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MENTAL HEALTH, THE STATE AND LABOUR-POWER:

DEINSTITUTIONALIZATION IN ONTARIO 1959-1965

by

Alan Sears, B.A.

A Thesis submitted to

the Faculty of Graduate Studies and Research

in partial fulfilment of

the requirements for the degree of

Master of Arts

Department of Sociology and Anthropology

Carleton University

Ottawa, Ontario

January, 1985

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ABSTRACT

The investigation of changes in the mental health system since World War Two has tended to be based on a narrow conception of deinstitutionalization as the decline of the asylum. However, the decline of the asylum was only one feature of a thorough reorientation of mental health services from the custodial care of destitute, chronically-ill people to the treatment of people capable of returning to the community.

In Ontario, the shift in mental health services began in the 1940's. It was not until 1959, however, that a policy of deinstitutionalization was announced at the highest official level by the Minister of Health, M.B. Dymond. The policy objectives articulated by Dymond, and their implementation during the following years, are the major focus of this thesis. Out of this account, a theoretical framework is developed which connects deinstitutionalization to the development of the welfare state in response to the conditions of the economic boom.

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1. INTRODUCTION

1.1 Aims and Constraints

The policy of deinstitutionalization in psychiatric services has become an area of lively debate over the past ten years. The phenomenon of large numbers of homeless, mentally ill people on the streets of major cities or in prisons has raised questions about the efficacy of deinstitutionalization policies pursued since the Second World War. This debate has attracted increasing numbers of sociologists and historians to the investigation of changing mental health policies.

There is a general tendency in the literature to conceive of deinstitutionalization narrowly as the decline of traditional psychiatric institutions. The complex history of the reorientation of mental health services since World War Two tends to be reduced to a one-sided account of the waning of the asylum. The relatively recent emphasis on cutbacks in state social policy is often read back into deinstitutionalization programmes introduced in the late 1950's and early 1960's.

The major contention of this thesis is that deinstitutionalization policies introduced during the period of the post-war economic boom had a profoundly different character than contemporary cutbacks in response to economic crisis. In order to demonstrate this, the transformation of Ontario's mental health from 1959-1965 will be the primary focus of this thesis.

Before World War Two, the insane asylum primarily provided custodial relief to destitute people who were classified as insane and secondarily provided some form of mental health treatment to inmates. People were incarcerated in asylums for long periods of time, with very limited

hopes for treatment towards a return to the community.

The deinstitutionalization policies introduced during the economic boom aimed to reorient the mental health system towards the active treatment on a minimally custodial basis of people capable of returning to, or remaining in, the community. This involved, on the one hand, the discharge of large numbers of long-term custodial patients out of psychiatric institutions into custodial situations (such as Homes for Special Care) paid for by general welfare programmes. On the other hand, it involved the modification of existing institutions and the development of new services to provide effective treatment to enhance the functioning abilities of less seriously impaired patients. The goal shared by revamped mental hospitals and newly developed outpatient clinics and psychiatric units in general hospitals was to provide treatment with minimal disruption to job, home and neighbourhood.

This first phase of deinstitutionalization, lasting into the 1970's, entailed an expansion of mental services. Expenditures increased, and the number of people receiving some form of treatment from mental health services grew dramatically. The decline of the in-patient population of mental hospitals can only be understood as part of a larger picture including increased admissions for short-term inpatient treatment and for outpatient care. The new clientele for mental health services was increasingly voluntary and less seriously disturbed. It was only with the shift in state social policy in response to the economic crisis that the mental health system as a whole began to be cutback.

The reorientation of mental health services during the economic

boom will be explained in terms of an overall shift in state social policy which can be generally categorized as the use of the welfare state. Before the second World War, the ideological foundation of state social policy was the reinforcement of the compulsion to work. Relief was provided primarily on a custodial basis through institutions such as the workhouse, the prison, the orphanage and the asylum. Only people who were classified as unable to work according to established criteria (e.g. age, illness, mental disorder) were to receive custodial relief in institutions.

This changed with the development of the welfare state. New programmes were developed which aimed to provide the necessary quantity and quality of labour-power to meet the needs created by the economic boom. These programmes included education, health care and income maintenance to increase the skills, the fitness and the productivity of workers.

Through social welfare programmes, the state assumed part of the responsibility for the reproduction of labour-power. Before the development of the welfare state, workers had to rely almost exclusively on wages for their own subsistence and for raising a family. Welfare state programmes provide a supplement to the wage in developing and maintaining suitable workers.

The reorientation of the mental health system towards treatment was part of this shift in state social policy. While the insane asylum had primarily provided custodial relief to people who couldn't work, the revamped mental health system aimed to enhance the productivity of people who were potentially capable of paid employment or raising a

family. Chronic patients, people who were unlikely to resume productive activity, were discharged entirely from the mental health system.

The basic argument of this thesis, then, is that deinstitutionalization during the economic boom involved a shift away from the custodial care of non-workers towards the productivity-enhancing treatment of workers and potential workers. Due to constraints of time and the limited nature of this project, this thesis can lay no claim to providing a definitive test of this argument. Rather, it attempts to establish the basic lines of this argument in a way that provides directions for further research.

This thesis will provide a historical narrative of the process of deinstitutionalization in Ontario from 1959 to 1965, informed by the sociological arguments outlined above. The period 1959 to 1965 has been chosen as it was during these years that the basic trends which were to make deinstitutionalization in Ontario during the economic boom were firmly established. This period began with a speech to the Legislature from the Minister of Health, M.B. Dymond, in which a policy of deinstitutionalization was enunciated for the first time at the highest official level. During the following years, the basic objectives of the Dymond speech were implemented in mental health services.

The historical narrative form has been chosen in order to highlight the relationship between the transformation of the mental health system, shifts in social policy and changing social conditions. A historical perspective permits an emphasis on movement and changing relationships rather than a static picture of the forms of a particular moment.

The constraints mentioned above imposed certain limits on this historical narrative. The broad historical sweep from the origins of the asylum to the cutbacks of the 1980's will be provided only through fragmentary glimpses forward and back from the period 1959 to 1965. These glimpses will rely primarily on second-order sources.

At the same time, the picture of changing mental health services during the period of the narrative will be drawn primarily from general sources such as Annual Reports of the Ministry of Health. The detailed analysis of the articulation and implementation of deinstitutionalization policy at different levels of the mental health system will not be possible.

This thesis can provide no account of the patients' experience of changing mental health policies. The composition of the patient population, the process of hospitalization, the nature of treatment within hospitals and the experience after discharge are beyond the scope of this project.

As well, certain theoretical questions will be raised but not answered in this thesis. The basic theory of state which underlies the arguments presented here requires further elaboration. In particular, no account will be provided of the process through which the needs of capital in given social conditions are translated into mental health policy. All that can be done here is to establish that there appeared to be a general relationship between the reorientation of mental health services, shifting social policy and the social conditions of the economic boom. The process through which this relationship operated remains to be concretely elaborated.

Finally, this thesis will provide no detailed account of the development of socially-determined standards of health. While asserting that the development of health standards is a political process reflecting the basic power relations of a given society, there is no room here for a full discussion of this process.

As a result of these constraints, end notes will be used for the following purposes: to identify empirical gaps; to raise theoretical questions and carry certain arguments; and to suggest directions for further research.

In short, this thesis aims to establish (in contrast with much of the contemporary literature) that deinstitutionalization during the economic boom was a thorough reorientation of the mental health system and not simply a reduction in services. A theoretical framework will be elaborated which, with further work, could hopefully provide an explanation for this reorientation. However, it is beyond the scope of this project to provide a definitive test of the theoretical framework developed here.

1.2 Describing Deinstitutionalization

The transformation of the mental health system since World War II has generally been examined in terms of deinstitutionalization, defined narrowly as the movement away from traditional psychiatric institutions. The decline of the asylum has overshadowed a wide range of related changes which have taken place throughout the mental health system.

In Ontario, deinstitutionalization did not mean the abolition of the asylum.⁽¹⁾ Instead, the character of existing institutions was altered to fit in with a range of new services developed since the 1940's.

These new services tended to be institutionally based; that is they were either located in or affiliated with psychiatric institutions or general hospitals.

The transformation of the mental health system was primarily a movement towards the separation of treatment from custody. Before World War II, the state mental health system was dominated by the asylum which provided treatment only on a custodial basis. Through the process of deinstitutionalizations, (2) a much wider range of services was developed. At one end of the range, outpatient clinics provided treatment without custody; while at the other end, nursing homes and similar facilities provided custodial care without treatment.

The movement towards the separation of treatment from custody facilitated the promotion of rehabilitation through psychiatric services. It ended the regime of universal long-term incarceration, which in itself impaired the functioning skills of patients through developing 'institutionalized' patterns of behaviour. At the same time, it permitted the streaming of patients according to the likelihood of achieving successful rehabilitation. Thus, resources could be concentrated on those most able to return to community life; while those least likely to respond to treatment were provided with custodial care on the cheapest possible basis.

Deinstitutionalization, then, was the movement towards the separation of treatment and custody, through the reform of existing institutions and the creation of new services. This process was directed towards two related goals: the promotion of effective rehabilitation and the streaming of patients according to their likely response to

treatment. The decline of the asylum was part of this process, but it was not an end in itself.

The emphasis on the decline of the asylum in the analysis of shifts in the mental health system is the result of two contributing factors. First, the way in which the initial claims for deinstitutionalization were articulated by policy-makers seemed to suggest the replacement of the asylum with an entirely new kind of service, rooted in the community and oriented to the promotion of mental health in everyday life.(3) Secondly, the retrospective analysis of deinstitutionalization has generally been informed by the libertarian critique of institutions which views psychiatry through a conceptual framework based on the opposition between incarceration (in institutions) and freedom.(4)

Deinstitutionalization, however, was neither a shift to qualitatively different community mental health promotion services, nor an act of liberation. The reorientation of the mental health system was primarily directed at increasing the effectiveness of treatment for rehabilitation(5).

The combination of custody and treatment in the asylum had, over the period of a century, proven to undermine the effectiveness of rehabilitation. The move towards a more effective alternative became both possible and useful due to an overall shift in the state's welfare policies beginning in the 1940's.

From the beginning, the asylum in Ontario was committed, at least in principle, to a programme of treatment. The first public provision for people with mental health problems in Ontario (Upper Canada) was a piece of legislation passed in 1830 allowing for the incarceration of destitute, insane people in jails (Splane 1965: 203). A decade later,

Ontario's first asylum was established by converting the old York jail, which already had a number of insane people incarcerated in the basement (Hurd 1916b: 129-31).

The conversion from jail to asylum was essentially achieved by grafting a treatment programme onto what had been an exclusively custodial institution. The 19th century saw a general development in Ontario's relief policies from a single form of exclusively custodial institution (the jail incarcerating vagrants, debtors, insane people and others) to a range of more specialized custodial institutions which offered some degree of treatment or training (workhouses, orphanages, asylums, homes for unwed mothers, etc).

The asylum, then, had a mandate to provide treatment on a custodial basis from the outset. Frequently, this treatment was explicitly geared to effecting a successful return to community life(6). These efforts at treatment, however, were persistently stymied by the custodial character of the institution; through both overcrowding and the development of 'institutionalized' behaviour patterns among patients.

The history of treatment in the asylum was dominated by a recurring cycle of reform undermined by overcrowding leading to adhoc solutions. The movement towards the separation of treatment from custody provided the means to break down this cycle.

This does not, mean, however, that deinstitutionalization was an unqualified advance in psychiatric services. The break towards more effective rehabilitation was accomplished through the abdication of responsibility for the provision of custodial care. At the same time, the adoption of narrow, functional treatment goals was not an

entirely positive shift in mental health services.

The separation of treatment from custody must be understood in terms of the two senses of custody: (1) legal confinement in an institution and (2) care through provision of the necessities of life. The asylum provided treatment on the basis of custody in both senses. The vast majority of inmates were legally incarcerated, generally for long periods of time. Inmates were maintained through the provision of the necessities of life, though often at abysmally low standards.

Through the process of deinstitutionalization, custody in both senses was separated from treatment. The proportion of legally confined involuntary patients declined dramatically from almost 94% in 1950 to about 15 per cent in 1981 (Ontario Ministry of Health: 1950: 68-9, 1981: ii). The provision of custodial care through the psychiatric system was largely curtailed through the discharge of long-term chronic patients and the development of short-term treatment for patients who were capable of rehabilitation.

Policies were adopted which sharply distinguished between treatable and chronic patients. Beginning in the early 1960s, chronic patients were moved out of psychiatric institutions into primarily custodial care (Allodi & Kedward 1973: 281-2). People who could not return to self-sufficiency in the community were basically written off in terms of treatment. They were discharged into custodial care outside of the mental health system with little or no active intervention to maximize their mental health.

Complementing the shift to exclusively custodial care for chronic patients was a reorientation of treatment for patients likely to achieve

self-sufficiency. The reorientation of treatment was linked to a redefinition of mental illness and mental health.

The social definition of illness changes with the nature and goals of health-promoting activity. The conception of illness is integrally related to some notion of treatment.

The purpose of a classification of medical disorders is to identify those conditions which, because of their negative consequences, implicitly have a call to action to the profession, the person with the condition, and society. (Spitzer, 1978: 15).

The dramatic change in the conception of mental disorders since the beginnings of the asylum can be generally summarized as a shift from 'insanity' to 'mental illness' to 'impaired functioning'. Insanity was primarily a legal label which implied both incorrigibility and irrationality (Klein 1978: 59). Mental illness was primarily a medical label which suggested some sort of organic dysfunction and, in principle, some possibility for treatment. The concept of impaired functioning comes basically out of the traditions of public health and rehabilitation; it stresses the development of coping skills rather than the treatment of diseases.

The shift from an emphasis on the treatment of mental illness to the development of effective functioning skills was linked to the process of deinstitutionalization. This shift began in the practice of military psychiatry during World War II.

American military psychiatrists Little and Harris (1957: 179) wrote:

It is to be noted in this connection that the tendency of military psychiatrists nowadays is to recognize no human form of mental illness, in itself, as precluding adequate performance as a soldier. Personal unhappiness may reign supreme, one may have symptoms in connection with all kinds of difficulties; yet it is possible that one may still be able to function adequately

in a military setting and get or not get ('on the side', so to speak) help for his troubles.

The shift to a functional definition of mental health problems developed out of the particular context of military psychiatric practice. A central task of military organization was to maximize effective performance under frequently horrifying conditions. There was a premium on manpower in fighting shape. Under those conditions, long-term incarceration could only be seen as counter-productive.

Whereas the prevailing practices in civilian institutions favoured the diagnosis of mental illness requiring hospitalization, in military psychiatry the need to retain soldiers rather than excuse them from duty favoured diagnosing patients as capable (Daniels in Hastings Centre Report 1978: 3). Military psychiatry aimed to close avenues of escape while intervening to make the patient aware of his own skills (Bushard 1957: 438-441).

Military psychiatry could not even hope to use conventional treatments as its limited resources were flooded with patients (Bushard 1957: 433). At the same time, treatments oriented to profound internal disorders (e.g. diseases or childhood traumas) were not appropriate when external circumstances seemed to play a major role in precipitating mental health problems. Col. Albert Glass (1957: 197), a psychiatrist with the American military, wrote: "Both the overt and disguised forms of psychiatric breakdown result from an inability to cope adequately with the terrorizing battle environment."

In these conditions military psychiatry developed a range of short-term treatments aimed at augmenting functioning skills with little or no absence from active duty. After the war, this functional

conception of mental health problems and treatment was carried over into what one psychiatrist called "the combat situations of life" (Hyde 1957: 453)..

Deinstitutionalization involved a shift away from either psychoanalysis or medical intervention to cure diseases. The emphasis in treatment was on short-term intervention to improve functioning skills with minimal custodial care.

...as compared to depth intervention, programmes designed to upgrade skills, both social and occupational, sometimes appear to bring out striking improvement at minimal cost. This leads to a redefinition of pathology as related to the parallel question of functioning effectiveness (Rendall 1981: 4).

Basaglia (1980: 185) wrote that one of the aims of the movement for deinstitutionalization in Italy was to redefine health "...as something other than mere availability for work..." In Ontario, through the process of deinstitutionalization, mental health was very much defined in terms of capacity to work and to carry out domestic responsibilities.

The actual techniques used to promote functioning effectiveness ranged from drugs to upgraded occupational and recreational therapy to group therapies. These techniques all shared the basic operating assumption that patients could cope with everyday life with certain kinds of support if they had no other choice.

The functional approach to mental health had the important strength of maximizing the independence of patients. But at the same time, it tended to reduce all problems to a narrow range of functional questions.

The personally-defined problems of patients became issues for the

mental health system only in so far as they impaired functioning capacity. To put it simply, it didn't matter whether patients felt unhappy, sick or afraid; what did matter was whether they could cope with the requirements of everyday life.

One of the effects of the functional definition of mental health was to dramatically increase the potential clientele of the mental health system. Before World War II, the asylum basically served people who could not continue in the community due to some combination of disturbance, material deprivation, and lack of an emotional support system. Through deinstitutionalization, the mental health system began to serve people who could continue in the community with relatively limited short-term intervention. In the United States, this meant a dramatic increase in the proportion of the population who saw some sort of mental health professional from about 1% in 1955 to about 6% in 1980 (Klerman 1982: 184). In Ontario, it meant that admissions to the mental health system grew far more quickly than the population(7).

Deinstitutionalization, then, was a reorientation of the mental health system achieved primarily through the movement towards the separation of treatment from custody. This reorientation led to six major changes in the mental health system: the decline in the patient population of psychiatric institutions; the decreased length of stay in various mental health facilities; the overall increase of admissions into mental health services; the increase in the proportion of voluntary admissions; the development of new institutionally-based services and treatments; and the changing professional composition of staff in mental health services.

Taken together, these changes from a pattern of separation of treatment from custody and the orientation of treatment towards the development of effective functioning. As psychiatric institutions dropped their custodial role, their population declined, the length of stay of patients was reduced, and the proportion of involuntary patients decreased. The emphasis on treatment for functioning effectiveness meant an overall increase in admissions, the development of new services and treatments, and the introduction of new categories of professionals who specialized in functional skills.

In section 2 of this paper, the changes in Ontario's mental health will be examined in some detail. This examination will highlight the movement towards the separation of treatment from custody and the reorientation of treatment towards functional goals through concentrating on the six major categories of change listed above.

End Notes

1. No psychiatric institutions were closed in Ontario until 1979, with the exception of the Toronto Psychiatric Hospital which was replaced with the much larger Clarke Institute of Psychiatry. In fact, new hospitals were developed in Port Arthur (1954), North Bay (1957), and South Porcupine (1967) (Allodi & Kedward 1973: 280). The population of existing institutions was reduced, but they continued to play a significant role in the mental health system.
2. I will use the word 'deinstitutionalization', because of its currency, to describe the overall transformation of the mental health system in the direction of separating treatment from custody.
3. An example of the initial claims stated for deinstitutionalization is the following quote from a speech to the Legislature by the Ontario Minister of Health in 1959:

We want to try to completely reverse the old order, to begin treatment where it should begin - at the home level - and direct that treatment toward keeping the patient in, or at least near, his home community.

The use of language such as 'treatment at the home level' and 'in the home community' seems to imply the development of new services, rooted in the community, aiming to promote mental health in everyday life (e.g. group homes, neighbourhood clinics, local drop-ins). Such services play only a marginal role in Ontario's mental health system.

Bassuk and Gerson (1978: 47) stated that the implied dual promise of community mental health was: "...treatment and rehabilitation of the severely mentally ill within the community and the promotion of mental health generally". This dual promise was essentially unfulfilled. The severely mentally ill tended to receive only treatment to make

them manageable in cheap custodial institutions, while there was very little attention to the general promotion of mental health. These unfulfilled promises have led critics to the conclusion that deinstitutionalization was a one-sided process in which the asylum was eroded without being replaced.

This view leads critics like Scull (1977: 140-144) to view deinstitutionalization as primarily a cost-saving measure. I can't comment on whether Scull's thesis is applicable in the United Kingdom or the United States, but in Ontario at least there was a considerable expenditure on the development and operation of institutionally-based services which have largely supplanted the institution as the primary focus of care. Deinstitutionalization always contained an element of neglect, particularly of those chronic patients discharged into custodial care, but it cannot be explained exclusively in terms of the benefits to the state of the decline of the asylum.

4. An example of the freedom/confinement framework is this quote from a Maclean's magazine article describing a recent report from the American Psychiatric Association:

{The report} said that the freedom to which many of them were condemned is often worse than life in mental hospitals.

(Block 1984: 58a).

A framework concentrating on the opposition between freedom and incarceration provides no basis for understanding the development of a range of institutionally-based services offering treatment on a minimally custodial basis to a primarily voluntary clientele.

5. This argument will be taken up in section 2.1 and 2.2 of the paper,

which will examine in detail both the articulation and implementation of deinstitutionalization in Ontario during the period 1959-1965.

6. Dorothea Dix, the renowned American asylum reformer, visited Nova Scotia in 1857 to petition for an asylum which would get insane inmates out of jails. Her argument was founded explicitly on the premise that an asylum could effectively return inmates to community life through treatment (Hurd 1916a: 481-497).

7. These figures will be examined in detail in section 2.2.

Section 2: Deinstitutionalization in Ontario 1959-1965.

On February 11, 1959 the Ontario Minister of Health, M.B. Dymond, made a speech to the Legislature in which he articulated the goals of deinstitutionalization in the province's mental health system and outlined the methods for achieving those goals. Though the process of deinstitutionalization had begun in the 1940's, this speech was the first major public enunciation of a shift in mental health policies at the highest official level. During the next few years the form of facilities and treatment the legislative framework and the patterns of patient movement to mark the process of deinstitutionalization until the late 1970's were firmly established.

This section will first examine in detail the goals and methods articulated in the Dymond report. It will then assess the extent to which the changes implemented over the following few years were true to the aims and direction of the Dymond report. Finally, section 3 will assess whether the goals stated and changes implemented during this period can be explained by the framework proposed in this paper.

The themes of the separation of treatment from custody through the streaming of patients and the adoption of 'functional treatment goals' will be the main focus of this examination of deinstitutionalization. These themes will hopefully provide the basis for understanding deinstitutionalization as more than a one-sided movement away from the asylum. 6

Section 2.1: The Dymond Report

The Dymond Report was a speech to the Ontario Legislature by the Minister of Health delivered on February 11, 1959. In his speech, Mr. Dymond proposed a dramatic break with previous policies governing the care and treatment of people who were mentally ill.(1)

The Dymond Report had three aspects. The nature and shortcomings of the asylum were critically examined. A set of goals for the reorientation of the mental health system was enunciated. Directions for changes in the form and operation of mental health facilities in order to meet these goals were proposed.

The Dymond Report was in many ways an articulation at the highest official level of policy changes which had been gradually introduced since the 1940's. At the same time, it contained new proposals which would dramatically intensify these trends.

Deinstitutionalization was not created all at once, by official fiat, in February 1959. Nor was it an accidental pattern formed by a range of separate policy decisions over a long period of time. Rather, it was a set of changes introduced over time linked by a coherent logic which was clearly outlined in the Dymond Report.

2.1.1 The Asylum

The Dymond Report advocated a dramatic break with the traditions of mental health care in Ontario. This break was to be achieved through the transformation of existing institutions and the development of new facilities to complement them, rather than through the abolition of the asylum. The Report therefore began with a critical examination of the asylum which isolated those features which had to be changed.

The major failure of existing psychiatric institutions was seen as their inability to provide treatment that was effective in returning patients to life in the community:

In these places, mentally ill patients who have been removed from society were put away with the expectation that they would remain ill permanently or that, at least, they would not be allowed to return to the community until cured, an improbable event (Dymond 1959:286).

The Report saw the asylum as a place which had once had an active treatment component. However, the Report stated, "by 1900, asylums which, for a time, had been centres of activity, had deteriorated to become custodial institutions (ibid)".

Dymond cited a report from the Inspector of Prisons and Public Charities in 1883 as an illustration of active treatment in asylums. The report emphasized the effectiveness of patient employment programmes developed in many asylums in the 1870's and 1880's, and credited them with creating the conditions for the abolition of restraint and seclusion in some institutions.(2)

The excerpt from the 1883 report concluded with a statement from the superintendent of the asylum in London, Ontario:

I attributed the success I have had in the disuse of all forms of restraint almost entirely to the advances we have made in the employment of patients...As already stated, I believe fully in the great importance of work as a curative agent (1959:291).

Dymond (1959:291) commented "That is 75 years ago, sir, and it has taken us only 75 years to come back to that enlightened opinion."(3) The deterioration of the asylum in the intervening years had therefore to be explained.

Dymond did not criticize the asylum as such. Rather, he identified specific defects which undermined the effectiveness of treatment in the asylum. The essential defect was that asylum treatment started "at the wrong end of the problem (1959: 286)."

Man, apparently, has always sought to lift these unfortunates completely out of the community setting, and tuck them away somewhere for their own protection and, perhaps, for that of others. But oftentimes it has appeared that, in so confining those patients, they dropped out of sight and, but for fleeting moments, out of minds of neighbours, friends and even relatives (Ibid).

The primacy of custody was expressed through the physical character of these institutions: their large size; their isolation; and their indestructible design (Ibid). It was also linked to a basic presumption of incompetence: "Many safety measures were introduced because it was felt these mentally ill people were incapable of showing any responsibility for themselves or their conduct (Ibid)".

To compound the problems created by isolation and the presumption of incompetence, patients were faced with inactivity: "Misguided humane motives finally removed opportunity for employment because unpaid labour was looked upon as exploitation (Ibid)." (4)

Dymond, then, criticized the asylum on the grounds that it did not provide effective treatment for return to the community due to its primarily custodial character. Neither the costs of providing custodial care nor the coercive aspects of incarceration were identified as major defects at this point.

This critical examination of the asylum established the terrain for a programme aimed at breaking the primacy of custody in mental

health care in order to facilitate active treatment for a return to the community. Dymond did not present a detailed account of how the custodial character of the asylum blocked effective treatment.(5) Nor did he offer a strong explanation for the custodial character of the asylum.(6) But these were of secondary importance. Of primary importance was establishing an overall direction for policy: the transformation of the essentially custodial mental health system into an active treatment service which minimized the interruption to life in the community.

Dymond concluded his discussion of the asylum by making it clear that, ..."we, here in Ontario, have no need to hang our heads in shame or apologize for what has been done (1959:286)." A dramatic break with the past was required, not to make up for a legacy of wrong-doings, but because reform efforts were obstructed by the persistence of the old institutions and traditions..

All of these concepts still leave their mark on the mental health services. In recent years, attempts to keep pace with newer concepts of care and treatment have been confined within the former old structures, with an occasional break-through into a new pattern.

However, we have to say here, as in so many other jurisdictions, there has not yet been a thorough-going renovation of the old patterns (ibid).

This "thorough-going renovation of the old patterns" which was to dominate mental health policy for the next twenty years has been retrospectively labelled as deinstitutionalization. It was a combination of building on changes well underway and introducing new measures to intensify these trends. It was not the end of the asylum, but, in principle, a new beginning.

2.1.2 AIMS

Dymond aimed to achieve a substantial shift in mental health policies which would enhance effective treatment by moving towards the separation of treatment and custody. This shift was to be accomplished not through covert reforms which tampered with the structure of the asylum, but through a clear, public declaration of a break with the past.

We want to try now to completely reverse the old order, to begin treatment where it should begin - at the home level, and direct that treatment toward keeping the patient in, or at least near, his home community. (1965:286).

This rather ringing declaration was qualified further on in the report:

Now, it is not possible for us to start all over again. If that were so, we would start at the community level. We must work with what we have at the present time, and again, I repeat, that that has been working backwards, trying to bring the mental hospitals closer to the community (1959:289).

The old order was to be reversed through the transformation of existing institutions and the development of complementary services. The resulting services were to be 'geared to the needs of the times':

...we have heard from both sides of this House the statement that this is 1959, that our various programmes should be geared to the needs of the times, and with this I am in full-hearted agreement...Particularly has this been in the minds of those guiding the programme in our mental hospitals (1959:289).

Dymond did not elaborate further on the needs of the times in 1959. He provided some indication, however, through laying

out the basis of the 'modern programmes of treatment' in the following paragraph. It was based on: (1) "...the recognition of the patient's need for contact with well people, and for the maintenance of his normal humanities"; and (2) "...the patient's need to express whatever capacities for creativity, productivity and responsibility that he may have(7) (ibid).'

The essence of the treatment programme was to be the promotion of effective functioning through social contact, productive activity and the maintenance of lifestyle habits. Treatment was to be provided in a way that minimized disruption to job, home or community (Ibid). Later in this paper I will attempt to show that this 'modern programme of treatment' was very much 'geared to the needs of the times.' (8)

The implementation of this programme required that the primacy of custody in mental health services be ended:

I want to say very emphatically that the mental hospital will not be considered as an institution for custodial care (1959:290).

The movement away from the primacy of custody had three aspects. Long-term custodial patients were to be placed in special custodial institutions outside of the mental health system. Custody in the sense of legal detention was to be minimized; while voluntary treatment was to be encouraged. Custodial care was to be provided as a complement to active treatment only where necessary on a short-term basis.

Dymond (1959:290) estimated that Ontario's mental hospitals had a population of about 5,500 mentally ill patients in the chronic category. These patients were to be discharged from mental hospitals.

This, we believe, is one of the most important steps in the whole new programme - the removal of those patients who have grown old in the institution and for whom no active treatment will serve any useful purpose (1959:290).

Once removed from mental hospitals, these chronic patients '... will not occupy the time of highly-trained specialists (Ibid)." Active treatment for chronic patients was essentially to be deferred pending further research.

I think we should bear in mind that these patients are not to be ignored or lost sight of completely, because it would appear that much of the research that has been going on for a long time might possibly yield some hope that effective treatment may yet be available for certain numbers of them (Ibid).

Clearly, treatment to maximize the capacities of people who could not achieve a return to the community was not to be a priority for mental health services. The elderly and the severely disturbed were to be provided with exclusively custodial care, and treated only as required to keep them manageable in institutions.(9)

The reduction of the use of legal custody was another of the aims of the Dymond report. Throughout the history of the asylum, treatment had generally been provided on the basis of involuntary, legal incarceration.(10) Dymond aimed to reverse this practice, and offer treatment "...without legal formality or other impediment (1959:289)." New community mental health services were to offer treatment on an informal, or voluntary, basis (Ibid). Dymond did not commit himself to eliminating legal custody, but he clearly intended to minimize it.

Patients receiving active treatment were to be provided with custodial care only on a short-term basis when required. Dymond

(1959:289) proposed treatment:

...without removal from job, home or community unless that is specifically indicated; restoration to normal activity as quickly and completely as possible.

Treatment and custody were to be separated as completely as possible. Patients were to be streamed through the development of a 'comprehensive service' which at one end would serve, "those who require treatment but not hospitalization"; and at the other end, "those who require only custodial care" (1959:289). The exclusively custodial end of the range would be shifted entirely out of the mental health system.

Active treatment would be provided both in mental hospitals and in new or existing community mental health services, which included outpatient clinics, daycare centres and psychiatric units of general hospitals. The emphasis in active treatment was to be on the promotion of effective functioning.

Treatment for effective functioning would rely heavily on group methods and activity therapies, such as "...occupational, industrial, recreational and creative arts (1959:293)". For those patients who required hospitalization, the emphasis would be on rehabilitation.

Rehabilitation should begin at admission, that is, all procedures should be undertaken with the eventual restoration of the patient to community living in mind (Ibid).

Dymond particularly stressed the role of work in mental health treatment.

I believe it is recognized by many authorities that

work is a very valuable weapon in our treatment armamentarium, and should be encouraged since the chief aim of our entire programme is to return the patient to home and normal living (1956:290).

Treatment should either maintain work habits or train the patient for employment (Ibid). The old qualms about patient employment programmes were to be left behind:

We should forget for all time that teaching patients to work, or encouraging patients to work, is exploiting them in any sense of the word (Ibid).

The Dymond report, then, aimed to reorient the mental health system towards active treatment for effective functioning. The responsibility for the provision of long-term custodial care would be removed from mental hospitals. The use of legal custody would be as limited as possible. Generally, custodial care would be used as complement to treatment only as required, on a short-term basis."

Dymond raised the issue of cost-saving on a few different occasions in his speech.(11) In general, he was profoundly ambiguous about the issue. While he did suggest that deinstitutionalization could bring about reductions in mental health care expenditures, he repeatedly qualified his statements by asserting that improved care was more important than cost-saving.

Dymond stated that day-care centres could be expected to bring about cost reductions, but even if not "...I am sure the benefits to the patients will far outweigh the outlay in money (1959:288)". While long range savings in staffing costs could be expected, in the short-term more staff would be required (1959:292).

Near the conclusion of his speech, Dymond (1959:295) stated:

No doubt some non-members will be thinking about what all this is to cost. I have said nothing about this so far, and shall not say anything since I expect to have a more appropriate opportunity to lay this before them. I would, however, ask that, in the meantime, the hon. members would think of this programme, not from the viewpoint of its cost in dollars, but rather, of what it will mean as an investment in the future.

While it was implied that deinstitutionalization might result in cost-savings, this was not a clearly stated goal. Of course, what politicians say about expenditures must always be checked against what they do. In terms of stated goals alone, however, Dymond clearly emphasized the importance of effective treatment rather than reductions in costs. In Section 2.2 I will show that this priority was reflected in the changes implemented.

2.1.3 PROPOSALS FOR IMPLEMENTATION

The transformation of Ontario's mental health system to meet the goals of separating treatment from custody and enhancing treatment involved the modification of existing facilities and services as well as the development of new ones. The Dymond report laid out directions for the implementation of this transformation.

Dymond discussed, in varying degrees of detail: the transformation of existing institutions; the discharge of chronic patients; the development of new services and treatment approaches; changes in the legal basis for admission to mental health care; and changes in the professional composition of staff in mental health services. Taken together, these changes added up to a dramatic reorientation of mental health services.

The patterns of patient care in existing institutions had been

established over a history of one century. Undoing these patterns while essentially maintaining the basic structures of these institutions was the task to which Dymond devoted the greater amount of attention.

The mental hospital was to be transformed into an active treatment centre (1959:290). This was to be achieved through structural reform (both administrative and physical); through upgrading treatment and research; through staffing improvements; and through changing patient use patterns.

The structural reform of the mental hospital would include: organization on a regional basis; breaking down large hospitals into relatively independent units; and giving consideration to the physical environment. These reforms were to some extent underway in 1959.

The regional organization of mental hospitals required assigning existing institutions to a specific regional mandate and developing a limited number of new institutions to fill in gaps. New mental hospitals for poorly served regions had already been developed in Port Arthur (1954) and North Bay (1957) (Dymond 1959:286).

Dymond (1959:290) believed that the ideal mental hospital should have between 250-300 beds. As many of the existing institutions were much larger, he hoped to achieve that optimum through breaking them down into smaller units, "...creating in effect 3 or 4 small hospitals (Dymond 1959:289)".

These administrative reforms were to bring the mental hospital closer to the community (Ibid). In addition, consideration would be given to the physical structure of institutions.

It is now believed that the architecture of the structures in which these patients are housed may

have some bearing upon, and be of some value in, their care and treatment (1959:291).

A range of additions and renovations to existing institutions had been undertaken in the 1950's (Dymond 1959:286). These changes to the physical structures of institutions would continue.

The physical and administrative structures of existing institutions were to be altered to create an environment conducive to treatment. Within these structures, treatment programmes were to be upgraded. The major emphasis was on the introduction of activity therapies and the development of the required facilities (such as workshops and recreation areas). These activity therapies would contribute to rehabilitation particularly through preparing patients for work:).

Some of the activity therapies should have value in pre-vocational and vocational training as well as in the establishment of work habits (Ibid).

An active research programme was to contribute to upgrading treatment in institutions (Ibid). Steps were to be taken to improve staff training and prepare the additional numbers of professionals who would be required to implement active treatment (1959:292). An increased proportion of non-medical staff would be taken on to carry out the activity therapies.

Group methods and activity therapies, we believe, can be carried out largely by non-medical staff, but under psychiatric supervision (1959:293).

Finally, the patient population of institutions was to be reduced to the 'rated bed capacity' (1959:289).(12) Dymond raised the issue of overcrowding implicitly in suggesting that the populations

of mental hospitals be reduced to bring them in line with Ministry standards.

The most important step Dymond proposed to reduce patient population was the removal of chronic patients from mental hospitals. This was to be achieved in two steps. First, chronic patients would be, "...removed from the hospitals, as such, and placed in a wing or cottages of the present structures (1959:290)." Secondly, they would be discharged completely from the mental health system into special, custodial institutions.

The mental hospital was to be modified to play a role in the new, comprehensive services. Through structural reforms, improved treatment programmes and facilities, changes to staffing and the reduction of the patient population, the mental hospital was to become an active treatment centre. It would provide services to patients who would benefit from treatment and yet required custodial care. At the same time, it would serve as a base for the provision of community mental health services.

The development of community mental health services was well under way in 1959 when Dymond made his report to the legislature. Construction grants had been made to develop ten psychiatric units in general hospitals, which together accounted for one third of all admissions to psychiatric facilities at the time of the report (1959:287). A limited number of outpatient clinics had been developed, generally based in psychiatric institutions (ibid). An infrastructure for community mental health services was taking shape, including an administrative structure and enabling legislation (ibid).

Dymond particularly held up the example of day-care centres opened in 1958 in Toronto and Cobourg. These centres, unlike outpatient clinics, offered on-going supervision and treatment for a certain portion of the day. They offered both day-care and night-care programmes.

Day-care and night-care programmes could offer relatively substantial treatment without disrupting family life (day-care) or work (night-care). Dymond (1959:287) mentioned three examples of groups who could benefit from such services: (1) patients on their way out of hospitals; (2) people who could continue at their jobs; (3) middle aged women who were alone during the day but could be with their families during the evening and on weekends.

The community mental health services mentioned in the report ranged from non-custodial (out-patient clinics) to partially custodial (psychiatric units in general hospitals). All shared an emphasis on treatment, primarily on a voluntary basis.

In general, the proposals for community mental health services were based on the acceleration and intensification of existing trends. The more dramatic departures in the report were in the modification of existing mental hospitals, particularly through the discharge of large numbers of chronic patients. By the time of the Dymond report, the foundations had been laid for a range of institutionally-based, treatment oriented services to complement existing institutions.

There were a few moments in the report at which Dymond seemed to go beyond the bounds of existing developments in alternative services. He implied that a new degree of comprehensiveness and

integration would be introduced into community services. He also raised the possibility that the 'community' itself might assume an active role in the rehabilitation of mental patients.

Since the aim is to keep the patient in as close contact with his normal home and community environment as possible, a great deal of responsibility will devolve upon the community (1959:289).

Specifically, Dymond (1959:290) discussed aftercare services which "...may include special provision for maintenance, education and/or employment". He suggested that community agencies ranging from public health services to welfare and educational agencies should play an active role in the rehabilitation of people with mental health problems (1959:293). He posed "...the great importance of keeping the community in touch with the patient (1959:295)."

It is difficult to assess how much importance should be given to these statements. In vague and momentary ways, they seemed to imply some sort of qualitative break with the traditions of institutional psychiatric care. In any case, the direction which these statements may have implied was not pursued in the implementation of deinstitutionalization.

The major emphasis in the Dymond report as we have seen was on upgrading treatment programmes to allow patients to return to community living. The development of work habits was to play a particularly important role in this process.

The mental health system was to be transformed in order to provide a suitable location for such a treatment programme. This

was to be achieved through the modification of existing institutions, particularly through the discharge of primarily custodial patients; and through the intensified development of complementary treatment-oriented services.

I will try to show in the next section that the Dymond report was an accurate guide to the changes which did take place in Ontario's mental health system over the following years. The aims articulated in the Dymond report were reflected in the actual transformation of the system. These aims will provide a basis for the explanation of deinstitutionalization I will offer in Section 3.

ENDNOTES

1. At the time of the Dymond Report, the care and treatment of both the mentally ill and the mentally retarded were the responsibilities of the Mental Health Branch of the Ontario Department of Health. The Dymond Report proposed goals and methods which were generally parallel for both groups. This paper will attempt, to the greatest degree possible, to separate out and exclude any discussion of mental retardation. The term 'mental health system', then, will apply to the treatment and care of mental illness and not mental retardation.
2. In Section 3.1 I will discuss the asylum reforms of the 1880's in greater detail. The methods of restraint employed in the 1880's will be identified in that section. In general, restraint is the use of physical or chemical means to control or immobilize patients.
3. Scull (1977:104-114), among others, pointed to the remarkable parallels between the 19th century asylum reformers and 20th century deinstitutionalization. In the case of Dymond, at least, these parallels were conscious and fully acknowledged.
4. Neither the patient employment programmes nor the fight to end them were quite as innocent as Dymond suggests. Patient employment programmes included not only on-site industries, but also the use of patient labour in the construction of institutions. At the Kingston asylum, for example: "A separate hospital...was put up largely through the efforts of the patients, who quarried all the stone, and did practically all of the labour in connection with its erection (Hurd 1916a: 155)."

The line between 'work as a curative agent' and patient

conscript labour seems to have been rather poorly defined in retrospect (not that it is an easy line to draw). Hurd (1916:154) assigned a major role in the elimination of patient labour in Kingston to the Knights of Labour Trade Union: "Of course, the Knights of Labour complained of the competition, with the results that politicians interfered and some of the thriving industries were destroyed".

I don't know whether the Kingston example was indicative of any sort of general struggle around patient conscript labour. Generally, the elimination of the various activity programmes developed in the 1880s would be a valuable area for further research.

Suffice it to say that what Dymond attributed to 'misguided humane motives' was probably a more complex and charged struggle than he implied.

5. For example, Dymond never specifically addressed the issue of overcrowding, which was arguably one of the major ways in which the custodial character of the asylum interfered with effective treatment. The Ontario Health Survey (1950:124) noted: "...at the end of 1948 there were 2,926 more patients in residence than the hospitals can properly accomodate". In that kind of situation, staff resources are stretched thin simply managing patients; keeping them alive and out of trouble.

Dymond (1959:289) implicitly addressed overcrowding when he proposed "reduction of patient population to the rated bed capacity". He did not, however, explicitly speak to the relationship

between custodial care, overcrowding, and the erosion of active treatment.

6. Dymond explained the custodial character of the asylum in the following way:

This was due, perhaps, to the ancient fear and superstitious notions surrounding mental illness, to the idea that this was, somehow associated with the supernatural and even demons. Or, it may have been due to the almost hopeless outlook for the mentally ill patient until relatively recent times (1959:286).

This explanation is contradicted by Dymond's own favourable citation of 'enlightened opinion' from 1883 which demonstrated both therapeutic optimism linked to patient employment and the abolition of earlier coercive restraint methods which might generally be associated with fear. Dymond combined a rather postivist view of advances in psychiatric theory and practice ('hopeless until relatively recent times') with a cyclical account of the history of the asylum in which advances were followed by deterioration.

The primacy of custody was not exclusively an official response to hopelessness and fear in the care of the mentally ill. The asylum itself surely contributed to hopelessness and fear as active treatment was undermined by its custodial character.

It is a major argument in this paper that custody cannot be explained internally as an outcome of the interaction between developing psychiatry and mentally ill people. Neither the underdevelopment of psychiatry nor the specific qualities of madness in themselves explain the custodial character of the asylum.

Rather, the asylum must be seen as part of a range of custodial

institutions aimed at relieving widely divergent social problems (poverty, single parenthood, madness, orphanhood). Following Scull (1977:129), I would argue that custodial institutions were developed in response to the imperatives of the capitalist labour market. It is not that the asylum was the best alternative given the stage of development of psychiatric treatment, but that the asylum was the only alternative given prevailing social conditions.

7. The maximization of creativity, productivity and responsibility are charged concepts which can only be understood in the context of prevailing social relations. The question which must immediately be raised is: productivity and creativity for whom? Responsibility to whom?

On the one hand, productive activity at work and/or in the home (raising a family) are basic conditions for full participation in society, providing both a level of subsistence and a sense of respectability. On the other hand, in a capitalist society the terms for the sale of labour-power and the conditions which govern raising families are such that productive activity is subordinated to the requirements of those who own or control the means of production.

8. See Section 3.2, for an extended discussion of the relationship between treatment for effective functioning and the social conditions which obtained in the late 1950s and early 1960s. It would be reading too much into the statement 'programmes should be geared to the needs of the times' to assume that it indicates that Dymond was consciously reorienting the mental health system

to meet specific conditions of labour shortage, etc. His statement raises this possibility, but at the same time it could be merely an indication of a desire to sound modern.

9. There are forms of treatment aimed at maximizing the health of people who will never return to the community. While such treatment cannot reverse the damage caused by diseases such as organic brain disorders, it can allow patients the fullest use of their limited capacities.

This kind of treatment is, by nature, time-consuming and therefore expensive. This kind of expenditure was not to be a priority for Ontario's mental health system under the terms set by the Dymond report. Active treatment was essentially to be reserved for those who could recover sufficiently to return to the community.

10. The vast majority of admissions were still on an involuntary basis at the time of the Dymond Report. In 1950, about 94 percent of admissions were involuntary. This had fallen to about 80 percent in 1960 (Ont. Dept. of Health, Mental Health Division 1950: 68-9, 1960: 73-4).

11. In Scull's (1977:139-140) account of decarceration cost-savings were seen as the primary factor in the deinstitutionalization of psychiatric patients. While I follow Scull's thesis that the welfare state created the conditions for deinstitutionalization, I will try to show in section 3.2 that cost-saving did not figure largely in the transformation of mental health services until the economic crisis of the late 1970's and 1980's.

I refer to Dymond on cost-savings in order to show that cost-savings were not a stated goal of deinstitutionalization in Ontario.

In Section 2.2 I will try to show that the implementation of deinstitutionalization in the 1960's involved considerable expenditures in developing new services and modifying institutions.

Finally, in Section 3.2 I will present a view of the relationship between deinstitutionalization and the welfare state which does not share Scull's emphasis on cost-savings.

12. The 'rated bed capacity' of mental hospitals represented the number of patients who could be accommodated according to the standards of the Ministry of Health. When the number of patients in hospital exceeded the rated bed capacity, the hospital was overcrowded by Ministry standards.

Section 2.2 Deinstitutionalization in Ontario 1959-1965

The process of deinstitutionalization did not begin all at once with the Dymond speech to the Ontario Legislature in 1959. The direction established by Dymond was already implicit in the development of new services and approaches in the period following the Second World War. (e.g. the introduction of outpatient clinics and psychiatric units of general hospitals and the use of the approaches of social psychiatry). The Dymond report was important both for making this direction explicit and for setting in motion the modification of the asylum.

In the years following the Dymond report, the pace of the development of new services was substantially increased. At the same time, new charges were introduced to modify existing institutions and to round out the legislative framework for deinstitutionalization. By the end of this period, the direction for deinstitutionalization in Ontario until the mid-1970s was firmly established.

The major themes that were to mark this period were the separation of treatment from custody, primarily through the discharge of chronic patients; and the enrichment of treatment programmes through the development of new services and the modification of existing institutions. Together, these changes had a dramatic impact on the patterns of patient use in the mental health system.

2.2.1. The Separation of Treatment From Custody

Dymond aimed to reorient the whole mental health system towards active treatment. People who could not be treated for a return to the community were to be removed entirely from the mental health system into custodial services. People who were likely to respond to treatment

were to be streamed through a range of services according to their requirement for custodial care(1). The mental health system was to offer custodial services only as a complement to active treatment & for a return to the community.

Dymond proposed that the discharge of custodial patients proceed in two stages: (1) removal to special sections of institutions set aside for exclusively custodial care; (2) discharge out of mental health institutions into custodial services. This two stage process was implemented over the following few years.

First, sections of existing institutions were designated as 'Residential Units', for chronic patients requiring custodial care. Residential Units were established in seven mental hospitals in July 1961 and by the end of that year 1,400 patients were designated as 'residents' in eight hospitals (Ontario Department of Health 1961:75). By the end of the next year, there were 3,466 patients in residential units (Ontario Department of Health 1962:77). The population of mental hospitals, exclusive of residential units, was 11,232 in 1962 (Ontario Department of Health 1965:96).

The second phase in the discharge of chronic patients began with the establishment of Homes for Special Care in 1964. Homes for Special Care were developed to provide custodial care outside of the treatment-oriented mental health system. These were private institutions which had to fulfill certain standards set by the Province (Allodi and Kedword 1973:281). By 1965, 1,800 patients had been transferred to Homes for Special Care (Ontario Department of Health 1965:88). As Homes for Special Care were developed, Residential

Units in mental hospitals were phased out.

The years following the Dymond report, then, saw thousands of chronic patients discharged first into Residential Units and then into Homes for Special Care. This achieved not only a reduction in the patient population of mental hospitals, but a change in the composition of that population. In 1959, the proportion of mental hospital patients diagnosis as psychotic was 62%; by 1965 it had fallen to 47% (Mental Health Division 1965:25). A diagnosis of psychosis generally indicates a greater degree of impairment than non-psychotic disorders.

The population of mental hospitals not only became smaller, but also more treatable. The separation of treatment from custody in practice meant streaming patients according to the amount of custodial care they required to achieve a return to the community. Chronic patients were streamed right out of the system; while others were streamed through a range of services providing varying degrees of custodial care.

This streaming can be seen by comparing the proportion of patients diagnosed as psychotic across the range of services. In 1965, 79% of the patients in Residential Units were diagnosed as psychotic; 47% of those in mental hospitals; 38% of those in psychiatric units of general hospitals; and 10.9% of those attending outpatient clinics (Mental Health Division 1965: 153, 25, 174, 18).

The separation of treatment from custody through streaming permitted the reorientation of the mental health system towards the rehabilitation of less seriously impaired people. In 1945, when

the system had consisted essentially of mental hospitals, 74% of the patients were diagnosed as psychotic (Mental Health Division 1959:27). The mental health system not only divested itself of responsibility for long-term custodial patients; it also took on the treatment of a new range of problems.

At the same time, treatment began to be separated from custody in the legal sense. The Mental Hospitals Amendment Act of 1960 aimed to facilitate informal (voluntary) admission and discharge (Ontario Department of Health 1960:12). In 1964 a commission was struck to study mental health legislation leading to the Mental Health Act of 1967. The proportion of voluntary patients in mental hospitals increased from 20% in 1960 to 24% in 1965, reaching 65% in 1970 following the passage of the Mental Health Act of 1967 (Mental Health Division 1960:73-4; 1965:84-5; 1970:86-7).

The shift away from the primacy of custody in mental health services proceeded very much along the lines indicated by Dymond. This side of deinstitutionalization could easily be mistaken for a straightforward reduction in services. The discharge of long-term custodial patients combined with a general movement towards treatment on a minimally custodial basis certainly seems like a cutback in services. For long-term custodial patients, it probably was. However, for the overall mental health system it was only one side of a process which also included the improvement of treatment services.

2.2.2 Improving Treatment

The Dymond report aimed to orient the mental health system

towards active treatment to enable people to manage in the community through the enhancement of functioning skills. This was to be achieved through improving the treatment capacities of mental hospitals and intensifying the development of new services.

One step in the improvement of treatment in mental hospitals was restructuring to create a suitable environment. This restructuring was both physical (renovation and construction) and administrative.

The years following the Dymond report saw a substantial amount of construction in Ontario's mental hospitals.(2) Between 1959-1965, two new mental hospitals were opened (Owen Sound and Goderich) and construction began on a third (South Porcupine). These new hospitals were built in regions poorly served by existing institutions. As well, the construction of new buildings to replace obsolete sections of the mental hospitals in Toronto, London and Penetanguishene was planned during this period and underway by 1966.

The administrative restructuring of mental hospitals involved breaking down large institutions into smaller semi-autonomous units. By 1960, this process was completed in one hospitals, well underway in another, and planned for a third (Ontario Department of Health 1960:71). As well, mental hospitals were organized on a regional basis with the exception of specialized hospitals which served a particular population.

The design, size and remoteness of the asylum had created an environment more suitable for incarceration than for treatment.

Rather than starting over with new, more appropriate institutions the attempt was made to restructure existing ones, with a few additions in remote areas.

At the same time as mental hospitals were being restructured, their treatment programmes were being reoriented. The reorientation had two sides. The coercive conditions governing treatment in the asylum were reduced or removed. New treatment approaches were introduced or expanded.

The coercive treatment conditions in the asylum were linked to the primacy of involuntary custody. They included locked wards, the use of restraint and treatment without consent. As part of the process of deinstitutionalization, moves were made to change these conditions. An "open door" programme was intended to reduce the number of locked wards. Legislative regulations passed in 1960 allowed for the establishment of 'special units' which offered treatment without restraint on the basis of informal admission and discharge (ibid:12). Restraint (particularly through chemicals) and involuntary treatment were not eliminated, but they were subordinated to the overall goal of returning patients to the community.

There seems to be a tendency for the mental health system to be able to minimize the use of coercive measures during periods of therapeutic optimism (i.e. belief in the possibility of treatment). The use of restraint was minimized in the 1880's during a period of therapeutic optimism linked to patient employment programmes. In such periods, patients are more likely to consent to treatment which is aimed at getting them out of the hospital. It is much less likely that people will

consent to treatment aimed primarily at making them manageable for long term incarceration."

The return of therapeutic optimism was central to the reorientation of treatment around a policy of deinstitutionalization. Mental health institutions were to be focussed primarily on the voluntary treatment of people capable of returning to community life. There were developments in both individual and group therapies aimed at enhancing patient's abilities to deal with everyday life.

The developments in individual therapies consisted primarily of new treatment technologies. In the 1940's and 1950's a range of new treatment technologies had been introduced into Ontario's mental hospitals. Electroconvulsive (shock) therapy and insulin coma therapy were quite widely used in the early 1950's, and prefrontal lobotomies were introduced on a limited scale (Allodi & Kedward 1973:282-3). The use of these technologies was reduced as psychotropic drugs were introduced on a wide scale.

These technologies were physical interventions designed to achieve a dramatic change in behaviour quite quickly. They could be used either to return people to the community or to keep them manageable in institutions. In the end, psychotropic drugs proved to be the most effective form of intervention, though electroconvulsive therapy has been retained in limited use up to the present day.

The Ontario Department of Health Annual Report in 1961 (74-75) stated: "Psychotropic drugs are used extensively in the treatment of in-patient, out-patients, and in after-care". The

use of various methods of individual psychotherapy was also mentioned, though without elaboration (ibid). The major development in non-technological treatments associated with deinstitutionalization was in the area of group therapies.

In inpatient care the importance of 'milieu' is emphasized and a variety of social, occupational and recreational activities are employed as therapy, as training, as diversion, and as occupation. These include group psychotherapy, remotivation techniques, experiments in patient government, music, art, drama, sports, physical training, "occupational therapy" per se, special training and educational programmes, employment in hospital industries, industrial projects involving commercial contract and payment of patient-workers (ibid:75).

These group therapies were mainly aimed at the enhancement of functioning skills. They were activity therapies which attempted to improve or develop work-related skills, social contact abilities and the capacity for self-care (e.g. grooming, shopping). Programmes to develop work skills were introduced at a rapid rate. In 1961, there were industrial projects at four hospitals (ibid). Six more hospitals established industrial activity programmes in 1963 (Ontario Department of Health 1963:71). Three workshops were established in two hospitals in 1964 (ibid 1964:100).

Other programmes introduced to enhance functioning skills included a grooming school and English instruction for New Canadians (ibid 1961:75, 1962:75). In general, these treatments sought to return patients to community through developing the practical ability to deal with the requirements of everyday life.

The two major changes in treatment, then, were the widespread

use of new technologies (particularly drugs) in individual therapies, and the development of group therapies to develop functioning skills.(3) Together, these treatments were to return patients to the community in the shortest time possible. The ability to return to the community was defined in functional terms as the capacity to deal with job, home and neighbourhood. The curing of mental illnesses was largely subordinated to the promotion of functional skills.

The reorientation and improvement of treatment in mental hospitals required changes in the size and composition of the staff. Overall, the staff of mental hospitals increased by 15% from 1960 to 1965, while the patient population in hospital declined by 26%. During this period, the number of psychologists and physicians in mental hospitals declined. The number of social workers increased by 24 per cent and the occupational therapy staff increased by 34 per cent. The small number of pharmacists in mental hospitals more than doubled during this period (Ontario Department of Health 1960:124; 1965:136-137; Mental Health Division 1970:30).(4)

The restructuring of mental hospitals, the development or expansion of new treatment programmes, and the change in the composition of the staff represented the reorientation of mental hospitals towards active treatment for functioning effectiveness. At the same time, the development of new treatment-oriented services was accelerated.

Psychiatric units of general hospitals had been developed under a construction grant programme since 1948. By 1959, they had reached a total bed capacity of 351, admitting 4,336 patients.

Through the development of new units and the expansion of existing ones, the bed capacity was increased to 662 in 1965, and admissions to 8,515. These numbers kept increasing, and in 1970 the admissions to psychiatric units surpassed those to mental hospitals (Ontario Department of Health 1965:180; Mental Health Division 1970:30 & 32).

Psychiatric units provided treatment on the basis of short-term custodial care. In the early 1960's a new type of facility, the community psychiatric hospital, was developed which provided similar services with somewhat more intensive custodial care. The average length of stay at community psychiatric hospitals (44 days in 1965) was longer than at psychiatric units (26 days in 1965) (Ontario Department of Health 1965:177).

The community psychiatric hospital was basically a service which fit in between psychiatric units and mental hospitals. Three community psychiatric hospitals were developed by converting existing tuberculosis sanatoria in the early 1960's. These hospitals had a combined bed capacity of 175 by 1965. As well, the Clarke Institute of Psychiatry was constructed between 1963 and 1966, providing an additional 200 beds (Ontario Department of Health 1966:47).

There was, then, a substantial expansion of services providing treatment on a short-term custodial basis. Outpatient clinics, providing treatment without custodial care, were also substantially expanded. In 1959 there were 21 outpatient clinics in Ontario (Ontario Department of Health 1959:68). By 1965, the number had

more than doubled to 49 (Mental Health Division 1965: 11).

These outpatient clinics were generally institutionally-based, located in mental hospitals, community psychiatric hospitals, or psychiatric units. Of the 49 clinics operating in 1965, only eight were located outside of hospitals (Mental Health Division 1965:166).

The shift towards active treatment, then, was not empty rhetoric. The contraction of custodial care was matched with the expansion of services providing treatment to enhance functioning skills on a minimally custodial basis. While these services did not include group homes, neighbourhood clinics or similar facilities commonly associated with 'community mental health', they did provide a particular kind of treatment oriented to the facilitation of community living for people with mental health problems. These developments substantially altered the patterns of patient care in Ontario's mental health system.

2.2.3. Changing Patterns of Patient Care

The separation of treatment from custody and the reorientation of treatment towards effective functioning produced the changes in patient care patterns generally associated with deinstitutionalization. While the reduction of mental hospital populations is frequently highlighted in accounts of deinstitutionalization, the overall pattern is best understood as a combination of changes in admissions, population, length of stay, basis of admission and type of service offered.

The population of Ontario's mental hospitals declined by 27% from 15,739 to 11,441 between 1959 and 1965 (Mental Health Division 1970:

30). This decline began in 1959. However, the rate of hospitalization per 100,000 population began to drop in 1948 (Ontario Department of Health 1960:76).

The large-scale discharge of long-term custodial patients played a very important part in this decline. By the end of 1965, the population of residential units for long-term custodial patients was 2,878, and an additional 1,800 patients had been transferred to Homes for Special Care (ibid 1965:88,98). Together, this added up to 4,678 discharged custodial patients which is very close to the overall population decline of 4,298.(5)

The reduction in the total patient population of mental hospitals (i.e. the number of patients actually in hospital at a given time) was accompanied by an increase in admissions to mental hospitals and other services. Both the number of first admissions (i.e. people entering a hospital or service for the first time) and readmissions increased substantially during this period.

A greater number of patients was circulating through a smaller number of beds. Admissions to mental hospitals increased from 7,121 in 1959 to 11,746 in 1965; an increase of 65 per cent at the same time as patient population decreased by 27 per cent (Mental Health Division 1970:30). So, the turnover rate at mental hospitals increased. In 1959, for every 100 patients in hospital there were 45 admissions and 34 discharges. By 1965, there were 102 admissions and 105 discharges for every 100 patients in hospital (ibid).(6)

The increased turnover rate in mental hospitals was also an expression of the fact that more patients were readmitted to hospital

after an unsuccessful return to the community. Both first admissions and readmissions increased between 1959-1965; but the increase in readmissions was far more dramatic (105 per cent vs. 39 per cent for first admissions) (from Mental Health Division 1965:40).

The increased rate of patient turnover in mental hospitals suggests a reduced length of stay in mental hospitals. If more people were being admitted to fewer beds, then the length of time they occupied those beds must have been declining. However, the actual information on length of stay compiled by the Ministry of Health is based on discharges; and therefore reflects the discharge of large numbers of long-stay patients during this period. While the length of stay in hospital for new patients must have been declining, the average length of stay did not decline consistently during this period due to the temporary effects of the programme to get long-term patients out of hospitals.(7)

The general result of deinstitutionalization was that the mental health system treated an increasing number of patients while providing less custodial care. The combined increase in first admissions across the whole range of mental health services was 61 per cent between 1959 and 1965 (taken from Mental Health Division 1965: 40,169,180). The total inpatient population declined dramatically, but the number of people treated on both an inpatient and outpatient basis increased.(8)

Deinstitutionalization, then, extended the reach of the mental health system. Not only did the number of people treated

increase, but the characteristics of patients changed. The mental health system became increasingly oriented to the treatment of people suffering from less severe disorders, while the most troubled were discharged into custodial care.

The modification of mental hospitals and the development or expansion of new services shared a common goal: to enhance the abilities of those people who were capable of continuing in, or returning to, the community. This was achieved through the reduction of custodial care and the reorientation of treatment. The treatments of preference for enhancing community functioning skills were activity therapies, particularly those oriented towards working ability; and the extensive use of psychotropic drugs.

The process of deinstitutionalization reduced services to long-term custodial patients and dramatically expanded services to patients likely to return to the community. The number of patients and staff was increased, existing facilities were modified and new facilities were developed.

This expansion was expensive. The expenditures of the Mental Health Division almost doubled from fiscal years 1959-1960 to 1965-66, going from close to 37 million dollars to almost 73 million dollars (Ontario Budget 1962: 87, 1967 :84). Nor was this a short-term increase, as the budget doubled again by 1970, reaching almost 150 million dollars (Ontario Budget 1971:97). In addition, considerable amounts were expended on construction, averaging over 10 million dollars a year on mental hospitals alone between 1959-1965.

Deinstitutionalization in Ontario, then, followed very much along the lines proposed by Dymond. Mental health services were reoriented towards the active treatment of the people more likely to return to the community, while long-term custodial patients were discharged into separate institutions. It was a culmination of trends which began in the 1940's with the introduction of new technologies, the development of new services (psychiatric units and outpatient clinics), and the increased use of therapies oriented to functioning effectiveness.

The emphasis on deinstitutionalization as a cutback in mental health services through the reduction of mental hospital populations is largely the result of retrospective analysis informed by the conditions of the economic crisis. There was a qualitative change in the direction of deinstitutionalization in the late 1970's which involved cutbacks in all areas of services. It is a mistake, however, to read back into the earlier phase of deinstitutionalization the tendencies of a later phase.

It is important, then, to examine the under what conditions mental health treatment becomes a priority for the state. Deinstitutionalization in its earlier phase cannot simply be dismissed as a set of empty promises obscuring a reduction in services. Rather, as Dymond indicated, deinstitutionalization was a shift towards a new kind of service for a different clientele.⁽¹⁰⁾ The new services were less disruptive to everyday life, while the new clientele was less seriously disturbed. The next section will attempt to explain why a shift of this nature took place at this time.

End Notes

1. A note on terminology:

Mental hospitals: were hospitals directly operated by the Ministry of Health providing exclusively psychiatric services. They were called Ontario Hospitals in the 1960's. Most of them had been asylums before World War II. A few new ones were developed in the 1950's and 1960's.

Psychiatric units in general hospitals: were units in multi-purpose general hospitals which provided psychiatric services.

Community psychiatric hospitals: were hospitals funded by the province though administered by their own Board of Directors. These hospitals were exclusively psychiatric. Four of them were developed during the 1960's.

Outpatient clinics: offered treatment without any custodial care. They were generally affiliated with and/or located in either mental hospitals or general hospitals.

Day-care centres: these centres offered 'semi-custodial' care; that is, they offered custodial care for a portion of the day or night but not on a 24 hour basis. These centres were often linked to outpatient clinics and were located in mental hospitals or general hospitals.

2. Scull (1979:139) stated that the first cost-saving in deinstitutionalization was in the cancellation of construction. This was certainly not true in Ontario. Not only was there substantial construction involved in the development of new services, but there was also a minor building boom in the renovation of existing mental

hospitals and the development of new ones.

3. To really assess the impact of these programmes, it would be necessary to examine in detail the proportion of patients who actually received vocational training, medication, etc. At this point, I can only provide a general outline to provide an impression of developments.

4. These figures are taken from the Ontario Ministry of Health staff classification tables by subtracting institutions other than mental hospitals. It is important to note that the active treatment staff (physicians, psychologists, social workers and occupational therapy staff) together made up only about 6% of the staff of mental hospitals in 1965. The occupational therapy staff numbered 207 (2.5% of staff), physicians 129 (1.6%), social workers 104 (1.3%) and psychologists 46 (0.6%). Overall, the major categories of staff in order of size were nursing staff 4,458 (54%), custodial and maintenance 2185 (26%), clerical 503 (6%), active treatment 486 (6%) and other 632 (8%).

The increase in occupational therapy staff (34 per cent) exceeded that in social work (24 per cent), nursing (5 per cent) or custodial and maintenance (15 per cent); and was surpassed only by the increases in clerical (40 per cent) and other (including administrators, technicians and unclassified others) which more than doubled.

In short, these figures show a change in the composition of the active treatment staff, though overall they remained a small proportion of the total. More information would be required on the 'other' categories in order to understand their dramatic increase.

5. This similarity provides a strong indication that the discharge of chronic patients was an important factor in the reduction of the patient population. The increasing proportion of non-psychiatric patients in mental hospitals reinforces this impression. However, more detailed information would be required on the way in which population reductions were achieved (e.g. - Were beds eliminated in larger wards? Were wards closed down? Did the admissions policies of mental hospitals become more selective?) in order to confirm up this impression.
6. These rates are my own calculations based on the table footnoted.
7. In other words, more work would have to be done on the length of stay data in order to demonstrate the general tendency towards decline. The Mental Health Division (1965:37) table on average stay in hospital shows very large year to year fluctuations, both up and down: from 10.7 months in 1959 to 27.5 in 1962 to 9.7 in 1964 to 15.6 in 1965. While the variations in the median length of stay are less dramatic, they reflect the same inconsistency.
- In order to demonstrate the decline in length of stay it would be necessary to be able to separate out the length of stay for new admissions from that of long-term patients. The increased rate of turnover during this period certainly required that new patients were spending less time in hospitals.
8. There was a slight decrease in admissions to outpatient services between 1963-1965, but by 1967 the pattern of steady growth returned (from Mental Health Division 1970:33).
9. Taken from Ontario Public Accounts 1959-1960:510-11, 1960-61:

510, 1961-62:R10-11, 1962-63:R10-R11, 1963-64:510, 1964-5:510, 1965-66:R10-11. This includes only capital expenditures on mental hospitals and excludes the expenditures on new facilities.

These global figures are intended only to provide a general perspective on the effects of deinstitutionalization on mental health expenditures. Further work on the various kinds of expenditure on mental health care through general welfare programmes would complete this picture.

These figures are intended to demonstrate (in contrast to Scull's thesis outlined in section 3.2) that deinstitutionalization in the 1960's did not produce reductions in expenditure. A more exhaustive account of expenditures would be useful, but it lies beyond the scope of this paper.

10. It would be interesting to examine this shift from incarceration to minimally custodial services in terms of Foucault's (1977:296-304) analysis of the development of 'discipline'. The movement towards more discrete form of intervention which extended the reach of disciplinary techniques beyond the bounds of institutions was seen by Foucault as an important tendency. These more discrete forms of discipline make the exercise of power less visible and more effective.

We are in the society of the teacher-judge, the doctor-judge, the educator-judge, the social worker-judge; it is on this that the universal reign of the normative is based; and each individual, wherever he may find himself, subjects it to his body, his gestures, his behaviour, his aptitudes, his achievements (Foucault 1977:304).

Deinstitutionalization could be examined as a move towards a

less overtly intrusive and more effective form of normative intervention. The use and critique of Foucault, however, cannot be undertaken in this paper,

Section 3: Explaining Deinstitutionalization

Deinstitutionalization in Ontario in the 1960's involved a thorough reorientation of the mental health system. After more than a century of primarily custodial care, mental health services shifted towards active treatment on the basis of minimal custody. The seriously impaired long-term custodial patients who had made up the greatest part of the population of the asylum were largely discharged out of the mental health system. Increasingly, it was people who could function in the community on the basis of some finite intervention who were treated through mental health services.

This section will attempt to explain both the form of this reorientation and its timing. There are, in the most general sense, two approaches to the explanation of deinstitutionalization. The first is to view deinstitutionalization primarily as a development within psychiatry; as the result of new knowledge, techniques or pressures which created the basis for a substantial reorientation. The second is to stress the role of broader social changes in bringing about shifts in mental health services.

This paper will offer an explanation along the lines of the second approach by locating the mental health system in the general context of state social services. This does not mean, however, that the importance of developments within psychiatry can simply be dismissed from the outset. Rather, it must be demonstrated that deinstitutionalization cannot be explained internally, exclusively on the basis of development within the mental health system.

This section will therefore begin by setting deinstitutionalization in the context of the history of mental health services in Ontario. Deinstitutionalization was in many ways remarkably similar to earlier attempts at asylum reform. These earlier attempts were ultimately constrained by the custodial character of the asylum. Deinstitutionalization managed to overcome these constraints by putting an end to the primacy of custody. The primacy of custody was not a unique feature of the asylum, determined by the underdevelopment of psychiatry; but a general feature of state relief, in response to prevailing social conditions.

The workhouse, the prison and the orphanage were as much custodial institutions as the asylum, for much the same reasons. All of these services underwent some form of deinstitutionalization during the period following World War II. The development of the welfare state during this period represented a major change in state social policy. The whole range of social services was modified and expended in order to meet the new goals of social policy related to the development of the welfare state.

Section 3.1: Deinstitutionalization and the Asylum

The history of the asylum was predominantly one of harsh conditions of detention and hopelessness. Through much of that history, inmates were regarded as incurable and treatment consisted primarily of measures to accommodate them to the grim realities of asylum life. However, there were also important moments of therapeutic optimism in which effective treatment was believed possible and the worst coercive measures were largely abandoned.

The moments of therapeutic optimism in the asylum prefigured deinstitutionalization to a remarkable extent. The most significant difference was that the link between custody and treatment wasn't broken in the asylum. It is crucial, then, to understand the basis for the primacy of custody in the asylum and why change was possible after World War II. This section will attempt to demonstrate that the primacy of custody was a general feature of state relief programmes related to prevailing social conditions and not a specific characteristic of the asylum resulting from the state of development of psychiatric theory and practice.

The asylum in Ontario was, from the beginning, committed in principle to the provision of treatment on a custodial basis.

It wasn't necessary to establish asylums in order to incarcerate insane people; that function was already being performed by jails.

In 1830, legislation was passed which provided for the incarceration of destitute insane people in jails (Ontario Health Survey Committee 1950:110). It is significant that destitution was, from the outset, a criterion for the provision of relief along with

insanity.

The asylum was established as a distinctive institution to provide treatment to ameliorate the condition of insane people. Dorothea Dix, a famous American asylum reformer, petitioned the Nova Scotia Legislature to establish a separate asylum for the insane in 1850. In her petition she wrote: "The malady of insanity, when brought under early efficient treatment, is, except there be organic disease, equally manageable and curable as a fever or a cold (cited Hurd 1916a:488)". She went on to cite statistics from American institutions showing that a very high proportion of inmates admitted were released as cured (e.g. 72 per cent at the Kentucky State Hospital (ibid:489)).

The treatment provided in Ontario's first asylum, located in the old York Jail in Toronto, was quite horrible. However, this was evident even to a contemporary observer, J.H. Tuke (the son of the founder of the innovative York Retreat in Britain) who visited the asylum in 1845 and wrote:

There were, perhaps, 70 patients, upon whose faces misery, starvation and suffering were indelibly impressed. The doctor pursues the exploded system of constantly cupping, bleeding, blistering, and purging his patients; giving them also the smallest quantity of food, and that of the poorest quality. (cited Tuke 1885:215).

This asylum, and its outdated treatment methods, were soon replaced. A new building, erected specifically as an asylum, was opened in 1850. Within three years this new asylum was seriously overcrowded (Hurd 1916b:139). Temporary buildings had to be used to reduce the overcrowding: a university building (1856) and a

military barracks (1859) (ibid:140).

Ontario's asylums could seldom get ahead of overcrowding in order to create a suitable treatment environment. Allodi and Kedward (1977:220-221) noted: "...one superintendent suggested to the architect of a new hospital not to build corridors because 'they became so easily filled with beds.'"

The asylum was developed with a specific mandate to provide treatment on a custodial basis. From the beginning, however, Ontario's asylums were beset by the problem of overcrowding. The asylum developed through a persistent cycle of innovation, overcrowding and improvisation.

Hurd (1916a:461) wrote that the acquisition of 'branch asylums' was a striking feature in the early development of the asylum in Ontario:

These in most cases were designed to relieve overcrowding without the expense of adding additional buildings to the original asylum. In general they occupied abandoned buildings, unsuited in every way for asylum purposes...

Among the abandoned buildings called into temporary use as asylums were the old Parliament Buildings in Toronto (1846), a university building (1856), a military barracks (1859), an unfinished hotel (1861), the stables of an old estate (1856) and a seminary (1885) (Hurd 1916b:132-154). The construction of new permanent asylums did not keep up with the press of numbers.

There were moments in this cycle where developments outpaced overcrowding and treatment in the asylum reflected therapeutic optimism. Probably the most significant of these moments in Ontario occurred during the late 1870's and 1880's. Dymond

(1959:290-1) held up the patient employment programmes of this period as an example to be emulated.

While it is not possible to examine this period in detail here, it is important to highlight some of the parallels to deinstitutionalization. The orientation of treatment to functioning skills, the move towards streaming on the basis of likelihood of rehabilitation, and the reduced use of coercion all foreshadowed deinstitutionalization. It was, however, impossible to sustain these developments in a primarily custodial situation.

The employment of patients was heavily stressed during this period. More than one half of Ontario's asylum inmates were employed in 1883, with the highest rate of about 70 per cent at the London Asylum (Tuke 1885:209)2. This employment was definitely regarded as therapeutic. The superintendent of the London Asylum reported: "I have always found that, no odds how violent a patient is, if you can ~~one~~ get him or her to work, the case will give you very little further trouble in that way (cited *ibid*:211)."

The Ontario Inspector of Asylums reported that the proportion of patients discharged as recovered was improving during this period (*ibid*:208). After visiting the London Asylum, Tuke (1885:221) wrote: "It is especially interesting to observe how a better system of treatment has become possible by the increased employment of the patients."

To complement these patient employment programmes a system of streaming inmates according to the likelihood of recovery was developed. In the London Asylum, separate cottages were developed

for 'quiet, working patients' (Hurd 1916b:158). At the Kingston Asylum, Tuke (1885:233) found "...as at the other asylums in Ontario, cottages for certain classes of patients." The attempt to segregate patients capable of recovery from those who required long-term custodial care took different forms at the various asylums, but it was a common feature from the mid-1870's to the late 1880's.

The therapeutic optimism linked to patient employment programmes provided the basis for a reduction in the use of restraint and seclusion. In London, the use of mechanical, 'chemical' (sedatives) and manual (by attendants) restraint as well as strong dresses (straitjackets) and seclusion was eliminated or strictly minimized (Tuke 1885:218-219). The Superintendent of the London Asylum attributed his success in eliminating restraint 'almost entirely' to patient employment programmes (Dymond 1959:291). The disuse of restraint and seclusion spread from London to the province's other asylums (Hurd 1916b:158).

These reforms had a very short life. Dymond (1959:286) stated: "By 1900, asylums which, for a time, had once been centres of activity had deteriorated to become custodial institutions". It is important then, to determine why deinstitutionalization had to start all over again, consciously or unconsciously picking up methods which had fallen into disuse decades previously.

The general parallels between the asylum reforms of the 1880's and later deinstitutionalization included: the stress on activity as therapy (particularly work-related activity); the streaming of

patients according to the likelihood of recovery; and the minimized use of coercive methods. However, in the 19th century it was impossible to prevent the accumulation of long-term custodial patients while the welfare state provided on alternate means of maintaining chronic patients after World War II.

The asylum reforms of the 1870's and 1880's could not be sustained in a custodial institution. This was partly because custody in itself presented a block to effective rehabilitation, and hence tended to undermine therapeutic optimism. The disruption to family life, daily habits and employment created by incarceration was difficult to overcome.

More importantly, the custodial character of the asylums meant that they were prone to overcrowding. Allodi and Kedward (1977:220) attribute the overcrowding to increasing population, unrestrained admissions, and the small proportion of discharges. The process of overcrowding was rather circular. Institutions would accumulate long term custodial patients to the point that bed capacity was exceeded. The crush of numbers made effective treatment more difficult, and so the turnover of patients through institutions was reduced. This compounded overcrowding, until the system was expanded. Then the cycle began again.(3)

As the proportion of chronically ill patients increased, the hospitals became overcrowded, patient care deteriorated and both psychiatrists and the public lost faith in the possibility of cure and return to the community.
(Bassuk & Gerson 1978:47).

This cycle was broken through the process of deinstitutionalization only by discharging long-term custodial patients right out

of mental health services. The link between treatment and custody was broken, and so it was possible to offer substantially the same kind of treatment on a minimally custodial basis with the effect of increasing patient turnover.

The problem of overcrowding was apparent to contemporary policy makers and critics in the 1880's. Tuke (1885:209) wrote: "The authorities in Ontario are not blind to the difficulties connected with the accumulation of incurable patients, for whom the question of separate accommodation arises". The solution envisaged at the time was to segregate chronic patients within the confines of the custodial institution. However, this solution could only be sustained if sufficient separate accommodation was provided so that chronic patients would not impinge on the space allotted to patients likely to recover. Instead, streaming tended to break down under the pressure of overcrowding.

The custodial nature of the asylum created on apparently insurmountable barrier to effective treatment, particularly through incessant overcrowding. This barrier was quite consciously attacked through the process of deinstitutionalization. The asylum reformers, on the other hand, worked within the bounds of the primacy of custody. To understand the difference between the two, the basis for the primacy of custody must be explained.

The primacy of custody in the asylum is most often explained in terms of the stage of development of psychiatric theory and practice. These explanations take many forms, but share a common foundation on the premise that custody in the asylum derived from

the knowledge, techniques or beliefs prevailing in psychiatry before World War II.

The first of these internal explanations sees psychiatry as an advancing science, progressing towards better knowledge and more effective therapy. The custodial nature of the asylum is associated with an immature stage in the development of this science.

Dymond (1959:286) offered an explanation along these lines when he related custodial care to 'the ancient fear and superstitions notions surrounding the mentally ill' and 'the almost hopeless outlook for the mentally ill patient'. The asylum reformers, however, were serious therapeutic optimists who not only believed in the possibility of cure but actually achieved some success in increasing recovery rates. At the same time, they believed that genuine 'asylum' was an important component of treatment:

Removal from all accustomed scenes and influences appears to be essential for successful treatment of the insane...The physician of the Retreat in New York stated in a late report that forty-nine years' experience establishes the fact of recovery of four cases to one brought under care within three months of the first attack, while it is less than one to four in cases of more than twelve months' duration when admitted. (Dorthea Dix cited in Hurd 1916a:488-489).

The asylum reformers advocated custodial care as the best means of providing effective treatment towards recovery. The fear of the insane was arguably more a product of incarceration than a grounds for it.⁴

By removing the insane from the community and

sequestering them behind the walls of an institution, the possibility of ordinary people misperceiving and exaggerating the most common features of mental disturbance was greatly exacerbated. (Scull 1977:126).

In any case, the recent controversies around group homes in neighbourhoods suggests that deinstitutionalization did not result from a considerable change in public attitudes towards mentally ill people. Nor does a sudden upsurge in therapeutic optimism linked to new developments in psychiatry explain deinstitutionalization; the asylum reformers foreshadowed not only the optimism but many of the techniques associated with deinstitutionalization.

So, if there was an advance in psychiatric theory and practice between the asylum reforms and deinstitutionalization, it had to do with the role of custody in treatment. The asylum reformers believed that removal to an institution was an essential component of effective treatment. There were, in the 19th century, a few lone voices who identified the negative impact of institutionalization on treatment, but they were "...greeted by silence, to be consigned to oblivion (Scull 1983:128-129)."

In contrast with the asylum reforms, post-war deinstitutionalization clearly set out to minimize the role of custody in treatment. However, the changes this implied are not as significant as they might first appear. Deinstitutionalization did not eliminate inpatient treatment. On the contrary, it remained an important feature of mental hospitals, community psychiatric hospitals and psychiatric units in general hospitals.

It is not inpatient treatment that created overcrowding, but the accumulation of incurable patients. The asylum reforms were

based on the premise that effective inpatient treatment could promote recovery and discharge. Deinstitutionalization largely shared this premise, but added the complementary premise that some people who were not seriously impaired could be treated without any custodial care.

There was, then, no major advance in psychiatric theory and practice regarding inpatient treatment associated with deinstitutionalization. The changes were, at one end, the large-scale discharge of chronic patients; and at the other end the development of outpatient services for a whole new clientele. Modern practice clearly confirms Dix's contention that removal to an institution is an essential component of treatment, with the qualification that this only applies to a certain proportion of the population defined by contemporary standards as mentally ill.⁵

Deinstitutionalization did not result from a major change in the attitude towards the benefits of inpatient treatment, or from a substantial shift in the public view of mental illness. There are two other developments within the psychiatric field which are commonly used to explain deinstitutionalization. The first is the introduction of psychotropic drugs, which are seen as providing the mental health system with the technological capacity to handle patient outside of the confines of the institution. The second is the libertarian critique of institutions, which along with some legal cases in the United States is seen as a source of pressure on psychiatry to recognize the rights and freedoms of patients.

There is a very strong empirical relationship between the

introduction of psychotropic drugs to widescale use in the mid-1950's and the dramatic reduction in the population of mental hospitals. There is an extensive literature which claims, on the basis of this relationship, that the introduction of psychotropic drugs was central to the process of deinstitutionalization. Psychopharmacology is seen as the 'third revolution' in mental health care, after moral management and psychotherapy (Walker & Penfold 1983:6-7).

Then came a major medical development: the wide-spread ~~and~~ effective introduction of antipsychotic drugs in the early 1950's. The possibility arose that thousands of patients previously considered manageable only within the confines of an institution could now be treated as outpatients (Bassuk & Gerson 1978:47).

The fundamental premise of this literature is that the development of new technological capacity created the basis for the shift in psychiatric treatment away from custodial care. Deinstitutionalization tends to be narrowly conceived in this literature as the reduction of the patient population in mental hospitals.

As stated previously, the process of deinstitutionalization began the 1940's, before the introduction of psychotropic drugs. For example, the first day hospital in Canada (offering care and supervision for only a portion of the 24 hour period) developed during World War II, largely in response to a personnel shortage (Lerman 1982:98).

Drugs were to play an important role in the orientation of treatment throughout the process of deinstitutionalization.

So, however, did the techniques of social psychiatry.(6) There was a general shift towards finite treatment which provided quicker results. The use of psychotropic drugs in treatment was part of this shift. Drugs also contributed to the discharge of long term custodial patients by providing a new, efficient means of restraining them for easy management.

In this respect drugs (and other technologies) largely superseded mechanical restraint, locked wards and straitjackets. However, the crucial factor in the discharge custodial patients was not so much having techniques for efficient management (these were, after all, older and cruder techniques) as having somewhere else to send them. The pace of the discharge of long-term custodial patients in Ontario was directly related to the development of residential units and homes for Special Care, and not to the introduction of new technologies.7

In short², drugs facilitated deinstitutionalization but did not create it. The deinstitutionalization of psychiatry was paralleled by a similar process in other services (e.g. prisons, mental retardation services) in which drugs played a much less significant role (Scull 1977:85). The timing of deinstitutionalization varied across nations, and in many countries (e.g. Italy, France) cannot be related to the introduction of drugs (Sedgwick 1982:197-199).

Deinstitutionalization was an overall reorientation of the mental health system which included changes in treatment (drugs, social psychiatry), legislation, arrangements for custodial care,

and so on. These changes were all founded on a common logic: the shift in mental health services towards the treatment of people capable of functioning in the community through the separation of treatment from custody. Deinstitutionalization must be explained in terms of this overall logic, rather than in terms of specific changes taken in isolation and given explanatory import.

There is another view of the overall logic of deinstitutionalization which has received considerable attention in the literature. This perspective stresses the role of the libertarian critique of institutions in pressuring psychiatry to attenuate its most coercive tendencies and increase the freedom of patients. The reduction of mental hospital populations is equated with freeing patients from oppressive incarceration (for better or for worse).

The libertarian critique of institutions was developed in the late 1950's and 1960's through the works of Szasz, Cooper, Goffman and Laing. While these works were very different from one another, they all viewed psychiatry in terms of the polarity between freedom and oppression. Psychiatry was viewed fundamentally as a coercive socialization apparatus which incarcerated non-conformists in order to reshape them into 'normal' citizens.

The libertarian critique has profoundly influenced the way people see the psychiatric system. This has had decided benefits, particularly through calling into question the objective nature of mental illness and the institutions developed to deal with it. (8) At the same time, the influence of the libertarian critique has tended to reduce issues around psychiatry simply and exclusively to

the polarity between freedom and oppression.

The freedom/oppression polarity has had two particularly negative effects. On the one hand, through reducing all psychiatric services to oppression it undercuts the legitimacy of any demand on the state for decent mental health care (Sedgwick 1982: 40-41). On the other hand, it implies that less mental health care can be equated with more freedom.

The retrospective analysis of deinstitutionalization has been very much informed by the libertarian critique of institutions. Deinstitutionalization is often seen as a recognition of the rights and freedoms of psychiatric patients in response to the libertarian critique and a few significant legal cases in the United States during the 1960's. (9) The common thread linking many of the supporters of deinstitutionalization (who hail the liberation of patients) and many of the opponents (who see patient 'condemned to freedom') is the polarity between freedom and oppression.

The freedom/oppression polarity has been imposed after the fact on deinstitutionalization. The major trends that were to mark deinstitutionalization until 1975 were established between the end of World War II and the early 1960's. The libertarian critique became influential after these trends were established, later in the 1960's.

"Freedom", as such, was not a consideration in the Dymond report. Rather, the reduction in the use of coercive methods (locked wards, involuntary commitment) was seen as part of a reorientation towards more effective treatment. The same was true

in the 1880's, when the disuse of coercive methods was linked to patient employment programmes. In general, the experience of the asylum reforms and of deinstitutionalization seems to indicate that the mental health system can be less overtly coercive when it is providing effective treatment which is linked, in the view of both patients and staff, to a return to the community.

The discussion of freedom and oppression in abstraction from the goals and effectiveness of psychiatric treatment doesn't clarify the issues. One of the most important effects of deinstitutionalization has been a dramatic increase in the proportion of patients who are admitted minimally custodial treatment on a voluntary basis. It is not sufficient to simply explain this away, as Friedenberg (1975 :20) does:

The hospitalization of the mentally ill is a service to ... others, not to the patient; a presumption which is almost self-evident when commitment is involuntary, but which is likely to remain true even of patients who commit themselves voluntarily, since this is usually done only under intense social pressure.

It is beyond the scope of this paper to investigate the process through which voluntary patients arrive into treatment. However, there is no reason to speculate from the outset that voluntary patients are really just involuntary patients who have been pressured rather than legally compelled to seek treatment. Rather, it is important to identify the circumstances under which patients might voluntarily consent to treatment which is at once the best option they have and possibly also a 'service to others.' (10)

The issues of freedom and social control in psychiatry are

important. The libertarian critique has added a new dimension to the investigation of psychiatry by raising these issues. However, if the examination of these issues is to be truly meaningful it must be in terms of the specifics of treatment and general social conditions.¹¹

The libertarian critique of institutions profoundly influenced the way in which critics and policy-makers viewed the psychiatric system. However, this influence was achieved in the late 1960's and early 1970's, after the process of deinstitutionalization was well underway. The libertarian critique called into question the power relations in psychiatric care and the loss of self through treatment. At the same time, the crucial issues of adequacy of care and the process through which the nature of care was socially determined were neglected.

In summary, the essential feature of the process of deinstitutionalization was a turn towards the treatment of people capable of functioning in the community accomplished largely through the separation of treatment from custody. Specific therapeutic or technological advances within psychiatry cannot fully explain either the nature or the timing of this turn. Nor can it be explained exclusively in terms of a developing concern for the freedom of patients.

The key to understanding this turn has lies not in specific developments within psychiatric theory and practice; but in a general characteristics which has shaped the mental health system from the outset. The asylum was a state institution, the

product of social policy. The turn towards deinstitutionalization was part of an overall shift in state social policy which began in the 1940's: the development of the welfare state.

End Notes

1. The asylum never completely replaced the jail as a place to incarcerate insane people. Hurd (1916b:146-150) pointed out that insane people were frequently sent to jail when asylums were overcrowded. This trend has continued; in September 1984 Dr. Don Craigen director general of medical services for Canada's prisons announced that an increasing number of mentally ill people are showing up in jails as the result of the closing of mental hospitals (Block 1984:58c).

2. These employment programmes were also of great benefit to the asylums. Many of the patients were employed in asylum farms, workshops, kitchens or wards doing labour necessary to sustain the institution (e.g. Tuke 1885:213,222,229). This labour was performed without pay, though extra food and beer were provided to working inmates (e.g. *ibid*:225). There is no way to assess the relative importance of the therapeutic value of work in comparison with the cost-saving aspects of patient labour in retrospect.

In any case, the asylum was preparing people to work for others, who ultimately appropriate the product of labour. The discipline of the capitalist labour process was therefore reproduced within the asylum, hence work and exploitation were inseparable. The actual labour process in the asylum was closer to slavery than to wage labour, which left patient employment particularly open to criticism. What is most important for our purposes here is that any consideration of productivity or work

habits under capitalism must immediately raise the question of exploitative relations of production.

3. The issue of overcrowding requires more attention than I can give it here. To begin with, it would be valuable to examine concretely how the increasing recovery rate of patients during the 1880's got turned around. Was streaming eliminated due to the demand for beds for long term custodial patients? Was the staff stretched too thin to supervise patient employment? Did asylums fill up with severely impaired patients, or was it in some cases people who might have been able to return to the community who became long-term custodial patients.

It would be helpful, in order to explain overcrowding, to better understand both the rhythm of patient population increases and the rhythm of government asylum development. For example, Brenner (1973:32) contends that there has been a consistent statistical relationship, through the history of the asylum in the United States, between increases in admissions to mental hospitals and increased unemployment. It may be that economic downturns were also the time at which asylum development was slowest, and so patient accumulation was particularly high.

In any case, this is not a matter on which I will speculate at this time. Generally, overcrowding is explained in terms of the finite capacity of buildings and the increasing number of patients. It would be useful to understand why these buildings weren't expanded rapidly enough and, conversely, why the number of patients continued to climb.

4. The issue of public attitudes towards mentally ill people and their role in determining the shape of mental health services is rather more complex than this summary statement indicates. In general, it would appear that coercive treatment of the mentally ill and public fear both play on each other.

The forbidding presence of the asylum certainly broadcast the message that the people inside were to be feared. The asylum in Dartmouth Nova Scotia, for example, had a siren on the roof to alert local residents when an inmate escaped (The Globe and Mail, Jan 2, 1984). This certainly must have contributed to fear of the insane.

More recently, the issue of public attitudes has appeared in relation to community residential care. It is not sufficient to simply dismiss these fears as ungrounded. The social process through which fear of the mentally ill is generated requires further investigation.

5. There has, in other words, been a substantial change in the basic definition of mental illness. Klerman (1982:178) stated that the sixfold increase in the utilization of mental health services (in the United States) over the past twenty five years does not indicate an increase in the prevalence of mental illness. The majority of the potential clientele for mental health services (which he estimates at 15 per cent of the U.S. population) suffered from states of alcoholism anxiety or depression (ibid: 192-3). In contrast, a census cited Tuke (1885: Appendix C) estimated that the proportion of insane people in the population

of the United States was 1 in 545 (or 0.2 per cent). Outpatient services generally serve a population who would never have been considered as insane in the 19th century.

6. Social psychiatry essentially emphasized the enhancement of functioning skills to deal with life conditions (e.g. work, relationships) which can be stressful and difficult. It developed largely out of military practice for two reasons. First, the shortage of military manpower meant that the pressure on military psychiatry was to keep people in the ranks as much as possible. (Hastings Centre Report 1978:3). Secondly, because the external sources of mental health problems were so evident in a military setting (Hargreaves 1957:449). These lessons were applied to civilian psychiatry after the War.

7. For example, Allodi and Kedward (1973:286) note that the decrease in the population of Queen St. Mental Health Centre in Toronto was almost the same as the population of Homes for Special Care: "This suggests the possibility that many patients had merely been transferred from the hospital to the Homes for Special Care." See also Section 2.2 of this paper.

8. In the words of Peter Sedgwick (1982:25), the central tenet of the libertarian critique was: "Mental illness is a social construction; psychiatry is a social institution incorporating the values and demands of its surrounding society."

9. These landmark cases include: a case in Alabama defining minimum standards of care which, in the absence of funds for improvements, mandated the release of thousands of patients

(Basruk & Gerson 1978:52); and litigation by the Civil Liberties Union in New York to establish mental patients' rights (Sedgwick 1982:215).

10. Weinstein (1982:142) found in a survey of quantitative studies of patient views of hospitalization that they generally show a favourable response to treatment in mental hospitals. Of course, this requires a more elaborate examination than I can present here. But in general, it is a useful corrective to presumptions that patients are simply passive objects treated against their best interests under duress.

11. It is not sufficient, in other words, simply to assert that psychiatry is an agency of social control. Szasz (1970:30) wrote:

Is so-called mental health work "a logical extension of traditional medical practice", either preventative or curative? I say it is not a logical but rhetorical extension of it. In other words, the practice of mental health education and community psychiatry is not medical practice, but moral suasion and political coercion.

Szasz, then, contends that it is a specific quality of psychiatry, as opposed to medicine, to be engaged in moral suasion and political coercion. At the bottom of this is a basic premise that physical medicine deals with objective problems (e.g. diseases, etc) while mental health deals with subjective problems (i.e. moral questions of conformity and non-conformity).

The reality of mental illness and the social construction of physical health are simultaneously denied. Social control is seen as an exceptional feature of psychiatry. Yet, this vision

of social control is neither concretely related to specific forms of psychiatric practice nor generally located in the context of class society.

The libertarians made an important contribution to the understanding of psychiatry through raising the issue of social control. However, the boundary that they have erected between coercive psychiatry and objective physical medicine obscures the real issues. It is only by setting the whole question of health care in the context of class society that the coercive aspects of psychiatry can be understood.

Unfortunately, it will not be possible to present a fuller assessment of the libertarian critique here. The libertarian critique largely established the terrain for the retrospective analysis of deinstitutionalization, and it is important to understand it for that reason alone. The weaknesses of the libertarian critique (particularly the absence of any recognition of treatment as such have been reproduced in much of the literature on deinstitutionalization.

Section 3.2: Deinstitutionalization and the Welfare State

The deinstitutionalization of mental health services cannot be explained exclusively in terms of developments within psychiatric theory and practice. From the outset, the mental health system has been a state institution, a product of social policy. The key to understanding shifts in the mental health system is to set them in the context of the changing social policies within the state.

Once mental health services are seen as a product of state social policy they can also be located in the context of prevailing social relations. State social policy isn't formulated in a vacuum, but in response to specific conditions and struggles at a given moment in the development of capitalist society. Deinstitutionalization must therefore be viewed as part of an overall reorientation of state social policy in response to changing social conditions. This will provide a basis for explaining both the primacy of custody in the asylum and the separation of treatment from custody through deinstitutionalization.

3.2.1. The Asylum and Custodial Relief.

The asylum was one of a range of custodial institutions developed by the state during the 19th century. These institutions (e.g. asylums, orphanages, workhouses) tended to serve a dual purpose: the provision of custodial relief to a destitute population defined by certain criteria (e.g. age, disability); and the provision of some form of treatment to promote a return to community life. All of these institutions were characterized by the primacy

of the former (custodial) purpose over the latter (treatment).

The first custodial institution in Ontario (Upper Canada) was the jail. In 1792, when the main body of English civil law was adopted in Upper Canada, the Elizabethan poor law was excluded (Guest 1980:12).(1) Incarceration in jail on vagrancy charges was the only form of state relief for the destitute. In addition, legislation was passed in 1930 to incarcerate destitute insane people in jails (Splane 1965:203).

Gradually, beginning in the 1830's, new institutions were developed to complement the jail. The first was the House of Industry, which offered relief in exchange for work.(2) In the 1840's and 1850's, the first insane asylum and orphanages were developed. The development of these new institutions reflected on increasing tendency towards specialization and the provision of treatment or training.

The House of Industry was specialized only insofar as it was distinctly a relief institution. The extent to which work in a House of Industry could be considered as training for outside employment (as opposed to a condition of incarceration) is debatable. The insane asylum was more clearly specialized and did offer treatment. The orphanages had selective admission policies (excluding "bastards, infants, epileptics, defectives and delinquents"); and provided both general instruction and job-related training (Rooke & Schnell 1983:81, 74-5).

Custodial institutions dominated relief for the poor in the 19th century, persisting in some forms until after World War II.

The primacy of custody in relief was founded on two principles. Relief was only to be offered to the 'deserving' poor, who were distinguished from the 'undeserving' on the basis of established criteria such as age or illness. This relief was to be offered in such a form that it would not provide an attractive alternative for even the lowest paid worker.(3)

The imperative shaping social policy in this period was the reinforcement of the compulsion to work. Relief was to offer neither a supplement nor an alternative to the wage. There was to be a hard line drawn between the private sphere of the capitalist labour market, in which able-bodied workers earned their subsistence exclusively from the sale of their labour-power for wages; and the public sphere, in which people who were unable to work according to established criteria might obtain custodial relief.

The line between private and public was much firmer in principle than in practice. The capitalist labour market could not consistently provide for the subsistence of all able-bodied people of working age. In Canada, the seasonal nature of some industries meant that inevitability of winter unemployment had to be acknowledged (Guest 1982:15). More generally, the cyclical nature of the capitalist economy necessarily created conditions in which able-bodied people could not obtain work.

The inevitability of periodic unemployment for a certain proportion of the able-bodied population of working age was not overtly acknowledged until after World War II. However, various forms of non-custodial (outdoor) relief were offered, generally on

an ad hoc basis. As early as 1846, provision was made for municipal outdoor relief in Ontario (Splane 1846:73). The established criteria (e.g. age, illness) for distinguishing between deserving and undeserving poor began to give way to the distinction between real needs and fraud.(4)

The hard distinction between public and private began to break down in another direction as well. The state gradually began to assume responsibility for the development and maintenance of workers who were suitable for the capitalist labour market. The treatment of the insane and the training of orphans could arguably be viewed in this way, as well as the introduction of free primary education and public health programmes.

The movement towards deinstitutionalization began quite early in some services. The establishment of the first Children's Aid Society in Toronto signalled the beginning of a process of deinstitutionalization in orphanages which was not completed until the welfare state was firmly established after World War II.⁶ (Rooke and Schnell 1983: 219, 408).

The polarity between public custodial relief for those meeting established criteria and private labour market relations for the able-bodied began to break down almost as soon as it was established. However, the principle of separating deserving from undeserving and private from public remained the ideological foundation of social policy until the development of the welfare state after World War II.

Scull's (1977:129-130) account of the primacy of custody in the

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asylum provided the basic framework for this argument. He located the asylum as one of a range of custodial relief institutions developed in response to the conditions of the capitalist labour market. The weakness in his account is that he does not offer an explanation of treatment in the asylum in terms of the same conditions. This weakness becomes a central problem in his account of deinstitutionalization as he is left with no basis for understanding the reorientation of mental health services towards treatment. (5)

The asylum had a dual character as a custodial and treatment institution. The primacy of custody in the asylum was a product of social policy in response to capitalist labour market conditions. The primacy of custody gave rise to the accumulation of long-term custodial patients (who had no where else to go) and undercut the effectiveness of treatment programmes (largely through overcrowding).

The development of specialized custodial institutions which offered some form of treatment or training was just as much a product of social policy. It reflected a secondary tendency towards state intervention to develop and maintain a supply of suitable workers. With the establishment of the welfare state, this secondary tendency was pushed to the forefront of social policy, and so mental health services were reoriented towards treatment.

3.2.2. Deinstitutionalization, The State and Labour-Power

The imperative shaping social policy before World War II was the sharp distinction between deserving poor, who were incapable

of working, and undeserving poor, who were to be compelled to work. There was, at least in principle, a strict demarcation between the public sphere of relief for the deserving and the private sphere of the capitalist labour market. Workers and their families were to rely exclusively on wages for subsistence.

This sharp distinction was untenable almost from the outset. The inevitability of periodic unemployment for a proportion of the able-bodied population necessitated various forms of ad hoc (and generally insufficient) public assistance. The requirement for suitable workers led to a range of state interventions (e.g. education, health) into the supposedly private sphere. However, the line of demarcation between the private reproduction of labour-power and the public relief of the young, old and incapacitated remained the fundamental ideological premise of social policy until the welfare state was established.

The asylum was therefore primarily an institution for the custodial relief of people suffering from some combination of destitution and mental illness. Secondly, it was to provide treatment to produce suitable workers (for both wage-labour and domestic labour).⁽⁶⁾ The emphasis on employment programmes in asylum treatment reflects this orientation to the development and maintenance of workers capable of working.

The orientation of social policy changed dramatically with the establishment of the welfare state after World War II. A range of programmes were introduced (e.g. health, education, income maintenance) which developed or maintained workers who were suitable

for the requirements of the labour market. At the same time, relief for non-workers was shifted onto a non-custodial (i.e. cash payments) basis.

The deinstitutionalization of mental health services was part of this dramatic shift in social policy. The separation of treatment from custody was made possible by the development of generic welfare programmes which created an alternative means of maintaining long-term custodial patients. The reorientation towards treatment for functioning effectiveness placed the mental health system in a range of services aimed at enhancing worker productivity.

Like deinstitutionalization, the welfare state was not created all at once, by decree. Rather, it consisted of a variety of new or expanded programmes introduced by all three levels of government during the period (roughly) between 1940 and 1975. These programmes were linked insofar as they represented a reorientation of state social policy away from custodial relief for the deserving poor towards: (1) increased intervention in the development and maintenance of workers (the reproduction of labour-power) and (2) non custodial welfare payment relief for non-workers. In addition, the line between workers and non-workers was increasingly regarded as permeable.

The welfare state was at once an intervention to create the conditions for capitalist production and a product of class conflict. The state acted in the interests of the capitalist class (though not every capitalist) by establishing the terrain for production in a way that competing enterprises could not. At the same time, the state

was responding to workers' struggles for improved standards of living.(7)

Gough (1979:44-5) characterized the welfare-state as: "... the use of state power to modify the reproduction of labour power and to maintain the non-working population in capitalist societies". The basic means used by the state are: (1) the provision of payments (welfare, unemployment insurance) or services (hospitals, schools), (2) the use of the taxation system (child tax credits, tuition deductions) and (3) the state regulation of employers and individuals (minimum wages) (ibid, examples added).

The welfare state was established at roughly the same time throughout the developed capitalist nations (though with significant variations). Welfare state programmes were introduced by governments of both social democratic complexion (the CCF in Saskatchewan) and conservative (the Progressive Conservatives in Ontario). The welfare state was a response to a set of problems created for capitalism by the conditions of economic boom, including: labour shortage; the need for certain kinds of skilled labour; and periods of intense class struggle in the 1940's, later 1960's and early 1970's.(8)

The welfare state is best understood as a modification to the way in which labour-power was reproduced under capitalism. Workers under capitalism sell their labour power (capacity to work) for a definite period of time to capitalists who own or control the means of production. In exchange for their labour-power workers receive a wage which represents the value of labour-power, the cost of

maintaining workers and their families at the socially determined level of subsistence. It is a specific quality of labour-power that when put to work it can produce more than its value, and this surplus-value is appropriated by the capitalist.

Before the development of the welfare state, the essence of social policy was to leave the reproduction of labour-power (the development and maintenance of workers) to the private exchange between capitalists and workers. The dramatic shift represented by the welfare state was that a portion of the costs of reproducing labour-power was "socialized", assumed by the state. The wage paid by the employer then represented part of the value of labour power, while the rest (the "social" wage) was made up by the state in the form of payments or services.

The state intervened in the reproduction of labour-power in order to meet the qualitative and quantitative needs for labour-power created by the post-war boom. The welfare state was also a means for meeting the rising aspirations of workers (expressed in increased strike activity in the 1940's, 1960's and 1970's) while bypassing conflict in the workplace by substituting concessions to the class as a whole for collective bargaining in individual enterprises.

The state took on some of the responsibilities from meeting the need for labour-power created by the post-war boom because individual employers could not (or would not) do so (Jones & Novack 1980:149). The need for labour-power was met in part by increasing the size of the labour force, through immigration and

a dramatic increase in the proportion of women in wage labour (Harman 1982:65-6). This alone was not sufficient. It was also necessary to enhance productivity through education (developing skills), health services (minimizing lost days) and income maintenance programmes (providing security to increase morale and reinforce discipline) (ibid:66-8).

The welfare state was not exclusively an intervention in the reproduction of labour-power to enhance productivity. It also involved a major shift in the way the state provided for non-workers, the population who had previously received custodial relief in institutions. Cash payments through generic welfare programmes became the predominant form of relief to non-workers. These payments tended to be set at a low enough level to deter workers from seeking an alternative to the wage, reproducing to some extent the gatekeeping function of the institution.

The deinstitutionalization of the mental health system was part of the shift in social policy represented by the development of the welfare state. The primacy of custody was ended, and long-term custodial patients were discharged into separate institutions where their subsistence was provided through generic welfare programmes. Mental health services shifted towards the productivity-enhancing treatment of people capable of returning to the community, that is workers and potential workers (including women raising children).

The reorientation of treatment towards the development of functional skills on a minimally custodial basis was, in essence,

the enhancement of productivity. Activity therapy, and particularly vocational training, prepared people for work. This both met the immediate requirement of equipping patients for self-sufficiency in the community and created a much-needed supply of labour-power in the conditions of the boom. At the same time, minimally custodial treatment created the least possible disruption to working or child-rearing time.

Deinstitutionalization, then, was part of the reorientation of social policy through the development of the welfare state. It was not caused by the welfare state as an external phenomenon. The mental health system was one of a range of social services which were transformed in order to meet new state policy goals established in response to the conditions of the boom. Deinstitutionalization was, as Dymally (1959:289) claimed, 'geared to the needs of the times', though I'm not sure he meant it as I do.

This account of deinstitutionalization can be clarified through the examination of two other explanations which are in some ways similar. Scull (1977) explains deinstitutionalization in terms of the welfare state, but he sees it as a cost-saving measure in response to fiscal crisis rather than a reorientation towards productivity enhancement. Ralph (1983) sees deinstitutionalization as productivity-enhancing, but primarily in terms of the coercive control workers to restrain class struggle and cope with the dehumanizing environment of the workplace.

Scull's 'decarceration' thesis linked deinstitutionalization

to the development of the welfare state. However, he sees it as a cost-saving response to a 'growing fiscal crisis' produced by the welfare state (1977:135). He emphasized the reduction in the population of mental hospitals which cut costs through the cancellation of construction, the reduction in beds, selective admissions, and so on (ibid:139-140). The reorientation of treatment towards those capable of returning to the community was seen as "...clearly the most desirable approach on cost-effectiveness grounds" (ibid:147).

As the economic downturn hit in the later 1970's and 1980's, deinstitutionalization did indeed become a pretext for cutbacks. However, the first period of deinstitutionalization, lasting roughly until the mid-1970's, took place in the context of economic prosperity. Sedgwick (1982:202) pointed out in response to Scull that deinstitutionalization began during the boom when "...the fiscal crisis of the state' had not been discovered by any economic researcher".

Before the economic crisis, deinstitutionalization was not simply a pretext for cutbacks. It involved a considerable increase in expenditures through which the mental health system was substantially expanded. New facilities were developed (outpatient clinics, psychiatric units of general hospitals, community psychiatric hospitals and even new mental hospitals) and old ones were extensively restructured and renovated. Admissions climbed dramatically, and these were largely made up of less seriously impaired people who were more likely to be capable of returning to the community. The number

of staff in mental hospitals continued to rise, even as the population declined.

Scull basically reduces deinstitutionalization to the decline in the mental hospital population which he sees as basically a cost-saving measure. This is in part because he found his analysis of social conditions on an economic theory (O'Connor) which dates the 'fiscal crisis of the state' back to the period of the long boom. But more significantly, it is because his framework, from his account of the asylum onwards, provides no basis for locating mental health treatment in the context of social policy. This thesis is one-sided, explaining custody and its decline but essentially neglecting treatment.

The central problematic for social policy during the period of the long boom was the supply of a sufficient quality and quantity of labour-power. The welfare state was a means of supplying this labour-power, while secondarily providing subsistence to non-workers. The welfare state required an increase in state expenditures (e.g. Guest 1980:173-174). Specifically, state health expenditures in Canada increased from 1.60% to 3.20% of the Gross National Product between 1949-1968, or from less than three hundred million dollars to almost three billion dollars (Task Force on the Costs of Health Services 1975:425).

The reorientation of mental health services towards treatment was part of the shift in social policy to deal with this central problematic. Mental health care, like health care in general, was a way of keeping workers fit to produce. It was only when the

economic crisis created a labour surplus that mental health expenditures were reduced, as the premium on fit workers declined.

Scull seems to share with the libertarian critique a basic reluctance to place mental health services in the general context of health care. Mental health services, like physical medicine, provide treatment according to socially-defined standards of health. Rather than regarding psychiatric treatment as exceptional we should concentrate on: (1) how standards of health are socially determined (which is generally beyond the scope of this paper) and (2) why health care becomes a priority for social policy at particular moments in the development of capitalism.

The major theme in the Dymond report was the transformation of the mental health system from a primarily custodial service to an active treatment service. The evidence of the following years indicates that Dymond meant what he said. Mental hospitals were modified and new services were developed or expanded in order to provide minimally custodial treatment to return people to the community, to job, home and neighbourhood. This is completely consistent with the general orientation of social policy during the period of the economic boom.

Ralph, in contrast to Scull, emphasizes the productivity-enhancing aspects of deinstitutionalization. However, she does not see psychiatric treatment as a means of achieving socially-defined standards of health and hence producing fit workers. Rather, she sees psychiatric treatment as an exceptional form of social control.

The labour theory proposes that community psychiatry developed primarily to control the productivity-damaging

side-effects of worker alienation." (1983:45)

Ralph (1983:43) sees that services to employable people were expanded through deinstitutionalization. However, she conceives of psychiatric treatment as a direct service to capital, either as an intervention in the class struggle to quell troublesome workers (ibid:1983:93-5); or as "a means of controlling workers in the stressful workplace (ibid:133).

Ralph separates out psychiatric treatment from health care, seeing it as a distinct apparatus of social control in the interest of capital. This, does not correspond with the apparent beliefs of policy-makers, mental health workers or (voluntary) patients that psychiatry is a form of treatment towards socially defined standards of health. If Ralph wanted to show that this belief was only an appearance obscuring an underlying reality, she would have to provide a specific account of how the appearances derive from the reality.

This, however, is not necessary. The maintenance of workers at socially-defined standards of health was, in itself, a priority for social policy in the conditions of the economic boom. Healthy workers are quite simply more productive than unhealthy workers. This applies both to physical and mental health. Thus capital's interest in healthy workers and workers' interests in their own health can converge at particular moments in the development of capitalism.

Capital and labour both have an interest in the reproduction of labour-power: Capital, because labour-power is the basis of

value; and labour, "because they are themselves the bearers of that labour-power" (Urry 1981:118). In other words, capitalism needs workers (in varying quantities and qualities) while workers need to survive. Social services can, to some extent, meet both needs at the same time. However, the standard of living which workers require to survive is established through class struggle. There is no optimum level of services which can consistently meet the needs of both capital and labour.

Clarke (1983:119) stated that the 'fundamental contradiction' of the capitalist mode of production' was:

In reproducing itself capital also reproduces the working class, but it does not reproduce the working class as its passive servant, it reproduces the working class as a barrier to its own reproduction.

In developing and maintaining workers, capital is reproducing an active and antagonistic class. The temporary coincidence of interests is only a moment in an ongoing struggle.

To return to mental health services, this means that the psychiatric system can fulfill the need for productive workers through providing treatment towards socially determined standards of health. On the other side, patients (who are generally, in state mental services, either working class or not employed) may actively consent to treatment which will make them healthier. However, this apparent convergence can only be understood in the context of the ongoing struggle to determine social standards of health: that is, those workers can only hope to be "healthy" according to standards arrived at over the years (in struggles over health, living standards,

etc.) (9)

Mental health services developed through the process of deinstitutionalization may have been sufficient to produce healthy workers. They did not, however, provide treatment to maximize the performance of patients who could not work. Even those workers who were able to return to work may be felt that serious questions of personal well-being were not addressed. The conflict between various standards of health, as defined by the priorities of capital and as self-defined by workers, is one feature of the ongoing class struggle. It was beyond the scope of this paper to examine this conflict in any depth.

Deinstitutionalization, then, was a serious shift towards treatment in mental health services. It was part of an overall reorientation of social policy through the development of the welfare state. Upgraded mental health treatment was part of a general intervention by the state to develop and maintain workers suitable for the conditions of the economic boom. At the same time, the welfare state provided an alternative means of caring for long-term custodial patients.

This explanation would be strengthened through examining the second phase of deinstitutionalization during the economic crisis. During the economic crisis, the priorities of social policy shifted. The conditions of labour surplus and falling profits created a situation in which many features of the welfare state are being eroded. It would seem that recent cuts in mental health services would fit into this context. That, however, is a subject for further

work.

It is not necessary, then, to conceptualize psychiatric treatment as an exceptional apparatus of social control. Rather, our attention should be focused on two issues: the struggle to determine social standards of health, and the process by which health care becomes a priority for social policy at particular moments. This paper has attempted to offer an explanation for the latter, while the former remains to be addressed.

End Notes

1. The Elizabethan poor law provided not only for custodial relief in workhouses, but also for a supplement to wages under certain conditions. This law was changed in the 1830's to exclude wage-supplements.
2. The first Houses of Industry established in Ontario were not actually state institutions. Legislation passed in 1837 to provide for the development of Houses of Industry was never implemented (Splene 1965:72). Private Houses of Industry were developed in Toronto (1836) and Kingston (1814) which did receive state funding (Rooke and Schnell 1983:79-80). Beginning in 1866, municipal Houses of Refuge were developed (Splene 1965:98-110). These were completely state-run workhouses.
3. This second principle was enshrined in British poor law as the principle of 'less eligibility'. It decreed that the standard of living of relief recipients must be lower than that of the lowest paid worker (Guest 1982:36).

While not given formal recognition in Canada, the principle of less eligibility pervaded the administration of public assistance to the poor from the outset. (ibid).

4. Guest (1982:37) gives some examples of the criteria for establishing real need which show that relief was still to be made unpalatable. In 1915, for example, an applicant for relief at the Toronto House of Industry had to break up a crate of rocks weighing 650 lbs.
5. This argument will be taken up in Section 3.2.2 I am not

claiming that Scull simply dismisses treatment, and he is moving to address the issue (e.g. 1983:132-4). However, he tends to sever the consideration of the primacy of custody from the analysis of treatment.

Nor do I claim in any way to have offered a comprehensive account of treatment in the asylum. I have tried to show that the asylum had a dual character, as a custodial (primary) and treatment (secondary) institution. Both sides must be explained in any account. If the state was constrained to providing custodial relief by the conditions the capitalist labour market, it was at the same time moving hesitantly in the direction of developing and maintaining suitable workers for that labour market through free education, public health and treatment or training in custodial institutions.

6. For the purpose of this paper, the labour of women raising children in the household and the wage-labour of men and women in workplaces will both be considered necessary for the reproduction of capital without any clear distinction to be made. This means that the specific role of psychiatry in the oppression of women will not receive sufficient attention. Nor will the relationship between deinstitutionalization and the increasing participation of women in wage-labour be examined.

There are volumes written on the relationship between domestic labour and wage-labour. To simply gloss over this distinction is, admittedly, a theoretical simplification. However, I contend that is not misleading to see mental health services as developing and maintaining both wage workers and domestic workers - and contributing

the perpetuation of capitalist relations on both counts. The family form of reproduction is not the only form theoretically compatible with capitalism, but it has been the form of preference. It is central to the family form of reproduction that wives and mothers be in sufficiently good shape to carry out their labours, just as wage labourers must be healthy enough to go to work.

7. This paper cannot provide an account of the process through which the needs of capital are translated into state policy. This paper is simply attempting to establish that the development of the welfare state (and specifically the deinstitutionalization of the mental health system) was a response to specific historical conditions which furthered the interests of the capitalist class (or at least a powerful section of that class). This is satisfactory only as a provisional solution, raising questions as much as answering them.

There is a process through which the decisions of policy-makers (such as Dymond) on the basis of medical rationale are at the same time responses to specific class interests under given conditions. For the purposes of this paper, this process must simply be identified as an unanswered question, on absence to be filled through further work.

8. I do not intend (for the purposes of this paper) to weigh these factors against each other, nor to elaborate on the process through which the state responded to changing social conditions.

9. To complete this discussion it would be necessary to consider in detail the process through which standards of health are socially determined. While that is not possible here, the basic direction for such

a consideration can at least be outlined.

The basic premise of this approach is that standards of health are not established according to eternal, objective criteria but according to changing, socially-constructed norms. As Sedgwick (1982: 30) wrote: "... there are no illnesses or diseases in nature." Humans do not discover illness, they construct it. Illness is a specific form of deviance from social norms (ibid:32). These norms vary through history and across cultures.

The second premise is that these social standards of health are determined through a political process reflecting the basic distribution of power in a given society. In a capitalist society, this means social standards of health are determined largely through antagonistic class relations.

In general, social standards of health in a capitalist society can be subsumed in the larger issue of workers living standards. Health is one of the areas of contention in workers' struggles for negotiated on a class basis through the collective bargaining process (e.g. health and safety issues, sick leave, paid maternity leave, insurance benefits, dental plans). At the same time, standards of health care are determined by state interventions to reproduce labour-power, which are shaped in response to economic conditions and class struggles.

So, the general level of health care can be considered as one aspect of workers' living standards determined directly or indirectly through class struggle. At the same time, there are other levels of negotiation determining social standards of health. For example, the

social definition of the 'healthy women' in a capitalist society directly reflects the oppression of women. The women's liberation movement has directly challenged these standards of health, in areas ranging from reproductive freedom to overdrugging in psychiatry. Similarly, the definition of homosexuality as a mental disorder is product of the oppression of gay people. The gay liberation movement has directly struggled to develop standards allowing for the notion of a healthy gay person.

In summary, it is not enough to state that standards of health are socially determined and changeable. The social construction of health is political process, the product of (in capitalist class society) relations of exploitation and oppression. The establishment of particular standards of health reflects antagonistic class interests as well as struggles around oppression. The process through which given social relations are translated into notions of health and illness is an area for further work.

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