

Mental Health Matters, Then and Now

The organizational meeting of a dedicated mental health movement in Nova Scotia occurred in Halifax on 4 June 1908. Spearheaded by female community activists, it brought together members of the Local Council of Women and an array of prominent clergy, jurists, business owners, physicians, and academics. While we do not know if anyone in the hall that night was affected by a mental illness either personally or through a family member, some of the attendees certainly understood the problem of disabilities since their deliberations occurred in the School for the Blind, a residential institution on Morris Street (later a portion of University Avenue). Because the major focus of the meeting was on how to control “feeble-minded” persons, inmates languishing in nineteenth-century mental asylums were not of immediate concern to the pioneers of the movement.

If we fast forward to the 2007 annual meeting of the Halifax-Dartmouth branch of the Canadian Mental Health Association (CMHA), we can identify quite a different audience in its crowded clubroom in the Bloomfield Centre on Agricola Street. Congregated were mental health workers, particularly those with jobs in the community, board members, including mental health “consumers” (a commonly used term to describe people living with mental illness), and consumers who relied on the services available through metro’s CMHA social programs such as the Sharing and Caring social club, the Among Friends social club, and the Building Bridges program. Signs of mental illness — the need to smoke, restlessness, a dishevelled appearance — might be apparent to the experienced observer. Meeting chair Robert Carter, a lawyer by profession, deplored the lack of core funding from government and the failure of the provincial Department of Health and the local district health authority, Capital Health, to agree on which of them was responsible for supporting the work of the long-standing Halifax-area voluntary organization. Featured speaker Roy Muise, branch volunteer, consumer, peer specialist (trained to help fellow consumers), and director of the Consumer Initiative Centre, told the meeting about the crisis in the community. His message about the lack of resources for mental health services (only 3.6 percent of Nova Scotia’s health budget is spent on mental health) was underscored by a recital of the familiar facts: we have a one in five chance of having a mental

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illness; 90 percent of people who commit suicide have a diagnosed mental illness; the World Health Organization predicts that by 2020 depression will be the number two illness.

This book attempts to make the connection between those beginnings in 1908 and the present in a movement that evolved from well-intentioned citizens presuming to act on behalf of people with mental illness to one in which consumers exert a strong voice on their own behalf. Because serious mental illness can often be controlled but seldom cured, there are no miraculous discoveries or stunning success stories with which to embellish this narrative. Indeed, since modern treatments have always been controversial, well-meaning professionals and administrators have received more than their share of vilification by the public, consumers, and their own peers. And as Nova Scotia is only one setting for a movement that is also national and international in scope, its story is not unique. The province was however the first in Canada to organize in support of mental health and for that reason this case study is central to the historical record. Moreover, in the middle decades of the twentieth century, Nova Scotia was seen to be a Canadian leader in community mental health. Now local members of the movement regard the province as the most backward jurisdiction in its support of mental health initiatives. For purposes of this discussion “movement” refers mainly to public, community-inspired attempts to promote mental health and prevent and treat mental illness. However the members involved have included people from all walks of life: lay and professional, non-governmental and governmental, healthy and ill, paid and voluntary.

It is possible that the reader is learning about the Canadian Mental Health Association for the first time although the organization frequently responds publicly to issues that have attracted or need attention and publicizes facts about the nature of mental illness. In Canada it is one of the oldest health charities with a public education agenda, second only to the Anti-Tuberculosis League, an antecedent to the Lung Association. It was the only voluntary organization in the field of mental health for almost half a century. Its earliest offshoot, in the 1950s, was the Canadian Association for the Mentally Retarded, now known as the Canadian Association for Community Living (CACL), which began in Nova Scotia as the Association for the Help of Mentally Retarded Children. In the 1980s the Schizophrenia Society came onstream in Nova Scotia and, like the CACL, was family, particularly parent, driven. Now there are national organizations, some with provincial chapters, to promote awareness of and support for people (and their families) with such mental conditions as Alzheimer's, Tourette's, autism, and mood disorders. In terms of financial contributions by the public, in 1959 the CMHA in Nova Scotia (including its branches) had the highest per capita support from United Appeal funds of all the CMHA Divisions (and

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their branches) in Canada. In 1965 its fundraising throughout the province was surpassed only by provincial chapters of the Red Cross Society and Cancer Society.

Today it is quite a different story. Like other health charities, the CMHA has gradually lost some of its authority as the leader in the mental health and illness field during the last fifty years with the establishment of disease-specific groups. This development raises the question of the continuing role of a general mental health organization, a question that has never been more pertinent than it is now at the beginning of the twenty-first century. Earlier in the decade the Nova Scotia Division of CMHA collapsed for a couple of years and had to be resuscitated with the help of the National organization. More recently the National itself has undergone decline and revival. At the branch level in Nova Scotia local organizations have come and gone, sometimes reinventing themselves more than once. None of these features is unique to this particular non-governmental organization. Organizations have to change with the times or they lose their relevance. Social movements produce breakaway interests that sometimes replace the parent. Ultimately, for those interested in preventing serious mental illness, securing improved facilities and supports for the mentally ill, and encouraging a humane and sympathetic attitude towards people living with mental illness, it is the ends not the means that count. And for a century, the CMHA (including its precursor organizations) has constituted a large portion of the means.

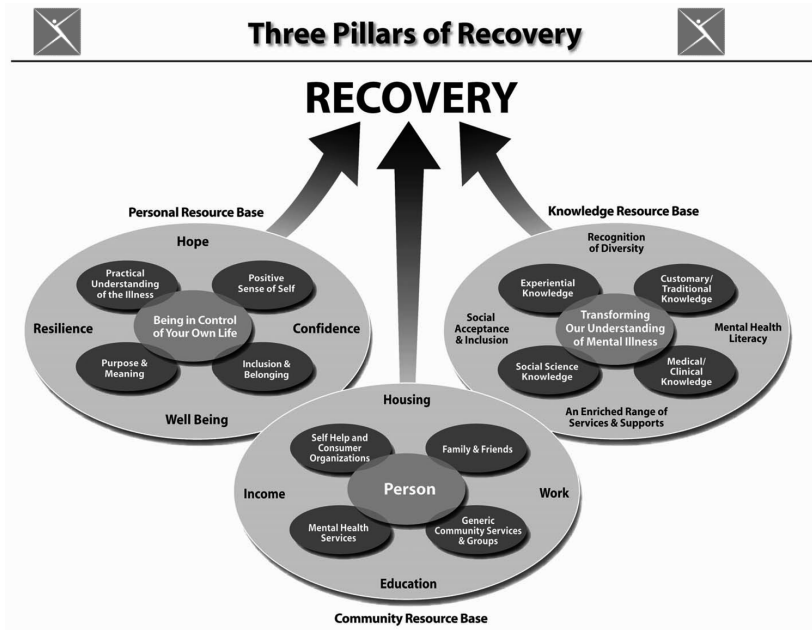
Funding has of course always been a critical requirement. The organization began and continued for many years as volunteer-run, but by the 1950s paid staff was needed to undertake the myriad of responsibilities that defined the CMHA as an active, energetic presence in the community. Subsequently, programming at both the divisional and branch levels required more staff. Unfortunately, financial support for programs, surveys, and staff could never be taken for granted. Indeed, it is no exaggeration to say that financial problems have continually plagued the organization. For many years the province contributed virtually nothing to the CMHA while expecting the Division and its branches to run public education programs, mount workshops for various professions, support community mental health centres, provide volunteers to visit the mental health institutions, and establish community-based programs for the post-mentally ill. Membership in the federated charity organization — called successively Community Chest, United Appeal, and United Way (UW) — helped for many years but Division policies, particularly financial relations with the branches and ultimately the Division's status as a provincial rather than a community organization, meant the UW was not always a good fit. The lack of federal money for mental health after dedicated post-war grants ceased meant that access to cost-shared dollars and project grants was limited. Going after project funding — federal, provincial and

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private — has consumed a disproportionately large amount of energy. The lack of support for the CMHA has resulted in the sacrifice of much talent in the field of mental health.

Amidst the perennial quest for funds, public education, social policy, and progressive reform constitute key goals of the mental health movement. Many of these goals have been enshrined in pamphlets, reports, surveys, and brochures. As part of a national organization since the 1950s, the CMHA in Nova Scotia has been profoundly influenced by policy documents produced at the National level. *More for the Mind* in 1963 and *A Framework for Support* in 1984 reflect the shift in thinking that occurred at all levels of the CMHA in the past half century. *More for the Mind* is subtitled *A Study of Psychiatric Services in Canada* and is just that. It addresses the nature of desired services, who should deliver them, and where and how future decisions in the system should be made. Its five major recommendations were that psychiatric and general medical services should be integrated; that mental health services should be regionalized by means of smaller, more widespread facilities; that administration should be decentralized through the appointment of local community boards to run hospitals and clinics; that continuity of care should be the guiding approach to treatment; and that the multiplicity of existing services across many disciplines and agencies should be rationalized. What made it controversial even at a time when service delivery was a central theme in the mental health movement was its medical emphasis. The CMHA's National Scientific Planning Council, which wrote it, consisted solely of psychiatrists; other professions were merely consulted. Its stance was anti-government; the evolving national health system engendered anxiety in the medical profession. It appeared to be inflexible when it came to planning — the right way was the medical model of care. One of the most vocal critics of *More for the Mind* was Clyde S. Marshall, a physician and the first director of Nova Scotia's Mental Health Services division (MHS) of the provincial DOH. His preference for a multi-disciplinary approach to the treatment of mental illness over a strictly medical one was encouraged not only by the U.S. report *Action for Mental Health*, written by a cross-section of mental health professionals, but by his genuine respect for the other mental health professions. He had also married a clinical psychologist, Frances Marshall, who was active as an educator in the mental health field. To a certain extent this CMHA study would be superseded by the report of the federal Royal Commission on Health Services (Hall Commission), which was published the next year and included mental health in the broad sweep of its analysis.

More for the Mind was never updated, in marked contrast to *A Framework for Support*, which was revised in 1993 and in 2004. The *Framework*, written by mental health professionals, bureaucrats, and paid CMHA staff, quite consciously relegated the mental health treatment system to the sidelines and



Three Pillars of Recovery from the CMHA's *A Framework for Support*, 3rd edition, 2004

focused instead on how policies affected the individual. While *Mind* had specific recommendations relating to a range of mental health ages and conditions in addition to chronic psychiatric cases — children, old people, addicts, criminals, workers, and mental retardates — the *Framework* “focuses specifically on issues faced by people with serious mental illness” in order to ensure that they “live fulfilling lives in the community.”¹ *Mind* was concerned about de-hospitalization and continuity of care, *Framework* promotes partnerships in the community, an expanded definition of knowledge, and respect for the personal experiences of the mental health consumer. While a focus on community is central to both policy documents, in the older one community represented a top-down approach defined by professional experts and lay leaders, whereas in the more recent one the community includes consumers and their families. *Mind* was concerned with treatment, *Framework* promotes recovery.

Critical Interactions: Government, Professions, Consumers

In order to set the scene for an examination of the major phases of the mental health movement as represented by the CMHA and its antecedents, this chapter introduces three major sets of relationships: the organization

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and the government, the organization and mental health workers, and the organization and people with mental illness.

The state has always played a central role in mental health. Probably only the public health movement has been more government-directed, and mental health was part of that wider public health concern. The best-known historical illustration of the state's approach to dealing with mental illness was the "discovery of the asylum," which resulted in Nova Scotia and other jurisdictions building residential refuges for people deemed to require segregation from society and virtual imprisonment, often for life, in what were supposed to be healthy, sympathetic surroundings. Nova Scotia followed an existing Anglo-American pattern of asylum-based treatment and poor-house-based long-term care. Built 150 years ago, a central facility, Mount Hope Asylum, aimed at cure through the contemporary moral treatment. In addition, by the end of the nineteenth century, municipally owned and managed institutions for the warehousing of chronic, incurable cases were dotted across the province. Many individuals were transferred from the provincial Mount Hope Asylum (later the Nova Scotia Hospital) to the municipal institutions as hopeless cases. Other troubled people, then as now, ended up in correctional institutions.

Given the well-established tradition of government involvement in mental health, the mental health movement from its beginnings constituted a pressure group to lobby government for reform. Since 1908 the CMHA has gone through a variety of relationships with the provincial government, which has remained the major source of health policy and health funding in Nova Scotia. The other levels of government were by no means unimportant but in matters of health, including mental health, the federal government was always constitutionally limited to working through the provincial bureaucracy, and the participation of municipalities (and now district health authorities) in mental health issues — which was considerable — was loosely governed by provincial legislation. The support of some municipal politicians for the mental health movement after the Second World War was crucial, but their influence tended to be local rather than provincial. Prominent among them was Abbie J. Lane in Halifax, a city councillor, member of the National CMHA board and honorary president of the Halifax branch, whose concern for the mentally ill resulted in the posthumous attachment of her name to the city's new mental hospital in 1971. Two outspoken Halifax county councillors who exposed the lack of public accountability in mental hospitals were Eileen Stubbs (member of the Dartmouth branch) and Percy Baker. In the late 1950s, Stubbs was outraged that the province's main psychiatric facility, the Nova Scotia Hospital (NSH), operated without a lay board. So concerned was Baker about hospital care that he eventually became, in 1971, the administrator of a mental hospital — the Halifax County Hospital — though

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lacking formal training and previous experience in the area. Outside the metropolitan area, Eric Balcom (mayor of Wolfville 1952–56) and Victor Cardoza (mayor of Digby 1959–61) were legendary among local politicians for their staunch support of the mental health movement. Both of them also became members of the Legislative Assembly (Balcom representing Kings North 1956–60; Cardoza, Digby County 1953–56, 1960–63). They both served as president of their local CMHA branch and of the provincial Division of the CMHA. As an opposition Liberal, Balcom called on the government in 1957 to establish more mental health clinics and reform municipal mental hospitals. Also a Liberal, Cardoza pushed in 1961 for free drugs for patients of mental health clinics.

Public policy pertaining to mentally ill persons was informed by provincial legislation and its ancillary regulations, by standards developed by the Department of Health beginning in the 1950s for hospitals, in the 1960s for clinics, and in the 1980s for decentralized psychiatric services, and by guidelines regarding the use of federal funds. Until the late 1970s two statutes set out the rules governing the NSH on the one hand and municipal mental hospitals on the other. Since all care was hospital-based until the 1960s, the only other relevant legislation was the Incompetent Persons Act, dating from the establishment of Nova Scotia as a colony, when it was called the Lunacy Act. Some modernization of the legislation occurred in 1965 and 1966, still in the form of separate acts for the municipal and provincial hospitals. They were consolidated in the Hospitals Act, which took effect in 1979. In 2007 the controversial Involuntary Psychiatric Treatment Act came into force to broaden the grounds for involuntary admission and introduce community treatment orders. The CMHA was always at the forefront in criticizing outdated legislation and advocating less coercive approaches to the hospitalization of people with mental illness. It also joined other groups, including the professions and the DOH, in deploring the failure of the federal government to include mental hospitals in the Hospital Insurance and Diagnostic Services Act. On the other hand, one of the likely effects of the federal hospital act — elimination of mental hospital beds and integration of psychiatry into general hospitals — was considered a desirable goal.

Mental health never had a leading politician as its champion in Nova Scotia as Alberta had in Premier Peter Lougheed in the 1970s, Ontario had in Minister of Health Larry Grossman in the early 1980s, and Canada had in Paul Martin Sr as Minister of National Health and Welfare after the Second World War. Despite having two physician-premiers in recent years, both of whom had experience as health care activists at the community level, Nova Scotians in the mental health movement have struggled, largely unsuccessfully, to keep the plight of the mentally ill on the political agenda. Andrew Crook, the first executive director of the Nova Scotia Division, vividly remembers

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that the CMHA did not even get a thank-you from Premier Robert Stanfield (1956–67) when he was informed that hospital volunteers recruited by the Association in one year in the 1960s devoted 100,000 hours of their time to befriending and assisting mentally ill patients, thereby providing the government with a substantial saving in staff costs. The tendency of government to take the contribution of volunteers for granted can be discerned in the hospital insurance commission's assumption in 1968 that the CMHA and hospital auxiliaries would cover the cost of clothes, eyeglasses, and dentures for patients in psychiatric hospitals if they could not do so themselves. From Crook's perspective the one progressive health minister in Nova Scotia between the 1950s and 1980s was D. Scott MacNutt (1970–74), who finally increased the government's pusillanimous \$500 annual grant to the CMHA to an initial \$7000. MacNutt understood the aims of the movement; both he and his wife had been active members of the Dartmouth branch.

Although mental illness has usually been treated like the poor cousin of physical illness, it has not been ignored in government studies. In fact it has been studied to death. The province has commissioned a long series of "blueprints" for the provision of health services beginning with the McIntosh Report in 1935, funded by the Rockefeller Foundation. Mental health services received separate attention in reports ranging from the *Mental Hygiene Survey of the Province of Nova Scotia* in 1920 by Clarence Hincks and his colleagues at the Canadian National Committee for Mental Hygiene to the Bland-Dufton report, *Mental Health: A Time for Action*, in 2000. Until F. Ralph Townsend, the second director of Mental Health Services for the province, produced the 1972 *Brief on Psychiatric Community Mental Health Services*, the studies, including the reports of two provincial royal commissions, tended to be critiques of municipal mental hospitals. Those committees or commissions that solicited briefs or held public hearings always received suggestions from the provincial CMHA. In addition, the Division often approached the government with its own agenda of urgent concerns. The CMHA at all levels also responded to federal studies, especially the Hall Commission in the early 1960s and the Kirby Senate Committee's *Out of the Shadows at Last* forty years later.

In Nova Scotia, the relationship between the movement and the government, especially the health authorities can be characterized in broad strokes. For almost forty years (1908–46) the movement acted as the conscience of the government when it came to mental health matters, although it took a long time to achieve anything significant in the way of new approaches or expanded services. With no minister of health until 1930, contact with the premier and senior civil servants like public health officers was established through letters, petitions, and specially arranged meetings. A well-advertised public meeting, which included invitations to key government officials, served as the equivalent to a modern press conference and like a press conference

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usually resulted in the sort of newspaper coverage few elected officials could afford to ignore.

For the next forty years, beginning with the creation of the MHS division of the provincial DOH in 1947, the mental health organization (the Nova Scotia Society for Mental Hygiene or NSSMH until 1956 and then CMHA Nova Scotia Division) served as a partner of government in the major reform and modernization of mental health care. As Andrew Crook suggested in 1955, “the government will never be able to meet all the problems of the mentally ill.”² With Clyde Marshall in charge of MHS in the DOH and active in the CMHA (he was also one of the province’s representatives on the National board after affiliation and became an ex-officio member of the Nova Scotia board of directors in 1955), a regular dialogue occurred which by 1956 consisted of frequent reports by Marshall to the board and periodic representations by the board to the minister of health, often at Marshall’s request, usually to ask for more funding for mental health. In the mid-1950s the CMHA was represented on a short-lived DOH advisory committee on the expenditure of the federal-provincial mental health grant. Board members were extremely critical of the under-expenditure of the grant in its early years.

Although the CMHA was always nipping at Marshall’s heels to secure improvements in services, as a civil servant Marshall had to contend with his political masters, men who seldom gave mental health top priority. The major emphasis in the negotiations in the 1950s and early 1960s was on the establishment of competitive salary scales for mental health professionals because good personnel were essential for the development of effective care. Plans for a crucial meeting with the minister of health concerning this issue in 1959 revealed differences of opinion within the membership of the organization itself. Samuel Prince, the doyen of the CMHA in Nova Scotia with twenty-six years’ experience as president of the Nova Scotia Society for Mental Hygiene, suggested that a moderate approach with government was likely to be more effective than the abrasive stand advocated by members comprising the Scientific Planning Committee (SPC), the CMHA’s major standing committee. Internal DOH correspondence indicates that Marshall’s concern about salary levels was greater than his public exchanges with the CMHA would suggest, pre-dating the board’s complaints about his failure to spend all the federal money. Although at the meeting the SPC’s views were conveyed only orally, this still strengthened Marshall’s hand.

For its support of the DOH’s Mental Health Services division, the CMHA was given a voice in a number of areas. In 1963, for example, when the province was attempting to reform municipal mental hospitals, CMHA branches were invited to suggest nominees for boards of these hospitals. Not surprisingly, given the close relationship between the two, public perceptions

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of CMHA-government relations were often confused. Crook suggested in 1962 that some people thought he was an employee of the DOH. To some extent the explanation for the confusion lies in the shared mission. Twelve years into his three-decade term as the Division's executive director in 1966, Crook wrote "Our ideas, and those of the Department of Health, have not always coincided with regard to means, but the harmony we enjoy today is indicative of the common aim to improve the lot of the mentally ill and develop better facilities for diagnosis, treatment, rehabilitation and prevention."³

As the CMHA witnessed the intensification of government bureaucratic involvement after the mid-1960s, including provincial financial support for municipal mental hospitals and participation in federally mandated medical insurance to provide for physicians' salaries, it also became aware of the unwillingness of government to cover all patient-related and aftercare concerns of mentally ill persons and provide for their human rights in a timely fashion. The DOH more or less washed its hands of responsibility for post-hospital accommodation for people in recovery, leaving the matter to the welfare department (identified in this book as DOCS, which recognizes its current name, Department of Community Services), thus requiring the CMHA to negotiate that aspect of its concerns with another government department. In 1964 Crook supported the promotion of a community residence program under the welfare authorities out of necessity rather than choice. Municipal welfare departments also assumed responsibility for securing facilities for discharged patients, which led to their interaction with the CMHA at the branch level. Nonetheless the DOH continued to see the CMHA as an active presence in the province's services. In his 1972 plan for the reorganization of the delivery of psychiatric services, Townsend, a long-time ally of the CMHA, assigned the organization three specific roles. They centred on arranging programs in the community, educating the public, and providing volunteer help where needed. As a result of its clearly defined participation in the mental health system, the CMHA was always called to the table for discussions. In June 1978, for example, the CMHA was included in the senior staff meeting of MHS along with the mental health civil servants in Halifax and representatives of all the mental health facilities across the province and the directors of the health organizations to which they belonged. This was quite a different relationship from that between the Ontario CMHA and the government of Ontario at that time, as described by Harvey G. Simmons in *Unbalanced: Mental Health Policy in Ontario, 1930–1989*.

The agonizing pace at which mental health legislation was reformed, with the minister of health admitting that it was not a government priority, graphically underscored the political powerlessness of the mentally ill and their supporters. Yet as Townsend suggested to the deputy minister of health

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in 1982, anger and frustration voiced by Crook and others did not mean “that the Mental Health/Canada and Nova Scotia are not going to keep pushing for more and more services, which is indeed their role and function.”⁴ On his retirement and the appointment of Douglas Archibald as his successor in 1983, Townsend confided to Nova Scotia Division president Donald Burgoyne that: “One of the factors in the Department choosing Archibald to replace me is his sensitivity to the need for community involvement in the development of mental health services, as well as his commitment to Mental Health/Nova Scotia over the years he has been in practice.”⁵ Archibald had indeed been a member of the CMHA board of directors in the 1970s.

When Douglas Crossman became executive director of the Division in 1985, he did not want to continue the cosy relations between the CMHA and the MHS division. He preferred a more formal relationship and refused to be drawn into off-the-record meetings with Archibald, who remained mental health administrator until his untimely death in 1989. Indeed the CMHA turned away from the bureaucrats and focused instead on the politicians, including the leaders of the opposition parties, and on lobbying government instead of partnering with the DOH’s mental health experts. This approach was not uncontroversial, especially in 1986, when Alexa McDonough, leader of the provincial New Democratic Party, was invited to be the keynote speaker at the Division’s annual general meeting. Concern was expressed that the CMHA must both be and appear to be politically neutral. Although the organization became more activist and outspoken in its criticism of government in the 1980s, it continued to be consulted in government circles as Nova Scotia moved towards regionalization of health services. The CMHA was represented on the Liberal government’s “Blueprint Committee” of the early 1990s, which resulted in the creation of four regional health boards (1994–2001). But by then the CMHA was only one of several stakeholders being accorded this courtesy; it was no longer seen as the sole lay voice of the mental health movement. From the CMHA’s perspective government no longer meant primarily the Department of Health. More and more from the 1970s on the mental health movement got drawn into DOH and DOCS wars, usually not as a combatant but as a victim. With the emphasis on the reform of forensic mental health services in the 1980s and 1990s, the justice authorities became another player with which to contend.

The movement’s relations with mental health professionals similarly changed over time. For many years, people in the emergent mental health professions in health, education, and child welfare were members and allies of the organization. They often acted as leaders on key issues and initiatives. Eliza P. Brison, a vice president between the 1930s and the 1950s, was involved in all three professional areas in a period before the specialization that accompanied expansion and modernization. Robert O. Jones, the first

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president of the NSSMH as the Nova Scotia Division after its amalgamation with the CMHA, was also the province's leading psychiatric educator. He believed, as did others after the Second World War, that it was important to foster a lay movement to support the efforts of mental health professionals when it came to lobbying for a share of health care dollars. While after Jones' presidency psychiatrists and the other professionals drew back considerably from actually running the organization, they remained a crucial resource for the movement through the SPC (renamed Professional Advisory Committee in the 1970s), which originally served to some extent as a bargaining agent with government for improving salaries and benefits for mental health workers. In the 1950s the board also felt that the SPC should plan the program of the CMHA by virtue of its members' superior knowledge of mental illness.

Like the MHS division of the Department of Health, the professionals wanted to use the CMHA to achieve their own ends and could be merciless in their criticism of its actions or its failure to act. In 1961, for example, R.O. Jones expressed dissatisfaction to National CMHA director J.D. Griffin about the rate of progress in advancing the mental health cause. He feared that the provincial executive director was dependent on directives from the National office and complained that "he seems to me to be falling into the great carcinoma which eats at the spirits of Nova Scotians, that is, never doing anything until Ontarians tell them to do it."⁶ From the perspective of some psychiatrists the CMHA was occasionally too bent on reform. Jones, for example, found the CMHA's support for early release of psychotic patients from hospital a cause for concern. He displayed a neo-eugenicist outlook and provoked the strong disagreement of the Division's president in 1968 when he suggested that schizophrenic women of child-bearing age should be segregated in order to prevent them from breeding. Other psychiatrists expressed concern about CMHA education efforts, especially the expense and time involved in public meetings and television programs, which seemed to achieve little for the movement and often did more harm than good. On the other hand, in 1975 psychiatrists at the Nova Scotia Hospital identified the CMHA as a "must" in any community-based mental health program, noting that: "It is committed to the concept of community mental health. Its volunteers and its permanent professional staff are of high quality and well-motivated."⁷ Furthermore, the multi-disciplinary Association of Mental Health Staffs of Nova Scotia and the Nova Scotia Association of Health Organizations considered the CMHA to be their organizational partner for promoting mental health in the province. As a former psychiatric social worker employed in a clinical setting, Andrew Crook remained committed to working with mental health professionals. In 1983 the Division advised branches to establish their own professional advisory committees to facilitate cooperation between the organization and the professionals. The membership

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campaign that got underway in 1985 targeted all psychiatrists and psychologists in the province.

Beginning in the late 1980s the CMHA sometimes found itself at odds with its members in the mental health professions and in particular with psychiatrists. The executive director of the day, Douglas Crossman, perceived a contradiction between advocating for the rights of consumers on one hand and maintaining a close working relationship with physicians on the other. How, he argued, could the Association speak on behalf of consumers when some of the reforms it promoted required changes to established practice in the “formal system?” The bond between the organization and the professionals weakened and criticism on both sides was not uncommon. The organization tended to write off the psychiatrists for being too conservative when disagreements over strategies arose. From the perspective of the psychiatric profession, support for the CMHA raised the likelihood of conflicts of interest, something that mental health professionals in government service had already identified as applying to them. As Arlene Goodwin, the psychiatric nursing consultant in the DOH, averred in 1983: “I have always been reluctant to sit on Mental Health/Nova Scotia’s committees, I do not want to line up against my employer, which I can see happening.”⁸ The exodus of mental health clinicians from the Nova Scotia Division board went hand in hand with the abolition of the Professional Advisory Committee as a separate entity in 1987, when it was amalgamated with the newer Public Policy Committee.

At the same time a cadre of different professionals came along during Crossman’s years as executive director to take the place of people in the clinical fields of mental health. This small group consisted in part of full-time academics, who had far more flexibility for participation than physicians when it came to freedom of expression and possible conflict of interest. The academic most involved was Dalhousie nursing professor Jean Hughes, whose teaching of psychiatric nursing stressed social policy not clinical practice. She embraced the mental health movement with a passion that continued through two terms as president of the Nova Scotia Division, many years on the National board and effective cooperation not only with Crossman but also with his successors. Another academic who welcomed the opportunity to advise the board on the basis of his legal expertise and teaching experience in mental health law at Dalhousie University was Archibald Kaiser, a steadfast supporter of the weak and oppressed including mental health consumers. They joined psychologist Leonard Denton, a long-time critic of the medical model of psychiatric care, whose participation in the CMHA spanned four decades. Fortunately, the breach between the Division and the psychiatric profession never jeopardized the good working relationships between psychiatrists and the branches. In the years since Crossman left the CMHA in 1997, the Division has tried to restore relations with the clinical

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community. Between 1998 and 2000 Celeste Gotell initiated meetings with staff at the Nova Scotia Hospital. More recently Carol Tooton has cultivated contacts with clinically based programs and the Division board again includes a prominent, well-regarded psychiatrist.

As the voice of the physicians and other mental health clinicians in the movement faded in the 1980s, that of the people who were at the receiving end of mental health services increased. The title of this book, emphasizing a progression from protecting to respecting, via friendship, attempts to capture that evolving relationship. Until the Second World War, the emphasis within the movement was not only on protecting people with mental disorders and defects but also on protecting society against both the afflicted and their afflictions. Prevention in the first half of the twentieth century had strong overtones of social engineering and was part of the eugenics movement. It took a long time for many ostensibly intelligent people to realize that there were other reasons than genetically determined “feeble-mindedness” for the birth of mentally challenged children, the creation of juvenile delinquents, criminals and prostitutes, and the poverty of poor families. If there were people within the Nova Scotia movement in this period coping with mental illness they kept it largely to themselves.

The second phase of the mental health movement took a far more humane approach to people troubled by mental problems. Part of the explanation for this shift relates to the popularization of environmental factors in mental illness, which promoted a positive and optimistic approach to mental health care. To some extent the new focus on befriending and encouraging people incarcerated in mental institutions or undergoing the difficult transition back to society through rehabilitation was fostered by a greater appreciation of stress experienced by most people at some point in their lives. The “worried well” and the psychotically ill could be regarded as the extremes in a continuum of mental conditions that appeared in most families, rich and poor, obscure and famous. The mentally ill could include one’s sibling or parent or child. The statistics, which have been amazingly consistent for half a century, suggest that between a fifth and a quarter of the population is likely to experience some form of mental illness in their lifetime. Thus, while conditions in the outside world might have contributed to a person’s problem, they might also, since they could be manipulated and improved, be a part of the solution. As one mental hospital medical officer commented in 1958, “in many cases the best medicine that could be prescribed was a visit from someone interested in the patient.”⁹ Dartmouth’s Mental Health Association volunteers at the Halifax County Hospital in 1959 were “bringing the outside inside.”¹⁰ In the same year a Nova Scotia Hospital social worker referred to volunteer “companionship” and a psychiatrist talked about the “friendship and cheer the volunteer brings.”¹¹ When Marshall unlocked the first wards at

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the Nova Scotia Hospital in 1958, he stressed that the more freedom patients experienced, especially through contact with ordinary citizens, the greater their chances of recovery. So many of the 2,161 mental hospital patients in 1960 were completely without friends that it was still common for the bodies of the deceased to be shipped to the Dalhousie University medical school for dissection without any form of permission, as the law allowed. In Cape Breton in 1961 the CMHA was trying to find “adoptive” relatives for some 150 patients in the Cape Breton Hospital who had no contact with family members. That branch’s director of volunteers suggested that it was “the therapy of personal interest that can arouse the will to improve.”¹²

It is not surprising therefore that the Division feared it would be perceived as hypocritical when the board let its first assistant director go in 1962 after two years on the job because of his inability as a mentally ill person to perform his duties. As board member R.O. Jones suggested, the assistant was being “released” because “his services were not satisfactory although this was nevertheless related to his illness.”¹³ The unfortunate man committed suicide ten years later. In a sense his life and death symbolize the intractable problems of mental instability that even the CMHA was poorly equipped to handle, although by the 1980s it was embracing the opportunity to try.

While there was no active recruitment of people with mental illness for either employment or volunteer service in the CMHA in the 1960s, interest in involving family members and friends was expressed. In 1962, for example, past president of the Division Laurence S. Mushkat of Yarmouth asked for ideas on how to attract people for service on his branch executive. In response Donald F. Campbell, his successor as president, pointed out that in his home branch of Antigonish they were finding that relatives of patients of the community mental health centre were taking an interest in the organization and providing a source of board members. In 1969, the Halifax branch urged education programs for those most intimately connected with the mentally ill in order to attract them as members.

The third phase of the mental health movement overlaps with the self-help movement in which people with mental health problems have been encouraged to become involved in the policies that pertain to their illnesses. By the 1970s branches began to reach out not so much to family and friends but to the people known to be mentally ill. In the period marked by the depopulation of the mental hospitals, more and more people with experience of mental illness and the treatments available in the province came into contact with the wider public and entered the workforce. A combination of discharge from hospital either to the community or to homes for special care for the disabled and elderly, adult residential centres, and rehabilitation centres meant that the number of patients in dedicated mental institutions in Nova Scotia declined from 2,702 (all conditions, including about 1,500

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long-term mentally ill) in 1959 to less than a hundred severe and persistent mentally ill cases in 1982. The CMHA was deeply involved in the reintegration of former patients into society. Self-help was recognized by the CMHA as a desirable feature of recovery from mental illness long before it became more widely accepted and formalized. In 1959, for example, Halifax psychiatrist and CMHA stalwart Robert Weil suggested that there should be a way ex-patients could talk problems over with other ex-patients. Although not much happened along these lines until the 1980s, a long-established approach, Recovery Inc., begun in the United States in the late 1930s, made its appearance in Nova Scotia in the 1970s. Several chapters of Recovery Inc. were sponsored by CMHA branches.

The inclusion of “first voices” in the CMHA has not been without its problems, but it is based on a model of allies showing respect for those going through the experience of mental illness and feeling the need to help shape their own recovery. In 1991 the Division followed a national initiative when the annual general meeting passed a resolution directing the Association to involve consumers in all its activities at all levels. The Consumer Participation Committee (CPC) was established in the Nova Scotia Division in 1993 and a consumer, Jerry Henderson, became president of the divisional board in 1998. Anticipating these developments, one of the first projects developed by Douglas Crossman was the Self-Help Connection (SHC), which began in 1987 with federal funding as an organization to promote self-help among mental health consumers. The SHC later expanded to include other categories of organizations whose members could benefit from networking and training.

The Language of Mental Illness

It is probably no exaggeration to say that in every generation since public care for the mentally compromised began, the definition of what constitutes mental illness has changed. “Madness,” “insanity,” and “lunacy” still predominated as descriptors in the nineteenth century, but by the Victorian age nervous diseases (neurasthenia) had also entered the lexicon of complaints. By the early twentieth century distinction was being made between a “mental defect,” as a result of which the afflicted person appeared to be of diminished intelligence, and “mental disease,” in which a poor grasp of reality was the dominant symptom. Out of the First World War came the first real recognition of “shell shock,” a condition that more recently garnered the term “post-traumatic stress disorder.” Stress and anxiety were also classified as problems arising out of major alterations of life experience such as death of a loved one or adjustment to marriage or job loss. In the latter half of the twentieth century, the gradual increase in life expectancy focused attention on the dementias of old age. Addictions also became classified as mental illness.

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Since the mid-twentieth century the development of the mental health professions has been accompanied by an explosion in diagnostic designations. Moreover, popular usages pertaining to mental disorders have tended to be superseded by “expert” terminology. Beginning in 1952, the American Psychiatric Association published the *Diagnostic and Statistical Manual of Mental Disorders*, known in the trade as the DSM, which categorized the types of mental illness. This controversial handbook has been characterized by inconsistencies and cultural biases during its successive editions, but most remarkable is the exponential growth in the number of the categories it describes. From a hundred pages in the first edition, the fourth edition runs to 943 pages. In a reference to the DSM in his popular history of mental illness, respected medical historian Roy Porter concluded: “More people seem to be diagnosed as suffering from more disorders than ever: is that progress?”¹⁴ Those who are concerned with severe and persistent mental illness (SPMI), for example the CMHA, wonder about the effect of the plethora of mental conditions, particularly those experienced by the worried well, on public perceptions and political purse strings. Richard Drewry, an Alberta Division CMHA president in the 1990s with a particular interest in people with chronic conditions such as schizophrenia and bipolar depression, “feared that the increasingly broad categories of mental illnesses would minimize the public’s perception of the devastating nature of the more serious diseases.”¹⁵

Because of changes in therapies and attitudes toward mental illness, many words and phrases that were common currency in the past now grate on the ear. As a work of history this study reports these terms as they were used in their day. They are needed to document popular usage over the course of a century, and their inclusion does not signify our approval of demeaning or prejudicial descriptors. In the 1950s members of the CMHA cautioned against the careless use of such terms as “crazy people, nuts or lunatics.”¹⁶ But mental health professionals themselves found vernacular terminology useful. Noel Murphy, the first psychiatrist at the mental health clinic headquartered in Antigonish, introduced himself to the public in 1960 as “the new headshrinker.”¹⁷ Outdated terms also have to be acknowledged because they appear in official titles of organizations, institutions, and provincial statutes. For example, there is no escaping the first name adopted by the movement — the League for the Protection of the Feeble-Minded — or the words in the title of the municipal hospital statute until 1954, which referred to “local asylums for harmless insane,”¹⁸ or the use of “retarded” in the former name of the CACL, or the inclusion still of the terms “lunatic” and “insane” in the Incompetent Persons Act.¹⁹ Other terminology requires some explanation because it is archaic. For many years the organization was known as a “mental hygiene” society. In 1923 Frederick E. Lawlor, superintendent of the Nova Scotia Hospital, defined mental hygiene as “mental sanitation, both

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of the environment and of the person” embracing “the mental and moral atmosphere into which the young are born, in which they grow up, and in which the adult has to live, and it seeks to keep this atmosphere clean and wholesome.”²⁰ The term public hygiene preceded public health in much the same way.

Today people with mental illness disagree among themselves about the preferred terminology to describe their relationship to their condition and health care professionals. Their families and care-givers describe them in an institutional setting as patients or residents; in the community in the early years of de-hospitalization they were called ex-psychiatric patients or the post-mentally ill. The term “client” was used by the 1970s and 1980s. Being in recovery, a description used quite early by Andrew Crook, resonated with many. Later “survivor” and “user” could also be found. Now the most popular term is “consumer,” although it is by no means universally approved by those with mental conditions or their supporters.

The Legacy of Stigma

Part of the problem with any terminology is that it has a labelling effect, and many people with mental illnesses not only do not want to be labelled; some of them do not perceive that they even have a serious problem. Convincing people, ill or well, that mental illness should be considered a disease, like tuberculosis or diabetes, has been a continuous struggle. Some of the problem relates to the locus of treatment, which was largely segregated. Most psychiatrists supported integrating the treatment of mental illness into the services of the general hospitals, but even there consideration turned on whether or not a psychiatric unit was appropriate. In *Canada's Mental Health* in 1966, some ten years after university-based psychiatrists in Halifax applauded the establishment of a psychiatric unit at the Victoria General Hospital, Eric Cleveland, the director of the Fundy Mental Health Centre in Wolfville, suggested on the basis of his experience that non-disruptive mental patients could be more appropriately integrated into general medical wards.

The mental health movement has been around a long time. Over the course of its existence, public education efforts have aimed at reducing the stigma associated with mental illness. That education has taken a variety of forms. In the mid-twentieth century, the opening of mental hospitals to visits by volunteers prompted R. Murray MacKay, superintendent of the Nova Scotia Hospital, to interpret their activities as a way of “assisting in educating the public and in freeing them from fear of mental illness.”²¹ Fifty years later it matters not how many times CMHA literature, health research by clinicians and social scientists, and official national statistics parade the figures confirming the extent of mental illness, it still conveys an aura of shame, suspicion, and futility. This study of one province's experience of the mental

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health movement appears as the federal government's new Mental Health Commission, chaired by Nova Scotian Michael Kirby, turns its attention to the continuing thorny issue of stigma.

Notes

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