, have to be obtained as in the past for lobotomy.[267]

Both 1953 memos revoke the right to informed consent unless complications were expected. Since it would be impossible to have a clear understanding of the potential

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[265] ibid., p.1.

[266] Memo to Marion Johnston from J.N. Senn, Permission Forms for Electro-Shock and Electro-Stimulation, (August 10, 1953).

[267] Memo to Medical Staff from J. N. Senn, Permission for Electro-Shock and Electro-Stimulation, (August 10, 1953).

risks, it was unrealistic to limit the conditions for obtaining consent; however, liability would be removed. Doctors were free to utilize electro-shock to treat any psychiatric patient without fear of reprisal. The authority who sanctioned the rescinding of permission is recorded only as the "Department," but is seems likely to infer the Ontario Mental Health Department. Regardless, the department should not have revoked the policy of informed consent, especially when considering the principles of the Nuremberg Code and the progressive nature surrounding issues of consent. By removing the need for permission, the hospital claimed that the medical staff was better able to decide treatment than the patients and their families, a very paternalistic attitude as the doctors were not merely proposing treatment but determining treatment. Of special note is that lobotomies still required some level consent as the 1955 letter from Senn never fully revoked the need to obtain permission. This may reflect a difference in cultural attitudes between invasive and non-invasive treatment, alluding to the ease with which consent for non-invasive surgery may have been bypassed. Yet one wonders if the preferred option sidestepped consent for all treatment of psychiatric patients.

Even the issue of complications with ECT treatment was treated lightly. The treatment committee reports,

> Dr. Bow's memo re Aspiration Complications with ECT. He recommended that facilities should be available for intubation in order to prevent aspiration complications with ECT. This point was well taken, and should certainly receive consideration if we were likely to have a large number of out-patient ECT. However, with our present technique and pre-treatment sedation, this does not present a problem at present.[268]

Although the issue of aspiration is raised, the likelihood is considered minimal due to pre-treatment sedation and hence the precautions are ignored. Pre-treatment sedation

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[268] Treatment Committee Report, (October 6, 1959), p.2.

was a practice that did not originate with the commencement of electro-shock therapy but years later, providing a gap in which ECT treatment resulted in severe injuries to the patient, and in early practice, even death.[269] Moreover, any out-patients receiving ECT were without the provision of intubation, even as a precaution, simply because of low numbers, and were therefore subjected to a potentially dangerous treatment. The article seems to suggest that the problem had not occurred since the modification of ECT to include sedation, but the relationship between sedation and its ability to prevent aspiration is not validated.[270] If aspiration did occur, the necessary aid would not have been immediately available. The possible outcome from the absence of intubation facilities, not properly considered, resulted in the employment of a potentially fatal process.

Concern over fatalities was a factor in determining hospital policy. The administration of insulin and electro-shock therapy by unlicensed physicians was revoked due to a patient death in Ontario. In 1954, the adjustment was made to allow only registered, qualified medical practitioners under the Medical Act of the province of Ontario to administer these treatments because, "there may arise, during the course of

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[269] In Shorter, A History of Psychiatry, p223, he cites the fracturing of limbs and vertebrae of patient while undergoing ECT. Also, from an interview with Dr. Emil Zamora, who interned at the Hamilton Psychiatric Hospital in 1958 and 1959, ECT without pre-sedation often resulted in both serious injury and in some cases, generally between 1930 and 1950, death to the patient. Part of the problem was the inability to provide for intubation as a conscious patient has great difficulty swallowing the tube.

[270] Again, from speaking with Dr. Amil Zamora, no direct or causal association exists between sedation and the prevention of aspiration. Dr. Zamora further claimed that Dr. Norris' response tended to be incorrect. Pre-treatment sedation in no way reduced the chance of aspiration, but moreover, Zamora pointed out that none of the patients were under anesthetic. Unless provided with anesthesia and unconscious, intubation remained unlikely to be possible. Dr. Zamora stated that anesthetic was not introduced at HPH in assocation with ECT until the 1960s, although discussions occurred earlier. Further, the reference to out-patients raises another issue. Patients undergoing ECT were not allowed to eat or drink for a lengthy time frame prior to the therapy – and out-patients could not be monitored to ensure their compliance – thus, it seems although a minimal number of out-patients may have been treated, the need for intubation is higher when treating out-patients and would be of sufficient concern. The entire memo, after conversing with Dr. Zamora, makes little sense. The lack of anesthetic, the inability to intubate conscious patients, and no causal relationship between pre-sedation and the prevention of aspiration results in a confusing suggestion for a precaution by Dr. Bow which, regardless, Dr. Norris incorrectly deemed unnecessary.

treatment, situations that call for immediate remedial treatment by way of administration of medicines or otherwise."[271] Motivation for the change came from Toronto newspapers,

> You may have seen reference...to a recent case where an unlicensed medical practitioner, who was an immigrant from Europe, had administered some form of antibiotic with a fatal result, and the incident gave rise to some comment in the press.[272]

It is interesting that negative press directly initiated the change in policy. The "incident," a death due to medical error, further required public disapproval as incentive for modifications. It is unclear if the administration of ECT or insulin therapy could have previously been provided by someone other than a doctor. Part of the problem lies in determining who qualifies as a psychiatrist during a period when licensing was not uniform.[273] But the removal of the general medical staff's opportunity to be involved in administering treatment is significant as it suggests doctors were not the only one's treating patients.

In 1964, a review of ECT as a treatment option reported no complications citing the

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[271] Memo to all Ontario Hospitals from Lewis, Administration of Insulin and Electro-Shock Therapy by Unlicensed Physicians, (July 16, 1954), p.1.

[272] ibid., p.1.

[273] At the beginning of World War II, psychiatrists remained limited in number and were thus, in high demand. The Canadian forces would accept anyone with some level of medical training to screen soldiers and treat military personnel within the field. In the 1940s, certification did not recognize any type of specialty in training, one was either a surgeon or a physician. Each province developed its own standards following the war, largely in the 1950s, with the Toronto Psychiatric Hospital setting the standard in Ontario. Although specialty exams in certification began in 1946, psychiatrists could receive their license without being certified by the College. While the frequency of obtaining certification remained high, obtainment was not necessary. By the 1950s, two methods of certification existed. Psychiatrists could either receive a certificate or fellowship. The fellowship comprised a significantly more rigourous examination and due to conceptions of a two-tier certification process and the low success rate of candidates within the fellowship route, the process was restructured. (The certificate became viewed as a lesser qualification and the process tainted by stigma and shame.) In 1972, the College returned to a single examination which remained a certification, but was more rigourous than the previous certification. All of this information was obtatined from interviews with Dr. Al McFarlane of the Department of Psychiatry at McMaster Hospital, Dr. Cyril Greenland, and librarian Michel of the Royal College of Physicians and Surgeons.

importance of using drugs for pre-medication, specifically barbiturate by mouth such as Amytal, Seconal, or Tuinal. Senn seemed unconcerned regarding the administration of ECT claiming, "We give more ECT's here than is given in the General Hospitals. Many persons would say I think, that without IV Pentothal[274] ECT is barbaric, but it is our thought that with ample barbiturate treatment before the ECT, that does not apply."[275] The role of drugs in minimizing the negative effects of ECT first appeared in the annual report for 1956. The use of anectine with ECT "without complications we regularly had before" altered the administration and effects of ECT for both staff and patients. The value of ECT remains a topic of debate; however, ECT currently is limited to use only for cases of chronic major depression disorder with psychosis that does not respond to psychopharmacological interventions.

Insulin Coma

Insulin coma therapy was another treatment of last resort and was used in conjunction with ECT. Used specifically for schizophrenics, for which it was considered most effective, insulin coma therapy was also given to patients with manic depressive psychosis, psychoneurosis and any other chronic cases. In total, 40 to 60 treatments were administered, 5 or 6 days a week with 1 or 2 days rest. Complications from insulin coma included cardiac arrest, convulsions, laryngeal stridor (difficulty breathing due to involuntary contraction of the muscles), and nausea and vomiting. Patients required monitoring 24 hours a day, with special attention paid to secondary reactions otherwise

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[274] Pentothal was a barbiturate given intravenously to induce anesthesia in the patient and then an anesthetic would be administered. The time lag between its use and pre-sedation (1964 versus 1959) further supports the claims of Dr. Zamora regarding ECT.

[275] Memo from Dr. Senn to Dr. McNeel, Electro Convulsive Therapy, (December 17, 1964), p.2.

true and possibly fatal comas occurred. The person responsible for the treatment was usually the doctor, but nurses and other medical staff often completed the monitoring and surveillance – even putting patients into or bringing them out of comas. A memo to Senn refers to, "The graduate who is administering the insulin,"[276] providing confirmation of others administering treatment, even if not fully qualified although presumably, under qualified supervision. The 1950 report on Ontario Hospitals claimed that of 629 schizophrenic patients treated, 481 patients improved on some level, 146 did not, 2 died and overall, the remission rate was 54%.[277] Remission statistics for other patients was higher: 81% for manic depressive psychosis and psychoneurosis although the sample size was considerably smaller (44 and 27 respectively). The positive analysis of insulin coma therapy reflects the new optimism of the possibility of cure and the increasing medicalization of psychiatry.

Electro-shock therapy (EST) was used first in 'catatonic excitements' to bring the patient out of the stupor and then insulin was administered, or occassionally both were combined when treating manic attacks. Insulin was mostly used to treat electro-shock case failures but there is some discrepancy regarding the exact relationship between EST and insulin. One letter was written asking if EST should be given prior to insulin, and what criteria should be used for the selection of insulin patients.[278] The response claimed that usually patients are treated with EST, and then insulin was tried before moving the patient to a chronic ward. However, no specific routine was to be set-up. EST was to be administered first, assessed and then it was to be decided whether insulin therapy was necessary.[279]

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[276] Insulin Coma Paper, p.17.
[277] Memo to Senn from Easton, Annual Insulin Coma Therapy Report, (1950).
[278] Letter From Harvey Clare to Easton, (January 5, 1951).

Obtaining informed consent was considered necessary as is evidenced in an Insulin Coma paper (unfortunately no date is given), "Relatives should be aware from the first of the dangers of the treatment. These should be discussed with them prior to starting treatment. An insulin treatment permission form should be signed."[280] Doctors were also concerned with adverse effects. One patient who proved to be extremely sensitive to insulin was the subject of a letter. Dr. Boyd wrote to Dr. Easton in Toronto for advice as he was afraid to proceed further with treatment.[281] The outcome is missing from the archives and while the adverse reaction most likely was an allergic reaction, the doctor correctly suspended treatment until more information could be obtained.

Confusion over the necessity for informed consent illustrates the recognition of consent as an issue. Despite no codification in law, the 1950s identified the need to obtain consent, a practice existing at the Broadmoor Asylum for the Criminally Insane in England [282] for insulin coma therapy, and also existing at HPH. The distinction between invasive and non-invasive surgery reflects cultural ideals about "surgery" and "consent" which still did not fully extend to psychiatric patients. Doctors most likely realized that consent should be obtained, although not necessarily. But acquiring consent, either familial or individual, could limit treatment options and therefore it remained easier to ignore as much as possible the issue of consent. Treatment options also neglected to evaluate the benefits and harms to the patients. Rather the benefits to the staff outweighed the potential results for the patient. If the staff no longer needed to dispense drugs three times a day or restrain excited patients, their jobs increased in efficiency and

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[279] Letter From Easton to Harvey Clare, (January 8, 1951).
[280] Insulin Coma Paper, p.22.
[281] Letter from Boyd (for superintendent) to Easton, Insulin Coma Therapy, (April 13, 1956).
[282] Fennel, Treatment Without Consent, p.133.

ease.

Industrial Work/Occupational Therapy

Industrial therapy reveals an assortment of attitudes towards patient therapy as well as motivations to cure patients. Memos regarding the selection of patients to be involved in industrial work programs stated that patients involved "could not be defective."[283] While the term "defective" does not specify the type of patient to be bypassed, most likely chronic patients or patients with limited intelligence were considered unable to work. And yet, some of these chronic patients who would not be able to perform "quality" work needed the therapeutic jobs the most:

> Dr. Boyd considered that a great deal of the so-called deterioration in schizophrenics is not necessarily the result of their illness but living for a long time in the way they have, having lost touch with outside work and living conditions. He emphasized the necessity of the patients living a healthy life with simple recreation and enough good jobs of a therapeutic nature.[284]

The purpose of the program was to teach the individual a trade that was marketable and to return the individual to the community. Work therapy was of the greatest values when applied to receptive and marketable individuals. The patient received 25 cents an hour and worked a maximum of 5 hours. The work was therefore to be both part of the patient's treatment, since the patient did not work a full day, and part cheap labour. Mostly, patients completed jobs other people would generally reject or were provided with "make-work" projects. However, the feasibility and value of the program was questionable as "it is not strictly an industrial atmosphere which makes it very hard to assess results."[285] Other problems included work which was economically feasible but

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[283] Minutes of Industrial Therapy Meeting, (February 27, 1967),p.1.

[284] Minutes of Co-ordinating Committee, (March 3, 1959), p.1.

not therapeutically feasible and therefore guidelines needed to be established.[286] The industrial/occupational program reflected the desire to equip the patient with marketable skills. Once returned to the community, the patient needed to be able to function independently, but to do so required a level of normalization in accordance with societal values which would allow acceptance and provide employment. Thus, the therapy sought to treat the patient, but the treatment was designed to ensure a level of social conformity both in terms of acceptable behaviour and productivity which equated with societal norms.

When assessing the program, no mention was made of the patients' experiences nor patients' impressions regarding the work. Whether patients' appreciated the job, found it likeable, or even wanted the job was not addressed. Yet, when some patients actually went out into the workforce, concern was raised over why the patients failed to succeed: "Recently a group of patient had been sent to work in a local cannery factory, and having been adjudged as too slow were returned to the Hospital...some preliminary training of patients should be done here to get them ready to compete in the community."[287] Perhaps, preliminary training was required to make the patients more effective but there was also the possibility that patients resented or disliked the work.

RESEARCH

The research committee is notably absent from HPH documents. While referenced to in meetings of the treatment committee, coordinating committee and yearly reports, only

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[285] Minutes of Industrial Therapy Meeting, (February 27, 1967),p.3.
[286] No document outlining these guidelines has been located.
[287] Meeting of Industrial Therapy Committee, (September 15, 1967), p.1.

one report by the research committee exists and it is not even a copy of the minutes. Written in 1959, the report outlined two research projects. The first, a pilot project to test drugs and the second, a focus on group psychotherapy. The first project recognized a lack of "objective indices" to guide the use of numerous drugs used in the hospital. The doctor sought to determine the effect of the drugs on patient behaviour. The beneficial result of the study was to provide the medical staff with data to guide the selection of drugs. No mention was made of benefits or risks to the patients, immediate or long-term. The second project was a study in the interpersonal interaction and personality change in group psychotherapy. Specifically, the possibility of producing therapeutic changes through small groups and the amount of change were to be investigated. The benefits would be "determining the most efficacious manner of using staff time to provide the greatest benefit to the greatest number of patients."[288] Here, benefits are suggested for both staff and patients.

A later, more detailed, report regarding Dr. Woodruff's research project on the drug research claimed: "Essentially this involves a double blind study comparing the results of two drugs with Largactil and Stelazine, with a Placebo."[289] The treatment committee approved of the project and no comment was made regarding the potential benefits of the research. In the end, the study "failed to show that there is any superiority of either of these drugs over a Placebo in the type of patient that was chosen for the project."[290] Yet, not stated is the type of patient chosen, the number of patients involved, nor the duration of the research project. All of this information is a basic requirement in

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[288] Report of the Research Committee to the Coordinating Committee, (March 18, 1959).
[289] Treatment Committee Report, (October 6, 1959), p.2.
[290] Memo to Senn, from Dr White, Treatment Committee Meeting on Dec. 7 1959, (December 22, 1959).

the evaluation and approval of a research claim. If the information was ever put together into a proposal, the proposal has vanished along with the remainder of the research projects and any committee minutes.

One other reference to the research committee is an extensive note in the coordinating committee minutes. Dr Boyd conducted research on the leucotomy program in the hopes of learning more about the prognosis of functional psychoses – using files from 5-10 years previous. Other plans included contemplation over when to stop electroshock, the number of treatments, and the creation of a group therapy program by Dr. Coons.[291]

The absence of research committee paperwork represents a myriad of possibilities. It is significant that the committee appears more frequently in other committees' minutes than exists research minutes. It may be that the committee met infrequently or that the committee lacked direction like many other committees, but the research committee continued to survive. This lacuna is representative of the mismanagement of Hamilton Psychiatric Hospital's internal administration. The disorder surrounding the research committee, the absence of minutes and lack of research guidelines substantiates the recurrent theme of haphazard policy development within HPH. The focus on research, however, reflects an attempt to professionalize. While the actual research projects may never be located, the fact that psychiatrists were conducting research, attempting to find cures or be published, emphasizes a desire to be recognized as professionals. Moreover, the one research project that appears multiple times is Dr. Woodruff's study on drugs. A research project devoted entirely to a medical and scientific nature lending credence to the theory of other historians that psychiatrists were seeking acceptance in general medicine.

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[291] Co-ordinating Committee meeting, (November 4, 1958), p.2.

Conclusion

Three points emerge from an examination of mental health policy, research and clinical practice at the Hamilton Psychiatric Hospital. First, mental health policy constituted a haphazard process whereby a plethora of committees pushed paper without implementing concrete goals or a long-term agenda. The lack of direction, whether from the provincial government or Department of Health, allowed for confusion to persist in the governance of the hospital. Thus, without the construction of tangible criteria to guide hospital development, treatment techniques and research projects undertook to strengthen the psychiatric profession as a legitimate, scientific field. Secondly, psychiatry was still seeking to professionalize and sought to do so via medically-based treatments. The variety of treatments reflected the movement from pessimism to optimism as psychiatry attempted to dislodge itself from the custodial framework. Moreover, the type of treatment and research, whether pharmacologically based or surgically derived, was committed to the pursuance and usage of science. Yet, psychiatry also extended into the community and implemented social ideals of normalcy upon the patients. The inability of psychiatrists to treat the actual medical illnesses affecting patients caused attention to focus upon symptoms. Thus, symptoms governed the course of action undertaken in therapeutic intervention. The alleviation of symptoms rather than curing the actual condition remained central to psychiatric practice due largely to an inability to treat the underlying disease.

This leads to the third argument, namely psychiatry sought to professionally intervene to improve humans socially and physically. Definite overtones of eugenics existed regarding mental health in the post-war years but overtones relocated in part to social betterment rather than just physical betterment. Treatment reflected both issues, but by only being able to address patient's symptoms. Psychiatrists needed to exercise due diligence in therapeutic intervention, especially as psychiatric patients are vulnerable to abuse. Yet, extra precautions in the obtainment of consent, and the policy regarding consent within Hamilton Psychiatric Hospital remained convoluted. Moreover, ensuring the acceptability and validity of the treatment in aiding the patient's well-being was not clearly put forth in memos. Lobotomies remained a treatment of last resort. Yet, lobotomies seemed largely beneficial to everyone except the patient.

Securing appropriate behaviour seemed to dominate psychiatry's attention and seemed to be equated with a cure attesting to psychiatry's validity. Thus, professionalization occurred by socially improving patients through both physically invasive and non-invasive treatments. Staff efficiency and ease further played a role in guiding treatment techniques as motivations included benefits to everyone except the patient. The disregard of informed consent and risk/benefit analysis, both present in 1947, also support an argument for professionalization through human betterment. Consent clearly represented an issue, but an issue that threatened psychiatric dominance in the field and attempts for legitimacy. For if consent needed to be secured, the decision to use the experimental treatments based upon social and physical intervention no longer resided with the psychiatrists. While psychiatry's intent was not eugenically driven, nor even an attempt to socially control the patients, the pessimism of the custodial institution and exclusion by medical peers combined with the "cornucopia" of new treatment techniques and an absence of mental health policy to create an opportunity to simultaneously advance professionally and perhaps even aid the mentally ill. The case study of HPH reflects an absence in the development of mental health policy allowing for professional human intervention to effect better humans socially and physically and thereby increase psychiatry's reputation.

Conclusion

> It is hardly surprising that a "new eugenics" should enjoy some popularity in the wake of current changes in attitudes toward human nature as well as stunning new developments in reproductive technology. Beginning in the 1960s scholars began to reexamine what passed for received wisdom in the social sciences, looking once more to biology to explain human nature.
>
> Ian Dowbiggin
> Keeping America Sane, 1997

From an examination of medical and social rhetoric, the internal policies and programs at Hamilton Psychiatric Hospital, and the development of mental health policy and legislation in the post-war years, the extent to which eugenics continued to influence medical policy and thinking remains startling. Despite generalized notions to the contrary, a form of eugenics continued past 1945 and underwent changes in accordance with a shifting medical paradigm. The impetus for government-provided medical care within Canada and a return to environmental factors reoriented eugenics to professional intervention socially as well as physically to effect better humans. The lack of a long-term mental health policy or a mental health agenda with tangible goals, other than to address the immediate needs within the country, allowed for eugenics to persist. The continuation of eugenics in the 'new' format appealed particularly to psychiatry, where legitimation and professionalization remained an ongoing concern. The pessimism caused by overcrowding and low cure rates in the 1940s resulted in increased optimism in the 1950s with new drugs, such as chlorpromazine, and the use of ECT, insulin coma and lobotomies. The use of 'scientific' treatments allowed psychiatry to become recognized as a branch of medicine that professed to be able to cure the mentally ill, much like general practitioners or surgeons cured the physically ill. Psychiatry further extended its power beyond the asylum and into the community by continuing to provide 'professional' conceptions of normalcy. The spirit of eugenics remained central within psychiatry, as the profession sought legitimation and required social and physical intervention to accomplish increased cure rates. Moreover, the absence of consent legislation allowed psychiatry to treat patients without the consent of families or patients, unless the treatment required physical intervention (such as lobotomies). Thus, the mentally ill still were without the legal rights accorded to the rest of society due to inequality in the application of the law. Overall, the haphazard mental health policies allowed the 'new eugenics' to persist and psychiatry utilized the absence in legislation and policy, as well as the continuation of eugenic ideals, to bolster the status of the profession.

The examination of psychiatry, eugenics and informed consent addresses a gap within Canadian historiography. The importance of addressing this absence lies in understanding and improving current health policies and agendas. The development of tangible criteria, especially consent legislation, to ensure equality under the law and to safeguard rights remains a primary concern. Moreover, with the advent of reproductive technology and genetics, eugenic ideology has undergone another transition returning largely to physical intervention to realize human betterment. This transition, I would argue, allows for the fulfillment of early eugenicists dreams and ultimately allows for a stronger eugenics – especially as it remains justified by science.

Amniocentesis reflects eugenic aspirations specifically as the test identifies congential diseases, providing parents with the opportunity to abort a fetus who is likely to be born with a 'defect.' Thirty to fifty-three percent of geneticists counsel a parent to abort by emphasizing the negative.[292] Despite the development of intra-womb surgery, diseases associated with genetics allow only for the correction of such 'defects' through abortion. Thus, amniocentesis allows for the ultimate eugenic practice, the abortion of the 'unfit.' While many counselors undoubtedly fear liability, such as in the case where a mother successfully sued for 'wrongful birth,' the counsellor's role is the provision of unbiased information, not the prevention of litigation. Thus, the role of counselor also becomes eroded by a fear of potential lawsuits reflecting a eugenic bias. In Perth, Ontario, a mother successfully sued her doctors for failing to inform her about the risks of the genetically based Duchenne muscular dystrophy. The doctors' failure to refer her for genetic counseling before having her first child and the failure to test the first child for the disease before having a second child, resulted in the jury finding the doctors one hundred per cent responsible.[293] This case illustrates the desire to prevent the birth of children who have mental or physical impairments, to the extent that doctors are now liable for genetic deviations.

The non-consensual sterilization of people with lower intelligence quotients, mental illness, and mental or physical impairments in Alberta and British Columbia between the 1950s and 1970s also raised concerns regarding human rights. The sterilization operation violated consent principles, but Ralph Klein's attempt in 1998 to prevent redress by former patients further evidenced a desire to again remove the rights of the individuals

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[292] "Eugenics Revival Possible: Scientist," Toronto Star, (December 31, 1995).

[293] Leonard Stern, "Mother of terminally ill boys wins 'wrongful birth' lawsuit," Toronto Star, (June 12, 1996).

with impairments. Although Klein reversed the Conservative government's Bill 26,[294] the 'notwithstanding clause,' which was to prevent lawsuits by ex-patients, the attempt to remove the rights of individuals with impairments also suggests the continuation of eugenics. To violate one's rights and then remove the vehicle for redress subjugates the people again to a lower status of citizenry. Moreover, the desire to prevent litigation against medical personnel originated in the earlier Mental Health Acts, between 1935 and 1967. Fennel also discussed the continuation of eugenics in England with the Abortion Act of 1967 which allowed for abortion if a serious risk existed that the child would be born with a serious mental or physical handicap. The 1960s also allowed for sterilization on contraceptive grounds and for consensual abortion, both of which would have been considered eugenic in the 1930s.[295]

Other medical innovations, such as genetic screening, gene therapy, and genetic manipulation all reflect eugenic ideals and share the desire to improve humanity. Genetic screening poses problems, particularly in the United States, regarding employment equity, health insurance and again, legislation. Distinctions between individuals who are asymptomatic and those in whom the disease is manifested remain irrelevant in the securing of life insurance, health insurance and even certain jobs. In many cases, these determinations are made solely upon diagnostic labeling and not upon the actual health of the individual.[296] A difference exists in the application of insurance, as the chance of developing a genetic illness, via predisposition, is considered greater than the probability of contracting an 'environmental' illness. Insurers tend to avoid

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[294] "Ralph Klein's Retreat," Toronto Star, (March 12, 1998) and Andrew Coyne, " 'Notwithstanding' Alberta still accountable," Hamilton Spectator, (March 12, 1998).

[295] Phil Fennel, Treatment Without Consent: p.106.

[296] Paul Billings et al., "Discrimination as a Consequence of Genetic Testing," American Journal of Human Genetics, 50, (1992), p.476-482.

applicants who undergo genetic tests and then withhold the results.[297] Some of the genetic tests used by companies are sickle cell, allergic respiratory disease, alpha-1-antitypsin deficiency and alpha and beta-thalassemias,[298] and positive results prevent the acquisition of health and/or life insurance as well as employment. Despite negative public press, many companies have tested since 1960 and continue to screen workers currently.

Concern over the absence of legislation governing genetic screening, clinical trials and research reflective of a 'new eugenics' also appeared in the 1960s and 1970s. Attempts already have occurred to create committees to secure genetic privacy and pass legislation outlawing genetic discrimination under the Disability Discrimination Bill in the United States – all of which have failed.[299] Human clinical trials recently have been noted for using aggressive recruiting, such as relying upon doctor referrals which questions the unbiased role of the doctor in treating the patient as well as threats of expulsion for a women housed in a nursing home. "Such recruitment practices are 'disturbing' and can lead to an 'erosion of informed consent' by subjects, who need to understand what they are getting into."[300] Moreover, the recruitment of patients not seriously ill, questions the viability of the research, as was the case with the death of Jesse Gelsinger. In this instance, many of the risks, such as the death of monkeys, remained absent from the consent form as well as the experimentation continuing despite Jesse having high levels of ammonia which were above the maximum allowed by protocol.[301] The result is that

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[297] Mitchel Zoler, "Genetic Test," Medical World News, (January 1991), p.32.
[298] ibid., p.34.
[299] King, "The State of Eugenics," New Statesman & Society, 8, (August 25, 1995), p.25.
[300] Edward Pound, "Series of Reports Prompted Reforms in Human Research," USA Today, (June 2000).
[301] Joanne Silberner, "A Gene Therapy Death," Hastings Center Report, (March-April 2000).

strong legal action needs to occur to limit experimental research, strengthen consent laws and reduce discrimination.

The association of eugenics with genetics, and the examination of the period between eugenics and genetics, questions the absence of strong legislation as well as evidences the propensity for eugenics to evolve and persist within different settings. For many,

> The danger is that in a society where power is unequally distributed between the haves and have-nots, the application of the new eugenic technology – as of any other – is as likely to reinforce as to ameliorate patterns of indignity and injustice.[302]

The exclusion of medical and life insurance largely targets the poor, which tend to need the aid the most as well as largely constitute minority groups, which raises other issues regarding racial eugenics. Yet, eugenics comprises an ideology able to fluctuate and modify with circumstances, settings and people. Any attempt to limit eugenics requires societal intervention in the creation of strong laws to prevent ongoing abuses. Moreover, the medical profession is increasingly associated with eugenics, not by desire, but rather by a set of circumstances that associates 'cure' with the prevention of mental and physical impairments. The examination of eugenics, psychiatry and informed consent, reveals that constant supervision is necessary to ensure that eugenics does not inform medical policy, to safeguard and strengthen the rights of people with impairments and to recognize eugenics exists outside of Nazi Germany. Eugenics has motivated reformers and aided in the conceptualization of genetics. Thus, we continue to face the same dilemmas, due largely to the multi-dimensional nature of eugenics.

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[302] Robert Proctor, "Genomics and Eugenics: How Fair is the Comparison?" in Annas & Grodin, (eds.) Gene Mapping: Using Law and Ethics as Guides, (New York:1992), p.84.

Appendix A

From Shorter, A History of Psychiatry, p228

Dr. Hatcher: "Peter, I'm doing transorbital lobotomies this morning. Come watch me."

Cranford: "If I saw one, you'd have to do the next one on me."

Dr. Hatcher: "Nothing to it. I take a sort of medical icepick, hold it like this, bop it through the bones just above the eyeball, push it up into the brain fibers like this, and that's it. The patient doesn't feel a thing."

Cranford: "And neither do you. I *was* going to breakfast but I've changed my mind."

Hatcher (laughing): "You can change your mind, but not like I can change it."

Appendix B

From Kenneth Gray, Law and the Practice of Medicine, p51-53

Opinion on Sterilization Operation

The following is the legal opinion which I have been asked to write by yourself and Dr. A with respect to a proposed sterilization operation in Miss X. A copy of this opinion is being sent to Dr. A. and to Dr. B, the superintendent of a hospital where Miss X is at present a patient.

Factual Basis for Opinion

The facts upon which this opinion is based have been received in a report from Dr. B dated September 8th; the report and certificate of Dr. C (dated August 12th and 13th respectively) and my telephone conversations with you and Dr. A.

It appears that Miss X suffers from a mental illness known as manic depressive psychosis, as a result of which she suffers frequent and acute manic attacks. These attacks are sufficiently severe that Miss X has required treatment in a hospital on many occasions. The severity of the illness is also evidenced by the fact that she required an operation on the brain (lobotomy).

As a result of this mental illness Miss X is unable to control her conduct, particularly during an acute attack and there is grave danger that she may become pregnant.

Legal Principles

There is no legislation in Ontario with respect to the subject of sexual sterilization. In a rather careful search I have been unable to find any decided cases in Canada, the United Kingdom or the United States containing any decision which would be a precedent for this case. It is necessary therefore to formulate an opinion by the application of those legal principles which are likely to be adopted by the courts when such a case is presented for decision.

There is considerable doubt about the legality of this operation where it is performed for eugenic reasons, that is, to prevent the transmission to offspring of some hereditary taint. Likewise, there is doubt about the legality where the operation is performed for economic reasons, that is, where the parents are unable to provide adequately for the maintenance of additional children.

On the other hand, it appears to me that the sterilizing operation is lawful where it is performed on the ground that it is necessary to preserve the mental or physical health of the patient and where the patient herself consents to the operation.

Application to the Present Case

In the present case it is not proposed to perform the operation on eugenic or economic grounds. The operation is to be performed to preserve the physical and mental health of Miss X. This is born out by the opinion and certificate of Dr. C (a specialist in psychiatry) which are concurred in by Dr. A who is well acquainted with Miss X's condition. The necessity for the operation is that there is a likelihood that Miss X will become pregnant because of her inability to control her conduct as a result of the manic depressive illness; as a result of the mental illness she would be unable to safeguard her health during the months of gestation; if she were to survive the period of gestation there is the additional danger that she might injure not only herself but the infant child during one of these manic attacks. These considerations supported by competent medical authority would provide ample justification for the necessity of the sterilizing operation.

Procedure

The procedure which I would suggest be adopted in this case is, -

(1) secure the consent in writing of Miss X and that of her father or mother; attached is a form for this purpose;

(2) retain in your files the opinion and certificate of Dr. C and secure an opinion in writing from Dr. A to the effect that in his opinion because of Miss X's mental illness, it is necessary to perform a sterilization operation in order to preserve her physical and mental health.

You will see that I have suggested obtaining the consent not only of Miss X but also of her father or mother. I suggest this because of any possible doubt as to Miss X's competence to give consent. I suggest that Miss X's signature be witnessed by a physician who should satisfy himself that she understands the nature and consequences of the consent form which she signs.

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