

A House Divided: Deinstitutionalization, Medicare and the Canadian Mental Health Association in Saskatchewan, 1944–1964

GREGORY P. MARCHILDON*

Defined as a set of distinct processes that included the declining use of large psychiatric institutions and the increasing use of outpatient services and general hospitals, deinstitutionalization occurred earlier in Saskatchewan than other provinces in Canada. It was led by a CCF government dedicated to major change across a number of sectors including mental health, assisted by one of the most influential and well-organized social movement organizations of the 1950s, the Saskatchewan Division of the Canadian Mental Health Association (SCMHA). However, by the late 1950s and early 1960s, the SCMHA opposed the CCF government's policy priority on medicare which it felt came at the expense of mental health care, in particular the implementation of a regional psychiatric hospital system called the Saskatchewan Plan. As a consequence, the SCMHA, once such a powerful ally of the CCF government in health reform, formed a strategic and temporary coalition with the anti-medicare forces in the province. Given the fact that a number of medical staff within the government's department of public health were prominent members of the SCMHA, the CCF government found that it occupied an increasingly divided house at the very time it was struggling to introduce medicare in the midst of civil unrest and a doctors' strike.

Définie comme un ensemble de processus distincts comprenant le recours déclinant aux grands instituts psychiatriques et celui croissant aux services de consultations externes et aux hôpitaux généraux, la désinstitutionnalisation s'est produite plus tôt en Saskatchewan que dans toute autre province au Canada. Ce mouvement était orchestré par un gouvernement CCF (Fédération du Commonwealth coopératif) qui s'était donné pour mission d'opérer un virage fondamental dans un certain

* Gregory P. Marchildon is the Canada research chair in public policy and economic history, at the Johnson-Shoyama Graduate School of Public Policy, University of Regina. The author greatly benefited from the reviews and assessments provided by Erika Dyck, Angela Scott, Colleen Walsh, and the journal's two anonymous reviewers. He is most grateful to Jessica Benjamin for her extensive and expert research assistance.

nombre de secteurs, dont celui de la santé mentale, et qui jouissait en l'occurrence du soutien d'une des organisations les plus influentes et les mieux organisées du mouvement social des années 1950, la division de la Saskatchewan de l'Association canadienne pour la santé mentale (ACSMS). Mais à la fin des années 1950 et au début des années 1960, l'ACSMS s'opposa au choix stratégique qu'avait fait le gouvernement CCF d'accorder la priorité à l'assurance-maladie, estimant que la mise en place d'un tel régime se faisait aux dépens des soins de santé mentale, allant particulièrement à l'encontre de la mise en œuvre d'un système d'hôpitaux psychiatriques régionaux appelé le Saskatchewan Plan. C'est ainsi que l'ACSMS, jadis un si puissant allié du gouvernement CCF dans la réforme de la santé, forma une coalition stratégique temporaire avec les opposants au régime d'assurance-maladie de la province. Comme d'éminents membres de l'ACSMS faisaient partie de l'effectif médical du ministère de la Santé publique de la province, le gouvernement de la CCF en vint à régner sur une maison de plus en plus divisée au moment même où il s'évertuait à instituer l'assurance-maladie sur fond d'agitation sociale et d'une grève des médecins.

THE TREATMENT of mental illness changed fundamentally in the three decades following the Second World War. For almost a century before the 1960s, care was largely relegated to mental hospitals that were located in the countryside, away from major centres of population. It was generally assumed that the majority of individuals in the custody of these large institutions had incurable, largely untreatable, conditions and would only rarely be re-integrated back into regular society. The eventual emptying of the mental hospitals in advanced industrial countries was the product of influential mental health advocacy movements as well as major shifts in mental health policy and psychiatric treatment.¹

As with most other advanced industrial countries, deinstitutionalization in Canada involved at least four distinct processes: (1) a decline in the use of dedicated psychiatric hospitals and the number of psychiatric hospital beds; (2) an increase in the number of mental health beds in acute care hospitals and community-based psychiatric hospitals; (3) an expansion in community-based outpatient services; and (4) the introduction of new psychopharmaceutical therapies.² There were also features that were more unique

1 For more comparative analyses (at least in terms of wealthy industrialized countries) of deinstitutionalization, see Simon Goodwin, *Comparative Mental Health Policy: From Institutionalization to Community Care* (London: Sage, 1997), and Mick Carpenter, "It's a Small World": Mental Health Policy under Welfare Capitalism since 1945," *Sociology of Health & Illness*, vol. 22, no. 5 (2000), pp. 602–620. On the American experience, see Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1990). Although there are provincial histories of deinstitutionalization, there is no single pan-Canadian history.

2 Patricia Sealy and Paul C. Whitehead, "Forty Years of Deinstitutionalization of Psychiatric Services in Canada: An Empirical Assessment," *Canadian Journal of Psychiatry*, vol. 49, no. 4 (April 2004), pp. 249–257. John A. Mills and Erika Dyck, "Trust Amply Recompensed: Psychological Research

to the Canadian experience. For one, deinstitutionalization coincided with the implementation of universal hospital insurance and the introduction of medical care insurance – popularly known as “medicare” – and the ultimate movement of psychiatrists from public sector employment to private clinics funded by the public purse.³ The other uniquely Canadian feature is the extent to which mental health policy is determined at the provincial rather than the national level of government. This is a consequence of a decentralized federation where, for constitutional reasons, the provinces have primary jurisdiction over health care. This means there have been significant differences among provinces in terms of the type and timing of mental health policy and programs, as well as the civil society movements – also highly provincialized – that have influenced the governments of these provinces. To take one example, Saskatchewan emptied its mental hospitals, and implemented the concept of community psychiatry, more rapidly than other provinces.⁴ As will be explored at length below, this was a consequence of two unique factors: 1) the ambitious social policy, including mental health reform, agenda of North America’s only social democratic government; and 2) the pressure exerted by a powerful civil society organization that combined considerable grassroots support with elite influence in the government itself.

The Co-operative Commonwealth Federation (CCF) – a party that combined high idealism, in the tradition of British-inspired Fabian socialism and North American social gospel, with a pragmatism born of grassroots populism and limited financial resources – was elected in Saskatchewan in 1944.⁵ The province was its first and only provincial beachhead until the 1970s, after the party worked out a formal affiliation with organized labour and changed its name to the New Democratic Party (NDP). Here, the party would hold government for two decades allowing it a unique opportunity to implement its extensive agenda of policy change, though always cognizant of its fiscal and social constraints, including the socially conservative attitudes of the general public in this largely rural population in the heartland of Canada.⁶

at Weyburn, Saskatchewan, 1957–1961,” *Journal of the History of the Behavioural Sciences*, vol. 44, no. 3 (Summer 2008), pp. 199–218. Andrew Scull, *Decarceration: Community Treatment and the Deviant: A Radical View* (Englewood Cliffs, NJ: Prentice Hall, 1977).

3 Gregory P. Marchildon, “The Policy History of Canadian Medicare,” *Canadian Bulletin of Medical History*, vol. 26, no. 2 (2009), pp. 247–260.

4 See Chris Dooley, “The End of the Asylum (Town): Community Responses to the Depopulation and Closure of the Saskatchewan Hospital, Weyburn,” *Histoire Sociale / Social History*, in this volume.

5 On the idealistic yet very pragmatic nature of the CCF in government in Saskatchewan, see A.W. Johnson, *Dream No Little Dreams: A Biography of the Douglas Government of Saskatchewan, 1944–1961* (Toronto: University of Toronto Press, 2004).

6 On the constraints imposed by conservative public attitudes, see Kathleen Kendall, “From Closed Ranks to Open Doors: Elaine and John Cummings’ Mental Health Education Experiment in 1950s Saskatchewan,” in this volume.

Tommy Douglas, in particular, was committed to a fundamental transformation of the funding, administration and delivery of health services as premier of the province (1944-61), as minister of public health (1944-49), and subsequently as the first leader of the national NDP (1961-72).⁷ Douglas's own knowledge and experience of the living conditions in mental hospitals, including his personal experience with the mental hospital in Weyburn, where he lived and worked as a Baptist minister and subsequently as a federally-elected politician during the 1930s, had a major influence on his thinking, and his zeal to reform mental health. Months after his provincial election victory in 1944, Douglas introduced a policy of "free" psychiatric care, three years before he spearheaded the introduction of universal hospital insurance.⁸

In its early years, the Douglas government was supported in its health reform efforts by the most organized voice of the mental health movement, the provincial wing of the Canadian Mental Health Association (CMHA). With its roots in a social movement dedicated to eliminating the stigma of mental illness and humanizing and improving treatment, the Saskatchewan Division of the Canadian Mental Health Association (SCMHA), to a greater extent than other provincial chapters of the CMHA, was a powerful "nexus for mobilizing resources and expressing grievances" in its formative years.⁹ The SCMHA's overall mission was to get the general public and the government to view and treat mental illness the same way as physical illness. From a policy perspective, this meant a government willing to devote the equivalent resources to mental health that it devoted to physical health at a time when considerably more dollars per capita were devoted to acute care in hospitals than for (what was almost entirely) custodial care in psychiatric hospitals.

The SCMHA was established in 1950 as the first provincial division of the national organization. Both the federal and provincial governments encouraged the CMHA to experiment with a provincial branch, and Saskatchewan was the preferred site because of the progress the province had already made in mental health policy. To assist in the start-up phase,

7 Thomas H. McLeod and Ian McLeod, *Tommy Douglas: The Road to Jerusalem* (Edmonton: Hurtig Publishers, 1987). Greg Marchildon, "The Douglas Legacy and the Future of Medicare" in Bruce Campbell and Greg Marchildon (eds), *Medicare: Facts, Myths, Problems and Promise* (Toronto: Lorimer, 2007), pp. 36-41.

8 This meant free psychiatric treatment during an individual's lifetime. After death, the province could claim \$3.50 a day for room and board from the individual's estate except where the estate had been passed on to any immediate family member residing in Saskatchewan. Dickinson, *The Two Psychiatries*, p. 223. Malcolm G Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes* (Montreal: McGill-Queen's University Press, 1987), chapter 2.

9 See Dominique Clément, "Generations and the Transformation of Social Movements in Postwar Canada," *Histoire Sociale / Social History*, vol. 42, no. 84 (November 2009), p. 363.

the SCMHA was provided an annual grant for three years from the federal government.¹⁰ The provincial government also provided financial assistance for five years.¹¹ Both governments wanted a social movement organization capable of developing “programs to increase public awareness of mental illness” and preparing “the population at large for the discharge of previously institutionalized people into the community.”¹² At least initially, the relationship between the CCF government and the SCMHA was so close that the organization was sometimes perceived as an agency of the government.¹³ The SCMHA was supportive of the government’s reform efforts, while Douglas and his cabinet members – all of whom were members of the organization – shared the SCMHA’s agenda of deinstitutionalization and its campaign to remove the stigma from mental illness.¹⁴

The SCMHA quickly grew to become into one of the most effective Canadian social advocacy groups of the 1950s. By mid-decade, the SCMHA had 20,000 members, nine branch offices, with a successful annual fundraising campaign that gave it financial autonomy from government, a freedom it used to push the Douglas government to deinstitutionalize even more rapidly.¹⁵ By 1960, at the very peak of its public influence, the SCMHA had 50,000 members and 15 branch offices in the province, and was in the midst of a protracted struggle with the provincial government on the direction of mental health.¹⁶ At the centre of what would ultimately lead to a deep rift, was the government’s inaction on a detailed blueprint for the construction of eight community-based psychiatric hospitals, a key element of what was known as the Saskatchewan Plan. Joined by prominent psychiatrists both inside and outside the government, the SCMHA became disenchanted with the Douglas government for making medicare its chief policy priority over the Saskatchewan Plan. Having already accomplished more than any other province in transforming mental health care, the CCF government in general was initially surprised and then angered at the SCMHA’s aggressive position, unleashing an internal fight that would weaken the government internally

10 John D. Griffiths, *In Search of Sanity: A Chronicle of the Canadian Mental Health Association, 1918–1988* (London, ON: Third Eye, 1989), p 158.

11 Saskatchewan Archives Board, Regina (hereafter SAB), Erb Papers, R-34, 172A1, letter, Erb To F.E.R. Badham (SCMHA President), January 14, 1960.

12 Chris Dooley, “The Politics of Deinstitutionalization: Federal Cost-sharing and the Transformation of Mental Health Care in Saskatchewan, unpublished presentation, September 2008, p. 5.

13 On the history of this close relationship, see Kendall, “From Closed Ranks to Open Doors.”

14 At least in 1951, every cabinet minister was a member of the CMHA: SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, Laycock to Douglas, February 9, 1951.

15 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), Canadian Mental Health Association, Saskatchewan Division, 6th Annual Report, March 1957.

16 John A. Mills, “Lessons from the Periphery: Psychiatry in Saskatchewan, Canada, 1944–68,” *History of Psychiatry*, vol. 18, no. 2 (2007), p. 183.

at the very time it needed as many allies as possible in order implement medicare against the wishes of organized medicine and its powerful allies.

Douglas Government's Early Support of Community-Based Mental Health

Douglas had been critical of the type of care offered in psychiatric hospitals long before he became premier of Saskatchewan. While serving as a Baptist minister in Weyburn, Saskatchewan, in the early 1930s, he concluded that the province's two "mental" hospitals were overcrowded "holding pens", primarily staffed by untrained workers. He studied a group of patients at the Weyburn mental hospital as part of his Master's thesis. While visiting the institution one late afternoon, Douglas was mistaken as a patient by an attendant who refused to release him until he could prove his identity, an experience he long remembered.¹⁷

Upon becoming Premier, Douglas appointed Dr. Clarence Hincks, the founder of the National Committee for Mental Hygiene – the organization out of which the CMHA would emerge in 1950 – to investigate the province's psychiatric hospitals. Hincks highlighted the problem of overcrowding – the Saskatchewan Hospital North Battleford (opened in 1914) had 1,716 patients in a facility meant for 1,174 patients, while the Saskatchewan Hospital Weyburn (opened in 1921) had 2,485 patients in a facility built for 1,040 patients. He recommended adopting a more community oriented system involving regionally-based outpatient clinics and psychiatric wards in all the general hospitals.¹⁸

While Douglas readily accepted Hincks' analysis and recommendation on overcrowding, he rejected Hincks' recommendation to forcibly sterilize mental defectives.¹⁹ In his Master's thesis (completed in 1933), Douglas studied a sample of the female population at the Weyburn hospital, and had then endorsed sterilization. However, his view on sterilization underwent a massive change in the years that followed as reflected in a "set of letters he wrote to concerned members of the public repudiating the use of sterilization."²⁰

Hincks' report also posed a dilemma.²¹ While he advised the provincial government to move towards a community-based system, Hincks also urged that a third psychiatric hospital be built as soon as possible to

17 Stuart Houston and Bill Waiser, *Tommy's Team: The People behind the Douglas Years* (Calgary: Fifth House, 2010), p. 118.

18 Harley D. Dickinson, *The Two Psychiatries: The Transformation of Psychiatric Work in Saskatchewan, 1905–1984* (Regina: Canadian Plains Research Center, 1989), pp. 77–80.

19 Houston and Waiser, *Tommy's Team*, p. 226.

20 John A. Mills, "Lessons from the Periphery: Psychiatry in Saskatchewan, Canada, 1944–68," *History of Psychiatry*, vol. 18, no. 2 (2007), p. 181.

21 Clarence M. Hincks, *Mental Hygiene Survey of Saskatchewan* (Regina: King's Printer, 1945). Unfortunately, there is nothing in Charles G. Roland's biography of Hincks concerning his work

alleviate the problem of overcrowding in the two existing provincial institutions. To help the government decide on the best way forward, Douglas recruited Dr. Donald Griffith (Griff) McKerracher from Ontario to occupy the new position of director of psychiatric services in the Department of Public Health in 1946.²² As Douglas explained to the members of the legislative assembly, McKerracher would spearhead the province's "ambitious mental hygiene [health] program" that would introduce outpatient clinics to "pick up cases in their early stages and provide early treatment" – a development Douglas considered even more important than improvements to treatment and care in existing and new psychiatric hospitals.²³

Heading a new division of mental health services within the Department of Public Health, McKerracher soon established one full-time (Regina) and three part-time (North Battleford, Weyburn, and Moose Jaw) outpatient mental health clinics connected to general and psychiatric facilities as a forerunner to a larger number of regional outpatient clinics.²⁴ At the same time, McKerracher's staff worked on improving the operations and facilities of the existing psychiatric hospitals, as well as on planning for a third hospital.²⁵ A psychiatric nursing program, the first of its type in North America, was introduced. As well, a training program for psychiatrists, the first one in Canada accepted by the Royal College of Physicians and Surgeons, was also developed in the province.²⁶

In 1950, the provincial *Mental Health Act* was amended to change the purpose of mental hospitals from custody to therapy. That same year,

in Saskatchewan: *Clarence Hincks: Mental Health Crusader* (Toronto: Hannah Institute and Dundurn Press, 1990).

22 Receiving his medical degree and subsequently his specialization in psychiatry at the University of Toronto, Griff McKerracher (1909–1970) had worked in various positions in the mental health system in Ontario before organizing psychiatric treatment for the Toronto military district and working as a specialist at a major neurological hospital in England during the Second World War. Houston and Waiser, *Tommy's Team*, pp. 117–118.

23 Douglas quoted in Colin M. Smith, "Necessity and Creativity: Innovations in Service Delivery in Saskatchewan Pre and Post War," text of unpublished speech delivered to the Saskatchewan Psychiatric Services Annual Clinical Conference, Regina, Oct. 16, 1980, obtained from CMHA Resource Centre, Regina.

24 D.G. McKerracher, "Community Psychiatric Developments in Saskatchewan," *Canadian Medical Association Journal*, vol. 59 (December 1948), pp. 546–548. The full-time clinics performed three functions: (1) providing consultation and diagnostic services on behalf of physicians and social agencies; (2) educating organizations and individuals on mental health; and (3) providing outpatient treatment. Part-time clinics were limited to providing the first two services. Dickinson, *The Two Psychiatries*, p. 140.

25 Implemented in 1947, the Saskatchewan Hospital Services Plan provided full coverage for patients in the psychiatric unit of a general hospital. According to Harley Dickinson (*The Two Psychiatries*, p. 74), it would take two more years before the Douglas government introduced universally free care in the province's two psychiatric hospitals.

26 Dickinson, *The Two Psychiatries*, pp. 110 and 140–144.

the CCF government reorganized the mental health division into the Psychiatric Services Branch (PSB) with McKerracher as director. Described by one scholar as a “semi-independent fiefdom,” the PSB would become one of the most powerful agencies in the Douglas government.²⁷ Although successive PSB directors were to report to the bureaucratic (deputy minister) and political (minister) heads of the Department of Public Health, they often bypassed these reporting relationships to deal directly with the premier. No branch in the Douglas government grew as fast. By the mid-1950s, the PSB had more than 1,200 employees, almost 60 of whom were medical staff, including 20 psychiatrists – to staff the two provincial mental hospitals, the policy and planning unit in Regina, and a psychiatric research unit in Saskatoon.²⁸ By 1964, the year the CCF government left office, the PSB had 2,140 staff members. This represented 17 per cent of the entire public service, and about 80 per cent of the Department of Public Health, the single largest department in the provincial government.

As the golden child of the government, the PSB’s budget climbed almost exponentially from 1950 until 1964.²⁹ However, the PSB was also a demanding child, insisting – often in concert with the SCMHA – that the government do more for mental health. As members of the SCMHA, PSB medical staff often assisted the organization in its advocacy efforts with government. Moreover, some PSB staff, particularly psychiatrists, viewed themselves more as medical professionals than as civil servants. By the mid-1950s, Douglas had become so frustrated by the PSB that he vented his dissatisfaction in a memorandum to Walter Erb, the provincial minister of public health from 1956 until 1961:

There is no Government activity which has had such a rapid increase in expenditure as the Psychiatric Branch. However, instead of telling the public how much has been done to improve conditions in mental institutions and in the treatment and care of mental patients, the whole aim of the psychiatric Branch seem to be to tell the public how little we have done in this regard. Consequently all the publicity from the Mental Health Associations groups has been critical rather than helpful. I lay the blame for this squarely upon some of our own employees who are apparently trying to blackmail the Government into complying with their proposals by trying to create a public demand which they think will force us into accepting their proposals. I am quite prepared to go as far as our finances will permit in extending psychiatric services but I do not propose to allow Government employees to create

27 Mills, “Lessons from the Periphery,” p. 191.

28 Mills, “Lessons from the Periphery,” p. 184.

29 Dickinson, *The Two Psychiatries*, p. 175.

appetites which cannot be satisfied and to encourage groups of laymen to criticize our program in order to satisfy their obsession for empire building.³⁰

The Saskatchewan Plan

The rift between the Douglas government and the SCMHA centred on the Saskatchewan Plan, a plan that was developed in the mid-1950s, but not implemented, and even then in a much altered form, until the 1960s. In 1953, the PSB was already discussing the feasibility of building seven or eight cottage-style psychiatric hospitals to serve every region of the province.³¹ The PSB would continue working on the details of the Saskatchewan Plan until it finally produced a comprehensive blueprint in 1955. The essence of the plan was to divide the province into eight mental health regions each with a psychiatric hospital with anywhere from 238 to 448 beds housed in cottage units. Each regional hospital would serve a population of roughly 73,000 people, and encompass a small enough geographic area that no patient would have to travel further than 130 kilometres to get to-and-from the hospital. As well, the hospitals would also provide a base for travelling clinic services.³² From the beginning, the SCMHA gave the Saskatchewan Plan its unqualified support, perhaps in part because its executive was so influenced by PSB psychiatrists.³³

In 1955, when Saskatchewan's first teaching hospital was opened beside the College of Medicine at the University of Saskatchewan, Griff McKerracher left the provincial government to become the founding department chair of psychiatry. His replacement as Director of the PSB was Dr. Sam Lawson (1902–1970). Like McKerracher, Lawson had qualified in medicine at the University of Toronto and specialized in psychiatry in Ontario. McKerracher had recruited Lawson as superintendent of the Weyburn psychiatric hospital in 1947, and then transferred him to become superintendent of the North Battleford facility a year later.³⁴

The Saskatchewan Plan had been largely a collective effort among PSB senior staff, including McKerracher, Abram Hoffer (Director of Research

30 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), memorandum, Douglas to Erb, January 31, 1957.

31 Canadian Mental Health Association, Saskatchewan Division, "Summary of the History of Psychiatric Services in Saskatchewan," unpublished manuscript dated Oct. 1981, p. 2.

32 Mills, "Lessons from the Periphery," p. 184.

33 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), Canadian Mental Health Association, Saskatchewan Division, Annual Report, March 1957. Lawson was Chair of the CMHA's Scientific Planning Committee. Griff McKerracher along with government-employed psychiatrists Abram Hoffer (Director of Research), Humphrey Osmond (Superintendent, Saskatchewan Hospital Weyburn), and M. Demay (PSB) as well as PSB psychologist Duncan Blewett.

34 See short biographies of both Lawson (pp. 87–92) and McKerracher (pp. 116–121) in Stuart Houston and Bill Waiser's *Tommy's Team*.

in Saskatoon), and Humphry Osmond (Superintendent of Saskatchewan Hospital Weyburn).³⁵ However, it was Lawson who would be most closely associated with the Saskatchewan Plan.³⁶ Though both he and Lawson were prominent members of the SCMHA, McKerracher consistently sought a balance in weighing what the SCMHA advocated and what the government could deliver, in part because he shared the government's health reform objectives and understood the fiscal constraints and competing priorities. In contrast, Lawson could not – or would not – separate his role as a civil servant from that of a mental health advocate. Unlike McKerracher, he was unwilling to revisit the Saskatchewan Plan and make adjustments to meet the needs of the government.

During his time as Director of the PSB, McKerracher had been willing to operate on two tracks simultaneously, one of which involved an expansion of outpatient mental health, and a second track that required continued investment in the existing psychiatric hospitals in order to improve inpatient services. Conversely, Lawson only operated on one track. He wanted the psychiatric hospitals closed and rapidly replaced with a series of smaller community mental hospitals, and he was dismissive of the concerns raised by members of cabinet and the government's senior officials responsible for planning and budgeting. Finally, preoccupied as he was with an innovative approach to psychiatric hospital care involving novel architectural designs, Lawson was simply less focused on outpatient mental health services than McKerracher though this too was an integral part of the process of deinstitutionalization.

Almost immediately after his appointment as PSB Director, Lawson pressed the minister of public health for approval of the Saskatchewan Plan, and thus to allow the PSB to immediately abandon plans to accommodate more than 1,100 new patients at Weyburn and North Battleford. Lawson argued that if the government refused to agree, the PSB would have to expand the existing psychiatric hospitals at a cost that would meet or exceed the cost of the eight new community-based psychiatric hospitals he was recommending.³⁷ Though the Minister of Health was attracted to the idea, he also realized that the cost of such a major program of construction might forestall an immediate decision from

35 On Hoffer and Osmond, see Erika Dyck, *Psychedelic Psychiatry: LSD from Clinic to Campus* (Baltimore: Johns Hopkins University Press, 2008).

36 Dickinson, *The Two Psychiatries*, p. 147. Hugh G. Lafave, Alex Stewart, and Frederic Grunberg, "Community Care of the Mentally Ill: Implementation of the Saskatchewan Plan," *Community Mental Health*, vol. 4, no. 1 (February 1968), pp. 37–38.

37 SAB, Erb Papers, R-34, 172G2, letter, Lawson to Thomas J. Bentley, June 1, 1955. Succeeding Tommy Douglas, Bentley held the post of Minister of Public Health from November 14, 1949, until July 27, 1956, when he was replaced by J. Walter Erb who, in turn, would hold the post until November 21, 1961: *Saskatchewan Executive and Legislative Directory, 1905–1970* (Regina and Saskatoon: Saskatchewan Archives Board, 1971), pp. 26–27.

cabinet.³⁸ In response to concerns about cost, Lawson simply asserted that the government would save money in the long-run, while the immediate cost would be little more than the money needed to refurbish the Weyburn and North Battleford hospitals. As well, Lawson noted that some European countries (Norway, Sweden, Denmark, the Netherlands and the United Kingdom) had already adopted similar policies, passing laws limiting the size of new mental hospitals to less than 500 beds.³⁹ From his new base at University Hospital in Saskatoon, McKerracher also lobbied the Minister of Health. While his description of what he called the “Saskatchewan Plan” was almost identical to Lawson’s version, he did not assume that the Saskatchewan Plan would cost less than the status quo. On the contrary, he claimed “this program will and should cost more” because (finally), “the mentally sick will receive the treatment that sick persons should.”⁴⁰

Cabinet refused to give Lawson and the PSB approval in principle. Instead, the government established a sub-committee to examine the potential costs and benefits of the Saskatchewan Plan. Lawson was infuriated because he thought cabinet was simply avoiding the difficult decision of decommissioning its old mental hospitals, and the sub-committee was its “polite” way of either delaying action or rejecting the proposal. Concluding that the committee was a waste of time, he resisted the Minister of Health’s suggestion that he appoint someone from the PSB to assist the committee on a full-time basis. Nonetheless, the PSB was forced to provide more details on the Saskatchewan Plan and its costs to the cabinet committee. Lawson took great offense at the extent to which the government’s central agency – the Economic Advisory and Planning Board and its secretary, economist Tommy Shoyama – questioned the estimates provided by the PSB.⁴¹

The expense of the plan, once tabulated in full, was shocking to the cabinet. The cost of building eight new regional psychiatric hospitals was estimated to be between \$13.2 million and \$18.8 million, while annual operating costs were estimated at \$11.4 million (fully double the \$5.7 million the government had budgeted to spend on all the psychiatric facilities in the province including its newly constructed home for the “mentally retarded” in Moose Jaw). The Saskatchewan Plan was impossible in the short-term and to even have a hope in the long-term, it would require federal assistance through the Government of Canada’s hospital construction grants. These grants could possibly pay for \$4.4 million of the construction but only if the architectural design met federally stipulated

38 SAB, Erb Papers, 172G2, letter, Bentley to Douglas, June 5, 1955.

39 SAB, Erb Papers, 172G2, letter with attachments, Lawson to Bentley, November 14, 1955.

40 SAB, Psychiatric Unit Papers, R-999, 42, letter, McKerracher to Bentley, December 2, 1955.

41 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), memorandum, Lawson to Erb, November 22, 1956.

hospital constructions standards, fire regulations, and building codes.⁴² Also, if the federal government was eventually able to secure sufficient agreement from the provinces to proceed, it might provide cost-sharing to the provinces for the operating costs of hospital care in a new national hospital insurance plan.

Unable to get the immediate support from government on his own for the Saskatchewan Plan, Lawson decided to use the SCMHA to pressure Douglas' cabinet. At the annual Regina branch meeting in January 1957, Lawson outlined the architectural plans prepared for the PSB for the eight new psychiatric hospitals in Regina, Saskatoon, Swift Current, Yorkton, Prince Albert, Melfort, Wadena, and Moosomin.⁴³ Although he explained that the plan's cost had not yet been approved by the provincial government, he raised hopes that action was imminent.

The television and newspaper coverage of the Regina SCMHA meeting focused on the SCMHA's criticism of the government for past inaction on the Saskatchewan Plan and its new found hope, conveyed by Lawson, that the government was finally about to implement the plan. According to Douglas, it was "completely irrelevant for Dr. Lawson to claim that he is merely outlining a plan which has been approved by the American Psychiatric Association. Dr. Lawson is an employee of the Saskatchewan Government and any plan which he outlines is assumed by the general public to represent the views of the Government." Moreover, "[w]hat Dr. Lawson and other members of the Psychiatric Services Branch are doing is to raise hopes which I see no prospect of the Government being able to satisfy. To speak of eight new hospitals with bed capacities ranging from 268 to 448 is to envisage a capital expenditure which the Government has never at any time contemplated."⁴⁴

In mid-March of 1957, on the heels of the provincial budget, the Executive Director of the SCMHA launched a second volley, criticizing the provincial government for not funding the Saskatchewan Plan. As a member of the SCMHA, Douglas immediately sent a letter to the SCMHA's President demanding to know "whether or not the views expressed in the press item" reflected the opinion and were authorized by "the executive of the Saskatchewan Division of the Canadian Mental Health Association." While he had "no desire to get into a controversy in the press with the officers of the Association," he nonetheless concluded

42 Dickinson, *The Two Psychiatries*, p. 154.

43 These plans, including preliminary sketches of the Y-shaped cottage units of the proposed hospitals that were prepared by Kiyoshi Izumi's Regina-based architectural firm, were published in the journal *Mental Hospitals* in March 1957 (pp. 27–31); SAB, Erb Papers, R-34, 172 G2. Also see Erika Dyck, "Kiyoshi Izumi and Mental Hospital Designs," *Annual Bulletin of the Institute for Economic and Cultural Studies* (2009), pp. 71–87.

44 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), memorandum, Douglas to Erb, January 31, 1957, attaching *Regina Leader-Post* article entitled "Mental hospital plan discussed" of January 29, 1957.

that “some of the statements which were made cannot be allowed to go unchallenged.”⁴⁵

The response to Douglas was sharp. The Executive Director’s views were indeed shared by the executive of the SCMHA (including Lawson as chair of the SCMHA’s scientific planning committee). After stating that the SCMHA was “very appreciative of all the Government has done and is doing” in terms of new outpatient clinics and psychiatric wards, the SCMHA President went on to blast Douglas’ government for its slow action on the Saskatchewan Plan:

We realize that the provision of adequate care of the mentally ill is a tremendous undertaking involving enormous cost; but we are sincerely advocating that a reasonable step towards more adequate care is the building of regional mental hospitals as quickly as possible. From the long range point of view, the hospital population with better treatment will decrease and, consequently, materially lessen the drain on public funds.

From the foregoing you will see that it is not the intention of this Association to belittle in any way the work which the Government has done. However, one of the aims of the Association is to carry on a vigorous education program so that the Saskatchewan public will realize that the care of the mentally ill should be comparable to the care given to people suffering from physical illnesses. We most emphatically believe that we must continually bring these matters to the attention of the public since in our democracy it is our belief that the work of the Government is the will of the people.

Throughout Canada and in the United States people are looking to Saskatchewan for leadership in the Mental Health field. What has been done is being recognized; but the fact remains that even with the progress which has been made in Saskatchewan, the amount of money spent on the care and treatment of the mentally ill is a small percentage of the amount spent to bring health to the physically ill.

I feel sure that you will understand our thinking in this connection. Should you be publicly commenting on Mr. Rohn’s press statement, I should be very happy to have you give this letter to the press.⁴⁶

To gauge how he should deal with the SCMHA, Douglas sought counsel from McKerracher who was also disturbed about the “misunderstandings” that had arisen between the government and the SCMHA. In McKerracher’s view, it “seemed unfortunate that the one Provincial

45 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, Douglas to Mrs. M.P. Toombs (President, SCMHA), March 15, 1957, with attachment of article entitled “Mental health aid criticized”, morning edition of the *Regina Leader-Post*, March 15, 1957.

46 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, N.M. Toombs (SCMHA President) to Douglas, March 18, 1957.

Government which has done the most for the mentally ill and the Provincial Association which has been so successful in arousing public support, should through unfortunate newspaper publicity be at loggerheads.⁴⁷ Douglas felt that the SCMHA should give the government credit for what he felt was the most ambitious and expensive psychiatric program in the country, but the SCMHA was about to do the opposite.⁴⁸

Just weeks after the exchange of letters, the president and executive director of the SCMHA followed up with an open letter to the press that expressed “grave concern about the [government’s] apparent disregard for the urgency of immediate action.” They insisted that while the CCF government had once had “the most progressive mental health program in Canada,” its current policy of “compromise solutions and half-measures” had allowed it to slip “from its leading position.” The official representatives of the SCMHA then took the Douglas government to task for “discriminating against the mentally ill by allocating disproportionate amounts of money for the care of the physically ill.” If only the government “accepted the recommendations of their advisors” to proceed with the Saskatchewan Plan, they claimed, the government would be spending not much more than \$750,000 it had just approved for an expansion and updating of the psychiatric hospital in North Battleford.⁴⁹

One of the striking features of the Douglas government, a reflection of its populist legacy and its linkage with progressive social movements in the province, was the regularity with which cabinet met with interest groups – particularly social movement organizations such as the SCMHA – a minimum of once a year in what were called “cabinet delegation days.”⁵⁰ For each of these meetings, the participating interest group would prepare a comprehensive position paper that would be circulated to cabinet members in advance of the meeting.⁵¹ These meetings usually served to improve or cement relations between the government and the social movement organizations, including the SCMHA, that shared at least some of the social policy objectives of the Douglas government. In many respects, these cabinet delegation days, and the relationships they fostered between the CCF and their natural allies in civil society, were

47 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, McKerracher to Douglas, March 29, 1957.

48 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, Douglas to McKerracher, April 8, 1957.

49 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), clipping entitled “Mental Health Needs Neglected (signed by Mrs. N.M. Toombs, President, and Mr. George Rohn, Executive Director, Canadian Mental Health Association), *Saskatoon Star-Phoenix*, April 13, 1957.

50 A.W. Johnson, *Dream No Little Dreams: A Biography of the Douglas Government of Saskatchewan, 1944–1961* (Toronto: University of Toronto Press, 2004), pp. 110–111.

51 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter with SCMHA brief, Lewis A. Henbury (Executive Director, SCMHA) to Douglas, September 27, 1957, and cabinet memorandum attaching SCMHA brief, H.S. Lee (Cabinet Secretary) to all ministers, September 30, 1957.

the support beams for the social democratic house that was built in Saskatchewan after 1944.

Before 1957, the SCMHA, in its annual cabinet delegation meetings, lauded the Douglas government's path breaking efforts in mental health, and accepted the government's argument that fiscal constraints and numerous other public policy priorities demanded patience in terms of implementation. However, in October 1957, the cabinet delegation meeting was a disaster for the Douglas government. The SCMHA's 12-page brief was blunt in its criticism of the CCF government for not implementing the Saskatchewan Plan despite the fact that the "idea of small regional community mental hospitals" had received "wide acclaim across the Dominion and other countries." The brief went on to say that the government of Ontario had "already accepted this plan in practice" and that it "would be regrettable if this idea, the 'brain child' of Saskatchewan, were to be effectively put into operation first by another province."⁵² The session was made even worse when the government chose the occasion to inform the SCMHA that it had decided to alter its approach to implementing the Saskatchewan Plan. Instead of building regional psychiatric hospitals, it would instead construct psychiatric units attached to existing general hospitals. Shocked – or at least feigning shock – the president of the SCMHA, M.P. Toombs, and her delegation, walked away from the meeting convinced that the provincial government had completely rejected the Saskatchewan Plan.⁵³ At the root of this confrontation were the provincial government's negotiations to obtain the federal government's support, in the form of shared-cost cash transfers, for its hospitalization program, as well as an agreement reached privately between Douglas and McKerracher months before.

Although the SCMHA accused the Douglas government of abandoning the Saskatchewan Plan in its cabinet delegation meeting in October 1957, the CCF government was simply trying to adjust the plan in order to make any proposed psychiatric facilities eligible for the federal hospital grants program. Federal cost sharing was the subject of a long meeting between Douglas and McKerracher months before. Sympathetic to the government's need for federal assistance, McKerracher suggested an idea: the proposed regional psychiatric hospitals could be built close enough to the general hospital that they would be "considered as an integral part of the general hospital," and thus eligible for the federal hospital construction grants, and perhaps even operating funds under the national hospital insurance program. Douglas concluded that the government could

52 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), submission (11 pp) to the Government of Saskatchewan by Canadian Mental Health Association, Saskatchewan Division, October 1957, resume and p. 4.

53 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, McKerracher to Douglas, October 10, 1957.

more easily afford two or three 50-bed units rather than the eight larger hospitals being recommended by Lawson and the PSB. McKerracher agreed on pragmatic grounds, suggesting that once the federal government's responsibility for the 50-bed units was established, these same units could be expanded to the size necessary to serve a designated region, as was originally proposed in the Saskatchewan Plan. On this point, Douglas disagreed with McKerracher, preferring the units be kept permanently small since there was a high risk that larger, separated facilities "would give these a stigma which General Hospital facilities would not have." McKerracher was not convinced of Douglas's argument but nonetheless accepted the point that obtaining federal cash was the key to any transition from the isolation of the old mental hospitals to a new community psychiatry model that would treat patients when necessary with the goal of reintegrating into society as soon as possible.⁵⁴

Lawson got wind of the conversation when he was asked to draw up new plans for 50-bed units attached to existing hospitals, and was infuriated by McKerracher's role in what he perceived as a gutting of the Saskatchewan Plan.⁵⁵ Although Lawson was told not to inform the SCMHA of this direction just in case any resulting publicity would encourage the federal Minister of Health to "change his rules in mid-stream", he was an executive officer of the organization, and it is hard to imagine Lawson did not complain to other members of the SCMHA about the government's new directions.⁵⁶ Moreover, it is clear that the SCMHA went into the cabinet delegation meeting ready to do battle with the government.

After the failed cabinet delegation meeting, Douglas wrote to the president of the SCMHA to explain the state of federal-provincial negotiations on universal hospital insurance. Parliament has just passed the *Hospital Insurance and Diagnostic Services Act* committing the federal government to cost-sharing universal hospital insurance in each province. The law stipulated that cost-sharing targeted acute care hospitals rather than institutions providing long-term chronic care including nursing homes and psychiatric hospitals. While the government's public position (echoing that of other provincial governments) was to try and convince the federal government to amend the legislation so that it would include cost-sharing for psychiatric hospitals, it was quietly seeking out the federal government's position on regional psychiatric hospitals, arguing that the proposed facilities would operate more like general hospitals,

54 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, McKerracher to Douglas, October 10, 1957.

55 In 1963, when the acting Deputy Minister of Health (Dr. Vince Matthews) accepted McKerracher's view that general practitioners should be more central in delivering mental health care, Lawson exploded, stating that "McKerracher's part in the delay in instituting the Saskatchewan Plan while we play with this inadequate nonsense is, to my mind, criminal." SAB, Psychiatric Research Centre Papers, R-999, 45a, memorandum, Lawson to V.L. Matthews, April 9, 1963, p. 1.

56 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, McKerracher to Douglas, October 10, 1957.

treating patients for a limited period and then releasing them back to the community. Although Douglas took pains to emphasize that the cabinet had not abandoned “the plan of constructing regional psychiatric units” to the SCMHA, he also made it clear that federal cost-sharing would be essential to funding the Saskatchewan Plan, and that his government was examining alternative ways of achieving the plan in order “to secure the maximum financial contribution possible” from Ottawa. “If regional psychiatric hospitals are to be excluded from the national hospital insurance plan,” Douglas stated, then the government would consider attaching psychiatric units to general hospitals. He also warned that the provincial government could not decide on its approach until the federal government was prepared to state its position on the question.⁵⁷

Complicating matters at the time was Sam Lawson’s increasingly testy relationship with the government he worked for. In almost continual conflict with the minister of public health and the premier, he complained about political interference in his management of the PSB. He complained to his colleagues in the Saskatchewan Psychiatric Association about Erb overriding his decision on the promotion of a psychiatric nurse. The Association then complained to Douglas, who responded: “if Dr. Lawson had a complaint regarding the actions of his Minister the proper thing for him to have done was to discuss this matter with me rather than to take his complaint to the Saskatchewan Psychiatric Association. It is somewhat unusual for a civil servant to be carrying on a controversy with his Minister through a third party especially when the third party cannot possibly be in possession of all the facts.”⁵⁸

Lawson’s direction of the North Battleford psychiatric hospital was also being questioned. Douglas had received a battery of allegations concerning abuse and intimidation in the workforce as well as the poor management and direction of the psychiatric hospital in North Battleford from one of his own backbenchers. The minister of public health ordered an investigation and the subsequent report was scathing in its assessment of Lawson’s ability as a senior administrator, both in his role as head of the PSB and in his former role as superintendent of North Battleford.⁵⁹ With its charges and counter-charges, the controversy over the North Battleford facility would go on for years. Although he was protected from being fired for insubordination because of his affiliation with, and influence within, the SCMHA, the North Battleford controversy

57 SAB, Douglas Papers, R-33.1, XIV 572 (14-26), letter, Douglas to M.P. Toombs, October 21, 1957.

58 SAB, Erb Papers, R-34, 013T, letter, Douglas to Colin M. Smith (Secretary Treasurer, Saskatchewan Psychiatric Association), September 9, 1957.

59 SAB, Douglas Papers, R-33.1, XIV 554 (14-8)d, memorandum on problems – North Battleford Hospital, R. Brown to Erb, November 25, 1958.

further damaged Lawson's already precarious standing with Douglas and Erb.⁶⁰

Both Lawson and the SCMHA showed relatively little interest in the federal-provincial negotiations over the implementation of national hospital insurance despite the fact that the final outcome of these proceedings would determine the fate of the original version of the Saskatchewan Plan. Earlier, the Saskatchewan government, joined by almost all other provincial governments, had argued that psychiatric hospitals should be included in federal cost-sharing, but the position was consistently (and publicly) rejected by successive federal administrations.⁶¹ At the same time, private instructions were given to provincial government negotiators to get smaller, regionally based psychiatric hospitals approved. After considering the nuanced provincial position on the redesigned version of the regional psychiatric hospitals, the federal health minister gave his final answer in August 1958. While the *Hospital Insurance and Diagnostic Services Act* contemplated "the recent development of psychiatric wards in general hospitals for the active treatment of acute phases of mental illness", the federal government would not fund any units separated in any way from a general hospital, even "relatively small mental hospitals in close relationships to general hospitals," because of the "specific exclusion of hospitals and institutions for the mentally ill" in the original law.⁶² From that point on, the Douglas government was hesitant to fund any psychiatric unit or facility that was not a psychiatric ward attached to a general hospital, and in the government's view, it was time to move past the Saskatchewan Plan.⁶³ Only a looming political battle could force the government to return to PSB's original vision.

60 SAB, Douglas Papers, R-33.1, XIV 554 (14-8)d, letters, F.B. Roth to Erb, March 25, 1959, Kramer to Douglas, March 31 1959, R. Brown to Erb, April 13, 1959, R. Brown to Douglas, October 24, 1960, Kramer to Douglas, December 22, 1960, Douglas to Erb, January 3, 1961. Chris Dooley arrived at the same conclusion in "The Politics of Deinstitutionalization."

61 SAB, Douglas Papers, R-33.1: XIV 572 (14-26), Erb to A.V. Svobads, August 1, 1957. SAB, Canadian Mental Health Association Papers, R-327, 1.61, clipping of *Regina Leader Post* article entitled "Federal Action Urged", January 11, 1963 in which it is stated that the Saskatchewan government continues to urge the federal government to deem psychiatric hospitals as eligible for cost-sharing.

62 SAB, Erb Papers, R-34, 015A, letter, Jay Waldo Monteith (Minister of Health and Welfare, Government of Canada) to Erb, August 22, 1958. Also see Dickinson, *The Two Psychiatries*, pp. 159–160.

63 SAB, Douglas Papers, XIV 554 (14-8), cabinet minute no. 9856, Lee to Douglas and members of cabinet, February 19, 1960. Although initially opposed to psychiatric wards replacing psychiatric hospitals, McKerracher said that, with the advent of psychotropic drug therapies, it could be made to work as long as general practitioners were providing primary care to patients in consultation with psychiatrists. Lawson was opposed entirely to the use of psychiatric wards, arguing that it would put the practice of mental health back a decade. See Dickinson, *The Two Psychiatries*, pp. 162–164.

Medicare and Conflict Within

In a 1959 by-election leading to the next provincial general election, Douglas announced his government's intention to introduce universal medical care insurance. Douglas had been promising medicare since his first provincial election campaign, and with the federal government now cost-sharing the hospital insurance program his government had established in 1947, the timing seemed perfect. The reaction was polarized – enthusiastic support from CCF Party supporters, organized labour as well as church and social action groups, but hostile opposition from organized medicine, the opposition parties, as well as business and professional groups. The election campaign of 1960 focused almost exclusively on this one issue, in part because of the vocal and well-funded opposition of the College of Physicians and Surgeons of Saskatchewan.⁶⁴

After the provincial election victory of 1960, his fifth since 1944, Douglas assumed that organized medicine in the province would accept the result. Instead, the doctors and their sympathetic allies in business and politics continued working together in a major effort to prevent the government from implementing medicare.⁶⁵ The SCMHA should have been one of the Douglas government's natural allies in the medicare battle. Instead, the government's awkward effort to begin implementing one dimension of the original Saskatchewan Plan only served to further alienate the SCMHA. As a consequence, the SCMHA became a strategic partner in the coalition opposing medicare.

Months before the 1960 election, a CCF backbencher announced with great fanfare that his Yorkton constituency would get a 150-bed psychiatric hospital, the first instalment of the Saskatchewan Plan.⁶⁶ The announcement sounded final, but in reality, the government was still in the process of reviewing three different levels of integration with the existing general hospital in Yorkton in order to qualify for shared-cost financing from the federal government – now a necessity given that the government's medicare proposal would have to be paid for without any federal assistance. In fact, the provincial department of Public Works redrew the plans to allocate more space per patient to meet the federal requirements for hospital construction grants.⁶⁷ In March 1960, the Yorkton facility was, in Douglas' own words, “squeezed into” the provincial budget, despite the

64 Johnson, *Dream No Little Dreams*, pp. 254–257.

65 Gregory P. Marchildon and Klaartje Schrijvers, “Physician Resistance and the Forging of Public Health Care: A Comparative Analysis of Doctors’ Strikes in Canada and Belgium in the 1960s,” *Medical History*, vol. 55, no. 2 (2011), pp. 203–222.

66 SAB, Erb Papers, R-34, 172G3, clipping from *Yorkton Enterprise* entitled “Mental Hospital At Once”, January 14, 1960, and clipping from *Regina Leader-Post* entitled “Mental Hospital Start in Yorkton”, January 14, 1960.

67 SAB, Douglas Papers, R-33.1, XIV 554 (14-8)a, cabinet memorandum (cabinet minute no. 9856), H.S. Lee to Douglas and Treasury Board ministers.

government still being without a guarantee of federal financing.⁶⁸ In fact, what the government had actually done was allocate only \$500,000 of the estimated \$1.1 to \$1.3 million needed for construction of the Yorkton facility, in the hope that a federal hospital construction grant would be forthcoming.⁶⁹ This was an uncharacteristic decision for a government with a long track record of fiscal probity. It is difficult not to conclude, as historian Chris Dooley speculates, that this decision was more about neutralizing “the mental health lobby in advance of an anticipated confrontation with physicians over Medicare,” than a sincere effort to implement the PSB’s original conception of the Saskatchewan Plan.⁷⁰ If this was the Douglas government’s intention, it soon backfired.

While the announcement prompted congratulations from many parts of the mental health lobby, including McKerracher in his personal capacity and the Saskatchewan Psychiatric Nurses Association in its corporate capacity, the SCMHA was relatively quiet in its support.⁷¹ One possible explanation for this is that the SCMHA was offended because its earlier application for a \$10,000 grant for the resocialization of psychiatric patients had been rejected in the same budget process that had approved the Yorkton psychiatric facility.⁷² The more powerful explanation is that the SCMHA executive no longer believed that the CCF government was committed to the Saskatchewan Plan and, while it might ultimately build the Yorkton facility, it would not carry out the rest of the plan as originally conceived by the PSB, and all of its discretionary funding would flow into medicare instead. Some SCMHA executive members asked the same question that the College of Physicians and Surgeons of Saskatchewan – the government’s chief opponent in the battle over medicare – was rhetorically posing to the public: why wasn’t the provincial government looking “after the needs of the mentally and chronically ill before undertaking a medical care insurance plan of such scope?”⁷³

68 SAB, Douglas Papers, R-33.1, XIV 554 (14-8)a, letter, Douglas to McKerracher, April 5, 1960.

69 SAB, Douglas Papers, R-33.1, XIV 554 (14-8)a, cabinet minute no. 9856 with attached treasury board minutes, February 16, 1960. SAB, Erb Papers, R-34, 172G3, Douglas to M.E. Yahnolnitsky (Secretary, Yorkton Branch of the SCMHA), January 13, 1961.

70 Dooley, “The Politics of Deinstitutionalization,” p. 9.

71 SAB, Douglas Papers, R-33.1, XIV 554 (14-8)a, McKerracher to Douglas, March 22, 1960. SAB, Erb Papers, R-34, 172G3, letter, Saskatchewan Psychiatric Nurses Association (Secretary-Treasurer) to Erb, March 14, 1960.

72 Erb gave two reasons for the government turning down the relatively modest \$10,000 request: 1) it would require overturning the policy of not providing financial assistance to established organizations (the SCMHA had received funding from the provincial government until 1956); and 2) if the money were granted “it would mean that some project under the Psychiatric Services Branch of my department would have to be reduced or abandoned.” SAB, Erb Papers, R-34, 172A1, letter, Erb to F.E.R. Badham (SCMHA President), January 14, 1960.

73 F.H. Kahan, *Brains and Bricks: The History of the Yorkton Psychiatric Centre* (Regina: White Cross Publications on behalf of the Saskatchewan Division, Canadian Mental Health Association, 1965), p. 177.

In early October 1960, the government suddenly announced that the weakening provincial economy and the deteriorating state of provincial revenues required that it postpone the Yorkton project for one year.⁷⁴ In a single stroke, the CCF government eliminated whatever goodwill it might have generated in the mental health community just months before. As might be expected, SCMHA members felt that the government was now showing its true colours.⁷⁵

Erb tried to control the damage by reassuring the SCMHA and other interested parties that the government would use the \$500,000 to construct the laundry, food, and other auxiliary service facilities that would be shared between the existing Yorkton municipal hospital and the proposed psychiatric hospital.⁷⁶ But by the end of 1960, the government halted construction work, having received no word from Ottawa as to whether the project had qualified for hospital construction grant. To reduce expectations, Douglas told the Yorkton Branch of the SCMHA that the future of the facility would be “entirely dependent on the availability of funds.”⁷⁷ This was followed by an announcement in the Throne Speech that construction of the Centre would be halted until funds were available, which prompted the SCMHA to demand what circumstances would be required for construction to continue. Moreover, if the Saskatchewan Plan was the priority the government claimed, why could it not delay one of its other capital projects and divert the money to the Yorkton Psychiatric Centre? The SCMHA went on to dismiss the government’s actions on mental health as merely “palliative.”⁷⁸

74 SAB, Erb Papers, R-34, 172G3, letter, Erb to F.E.R. Badham (SCMHA President) October 7, 1960.

It appears that the announcement occurred at approximately that same time as cabinet delegation day for the SCMHA (October 4, 1960): SAB, Douglas Papers, R-33.1, XIV 572 (14-26), cabinet memorandum (cabinet minute no. 226), H.S. Lee to cabinet members delegated to meet with SCMHA, September 12, 1960, with handwritten note on minute indicating that Erb had arranged for the date and time, and that while T.C. Douglas “not on committee he may wish to sit in.”

75 SAB, Erb Papers, R-34, 172G3, letter, F.B. Roth (Deputy Minister of Public Health) to Erb, October 19, 1960.

76 SAB, Erb Papers, R-34, 172G3, letter, F.E.R. Badham to Erb, November 2, 1960.

77 SAB, Erb Papers, R-34, 172G3, letter, Douglas to M.E. Yaholnitsky (Secretary, Yorkton Branch, SCMHA), January 13, 1961. In addition (letter, Clarke, President, SCMHA Yorkton Branch, to Erb, February 21, 1961) the SCMHA claimed that the government’s decision has done irreparable harm to its annual fundraising campaign, one of the objectives of which was to help fund the move to community-based mental health. In 1959, the SCMHA had raised \$73,078 in its provincial campaign, 90 percent of the organization’s operating revenues: SAB, Canadian Mental Health Association Papers, R-327, 1.61, SCMHA Ninth Annual Report, 1960, financial statement for the year ended December 31, 1959.

78 SAB, Erb Papers, R-34, 172G3, letter, Badham (President, SCMHA) to Douglas, February 24, 1961. In response, Douglas argued that his government’s per capita expenditures on mental health were the highest in Canada. He assured the SCHMA that the Saskatchewan Plan was among his government’s highest priorities and that he intended to proceed with the construction of the Yorkton Psychiatric Centre and other community-based psychiatric hospitals “at the earliest date

As this exchange occurred, the Advisory Planning Committee on Medicare (the Thompson Committee) was simultaneously conducting hearings on the government's proposed medicare scheme. In the highly publicized hearings, the SCMHA joined with the College of Physicians and Surgeons and the business lobbies in criticizing the government, arguing that it should implement the Saskatchewan Plan before launching a new insurance program.⁷⁹ The College gave support to the SCMHA and the Saskatchewan Plan, arguing that the "treatment of the mentally ill in our institutions constitutes a travesty of a basic public responsibility." Likewise, the Saskatoon Board of Trade, claimed that the government should implement the Saskatchewan Plan before it considered medicare, because the "mentally ill, who comprise a significant percentage of all those requiring medical care in Saskatchewan, are receiving very unfair consideration."⁸⁰

Throughout 1961, the SCMHA criticized the government for halting construction on the Yorkton project. On August 4, 1961, Douglas was acclaimed leader of the national NDP and announced that he would resign as premier of Saskatchewan in November. Douglas wanted medicare implemented before he left provincial politics, but organized medicine used every delay tactic possible to prevent the Thompson Committee from submitting a final report. By September 1961, the Thompson Committee had only submitted a majority interim report, delaying the introduction of the medicare bill for first reading in the legislature to October.⁸¹ That same month, Abram Hoffer, the PSB's research director, had begun a major letter writing campaign orchestrated by the SCMHA to pressure the government to resume constructing the Yorkton psychiatric facility. As the SCMHA saw it, "if the Government did not build the centre before medicare, it would never build it" because of the "great sums of money" that would "be involved in the scheme."⁸²

Lawson not only supported the SCMHA's campaign against the government, he was suspected by many of feeding information to opposition members who were taking full advantage of the anti-medicare coalition to attack the government on its medicare bill.⁸³ In October, as the SCMHA launched its letter writing campaign, Lawson spoke openly in

possible, consistent with" its "financial resources and other responsibilities (Douglas to Badham, March 1, 1961)."

79 Kahan, *Brains and Bricks*, pp. 117–119.

80 Selections from briefs quoted in Kahan, *Brains and Bricks*, p. 119.

81 Johnson, *Dream No Little Dreams*, pp. 267–269.

82 Kahan, *Brains and Bricks*, p. 131.

83 SAB, Douglas Papers, R-33.1, XIV 554 (14-8)c, letter, A. Hoffer to Douglas, March 16, 1961. Hoffer defended Lawson but he strongly supported Lawson in his Saskatchewan Plan campaign against the government.

a meeting of the College of Physicians and Surgeons, publicly accusing the CCF government of “duplicity and immorality” for the manner in which it had dealt with the Saskatchewan Plan explaining that “[a]fter six years of effort and frustration there has not been any acceptance by the government of the plan nor has even one unit been constructed.” He then stated that politicians “have an entirely different sense of values from what we [physicians] have” and, suggesting that medicare was little more than a cheap political gambit, “[t]o them the vote is all important.”⁸⁴ When these statements were reported in the newspaper the next day, Erb told Douglas that Lawson had “gone beyond all limits of conduct that can be tolerated” and that he would fire him at the conclusion of the current session of the legislature.⁸⁵

Immediately after Douglas departed, his successor Woodrow Lloyd shuffled his cabinet. William G. Davies was appointed minister of public health while Erb was made minister of public works, a demotion. For some time, Erb had been viewed as a weak minister, and Lloyd wanted a stronger politician at the helm while the government implemented medicare against the strenuous objection of the doctors and the other powerful members of the anti-medicare coalition.⁸⁶ Lawson was not fired, presumably because of the government’s desire not to further damage its deteriorating relationship with the SCMHA, and its single-minded focus on the battle with the College of Physicians and Surgeons of Saskatchewan that ultimately culminated in a 23-day doctors’ strike in July 1962.⁸⁷

The Lloyd government was prepared to go further to neutralize the SCMHA in the medicare battle. On March 5, 1962, Davies announced in the legislature that construction on the Yorkton Psychiatric Centre would recommence. In addition, the government would also work with the SCMHA in building a psychiatric research centre in Saskatoon, news that would also please Hoffer and the PBS. At the same time, the health minister took the opportunity to vigorously defend the government’s record in mental health and attack the “rather irresponsible statements made about the [government’s] mental health program” in the past. The government paid for the construction of the Yorkton Psychiatric Centre as a winter works project so work did not begin until the end of the year. Built at a cost of \$2.5 million, almost double the PSB’s original estimate, the Centre was finally opened in October 1963.⁸⁸

84 Lawson quoted in Dickinson, *The Two Psychiatries*, p. 168.

85 SAB, Erb Papers, R-34, 110A, memorandum, Erb to Douglas, October 25, 1961. “Psychiatrist Hits Govt. Indifference,” *Regina Leader-Post*, October 21, 1961.

86 Johnson, *Dream No Little Dreams*, p. 272.

87 Robin F. Badgley and Samuel Wolfe, *Doctors’ Strike: Medical Care and Conflict in Saskatchewan*. Toronto: Macmillan, 1967.

88 Kahan, *Brains and Bricks*, pp. 134–135.

Epilogue and Conclusion

In 1964, the CCF government that had been in power for twenty years was defeated. The new Liberal government under premier Ross Thatcher continued the PSB's policy of deinstitutionalization, and actually accelerated the emptying of the two mental hospitals in an effort to save money. In shifting the locus of care from the mental hospitals to community care, the Thatcher government also continued with a very modified version of the Saskatchewan Plan – so modified, that it bore little resemblance to the original PSB plan though the label continued to be used by Lawson's successors.⁸⁹ The SCMHA lost much of its influence as well as its membership in the 1960s, largely because of its difficulty in accepting the new version of the Saskatchewan Plan.

Lawson remained PSB director until his retirement in 1965. According to psychiatric historian John Mills, Lawson's rigidity in terms of his particular vision of community psychiatry combined with the "obduracy" of the SCMHA, contributed to the failure of the original plan, and the decline of the influence of the SCMHA in the 1960s.⁹⁰ The Lawson-SCMHA dream of a publicly-delivered system of hospitals and outpatient clinics, staffed by publicly-employed PSB psychiatrists, nurses, and social workers, was never achieved. In its place, private practitioners – both family doctors and psychiatrists – working in private clinics, provided the bulk of primary mental health care and treatment, while psychiatric wards in general hospitals provided acute care, and patients suffering from chronic mental conditions were still sent to the psychiatric hospital North Battleford (the Weyburn hospital was closed in 1971) if their conditions could not be managed through drug therapy and regular contact with a family physician and consulting psychiatrist. Ultimately, it was the "private practice, public payment" policy of medicare that facilitated this approach to mental health service delivery, with psychiatrists leaving the employ of government bodies such as the PSB of the department of the public health to establish private practices with governments paying patient bills through medicare.⁹¹

The Saskatchewan Plan as originally conceived by the PSB assumed a world without medicare, one in which psychiatrists would remain in the employ of government, and provide inpatient psychiatric services in eight regional psychiatric hospitals, and use these hospitals as the base

89 Lafave, Stewart, and Grunberg, "Community Care of the Mentally Ill." Barbara L. Moss-Herjanic and Marijan Herjanic, "Community Psychiatry in Action," *Canadian Medical Association Journal*, vol. 97 (August 1967), pp. 328–331.

90 Mills, "Lessons from the Periphery," p. 192.

91 C. David Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911–1966* (Montreal: McGill-Queen's University Press, 1986). See Dickinson, *The Two Psychiatries*, pp. 209–213 on private sector psychiatry, and pp. 232–236 on the growth of psychiatric services provided by fee-for-service general practitioners and specialist psychiatrists.

to provide outpatient services. Even before medicare was implemented in Saskatchewan, however, this original vision was being altered by the government because of the policy regime insisted upon by the Government of Canada through its hospital grants and in its introduction of cost-sharing for a national system of universal hospital insurance. Self-standing psychiatric hospitals were not eligible for cost-sharing but psychiatric wards in general hospitals were, largely based on a distinction between chronic care – which was perceived, falsely, as the predominant concern of even the new psychiatric hospitals proposed by the PSB – and acute care in general hospitals. Although lethal to the Saskatchewan Plan as originally conceived, even within this policy regime (as recognized by Griff McKerracher), it was more than possible to shift from old-style psychiatric care to a more community-based system of mental health care, something that the CCF government commenced and a subsequent Liberal government achieved.

Finally, as sociologist Harley Dickinson surmises, there is a strange parallelism between the asylum movement of the nineteenth and early twentieth century and the community mental health movement of the postwar era. At their essence, both were based more on ideological claims or beliefs than on hard evidence. The asylum movement asserted as a self-evident truth the therapeutic quality of rural settings, segregated from the complications, confusion, and noise of regular urban life.⁹² Vigorously attacking the isolation of the asylums and mental hospitals, the community mental health movement asserted in its place the community, “an almost mystical entity, exposure to which was thought to cure mental illness.”⁹³

92 Oliver Sacks, “The Lost Virtues of the Asylum,” *The New York Review of Books*, September 24, 2009, pp. 50–53.

93 Dickinson, *The Two Psychiatries*, pp. 149–150.